Communities Shaping a Vision for America's 21st Century Health and Healthcare

Phase II Progress

YOUR *choice*
YOUR *health*

ACKNOWLEDGEMENTS

The concept for "Communities Shaping a Vision for America's 21st Century Health & Healthcare" was based on our experience and longstanding belief that many practical solutions to contemporary health care issues can be found in communities across America. Community leaders clearly understand the need to carefully define a problem, and then work collaboratively to identify potential solutions.

The success of the first phase of the leadership effort, completed in the Fall of 2003, was enormously gratifying. As we moved into the second phase and began to work with each community to organize and advance ideas, the potential benefits to be realized from the initiative grew. We suddenly recognized the broad application of this incredible network of leaders to health care policy, demonstrations and pilot projects, and as a motivating force in enticing other communities to be a part of the movement.

Our continuing gratitude goes to Dr. Rex Cowdry, who championed the initial concept within the White House and enabled us to engage the Washington, DC community. His conviction that community ideas could help our nation overcome some of the challenges Washington has struggled with for years proved to be quite accurate.

We thank the American Cancer Society, the American Hospital Association, the American Medical Group Association, and the American Psychological Association for their confidence and leadership in advancing this practical grass roots approach to public policy, through financial sponsorship of phase two.

We also want to express our appreciation to the National Association of Chain Drug Stores and its Foundation for underwriting the technology work of the Advanced Strategy Center (ASC) for the "Community Leaders' Blueprint for American Health Care Policy," which is described in this report. The ASL technology enabled us to harness the collective wisdom of scores of community and national thought leaders, tackle many complex public policy issues and drive the discussion to closure. As this publication goes to press, plans are being made to release the Blueprint in a congressional briefing. The recommendations will serve as the foundation for our policy work through 2005 and into 2006.

To augment the Blueprint, we commissioned a National Study on Consumer Health Values, through Harris Interactive, in December 2004. The results of the survey, which will also be released shortly, support many of the recommendations which are outlined in the Blueprint, and reaffirm the importance of listening to and learning from community voices. We are grateful to Definity Health for underwriting this work.

As you will see throughout the pages that follow, this report is rich with keen insights and visionary ideas from leaders in Albuquerque, NM; Chicago, IL; Fort Lauderdale, FL; Hanover, NH; Muncie, IN; Jackson, MS; Portland, OR; Raleigh-Durham, NC; Salt Lake City, UT; San Diego, CA; San Antonio, TX, Spokane, WA; and other communities.

We are indebted to the hundreds of individuals throughout these communities who expressed their belief that this endeavor has merit and is long overdue. They told us they felt proud and honored to be part of an effort that demonstrates Washington leaders care about their views.

For more information on Wye River Group on Healthcare or the Foundation for American Health Care Leadership, please see our website, www.wrgh.org, or contact us.

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EXECUTIVE SUMMARY

In this update report we are pleased to describe the progress made through the community leadership initiative, “Communities Shaping a Vision for America’s 21st Century Health and Healthcare,” which Wye River Group on Healthcare (WRGH) and its supporters launched in July 2002.

A report on phase one was published in the fall of 2003. Phase II extended from September, 2003 through the fall of 2004. Several "spin off" initiatives that have developed as a result of this work are also described in this report.

During phase I, WRGH successfully identified and recruited in each community a representative cross-section of public and private stakeholders with detailed knowledge of health and health care in their community. With the active participation of the Bush administration and democratic leadership, we then held a series of Healthcare Leadership Roundtables, or “listening sessions,” in 10 diverse communities around the country.

During the second phase, WRGH built on the momentum by working with our sponsors, national leaders, and local community leaders to create channels that would 1) allow national health policy leaders to gain insight from communities; 2) identify local, community-based health care solutions that have the potential to be replicated in other communities and nationally; 3) raise awareness and engage the public in constructive dialogue on health care challenges; and 4) encourage each leadership group to undertake an initiative to address a local healthcare challenge.

We returned to each of the original ten communities involved in the initiative and facilitated leadership forums designed to turn discussion into action through partnerships. These communities include Albuquerque, NM; Chicago, IL; Fort Lauderdale, FL; Hanover, NH; Jackson, MS; Portland, OR; Raleigh/Durham, NC; Salt Lake City, UT; San Diego, CA; and San Antonio, TX . We also invited two additional communities to join the original ten. A leadership group in Spokane, Washington, signed on to the initiative in December, 2003, and a group in Muncie, Indiana, joined in September, 2004.

In all 12 of these communities, we have sought to organize, maintain and expand the existing base of thought leaders. WRGH helped the groups prioritize initiatives, identify potential funding sources and organize their activity. The specific efforts to be advanced were based on recommendations found in the Phase I report. We have employed these leaders in outreach efforts at the local, state and national levels in three broad areas: shaping public policy, identifying and encouraging community-based leadership, and raising public awareness and engagement. The results of these efforts are described in this report.

Initiatives to Shape National Health Care Policy

In Phase II we initially organized the values and principles identified in Phase I into a set of policy priorities. Our first effort during Phase II was designed to influence the debate on national health care policy. Working with a cross section of leaders, we developed “10 Questions for Political Candidates” for use in the 2004 elections. These questions were endorsed by leaders in all of the communities, as well as by a number of Washington allies. The goal was to have local, state and national candidates responding to a series of questions that enjoyed the broad-based support of leaders in more than a dozen states. We wanted to promote constructive debate and to raise public awareness of contemporary health care issues. The questions and the list of more than 100 endorsers are included in this report, in Section I and in Appendix B respectively.

Next, we worked with the community leaders to draft a "Statement of Principles for Health Policy." This statement, based on the policy recommendations developed in the first report, and building from the ten questions, is also included in Section I. It is intended to provide a benchmark against which health policy proposals can be judged. It reflects the input of dozens of leaders from around the country and also enjoys diverse and broad support. Endorsers are listed in Appendix B.

In order to bridge the gap between local health and healthcare leaders and national public policy, WRGH created an affiliate in January, 2004, the Foundation for American Health Care Leadership (FAHCL). The goal of the Foundation is to promote and enable the thoughtful exchange of ideas in a neutral environment, among a broad cross-section of senior corporate and public sector executives across America in direct coordination with national thought leaders.

The Foundation convenes meetings and conferences with health care leaders to deliberate on and study national health care trends and specific contemporary health care issues affecting the nation's health and productivity. The Foundation then works to advance the outcome of these discussions before public policy experts, private and public sector leaders, and the general public. This "dialogue to action" approach distinguishes the Foundation and enables it to convert ideas into public policy.

The Foundation will serve as the principal agent to administer the ongoing twelve-state community leadership initiative into 2005-2006.

One of the first initiatives of the Foundation was development of a "blueprint" for health reform to be offered to the president, his administration and congress. The blueprint is intended to serve as a comprehensive roadmap for addressing key challenges in health care, such as access, quality, affordability, and infrastructure. The document was developed through a methodical process combining electronic brainstorming (underwritten by the National Association of Chain Drug Stores) with facilitated discussions, and involved input from dozens of community leaders across the spectrum of health and health care, as well as prominent national thought leaders in health care policy. The blueprint's recommendations frame a series of actionable steps that can reasonably be achieved by the administration within a 4-year term.

As a complement to the leaders' opinions, we commissioned a national survey by Harris Interactive (underwritten by Definity Health), to capture public opinion on a variety of salient health-related questions.

Initiatives to Raise Awareness and Engage the Public

WRGH/FAHCL is currently involved in developing a number of partnering initiatives that are designed to raise public awareness about current health challenges and to engage the public in helping to address them. These initiatives are focused on utilizing the media and the arts as effective tools in educating and motivating the public, including children, about the importance of health and lifestyle.

One of these collaborations is a joint proposal with the Society for the Arts in Healthcare (SAH) to develop a children's television program aimed at educating kids about health, creating a new channel for cultural/social change, and promoting healthy behavior. The proposal outlines the concept of an entertaining television series that will encourage children to make choices that support their health and well-being. The proposal recommends linking the show with interactive web content for children and parents as a means of extending their involvement and measuring the success of the program. A description of the rationale and proposed approach is included in Section II.

In a similar vein, WRGH/FAHCL has developed an agreement with the Professor Garfield Foundation, (PGF). PGF is an exciting, unique and inspired educational Internet web portal designed to complement and fill existing gaps in traditional educational curricula for kids in kindergarten through 8th grade, by combining educational content from leading experts with one sassy fat cat! We will identify and recruit sponsors and provide the content, through our allies, to create innovative and stimulating health and wellness "edutainment."

Another collaborative effort by WRGH/FAHCL and the SAH is a series of proposals for community-based arts projects designed to improve health and health care. Initial proposals include arts projects aimed at the following goals: working with the public schools to reduce childhood obesity; improving end-of-life care; reducing the incidence of type II diabetes among children; and encouraging appropriate use of the emergency room. These proposals can be found in Section II of this report.

Reports on Community Leadership

During Phase II, two new communities – Spokane, Washington, and Muncie, Indiana -- joined the community leadership initiative. WRGH held a leadership roundtable discussion in Spokane in December, 2003 and one in Muncie in September, 2004. Summaries of the two discussions are included in Section II.

Because voices from the communities are so central to the work of WRGH and the Foundation, we invited community leaders from around the country to contribute their perspectives to this report. In the “Voices from the Communities” section, community health care leaders attest to the value of partnerships, creativity, leadership and cross-sector collaboration in designing new approaches to old, and seemingly entrenched, problems in health care. Their commentaries are found in Section III.

We also provide “case studies” of effective, measurable, community-based, collaborative efforts to improve health and health care. We included 40 such case studies in our Phase I report; we include another 40 – drawn from communities all around the country – in Section III of this report. These case studies describe efforts that have successfully addressed specific goals designed to improve the health and well-being of a community, such as expanding access to health care, engaging residents in physical fitness, and creating new health care payment and delivery structures to better meet patient needs. Our intention in describing these various efforts is to provide readers with ideas and inspiration to explore new ways of addressing their communities’ health system challenges. These case studies are generally organized by the topical area addressed.

We hope the reader will find a good deal of inspiration from the multitude of ideas and the clear enthusiasm of community leaders for collaborative approaches to our many healthcare challenges!

SECTION I: INITIATIVES TO SHAPE HEALTH CARE POLICY

The importance of public policy to the health and wellness of our nation cannot be overemphasized. In Phase II we developed several initiatives taking advantage of the momentum of the political season and harnessing the collective wisdom of leaders across the twelve communities where we have been active. Below we have described the objectives and impact of these initiatives as we advanced them over the past 15 months.

Questions for Political Candidates

Recognizing the opportunity to influence public policy inherent in an election year, we initially worked with a cross section of leaders to develop and refine a series of questions to be put before candidates for public office. Over several months, we were able to gain the endorsement of over 100 leaders and organizations in communities across the country, as well as a number of Washington allies.

The goal was to have local, state and national candidates responding to a series of questions that enjoyed the broad-based support of leaders in more than a dozen states. We wanted to promote constructive debate and to raise public awareness of contemporary health care issues. The questions proved to be very useful in many venues. They were used by some to screen candidates, others published them for comment and still others used them to stimulate dialogue in public and private forums across the country.

The questions are set out below. The list of endorsers is included in Appendix B.

10 QUESTIONS FOR POLITICAL CANDIDATES

The questions below represent the best thinking of more than three hundred executives from across the spectrum of healthcare, including the physician, hospital, pharmacy and pharmaceutical, insurance, employer, government, advocacy, public policy, allied professionals and consumer sectors. We ask that you, as a candidate for public office, consider these questions as a framework for public policy development and execution. While there are no simple answers to these complex ideas, they represent the core issues our nation, our state and our communities face in responsibly meeting the health and healthcare needs of our citizens.

The organizations and individuals endorsing these questions and their value to the healthcare debate are collectively calling on you to promote public discourse on these important issues.

- Our country currently has no shared vision for healthcare policy. Do you believe that such a policy/vision is an important predicate to addressing health system deficiencies, and, if so, how would you go about developing one?

- Do you believe health care is a right or a privilege? Should we have a social contract for healthcare the way we do for education?

- What policy changes would you support to motivate individuals to assume a greater sense of individual responsibility for health-related decisions? How do we get people to understand there are limited resources and trade-offs have to be made?

- The healthcare system often lacks clear accountability that would encourage adoption of standards of care and quality improvement. How would you go about aligning financial and personal incentives to optimize outcomes?

- What steps would you take to address the current fragmentation in healthcare to promote continuity and coordination of care and access to the continuum of quality care, including prevention, mental and oral health services, and long-term and end-of-life care?
- What role can political leaders play in facilitating a change in emphasis in healthcare from high-end acute care to health promotion and prevention of chronic disease and injury?
- Currently our country has many citizens who lack access to healthcare services either because they cannot afford insurance, are underinsured or face social or cultural barriers. What steps would you take to correct this imbalance?
- What steps would you take to address the medical liability problem and create a legal environment that fosters openness, disclosure and high quality patient care?
- What steps would you take to relieve providers of unnecessary administrative and regulatory burdens in order to maximize the percent of healthcare dollars that support direct provision of patient care?
- What role should government play in advancing science-based medicine and technology and fostering a robust healthcare information infrastructure?

Principles for Health Policy

As the "10 Questions for Political Candidates" were being vetted in various venues, we began work on a draft statement of principles for health policy. As a launch point, we used information distilled from our Phase I "community vision" meetings. These principles have also been endorsed by dozens of leaders, as listed in Appendix B.

A STATEMENT OF PRINCIPLES FOR HEALTH POLICY

As a prerequisite to developing effective health policy, citizens must be engaged in the creation of a shared vision for American healthcare. Healthy people are vital to the health and well-being of the United States and its economy. Appropriate healthcare is necessary for the well-being of individuals, families, and communities.

This Statement of Principles is intended to provide a "benchmark" against which health policy proposals should be evaluated. Given the sensitivity that surrounds language and the use of terms certain points need to be clarified with regard to the statement.

While the definition of "basic" goes beyond the scope of this document, it must encompass some elements often "siloed" e.g., mental health, oral health and long-term care. The notion of "choice" does not imply that it is without increased cost to the individual. The term "universal coverage" does not refer to benefits, rather it refers to financing of care through health insurance and other mechanisms.

- Every American should have the ability to access basic high quality, safe, affordable, culturally appropriate health care services. Every American should have choice with regard to the provider of these services, and sound, understandable health information to facilitate good choices.
- Every American should have some financial responsibility for the cost of his/her health care, consistent with ability to pay, but should have access to financing mechanisms that protect against

financial catastrophe and promote optimal health for each individual.

- Universal coverage of basic healthcare services and the elimination of health disparities should be a major goal of national health policy. The strengths of the current public-private system should be used in advancing toward this goal.

- Every provider should be responsible for practicing according to current standards of care and, in return, should receive fair reimbursement.

- Every American should be responsible for taking all reasonable steps to preserve his/her health.

- To promote patient-provider partnerships that maintain and improve individual health, education about health and the appropriate use of healthcare services should be integral components of the U.S. public educational curricula and our nation's healthcare system.

A BLUEPRINT FOR HEALTH REFORM

As this report goes to press, the Foundation for American Health Care Leadership is in the final stages of creating a “blueprint” for health reform. It is intended to provide the second term of the Bush administration, Congress and state legislatures, with a potential roadmap for addressing key challenges in health care such as access, quality, affordability, and infrastructure.

The blueprint was developed through a methodical process that combined electronic brainstorming with facilitated discussions, and involved input from community leaders across the spectrum of health and health care, as well as prominent national thought leaders in health care policy. Prior to beginning the blueprint development, the idea was vetted with policymakers in both the Bush administration and the Kerry campaign and the process enjoyed their support.

We have engaged more than one hundred community leaders as the primary architects of the blueprint. To launch this initiative, in August, 2004 the FAHCL held an on-site work session at the Advanced Strategy Center (ASC) in Scottsdale, Arizona. The ASC is an innovative meeting and strategic planning facility that offers not only traditional meeting space and support, but also provides advanced “electronic brainstorming” capabilities that create an enhanced level of focus on strategic issues.

Twenty-eight participants, came at their own expense from the twelve communities that have been involved in our two-year-old community leadership initiative. They worked through a detailed protocol to develop a draft national policy document. Participants in the work sessions used the ASC’s laptop computers and state-of-the-art electronic brainstorming software to generate ideas, develop key themes, prioritize, rank and categorize themes, and identify next steps and potential barriers. Guided by expert facilitation, participants were able to respond simultaneously and anonymously to critical planning and input questions. By using this process, we were better able to drive complex open-ended questions to closure quickly, decide appropriate next step recommendations, and ensure a high level of ‘buy-in’ to the results.

Next, we presented the draft developed to a broader group of community leaders for their input. In October 2004, FAHCL held a series of four on-line brainstorming sessions that enabled an additional 50 plus community leaders to participate in strategic planning and refining sessions over the Internet from their home or office. These online sessions were conducted with simultaneous telephone access for audio conferencing. Through these Internet-based work sessions, we further distilled the blueprint draft and expanded commitment to the ideas contained in the document. We want to thank the National Association of Chain Drug Stores and its Foundation for their financial support of the ASC-related components of the blueprint.

During the process we also solicited, through separate survey instruments, several dozen additional opinions from thought leaders in Washington, DC, along with other experts in the field, to refine these ideas and build out the blueprint recommendations for execution.

Immediately following the November election, we held a second face-to-face session in Washington, DC, where we presented the work of the community leaders and the draft blueprint for comment and further refinement by professional and trade association executives and other respected health policy thought leaders. Three hundred and forty ideas and recommendations were put before the group to evaluate, rank and prioritize. We then distilled the results and selected over eighty where there is the "making of a consensus," and are developing them into a memo to deliver to the President and Congress in February, 2005.

The blueprint's recommendations frame a series of actionable steps that can reasonably be achieved by the Bush administration within a four-year term. These recommendations are grouped by topical area and into policy recommendations and implementation steps under each category.

Currently, plans are underway for sharing the memo with key leaders in Congress, committee staff, and executive branch agencies, as well as with health policy advisors to the President and democratic leadership. A Congressional and media briefing is planned for the first week in February.

A list of those individuals and organizations contributing to the blueprint can be found in Appendix B.

Consumer Polling

In order to explore attitudes around specific trade-offs inherent in policy development and execution, and augment the thinking of health and health care leaders as expressed in the blueprint, we commissioned Harris Interactive to conduct a national survey to capture public opinion on several salient questions. The questions are set out below. The results of this survey will be made public at the Congressional/media briefing, in conjunction with the health policy blueprint in February 2005. We are grateful to Definity Health for their financial support of this effort.

Harris Interactive Consumer Poll

How much do you agree or disagree with the following statements?

Response: ***Agree Strongly; Agree Somewhat; Neither Agree nor Disagree; Disagree Somewhat; Disagree Strongly; Don't Know; Decline to Answer***

- If I won the lottery tomorrow, I would change where my family and I get our healthcare.
- If I had reliable information from a knowledgeable source, for example, Mayo Clinic or Johns Hopkins, that conflicted with my doctor's opinion, I would still follow my doctor's advice.
- Where I go to receive medical care for a serious medical problem can influence if I live or die.

- If the healthcare system were easier to navigate, I would be more involved in making healthcare decisions for myself and my family.

- I would be willing to work an extra two or three years in order to ensure I have enough money to pay for my healthcare in retirement.

- Society should put a dollar value on living another year to help decide how much to spend on prolonging life.

- By making healthy lifestyle choices—such as not smoking, exercising frequently and controlling my weight—I can prevent or improve many serious medical problems.

Response: ***Fair; Unfair; Not Sure***

- People with healthy lifestyles, who don't smoke, exercise frequently and control their weight tend to incur fewer health care costs than people with unhealthy lifestyles. Do you think it would be fair or unfair to ask people with unhealthy lifestyles to pay higher health insurance premiums than people with healthy lifestyles?

- Do you think it would be fair or unfair to ask people with unhealthy lifestyles to pay higher deductibles or co-payments for their medical care than people with healthy lifestyles?

- Do you think it would be fair or unfair for patients to pay more to be treated by medical groups or hospitals which have been shown to provide better care?

Response: ***Favor; Oppose; Not Sure***

- Would you favor or oppose different levels of health insurance premiums, co-payments or deductibles for smokers vs non-smokers?

- Would you favor or oppose different levels of health insurance premiums, co-payments or deductibles for people who are overweight vs. people who are within their recommended weight?

- Would you favor or oppose different levels of health insurance premiums, co-payments or deductibles for people who do not wear set belts vs people who do wear seat belts?

- Would you favor or oppose different levels of health insurance premiums, co-payments or deductibles for people who exercise regularly vs people who do not exercise regularly?

Response: ***Willing; Not-Willing; Not Sure***

- Would you be willing to pay significantly higher premium for a health insurance plan which covered you to go to hospitals and medical groups shown to provide superior care?

- What is responsible for rising health care costs? *(High-profits/drug companies; greed and waste in the system; aging of the population; malpractice suits; use of expensive technology; consumers have little incentive to seek lower cost care)*

FOUNDATION FOR AMERICAN HEALTH CARE LEADERSHIP^{SM}

The blueprint for health reform and other public policy initiatives will be carried forward through Wye River Group on Healthcare's new affiliate, the Foundation for American Health Care Leadership. The Foundation will serve as a catalyst for bringing together disparate interests with the shared goal of effectuating constructive change from within the industry, drawing from the experience of community leaders. We will advance key issues and recommended next steps that need to be taken by private and public health sector leadership, public policy experts, and the general public.

Healthcare thought leaders across the country express a desire to interact informally with peers to candidly discuss current issues and trends affecting the business of healthcare. There is broad appreciation for the value of collective insight in working though complex issues.

Creating an opportunity for senior executives from across the health and healthcare spectrum to gather periodically to broaden their understanding of, and gain a deeper appreciation for, each other's perspective is valuable in advancing constructive health system change. Optimizing relationships among sectors – physician, hospital, business, consumer, government, insurance, and health policy – is key to effectively meeting the healthcare challenges we face as a nation. Enhancing personal as well as business relationships will serve to improve the overall environment and will enable meaningful health system reform.

The creation of the Foundation is timely, given the convergence today of many problematic dynamics related to our country's healthcare system. Effectively addressing widespread quality problems, a lack of healthcare infrastructure, uninsured and underinsured Americans, health disparities, unique demands of an aging population, unrealistic public expectations, and appropriate use of burgeoning technology will require thoughtful and visionary leadership focused on a shared vision for American health and healthcare.

SECTION II: INITIATIVES TO RAISE AWARENESS AND ENGAGE THE PUBLIC

PROPOSAL TO CREATE A TELEVISION SHOW THAT PROMOTES HEALTH TO CHILDREN

Wye River Group on Healthcare (WRGH) and the Society for the Arts in Healthcare (SAH) propose the creation of an entertaining daily television series that will educate and encourage children to make choices that support their health and well-being.

Given the escalation in childhood obesity and the prevalence of mental and behavioral health problems among young people, we believe there is a need to communicate directly to children about making positive choices such as healthy eating, daily exercise, avoiding drugs, and dealing with emotions in constructive ways.

Television is currently underutilized as a tool for communicating to children about health. Programs such as Sesame Street and Mr. Rogers' Neighborhood have demonstrated that television can be a powerful tool for educating children and encouraging positive social behavior. These programs can also be used as a model and a guide for programming that would engage children around health information and encourage health-promoting behavior.

Our proposal is meant to empower children, many of whom are under increasing stress in our 24-7 culture. Parents often don't have time to make sure their children consistently eat a healthy diet and get adequate physical activity and a good night's sleep. Lack of balance at an early age can develop into more serious problems later on, such as obesity, eating disorders, drug use and early sexual activity. That's why it's important to communicate with children early on – even as young as 4- and 5-years-old – about what they can do to stay healthy.

We propose that a children's television show focused on health be tightly linked to interactive web content for children and parents as a means of extending their involvement and measuring the success of the program. It is also critical that both the show and the interactive website be available and promoted to educators, caregivers, librarians, and anyone who is involved in the daily lives of children. Therefore, we suggest launching the program through a community-based promotional campaign involving elementary and middle schools, community centers and libraries.

The need to address behaviors that affect children's health

There is increasing recognition among health care professionals, policymakers and parents that one of the most serious health issues affecting America's children today is obesity and obesity-related conditions. During the past two decades, childhood obesity has risen to epidemic proportions, according to public health researchers. As a result, it is increasingly common for overweight children and adolescents to be diagnosed with Type 2 diabetes, a serious health condition that is almost entirely preventable among children.

Given the explosion in childhood obesity and its lifelong effects on health status and quality of life, there is an urgent need to develop strategies that will help children avoid becoming obese and at risk of developing diabetes and other chronic illnesses. Therefore, the consensus on all sides is that there needs to be a much greater emphasis on educating both children and their parents about the importance of eating a healthy diet and engaging in regular physical activity.

Obesity is quickly closing in on smoking as the leading preventable cause of death, according to the Centers for Disease Control and Prevention. But smoking among children remains an urgent concern, with 80% of smokers beginning to smoke before age 18, according to the American Lung Association.

Smoking, drug use and sexual activity are all behaviors that have serious negative health consequences for children and adolescents and are therefore subjects that should be included in communicating with children about health. In addition, it is important to educate both kids and their parents about depression and other psychiatric disorders that can affect children, but which are often left unrecognized and undiagnosed.

Using television as a medium to promote healthy behavior

Research indicates that children spend a substantial amount of time watching television – a behavior that is widely seen as contributing to childhood obesity because it displaces physical activity and increases caloric consumption, both through advertising and because of children's tendency to snack while watching TV.

Even very young children are growing up immersed in media today, according to a study released in October 2003 by the Henry J. Kaiser Family Foundation. A survey of more than 1,000 parents found that children six and under spend an average of two hours a day using screen media, which includes television, videos, computers and video games.

Television viewing is considered to be a significant part of the problem of increased childhood obesity, but what if television could become part of the solution?

Messages that are conveyed through television can be very influential in shaping children's views on a variety of topics, including behavior that affects their health.

While screen media can have a negative influence on children's behavior by presenting violence and sexual content, the Kaiser Family Foundation study found that parents of young children have a largely positive view about television and computers.

Parents are significantly more likely to say TV "mostly helps" children's learning (43%) than "mostly hurts" it (27%). About half of parents consider educational TV shows (58%) and videos (49%) to be "very important" to children's intellectual development. They are also far more likely to say they have seen their children imitate positive behaviors from TV like sharing or helping (78%) than negative ones like hitting or kicking (36%).

In addition, there appears to be great potential for extending the value of a children's television program about health through the use of tightly linked interactive web content.

Nearly half (48%) of children six and under have used a computer. In a typical day about one in four (27%) 4-6 year-olds uses a computer, and those who do spend an average of just over an hour at the keyboard. The overwhelming majority of parents (72%) say computers "mostly help" children's learning.

Recognizing that many children do not live in household with a computer, the show will work closely with schools, preschools, libraries, community centers and other organizations with Internet capability to ensure that children have access to interactive web content related to the television show.

Public television – a model for educating and influencing children

Children's public television programs such as *Sesame Street* and *Mister Rogers' Neighborhood* were created more than 30 years ago from the conviction that high-quality television programming could actually have a positive impact on children's early development and learning.

These shows became two of public television's greatest success stories, reaching tens of millions of children over the years. They have certainly had a positive and lasting impact on their millions of viewers by improving preschoolers' readiness for school.

But it remains an open and relatively untested question whether children's television programming can be used successfully to teach children behavior that will benefit their health.

In the history of children's television, there have been modest efforts to encourage healthy behavior and increase health awareness among children. For example, in one episode of *Mister Rogers' Neighborhood*, Fred Rogers receives an immunization. Other segments encourage a child to eat healthy foods. But there has not yet been a children's television series dedicated solely to the goal of improving children's health.

The potential for such a program to impact children's behavior – and that of their parents – appears to be promising. "Research has shown that television can be used effectively to shape audience response; and if properly used, to positively influence attitudes and behavior," writes Aisha White, national coordinator for Mister Rogers' Neighborhood Child Care Partnership, in *Television and Healthy Behavior: Not a Paradox*.

"Appropriate television programming can motivate viewers through: modeling of healthy behaviors; producing an emotional response to a health issue; applying social pressure or influence; serving as a subconscious memory prompt; and, actively encouraging healthy behavior."

There appears to be significant potential for creating a television program that can serve as an effective vehicle for promoting healthy behavior to children, and hopefully to parents and other caretakers who watch television with them.

Creating and sustaining a television show to educate kids about health

WRGH and SAH recommend creating a television series, connected with an interactive web site, to promote healthy behavior among children. Some segments of the program would be designed to appeal to children ages 4-6 years old, while others would be targeted to children ages 7-9 years old. Creating segments that appeal to different age groups is a strategy used by the producers of Sesame Street, who found that children of different ages often watch television together, as well as with a caregiver, and that therefore it helps if there is content that appeals to each audience member.

The show will present content in an entertaining format that is designed to catch the attention of children, recognizing that they tend to have short attention spans, prefer recognizable characters and stories, and are helped by repetition of key concepts.

Content will focus on topics that support the promotion of healthy eating and physical activity, and will be designed to influence not only children but also their parents and other caretakers who are watching with them. It will also be important to develop materials that parents and caregivers can use to reinforce the show's message with children.

There will be a strong emphasis on connecting segments of the show to post-viewing activities, such as encouraging kids to exercise and engage in "normal" eating, i.e. eating a balanced diet with moderate consumption of calories.

To encourage physical activity, segments of the show would be designed to get kids up off the couch and doing exercises. There could also be images shown of kids playing outside and enjoying the outdoors so that outdoor physical activity is represented as positive and fun.

Just as television advertising for sugary snacks is designed to attract children's attention and influence their behavior, this proposed television program could use advertising-like content that promotes healthy food.

Content will also portray the cause-and-effect relationships between how children feel and the food they eat. Just as *Sesame Street* uses Oscar the Grouch to communicate to children about emotions, this program could use characters that represent the connection between emotions and eating habits.

We envision a television program that includes segments designed to get children and their parents thinking about how they feel, both physically and emotionally, because feelings are an intrinsic aspect of health and well-being. Kids who feel lonely, isolated or angry are more vulnerable to using tobacco and other drugs and using violence and other behavior that is unhealthy.

In addition, the show could address other health-related issues that young children face. Possible ideas include immunization shots and preventive check-ups, getting the chicken pox, what to do when you catch a cold, the importance of washing your hands, what to do when you get a cut or a scrape, the importance of brushing your teeth, etc.

Among the lessons learned from *Sesame Street* is that there must be a strategy for building and sustaining an audience if a children's television show is to be successful. Therefore, in creating this show, part of the process will focus on developing a strategy for reaching a sizable audience and maintaining that audience over time.

Background

WRGH's interest in creating a children's television program about health grew out of the Communities Shaping a Vision for America's 21st Century Health and Healthcare initiative.

Among the concerns we repeatedly heard from community leaders was the need to encourage healthier choices about diet and exercise among all Americans, and especially among children. Many Americans are contributing to their own illnesses – whether diabetes, heart disease, etc. – through their own unhealthy eating patterns, sedentary lifestyle and difficulty managing stress.

As a result, they are contributing substantially and unnecessarily to the high cost of their own health care by using services and therapies that they would not need if they made better decisions about what they eat, how often they exercise, etc.

It is important to promote healthy choices to people of all ages. However, there is a widespread view in the health care community that it is especially urgent to develop strategies for reaching children at a young age, when obesity, diabetes and other chronic illnesses are most preventable and/or treatable.

"As [the numbers of] chronically ill patients grow, we're really missing the boat by not getting kids when they're young," said one community health leader.

Teaching kids the right habits can put them on a healthy path that will benefit them for life. But in many communities, schools are not getting the job done when it comes to comprehensive and sustained health education. There was general agreement that health education in the public schools is woefully inadequate.

We not only need to help kids change behaviors, we also need to impact the thinking and behavior of adults that have an influence on them.

WRGH and the Society for the Arts in Healthcare envision linking the television series to interactive web content as a means of extending children's learning and involvement and to measure the success of the show.

The program could be launched through a community-based campaign, in conjunction with local schools.

Seeking Partners

WRGH and SAH are seeking to explore this concept with interested parties in the private and public sectors that could financially support the development of this proposed television series to be aired on public television, cable or network television.

We will target private foundations, philanthropies, and health and justice grants as potential sources of development and planning funds.

We are also looking for creative collaborators and advisors, following the example of Children's Television Workshop. A key reason that Sesame Street has been so successful is that early in its development the show's producers brought together a broad range of highly qualified experts, such as psychologists, researchers, pre-school educators and PR professionals, to advise them.

Therefore, we also propose bringing together a broad group of experts in the fields of children's health, psychology and children's media to develop the concept outlined in this paper into a pilot for a television series.

In addition to health care organizations concerned about children's health, key partners in this effort could include Head Start, the National Association for the Education of Young Children, the Parent-Teacher Association, the Children's Defense Fund, Parents as Teachers, Child Care Resource and Referral, PBS stations, the National Education Association, American Federation of Teachers, and others.

In addition, WRGH is considering creating a Media Center within its Foundation for American Health Care Leadership that will serve as an incubator for developing the idea of a children's television program focused on promoting healthy behavior. The Media Center would bring together the advisory councils that are needed to create this program.

PLAN TO PARTNER WITH THE PROFESSOR GARFIELD FOUNDATION

Our country, as well as much of the rest of the world, is facing an impending epidemic of chronic disease, much of which can be prevented. As a result of our work nationally and internationally, we have become aware of the urgent need to develop “upstream” strategies designed to enable and encourage children and youth to learn about health and healthcare issues at an early age and to facilitate the adoption of positive health behaviors.

Our initial concept for development of a "Health on Sesame Street" type of TV program, described above, included a tight link to interactive web content for children and parents as a means of extending their involvement and measuring the success of the program.

Through our community leadership work, we were introduced to the Professor Garfield Foundation (PGF). PGF is an exciting, unique and inspired educational Internet web portal designed to complement and fill existing gaps in traditional educational curricula for kids kindergarten through 8th grade, by combining educational content from leading experts with one sassy fat cat.

The Garfield comic strip is the most widely syndicated comic strip in the world, with circulation in 2,570 newspapers in 63 countries, and a daily readership of 263 million! Today the Garfield web site has over 12 million page views and over 2 million unique visitors a month. Imagine what that branding can do in launching the Professor Garfield educational portal. We are convinced that the popularity of Garfield the Cat can be converted to Professor Garfield, and successfully leveraged as the “hook” to educate kids in this country and around the world. As such, PGF can help to create a new generation of well-informed people on health and wellness related topics. Wye River Group on Healthcare (WRGH) is pleased to have entered into a agreement with PGF to provide the content, through our allies, to create innovative and stimulating health and wellness "edutainment."

The PGF was formed in 2003 as a 501 c-3 NFP. It is designed to enhance and support classroom learning by providing children, parents, and teachers with free access to motivating messages in a fun and friendly environment. The portal will complement the web-based content with turnkey in-classroom teaching tools to ensure topics are effectively presented to the K-8 audience. Ball State University, a partner with PGF, will provide the appropriate pedagogy and assessment criteria, to assure that the content on the Professor Garfield Learning Portal is academically sound and well structured.

We will serve as the health and healthcare interface for PGF with sponsors, content experts and a recommended "youth advisory" board to develop and maintain the health portion of the site. During the first year, we plan to focus on three key areas: exercise, diet, and behavioral health issues, as well as more specific topical areas, e.g., sun safety and oral health. The content presented in each topical area will be developed working with our sponsors, with CDC and through a series of focus groups where we will seek the opinion of teachers, parents and children on what information would be most useful to them and how the information should be presented.

We are in the process of identifying financial sponsors and supporters. Strong interest has been expressed by organizations ranging from healthcare, to the food and beverage industry to governmental agencies, such as CDC.

PROPOSALS FOR COMMUNITY-BASED ARTS PROJECTS TO IMPROVE HEALTH AND HEALTHCARE

INTRODUCTION

Naj Wikoff
President, Society for the Arts in Healthcare
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Following the Foundation for American Health Care Leadership's June, 2004 Chicago conference that focused on the "Economic Value of Health and Healthcare", WRGH sent out a memo to the leadership of its twelve model communities seeking concepts for case studies and demonstrations projects. The SAH, WRGH and leaders from four of the communities identified three issues of high concern: enhancing the quality of end of life care through increased participation in hospice; reducing the use of Emergency Rooms for non-emergency health assistance, and encouraging young people to adopt healthier lifestyles as a means of reducing obesity and the attached health problems. Each of these issues was felt to have a high impact on the economics of health care delivery.

Set out below are four proposals that WRGH and SAH developed as a result of those discussions and put forth for possible modification and implementation. Those attached to a specific locale can be either developed there, if interest remains, or adapted for another community. While it is our shared desire to pursue these projects, they also pose as examples of how the arts can be used to address critical health care issues. SAH and WRGH are also willing work with community leaders to craft proposals tailored to specific needs.

WORKING WITH THE PUBLIC SCHOOLS TO REDUCE CHILDHOOD OBESITY IN JACKSON, MISSISSIPPI

We propose to create a model program in Jackson, Mississippi that would teach good health practices to very young children, from kindergarten through 3rd grade. According to Center for Disease Control & Prevention (CDC) research, nearly one in four Mississippians is overweight. As such, Mississippi reflects a growing trend throughout the United States towards greater obesity and the associated risk increase for heart disease, diabetes and stroke – a trend that, if left unchecked, threatens to overwhelm our health system. The challenge and opportunity is to stimulate and reinforce a change in behaviors, especially among young children, that will lead to greater individual awareness of the health hazards of obesity and actions that will lead to obesity prevention.

Proposed plan

The Jackson public school system has 38 elementary schools providing education from kindergarten through 5th grade. Eighteen of these schools also provide pre-K classes for children who are identified with the greatest socioeconomic and academic needs.

It is proposed that a model program be established and tested that will include a partnership between a medical center, the local arts council, and at least six elementary schools, including three of the schools that offer pre-K programs. CDC research has shown that one of the most influential individuals to convey health information is a doctor. Therefore, as a first step, the medical center will conduct a "health report card" of the schools by conducting a health review of all staff and students, as well as a review of the food served through the school cafeteria and vending machines. This review will also include a questionnaire to determine each individual's health knowledge, including their level of comprehension about the causes of cancer, stroke, heart disease and diabetes. The health report will then be presented to the schools, both staff and students.

Two schools, one with a pre-K program and one without, will get the test results and no further action will take place. At the other schools, parents, staff and health officials, with participation from representatives of the arts community, will set goals for a healthier school. The arts team will then partner with ad-hoc groups to develop an in-school media campaign that includes posters developed by students working with professional graphic artists, coupled with arts activities designed to foster and support behavior change, such as creating student (or faculty or staff) dance ensembles, theatrical events, banner celebrations and the like.

Part of the goal is to make the idea of eating less, eating right, and getting more exercise fun. Part of the goal is to encourage adults (faculty, staff and parents) to be positive role models for children and, at the same time, encourage the children to be positive role models for adults. Part of the goal is to create pride in efforts to live a healthy life and to help people, no matter what their economic background, realize that they can make choices that will lead to a healthier and more productive life – to enhance their sense that they can control their lives.

The arts-health activities will be planned, in partnership with educators, to fit in with their regular school activities and special needs and will include monthly mailings to parents on health information/program goals. The pre-K programs will be designed to create positive early childhood experiences and to nurture the whole child. Parent participation is highly encouraged. Thus parents will be invited to participate in all aspects of the planning process. Special emphasis will be given to providing foods to children that minimize the use of products that are high in sugar, fat and carbohydrates. Parents will also be taught ways to reduce their children's television exposure and replacing it with other activities that meet parenting time constraints and economics.

After one year, all of the participating schools will be retested by the medical center to determine if there has been any change in the overall health of the schools, and to compare the individual knowledge/awareness of the health dangers of obesity (and smoking) and to compare the results with the two control schools.

The Arts

The reason for using the arts is that they not only inspire and engage people but also communicate information in fresh and charming ways. The arts can be used to deliver information not in the dry clinical way of so many health posters, but by using the images and language of ones own peers. The arts can motivate people to get active, for example, by enjoying live drumming music or the excitement of being on stage or having one's paintings displayed on the walls. The arts have a proven track record of providing people a voice and sense of control, providing instant graphic results of one's efforts, and involving everyone no matter what their health circumstances, and they can be very sensitive to differing cultural traditions.

The Elementary School

The reason for involving elementary schools and pre K programs is to try to change people's behaviors when they are young, and to take advantage of adults concerns for children as a means of inspiring their behavior change so they can serve as positive roll models for children.

Television

According to a recent article by Jane Brody in the *New York Times* ("TV's Toll on Young Minds and Bodies", August 3, 2004), the average young child watches four hours of television each day, "seeing tens of thousands of commercials often for high-fat, high-sugar or high-salt snacks and foods." While sitting, children are using the fewest calories of any activity except sleeping, and have more opportunities for consuming foods than children who are engaged in physical exercise, the arts and other activities.

According to Dr. William H. Dietz of the Center for Disease Control, "TV reduction appears to be the most effective measure in reducing weight gain." Complicating the situation is that over 60% of all children aged 8-16 now have a TV in their bedroom. Thus a strong challenge for the planning team will be to devise activities that will encourage the reduction of children's TV exposure – activities that will require strong participation in their creation and enforcement by parents.

* Note that watching two or more hours of TV per day increases the risk of children developing attention-deficit hyperactivity disorder. Thus while our effort is to reduce exposure to TV for physical benefits, it may well have mental and emotion benefits as well.

The Medical Center

The Medical Center will benefit through being seen as a pro-active community resource. The doctors are not sitting in their offices waiting for patients to come to them, but are willing to go out into the community and help young children learn how to take better care of their own health.

Planning Team

A planning team will have to be established that includes representatives from the medical center, community health agencies, school system and local arts council. SAH and WRGH will provide arts coaches to help support the planning, implementation and evaluation process. A budget, timetable, goals and method of funding and evaluation will be established.

This is expected to be a multi-year project; year one for planning and fundraising, year two for implementation, followed by six months for evaluation and reporting.

Outcomes

- Inventory and assessment of heath and health awareness of the staff and students of participating schools (creation of a healthcare line)
- Inventory of how the participating schools do/do not contribute to good health (food services, supporting sedentary lifestyles, vending machines)
- Inventory of the exposure to television by children participating in the studies
- Establishment of ad-hoc planning groups including representatives from schools (staff, students and parents), health agencies and arts agencies
- Development of models for changing and reinforcing change in lifestyle behaviors
- Development of training models
- Development of evaluation models

- Raised profile of medical centers as being proactive in community health
- An increased awareness in the value of good health and an improved health in the students and staff of participating schools
- Reduction in children's exposure to television

IMPROVING END-OF-LIFE CARE IN ALBUQUERQUE, NEW MEXICO

Our proposal is to create a pilot program in Albuquerque, New Mexico, intended to enhance end-of-life care by integrating the arts into hospice practices. Incorporation of the arts into end-of-life care is projected to lead to an increase in the use of hospice by minorities, augment patient and family satisfaction, and improve key outcomes such as patients' sense of dignity, control and self-determination. It is also posited that activity incorporating the arts into day-to-day care will increase caregiver sensitivity and awareness of individual, family and community (cultural) values at this critical time of patients' lives.

Opportunity

Seventy-five million adults born between 1946 and 1964, often referred to as the Baby Boomers, are rapidly reaching retirement age and will soon require end-of-life care at a time when our aging population is already placing increased stress on our health systems. Sunbelt states such as Florida, New Mexico and Arizona are further burdened as they increasingly attract retirement populations, skewing their demographics to include higher percentages of the elderly. The growth of the older-age demographic comes at a time of concurrent growing cultural diversity in the United States, particularly in these states.

On the one hand, there is an urgent need to teach healthcare providers end-of-life care giving skills, coupled with an understanding of the customs and mores of diverse populations. On the other, there is a need to empower families and communities to increase end-of-life care giving capacities at home – in a community setting.

Albuquerque is located in a bell-weather state facing increased stress on its healthcare systems because of the increasing number of aging individuals with end-of-life care needs and a proportionally large and ethnically diverse population, including Native and Hispanic Americans. Thus, it is an ideal community to develop pilot programs around end-of-life care.

Cultural Diversity Issues

Culture and ethnicity influence an individual's thoughts about death. They can influence choices about life support, place of death (e.g. home or hospital), and candor in diagnosis and prognosis (this is an especially sensitive issue among many Native American tribes. Within any larger cultural or ethnic group there can be subgroups with differing views. For instance, the Apache, Pueblo and Hopi tribes have commonalities and distinct differences in their value systems, yet clans within the tribes can have further diversity still, all impacting end-of-life care issues. Decision-making authority and beliefs about modern medicine versus traditional medicine are examples of highly important and sensitive issues that must be well understood in order to meet the needs of terminally ill individuals and their family members.

Of the 30% or so of dying Americans who utilize hospice care, 83% are white, 8% are African Americans, 6% are Native Americans and 3% are Hispanic Americans (National Palliative Care and Hospice Organization). For African Americans, hospice care has been viewed as "giving up", or worse, "second rate" care, compared to aggressive care (Mouton, 2000)*. Availability of hospice care that is culturally sensitive and tailored to the needs of ethnically distinct groups appears to be the main barrier both to access and utilization among minorities.

End of Life Issues

Eighty percent of deaths in the United States occur in people 65 or older (i.e., the Medicare population). About half of all deaths occur in hospitals, whereas 20% of people die in non-acute care institutional settings. Many studies and surveys have documented that people facing the end of life share similar concerns about unnecessary pain and suffering, unwanted and traumatic treatments, and that their preferences will be ignored. Although a small minority of patients has actually written advance directives, when queried, many of these patients fear that their advance directives will not be heeded. Sadly, these concerns are well founded, as most dramatically revealed by the seminal SUPPORT study (JAMA 1995)**. What most people desire at end of life can be broken into two forms of decisions, (1) meaning making (what's important to them, leaving a legacy, not leaving something unsaid, being treated with dignity and not dying alone), and (2) decision making (advance directives, type of treatment and being in control) (Bertman, 2004)***.

Therefore, a significant means both to reduce the stress on the healthcare system and meet the needs of the dying is to (a) educate professional caregivers about differing belief systems and values, with a focus on teaching effective and ethnically appropriate communication skills, and (b) provide them with hands on experiences to help them witness differing meanings of what constitutes a "good death". Furthermore, it is necessary to help communities and families with older members to gain a greater understanding of their options including the use of community resources, such as hospice and the arts, that can help people through their final transition adding in the search for meaning while providing a sense of control, dignity, and symptom relief while surrounded by the comfort of family.

Project Outcomes

Goals of this project will be to create demonstration projects to:

- Increase the use of hospice by Native Americans and Hispanic Americans in Albuquerque
- Increase patient and patient family satisfaction in the quality of end-of-life care
- Increase caregiver awareness and understanding of cultural and ethnic issues around end-of-life care
- Break stereotypes and myths about aging, end-of-life care, and peoples of differing cultures

Unique Community Assets

Native American hospitals in New Mexico have been in the forefront in the United States of including traditional healers as part of patient care. While many hospitals have long provided pastoral care, traditional healers are rooted in the cultural history of a community and their people and thus represent an invaluable resource for helping to understand and teach patient values and end- of-life concerns and desires.

At the same time, there is a growing interest in, and use of, the arts as part of end-of-life care. Often the arts are used in conjunction with traditional healers and pastoral care. The arts have proven effective at reducing pain, providing opportunities for sharing emotions and creating a legacy, and providing an overall sense of comfort. Albuquerque has rich artistic resources (music, storytellers, various forms of dance, poetry, painters, crafts, cultural institutions) that can be drawn upon to enhance hospice care.

The incorporation of the arts along with traditional values and faith will provide opportunities to explore how the arts, spirituality and healing can be used to serve both patients and caregivers, realizing the bio-psychosocial-spiritual paradigm of healthcare.

Planning Team

A planning team will be established that includes representatives from medical center(s), the University of New Mexico Medical School of Medicine, community hospices, local arts agencies, community social service and selected health professionals with expertise in end-of-life care, geriatrics, healthcare policy, and medical ethics. SAH and WRGH will provide arts coaches to help support the planning, implementation and evaluation process. A budget, timetable, goals and method of funding and evaluation will be established to accomplish the planning phase, implement the program and measure outcomes.

This is expected to be a multi-year project; year one for planning and fundraising, years two and three for implementation, followed by six months to twelve months for evaluation and reporting.

Outcomes

- Inventory of end-of-life care preferences, attitudes, and ultimate disposition among African-Americans, Hispanic Americans, Native Americans by tribe, and Caucasian Americans (e.g. hospice utilization, hospital deaths, home deaths)
- Inventory of experiences related to quality of death by patient's family (e.g. were advance directives headed, did patients suffer pain)
- Inventory of current end-of-life care services provided by health institutions to patients (i.e. the percentage that requested hospice, rigorous intervention)
- Inventory of the concurrent use of the arts (and what type) in end-of-life care, and perceived value of the arts by patient, family and professional caregiver
- Inventory of current caregiver (and medical student) awareness of and understanding of cultural and ethnic issues around end of life care
- Establishment of ad-hoc planning groups including representatives from medical center, social centers/agencies, medical schools, arts agencies and Native American agencies
- Development of models for changing and reinforcing change in end-of-life care services, choices, and sensitivity to cultural mores
- Development of training models and materials for caregivers and artists
- Development of evaluation models
- Raised profile of medical centers as being proactive in end of life care that is sensitive to cultural mores
- An increased awareness in the choices one has in end of life care and (ideally) an increase in the use of hospice and other community interventions, including end of life at home
- An increased use of the arts to support end of life care
- Reduced pain, increased attention to end of life directives and increased satisfaction in end of life care

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REDUCING THE INCIDENCE OF TYPE II DIABETES AMONG CHILDREN IN SAN DIEGO, CALIFORNIA

Our proposal is to create a pilot program in San Diego, using the arts, to reduce the rate of Adult Onset Type II diabetes in children by motivating children to change lifestyle and eating practices that lead to obesity and increase their risk. The program will target minority and other children who are at higher risk, and will seek to educate and motivate all children in the study to be aware of the value of taking responsibility for their health.

Opportunity

According to Center for Disease Control research, in 2002 over 206,000 children under the age of twenty, or one out of every 400, had diabetes – a number that is growing at such a fast rate that it is now called an epidemic. Minorities are especially hard hit by diabetes, with 11.4% of all non-Hispanic blacks having diabetes (1.6 times more likely than non-Hispanic whites), and 8.2% of all Hispanic/Latino Americans (1.5 times more than non-Hispanic whites), with Mexican Americans being over twice as likely to have diabetes. Nationwide, over 18.2% of Americans have diabetes.

Considered a contributing factor in the rapid growth of diabetes is parallel CDC research demonstrating that between 16% and 33% of all children are obese, with again the highest rates found among Hispanic/Latino and Afro American children. Unhealthy weight gain due to poor diet and lack of exercise is responsible for over 300,000 deaths each year, and its annual cost to society is estimated at nearly $100 billion. The growth in obesity has resulted in an increase in heart disease, diabetes and strokes, among other conditions – a trend that, if left unchecked, threatens to overwhelm our health system. The challenge and opportunity is to stimulate a change in behaviors, especially among young children, that will lead to greater individual awareness of the health hazards and actions that will lead to weight loss.

San Diego is a bell-weather community in a bell-weather state. As the second largest city in California, it represents one of the most culturally diverse communities in the United States and, reflecting a growing trend in the United States, Caucasians will soon no longer be the dominant ethnic group. San Diego has a very large and growing Hispanic/Latino population and with it comes a large population of children who have Type II Adult Onset Diabetes at nearly twice the national average – a health epidemic that is severely straining health care resources and, if unchecked, will threaten the community's ability to provide future quality care for all in need. San Diego is thus an ideal community to explore creative means of educating and motivating young people to take greater responsibility for their health.

Proposed Plan

Our proposal is to establish and test a model program that will include a partnership between the San Diego Children's Hospital and the Scripps Healthcare system, and community arts, health, education and social service agencies to change behaviors that contribute to excessive weight gain and the growth of Type II Adult Onset Diabetes in children.

It is proposed that a model program be established and tested in one or more communities that will include a partnership between the medical centers, at least two elementary schools, and San Diego arts agencies.

CDC research has shown that one of the most influential individuals to convey health information is a doctor. Therefore as a first step, the medical centers will conduct a "health report card" of the selected schools by conducting a health review of all staff and students, as well as a review of the food served through the school cafeteria and vending machines. This review will also include a questionnaire to determine each individual's health knowledge, including their level of comprehension about the causes of cancer, stroke, heart disease and diabetes. The health report will then be presented to the schools, both staff and students.

One school will get the test results and no further action will take place. At another, students, staff, health officials, with participation from representatives of the arts community, will set goals for a healthier school. Their task will be to use the arts, coupled with other initiatives, to help change behaviors and address some of the root causes of obesity such as low self-esteem, stress, potential family histories of obesity, overeating, eating patterns and sedentary lifestyles.

The arts team will partner with ad-hoc groups to develop an in-school media campaign that includes posters developed by students working with professional graphic artists, coupled with arts activities designed to foster and support behavior change, such as student (or faculty or staff) dance ensembles, theatrical events, banner celebrations and the like. Part of the goal is to make the idea of eating less, not smoking and getting more exercise fun; to build self-esteem; and to empower children with the sense that they can make a difference. Studies have shown that exposure to television encourages children to eat snacks that are high in sugar, salt and fat, and that while watching TV children spend the least amount of calories than during any activity other than sleeping. Therefore, reducing exposure to television will be among the goals of the campaign.

Another goal will be to encourage adults (both faculty and staff) to be positive role models for children and, in turn, to encourage students to be positive role models for adults. Part of the goal is to create pride in efforts to live a healthy life and to help people, no matter what their economic background, realize that they can make choices that will lead to a healthier and more productive life – to give them an enhanced sense that they can take control of their lives.

In a year, both schools will be retested by the medical center to determine if there has been any change in the overall health of the schools, to compare individuals' health knowledge and awareness of the dangers of obesity, and to compare the results of the school with arts-health activities with the control school.

The Arts

The reason for using the arts is that they not only inspire and engage people but also communicate information in fresh and charming ways. The arts can be used to deliver information not in the dry clinical way of so many health posters, but by using the images and language of ones own peers. The arts can motivate people to get active, for example, by enjoying live drumming music or the excitement of being on stage or having one's paintings displayed on the walls. The arts have a proven track record of providing people a voice and sense of control, providing instant graphic results of one's efforts, and involving everyone no matter what their health circumstances, and it can be very sensitive to differing cultural traditions.

The Elementary School

The reason for involving elementary schools is to try to change people's behaviors when they are young, and to take advantage of adults' concern for children as a means of inspiring their behavior change so they can serve as positive role models for children.

The Medical Center

San Diego Children's Hospital and the Scripps Heath Systems will benefit through being seen as a pro-active community resource, and by reducing the trend of increased Type II Adult Onset Diabetes in children. In this initiative, the doctors are not sitting in their offices waiting for patients to come to them, but are willing to go out into the community and help young children learn how to take better care of their own health.

Television

According to a recent article by Jane Brody in the *New York Times* ("TV's Toll on Young Minds and August 3, 2004), the average young child watches four hours of television each day, "seeing tens of thousands of commercials often for high-fat, high-sugar or high-salt snacks and foods." While sitting, children are using the fewest calories of any activity except sleeping, and have more opportunities for consuming foods than children who are engaged in physical exercise, the arts and other activities.

According to Dr. William H. Dietz of the Center for Disease Control, "TV reduction appears to be the most effective measure in reducing weight gain." Complicating the situation is that over 60% of all children aged 8-16 now have a TV in their bedroom. Thus a strong challenge for the planning team will be to devise activities that will encourage the reduction of children's TV exposure – activities that will require strong participation in their creation and enforcement by parents.

* Note that watching two or more hours of TV per day increases the risk of children developing attention-deficit hyperactivity disorder. Thus while our effort is to reduce exposure to TV for physical benefits, it may well have mental and emotion benefits as well.

Planning Team

A planning team will have to be established that includes representatives from the medical centers, community health program, school system and local arts council. Members of the target group – children – should be included in the planning process as well as parents. SAH and WRGH provide arts coaches to help support the planning, implementation and evaluation process. A budget, timetable, goals and method of funding and evaluation will have to be established.

This is expected to be a multi-year project; year one for planning and fundraising, year two for implementation, followed by six months for evaluation and reporting out.

Outcomes

- Inventory and assessment of heath and health awareness of the staff and students of participating schools (creation of a healthcare line)
- Inventory of how the participating schools do/do not contribute to good health (food services, supporting sedentary lifestyles, vending machines)
- Inventory of how much television each child watches, on average, each day
- Establishment of ad-hoc planning groups that includes representatives from schools (staff, students, parents), health agencies and arts agencies

- Development of models for changing and reinforcing change in lifestyle behaviors
- Development of training models
- Development of evaluation models
- Raised profile of medical centers as being proactive in community health
- An increased awareness in the value of good health and an improved health in the students and staff of participating schools
- A reduction in the amount of television watched

ENCOURAGING APPROPRIATE USE OF THE EMERGENCY ROOM IN SAN ANTONIO, TEXAS

Our proposal is to create a model program in San Antonio, Texas, to reduce the use of the Emergency Rooms (ER) for health concerns that do not meet ER standards – in other words, conditions that can be treated more effectively and affordably by family physicians, clinics or other providers.

Opportunity

A severe challenge facing the medical centers in San Antonio, and throughout the United States, is the high use of its hospital Emergency Room as a place to come for health services that can often be treated more appropriately by a health clinic or family doctor. Indeed, a large percentage of people coming to the ER have health concerns of this nature, costing the health system millions of dollars each year in staff time and resources. A difficulty is that many people approach the ER as the result of a perception that they will be turned away by clinics, hospital general admissions or family doctors because of their lack of health insurance.

The opportunity is to develop a media campaign aimed at educating San Antonio residents where they should go (and where they should not go) for appropriate treatment and where they will not be turned away, regardless of whether they are insured or have the ability to pay.

Proposed Plan

It is proposed that a model program be established and tested in San Antonio that engages members of the target population – individuals who currently use the ER inappropriately – to help identify how best to reach this audience, and, using the arts, to design a media campaign. First, a random phone survey will be made of an appropriate number of households to determine their awareness of community health resources, their assumptions about the health services the ER provides, their assumptions about health insurance being a factor as to where they go for health care, and when is or is not the time to go to an ER.

Working with the San Antonio Arts Council, an arts media campaign will be created using images and language developed by an ad hoc group reflecting the cultural and other demographics of the target audience(s). The campaign may use posters placed in bus stops, beauty shops, grocery stories and other places people gather. Information will be promoted in the ER, on TV and radio Public Service Announcements (PSAs) and banners, through theatrical events and in partnerships with schools and community civic and arts agencies.

After one year, a second random survey will be conducted to determine if there has been any change in the target population's awareness of where to seek (emergency vs. non-emergency) health services, and to determine if people are using the recommended venues for particular health services. In addition, ER use will be profiled to determine if there has been a reduction in or change of character of caseloads.

Cultural Diversity and Economic Issues

Culture and ethnicity along with economic circumstances can influence an individual's thoughts about care. They can influence choices about where quality care can and will be provided (e.g. home, ER, clinic, general practitioner), and candor about diagnosis and prognosis (this is an especially sensitive issue among many Native American tribes). Within any larger cultural or ethnic group there can be subgroups with differing views. For instance, the Apache, Pueblo and Hopi tribes have commonalities and distinct differences in their value systems, yet clans within the tribes can have further diversity still, all impacting care issues.

Decision-making authority and beliefs about modern medicine versus traditional medicine are examples of highly important and sensitive issues that must be well understood in order to meet the needs of individuals seeking care and their family members. In addition, some people feel that non-aggressive care is not as good as aggressive care (i.e. ER care). Availability of care that is culturally sensitive and tailored to the needs of ethnically distinct groups may be a barrier to both access and utilization of non-ER care among minorities, just as fears of being turned away for lack of health insurance may drive economic decisions for going to the ER. Thus the combination of desires for quality care and care that will not be denied for economic reasons may contribute to the high use of the ER.

The Arts

The reason for using the arts is that they inspire and engage people, and they communicate information in fresh, charming and culturally sensitive ways. The arts can be used to deliver information not in the dry clinical way of so many health posters, but by using the images and language of ones own peers. Furthermore, the arts can be used to create a more calming atmosphere in the ER, can help break ethnic stereotypes and can help communicate to people in language, symbols and imagery that they readily understand.

Project Goals

Goals of this project will be to create demonstration projects to:

- Reduce the use of the ER in Albuquerque for non-emergency services
- Increase the use of alternative health services for non-emergency care
- Increase patient and patient family satisfaction in the quality of non-emergency care
- Increase caregiver awareness and understanding of cultural and ethnic issues around non emergency care
- Break stereotypes and myths about non-emergency care, what constitutes quality care, and peoples of differing cultures

Planning Team

A planning team will have to be established that includes representatives from the medical center, community health programs, and community social service and arts agencies. Society for the Arts in Healthcare and Wye River Group on Healthcare will provide coaches to help support the planning, implementation and evaluation process. A budget, timetable, goals and method of funding and evaluation will be established to accomplish the planning phase, implement the program, and measure outcomes.

This is expected to be a multi-year project; year one for planning and fundraising, years two and three for implementation, followed by six months to twelve months for evaluation and reporting.

Outcomes

- Inventory of current use of the ER, including preferences, attitudes, and ultimate disposition among African-Americans, Hispanic Americans, Native Americans by tribe, and Caucasian Americans (e.g. impact of attitudes about being accepted whether or not they have health insurance, services that can be better treated elsewhere, and cost to hospital for excessive use of the ER)
- Inventory of alternative health services available, including services provided (or not) whether clients have or do not have health insurance
- Inventory preferences, attitudes, and ultimate disposition among African-Americans, Hispanic Americans, Native Americans by tribe, and Caucasian Americans in regards to alternative health services (e.g. impact of attitudes about being accepted whether or not they have health insurance)
- Inventory of experiences related to quality of care by the patient and patient's family (e.g. were advance directives heeded, did patients suffer pain)
- Inventory of current end-of-life care services provided by health institutions to patient at the ER and at alternative health providers
- Inventory of the concurrent use of the arts (and what type) in end-of-life care and perceived value of the arts by patient, family and professional caregiver
- Inventory of current caregiver's (and medical student's) awareness of and understanding of cultural and ethnic issues around providing health care
- Establishment of ad-hoc planning groups including representatives from ER (staff, patients), health institutions, and social and arts agencies
- Development of models for changing and reinforcing change in use of ER services, choices, and sensitivity to cultural mores
- Development of training models and materials for caregivers and artists
- Development of evaluation models
- Raised profile of medical centers as being proactive in emergency care that is sensitive to cultural mores, affordable and appropriate
- Increased awareness in the choices one has in end of life for emergency services, decreased use of ER for non-emergency services, and increase in alternative services for non-emergency care
- An increase in the use of the arts to communicate health information and in the ER to help create a more calming environment

SUPPORTING RADIO-H

Any campaign intent on reaching the American public and raising awareness must include media as a tool. We have developed a partnership with Andrew Holtz, award winning former CNN Medical Correspondent, to create a radio talk show focused on health.

Andrew wants to help the public understand "*the hows and whys of the crazy-quilt US health care system.*" To quote Andrew further, "*Our so-called health care system is a mix of historical accidents, unintended consequences and good intentions gone awry, locked in place by entrenched interests…. One reason our health care problems appear unsolvable is the veil of mystery that obscures how the system works… or doesn't work… and what the effects of proposed fixes really might be. We can rip away that veil and let the light shine in.*"

WRGH is actively supporting Andrew's proposal for a talk show in the Portland, OR market, "Radio-H." Community leaders in Portland have enthusiastically responded to our request for financial support and are now providing letters of endorsement, to convince the radio stations to provide the air-time that it needs.

Andrew's description of the rationale and plans for the show are set out below.

Why Radio-H?

Radio-H is a call to action.

Despite substantial advances in medical science (and often because of those advances), the U.S. health care system is failing to meet the needs of individuals and society. Simply tweaking the current structure of the system is untenable. Fueling the current system with an ever-larger share of our money and manpower won't solve our health care problems, even as the drag on our economy robs us of the resources to achieve our other goals. Fundamental and comprehensive change is necessary in order to get not only the medical outcomes, but also the larger goals of health, that we seek.

Radio-H will promote grassroots efforts by engaging listeners in discussions of the fundamental issues facing our health care system; and provide them with the ideas, vocabulary and other tools they need to push for real change. Radio-H will not advocate a specific plan; rather, in tune with the essential spirit of journalism, it will inform citizens about the true state of affairs and the options available, so that they can act through the political system and other institutions.

Beginning in Oregon, Radio-H will exclaim that we need not and should not wait for someone else to rescue us: we can act now. Indeed, the program will proclaim that delay is unacceptable.

Radio-H will stir things up. It's about time.

Why Commercial Radio?

Two factors make commercial talk radio stations the best outlets for this program: Availability and Audience.

Many talk radio stations sell blocks of time on weekends. By purchasing the time, we would control the content and format of the program. By contrast, most public radio stations not only have full schedules, generally they air only programs produced by their own staff or one of the two major networks, NPR and PRI.

While the audiences of many public radio stations may include many well-educated listeners sympathetic to health care reform, the audiences of commercial radio stations more closely reflect the broader American public; the audience we need to reach. As with a physical activity campaign, the greatest public health gains are made not by spurring frequent joggers to become marathoners, but rather by getting "couch potatoes" off their duffs and around the block.

By grabbing the attention of listeners between a gardening program and a computer advice show, our program will provide the background, vocabulary, and avenues for action that can energize a broad spectrum of the American public.

Program Approach

We all want good health and we all use the health care system. But our encounters with the system often leave us frustrated and bewildered. At a minimum, the rising cost of health care pokes a hole in our family budgets and cramps our job opportunities. At worst, the cost blocks access to care or pushes us toward bankruptcy. And after all that spending, we don't really know what we're getting for our money. And so we gripe about the system… about the cost and the confusion… but we feel powerless to do anything.

On the other hand, those who work in health care or study its Byzantine ways often feel just as frustrated; but for different reasons. Many insiders have an understanding of the challenges facing us, but don't know how to rally support for change.

Radio-H bridges the gulf between health care insiders and the rest of us.

Radio-H takes an "Oh, my!" approach. It uses callers' stories of "oh, my!" exasperation to spark discussions that are concrete and real world. By framing the issues within four major areas, every program answers the listener's number one question, "How does this issue affect me?"

The Four "My"s:

- ***My Money*** (premiums, out of pocket costs, taxes, etc.)
- ***My Job*** (job lock, hiring barriers, drag on wages, international competition, etc.)
- ***My Health*** (access, availability, quality, R&D, etc.)
- ***My Values*** (freedom, responsibility, community, individuality, equity, etc.)

Radio-H fits comfortably on the radio dial between programs about gardening or investments, car repair or computers. Radio-H meets listeners where they are. Radio-H answers the questions they have. Radio-H delivers the information and understanding they crave. Radio-H offers listeners tools to engage in the work of making our health care system better meet our needs and desires.

Program Elements

Radio-H has the look and feel of most radio talk programs. The familiar format eases listeners into discussions of serious topics other programs shy away from.

Standard Segments

Call-ins & Experts

Interviews with expert guests, including questions from callers (and e-mailers), are a major part of the program. Through voice mail messages and e-mail, listeners help shape future programs.

News & Perspectives
By using the resources of health policy information sources, the news update and commentary segments of Radio-H take listeners beyond what local news outlets typically offer.

Special Segments
(The final mix of segments has yet to be determined. Not every segment will appear in each program.)

Kitzhaber (Kitzhaber's Korner, Kitzhaber & Co.)

Gov. John Kitzhaber brings his unique perspective and experience to bear. Through commentary, exchanges with host Andrew Holtz, and interviews with special guests, he cuts through the usual excuses to bring the real issues and choices into sharp focus. He cuts through the fog to make us face the fundamental questions: what do we really want and how do we get it.

Contributor(s) TBA

Another voice or voices will complement the contributions of John Kitzhaber.

The "H-Vox"

Sometimes it is hard to speak freely. Putting your name on strong statements may threaten your job or friendships. The words of those who are identified with particular institutions or perspectives may be accepted or rejected based on that identification, rather than the actual content of the message. The "H-Vox" is a way for insiders and others to say what they really think anonymously. This technique presents risks. It must not be used as a vehicle for stealth attacks on individuals or institutions. The listeners benefit by hearing ideas without "baggage." The resulting discussions can focus on the strengths and weaknesses of the words and ideas themselves, rather than being distracted by the identity of the speaker.

Health Affairs

Much of the best data and analysis of the health care system appears in the journal *Health Affairs*. Through a special arrangement (under discussion) Radio-H features the authors and commentators who provide powerful reality checks on the true state of the system.

The Regulator

Each segment focuses on how a particular rule or set of regulations (local or federal) affects us.

What's Up, Doc?

Chats with providers about hot topics influencing how they go about their businesses. The featured guests include not only doctors, but also nurses, administrators, public health and social service practitioners.

Thinking Outside the Clinic

We push beyond the typical confines of health care discussions to look at the broader forces that shape the health of individuals and communities. Topics include money, education, sprawl, crime, social capital, zoning (e.g. does a neighborhood have produce stands or liquor stores?) and other factors that deal with health in the broad sense as the WHO defines it, not just the absence of disease.

Bizarro World

Competition brings prices down. The more you pay, the better the results. And the payer decides what is purchased. Well, maybe in the normal world, but not in the “Bizarro” world of health care. This segment highlights cases in which it seems down is up and trying to turn right pushes you far to the left.

Prof. Schwitzer’s Media Check-Up

Since few of us (fortunately) deal with the health care system enough to get first-hand experience with all of its convoluted aspects, we rely on the media to bring us the news and features that are supposed to help us understand things. But it doesn’t always work out that way. This feature picks apart recent news coverage to expose the myths, conflicts of interest, and confusion that distort many stories. (Former CNN Medical Unit Chief Gary Schwitzer, who is now an associate professor at the University of Minnesota School of Journalism, may be a regular correspondent.)

The Citizen's Health Care Working Group

Nearly two years ago, WRGH met with Senators Wyden and Hatch to discuss their bipartisan legislation calling on Congress to conduct public "town hall" meetings across the country to capture the “will” of the American people on health care. WRGH was very supportive of this legislation, as the approach is very complementary to Phase I of WRGH's "Communities Shaping a Vision for America's 21st Century Health & Healthcare," where we sought to identify the values and principles for health and health care that are shared among our citizens.

While the initial Wyden-Hatch legislation failed to pass, many of its components became an amendment to the Medicare Modernization Act of 2004. WRGH was asked to source qualified community leaders to apply for 14 appointed positions on a Citizens Health Care Working Group, The working group, which the Secretary of Health And Human Services will be a part of, will lead the nationwide public debate on ways to improve the health care system to provide every American with the ability to obtain quality and affordable health care coverage. The Working Group will make recommendations to the President and the Congress.

We are very pleased to have an opportunity to help shepherd the Citizens Health Care Work Group into existence and shape its composition. Our gratitude to both Senator Wyden and Senator Hatch for seeking our involvement.

SECTION III: REPORTS ON COMMUNITY LEADERSHIP

TWO NEW COMMUNITIES JOIN THE COMMUNITY LEADERSHIP INITIATIVE

SPOKANE, WASHINGTON
COMMUNITY LEADERSHIP ROUNDTABLE
DECEMBER 4, 2003

As the largest metropolitan area between Seattle and Minneapolis, Spokane is an important locus for providing health care services not only to its own residents and those living in the immediate area, but to patients who come from other states as well.

Health care is among the most important industries in Spokane, employing about 22,000 workers and providing a vital backbone to the local economy. While the fortunes of other industries rise and fall, the need for high-quality health care remains a constant. In fact, with the aging of the baby boomer population, the demand for health care services will only continue to grow.

The health of Spokane and its residents – in physical, economic and social terms – is inextricably linked to the health of its health care industry. This connection is clearly recognized by the city's health care and business leaders. Not only is health care a major employer in Spokane, "health is one factor that attracts people and employers to a community," said a physician.

Health is certainly one factor that attracts people to Spokane. Despite generally lower salaries and fewer employment opportunities than larger cities, Spokane boasts a high quality of life for its residents – particularly in the area of health. There is a strong community emphasis on the importance of physical fitness. The city hosts annual fitness activities such as a community basketball tournament called Hoop Fest and a fun run called Bloomsday. These activities attract broad public participation and encourage residents to maintain fitness year-round.

In many of the communities we've visited, participants have said that schools need to be much more engaged in health education. The Spokane public schools are actually taking a step in that direction by putting a strong emphasis on health and wellness. The Robert Wood Johnson Foundation recently recognized the Spokane schools for their innovative physical education program, which includes noncompetitive fitness and nutrition education.

Top Issues in Health Care That Are Facing Spokane

The Spokane community is doing many good things to promote the health of its residents, but the issue of access to health care and health care coverage continues to be a major challenge. Despite the wealth of medical resources in Spokane, many residents – particularly those on Medicare and Medicaid and those who are medically indigent – face significant difficulty in finding willing providers.

A lower-than-average Medicare reimbursement rate has caused some physicians to stop accepting new Medicare patients. In addition, Spokane has a high percentage of low-income residents who lack health insurance – only about one-half of Spokane employers provide health benefits to their workers. Severe budget pressures recently caused Washington State to drop 25,000 children from state-subsidized health care coverage.

To make matters worse, Washington State is considered a "high-risk" state for medical malpractice. Liability insurance premiums tend to be extremely high, which – combined with low reimbursement – has caused some physicians to leave Spokane. It has also forced physicians to practice "defensive medicine". While physicians recognize that ordering more medical tests than necessary wastes resources, they feel they have little choice if they are to protect themselves from potential litigation.

In addition to the problem of "physician flight," Spokane is facing workforce shortages among nurses, some specialty physicians, pharmacists, dentists and medical technicians. In the area of public health, the Spokane Regional Health District recently eliminated about 8 positions.

All of the issues described above point to one key issue raised by participants in Spokane: appropriate resource allocation. There is frustration and concern that a lot of money is being directed to high-ticket items that provide marginal benefit, while necessary and cost-effective services are chronically underfunded.

Among the problems with resource allocation is an "addiction to technology," said one physician. "Hospitals are building big new wings that are losing money." Prescription drug advertising is driving consumers to demand expensive medication for conditions they could heal or prevent through lifestyle modification. "The message in the ads is that you can do whatever you want to do and a pill will make it all better," said a business representative. Defensive medicine, misaligned incentives, and excessively "high-tech" end-of-life care also add heavy costs to the overall system.

On the other side, there is continued underfunding of the public health insurance system, which means inadequate Medicaid and Medicare reimbursement to providers, fluctuating eligibility levels for Medicaid and the State Children's Health Insurance Program (S-CHIP), cost-shifting to private payers, and inadequate investment in public health infrastructure.

There is a lot of confusion about what we are all spending our money on, and what it is we want to spend our money on so that we get the best return on our collective investment. Said one physician: "We don't have any vision at all on how we want to spend our resources."

The Lack of a Social Contract: What Is It Costing Us?

In Spokane, as in most other communities we've visited, there is broad agreement that a meaningful social contract for healthcare – one that applies to the entire population – does not exist in this country. "Currently, there is no social contract to care for each other and to care for our own health," said a public health official. In contrast, there is a functioning social contract for education: all children are entitled to 12 years of taxpayer-funded education, and all taxpayers are required to contribute to that system, regardless of whether or not they have children in public schools.

In health care, instead of one social contract that applies to everyone, there appear to be multiple social contracts that apply to specific populations. For example, there is a contract, albeit an eroding one, between employers and their workers around health care benefits. There is a social contract that applies to Medicare and Medicaid and its beneficiaries. A public health official noted that our country also has a social contract to protect people from environmental hazards that threaten their health.

But our country has stopped short of creating a social contract for health care that suggests we are "all in this boat together." We don't yet have a meeting of the minds about health care that connects individual rights and responsibilities to societal resources and responsibilities.

In Spokane, there is a strong perception that health care responsibilities are "all on the providers' side, with none on the patients' side." But a social contract has to be two-sided, which means that patients have to gain a better understanding of their own responsibilities and not just focus on their rights. We have to have a "meeting of the minds" or "covenant", with the patient as a full participant.

In practical terms, this means the patient has to be fully engaged in the responsibilities that go along with having a "right" to health care. There are a number of chronic illnesses, such as adult-onset diabetes, that are related to lifestyle choices, said one participant. These illnesses present a heavy cost to the health care system. "If you are involved in unhealthy behavior, maybe you should get less," he said.

On the other hand, another participant warned against making a social contract that is perceived as compulsory. People have to be able to opt out, and to make unhealthy choices if they want, he said. The goal, said another, should be to develop a "social conscience" about health, not an explicit social contract, which is probably not achievable anyway, she said.

There is also skepticism about whether the federal government is capable of moving the country toward an explicit social contract for health care. Given the enormous difficulty in bringing all sides together to support major action on health care, it is a lot to expect significant action on a social contract or major health system change, particularly given the costs that are involved, said a health care executive.

But another participant countered that the key to moving policymakers and the public to support a social contract for health care is to point out that it would, in fact, mean savings to all of us, *not additional cost*. The current system, with its gaps and inefficiencies, is actually costing us more, both in economic and human terms. There would be substantial return on investment, he said, if we could ensure that all residents have adequate health care coverage, particularly if such a right were linked to an enhanced sense of personal responsibility for one's health.

Community Efforts at Collaboration

In Spokane, there is clearly an interest in moving forward with community-based efforts to improve health care, rather than waiting for a solution to be handed down from Washington at some future date. "We need more emphasis on community leadership," said a surgeon. "Health care, ultimately, is local."

Already, the Spokane community has come together in support of community-based, collaborative efforts to improve health care access. The 4 major hospitals in Spokane created the Health Improvement Partnership (HIP) in the early 1990s with the goal of improving the overall health of Spokane area residents. In cooperation with partners such as the Spokane Regional Health District and the Inland Northwest Health Services, HIP serves as a catalyst organization that pulls together diverse interests in the community to identify and address health care needs.

Among its achievements, HIP has help 17,000 residents of eastern Washington gain health care coverage. The partnership is currently working with small employers that cannot afford the full cost of coverage for their workers and is educating them on how to tap into state insurance subsidies that will enable their employees to gain coverage.

In other examples of community collaboration, about 30 hospitals in the Spokane area have succeeded in connecting with each other through one electronic medical record. About 50 hospitals in eastern Washington and north Idaho are now covered by a joint "tele-health" system. "We've got lots of assets if we just look at them differently," said one participant.

Most recently, Spokane physicians created a program called "Project Access" to provide health care to low-income residents. Currently, 550 physicians, out of the 950 practicing in Spokane, are donating care under the program, which began seeing patients in September this year. All area hospitals and many pharmacies are also participating. The program offers patients low co-pay prescription drugs in addition to primary, specialty and hospital medical care. Described as a "very positive public-private community action," Project Access has received funding from local government entities as well as the Robert Wood Johnson Foundation and the Foundation Northwest.

Next Step: Connecting Health Care to Economic Development

In Spokane, there is a strong interest among business and health care leaders in the idea of linking health care improvement to economic development in a way that would promote both goals. The Spokane Regional Chamber of Commerce is positioned at the intersection of these two initiatives – both because health care is such a vital industry in Spokane, and because workers' health and health care are major concerns for employers generally.

Spokane employers, many of whom are small businesses, are struggling with their role as providers of health care benefits. Only about half the employers in eastern Washington can afford to offer health care benefits to their workers. "And the other half are cutting back," remarked a business representative.

On the other hand, some in the health care community said that many local employers don't understand the value of providing health care benefits and promoting health and wellness to their employees. "If employers invested in the concept of health as an investment and a resource to be managed, that would have tremendous power," said an insurance company executive. "But not many employers in this community have invested in that concept."

But those employers who *have* made the effort to invest in employees' health said they are frustrated. A representative of a company that self-funds its health insurance said the company expects a whopping 14% premium increase next year, even though its experience rating actually declined this year. "So that takes away a sense of motivation," he said. Also, the company built a fitness center for its employees, but few ever used it. Employers are confused about what they should do on behalf of employees' health and what the benefits would be.

Recognizing that the business community needs a clearer idea of the value of their contribution to health care, a physician said there is a need to draw direct connections between economic development in Spokane and collaboration on health improvement. "The goal of bringing business to Spokane is a way to drive collaboration on health," she said. An insurance executive agreed: "We need to communicate that health care is not an expense, but an investment."

A HIP representative suggested that performing a community assessment would provide critical information to the Spokane community at large and its business community in particular. Assessing how health care dollars are being spent in Spokane and the return on investment they produce could go a long way toward convincing the business community of the value of spending on health care. It could also provide information on whether and how health care dollars could be spent more effectively.

“There’s enough research that we could put (a community assessment) together,” said the HIP representative. “It would put us out-front nationally – we’d be the first in the country.” Other participants seemed interested in pursuing the idea, which is also one of the recommendations contained in WRGH’s Phase I report, released in September.

“We’ve got lots of assets,” said a health care executive, “if we just look at them differently.”

MUNCIE, INDIANA
COMMUNITY LEADERSHIP ROUNDTABLE
SEPTEMBER 29, 2004

The Muncie metropolitan area, located 60 miles northeast of Indianapolis, is home to nearly 120,000 residents. Among cities its size, Muncie boasts significant resources in the area of health care, including a regional health center, a university with a national reputation in the field of wellness, and several private foundations, including one whose focus is health and wellness. However, Muncie also faces a significant challenge in trying to provide access to high-quality health care for all of its residents. Nearly one in five residents of Delaware County, in which Muncie is located, is uninsured.

Among the community’s major health care resources is Ball Memorial Hospital, a tertiary referral center and teaching hospital that serves the East Central region of Indiana and is the flagship of Cardinal Health System. With more than 50 medical specialties, Ball Memorial Hospital provides Muncie with the kind of medical center that most other communities its size don’t have.

In addition, Muncie is home to Open Door/BMH Health Center, Inc., one of only 15 federally qualified community health centers in the state of Indiana. Open Door provides a full range of affordable health care services to all patients regardless of their income. During the past year, Open Door has collaborated with Ball Memorial Hospital Foundation (BMHF) and Cardinal Health System to launch Cardinal Access, a program designed to provide uninsured residents substantial discounts on health care services.

Muncie also has tremendous resources in the area of philanthropy, which is supported by a private sector that is progressive and community-minded. In addition to foundations such as BMHF and the Community Foundation, Muncie is served by hundreds of non-profit organizations, including an active local chapter of United Way. An important project currently underway is Partners for Community Impact, a collaborative effort by United Way and other private organizations to address the health and human service needs of Delaware County.

Although Muncie’s vibrant non-profit sector is a great asset to the community, it also presents something of a challenge, according to several roundtable participants. “One of our liabilities is the opposite side of the coin of our strengths,” said one. “We have a desire to ‘do good,’ but our non-profit sector is expanding faster than our resources.” There is a strong “can do” spirit in Muncie, but one of the community’s challenges is to bring focus and collaboration to the efforts of its non-profit sector.

Top Health Care Issues Facing Muncie: Access, Cost, and Disparities

Despite its tremendous resources, Muncie faces major issues in the area of health care, particularly in ensuring that all residents have access to health insurance and keeping costs affordable for individuals, employers and local government.

Many residents lack the insurance coverage and financial means to gain access to needed health care services. Indeed, nearly 19% of residents in Delaware County lack any form of health insurance – one of the highest rates of uninsured in the state of Indiana. As an administrator at Ball Memorial Hospital noted, “If you can’t get into a doctor’s office, you can’t get care.”

Among those who do have health insurance, there is confusion about coverage and billing issues, particularly among seniors who are dually eligible for Medicare and Medicaid. A local pastor said that many seniors in his congregation are confused about the billing for their health care services. Another participant agreed that “there is a lack of awareness among seniors about what they can get and what is covered.”

Another key concern is the escalating cost of health care and how the costs are distributed. Noting that health care expenditures now account for about 15% of the Gross Domestic Product, one participant said: “We’re getting to the point where it’s not going to be sustainable.” In Muncie, as in other communities, the issue of liability/medical malpractice was mentioned as a factor that is contributing to the rising cost of health care. However, it was also noted that Indiana is relatively fortunate because it is considered “low-risk” compared to other states such as Illinois, which helps Indiana in physician recruitment.

For employers, health care is putting an increasing strain on their bottom line. “When we compete in the global economy with countries that have national health care, we’re at a competitive disadvantage,” said the president of the Muncie/Delaware County Chamber of Commerce. Small employers and non-profit organizations in Muncie have a particularly tough time providing coverage for their employees; indeed, many of them don’t. The mayor of Muncie also noted that the rising cost of employees’ health care coverage is the one element of the city budget that seems beyond control.

Another significant issue identified by roundtable participants is that of health disparities. Racial prejudice and inequality were identified as ongoing concerns in the Muncie community and factors that continue to affect patients’ health and health care. “We have a real need to look at health disparities in Delaware County,” said the CEO of Open Door/BMH Health Center. Others agreed on the need to look closely at the issue of health disparities and to ensure access to high-quality care for all segments of the community, regardless of race, gender and age.

Other issues of concern that were mentioned by participants include misaligned incentives, inefficient health care delivery, and inconsistent quality of care. And finally, participants noted there is a need for better communication among providers. “Health care has to be a whole system,” said the director of a local non-profit organization. “Even providers don’t know all the resources that exist in this community.

A Lack of Consensus about the Social Contract for Health Care

In Muncie, there does not appear to be a clear consensus about whether a social contract for health care exists. Nor is there agreement on the question of whether there *should* be a social contract for health care.

Asked if health care is a right or a privilege, participants offered a variety of responses. “I think anyone you ask would say that health care is a right because there are so many regulations that make it so,” said one, explaining that “if you end up at a hospital, they have to treat you.” However, another said that “if you look at the system now, health care is more of a privilege; it’s not a right.” Several others agreed. “I think it’s clear that health care is a privilege,” said one. “We don’t have a right guaranteed by government, like the right to vote.”

Even if one *could* say there is a right to health care, the question is then raised: What exactly do people have a right *to*? There hasn’t been enough focus on that question, said a hospital executive. “There is no *one* social contract – no single version of what it covers,” he said. The fact that hospital emergency departments are required to care for any patient that walks through their door is not the same as a social contract, he added. “Generally, they deliver care when it’s too late, and it takes more resources than otherwise would have been necessary if the patient had gotten care earlier. Yes, people have access, but it’s a question of what they have access to.”

There was also no agreement on whether a social contract for health care *should* exist.
“Ideally, yes,” there should be a social contract, said one. “But the question is whether we can we afford it.” In response, another pointed out: “We already spend more than any other country anyway.” Every other Western industrialized country not only defines health care as a right guaranteed to all citizens, but also has a more efficient health care system and better health indicators, he said.

Engaging Consumers by Linking Personal Responsibility with Education

On the subject of a social contract for health care, it was noted that a social contract – by definition – involves both rights and responsibilities. If one has a “right” to heath care, than surely one has certain responsibilities as well. One issue of great interest in Muncie is the question of how to encourage individuals to have a sense of personal responsibility about their health and health care – not only for their own sake, but also for the sake of the community.

One participant brought up a personal example of how individual responsibility plays a vital role in health care. He said that recently he was prescribed medication for his high blood pressure. But rather than fill the prescription, he asked his doctor if there was anything he could do to lower his blood pressure instead of taking medication. The doctor told him he could do cardiovascular exercise 30 minutes a day and lose some weight. “I followed his advice and my blood pressure went down,” he said. Not only is his blood pressure now under control, he also feels better overall – and at no cost.

This example of an individual taking personal responsibility for his health and health care became the subject of considerable discussion during the Muncie roundtable. The increasing prevalence of obesity, diabetes, and other chronic conditions in communities all over America has heightened the collective sense of urgency about getting people to adopt healthy habits, including a balanced diet and adequate exercise.

Unfortunately, persuading patients to make healthy choices in their daily lives remains an uphill battle, said many participants. “For every person who wants the exercise, I can guarantee you 10 people want the pill,” said a physician. It is a massive paradigm shift to begin asking patients to become active and engaged in their own health instead of functioning as passive recipients of care, he said. The administrative director of the emergency department at Ball Memorial Hospital noted that the extent of this challenge can often be seen in hospital ERs. Many patients go to the ER to receive care for problems that could easily be treated with an inexpensive home remedy, if only patients had the knowledge, she said.

One factor that prevents some patients from seeking out information and support to adopt better health habits is that they are intimidated by the health care system, according to several community leaders in Muncie. "There is an underserved element in our society that is going to be underserved because they are intimidated by the system," said a local pastor. "These are people who have low self-esteem, or they are undereducated." He mentioned a project at his church that refers people to providers where they can get care for little or no cost. "But we find that even when they know where to go, they are afraid to go down there," he said. A hospital executive agreed. "We can offer free care and screenings, but people won't come," he said. "They're either intimidated, or they don't think they need it."

As a result, any effort to increase personal responsibility for health and health care should be linked with efforts to educate and actively reach out to patients, particularly those who are underserved. "Sometimes we fail in the health care delivery business because we think we know what people want," said one participant. "But we need to ask people what *they* actually want." Often patients hesitate to seek health care services because they lack trust in providers. Making services more accessible, convenient, and tailored to the needs of underserved populations is likely to improve patient compliance, according to several participants. For example, "we see great success with 'promotores de salud' – health promoters – in the Hispanic community," said the head of a local non-profit.

People need information not only about prevention and wellness, but also about their insurance coverage. As one participant pointed out, many patients don't know what their insurance covers or whether they qualify for coverage under programs such as Medicaid. "Many of us could use more education on that," she said.

But two participants noted that it's not just a matter of better educating people. "Socioeconomics plays into it," said a hospital executive. "[Low-income patients] have other needs that are often more fundamental, like food," he said. "Other priorities are determined by the economy and what their life is like." Many low-income patients are more worried about meeting their short-term survival needs than about reaping the long-term benefits of healthy behavior. For these patients, there should be tangible and immediate rewards for making choices that support their health, he said.

Community Efforts at Collaboration

In Muncie, there is increasing support and momentum for two major collaborative efforts designed to improve residents' access to high-quality health care and to make the health care delivery system more efficient and effective. One is Cardinal Access, which is funded by BMHF and involves collaboration from a number of community partners, including Open Door/BMH Health Center, Cardinal Health System, several United Way agencies, and Ball Memorial Hospital.

Beginning in October 2004, Delaware County residents who are uninsured and whose household income is equal to or less than 200% of the federal poverty level will be eligible for participation in Cardinal Access. Those who enroll in the program will receive a card that entitles them to a discount for select hospital services, and either a sliding fee scale or a flat co-pay for more primary care services depending on the site of service. To qualify, patients must be uninsured and not eligible for government programs. Moreover, the program attempts to link patients to a primary care provider in the community as well as create a network of specialists who will accept Cardinal Access patients.

Another major collaboration is Partners for Community Impact, a two-year-old program that is designed to improve health and human services in Delaware County. Health and wellbeing is one of several areas the program hopes to address. The plan is to first research the current state of the county's health and human services, including their strengths, weakness and gaps. In early fall 2004 Partners held several community forums to solicit input and concerns from Muncie residents about their health care. The program intends to present all its findings to the community at a later date in order to generate discussion on what direction the community should take.

There is significant cross-over between the Partners effort and the community roundtable work facilitated in Muncie by Wye River Group on Healthcare. Several individuals and organizations are involved in both efforts, which will hopefully provide added momentum for both. Already there have been tangible benefits from the collaboration. "Health and wellness was one area we were addressing, but we weren't aware of the depth of the problem until we heard from [BMHF President] Kelly [Stanley], the Wye River Group, and others," said Allison Bell-Imel, managing director of Partners. "So that has become an integral part of what we're presenting to the community and in building a focus and a message."

Partners plans to submit an application soon to the Lilly Foundation for a $250,000 planning grant. It has already raised the dollar-to-dollar match that is needed to qualify for the grant but continues to seek matching funds for a $250,000 implementation grant from the Lilly Foundation. One of the grant requirements is to demonstrate community buy-in for the project, said a participant who is involved with Partners and sits on the board of the Indiana Association of United Way, which will be the conduit for the Lilly grants. The community roundtable provides "perfect timing" for their efforts to move forward with defining a tangible outcome for the grant, she said. "The time is now."

Next Step: Creating a Community Health Council

In Muncie, there is strong interest among community leaders in the private sector, non-profit sector and local government to move forward with a coordinated effort to improve health care. Participants therefore agreed to establish a Community Health Council that will be tasked with determining how to optimize all of the efforts that are being made to provide high-quality health care to Muncie residents.

The aim of the Council will be to support and encourage collaboration among health care providers, service agencies, non-profits and other organizations. The emphasis will be on finding ways to improve communication and coordination.

BMHF was chosen as the convener of the Council, whose first undertaking will be an inventory of the community's health care delivery services. The goal of the inventory will be to determine whether and where greater efficiency can be achieved, particularly in the not-for-profit sector.

The organization of the Council has yet to be determined, but it may be modeled after the Downtown Development Group in Muncie. Initially, a small group representing key players will meet to draft a "charter", which will be circulated broadly for review and comment.

VOICES FROM THE COMMUNITIES

COMBINING ACTIVE TREATMENT AND HOSPICE CARE FOR PATIENTS WITH TERMINAL CANCER THROUGH A PALLIATIVE CARE PROGRAM

Dottie Deremo
President and CEO, Hospice of Michigan
Detroit, Michigan

Several health care stakeholders in Michigan have collaborated on a project designed to introduce hospice care earlier into the active treatment phase of terminal cancer. Called the Palliative Care Program, it is a phase III randomized study intended to demonstrate that a system combining both conventional medical care and hospice care can improve quality of life for terminally ill cancer patients and their families, provide better outcomes, and also be cost-effective for health care systems.

The study was led by researchers from two organizations: Hospice of Michigan – Maggie Allesee Center for Quality of Life in Detroit, and the University of Michigan Comprehensive Care Center in Ann Arbor. A number of different health care settings were involved in carrying out the project, including Hospice of Michigan and the University of Michigan Comprehensive Cancer Center, as well as two community-based cancer centers, two private oncology practices, and a Veterans' Administration center.

Under the project, patients with advanced, metastatic cancers of the lung, breast, prostate, pancreas and colon were identified as terminally ill from the outset and randomly assigned either to conventional oncology management or to conventional oncology management plus hospice enrollment and support. For those patients who received hospice support, a palliative care nurse coordinated ongoing treatments and hospice care, supported by a leading comprehensive hospice program and hospital system partners.

One hundred sixty-nine patients were enrolled in this program over a three-year period. Median survival on both arms of the study was 5.5 months. Study measures included symptom control, quality of life, caregiver burden index (CBI), health care outcomes, and cost of care in service units.

Although no difference was noted in symptom control, there was a significant reduction in the decrease of quality of life in the intervention group (thus quality of life was perceived as higher by the intervention group versus the control group). CBI was also impacted positively versus the control group, especially in the first month.

Preliminary comparative cost analysis revealed a 27% cost reduction in the group that received hospice support, which represents an extrapolated Medicare cost savings of $2,540 per patient. The cost savings was due to reduced chemotherapy, diagnostic, professional and hospital services.

Findings from this study should be considered preliminary as only 55 of the 169 patients have complete data. Twenty percent of the patients are still enrolled in the trial; forty-five percent of the patients have data that have not been completely entered. Although still incomplete, pilot data derived from this palliative care model may assist in the development of future demonstration projects.

Although the findings are preliminary, it appears that the Palliative Care Program is associated with cost savings of between $4,371 and $7,523 per patient. It is noteworthy that the period of observations (enrollment to death) is substantially different between the two groups of patients (227 days for conventional care and 266 days for palliative care). While the difference of 39 days is not significant, it is substantial.

Public policy implications of this research suggest a potential solution for the impending health care crisis that will be caused by the tsunami of aging baby boomers and their chronic disease conditions. The hospice delivery model and providers could offer a high quality, low cost, robust, ready-made delivery system alternative for advanced chronic disease case management. Further regional demonstration projects would need to be conducted to test this hypothesis across a broader population of patients with a wider range of progressive incurable diseases in several geographic locations.

A PUBLIC-PRIVATE COALITION WORKING TOGETHER TO IMPROVE CHRONIC ILLNESS CARE FOR VERMONTERS

Paul Harrington
Executive Vice President, Vermont Medical Society
Montpelier, Vermont

Physicians, hospitals, insurers, and state agencies in Vermont have agreed to work together in a groundbreaking effort to redesign the health care system so that treatment for Vermonters with chronic conditions is improved.

When Vermont Governor Jim Douglas announced the Chronic Care Initiative in the fall of 2003, he pointed out that chronic illness care is a critical area to address because 78 percent of all health care spending is incurred by people with chronic conditions. Douglas said his goal was that Vermont would become a model for health care system reform, and he called upon public agencies, private-sector groups and consumers to form a task force to identify priorities for implementation in the next two to five years.

The Vermont Medical Society is participating in the task force, along with the Vermont Association of Hospitals and Health Systems and the Vermont Program for Quality Health Care (VPQHC). Major insurers including Blue Cross Blue Shield of Vermont, MVP, CIGNA, and Medicaid are involved, as are Fletcher Allen Health Care and the Dartmouth Hitchcock Medical Center. Several state agencies are taking part, including the Vermont Department of Health, Medicaid program, Department of Insurance, and the Department of Aging and Disabilities.

Looking at chronic care initiatives in other parts of the country, Vermont's Commissioner of Health, Dr. Paul Jarris, says it is clear that changes in a number of areas will have to be made in order to be successful. Patient self management, physician office systems, decision support tools, and office flow all factor in, he says. Not to be overlooked is the payment structure for physicians.

The Department of Health is funding VPQHC to conduct a second diabetes collaborative, adding to the 25 practices in the state that have already entered into the program to improve care for patients with diabetes. Insurers are participating in the diabetes collaborative, and they are starting to look at how they can better support physician practices in terms of both compensation and rewarding physicians for making investments to improve quality of care.

The diabetes collaborative is also moving toward making patient data more widely available to physicians. The goal is to create a statewide chronic disease registry that will be accessible for all physicians. The registry would be populated by claims data from insurers and test results from laboratories. Physicians would be able to pull up a list of all their patients with diabetes and they would be able to see the last time there was a claim for an eye or foot exam. They could also quickly find out what a patient's last HbA1c test was. A summary sheet could be printed out for quick reference during an office visit.

Better patient self management is another key aspect to improving chronic care. The task force will address giving patients the training, skills, and tools to manage their care in the best possible way. Disease management programs do provide such training already, but they tend to be limited to one disease process. The Vermont initiative will look at how to manage patients with multiple conditions. "We want one comprehensive program that can be tailored to that patient and all the needs that they have," Dr. Jarris says.

A comprehensive statewide program also gets around the problem of patients losing disease management services as they change insurers. If Vermont has a single program for everyone, residents will get a set of consistent messages no matter who their insurer is.

Having all the major stakeholders involved is important for making that statewide program a reality, says Dr. Jarris. "No other state in the country has gotten the group of stakeholders at the table that we have here in Vermont, which is why we are getting such interest. No one else has pulled private and public insurance together."

ENLISTING SUPPORT FROM LOCAL EMPLOYERS FOR LAUNCHING A PATIENT-CENTERED HEALTH IMPROVEMENT AND DISEASE MANAGEMENT PROJECT

Martin Hickey, MD
Former CEO and Chief Medical Officer, Lovelace Health Systems
Albuquerque, New Mexico

The federal Agency for Healthcare Research and Quality (AHRQ) announced in early 2004 a $50 million grant initiative to foster the development of community-based medical information sharing. Over 300 applicants from across the country applied for this Health Information Technology demonstration grant. Only about thirty were funded, including the Lovelace Clinic Foundation. A not-for-profit health services research organization, the Foundation was awarded a three-year, $1.5 million grant.

To qualify, the Foundation had to first create broad community partnerships and raise a matching $1.5 million in cash and in-kind services. Our attempt to create these partnerships came in response to the Wye River Group on Healthcare's encouragement and support for community-based collaboration to improve health and healthcare.

As a result of our efforts, matching support was pledged by a wide range of local organizations, including businesses, healthcare systems (including all hospitals and health plans in Albuquerque), the public schools, the University of New Mexico and several community-based charitable organizations. It is an unprecedented public-private collaboration to improve health care in New Mexico.

The funding from AHRQ and local organizations will be used to establish the "New Mexico Health Information Collaborative" (NMHIC) – a disease management data warehouse that tracks chronically ill patients and their treatment by using claims data from the four major health plans in the state. Diabetes, pediatric asthma, low back pain, and depression will be addressed in the first four to five years of the project; others will be added later.

The Collaborative will create HIPAA-secured and protected disease registries, enabling physicians and other providers to obtain appropriate claims-based information on medications, lab results and acute occurrences (such as ER visits, admissions, etc.). This will be particularly helpful to ER physicians and school nurses who encounter acutely ill, breathless children and often do not have medical information to support them in making appropriate treatment decisions. In addition, patients with the targeted conditions will be able to access their own health information via a secure web site that will also offer education and interactive tools to improve self-care.

A unique feature of this initiative is the inclusion of major employer groups as full partners in the collaboration. In addition to the financial support these employers are providing, the workplace provides an opportune site to offer disease management education, given that most employees spend the majority of their waking hours at work. In addition, employers will receive aggregate (not patient-specific) profiles on the prevalence of the targeted diseases at their work site as well as support in developing programs to reinforce disease management behaviors in the workplace. A similar approach will be taken for children with asthma in the schools.

The development phase of the NMHIC will focus on diabetes and pediatric asthma. Depression and low back pain will be undertaken in subsequent years, once the infrastructure is developed. The collaborative will begin in Albuquerque, but will later be disseminated throughout the state. In Taos, Holy Cross Hospital and the local medical community will serve as the test site for the development phase of the project. What is learned from the implementation in Taos will later be spread to the rest of the state.

The New Mexico Medical Society, the New Mexico Hospital and Health Systems Association, the Greater Albuquerque Medical Association, the Greater Albuquerque Chamber of Commerce, and the Association for Commerce and Industry have all endorsed the project and will be encouraging their members to participate. During the first year, a community-based, not-for-profit governance mechanism will be developed with representation from employers, health systems, community advocates, and providers. The community-governance structure will encourage equal participation across the community. It will also serve as a basis for the procurement of additional grants and projects to advance the use and coordination of digital health information for Albuquerque and eventually all of New Mexico.

THE VALUE OF COLLABORATION BETWEEN A COMMUNITY-BASED HOSPITAL AND LOCAL EMPLOYERS

J. Edward Hill, MD
Director, Family Practice Residency Program, North Mississippi Medical Center
Tupelo, Mississippi

North Mississippi Medical Center (NMMC), based in Tupelo, Mississippi, is the largest non-urban hospital in the United States and the flagship facility of North Mississippi Health Services (NMHS). An integrated system throughout, NMHS is now in twenty-two counties and provides a continuum of care to 650,000 residents in north Mississippi, northwest Alabama, and portions of Tennessee.

It started because of a marriage between the business community and the physician community. I went there 9 years ago as the founding Director of its residency program in Family Medicine. NMHS was going to sign an affiliation agreement with the University of Mississippi Medical Center. At the signing, there were 73 businessmen and 5 or so doctors in attendance. The businessmen who were there said they needed to have a family medicine residency program to train doctors to take care of their employees. That amazed me. I'd never seen such a close partnership between the business community and the medical community before. That's just one illustration of how important it is to have an entire community involved in the system of care.

As is common in large and successful organizations, NMHS became somewhat arrogant. We became somewhat insensitive to the people in the community, and that happens in a lot of places – particularly big, successful hospital systems. As a result, a member of the state legislature introduced a bill asking for a certificate of need for a new private hospital in Tupelo. In response, NMMC commissioned an economic impact study of our system to evaluate its economic impact on the region and on the state. This was the second time this had been done; the first time was in 1999. The survey revealed a major economic impact on the communities in which NMHS operated as well as on the state. When the study looked at its economic impact on the region and the state, the results were staggering. NMHS is responsible for 5,500 jobs in the one small county in which it is headquartered, and it's responsible for over 12,000 jobs statewide. It generates about $550 million in income for the state economy, which is roughly four times the economic impact of the Nissan plant in Mississippi. Only the poultry industry is a larger employer in the state.

NMMC received the "Nicholas Davies Award" three years ago for excellence in computerized patient records. We are consistently named one of the "100 Most Wired" hospitals and health systems by Hospital and Health Network. We also have the most "profiled" physicians of any hospital in the country. And this is in Mississippi, the poorest state in the Union. So if we can do it, it can be done anywhere.

The hospital operates in a mostly fee-for-service market. As a consequence, every year we have a 3%, 4%, or 5% margin, which has allowed us to put capital into our information system, and allowed us to put millions of dollars in a residency program, in indigent care programs, and in school nurse and athletic trainer services for the region's schools.

We're using a lot of strategies similar to those developed by the Institute for Healthcare Improvement in Boston. One of the innovative ideas we're promoting in the community is school-based clinics, as well as a desire to pilot pre-kindergarten electronic health records for all kids as the beginning of a personally owned health record.

We have found in Tupelo that the marriage of the medical/health community with a progressive business community can become a powerful economic engine that benefits the entire community, region, and state. For those who are interested in more information, I refer you to Robert D. Putnam's book, "Better Together: Restoring the American Community." Chapter 5 is titled "The Tupelo Model: Building Community First."

LINKING A LARGE HOSPITAL DISTRICT TO THE PEOPLE IT SERVES THROUGH A COMMUNITY RELATIONS COUNCIL THAT TRULY REPRESENTS THE COMMUNITY

Maxine James-Francis, RN
Administrator, Seventh Avenue Family Health Center
Ft. Lauderdale, Florida

The North Broward Hospital District (NBHD) is a non-profit community health system that offers a full array of healthcare services to over 26,000 patients on a monthly basis. Established as a taxing district in 1952, NBHD has grown to become one of the ten largest hospital systems in the country and the largest hospital system in Florida. The District encompasses more than 35 health care facilities, including Broward General Medical Center, North Broward Medical Center, Imperial Point Medical Center, Coral Springs Medical Center and the Chris Evert Children's Hospital at Broward General Medical Center.

The District's mission is to care for the people of Broward County, regardless of income, status or circumstance. The District reaches out to all segments of the community through its four hospitals, children's hospital, seven primary care centers, four Family Health Places, school-based clinics, specialty care programs, home health services, health education programs, free and low-cost screenings, and business partnerships. NBHD is the health care safety net for the northern two-thirds of Broward County.

The 7th Avenue Family Health Center, which opened in Fort Lauderdale in 1998, is one of the District's primary care centers. A state-of-the-art healthcare facility, we provide a full range of services, from prenatal care and dental services to disease state management and transplant case management. Open to everyone, regardless of ability to pay, the center is truly part of the community it serves. Members of the immediate community serve on its Planning Committee and provide input into designing available services.

Similarly, NBHD has a Primary Care Community Relations Council (CRC) that represents the voices of all segments of the community in the District's decision-making. The CRC, which was established in 1993, has a large, diverse membership and includes not only District representatives but also city commissioners, members of Congress, key individuals in the community, and representatives from local and state organizations.

The CRC's many past accomplishments include the development of the Seventh Avenue Family Health Center as well as the offering of behavioral health services at Seventh Avenue, the creation of school-based health centers and the enhancement of partnerships with the Broward County School Board, and increased patient volume of the Lauderhill School Heath Center.

The goal of the CRC has been to create a coalition of people from every area of the county where the District's primary care sites and school-based centers are located so that NBHD can better address the needs of the entire community. We want to have a coalition of representatives on the Council who are not only interested in strengthening the District's primary care system, but also have a vested interest in making sure that the community has the ability to influence how we deliver primary care services.

As part of its mission, the CRC performs an annual community assessment in order to prioritize community needs, decide which projects to undertake and determine future primary care needs. Current projects include providing additional behavioral health services, specifically in the northern part of Broward County; expanding primary care services in the county's western corridor; and either expanding an existing site or creating a new site for the primary care center in Pompano. In pursuing this projects and communicating how they will serve the needs of the community, the CRC serves a vital role as community liaisons.

ALIGNING INTERESTS TO PROMOTE HEALTHY COMMUNITIES

Sanford R. Kurtz, MD
Chief Operating Officer, Lahey Clinic
Burlington, Massachusetts

Lahey Clinic in Burlington, Massachusetts, and the communities it serves are challenged by circumstances that are increasingly common. Rising community infrastructure costs and tax revenues that fail to keep pace have cut into funding for state and locally sponsored public health initiatives. Slim health care reimbursement margins and hospital closures paired with the steadily growing demand to care for more patients is approaching the limits of hospitals' and physicians' capacity to care for them. At the same time, Lahey Clinic and local community leaders remain committed to advancing the health of people in their communities.

In the 1990's Lahey Clinic crafted a strategy designed to align the interests of community organizations and Lahey and optimize the use of our combined resources to promote the overall health of the community. The strategy is focused on implementing programs that:

- Create partnerships with community organizations that build on the capabilities and resources of each organization as well as the clinic;
- Prevent or reduce the likelihood of health problems that require the intervention of a health care professional;
- Deliver programs and interventions where they are likely to be most effective, whether in the community or in a health care setting; and
- Ensure access to hospital-based care for those most in need.

At the outset of this strategy, Lahey established a health care planning committee comprised of members of community groups and organizations, residents of local communities, and Lahey employees. Through collaborative planning and coalition building, Lahey Clinic and its partners decided to focus on the unmet health needs of residents, with particular emphasis placed upon underserved and economically deprived individuals. The committee conducted a needs assessment that included:

- An assessment of demographic and census data on health care needs in the region;
- An inventory of health care organizations and institutions in the area;
- An assessment of cultural and language needs that is updated regularly to monitor population trends; and
- Focus groups, interviews, and surveys of local leaders to gather their input on priority health care needs.

Periodically, the community reviews and updates this assessment to confirm or redefine program priorities. The committee and its current programs are designed to address two public health issues – domestic violence and tuberculosis – and three vulnerable populations – the uninsured/under-insured, the elderly, and the youth population in the Burlington area.

Currently, the committee has a portfolio of over twenty active programs in place. These include:

- A domestic violence prevention and treatment program that includes both outreach and support to community organizations as well as training programs for community members and Lahey staff in recognizing and responding to domestic violence;
- A regional tuberculosis clinic that serves at risk populations in fourteen communities;
- A public educational campaign to ensure access to care for those who are uninsured;
- A community clinic that provides primary care, prevention, and early diagnosis programs for the uninsured and underinsured residents in the Burlington area;
- An elderly fitness program publicized and delivered by a partnership of the Burlington Council on Aging and the Lahey physical therapy department;
- A community-based wellness program for the elderly;
- Collaborative programs designed to prevent under-age drinking and teen dating violence, and smoking;
- Programs designed to develop effective parenting skills for raising adolescents with strong self-esteem and good life decision making skills;
- A broad array of community support groups for residents with various chronic conditions and survivors of serious acute illnesses (e.g., breast cancer, heart attack).

Measures of results vary depending on the type of program and its objectives. Evidence to date indicates increasing participation in these programs over time, with the expectation that strong participation will translate both to improved health and to more effective use of existing professional health care resources.

ASSESSING THE HEALTH OF HEALTHCARE IN SPOKANE

Jeff Selle
Public Affairs Manager, Spokane Regional Chamber of Commerce
Spokane, Washington

Like many other mid-size metropolitan areas across the country, the city of Spokane, Washington, supports a significant healthcare industry that is critical to the economic vitality of our region. Likewise, our regional healthcare system is facing many of the same fiscal and regulatory challenges that have plagued the industry nationwide. Those challenges, combined with escalating competition from healthcare providers in bordering Idaho communities, began to seriously threaten the stability of what is considered to be our region’s largest economic driver.

While the Spokane Regional Chamber of Commerce (SRCC) has always been supportive of the healthcare industry, about three years ago it became apparent that much more support was needed to protect and grow the industry in our region. To this end, the Chamber organized an effort to ensure that the industry – which accounts for 21 percent of our economy and 22 percent of our regional workforce – would remain viable.

The Chamber began by establishing its Health Industry Development Group (HIDG), which is comprised of 10 CEOs from the healthcare industry and 19 CEOs from a diverse range of industries in Spokane. The purpose of this group is to have the healthcare CEOs identify an agenda of common issues and enlist the support of the other CEOs to help them develop and implement strategies to address the critical issues facing the industry. One of the group's initial successes was the development of a new university district in Downtown Spokane that is focused primarily on healthcare education and research. The group has also been instrumental in raising awareness of the healthcare information technology network and capabilities that are available in our region through Inland Northwest Health Services. (*See the case study about INHS on page 94*)

Meanwhile, other initiatives were also under way in our community to resolve specific issues with regard to charity care and bridging the gap of the uninsured. (*See the case study about Project Access on page 67*) The Chamber has also played a supportive role in those initiatives. The purpose of Project Access is to better organize and distribute the charity care in our community among the doctors, hospitals and clinics who volunteer to participate. The Health Improvement Partnership is also developing innovative ways to provide health insurance to those who could not otherwise afford it. (*See the case study on HIP on page 114*)

Despite all of the successful initiatives that are under way in our community, the Chamber soon realized that policy changes were also necessary to improve the health of this industry, and those changes were going to take much more work than we had initially thought. We began inviting our elected officials to summits, forums and conferences to highlight specific policy issues that were impacting our healthcare industry. We engaged our state lobbyist in the issues and began raising money to hire a full-time federal lobbyist to help us in DC. Then, during a fall summit in 2003, we were introduced to the Wye River Group on Healthcare (WRGH). Jon Comola and Marcia Comstock, MD, who were keynote speakers at the event, said they were impressed with the community work that was already under way in Spokane. Subsequently, they agreed to adopt Spokane into Phase II of their Community Leadership Initiative project.

WRGH helped the Chamber organize a taskforce structure that fit with the rest of the communities involved in the initiative. We held roundtable discussions and invited a diverse range of people representing various aspects of healthcare. We assessed the values that our community felt should be included in a nationwide blueprint for healthcare. We wound up with a list of values and quickly determined that policy change was going to be needed to achieve our goals. This was a bit disheartening for some us, as we knew the challenges ahead.

After some discussion with the taskforce participants in this project, we identified the need to change the way we address healthcare policy. Some questioned the "old saws," and the tactics that are repeatedly used to affect change at the national level. With such a diverse group, we also had people questioning the validity of specific issues. Some claimed that many of the issues were based in assumption rather than fact. For instance, some wondered if rising medical malpractice premiums were in fact nothing more than a pocketbook issue for doctors in our community. Were the premium increases really responsible for doctors leaving our community for better rates somewhere else? Was this limiting access to specialty healthcare services in our community? We realized that we needed more solid data if we were going to reach consensus on policy issues.

Our taskforces felt that a starting point for getting to consensus was to assess the current status of our healthcare system and the needs of our community. This sounded like a much simpler task than it turned out to be. We selected a core group of healthcare leaders to sit down and define the scope of the assessment. The WRGH put us in touch with Paul Harrington, from the Vermont Medical Society, who had accomplished a statewide assessment for the Governor of Vermont a few years ago. Harrington helped us get the process started with a copy of his plan, and we decided to break the assessment out into several stages. We eventually chose to do a series of separate reports on the following topics:

1) access to healthcare;
2) the economic impact of healthcare;
3) a gap analysis of the healthcare infrastructure;
4) an assessment of the quality of healthcare;
5) a study of the cost drivers in healthcare.

We felt that the data collected in the process could then be used to identify and prioritize real issues, and to backup our advocacy efforts at the local, state and federal levels. We enlisted the help of our public health district and area universities. We started with existing data that could be pulled from other reports to formulate our assessment. We chose to start with an access assessment and an economic impact study. The Chamber raised the money and hired Eastern Washington University to conduct the economic impact study, and the health district paid for and conducted the access assessment. Both of those were completed in May 2004, and we are currently conducting a gap analysis of the healthcare infrastructure.

Currently, the taskforces established in Spokane are analyzing the access report to identify the poor access issues that we face in our region. A list of issues will be generated and prioritized for action. It is our intent to use the infrastructure report to form coalitions to address these issues that are surfaced in the process, and the economic impact study will help us make a business case when advocating for change.

It should be noted that any assessment of this magnitude will never be fully completed, but it is the intent of this group to use the assessment as a benchmarking tool – a starting point. It is understood that this assessment is a continual work in progress.

COMMUNITY OUTREACH EFFORTS FOR A HEALTHIER CHICAGO

Herb Sohn, M.D., J.D.
Strauss Surgical Group;
Vice-Chair, Board of Trustees, Finch University

Chicago is a medical city. It is home to the American Medical Association, American College of Surgeons, American Hospital Association, American Dental Association, and many other national organizations. Having these organizations headquartered in Chicago makes it very easy to get a lot of help for the various programs that we deliver in Chicago.

When John L. Wilhelm, MD MPH, was appointed the city's Commissioner of Public Health in December 2000, he outlined his vision for a healthier and safer Chicago. This vision was based largely on a recognition that the Department needed to partner with city residents, providers and community organizations in its efforts.

One of the Department's major contributions to neighborhood partnerships has been to provide information that community participants can use to educate residents about the health status of their neighborhoods and the health resources that are available to them. The goal of this effort has been to provide information that will guide residents' decisions in ways that will improve their health and well-being.

To that end, the Department has created the ***Chicago Health & Health Systems Project***, funded in part by the Otho S.A. Sprague Memorial Institute. The project offers residents and organizations general information on the health status of each Chicago community and the local health systems that are available in each.

The Community Health Profiles were developed for each of Chicago's 77 formally-designated community areas. They contain a mix of health status and health resource data. Each profile presents information for the specific community, and in some instances, comparable information for the city as a whole. In addition to a map that depicts the locations of health care facilities, each community profile includes Census statistics; estimated primary care capacity and utilization; health care resources; hospital capacity and utilization data; hospitalizations for ambulatory care sensitive conditions; leading causes of death; leading causes of hospitalization; maternal and child health indicators; and where residents obtain hospital care.

In addition to the Community Health Profiles, Hospital Profiles were developed for 41 Chicago hospitals and a select number of suburban hospitals that serve a large number of Chicago residents. Each hospital profile contains the same basic information, to the extent it was provided by the hospital. In addition to the name and address of the hospital, the information includes market share and patient origin; number, type of hospital beds and average daily census; select personnel; source of admissions; sources of payment; top 10 diagnoses for patients that were admitted to the hospital; and utilization data for select indicators, such as live births and admissions.

In July 2004, Chicago Health & Health System Project Community Health and Hospital Profiles were updated in several ways. Maps and listings of health care resources were amended to reflect the addition of new sites and closing of others; the U.S. Census race/ethnicity categories were expanded; hospitalization data were revised to include rates of hospitalization; and Health Care Resources profiles were updated to reflect the inclusion of new data and facility changes (e.g., changes in facility name, type, or ownership).

A program called "How's Your Health Chicago?" was started by the Chicagoland Chamber of Commerce in 2003. They developed a vision of better health for Chamber members and their employees, who comprise about 1 million of the roughly 8 million people who live in the Chicago metropolitan area. The vision was to improve health care by providing local information about what needs to be done, support change at the medical practice level to meet these needs, and initiate community-wide approaches to manage prevalent and important health care needs without requiring direct involvement by health professionals.

To carry out this project, the Chamber formed the Chicagoland Health Alliance, which is an active collaboration between providers, health systems, and associations representing patients, employers and communities to improve personal and population health. A community health alliance can focus divergent interests within a community – not just those interests directly involving health care – on reaching the public and meeting health goals. Because it is broad-based and led by respected organizations, this type of alliance is also in a strong position to present health needs and concerns to the individual medical care systems.

Implementation of "How's Your Health Chicago?" is divided into two phases. The first phase used a web-based approach for community assessment; the input and participation of the Chicagoland Health Alliance was critical. Chicago residents were invited to use the website, www.howsyourhealth.org to receive a self-assessment of their healthcare needs. The website education is based on self-assessment and provides an action summary which can be printed and taken to a medical provider to help ensure important issues are not overlooked during a visit.

The business community has been very active in another area. With the help of a grant from the Commonwealth Fund and directory standards developed by the National Committee for Quality Assurance, The Midwest Business Group on Health (MBGH) has launched “Finding Doctors in Chicago.” Unfortunately, surveys have shown that consumers do not usually think about selecting a doctor until open enrollment, a move to a new community, a change in health plans, or when an accident or illness occurs. At those times most people rely on their personal experience or the advice of family and friends. Increasingly people turn to the website of their local hospital, but these directories are not objective and are frequently confusing. The MBGH's goal is to provide a directory with relevant and objective information based on sound standards that will improve the ability of Chicago area consumers to find a doctor who meets their needs.

Addressing disparities in health care is a serious challenge, one recognized by many prominent health care leaders, organizations and governmental agencies. The Institute of Medicine, along with multiple co-sponsors recently hosted a program in Chicago, as a launch point for beginning the task of eliminating health disparities in Chicago. The plan is to develop a framework for collecting data on race, ethnicity, and language preferences so that educational and workforce training programs have the necessary information to enhance multiculturalism and performance.

Another area of significant concern to the Chicago community is the problem of medical liability. As a result of escalating premiums for malpractice coverage, Illinois is losing physicians to other states where the burden is less. The Chicago Medical Society together with the Illinois State Medical Society has been working to raise public awareness around this issue. In local, state and national races, the Medical Societies have actively urged the public to vote for candidates who support tort reform.

The Illinois State Medical Society (ISMS) is a repository of valuable information for physicians and patients.

Here are some examples of the type of information available through its publications:

- A guide to HMOs outlines the financial status of every HMO with an Illinois license. The information provides insight into the financial stability of the HMO, the number of members served, and the amount of total income spent on administrative, medical and surplus costs. The guide provides relevant information for patients in selecting an appropriate HMO.

- *Moms to Be and HIV* provides medical information regarding the importance of testing for HIV to mothers and mothers-to-be.

- “A Personal Decision” contains information regarding end of life decisions, including an explanation of advanced directives and the forms necessary to make one’s medical preferences known in the event that one is incapable of expressing those decisions to caregivers.

In addition, useful information can be found on the ISMS website, including:

- A web page focused on Women’s Health, which includes suggested testing and tips on preventive health;

- A web page, "A Prescription for Caution: Searching the Internet for Medical Information," which gives patients a list of what to consider when searching the internet for medical information, e.g., timeliness of information and author’s credentials. and the timeliness of the information provided; and

- An explanation of The Managed Care Patients Rights Act, which protects the rights of patients with regard to their managed care plans.

As apparent from the multitude of diverse initiatives underway in Chicagoland, our community is a strong supporter of the value of bridging the healthcare divide through cooperation, cross-sector collaboration, and engagement of all our citizens in meeting our healthcare challenges.

WORKING TOGETHER TO CREATE A HEALTHIER SAN ANTONIO

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During 2003-2004, a broad coalition of public officials, health care leaders, concerned citizens, and community organizations in San Antonio have take action in a variety of areas to improve the health of the people of San Antonio. There has been positive change in a number of key determinants that affect community health, including access to timely, quality health care, as well as overall social conditions, individual behavioral choices, environmental factors, and hereditary predispositions. Some of this change was the result of planning and collaboration – and some was simply fortuitous.

Texas ranks at or near the bottom in terms of people without comprehensive health coverage, but future economic trends for employment and improved health insurance are favorable for the San Antonio area. Employment is up, unemployment down, and significant new companies are choosing to locate in San Antonio, such as the much heralded Toyota truck manufacturing plant. While Texas has tightened eligibility for the Children's Health Insurance Program (CHIP), reducing the number on the rolls, the number covered under Medicaid has increased. The state further took action to reorganize state agencies dealing with health services, public health, and social services in an effort to improve service delivery, reduce bureaucracy, and save money that ultimately could be directed into services for the people.

The availability of timely, high-quality health care continues to expand in San Antonio to meet the demands from a growing and aging population. This past year has seen the opening of a new heart hospital, and several hospital systems have completed or announced plans for new or expanded hospitals, including emergency departments and obstetrics services. University of the Incarnate Word has announced plans to open a School of Pharmacy, and the Alamo Community College District is exploring the need to significantly expand its health-related programs.

Two years ago, San Antonio, like much of the country, was facing a significant shortage in the nursing workforce. Local officials, the business community, our schools of nursing and hospital systems responded with funding to expand enrollment at our five nursing school programs. With well-qualified applicants being turned away, largely due to insufficient faculty to meet accreditation ratios, our nursing schools used the available extra funds to bring in new faculty and significantly increase enrollment.

When Urgent Matters, funded by a grant from the Robert Wood Johnson Foundation, looked at San Antonio's services to the underserved population, they had a number of recommendations for improvement. But they cited the Bexar County Hospital District's CareLink as an innovative program to integrate the “safety net” of services available to individuals at or below 200 percent of the poverty level. Enrollment is now approximately 50,000 of 200,000 eligible. Each person has a designated primary care home, and in a “managed care” type program have their specialty care and other health services coordinated for them. This has resulted in less use of emergency services and better health status. (For more information on Care*Link*, see the case study on page 105)

While emergency services continue to be a challenge for many metropolitan areas, including San Antonio, the trauma diversion crisis we have seen in recent years has abated due to a number of positive actions at our military medical centers with Level 1 trauma capability, the University Health System and the trauma regional advisory council. The effectiveness of the Critical Care Transfer Coordination Board for Trauma, now in its eleventh year, continues to improve and now includes representation from two Level 3 trauma centers, which was especially important as San Antonio faced contingency planning for wartime mobilization of our two Level 1 military trauma centers. During the Iraqi war, on one occasion San Antonio received over 60 patients from one medical evacuation flight. Further solidifying trauma support and collaboration within health systems in San Antonio was the establishment of the Trauma Institute of San Antonio (TRISAT), with initial funding through a Congressional appropriation sponsored by Senator Kay Bailey Hutchison. TRISAT focuses not just on trauma services, but on research and education as well. These cooperative, coordinated relationships have had positive effects on San Antonio’s preparedness posture in protecting the health of the people. Through leadership at the Greater San Antonio Hospital Council, public health officials, and city/county government, the Regional Emergency Management Preparedness Steering Committee (REMPSC) constantly is working to improve planning, exercises and good stewardship of homeland security funds coming to the area. Additionally, the people of San Antonio approved a bond issue for $25 million to build a new city/county Emergency Operations Center (EOC). Other improvements include implementing “reverse 911” and a “311” system for community service information.

City officials have recognized the influence that behavioral lifestyle choices can have on an individual’s health and the development of chronic diseases. These officials have been instrumental in passing a city ordinance that further restricts smoking in public places, including restaurants, and they have championed programs to reduce obesity, improve fitness and activity levels, which also helps to attack the diabetes epidemic in our community, particularly among the Hispanic population.

The public health authorities have carefully tracked health status, health trends, and environmental hazard exposure in the county. Their most recent report indicates a favorable stabilizing to improvement in various factors, including in many of the disadvantaged parts of the county. This includes a favorable reduction in teenage pregnancy which some attribute to implementation of specific programs targeting this condition.

Various health organizations and leaders have recognized the positive impact on health outcomes, potential reduction of health costs, and improved efficiencies in the health system that could come from a community-wide health information system that shares relevant patient information in a secure manner and in compliance with privacy issues required by HIPAA. Initial informal discussions are being held to build support for and implement a Local Health Information Infrastructure (LHII) that could take advantage of the considerable federal health information systems in place at the Department of Veterans Administration and Department of Defense hospitals.

The Texas legislature voted to enact legislation to cap certain awards on medical liability law suits, and the people of Texas voted to approve a constitutional change to allow for these liability caps. Already, malpractice premiums and the number of lawsuits have declined. Proponents argued that these changes would have positive effects on access, availability, and cost of health care, and ultimately on the overall health status of the people of Texas.

It has been three years since community leaders and concerned citizens came together in a focused "Health Summit." As a result, there is a growing realization from all sectors of the community that healthcare and the bioscience industry are important to the vitality of Greater San Antonio. The Greater San Antonio Chamber of Commerce has now elevated Health and Bioscience to full committee status, and the "San Antonio Healthcare and Biosciences Industry Economic Study" is now being done on an annual basis. At $12 billion, this represents the largest economic generator for the community and is twice as large as the next two sectors combined! We now recognize that it is time again to bring people and decision-makers together to discuss health and health care in the community and develop priorities and action plans to address community health issues. Plans are underway to build support from appropriate officials and others to hold another "Health Summit" in early 2005.

While many of these actions and initiatives proceed from their own constituencies, and individually they may have little impact on the overall health of the community and the reduction of health disparities among all population groups, nevertheless, collectively they represent positive trends and important efforts. San Antonio is committed to building a vibrant, creative, productive community. The people of San Antonio and its leaders recognize that a healthy community with minimal health disparities is the centerpiece of that vision. We look forward to more progress in the coming year in moving towards a healthier San Antonio.

TURNING A COMMUNITY-BASED VISION OF HIGH-QUALITY, PATIENT-CENTERED HEALTH CARE AND URBAN RENEWAL INTO REALITY

Primus Wheeler
Executive Director, Jackson Medical Mall Thad Cochran Center
Jackson, Mississippi

In 1995, Dr. Aaron Shirley – a well-known physician in Jackson, Mississippi – had a vision. He pictured a desolate, unused shopping mall thriving once again – not with retail, but instead with health care. He proposed that the old mall property be converted to a state-of-the-art ambulatory health care facility providing quality health care for low-income residents of Jackson. This ambitious concept for rebirth and renewal would be, in Dr. Shirley's words, "a community-based venture," in terms of its ownership and its mission.

Today, the Jackson Medical Mall is the only facility of its kind in the nation that provides quality health care, human services and retail to the community. Renamed the Jackson Medical Mall Thad Cochran Center in 2001, the Mall is a hub of growth and revitalization in the City of Jackson. The Mall has made significant progress in several major areas: health care, public safety, education, and community events. The focus of our first seven years has been health care and human services. With these components soundly in place, our focus now is to develop the community that comprises the Jackson Medical Mall District.

Our continued vision for the Jackson Medical Mall is of a well-planned, high-quality community, integrating heath care, community development and economic development with a stable, desirable residential neighborhood. We see a thriving community where safety and security are trademarks, where recreational facilities enhance the quality of life for both residents and employees, and where well-maintained and attractively landscaped streets highlight the power of vision and the spirit of a revitalized community.

The mission of the Jackson Medical Mall Foundation is to foster a holistic approach to health care for the underserved and to promote economic and community development in the Jackson Medical Mall area. The neighborhood surrounding the Jackson Medical Mall is part of the City of Jackson's Federal Enterprise Community Designation.

Along with economic distress, the community carries a significant risk for poor health outcomes such as hypertension, heart disease, stroke, kidney disease and tuberculosis. Hinds County, where the Medical Mall is located, has rates of low birth weight, infant mortality and births to teenagers that rank among the nation's highest. Appropriate preventive and primary health care continues to effectively reduce these unfavorable factors. In the past, when area residents attempted to access such care, they usually encountered a fragmented, inconvenient, inaccessible health care delivery system. They would seek expensive emergency room care rather than lower-cost primary care and preventive services. The Medical Mall's community healthcare approach is having an impact on this segment of the population.

The Jackson Medical Mall's one-stop shopping concept brings together health care providers and human service agencies in an easily accessible, collaborative environment. Patients enjoy a 165,000-square-foot ambulatory clinic, which includes a primary care clinic and specialty clinics, operated by the University of Mississippi Medical Center (UMC), and a 20,000-square-foot Hinds County Health Department clinic. Using case management procedures, these primary care clinics coordinate patient care with UMC's outpatient specialty clinics and other health care providers at the Mall. A computerized data network linking all primary and specialty care providers reduces duplication, improves quality of care, and lowers costs. Additionally, the comprehensive, collaborative system of care provides fruitful research opportunities for medical, nursing, social work, health-related professions and pharmacy students at the Mall. The one-stop-shopping concept of locating a variety of services under a single roof facilitates timely treatment and same-site referrals at the Medical Mall.

The Foundation is currently acting in the capacity of lead agency for a Robert Wood Johnson Communities In Charge Grant and a HRSA Community Access Program Grant. The Mall Services Division, headed by Dr. Shirley, established the Hinds County Health Alliance as a result of these grants to arrange for health care coverage to the 45,000 uninsured residents of Hinds County between the ages of 19 to 65. The Health Alliance is currently collaborating with primary health care organizations and community health care organizations to bridge the gap to affordable quality health care for the poor. Since enrollment began in the winter of 2001, over 500 people have been enrolled for health coverage with Hinds County Health Alliance primary care providers.

The Foundation has strong ties to the community and builds on that relationship with an extensive community development program. The basis for that relationship was established in the spring of 1997 with the first meeting of the Jackson Medical Mall Community Advisory Board (CAB). This board is made up of representatives from local neighborhood associations, area businesses, churches, and schools. CAB members continue to be successful in helping the Foundation target and pinpoint areas seeking growth and renewal. Community Development projects spearheaded by the Foundation include funding to the CAB for neighborhood health fairs and initiatives, beautification projects, educational programs, crime prevention, and business development.

THE OREGON STORY CONTINUES: TRUE TO ITS ROOTS

Karen Whitaker, Vice-Provost, Rural Health
Director, Center for Rural Health
Peter Kohler, MD, President
Oregon Health & Science University

Oregon has a rich tradition of health care policy consensus building at the grass roots level. While developing the Oregon Health Plan during the early 1990s, a major component of the design was conceived through a series of statewide town hall meetings that considered Oregonians' values regarding health care. Notably, Oregon's health policy activities have been remarkably free of political partisanship, affording an opportunity for reasoned dialogue and rational decision-making.

More recently, Oregon has suffered disproportionately from the nationwide recession and led all other states in percentage of unemployed for several months. Recovery has been slow and erratic, resulting in state revenue deficits that threaten Oregon's innovative programs to increase access to health care for vulnerable populations.

Ambitious Beginnings. The Oregon Health Plan (OHP), which began as a determined effort to provide health insurance coverage for all Oregonians, has been hailed as a national model. Originally, the OHP had three elements (1) a Medicaid program that offered coverage to everyone whose income fell below 100% of the federal poverty level; (2) a high risk insurance pool for those whose health history precluded conventional coverage; and (3) a phased-in mandate for employers to offer health insurance coverage to workers and their families. While all three elements were passed by Oregon's Legislature in 1989, a subsequent legislative assembly repealed the third.

Nevertheless, the Oregon Health Plan ultimately offered insurance market reforms, an expansion of the state's Medicaid program to everyone below the poverty level without regard to " category", the creation of a high-risk pool, low-cost group plans for small employers and the development of a prioritized list of services for OHP clients. In addition, the Family Health Insurance Assistance Program (FHIAP) helps Oregon families afford the protection and benefits of a health insurance plan. FHIAP subsidizes the purchase of health insurance for qualified, uninsured Oregonians by paying a large part of their health insurance premiums. This helps families and individuals obtain health insurance, maybe for the first time ever. In 2004, about 15,500 Oregonians participated.

An unavoidable downturn. Elected and appointed officials have struggled to maintain the Oregon Health Plan during the current fiscal predicament. Reluctantly, drastic steps were taken in the past year to preserve the basic structure: various cost sharing methods were devised, eligibility was limited, the Medically Needy program was eliminated and benefits were reduced. More than half (55,000) of Oregon Health Plan recipients were disenrolled.

Despite sound policymaking and best intentions, Oregon's health care system finds itself in crisis. "Over 500,000 Oregonians lack health insurance. Low wage families – those earning too much for Medicaid, but not enough to be able to afford health care – are in an impossible bind. At the current rate of health care cost inflation, by 2010 the annual cost for health insurance alone for an Oregonian could equal a minimum wage income. Increasingly, health care costs are constraining our economy and making us vulnerable to overseas workers and business competitors. Close to one-third of our health care expenditures are for care that is duplicative, fails to improve health, or may even make the patient worse..."[1]

Decisions have not been made in a vacuum. Official and ad hoc advisory groups have functioned diligently to carefully consider all available options and Oregon's Office of Medical Assistance Programs (OMAP) has not acted unilaterally, but with input from citizens, providers and public officials as well as interim legislative committees.

Valuable information regarding the impact of changes in OHP has been gathered. In February 2004, The Kaiser Commission on Medicaid and the Uninsured conducted focus groups in Portland, Oregon among previous and current OHP and FHIAP enrollees. The Oregon Health Research & Evaluation Collaborative (OHREC) collected similar data in Lane County. The governor's office has thoroughly studied the recent history of Medicaid in Oregon and the governor's health care expert presented a detailed report to a Health Forum gathering in December 2004.

The consensus is sobering. The Kaiser Commission concluded that

- Most OHP Standard respondents had significant health care needs and had greatly valued OHP coverage, but the increased premiums and stricter payment policies made it difficult for them to maintain coverage.
- All OHP disenrolled respondents were uninsured and many reported significant problems obtaining care.
- The loss of coverage for certain benefits had significant consequences for many respondents who were still enrolled in OHP standard, in particular the loss of mental health coverage.
- Respondents who lost Medically Needy coverage all had serious medical conditions, including multiple sclerosis, severe diabetes and Crohn's disease, in some cases, compounded by mental health needs.[2]
- In Lane County, 29% of OHP members with severe mental illness lost their mental health benefit
- In Lane County, 48% of OHP members with a recent history of drug dependency diagnosis lost their chemical dependency coverage[3]

A characteristic response. A determined bipartisan effort to salvage as much of the OHP as possible has been evident. Diverse and numerous groups, both official and unofficial, have met to discuss options and to consider the far-reaching implications of a weakened OHP.

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[1] Kerry Barnett, Chair, Oregon Health Policy Commission, September 2004

[2] Kaiser Commission on Medicaid and the Uninsured, The Impact of Medicaid Reductions in Oregon: Focus Group Insights, December 2004

[3] OHREC, Projected Impact of Oregon health Plan Changes: A Combined Data Set Analysis in Lane County, June 2003

The 2003 legislative assembly initiated one of the best-organized and most effective mechanisms for health policy development: they created the Oregon Health Policy Commission (HPC). With ten voting members, four legislative members and a talented staff, the HPC carefully and comprehensively examined Oregon's health care environment during the past year and made a report to the interim legislative body in September 2004. Because of the manner in which the Commission deliberated (appointing four diverse workgroups and holding statewide public meetings), their conclusions and recommendations may be instructive for other states as well as Oregon.

The process. One of the first tasks of the OHPC was to adopt a mission statement:
"To develop and promote policy recommendations to the Governor and Legislature that improve the health of all Oregonians by ensuring access to essential health care and support services, increasing quality and improving outcomes for individuals and society, controlling costs, and encouraging healthy lifestyles."

Drawing upon the rich health policy expertise available in the state, the Commission appointed four work groups of approximately ten members each (1) Access (2) Cost (3) Health Status and (4) Quality. The working groups began meeting at least monthly in February 2004 and concluded their work in August. In keeping with Oregon's tradition of grass roots involvement, the HPC also spent the month of September 2004 on the road to undertake "a month long dialogue with Oregonians to capture their thoughts on health care problems and solutions."[4]

The four working groups were encouraged to establish guiding principles and both short and long term approaches to reform. Their recommendations were generally very specific, and ranged from requiring school district administrators to convene advisory committees on promoting nutritious foods and appropriate exercise to requiring the fluoridation of all public water systems in the state. The full text of their recommendations is at http://egov.oregon.gov/DAS/OHPPR/HPC/docs/rpts04/Fulldocument.pdf

The results. The Commission's general deliberations, coupled with the results of the working groups, led them to formulate the following broad principles for improving Oregon's health care system:

1. Simplify the system. Unnecessary complexity leads to confusion, cost and errors.
2. Invest in prevention. Scarce dollars result in the greatest return when we act to prevent injury and disease, rather than merely treat it when it occurs.
3. Manage chronic and catastrophic care. Only ten percent of our population is responsible for 69% of our health care costs. This means that we'll never control costs until we learn how to better manage treatments for the chronically and catastrophically ill.
4. Align incentives. Consumers must have incentives to make health care decisions that drive quality and control cost. Providers, too, must be responsible for the cost and quality effects of the treatment decisions; the current predominant fee for service payment system fails to do this.
5. Increase transparency. To drive quality through the health care system and for patients, providers and employers to make informed decisions, appropriate information must be available.

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[4] Kerry Barnett, Commission Chair, letter dated September 13, 2004 to Co-Chairs of Joint Interim Committee on Human Services

6. Maintain a broad and strong safety net. Over the past few years, Oregon's safety net infrastructure has been stretched thin – reflecting a growing number of uninsured and few providers serving Oregon Health Plan patients.
7. Better to ration benefits than to ration people. The realities of our current budget suggest that we simply can't cover everything if we are to cover everyone. We need to have a rational system for deciding what doesn't get covered. Evidence-based medicine should be central to this system.
8. Focus on children. Providing health care to children provides an excellent return on investment.

The Health Policy Commission shows every sign of becoming an active part of the upcoming legislative process, using these principles to guide them as they propose new legislation and interpret initiatives from other sources.

On the other hand - New partners. One of the most encouraging trends in the past year has been the re-involvement of Oregon's business community. It has been several years since the demise of the Portland Business Group on Health, a once active organization that played an important role in policy deliberations. Prompted by the Wye River Group on Healthcare, the Oregon Business Council (OBC) convened a Healthcare Leadership meeting in September 2004 "to determine whether, if convened by independent, credible catalysts, the individuals/interests advancing independent health care reform proposals in Oregon see potential value in and are willing to seize the opportunity that combining their efforts could offer." [5]

In December 2004, the OBC published a white paper, "A New Vision for Health Care," that emphasizes the importance of health policy involvement to the business community, examines the forces driving the costs of health care, and proposes the following vision of a future health care system for Oregon:

"We support actions to give all Oregonians access to quality health care by creating a fair market where everybody is motivated to improve health, ensure quality and control costs. In such a system, providers of health care goods and services will compete – and consumers will make informed choices about treatment options – based on transparent prices and quality." [6]

Conclusion. The work of the Health Policy Commission represents Oregon's best-organized and most informed response to our current health care crisis. The synchrony between the HPC's approach and the business sector's goals is a promising factor as the legislature begins its 73rd biennial Assembly. Oregon is poised to capitalize on its unique tradition of broad and diverse participation in its health care policy-making process.

HPC Chair Barnett expresses cautious optimism: "As we consider changes in Oregon's health care system, we must necessarily pay attention to work being done in other states and nationally. Changes in Oregon's health care system must be compatible with national health care policy and economics...Nonetheless, we

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[5] Dawn Bonder, Oregon Business Council, Meeting Notes, October 6, 2004

[6] Oregon Business Council Health Care Task Force, A New Vision for Health Care, December 6, 2004

remain optimistic that Oregon can make dramatic improvements in our health care system – even lead the nation.[7]”

The Oregon story continues and awaits its next chapter with a mixture of realism and confidence.

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[7] Letter to co-chairs, Joint Interim Committee on Human Services, September 13, 2004

CASE STUDIES OF COMMUNITY-BASED LEADERSHIP TO IMPROVE HEALTH AND HEALTH CARE

EXPANDING ACCESS TO HEALTH CARE

A statewide initiative to improve access for low-income residents

Health Access Network
New Hampshire

The New Hampshire Health Access Network is a voluntary effort by the state’s health care providers to improve access to health care for low-income children and adults. Its primary mission is to help uninsured patients gain access to hospital care, doctor visits and other medical care they otherwise could not afford.

There are a number of similar “access projects” in communities around the country, but the NH Health Access Network is the first such initiative that is statewide rather than limited to one county or community.

The Network started operating in July 2003, and is expected to take 3-5 years to develop, says Shawn LaFrance, vice president of the Foundation for Healthy Communities, which coordinates the Network. Previously, there were three local areas doing access projects in New Hampshire: Laconia, Exeter and Derry. The Foundation decided to expand upon their efforts and make it a statewide network because people in New Hampshire often go outside their own community for health care.

Currently, the statewide Network includes 26 community hospitals, more than 75 physician practices, the Dartmouth-Hitchcock multi-specialty clinic system, community health centers, several specialty hospitals and other health providers. In the future, the Network will invite additional health care providers, such as doctors, home care agencies or mental health providers to join. Staff support for the Network is provided by the Foundation for Healthy Communities.

The Network’s main goals are to provide dependable access to care for vulnerable residents, regardless of their ability to pay, and to offer free or discounted care for patients who meet or exceed eligibility thresholds. The Network’s eligibility levels are the same as the federal requirements for community health centers. In addition, the aim is to collaborate with others through the Network to reduce or eliminate structural barriers to access and enhance continuity of care and coordination of care for vulnerable residents.

As a starting point, each member organization appointed a staff member to be a liaison with the Network to review their current policies and procedures related to financial assistance activities. One of the goals is to make it easier for people to get financial help for the health care they need. The Network has designed a single application process and procedures to more make efficient the expectations related to financial assistance.

More than half of the hospitals in New Hampshire are now using the Network’s application procedures for patients who need financial assistance. Many of them had to go to their boards to change their financial assistance guidelines, says LaFrance. The Network adopted community health center guidelines, but some hospitals decided to set their income threshold even higher, some up to 300% of the Federal Poverty Level.

The primary tasks of the Network at this time are implementing a common application form and screening and eligibility procedures at participating sites, training staff members at Network organizations to ensure that they understand the financial assistance programs, and communicating with New Hampshire residents statewide to ensure they are aware of the financial assistance programs at every community hospital in the state.

As of January 2004, the Network's sole funding source was the Foundation for Healthy Communities, but they were starting to look for other funding. The Network applied unsuccessfully for a CAP grant in 2003 and planned to re-apply in 2004, says LaFrance.

An estimated 5% of people seeking financial assistance at hospitals statewide used the Network in its first six months of operation.

For more information, contact Shawn LaFrance, Vice President of the Foundation for Healthy Communities, at slafrance@healthynh.com.

Leveraging a CAP grant to coordinate donated care for uninsured patients

Health Access Project
Salt Lake County, Utah

The growing number of low-income uninsured residents in Salt Lake County prompted the Salt Lake Valley Health Department to convene local health care providers in 1999 to discuss what could be done to address the issue. The providers responded by forming a coalition in partnership with the local medical society, a health policy research group and other organizations interested in improving the system of care for low-income, uninsured residents.

Approximately 110,000 residents of the county currently lack health insurance. A majority of them do not have access to affordable health care. Studies have found that many uninsured patients use hospital emergency rooms as their main source of care, which increases health care costs for the entire community.

The Salt Lake Valley Health Care Coverage Coalition began its work with an assessment in 2000 of primary care safety net provider capacity in Salt Lake County. Out of that assessment came two strategies: to involve more private physicians in providing care for the uninsured, and to better support those physicians who were already volunteering their time. In January 2001 the Coalition formed a subcommittee chaired by Dr. Scott Leckman to develop a plan for creating the Volunteer Physician Network.

Later that year, the Coalition applied to the federal Health Resources and Services Administration (HRSA) for a Community Access Program (CAP) grant that would enable the Coalition to implement its ideas for improving care for the uninsured. CAP grants are intended to help community partnerships develop more effective systems of care for uninsured residents.

In September 2001, HRSA awarded a $1 million CAP grant to Community Health Centers, Inc., which administers the grant on behalf of the Coalition. The Coalition has subsequently used the grant to establish the Health Access Project (HAP).

In collaboration with health care providers, HAP has created a system for enabling uninsured patients to obtain needed health care in appropriate, cost-effective settings and on a timely basis. The project accomplishes this by leveraging donated physician and hospital care, and by providing culturally-appropriate case management and interpreter services.

The project targets uninsured individuals who have incomes at or below 150% of the Federal Poverty Level. Close to 2,000 uninsured patients had been helped through the project through March 2004, says project director Tanya Kahl.

Receiving the CAP grant was “absolutely critical” in establishing HAP, says Kahl. The CAP grant provided $1 million to the project in 2001, $700,000 in 2002, and $490,000 in 2003. The grant, which ends in 2004, has provided the bulk of the project’s funding to date.

The Utah Medical Association has also been key to the success of the project by actively recruiting physicians to donate care. In September 2001, the UMA passed a resolution supporting creation of the Volunteer Physician Network, which is the heart of HAP. Two months later, HAP began recruiting physicians at a Salt Lake County Medical Society meeting. About 500 of the approximately 1500 physicians practicing in Salt Lake County were donating care to HAP in 2004, says Kahl. The UMA Foundation has also provided funding for the project.

By March 2002, HAP had stationed case managers at three local hospitals to refer clients to volunteer physicians for primary and specialty care and to community clinics for primary care. HAP case managers also assist clients by providing interpreters for medical appointments and helping complete applications for assistance from other agencies or for charity care from hospitals.

In April 2002, HAP began referring patients to its Volunteer Physician Network. And by June, there were procedures in place for HAP patients to receive donated care at 6 local hospitals. In 2003, all Salt Lake County hospitals provided charity care to HAP patients. The project also stationed case managers at two additional hospitals.

Initial data show “we are having a positive financial impact for the hospitals,” says Kahl. An independent, third-party appraisal of HAP and its effects on the use and cost of hospital services found that “HAP was associated with fewer total visits and higher compensated charges, with relatively little change in total charges.”

The initial evaluation of HAP by the SPHERE Institute in November 2003 notes that the benefit to local hospital partners will depend on the fraction of compensated charges that can be recouped from third-party payers. “Assuming payment in full for a hypothetical cohort of 300 clients, local hospital partners should realize a 2-year net revenue between $202,000 to $639,000,” the report concludes.

For more information, contact Tanya Kahl, Health Access Project, at tkahl@healthaccessproject.org.

Managing care for the most complex uninsured patients

Care One Indigent Care Model
Albuquerque, New Mexico

Safety net providers carry a heavy load in New Mexico. The state has one of the highest rates of uninsured residents and the lowest per capita income in the country. As the state's largest safety net provider, the University of New Mexico Health Sciences Center in Albuquerque saw its uninsured patient population increase during the 1990s amidst declining sources of revenue for uncompensated care.

By 1997, federal disproportionate share hospital (DSH) payments and a local indigent care fund for county residents were not covering the Center's uncompensated care costs, threatening its service and academic missions.

The Center responded by developing a "medical home" patient care plan for uninsured county residents that was designed to improve access to care and quality of care, while containing costs. Called the "UNM Care Program," it used managed care tools such as assigning each patient to a primary care physician and emphasizing preventive and primary care. At the time, many of the Center's uninsured patients (about 30% of the Center's total patient population) had been receiving care at emergency departments and other settings that were both inappropriate and costly.

The Center developed the Program in partnership with a number of entities, including the county government, a local network of community health centers called First Choice Community Health, and the New Mexico Department of Health. During the two-year planning process, providers and administrators from the Center and other safety net institutions came together to learn about the needs and characteristics of the target population, and to design and develop the Program.

Since its implementation in April 1997, the Program has worked well for most of the patients enrolled, says Elizabeth Fingado, the Center's Director of Information Solutions. However, the Center determined that for a certain number of patients – those with the most complex set of health conditions and other issues – the Program did not yield the same results.

These patients – known as "Care One" patients because they are the 1% most complex and costly patients to treat – needed more than the standard tools used by the UNM Care Program to manage patients' care. These are the patients "that you predict to be at-risk for a catastrophic health event in the coming year," says Fingado.

They range in diagnoses, but typically Care One patients present a difficult combination of complex medical and/or behavioral health issues. For example, they may be obese, diabetic *and* schizophrenic. Often, these higher-risk patients are unable to navigate the health system effectively to keep up with their appointments and referrals. Consequently, they may drop out of the system until a catastrophic health event occurs, at which point their prognosis is poorer and emergency services more congested and expensive to the patient and the Center. "Case management needs to be more intense for these patients," says Fingado.

The Center decided that for these UNM Care Program patients it would create a program called "Care One".

Rather than assign a patient to a primary care physician, the model would assign the patient to a physician-led team of care providers that would include a medical director, mental health practitioner, and "shepherd" – or nurse case manager – who would help the patient navigate the system and actively coordinate his or her care. Additionally, they would create an assessment center that conducts an in-depth assessment of patients prior to assigning them to their primary care "home". The assessment center has been piloting since May 2004.

Currently, there are about 100 patients using the model, which uses the same sources of funding as the standard UNM Care Program. UNM has not received any additional funding from outside sources to provide intensive case management to its Care One patients.

Although the effectiveness of large-scale case management models has been well documented in the literature, Fingado describes the initiative as a calculated "leap of faith" on the part of the UNM Health Services Center. "We realized that, for whatever reason, we were not affecting their outcomes with the UNM Care Program alone," she says. "We're taking a risk that putting some additional resources in (Care One) will result in better outcomes."

For more information, contact Elizabeth Fingado, University of New Mexico Health Sciences Center, at EFingado@salud.unm.edu.

Spokane physicians adopt model to coordinate donated care for uninsured patients

Project Access
Spokane, Washington

In September 2003, the Spokane County Medical Society Foundation began operating Project Access – a physician-led community partnership to provide the full range of health care services to low-income, uninsured residents of Spokane County in eastern Washington State.

The Project Access model was first developed by the Buncombe County Medical Society in Asheville, N.C., in 1996. Because of its remarkable success in improving access to health care for uninsured patients, the model has since been adopted by more than 20 other county medical societies in communities around the country.

Spokane is the first community in the Northwest to adopt the Project Access model. Its goal is to provide universal, on-demand access to the full continuum of health care services for residents whose incomes are at or below 200% of the Federal Poverty Level (currently about $36,000 annually for a family of four). But Project Access is not health insurance. Patients are enrolled only when they need treatment and then only for 90 days, although their enrollment can be extended if they are still in treatment.

Services provided through Project Access include free office visits for both primary and specialty care; free surgery and treatments – both inpatient and outpatient; free laboratory and radiology services; free hospitalizations, inpatient and outpatient; prescription medications with a $4.00 co-pay per prescription, with a maximum value of $750 per year; and patient appointment reminders within 24 to 48 hours of the appointment.

From September 2003 to July 2004, Project Access served more than 700 uninsured patients. Some patients had major and complicated surgeries or diagnostic tests, but most simply needed specialty care consults and prescription medications. Project Access currently enrolls about 25 to 30 new patients each week.

The project is based on a system of donated physician and hospital care, as well as donated services from pharmacies and diagnostic testing centers. In Spokane County, more than 700 doctors – both general practitioners and specialists – are donating care. Primary care physicians are asked to see at least 10 patients per year, and specialists to see 20 patients per year, or to donate 8 sessions at a neighborhood free clinic.

The driving force behind the creation of the program was Sam Selinger, MD, a semi-retired cardiac surgeon who spent more than a year and a half gathering support among local health providers and other groups for this grassroots effort. Pointing to the experience of Buncombe County, he explained that offering free medical care to the uninsured can improve patients' health and lower overall medical costs. Dr. Selinger is now Medical Director of the Spokane County Medical Society Project Access.

Administration of the Project Access initiative is housed within the Spokane County Medical Society Foundation, which administers a centralized system of applications and referrals as well as a database of enrolled patients, physicians, and appointments. The Foundation determines eligibility, enrolls patients, and issues Project Access ID cards. Project Access is staffed by two patient care coordinators, in addition to an executive director, executive assistant, and communications coordinator.

All of the hospitals in Spokane are donating inpatient, outpatient, lab and radiology services. Local hospitals are "very supportive" of the project, says former executive director Julie Lake, because "every Project Access community has shown a huge savings to hospitals." By coordinating patients' care early, before their condition becomes so acute they have to go to the ER, hospitals are able to save money on the uninsured patients they treat. Participating pharmacies provide medication at cost, waiving counseling and dispensing fees.

Project Access also received critical funding in its early stages from The Robert Wood Johnson Foundation. An administrative grant from the Foundation combined with matching community dollars funded the program's start-up and brought $800,000 of new money into Spokane, says Dr. Selinger. Integral to the obtaining the grant and starting Project Access was $100,000 for at cost pharmaceuticals from the City of Spokane.

For more information, contact Carol Darby, Project Access, at cdarby@spcms.org.

Foundation funds school-based efforts to enroll kids in state health insurance

insure•a•kid
San Antonio, Texas

Private foundations such as The Robert Wood Johnson Foundation, Kaiser Family Foundation and others have made a major contribution to American health care, in part by filling the gaps created by inadequate public funding.

A relatively new example of a private foundation taking on this role is the Michael and Susan Dell Foundation (of Dell Computer). The foundation was established in 1999 and is headquartered in Austin, Texas. With an endowment of more than $1 billion, the Foundation's mission is to help children reach their greatest potential by funding initiatives and programs that directly improve children's well-being.

A top priority of the Michael and Susan Dell Foundation (MSDF) is to improve the health of Texas children by increasing their access to affordable health care and health insurance. To carry out this effort, MSDF created a grant program in 1999 to fund community-based partnerships designed to increase the number of children enrolled in health insurance in Central Texas.

The program – called insure•a•kid – initially provided grants to community partnerships in Travis and Williamson Counties in central Texas, with the goal of increasing the number of children in those counties enrolled in the state's Children's Health Insurance Program (CHIP) and Children's Medicaid. The community partnerships receiving these grants included schools and businesses, as well as health care, social service and faith-based organizations.

Through this initiative, the Foundation discovered that schools are one of the most effective communication channels for educating families about CHIP and Medicaid and getting children enrolled in health insurance. According to MSDF, research shows that families perceive schools to be one of the most trusted sources of information. Nationally, schools have been recognized as one of the best ways to reach out to families about children's health insurance.

Under the insure•a•kid program, grantee organizations help schools incorporate health insurance outreach into their activities. Schools are provided information to send parents about children's health insurance options during the school year. Parents are encouraged to bring their questions about coverage and enrollment to school nurses and other school personnel who are given training to provide information about health care benefits, availability, and the application process.

"The goal is to integrate outreach into their daily processes, particularly through nurses," says Kit Abney Spelce, statewide grant manager for insure•a•kid. "Nurses often feel overloaded already with everything they have to do, so we try to show them the natural links," like slipping information about CHIP into reminders that nurses already have to send parents whose children are overdue for immunizations.

In addition, the grantee organizations help schools track their progress in enrolling children in health insurance, and they provide a system for recording each child's health status into a district database, which helps document the number of uninsured children.

Following its initial success in the Austin area, MSDF decided to expand its grant program statewide in 2002 and launched a three-year effort to make schools a primary source of health insurance information for children and their parents.

Under the expanded program, MSDF awarded more than $3.4 million in grants in 2003 to help 39 school districts in 13 communities throughout Texas improve access to children's health insurance. One of these communities was San Antonio. Its grantee recipient, United Way of San Antonio & Bexar County, was awarded $247,250 in July 2003, and used the grant award to partner with four school districts in the San Antonio area.

Each of the grants can be renewed yearly for a total of three years, but recipients need to re-apply each year and submit information on their progress, says Spelce. The goal is that after three years school districts will have established a plan for their district on how to best educate families on children's health insurance.

In the case of San Antonio, insure•a•kid decided not to renew the grant in 2004. But insure•a•kid will continue to support San Antonio school districts with new information and materials, says Spelce. "I've met with the nurse administrators for the school districts in San Antonio and they are very committed to continuing the outreach effort."

In addition, the program will continue its radio advertising campaign in San Antonio, which supports its health insurance outreach efforts by encouraging parents to "Get it. Use It. And Renew It."

It's difficult to evaluate the success of insure•a•kid by looking at the number of enrollees, says Spelce. In Texas, the eligibility criteria and enrollment processes have fluctuated significantly over the past few years. "But no matter what the state does around eligibility, the Dell Foundation is committed to making sure that there will always be outreach through the schools."

For more information, contact Kit Abney Spelce, insure•a•kid, at kabney@seton.org.

Utilizing church space and students to provide health care to underserved patients

Point Loma Nazarene University's Health Promotion Center
San Diego, California

In 2000, Point Loma Nazarene University (PLNU) became interested in establishing a clinic in the inner city of San Diego so that its nursing students could gain practical, hands-on experience with an underserved patient population. Around the same time, 5 local congregations (Sudanese, Cambodian, French, Spanish-speaking and English-speaking) decided to found a church, called Church of the Nazarene in Mid City, in an inner-city San Diego neighborhood.

As the new church was formed, the congregation chose to dedicate space in its building to be used as a "wellness center," which they invited faculty from PLNU to staff and administer. Many of the church's parishioners and neighbors were young immigrants, some of them suffering from severe depression and other chronic illnesses, and many of them lacked health care coverage.

With the help of grants, Point Loma Nazarene University opened its Health Promotion Center in the Church of the Nazarene in Mid City in September 2003. Its mission is to provide free medical care and specialty referrals to patients who had nowhere else to turn.

"Our goal is to provide health care for people with no access to care," says the Center's director, Margaret Stevenson, EdD RN, Chair Emerita and Professor Emerita of PLNU's Department of Nursing. Typically, the clinic's patients are the working poor, many of them earning minimum wage and without access to insurance. "There are lots of them, and it's only getting worse," says Dr. Stevenson. About 70% of the clinic's patients are Spanish-speaking.

PLNU's Health Promotion Center has received significant funding and support from the San Diego Health & Faith Alliance (SDHFA), a non-profit organization dedicated to providing health care and counseling services, free of charge, for needy patients in San Diego County. In June 2003, the program also received a $40,000 grant from the Compassion Capital Fund, an initiative of the Bush Administration that provides grants to faith-based organizations.

Three local universities provide students and faculty to staff the clinic. PLNU provides nursing students and faculty as well as volunteer nurse-practitioners. The clinic provides PLNU's nursing students a valuable opportunity to put their skills to work in an inner-city setting, says Dr. Stevenson. They not only provide care at the clinic, they also do home visits for patients, she says. "It's our hope that students who get inner-city experience will go into this as a career."

The University of California at San Diego (UCSD) School of Medicine provides resident physicians who are supervised by Margaret McCahill, MD, Director of the Combined Family Medicine-Psychiatry Residency Program. Dr. McCahill is also one of the founders of the San Diego Health & Faith Alliance. In addition, UCSD provides pharmacy students and supervising faculty who fill prescriptions.

The University of San Diego (USD) provides marriage and family therapy students and faculty who provide therapy services to patients. Eventually, students from USD's Clinical Pastoral Education program will also join the team. According to Dr. Stevenson, "it's unusual to get this kind of collaboration from 3 universities."

The SDHFA provides multidisciplinary coordination for the clinic and shares in the cost of administrative support, clinical faculty support, laboratory services, and medications.

The center, which is open two days a week, typically serves about 20 patients each day it is open. The nurses are there all day, setting up doctor appointments, doing screenings for blood pressure, diabetes, vision and hearing, and providing health information to patients. Resident physicians and faculty are on hand to see patients in the afternoons. Between September 2003 and March 2004, the center logged about 800 patient visits, says Dr. Stevenson.

Since its inception, the center has provided its services to patients in a converted tool room in the church. But this year there are plans to remodel the space and add a second examination room.

The congregation does not have much money, so the program will continue to rely on grants and volunteer commitments from health care professionals and students. But parishioners are very supportive of the Health Promotion Center and have formed an advisory board to provide input.

"Having health care in a faith-based community is wonderful, because there's a trust there," says Dr. Stevenson. "Patients are so grateful, and they say they can trust us."

For more information, contact Dr. Margaret Stevenson, director of Point Loma Nazarene University's Health Promotion Center, at MargaretStevenson@ptloma.edu.

A private group practice establishes a free clinic for uninsured patients

Lakeland Volunteers in Medicine Clinic
Lakeland, Florida

The Watson Clinic, an integrated, multi-specialty group practice in Lakeland, Florida, established a new clinic in 2001 to provide free medical care to uninsured patients. More than 100 physician volunteers staff the Lakeland Volunteers in Medicine Clinic, in addition to more than 300 lay volunteers.

The facility is well equipped, with ten exam rooms for pediatric and adult medicine, two ophthalmology rooms, three dental chairs, diagnostic radiology, and a laboratory. Lakeland Volunteers in Medicine Clinic has been successful in raising the quality of patient care for Lakeland's uninsured residents by providing them access to important primary and preventive care services.

The Watson Clinic's community fundraising work in support of this facility is particularly remarkable. The goal was to raise $3.5 million; however, through the committed efforts of the leadership and senior staff of Watson Clinic, over $7 million dollars were raised to support the initial opening of the facility. Land for the facility was donated by the City of Lakeland and the county in which it is located, and an original school building on the site was refurbished into a state-of-the-art medical clinic.

Watson Clinic's leadership assembled a diverse array of civic, church, and physician leaders to spearhead the project. A detailed business plan and policy manual were prepared for the community as part of Watson's marketing and fundraising endeavors. Local media were kept informed of developments along the way, which resulted in substantial, positive news coverage.

As a result of the overwhelming local support and interest, the state of Florida also contributed $500,000 to the project. Because of the humanitarian aspect of this project, Watson Clinic was a recipient of the Preeminence Award of the American Medical Group Association.

For more information, contact Lou Saco, MD, Watson Clinic, at (863) 680-7250.

Helping low-income patients apply to drug companies for free and low-cost medication

Medication Bridge Program
New Hampshire

The NH Medication Bridge Program is a private-public partnership that helps eligible uninsured and underinsured patients receive needed prescription medications at little or no cost from Patient Assistance Programs that are administered by pharmaceutical companies.

The program is operated by the Foundation for Healthy Communities, a non-profit organization in New Hampshire dedicated to improving health and health care.

The program grew out of a realization among public policy leaders that many chronically ill patients in New Hampshire were not able to afford the medications they were being prescribed. Unlike many other states, New Hampshire does not subsidize drug costs for low-income people who are uninsured and do not qualify for Medicaid, says Shawn LaFrance, the Foundation's vice president for planning and development.

A few years ago, a New Hampshire legislator held hearings around the state to learn more about patients' difficulty in paying for their prescription drug costs. Through the hearings, lawmakers became aware that every major pharmaceutical company has a Patient Assistance Program that offers many of its medications free to low-income patients with chronic illnesses who need long-term medication.

At that time, several community health centers and a few doctors' offices around the state were helping eligible patients apply for assistance from these programs. The problem was that every drug company had its own application form, which makes the process of helping patients apply for medication time-consuming and often confusing. "It took a lot of time just figuring out the different applications," says LaFrance.

So the Foundation raised some funds – $50,000 from the Pharmaceutical Research and Manufacturers Association (PhRMA) and smaller amounts from local businesses and the state – to develop materials that would help clinic staff better understand the application process. The Foundation studied which medications were most used among the eligible population in New Hampshire and put together a manual to assist staff with applications for these medications.

The program also developed software that is now used in tracking and reordering medications. The software is provided free of charge to all sites participating in the program.

The program currently works with sixty sites across New Hampshire that assist people in accessing medications. The sites include hospitals, community health centers, physician offices, senior housing, ServiceLink, and non-profit organizations. Between January 2001 and January 2004 the program provided 250,000 prescriptions valued at $53 million for over 14,000 individuals throughout the state.

In addition, the NH Medication Bridge Program has published, updated, and distributed over 18,000 copies of a brochure called "NH Prescription Assistance Guide" to targeted agencies throughout the state. This brochure lists the NH Medication Bridge sites as well as all state programs that can assist with the cost of prescriptions. The brochure also describes general drug company eligibility requirements and contact information. In addition, the Medication Bridge program gives presentations throughout the year to notify both consumers and service providers of the availability of assistance with pharmaceutical costs.

The program also provides important, ongoing technical support and resources to the currently established sites in New Hampshire. This is accomplished by means of the Medication Bridge List-Serve, which notifies members of changes in the Patient Assistance Programs. Members are also invited to attend quarterly meetings where they can exchange information and ideas.

For more information, contact Shawn LaFrance, Foundation for Healthy Communities, at slafrance@healthynh.com.

Establishing a non-profit to improve underserved patients' access to health care

Northeast Arkansas Clinic's Medical Assistance Program
Jonesboro, Arkansas

Northeast Arkansas Clinic (NEA) is an integrated medical group practice with 60 physicians and more than 300,000 patient encounters each year. The Clinic's accomplishments in community outreach include formation of the NEA Clinic Charitable Foundation, whose mission is to improve the health status and knowledge of local residents who are medically underserved.

The programs provided through the Foundation range from providing health educational programs for elementary school students to scholarships that help regional students in need attend nursing and medical schools.

However, the Foundation's most successful program is the Medical Assistance Program (MAP), which enables low-income patients to obtain needed medications. Funds raised by the Foundation support MAP's staff of three individuals, including a medical social worker.

Physicians from NEA Clinic and the region provide the referral base to MAP. NEA's Information Technology Department also developed software for MAP to determine the economic status of patients, and to match their pharmaceutical needs with a corresponding pharmaceutical company. The MAP staff certifies the status of the patients and dispenses the medications according to physician directions. If the patient meets the economic guidelines of need, the medications are provided at no cost.

In the first year of MAP, the project worked with 190 pharmaceutical companies on behalf of 1500 patients and saved these patients more than $1.5 million in pharmaceutical costs. Although most of the companies have had indigent programs in place, the complex process and forms required for qualification for free medications have been an obstruction to patient access of the programs. The streamlined advocacy system of the MAP has helped not only to make the linkages for the patients, but has also improved medication compliance and the quality of life for the patients.

Over 200 new patients are enrolling in MAP each month. For its successful efforts in community outreach, Northeast Arkansas Clinic was awarded the Preeminence Award of the American Medical Group Association.

For more information, contact executive director Holly Acebo at (870) 934-5109.

IMPROVING ACCESS TO ORAL HEALTH CARE

Improving children's oral health through partnership with Early Head Start

Willamette Dental Group
Portland, Oregon

Head Start and Early Head Start are federal programs designed to support the early development of low-income children and ensure they are ready when it is time to enter kindergarten. Both programs put a strong emphasis on supporting and promoting the health of the children they serve, the majority of whom live below the federal poverty level and have at least one working parent.

More than 1 million children are enrolled in Early Head Start, which is for children ages 0 to 3, and Head Start, for children ages 3 to 5. The programs must adhere to strict federal standards for providing health services, either directly or through referrals.

In the area of oral health, Early Head Start and Head Start children are at high risk of developing tooth decay, which is the single most common chronic childhood disease and often a precursor to more serious dental problems. In Oregon, 20% of Head Start children suffer baby bottle tooth decay and 47% of all children between ages 3 and 5 have experienced cavities, according to the Oregon Dental Association.

Children in Early Head Start are at an especially critical age for preventing and treating tooth decay, says Kristen Simmons, director of hygiene at the Willamette Dental Group, the largest group practice model for dental care in the Pacific Northwest. “If they have it at 2 or 3 (years old), it’s a big issue because when they get into Head Start the problems will be even worse,” says Simmons.

Unfortunately, most dental practitioners will not see children until the age of three, unless their decay is so advanced that emergency treatment is required. However, federal standards require that Early Head Start and Head Start programs determine each child’s oral health status, assist parents in finding a “dental home” for their child, and arrange for evaluation and treatment if the child shows signs of having dental problems.

Early Head Start and Head Start have good track records of providing oral health services to low-income children. In 2002, 78 percent of children in Head Start received a dental exam. By comparison, just over 20 percent of all two- to five-year-olds below the poverty level visited the dentist in the preceding year, according to a 2000 General Accounting Office (GAO) report. But despite these programs’ effectiveness in providing dental services, sometimes problems can arise that adversely affect children’s care.

In Portland, Early Head Start administrators were noticing in the late 1990s that communication gaps between dental professionals and parents of enrolled children were affecting the children’s oral health care, says Simmons. Parents felt the dental professionals who were screening their children were often judgmental and condescending. Sometimes an adversarial relationship developed. As a result, parents were not taking in important information about their children’s dental health.

In response, Simmons of Willamette Dental designed a two-part initiative designed to improve communication with parents about their child’s dental health and to address the larger concern about the prevalence of tooth decay among Early Head Start children.

As a first step, the initiative involved training the child development specialists who work for Early Head Start to counsel families on oral health and identify signs of early childhood caries in primary teeth. The rationale was that because specialists are already experienced and adept at communicating with parents about their children, parents are more likely to talk openly with them and less likely to be defensive about their child’s dental problems.

Simmons and a colleague developed a resource guide and training program to provide the specialists basic information about the cause, risk factors, prevention, assessment, documentation and management of early childhood carries. Specialists in the Portland Early Head Start program now do the initial assessments of children's teeth and call dental professionals at Willamette Dental Group to arrange follow-up screening examinations.

The second part of the initiative was designed to reduce the number of referrals for treatment of early childhood caries by providing all at-risk children an oral health assessment and fluoride varnish every three months. Dentists, dental hygienists and dental assistants visit the Early Head Start Center to continue the oral health message, assess each child again, and apply a fluoride varnish to their teeth.

"It seems to work really well," says Simmons. The combined effect of continuous education and monitoring by child development specialists and regularly scheduled fluoride varnish application by dental professionals resulted in a reduction of dental referrals from 9% of the Early Head Start population in 1998-1999, the initial program year, to less than 1% in 2002-2003.

The Willamette Dental Group supports the initiative in several important ways. As a large group practice with more than 50 offices and 1,000 employees in Oregon, Washington and Idaho, the Group uses its size and connections to negotiate favorable prices on products used for treating Early Head Start children, says Gary Allen, DDS, director of clinical support. The company also paid for the printing of the resource guide that is provided to child development specialists and has enabled Simmons, Dr. Allen and other employees time off to visit Early Head Start programs and do the assessments.

"This is a project that we feel is really valuable," says Dr. Allen. "The beauty of the program is that it's prevention-oriented. We've been able to prevent and arrest tooth decay in a number of children."

The initiative has received recognition within the Early Head Start organization as a model for oral health education and prevention. Simmons and her colleagues were invited to present the model and its results to a national Head Start conference in January 2000. Since then, the project has been replicated by Early Head Start programs in Missouri and Idaho.

For more information, contact Dr. Gary Allen or Kristen Simmons, Willamette Dental Group, at gallen@willamettedental.com or kristens@willamettedental.com.

Working with child care centers to improve children's oral health

Mississippi Building Research Infrastructure Capacity
Delta Region, Mississippi

One of the most widespread health problems facing children in the U.S. is a severe form of decay in baby teeth known as early childhood caries. A preventable condition, early childhood caries is especially prevalent among children in low-income families.

Oral disease is also one of the areas in which health disparities are most apparent, which has prompted social science researchers at Mississippi State University (MSU) and child health experts to develop an initiative targeted at improving the oral health of children living in the Mississippi Delta region. The initiative is part of a larger project, called Mississippi Building Research Infrastructure Capacity, which is focused on building research infrastructure and capacity around children's use, with a particular focus on using child care centers as a research venue.

"The genesis of the idea came as a lot of good ideas come – when people get together and talk about how they can use their resources more effectively," says Linda Hill Southward, Ph.D., coordinator of the Social Science Research Center's Family and Children Research Unit at MSU.

Dr. Southward and colleagues at the Center met with representatives of the American Academy of Pediatrics (AAP) in 2001 and decided to formalize collaboration between the Center's Family and Children and Research Unit and AAP's Center for Child Health Research.

Together, they developed the idea of carrying out a research initiative that would involve child care centers, "because clearly that's where the children are," says Dr. Southward. Then the Agency for Healthcare Research and Quality (AHRQ) put out a Request For Application (RFA) focusing on building health care infrastructure. Eligibility for the RFA was limited to entities in the 16 or 18 states, including Mississippi, which had received under $1 million in cumulative grants from AHRQ during the past 5 years.

As a result of the RFA, MSU's Social Science Research Center received a 2-year planning grant from AHRQ, which it applied to an initiative to form a research network of child care centers. "Then the cards just kind of lined up that oral health was where we could bring the most resources to bear and where there was a real need," says Dr. Southward.

With her colleague, MSU research psychologist Elisabeth Wells-Parker, Dr. Southward brought together a group of health researchers that included scientists from AAP's Center for Child Health Research, the University of Mississippi Medical Center's School of Dentistry, Columbia University School of Dentistry and Oral Surgery, and the Children's Dental Health Project in Washington, DC.

In 2003, they launched a pilot project to conduct oral health assessments of preschool children in low-income areas of the Delta. Together with teachers and parents, they started by forming a research network of 15 childcare and Early Head Start centers. The network has since expanded to 19 sites, extending the potential number of research participants from 626 children to 857, an increase of approximately 14%.

As part of the pilot, they developed a questionnaire for parents and child-care workers to determine behaviors and practices that play a role in early childhood caries. Currently, there is very little information on the eating and drinking habits of preschool children, which are a key factor in whether children develop caries, says Dr. Southward. The questionnaire, which asks about the parent's oral health history and about what children and drink, is the first step in making a caries risk assessment.

In addition to the questionnaire, two professors from the University of Mississippi School of Dentistry screened about 350 children at participating child-care centers during 2003. One of the goals of the screening was to determine a biological marker for streptococcus mutans, the bacteria that causes dental caries.

They plan to use the data collected on streptococcus mutans in young children to develop the next phase of the initiative, which will begin in the fall of 2004, says Dr. Southward. "We don't have specifics (on the next phase) yet," she says. "But we want to do something that hasn't been done before."

Rather than do a one-size-fits-all intervention that others have tried, such as applying fluoride varnish to the teeth of all children, the plan is to tailor the amount of treatment on the basis of each child's risk of developing caries. "We now have the biological markers for S. mutans," says Dr. Southward. "So we can deliver intensive treatment to children with the highest risk and most acute need, and other children will get less treatment. The long-term implications are really exciting."

For more information, contact Linda Southward, Ph.D., Social Science Research Center, Mississippi State University, at Linda.southward@ssrc.msstate.edu.

A mobile van brings dental services to low-income children who need them

"Tooth Ferry" Dental Van
Durham, North Carolina

In 2001, Duke University Health System, the Durham County Health Department and Durham Public Schools launched an innovative collaboration to provide dental care to children in Durham County whose families cannot afford visits to a private dentist.

The partnership was motivated by the results of a health department assessment that determined that one out of every three children in elementary school in Durham County either had visible dental problems or was infected or in dental pain.

With a $200,000 grant from The Duke Endowment, the three partners bought a 40-foot recreational vehicle and outfitted it with 2 dental stations, an X-ray room, and a front office. The Durham County Board of Commissioners provided an additional $15,000 to equip the van with dental supplies.

The "Tooth Ferry" dental van was born.

Now the van travels on a scheduled rotation to 12 elementary schools, all of which were chosen because they have a large number of free- and reduced-lunch recipients. A dentist and dental assistant, hired by the health department, provide comprehensive on-site services four days a week to children who are identified as needing oral health services.

In addition, the van is staffed 3 Fridays each month by volunteer dentists in private practice. The local dental society has been active in recruiting dentists to participate in this effort.

Durham Public Schools have played a major role in facilitating the work of the dental van. The school system provided the labor to install outside water and electricity plugs, which enabled the van to hook up to each school from the outside. The schools also work with parents to have them sign a consent form and provide their child's medical history, and school coordinators arrange for staff members to escort children to and from the van.

During the summer months, the van visits locations where children are receiving supplemental classes, such as English as a Second Language classes or preparation to re-take tests they must pass to advance to the next grade.

The health department has determined that the dental van is a highly efficient way to serve the community's children. From July 2003 through June 2004, 3566 procedures were provided for 760 individual children, says Gayle Harris, assistant director for the Durham County Health Department. Many of these children had severe oral health problems that probably would have gone untreated had it not been for the "Tooth Ferry".

In May 2003, Duke University Health System gave the dental van to Durham County to ensure that the program could continue once the original grant was complete.

The Tooth Ferry required grant support only for start-up. Now the county is working to make it sustainable through third-party reimbursement. The health department bills Medicaid and Healthy Choice, the state's Children's Health Insurance Program, for services provided to children who are enrolled, and uses the reimbursement to offset the costs of the van.

However, so far, third-party reimbursement does not fully cover the costs of the dental van, says Harris. "We thought the van could be self-sufficient, but our population has shifted and now more of the kids are uninsured," she says.

If a child is found to need dental services, the county works with the family to determine whether that child is eligible for Medicaid or Healthy Choice coverage. If they are, the county works to get them enrolled. "But even if they're not eligible, we don't turn anyone away," says Harris.

For more information, contact Gayle Harris, Durham County Public Health Department, at gharris@ph.co.durham.nc.us.

Public-private collaboration on a statewide plan to improve access to oral health care

Coalition on New Hampshire Oral Health Action
New Hampshire

In response to growing concern about the oral health of New Hampshire's residents, the state's Department of Health and Human Services (DHHS) and the New Hampshire-based Endowment for Health jointly convened a coalition in July 2002 that was tasked with developing a comprehensive oral health plan for the state.

Called the Coalition on New Hampshire Oral Health Action, its members represent a broad group of individuals and entities concerned with oral health. They include representatives from the oral health community, the medical community, the legislature, advocacy groups, the insurance industry and the education community, as well as DHHS, other state agencies and the Endowment for Health, a private foundation in Concord that funds efforts to improve the health and well-being of New Hampshire residents.

Oral health was identified as a critical need in New Hampshire through public hearings, says Endowment Vice President Mary Vallier-Kaplan. It was determined that access to oral health care varies greatly throughout the state, and oral diseases affect the overall health of a significant percentage of residents. Although past efforts to address these concerns had met with some success, the lack of a comprehensive, coordinated approach among funders and policymakers was hindering further progress.

Before going forward, the Endowment and DHHS had to sit down and figure out how they would work together on the goal of creating a statewide plan to improve oral health care, says Vallier-Kaplan. "As a foundation, we needed to figure out how a private foundation with public money would interface with the state in its role in public health."

Together, they created a formal written agreement that stated their relationship on the project and stipulated that neither party had the right to "red-line" anything that emerged from it. As part of the agreement, which was sanctioned by both the Commissioner of DHHS and the Endowment's board of directors, the Endowment agreed to hire and fund a facilitator to lead the effort. This allowed both parties to sit at the table with others as interested participants.

With the new facilitator, Wendy Frosh, in place, the coalition proceeded to create a blueprint for addressing the oral health needs of all New Hampshire residents and communities, and to create a model for action that would build upon the oral health improvement activities already underway across the state.

Before the plan was completed, Frosh met with each coalition member one-on-one to let them "say their piece" to her in private. She credits this step of allowing people to get their concerns expressed beforehand with making it possible to hold productive discussions among coalition members. Not only did it allow people to get concerns "off their chest" in private, it enabled her, as the facilitator, to frame those concerns in a way that allowed for substantive discussion rather than an argument.

That extra effort paid off by producing a high degree of collaboration and partnership among the nearly 40 coalition members. "This was the first time these people had sat in a room together and had a conversation about oral health in a community," Frosh says. Not only were there people from DHHS, there were also other government stakeholders, school nurses and principals, dentists and dental hygienists, pediatricians, family doctors, insurers, and nursing home administrators.

Another refreshing aspect of the coalition was that discussions were not dominated by people who provide dental care. People came in to the process with their own set of ideas and goals, but over time they built bridges with each other and began to understand the other's point of view. "It was amazing to watch the process and see how people's attitudes changed by the time we produced the plan," Frosh says.

An example of the coalition's success in changing people's attitudes was its ability to move beyond a thorny scope-of-practice issue. One of the most effective measures available to prevent tooth decay is the application of sealants to children's molars. Given the inability of many families to afford a dental examination and treatment for their kids, the question was asked: can we figure out a way to get sealants on more kids' teeth?

Working with New Hampshire's many school-based oral health programs seemed to be an answer, but in New Hampshire, dental hygienists can apply sealants only after a dentist has examined a child's teeth and prescribed the treatment. Rather than work toward a change in scope of practice, which might have alienated many of the state's dentists, the group focused on how they could best meet this need, given New Hampshire's limited resources. This resulted in the NH Dental Society's offer of 200 days of volunteer dentists' time to provide the examinations necessary to enable hygienists to apply those sealants to the teeth of the state's high-risk children, which everyone agreed was a good place to start, but would be evaluated after a reasonable amount of time to see if the model was sustainable and able to address all of the unmet need.

To encourage public input in the process, a series of six community “listening sessions” were held across the state. In addition to research conducted within the state, the coalition reviewed a broad spectrum of national initiatives regarding oral health, such as the Surgeon General’s Oral Health in America report and Healthy People 2010.

Using the principles identified in the Surgeon General’s report as its framework, the coalition developed a vision for New Hampshire and strategies to reach that vision. Ultimately, the plan identified a “standard” level of oral health for all residents, articulated priorities for both statewide and community-level action, and identified tools and resources to address oral health needs. Coalition members also committed to implementing the plan and monitoring the success of its initiatives.

Among the top priorities they identified is pursuing a campaign to raise public awareness about the value of oral health. “We need to change people’s attitudes,” Frosh says. “Too many people see oral health care as cosmetic and think it’s natural to lose your teeth.”

For more information, contact Wendy Frosh at wfrosh@ttlc.net and Mary Vallier-Kaplan at mvkaplan@endowmentforhealth.org.

REACHING OUT TO THE COMMUNITY

Using “micro-grants” to support community efforts aimed at achieving health goals

Community Implementation “Micro-grant” Pilot Program
North Carolina

In 2001, the Department of Health and Human Services’ Office of Disease Prevention and Health Promotion (ODPHP) announced plans to award hundreds of “micro-grants” to community organizations that support the goals of Healthy People 2010, the nation’s public health agenda for the first decade of the 21st century.

Under the two-year pilot project, ODPHP chose two intermediaries to distribute the micro-grants. One was the Yale-Griffin Prevention Research Center in Connecticut, and the other was the North Carolina Department of Health and Human Services’ Office of Healthy Carolinians/Health Education. Together, these intermediaries received a total of $1.1 million to conduct the local selection and awarding of the funds to community-based organizations.

With the money it received from ODPHP, North Carolina’s Office of Healthy Carolinians/Health Education made approximately 200 awards to 32 of its “Healthy Carolinians” partnerships across the state, says director Mary Bobbitt-Cooke, MPH.

These Healthy Carolinians partnerships – which exist in more than 80 North Carolina counties – represent public health, hospitals, health and human services, not-for-profits, businesses, churches, schools and community members. Their goal is to mobilize resources to address health concerns in their communities.

Once the Healthy Carolinians partnerships received the money, they each gave away between 4-9 micro-grants to a variety of community organizations, ranging from scout troops and Parent-Teacher Associations to American Indian organizations and rape crisis and domestic violence agencies. The grants were worth up to $2,010 each – in honor of Healthy People 2010.

"It was a win," says Bobbitt-Cooke. "The small amount of money meant that the big organizations weren't interested, but it attracted the small groups whose passion motivated them to do work as volunteers, on their own time." Each grant was intended to support efforts by these small, local groups to promote health education, quality care, access to care and other projects that support the national health goals of Healthy People 2010.

The goal was to leverage very small grants into widespread action by tapping the potential of local organizations to make a difference in the lives of local residents. This approach was borrowed from the field of international economic development, which determined that giving small grants to grassroots, cottage industries is a highly effective way to build the local economic infrastructure. Under the ODPHP initiative, that theory was translated to the area of public health. "It just amazed me what people could do with two-thousand dollars," says Bobbitt-Cooke. "Lives were changed."

One of Bobbitt-Cooke's favorite stories about the micro-grant initiative is that of a volunteer parish nursing program in a small community in Caldwell County. In that community, "a group of little old ladies set a goal to do a walking initiative," she says. "They decided they were going to 'walk to Jerusalem' by the following Easter."

So with the grant money the group received, they bought themselves snazzy silver tennis shoes, pedometers and a map, and they charted their course to Jerusalem. All of the members of the walking group kept track of the miles they walked and reported their mileage as part of the group's progress toward Jerusalem.

In the beginning, many of the women in this group were not used to walking very far, says Bobbitt-Cooke. "These were people who were typically house-bound and aching with arthritis. One woman, when she started, could not walk out to her mail box without having to sit down and rest on the way."

But now they had a purpose – to make it to Jerusalem – and that was motivating them to get out and walk. Over time, the group increased from 12 to 54 members. By March 2004, the group had made it as far as Morocco, said Bobbitt-Cooke, "and they were sure they would be in Jerusalem by next Easter."

Several of the micro-grants resulted not only in health promotion activities, but actually spawned development of community infrastructure. In the mountains of Macon County, a micro-grant was awarded for the purpose of creating a walking trail that would encourage physical exercise. The grant was matched by a local community development organization.

The planned walking trail was to be located between a school and an industrial park, to be used by both students and staff at the school as well as employees at the industrial park. The local system ended up donating land valued at $45,000 to the project. Then the Cherokee Preservation Foundation provided a grant to pave the trail and make it "all-weather" track.

The Foundation had awarded the grant on condition that homage would be paid to the Wild Potato Clan of Cherokee Indians. So the community hired an artist to make plaques along the trail that commemorate the history of the Wild Potato Clan.

The local power company donated poles and light fixtures so that the walking trail could used at night. Local contractors donated time and supplies to construct a parking lot near the trail. A community fundraising effort raised enough money to build a pavilion next to the trail where people could enjoy picnics.

A footpath to a nearby rest home was built so that residents of the home could also enjoy the trail. And finally, a soccer field was added. In short, the $2,010 micro-grant that was awarded to this community to support increased physical exercise among its residents was matched by more than $90,000-worth of grant money, contributions, and donated land, labor and supplies. “It was exactly what the micro-grants were intended to do,” says Bobbitt-Cooke.

The pilot project ended in 2003, and was not made into a permanent program. But Bobbitt-Cooke says the results of the micro-grants in North Carolina show that micro-financing is an effective method to mobilize community-based organizations and community resources.

For more information, contact Mary Bobbitt-Cooke, MPH, at mary.bobbitt-cooke@ncmail.net.

A community-wide program that encourages residents to lose weight and stay fit

“Scale Down for Your Health”
Leflore County, Mississippi

The state of Mississippi is at the leading edge of the national obesity epidemic. Mississippi has now become the first state where more than a quarter of its population is obese.

The prevalence of obesity and its link to chronic illnesses such as diabetes and hypertension have set off alarm bells with the state’s elected officials and public health leaders. In 2001, the Mississippi Legislature passed legislation creating the Mississippi Council on Obesity Prevention and Management, which is tasked with assessing the state’s obesity problem and suggesting policies and programs for addressing it.

The legislation was authored in the House by state Rep. May Whittington of Schlater, which is in Leflore County, a rural county of about 40,000 residents in the Lower Mississippi Delta region.

As a result of her participation on the obesity council and her increased awareness of the link between obesity and chronic illnesses, Rep. Whittington decided to spearhead an effort in Leflore County to help residents adopt a healthier lifestyle that includes good nutrition and regular exercise.

In 2003, Rep. Whittington joined with longtime health and physical education teacher Dr. William Ware to form the Leflore County Obesity Committee. The committee of volunteers also included local physicians, public school officials and a reporter for the Greenwood Commonwealth in Greenwood, the county seat.

The committee decided to sponsor a community-wide weight-loss program for county residents called “Scale Down for Your Health.”

The six-month program was launched in October 2003 with a weigh-in and free educational seminar at Greenwood Leflore Hospital's Wellness Center in Greenwood. About 140 people got themselves weighed, set weigh-loss goals, and received information and encouragement to develop a healthier lifestyle.

At the kick-off seminar, participants were encouraged to add walking to their daily routines and were given a map drawn up by a local retailer of all the walking sites in the Leflore County area.

Participants were also told that there would be prizes awarded to those who lost the most weight each month and for those who lost the most by the end of the six-month program. Local businesses donated health-related prizes such as running shoes, jogging clothes and free memberships to fitness clubs.

Each month during the program, participants were invited to weigh in and attend an educational seminar on weight loss. The goal of the monthly get-togethers was to keep participants on track in reaching their weight-loss goals and to educate them on how obesity affects their health.

Experts on health and exercise spoke to the group on subjects such as the effects of stress and emotions on people's eating choices. Participants also talked with each other about their struggles and strategies to lose weight. They offered each other support and encouragement in their efforts to lose weight.

The "Scale Down for Your Health" program ended in April 2004. The last day of the program – and the last weigh-in – was scheduled in conjunction with the American Cancer Society's Relay for Life.

On that day, the person who lost the most weight was found to be a woman who lost 33 pounds during the six-month period. She was awarded a membership to Greenwood Leflore Hospital's Wellness Center. "I've got a new attitude," she told the Greenwood Commonwealth. "I advise everybody who is trying to lose weight to come and be my friend, and we'll walk together."

For more information about "Scale Down for Your Health," contact Alfio Rausa, MD, District Health Officer, Mississippi Department of Health, at arausa@msdh.state.ms.us.

Collaborating with community partners to encourage health-promoting behavior

TEAMwork for Quality Living
Muncie, Indiana

Beginning in the fall of 2004, Muncie residents who shop at their local Wal-Mart have been encouraged to park their cars in the farthest corners of the store's parking lot – and to do so for the sake of their health.

The idea is to give shoppers an opportunity – and a reminder – to fit a little more exercise into their daily routine. Remote sections of the Wal-Mart parking lot will be adorned with brightly painted signs urging shoppers to choose to park their car far from the store and to walk the extra 120 steps or so to reach the front doors.

The walking campaign, called "Park in the Back 40," is part of a broader effort in the city of Muncie and surrounding Delaware County to get residents to do more walking on a regular basis. The initiative is the brainchild of TEAMwork for Quality Living (TQL) and their most active collaborative, "Living

Healthy: The Heart of the Matter." TEAMwork is a nonprofit volunteer organization in Muncie whose mission is to unite Delaware County residents in efforts to improve the health, quality of life, and pride of the community.

TQL was launched in 1996, when a group of community leaders and educators came together out of concern for the health and well-being of Delaware County residents, says TQL's executive director, Molly Flodder. "All of us were looking at community issues and thought, wouldn't it be more effective to figure out a structured way for us to work together on this?"

That's when the group decided to form an organization that would bring together diverse partners in the community. Their first move was to hire the Denver-based National Civic League to help put together a plan and pull in a number of organizations representing all different sectors of the community – from government and business to non-profit organizations and educational institutions.

TQL is now supported by a broad range of public- and private-sector partners and currently runs initiatives in race relations, lead poisoning awareness and heart health. Key partners include Cardinal Health System, the City of Muncie, Delaware County Health Department, American Heart Association, Cancer Services of Delaware County - Little Red Door, Ball State University, Muncie Community Schools, YMCA, Open Door/BMH Health Center, Collective Coalition of Concerned Clergy, STAR Financial Bank, IVY Tech State College and several other organizations and foundations.

"We've evolved into being a convener – a group that brings people together around discussions that either our board or our staff or some other group has identified," says Flodder. For example, TQL created its Lead Task Force at the request of a local township trustee who was concerned about the number of children in the area who had been exposed to lead paint. The task force was able to secure funding that allowed them to hire a health educator to raise public awareness about the danger of lead paint in homes.

TQL has focused much of its energy on its "Living Healthy" initiative, which is designed to promote healthy lifestyle choices and prevent the onset of obesity and related chronic illnesses, especially cardiovascular disease. The collaborative has focused on teaching people about reducing visceral fat through walking; both are ways to reduce the risk of heart disease. Living Healthy's goals are congruent with other projects, including an assessment of Delaware County's recreation and leisure facilities.

"We have serious problems with obesity, sedentary lifestyles, and smoking," says Flodder. After carrying out a health behavior survey in 1998 to assess the extent of these problems in the community, TQL partnered with Cardinal Health System (CHS). Together, they formed the Cardiovascular Health Project – led by a task force of physicians, CHS leaders, non-profit agency representatives and community members – whose aim is to prevent cardiovascular disease among local residents.

Through the work of TEAMwork and its Living Healthy initiative, Muncie/Delaware County residents are becoming more aware of walking opportunities and venues in the community. In 2004, TQL sold more than 1500 pedometers to community residents and held monthly walking events around the community.

A new initiative of the "Living Healthy" initiative is "Park in the Back 40" – the walking campaign that encourages shoppers at Wal-Mart and other stores to get more exercise by parking their cars further from the front door. As part of the campaign, shoppers are offered additional incentives to "park in the back 40."

For example, shoppers who park in that designated area may return from their shopping to find a coupon for a free gallon of milk slipped under their windshield.

TQL's next area of focus is children and obesity. They will work with physicians to refer obese children and their families to available community services for physical activity and health education. The group will add to the community's current services an activity program for obese children based on the "Hearts 'n' Parks" model and, eventually, incentives to encourage local restaurants to make children's menu items more healthy.

For more information, contact Molly Flodder, TEAMwork for Quality Living, at teamwork@localnet.com.

Training "natural helpers" to educate about cancer prevention and early detection

Deep South Network for Cancer Control
Mississippi and Alabama

In 1999, the National Cancer Institute (NCI) awarded a five-year grant to the University of Alabama at Birmingham (UAB) to implement community-based strategies designed to reduce the disparity in cancer mortality rates between African-Americans and whites. The grant is part of the NCI's initiative to implement cancer control, prevention, research and training programs for minority and underserved populations.

The UAB grant directly targets African-Americans, who have been found to be at higher risk than whites of dying from breast, prostate, colon and other cancers. Not only does cancer incidence continue to rise among African-Americans, especially in rural, underserved communities such as the Mississippi Delta, but African-Americans are also less likely to participate in cancer screenings and clinical trials.

Upon receiving the NCI grant, UAB partnered with the University of Southern Mississippi (USM) to create the Deep South Network for Cancer Control. The network targets two poor rural areas – one in the so-called Black Belt counties of Alabama and the other in the Mississippi Delta, along with two urban areas – Alabama's Jefferson County and the Mississippi cities of Hattiesburg and Laurel.

"Most of the focus is on education and early screening," says Agnes Hinton, Dr.P.H. R.D., Co-Director of the Center for Sustainable Health Outreach at the University of Southern Mississippi, and Co-Principal Investigator of the Deep South Network for Cancer Control. She says the Network uses an adaptation of the Community Health Advisor Network (CHAN) model to raise cancer awareness, teach prevention, and encourage screenings to underserved patient populations in targeted areas.

The CHAN model was developed in Mississippi in the late 1980s and relies on empowering "natural helpers" to share important health information with their family, friends and neighbors and direct them to available health services.

To date, the Network has recruited and trained almost 900 lay people – mostly women – in Mississippi and Alabama to serve as Community Health Advisors as Research Partners (CHARPs). These are people from the community who are trained to talk with their family, friends, and neighbors about the importance of cancer prevention and early cancer detection.

The network's initial focus was breast and cervical cancer. Thanks to funding provided by the CDC's Breast and Cervical Cancer Early Detection Program, screening and treatment for these cancers can be provided to eligible women regardless of their insurance status or ability to pay. "That's one reason we started with breast and cervical cancer," says Dr. Hinton. "We knew the money was there," to provide screening for women in the highest risk groups (those over 50 years old and those without medical insurance).

The Network has since expanded its focus to include colorectal cancer screening and prevention. The Network has also begun working to raise awareness about the dangers of obesity, which has been shown to raise the risk of developing some forms of cancer. CHARPs are now trained to talk with their family, friends and neighbors about how making simple changes in diet and increasing daily exercise can reduce one's cancer risk.

The CHARP volunteers receive 16 hours of initial training, attend monthly meetings, and are given a small stipend for their expenses. A relatively new innovation has been to award groups of CHARPs mini-grants of $2,000-$3,000, which can then be used to implement activities at the local level. Dr. Hinton says one group has already achieved 501c3 status, which will allow them to apply for additional funds from other sources.

The Network has also sought partnerships in local communities. "We've worked really hard to get community buy-in, and it's become quite significant," says Dr. Hinton. Much of the support has been received as in-kind contributions, such as allowing CHARPs to use space so they can meet with local residents and present information.

However, an ongoing challenge has been transportation, says Dr. Hinton. "Some of the distances our program coordinators have to travel are considerable, particularly in the Delta." In addition, CHARPs do a lot of work arranging transportation for patients to get to health care providers, which are sometimes as much as 2 or 3 hours away from where the patient lives.

In addition to raising cancer awareness, another major focus of the Network has been to promote enrollment of African-Americans in cancer clinical trials. Towards that end, the program volunteers are trained to identify and recruit African-Americans to participate in clinical trials.

The CHARPS serve as a vital link in this effort, which involves bringing the academic institutions into the communities and connecting them with "hard-to-reach" patients. It also requires communicating with patients about the value of participating in clinical trials. "In Mississippi, we were just trying to get people to understand what a clinical trial was," says Dr. Hinton.

In addition, the Deep South Network has provided training programs designed to encourage minority undergraduates and graduate students to go into cancer research and grants to support minorities who become grant investigators.

For more information, contact Agnes Hinton, Dr.P.H. R.D., University of Southern Mississippi, at agnes.hinton@usm.edu.

Community leaders collaborate to keep at-risk students on track toward high school graduation

Community Alliance to Promote Education
Muncie, Indiana

Socioeconomic factors play a major role in determining one's ability to access timely and appropriate health care. It's well documented that people living in poverty, for example, face significant barriers to access, which in turn impacts their health. One factor that can have a lifelong impact on health is whether an individual succeeds in earning a high school diploma and thereby increases his or her chances of gaining employment that provides a livable wage and health care coverage.

In Delaware County, Indiana, awareness about the link between completing high school and one's prospects for future employment led community leaders to create an initiative aimed at helping more kids complete their high school education rather than drop out early. Called "Priority School," the initiative gives students who have been suspended or are facing expulsion from their regular school the opportunity to attend an alternative school and continue their education rather than spend that time unproductively either at home or on the streets.

"Priority School" includes two components: one for middle school and high school students who have been temporarily suspended from school and a component for students who are under threat of expulsion. Students who are facing expulsion are given the option of attending "Priority School" in lieu of expulsion. If they remain in good standing during their time at "Priority School," they will have the opportunity of being reintegrated into their regular schools. The program is open to students from the seven public school corporations in Delaware County, but is run by the Muncie Community Schools, which is the largest.

"Priority School" served hundreds of students in 2003-2004 (662 in the suspension component and 50 in the expulsion component), says Don Holderman, director of student services for the Muncie public schools. "These students otherwise would not have had anywhere to go."

As for the impact of "Priority School" on students' health, Holderman notes that the alternative schools provide a free lunch to students – many of whom might otherwise go without lunch – as well as access to the school system's health services. But the real impact is more long-term, he says. Many of these kids – especially those who are facing expulsion – are at risk of dropping out of school altogether, a choice that significantly damages their future prospects.

"I don't think it's a stretch to say that to have these kids continuing in school gives them the opportunity to complete high school and get a good job with benefits," says Holderman. "The alternative is for these kids to drop out, end up on welfare, and be a burden to the community for the rest of their lives."

The "Priority School" would not have been created had it not been for grant money offered by the Indianapolis-based Lilly Endowment Inc., and the determination of a group of community leaders in Delaware County. In 2000, the Endowment announced the creation of a $50 million initiative called Community Alliances to Promote Education (CAPE), which was designed to encourage local foundations in Indiana to prioritize and address their communities' education needs. The Endowment offered each county in Indiana the opportunity to apply for a $5 million grant.

Led by The Community Foundation of Muncie and Delaware County, Inc., a group of community leaders responded to the grant opportunity by coming together in 2000 to apply for the grant. They formed the Community Alliance to Promote Education (CAPE), with a 15-member board representing a broad array of community leaders, including clergy members, lawyers, bankers, businesspeople, school representatives and representatives from other youth service agencies. Their initial grant application, in 2000, was not successful. So they re-grouped and reapplied, and the grant was approved in the summer of 2001.

After that, the process moved quickly. Former Muncie school superintendent Sam Abram, Ed.D., was hired in October 2001 as the program's executive director, and the CAPE programs got underway in January 2002. "We've been blessed to pull together all seven school corporations in Delaware County around the goal of working together to improve the well-being of children and their families," says Dr. Abram. "Part of the uniqueness of CAPE is the make-up of its board. It's a very active board, with members that bring a diversity of skills and backgrounds." The CAPE team and the partnership with Ball State University have also been big pluses, he notes.

The "Priority School" is not the only program that CAPE operates in Delaware County. The other major component is 10 community learning centers throughout the county that provide after-school programs to children in grades 1-3. Children who are identified as being most in need of enhanced learning opportunities are provided a 2-and-a-half-hour after-school program that includes tutoring in reading, math and other subjects, a nutritious snack, opportunities such as field trips and guest speakers, and transportation home.

The grant from the Lilly Endowment was for a three-year period beginning in the fall of 2001, but CAPE has been extended an extra year with Lilly Endowment approval and because of when the program started, the use of local resources, and partnerships. Currently, the CAPE board and staff are planning their program strategy for CAPE II – a modified program maintaining the core components of the original C.A.P.E. grant.

For more information, contact Sam Abram, Ed.D., at sfabram@prodigy.net.

Tithing as a commitment to invest in community outreach projects

Memorial Hospital and Health System of South Bend
South Bend, Indiana

In 1993, the board of directors of Memorial Hospital and Health System of South Bend, Indiana, made the decision that the health system would tithe – in other words, give 10% of its budget surplus each year to support community programs. Subsequently, Memorial invested more than $20 million in nearly 100 community programs between 1993 and 2001.

In 2001, Memorial was awarded the prestigious Foster G. McGaw Prize for excellence in community services. The prize is sponsored by the American Hospital Association, Baxter International Foundation, and Cardinal Health Foundation.

One of the community outreach projects to which Memorial has devoted funding is a health museum called HealthWorks! Kids Museum. Its mission is to teach children about the effects of unhealthy choices and encourage them to make good decisions. The 12,000-square-foot museum, aimed at children from kindergarten through eighth grade, receives school visits during weekdays and families on the weekends.

The museum offers learning about bodies, safety issues and healthy habits in a multi-sensory way that engages kids and makes information readily absorbable. For example, a child can touch a healthy pair of pig's lungs, or smell stale cigarette smoke while sitting in a vented plastic chair stuffed with 37,600 cigarette butts. While sitting on the chair, kids watch anti-smoking public service ads on a TV set.

Another area in which Memorial Hospital is active is early intervention with homeless infants and toddlers. In the city's homeless center, occupational therapy students play with children up to 3 years old, stimulating their minds and fostering physical development. The program, called PEDS for the Play, Exploration & Development Support Program, has been in place since 1998.

PEDS provides developmental screenings for children and educates parents about their children's health and well-being. In 2001, PEDS served 50 children. All 24 parents surveyed said they noticed positive changes in their children since they began the PEDS program. In one case, a pair of 23-month-old twins couldn't walk because their homeless mother had confined them to a stroller for safety's sake. Within a month of starting PEDS, the twin girls were on their feet and doing what toddlers normally do.

Memorial also provides medical services for adults at the Center for the Homeless, staffing a 3,000-square-foot clinic. Medical services are available for neighborhood residents and homeless center guests. The hospital also assisted in developing a landscaping maintenance business that provides jobs for the homeless and revenue for the homeless center.

For more information, contact Reg Wagle, Vice President, Memorial Health Foundation, at rwagle@memorialsb.org.

Better meeting the needs of non-English-speaking patients

Bridging Cultures Initiative – Mayo Health System
Albert Lea, Minnesota

When the Hispanic population of Albert Lea, Minnesota, doubled during the 1990s, the Albert Lea Medical Center – part of the Mayo Health System – noticed a sizable increase in non-English and limited English-speaking patients being served. Although the Center had a contract interpreter, the staff realized there was a need to put a formal process in place to ensure that these patients received quality, safety and satisfaction.

Under the Center's leadership, the Bridging Cultures Initiative was developed as a response. The initiative was intended to (a) better meet then needs of non-English-speaking patients; (b) become the community leader in accommodating Spanish-speaking patients; and (c) diversify the Center's workforce to better reflect the community's changing demographics. Local Spanish-speaking residents were convened to solicit their input and to confirm the Center's commitment to better the healthcare services of this population.

The outcomes of this endeavor have been significant. Spanish interpreting services for all Center activities and programs are now available on a 24/7 basis. Appropriate signage has been posted throughout the

Center. Patient ID cards now include identifiers for patients requiring assistance in interpretation. Staff interpreters now undergo competency assurance and certification programs. A contact point for non-English speaking patients has been established to facilitate scheduling of appointments, assistance with billing and transportation and advocacy. Electronic coordination of interpreters when needed was instituted along with documentation of their services in the patient's medical records. Community scholarships were awarded to the University of Rochester to create an ongoing community pool of competent interpreters.

Albert Lea's Cultural Services Department has grown to four Spanish-speaking staff members who are products of the two year translating and interpreting program at the University of Rochester. Of particular note is that the annual cost of the *Bridging Cultures* initiative is over $300,000 and is funded entirely from internal administrative costs. No direct revenue is received for this service.

Albert Lea Center Medical Center was recognized with the Preeminence Award of the American Medical Group Association for this exemplary community outreach program, unparalleled in Southern Minnesota or the entire Mayo Health System.

For more information, contact Jenny Larson, Albert Lea Medical Center, at (507)377-6450.

Building coalitions to address a range of community issues that affect health status

Phoebe Putney Memorial Hospital and Health System
Albany, Georgia

Phoebe Putney Hospital and Health System is a not-for-profit, hospital and health system in Dougherty County, Georgia, one of the poorest areas of the country. The region bears a disproportionate share of the state's Medicaid burden, with 33% of the population receiving Medicaid compared to 19% of the state's overall population. A shortage of available health care professionals in the region creates an additional challenge.

Nearly 1 of every 2 children lives in poverty in this region of Georgia, and 25% of all households have an income less than $10,000 per year. Illnesses from lifestyle factors and stress are among the leading causes of death. In fact, the incidence of cancer in the region is 35% higher in Dougherty County than elsewhere in the state of Georgia. Cardiovascular disease has been the number one cause of death since 1986, with stroke and cancer alternating in second and third place. All 10 leading causes of death are higher in the region than in the state as a whole.

In this region, Phoebe is the region's largest employer, with more than 3,400 full- and part-time employees. Founded in 1911, the organization includes an acute care hospital licensed for 450 beds, four rural clinics, two urgent care facilities, two critical access hospitals, specialty physician practices, home health services, a community hospice and palliative medicine program and an assisted living facility.

Phoebe's founding mission guarantees health care to all, regardless of ability to pay. That commitment drives Phoebe's support for "upstream investment" that creates an environment conducive to health. "It's not enough to fish people from the river and build a hospital to make them well again," says Phoebe's President and CEO Joel Wernick. "Eventually, we must look upstream to find out why they fall into the river in the first place."

Phoebe has actively worked to harness the collective energies in the community to address the patterns of a problem before they becomes issues of care inside the hospital. For its exceptional work in building coalitions to address a wide range of community issues, Phoebe was selected to receive the prestigious Foster G. McGaw Prize for excellence in community service in 2003. The prize is sponsored by the American Hospital Association, The Baxter International Foundation and the Cardinal Health Foundation.

In 2002, Phoebe provided $51.6 million in indigent care. But Phoebe's strategies for promoting community health go beyond patients' access to care. The strategies are broad-based and flexible, relying on partnerships, shared resources and people, and the programs change as the community's needs change.

Examples of Phoebe's strategies and programs include:

- The Arcadia Project, which started as a simple, inner city, Arbor Day tree planting event and grew into wide reaching men's health and lay worker initiatives that have touched thousands of lives.

- Teen Dads and Network of Trust, which connect teens to support systems and programs that break the cycles of poverty, teen pregnancy and school dropout.

- Southwest Georgia Cancer Coalition, which is a regional collaboration that has designed a model cancer control program to change the health behaviors of the region and improve access to care so that no one is left behind.

- PeachCare project, which increased six-fold the number of children in a nine county area enrolled in state-provided insurance.

For more information, contact Jackie Ryan, Phoebe Putney Memorial Hospital and Health System, at 229-312-7126.

Extending a public health care district's mission further into a struggling community

Kaweah Delta Health Care District
Visalia, California

The Kaweah Delta Health Care District operates in Visalia, a struggling agricultural community in California's Central Valley. In addition to high rates of unemployment and poverty, more than one-third of the area's 100,000 residents don't speak English, most of them undocumented farm workers.

The valley has the highest percentage of uninsured in California. Lack of access to health care contributes to unusually high rates of diabetes, heart disease and strokes. In addition, the area has a difficult time attracting physicians because of low reimbursement under Medi-Cal and Medicare.

In 1994, the state legislature passed a law requiring all private, not-for-profit California hospitals to develop an annual community benefit plan. As a public health care district, Kaweah was exempt from the new law but its leadership decided to use the challenge presented to private hospitals as an opportunity to extend its own mission out into the community.

Visalia’s then-mayor, Mary Louise Vivier, formed a task force to address some of the area’s most pressing issues, including gang violence, teen pregnancy and child abuse and neglect. Out of that grew many of the programs for which the Kaweah Health Care District won the 2000 Foster G. McGaw Prize, a community service award sponsored by the American Hospital Association, Baxter International Foundation and Cardinal Health Foundation.

The district created a pregnancy-prevention program called Youth Connect for adolescents in grades six through 12. The program focuses on prevention and encouraging teenagers to make responsible choices. Other programs include the Mobile Dental Project, in which interns from the University of Southern California School of Dentistry visit schools to treat dental problems among low-income elementary schoolchildren; Parents Helping Parents, a program to help parents become more effective in developing healthy family relationships; and Good News Clinic, which includes a kitchen, health clinic, battered-women’s shelter and thrift store founded by the Daughters of Charity.

Kaweah also established the Lifestyle Center, which promotes wellness and self-improvement through fitness, education and rehabilitation. The 55,000-square-foot complex opened in 1995 and serves nearly 9,000 Visalia residents – many of them referred by physicians – and offers free membership to select low-income residents.

For more information, check www.kaweahdelta.org.

A hospital-run food bank helps meet the daily needs of neighborhood residents

John C. Lincoln Health Network
Phoenix, Arizona

The main campus of John C. Lincoln Health Network is located in an area of Phoenix known as Sunnyslope, a neighborhood plagued by high rates of crime and poverty and urban blight. About 72% of the neighborhood’s elementary schoolchildren qualified for free or reduced-price lunches in the 2001-2002 school year, compared with 40% nationwide.

In this neighborhood of 50,000 residents, John C. Lincoln focuses the work of its community service arm, Desert Mission, which has poured millions of dollars into providing services intended to meet the daily needs of neighborhood residents.

Over the years, Desert Mission has created and funded a variety of services, including a food bank, real estate development, family support programs, a children’s dental clinical and a 326-child day care center.

The Desert Mission Food Bank gives out about 17,000 emergency food boxes each year. The food bank also provides discount food boxes that are worth $40 but that residents can purchase for $15 in cash or food stamps. The hospital’s dietary staff makes sure the food boxes are nutritionally balanced.

Through a statewide “gleaning” program, the food bank’s 7,000-square-foot warehouse receives produce that farmers can’t sell to stores. The food bank also provides daily snacks to four elementary schools. About 70 food bank volunteers spend 21,000 hours each year at the pantry, the equivalent of 10 full-time staffers.

John C. Lincoln seeks both public and private sources of funding to sustain its community outreach efforts. For example, the network used a four-year federal grant to launch in 1996 the Marley House Family Support Center, designed to be a one-stop family resource center. Its main goal is to prevent child abuse and neglect. After the grant ended, the network raised $2.8 million to create a Marley House endowment. The network also held capital campaigns to sustain its food bank and child care center.

The network also formed in 1994 the Sunnyslope Youth and Family Partnership in the hopes of getting community organizations to work more collaboratively to meet residents' needs, thereby increasing effectiveness and reducing duplication. By 2002, the partnership had grown to 44 members, including schools, churches, the police, neighborhood watch groups, and youth outreach programs, such as Big Brothers/Big Sisters. These partners meet monthly to learn about community needs and work on solutions.

As a result of these and other initiatives, quality of life in Sunnyslope has been measurably improved. Drug crimes are down, as are the high school dropout rate and domestic violence reports.

John C. Lincoln's commitment to community outreach earned the health network the 2002 Foster G. McGaw prize for community service. The $100,000 award is sponsored by the American Hospital Association, Baxter International Foundation, and Cardinal Health Foundation.

For more information, contact Carolyn Wemp, John C. Lincoln Health Foundation, at cwemp@jcl.com.

CREATING NEW STRUCTURES TO BETTER MEET PATIENT NEEDS

Competing hospitals collaborate to expand services, improve outcomes and lower costs

Inland Northwest Health Services
Spokane, Washington

In Spokane, Washington, there are two competing hospital systems that serve patients from throughout the Inland Northwest region, including eastern Washington, Montana, Idaho, northeast Oregon and sometimes Canada. One of these hospital systems is Empire Health Services, which owns Deaconess Medical Center and Valley Hospital & Medical Center, and the other is Providence Health Services of Eastern Washington, which owns Sacred Heart Medical Center, and Holy Family Hospital.

Prior to the 1990s, leaders from the two systems did engage in collaboration and met regularly with each other to discuss various issues. But beginning in the early 1990s, both sides realized that rapid changes in health care demanded new approaches. A group of key leaders began to consider ways in which Empire and Providence might collaborate more extensively, not only to provide better services for patients, but also to improve the financial health of both hospital systems. Shared thinking among this group of leaders led in 1994 to the creation of Inland Northwest Health Services, a joint, non-profit corporation whose mission was to find and implement collaborative health care opportunities.

At the time, all of the hospitals in Spokane were losing money on inpatient rehabilitation. St. Luke's Hospital continually operated in the red. One of the first actions taken by INHS was to transform the former

St. Luke's Hospital into St. Luke's Rehabilitation Institute, a 102-bed physical rehabilitation center in Spokane that is now owned by INHS. It is the only freestanding hospital in the state dedicated solely to medical rehabilitation. Collaborating on rehabilitation care wasn't strictly a cost issue; it allowed for more efficient operation at St. Luke's and greater availability of acute care beds at Sacred Heart and Deaconess. It was a response to a critical examination of how to improve care delivery through a new approach that generated better outcomes and lower costs.

Other companies created by INHS include Northwest MedStar, which is now a large air ambulance system consisting of three distinct geographic bases; Children's Miracle Network, which is the largest such network in the nation and generates about $1 million annually to benefit children and children's programs at affiliated hospitals; Community Health Education and Resources (CHER), which provides health screenings, parenting classes, and forums on health and wellness; and Northwest TeleHealth, a telemedicine network that enables patients to access specialty care from remote locations.

By creating these and other jointly owned companies under the auspices of INHS, Empire Health Services and Providence Health Care "are collaborating in ways that hospitals haven't collaborated before," says INHS CEO Tom Fritz. In addition to Fritz, INHS is managed by a board of directors comprised of members of the sponsoring hospital group boards, respective CEOs and other medical and community professionals. "These are people who have stepped out of narrow territorial worlds and into an arena where the only question is, how do we provide better quality care at lower cost?" says Fritz.

Once everyone came to the table and agreed there were ways for the two hospital systems to aggregate shared services yet retain their independence, they moved on to identifying best practices that would drive higher efficiency, better outcomes and lower costs. Information technology was identified as one area where consolidation had no impact on competition and yet would lower costs for both hospital systems.

But the people in INHS, with the encouragement of their sponsor hospitals, said let's take it to the next level. They explored the opportunities that telemedicine and electronic medical records (EMR) offered and began implementing them. They found wireless technology held great promise for provide better care more quickly and began implementing that aspect of EMR. The Information Resources Management Group (IRM) within INHS was so successful that they now connect 32 hospitals and over 1000 physicians throughout the Northwest region with an integrated system that uses a single client identifier. This integrated system is helping to improve outcomes and lower costs for patients throughout the region. The same is true for the Telemedicine group that now has 55 sites across the region that provide everything from critical care consults to continuing education for nurses, doctors and emergency medical technicians.

For its work in this area, INHS was recognized twice in 2003 as being a technological leader in health care. Five regional hospitals in its information network were named among the 100 Most Wired hospitals in the nation by *Hospital and Health Networks*, the journal of the American Hospital Association. In addition, INHS received the Technet Catalyst Award for being among the most technologically advanced hospitals in the country.

INHS was also responsible for the creation and spin-off of the Health Improvement Partnership (HIP) – a non-profit "catalyst organization" in Spokane that is dedicated to creating partnerships that support and promote the wellbeing of communities. (*See the case study about HIP on page 114*)

Shared vision is vital to a successful collaboration like INHS, which involves competitors operating a shared business unit, according to Fritz. "INHS is about functioning successfully in a world without boundaries," he says. "It is about being driven by outcomes and allowing people to use their creativity to create a successful process."

As a result of INHS and its collaborative efforts, there is now "a high level of trust among hospital leaders in Spokane," says Fritz. INHS continues to grow as a stand-alone company with an annual operating budget of $80 million, owning significant capital assets, and a staff of over 800 employees.

For more information, contact Tom Fritz, Inland Northwest Health Services, at fritzt@inhs.org.

Improving health status and lowering costs through community-wide coordination of health information

New Mexico Health Information Collaborative
Albuquerque, New Mexico

Diverse organizations in the Albuquerque and Taos areas of New Mexico have joined together in a unique effort to improve health care delivery for chronically ill patients by creating a centralized electronic warehouse of health information. Data and outcomes have demonstrated that chronically ill patients benefit significantly from disease-based care management, which relies heavily on providers' access to relevant patient information.

Called the New Mexico Health Information Collaborative (NMHIC), the initiative will combine patient information on four chronic conditions – diabetes, pediatric asthma, depression and low back pain – from the major New Mexico health plans, all of the Albuquerque hospitals and health systems, and Taos Community Hospital into one centralized electronic warehouse. The information can then be accessed by clinicians at the point of care.

The goal is to make available complete, timely and accurate health information about patients with these chronic illnesses, says Martin Hickey, MD, a member of the Lovelace Clinic Foundation's board of directors and lead coordinator for the project. A community-wide, clinical data warehouse will allow for better coordination of patient care, thus improving patients' health status, reducing medical errors, and lowering health care costs, says Hickey. The data warehouse will also facilitate benchmarking of diseases and processes of care, improve the efficiency and effectiveness of physicians, and facilitate care coordination by lower cost healthcare workers.

The other unique feature of the NMHIC is that patients will be able to make use of the data warehouse to compare their care, laboratory results and outcomes to national standards, sub-cohorted peer group outcomes, and their own past results, which will hopefully motivate them to take better care of themselves. "This program," notes Dr. Hickey, "fundamentally changes the way we deliver healthcare in this country by changing the patient from the recipient of care to an actual participant in the care."

To get the project off the ground, NMHIC is creating a pilot program to determine feasibility, engage all the appropriate parties, define barriers and costs, and gain credibility among stakeholders and the public.

The pilot's initial focus will be to create a pediatric asthma patient registry for Bernalillo and Sandoval Counties, which are the two counties that encompass the Albuquerque area. The patient registry was expected to get underway in late summer of 2004 and will be populated with all known pediatric patients and the appropriate clinical data cohorts to assist providers when they encounter a pediatric patient with asthma.

Among the reasons that the pilot project will focus on pediatric asthma is that asthma is the most common chronic childhood disease in the United State and the leading cause of hospitalizations among children, says Hickey. Also, each major Albuquerque health system and the public schools have existing registry information that can be used in the pilot. In addition, pediatric asthma is clearly an area where improved coordination of care can benefit workers and their employers. A Lovelace Episode of Care Asthma program in the mid-1990s demonstrated a dramatic decrease of parental days lost from work for patients who participated in the program.

Diabetes was chosen as the other initial disease pilot because it affects so many New Mexicans. Over 12 million days are work are lost each year to diabetes, which is why employers urged that it be included in the pilot. It is also known that poorly controlled diabetes can impact any individual's daily work productivity by about 15% and raise the risk of debilitating complications such as heart and renal disease.

Once the asthma and diabetes programs are progressing, low back pain will be the third disease to be addressed. Low back pain generates the second most work days lost in the nation – over 120 million days each year. NMHIC hopes to ultimately extend its work to include depression as well. Hickey says there are billions of dollars to be saved by reducing the incidence of errant, unnecessary, and non-beneficial interventions that result from lack of accessible patient information and coordination.

To support the creation of the data warehouse, in 2004 NMHIC applied to the Agency for Healthcare Research and Quality (AHRQ) for a grant and was awarded $1.5 million. The group had raised matching funds (one-third in cash and two-thirds in services) from local partners in order to qualify for the grant. Contributors include local health systems and health plans, businesses and charities (including United Way, which authorized $75,000 for the project).

What is particularly unique about this project, says Hickey, is that all of the participating health care organizations are overcoming traditional competitive differences to collaborate, which is a first for any community health information initiative in the nation.

The Lovelace Clinic Foundation, which is an independent, not-for-profit and community-based health services research organization, is the prime designer and initiator of the Collaborative. There is additional support from Lovelace Sandia Health Systems, the University of New Mexico, Presbyterian Health Systems, Cimarron Health Plan, Blue Cross, First Choice Community Health, and the New Mexico Heart Hospital.

The healthcare community will be engaged from the outset to design a diabetes and pediatric asthma data warehouse and build commitment to the broader effort of adding future diseases to the repository, in particular depression and low back pain. Outside advisors such as the American Medical Group Association (AMGA) and Intel will be asked to assist in identifying and implementing the appropriate technology and HIPAA compliance measures.

Several local businesses, such as Intel, The Public Service Company of New Mexico, four banks, and Don Chalmers Ford, are also involved in NMHIC. "Part of the cultural shift is to get employers more involved here," says Hickey, noting that considerable effort has been made to persuade the business community that it is in their immediate vital interest to be engaged in an initiative that will reduce health care costs and improve employee health and productivity. Hickey says the business community's active involvement in, and support for, this health information initiative provides an innovation that other communities may want to study.

NMHIC is developing a hybrid, community governance structure representing the health systems, providers, business community and patient advocacy groups. Once the data warehouse is initiated and stabilized, the community governance board will have fiduciary responsibility to execute and administer the program. Lovelace Clinic Foundation will administer the program during the start-up phase.

For more information, contact Martin Hickey, MD, Lovelace Clinic Foundation, at mhickey37@comcast.net.

Expanding a telehealth network to provide telepharmacy services in rural areas

Utah Telehealth Network
Salt Lake City, Utah

In rural Utah, health care is limited and often difficult to access. Patients in remote areas typically have to travel long distances, often over rugged terrain, to reach health care providers. But the state's telehealth network, managed by the University of Utah Health Sciences Center, allows providers to reach patients in remote locations by using telecommunications and information technology.

Former Gov. Mike Leavitt was an important catalyst for developing the telehealth network in Utah, says the network's program manager Deb Lamarche. In 1995, at Gov. Leavitt's request, the Utah Legislature approved $200,000 in one-time funding for a pilot project in what was then called "telemedicine."

"Gov. Leavitt was someone who had a real vision for how technology could be used to help the citizens of Utah, particularly in the area of health care," says Lamarche. "He's from a rural part of the state, so using technology in health care seemed to make sense to him."

When the Legislature allocated money for a telehealth pilot project, the state health department asked the University of Utah Health Sciences Center to manage the project. At the time, the University had already decided to establish a telemedicine outreach program that would link the University with its clinic on the Nevada border. So it was a natural fit.

Since then, the University has managed the Utah Telehealth Network, which has been funded through multiple one-time state allocations, federal grants, foundation grants and significant support from the university itself.

Most of the network's funding has come from the public sector, but the network is best described as a public-private partnership, says Lamarche. "It's those that use the network that really make it work," she says, and that's the providers. "A strength of our network is that it has been an 'open network' since the beginning, meaning that it is open to any provider in Utah," says LaMarche. The University of Utah is the "hub" of the network, while the "spokes" include small, community hospitals throughout the state, a clinic on a Navaho reservation, and local public health departments.

An example of this public-private partnership can be seen at Allen Memorial Hospital – a small, non-profit hospital in rural Moab that used to have trouble financing round-the-clock monitoring of its cardiac patients. Through the Utah Telehealth Network, the hospital partnered with St. Mark's Hospital – a private, for-profit hospital in Salt Lake City – to monitor its cardiac patients in real time, says Lamarche.

Among its core services, the network uses interactive video to deliver patient care, provide continuing education to health professionals, and facilitate administrative meetings. In addition to videoconferencing, the network uses digital images such as CAT scans and X-rays to be transmitted for second opinions.

The network continues to grow by expanding its technological capabilities and adding more sites and network members. Its current services include mental health, orthopedic and pediatric consultations, nutritional assessments, home health care visits and skin cancer screening.

One of the network's recent expansions is into telepharmacy, which is a relatively new application of telemedicine. The University of Utah was one of the first organizations in the country to make use of telepharmacy, which allows pharmacists at the University to remotely fill prescriptions and counsel patients by using an automated dispensing machine at the point of care that is linked with a personal computer and video unit.

There was an urgent need for telepharmacy among several of Utah's rural hospitals, Lamarche explains. Hospitals need to have a pharmacy. "But the nationwide pharmacist shortage is getting worse, and it's even harder now for hospitals to find pharmacists who will locate to remote areas."

The University worked with the State Board of Pharmacy to allow pharmacists at the University of Utah Outpatient Pharmacy to fill prescriptions for patients at the University's Park City Clinic. The pharmacy board's support was crucial, says Lamarche. "They have to be very strict in terms of rules governing pharmacists," she says. "But they also understood the need in rural areas."

In addition, the Utah Legislature passed legislation in 2001 that allowed telepharmacy to be implemented. The Legislature also provided a grant for the purchase and installation of four automated dispensing machines at Allen Memorial Hospital in Moab and San Hospital in Monticello. Pharmacist technicians are employed at both hospitals and work under the remote direction of pharmacists at the University of Utah. Pharmacists at the University also counsel patients at the remote sites by using the video connection.

The Utah Telehealth Network is continuing to build its telepharmacy capabilities by expanding to additional sites, says Lamarche. In 2004, the network is implementing a bar code safety system for the automated dispensing units to ensure that the bar code on the prescription label matches the bar code on the medication that is dispensed.

For more information, contact: Deb Lamarche, University of Utah Health Sciences Center, at deb.lamarche@utahtelehealth.net.

Improving information exchange and tracking to provide better chronic illness care

Oregon Health Care Quality Corporation
Portland, Oregon

Given the aging of the U.S. population and the prevalence of chronic health conditions among young people, the need for widespread use of effective care management strategies has grown increasingly acute. Not only does effective management of chronic conditions improve patient outcomes and individual quality of life, it offers important tools for containing rising health care costs.

In response to the need for better chronic illness care, the Oregon Health Care Quality Corporation (OHCQC) has been working on efforts to provide clinicians in Oregon with information and systems that will support best clinical practice for chronic diseases and provide them with the data needed to improve practice.

OHCQC is a broad-based collaborative and non-profit 501c3 organization based in Portland. Its board of directors includes representatives of health plans, physician groups, hospitals, public sector health care representatives, purchasers, health care providers and others with a commitment to improving the quality of care in Oregon.

The organization has determined that there is a pressing need at all levels of the health care system for more information about patients with chronic conditions, says its executive director, Vickie Gates. Physicians need tracking systems for patients with chronic conditions. Much of the data that makes such systems effective must be drawn from multiple sources outside of the physicians' own records. In addition, patients, payers and providers need aggregate information to support benchmarking and improve quality of care and patient outcomes.

In response to these needs, OHCQC has brought together a coalition of stakeholders to carry out pilot projects focused on two critical areas for improving chronic care: automated tracking systems serving the clinician, and the creation of a clearinghouse for improved information exchange among health providers and clinics in Oregon.

In the first stage, both pilots to improve tracking systems at the clinician's level have focused on patients with diabetes and asthma, with a later expansion to other chronic diseases planned. The first pilots focusing on diabetes were selected in September 2001, and two are completed. The three asthma pilots began in November 2004 and were scheduled to end in September 2004.

The pilot for creating an automated tracking system is currently using three sites for tracking diabetes (Legacy Health System, Samaritan Health Services, and Interhospital Physicians Association) and three for tracking asthma (Marion Polk Community Health Plan, Tuality Health Alliance, and Legacy Health Systems).

A grant from the Northwest Health Foundation will make it possible for OHCQC to evaluate all six sites and how their experiences can help others improve the quality of care for patients.

The second effort in the project is to create a pilot chronic disease data clearinghouse. The Oregon Medical Professional Review Organization (OMPRO) has been selected to test the feasibility of integrating asthma and diabetes data from multiple health plans to create reports that are useful to physicians in understanding and managing care for patients with chronic disease.

An important element of this pilot is to use patient- and physician-centered health plan data on in-patient, out-patient, laboratory and pharmacy, and to integrate the data across plans in a physician-friendly format. OMPRO has worked with the Clearinghouse Steering Committee to solve the myriad of legal and data issues necessary for a successful pilot.

A key portion of the project is on-site interviews with physician/provider groups to solicit their input on process and product. The first stage of the interview process was completed and presented to the Steering Committee in December 2003. Subsequent stages of this portion of the project will seek clinician evaluation of end products and suggestions on further clearinghouse development.

One of the project's most important accomplishments has been the creation of a committed coalition of public and private leaders in improving care to persons with chronic disease. In addition to OHCQC, sponsors of the project include two important statewide organizations, the Oregon Asthma Network and the Oregon Diabetes Coalition.

The Chronic Disease Clearinghouse Steering Committee has also brought a variety of health care leaders and consumers into the process to provide valuable perspective and oversight. Staff support and resources have been provided through the Health Promotion and Chronic Disease Prevention section of the Oregon Department of Human Services, and OMPRO has been a valued staff and design resource.

The leadership and broad participation of stakeholders has been vital to securing financial support and the unprecedented agreement of major health plans and Oregon's Medicaid program to merge their data on these chronic conditions through the Clearinghouse. Currently the clearinghouse has data from 12 Oregon health plans participating in this project.

The pilot projects have secured a variety of funding resources to support work to date. Resources have included CDC funds through the Oregon Department of Human Services, donations from AstraZeneca, GlaxoSmithKline, and Regence Blue Cross Blue Shield, in-kind and cash resources from the pilot sites, in-kind resources for plans submitting data and a grant from the Northwest Health Foundation for evaluation of the automated tracking and the Clearinghouse pilots, and development of the next steps in advancing the use of automated and connected health information systems and continuation of the Chronic Disease Clearinghouse.

For more information, contact Vickie Gates, Oregon Health Care Quality Corporation, at Vickie.Gates@Q-Corp.org.

Integrating better coordination of care for diabetic patients into physicians' practices

Vermont Community Diabetes Collaborative
Montpelier, Vermont

One of the key issues in health care today is finding ways to better coordinate care for patients who are living with one or more chronic illnesses. Often patients fall through gaps in the system, resulting in less-than-optimal health care. One of the areas most in need of improved coordination is diabetes care, both because of its high prevalence and the large gap between expected standards of care and actual care delivered.

In 2002, the Vermont Program for Quality in Health Care (VPQHC), a private, non-profit corporation based in Montpelier, launched a collaborative that was designed to implement the Chronic Care Model, with a specific focus on diabetes care. The model, which uses case management and other strategies to keep chronically patients as healthy as possible, was developed by the MacColl Institute for Healthcare Innovation in Seattle, WA. VPQHC received funding from The Robert Wood Johnson Foundation for implementation.

Currently, there are organizations all over the country that are implementing the Chronic Care Model to address the needs of patients with various chronic illnesses, says VPQHC Executive Director Helen Riehle. "We started with diabetes in Vermont because the guidelines are clear," she says. "There isn't a lot of argument."

In addition, VPQHC had already done considerable work to develop standards of care and measurement that are used by all insurers operating in Vermont as the basis of their diabetes care. These measures, which are updated each year, have also been adopted by the state of South Dakota and have been commended by the Centers for Disease Control & Prevention.

The next step was to translate the measures for diabetes care into physicians' practices, says Riehle. First, VPQHC sent six staff members to the Institute for Healthcare Improvement (IHI) in Boston for training in implementing the Chronic Care Model. When they returned, they launched a 15-month collaborative, starting in 2002, to implement the model in nine physician practices throughout the state of Vermont.

"Some were very successful," says Riehle. "In fact, it was so well received that we got funding from our health department to continue." So VPQHC decided to implement a second collaborative, beginning in October 2003, that would be double the size of the first and focus on patients with diabetes and diabetes-related heart disease.

Riehle notes that the Chronic Care Model used in the collaborative can be successfully applied to many other diseases to effectively translate best practices into improved health and quality of life for patients. In fact, the model is being used in several other areas of the country to improve the delivery of care.

But VPQHC is doing one thing very different from the others, says Riehle. In the second collaborative they're looking at aligning payments with best practices. "We realized we had to align payments with best practices," she says. All major insurers in the State of Vermont, including Medicaid and the Medicare Quality Improvement Organization for northern New England, are involved. "So in that respect, we're breaking new ground."

In addition to aligning payments with best practices, all the payers are assigned to several physician practices to learn from them what it takes to put the Chronic Care Model into practice and what the barriers are, says Riehle.

For example, when you provide care to a diabetic, on any given day you can only bill for one unit of care, whether it is a podiatrist looking at the patient's feet or a retinal exam. If the office visit includes two different services, you can't bill for that, which is inefficient for both patients and providers. That's standard in the industry, says Riehle. But now insurers are figuring out how to systemize paying for all services provided, even if they are done on the same day. "This makes it consumer-friendly, patient-centered and convenient, particularly in rural areas."

Another example of what they're trying is in the area of information technology. Initially they used a publicly available patient registry known as CVDEMS. But now they are using a more sophisticated, web-based patient registry developed by a company called "DocSite".

Insurers have bought the license for physician practices to use this registry. The cost – around $1,000 – was a barrier for many practices. The registry allows a practice to do population-based queries, such as producing a list of all diabetic patients who are due for a retinal exam. This allows a practice to use a reminder system to keep patients up-to-date.

Results are still preliminary. "A few practices have seen some clinical improvements," says Riehle. They've also gotten interesting feedback from providers. Riehle says it's hard work for practices to implement the model because it's a change in how they schedule patients and how they figure out what works in their offices. "The doctors who get it think it's marvelous," she says. Now practices can track the data and see which of their patients are getting the care they need.

Riehle says VPQHC is considering doing a third collaborative that would expand the tools developed in the diabetes collaborative to treat patients with asthma or depression as well as to continue the work on payment alignment and to tackle another challenging dimension – involving the community with improved care for the chronically ill.

For more information, contact Helen Riehle, Vermont Program for Quality in Health Care, at hriehle@vpqhc.org.

A statewide initiative to prevent and treat cardiovascular disease

Community-Wide Treatment and Prevention Initiative
New Hampshire

Cardiovascular disease is the number one cause of mortality in New Hampshire and a major priority of NH Healthy People 2010, the state's disease prevention and health promotion document.

With that in mind, the New Hampshire-based Endowment for Health awarded a grant in 2001 for developing a community health model that could provide better prevention and treatment services for cardiovascular disease, especially among vulnerable populations.

The grant was awarded to the Foundation for Healthy Communities, a nonprofit corporation headquartered in Concord, New Hampshire, that is dedicated to improving health and health care. The Foundation's core partners are hospitals, managed care organizations, physicians, and home care agencies. Many other groups work with the Foundation on special projects. But today it also functions as an incubator for research that may affect people's health beyond the hospital – and beyond New Hampshire.

In this initiative, the Foundation aims to create a replicable community model that can inform future prevention and treatment health activities in New Hampshire, says Rachel Rowe, RN, the Foundation's executive vice president. But first they needed to find out what works.

The Foundation identified Gerald O'Connor, ScD PhD, of Dartmouth Medical School's Center for the Evaluative

Clinical Sciences to be the project's principal investigator and selected 4 communities to participate in a study of clinical and community interventions to prevent and treat cardiovascular disease.

They looked for communities that not only had a high percentage of underserved patients and significant problems with cardiovascular disease, but also had a collaborative group already in place that could be used to develop this initiative. The four communities that were chosen – Laconia, Franklin, Dover and Rochester – also expressed willingness to participate in the project. Keene agreed to be the "control" community.

In each of these communities, Dr. O'Connor and the Foundation used interviews, surveys, and internal and managed care data to identify processes for current prevention and treatment practices. To compare the effectiveness of both clinical and community interventions, they chose one community to do only clinical interventions and another to do only community interventions. The other two are doing both community and clinical interventions. The fifth community is being used as a "control".

The project created two task forces within each community to develop and implement action plans – one task force to focus on clinical measures such as cholesterol screening/treatment procedures and referral processes, and another task force to focus on the promotion of cholesterol screening and strategies to promote physical fitness. Each task force will build upon the work of an existing community network (schools, churches, workplaces, etc.) as well as local health care providers (hospitals, community health centers, physicians, visiting nurse agencies, etc.).

In March 2003 the project performed a baseline assessment of all five communities. They used clinical data and telephone surveys with the Behavioral Risk Factor Surveillance Survey to establish baseline measures for cardiovascular disease screening within the community and provider organizations. This data was used to determine community-specific measures of success.

The project conducted interventions from the summer of 2003 until August 2004, with plans to re-measure in the fall of 2004. They expected to find that the number of interventions has gone up, that treatment-to-goal rates have improved, and that physical activity rates have increased.

They also plan to do an analysis of the interventions to determine which were most effective. For example, they plan to assess the effectiveness of using electronic medical records versus paper records, and the efficacy of tickler systems to remind patients of appointments.

The goal is to create a model that can be replicated for use in preventing and treating other illness, and that can be transferred to other communities.

For more information, contact Rachel Rowe, Executive Vice President of the Foundation for Healthy Communities, at rrowe@healthynh.com.

Combining a unique payment formula with care management for uninsured residents

*Care*Link
San Antonio, Texas

For the past decade or so, public health care systems around the country have been implementing new and innovative payment and delivery structures designed to improve care for uninsured residents, and to rationalize the costs associated with their care.

One leader in this effort has been University Health System (UHS) in San Antonio, which functions as the Bexar County Hospital District. As the public health system for the county, UHS has the ability – and the responsibility – to use county tax funds to deliver care to uninsured and indigent residents who are not eligible for Medicaid, Medicare or other subsidized health insurance programs.

The program UHS has created for these patients is called Care*Link*. Funded by county taxes, Care*Link* is what Executive Director Juanita Simmons calls a “health membership program” for uninsured and indigent residents. The program combines managed care concepts – such as matching each patient with a medical home, and emphasizing prevention, screenings and wellness – with a unique payment formula that requires patients to pay a manageable portion of the cost of their care.

Unlike most hospital districts in Texas and many public health systems around the country, Care*Link* does not charge payments based on a sliding fee scale. Instead, the program uses a unique formula for determining a patient’s monthly payments and maximum liability for the cost of their care.

Under the payment formula, a family’s maximum liability is their income multiplied by its percentage of the Federal Poverty Level multiplied by 11%. That number is then divided by 48 months to determine the family’s monthly payment to Care*Link*.

So, for example, if a family of four has an income of 100% of the Federal Poverty Level, their maximum liability is $1941.50, and their monthly payment obligation is $40.50. No matter what the cost of their care is – whether it’s a $60 office visit or a $10,000 hospital stay – their monthly payment and maximum liability remain the same.

When this strategy was developed, it was taken to community focus groups for input, says Simmons. “There was a very positive response.”

By using this approach, which requires financial responsibility on the part of patients but also offers them predictability, Care*Link* has been very successful in getting enrolled members to meet their obligation, says Simmons. In 2003, CareLink collected just under $10 million from about 55,000 members.

Care*Link* also revised its billing process to make it easier to collect payments. Rather than send members different bills for physician costs and hospital costs, CareLink combined all charges into one monthly bill.

To further improve the experience for members, CareLink handles all billing “behind the scenes,” says Simmons. In other words, a member does not have to face questions about billing at the point of service. This means, for example, that parents don’t have to deal with billing hassles when they bring their child to the doctor. They simply present their Care*Link* card as they would a private insurance card.

Another patient-friendly change implemented by Care*Link* was to begin paying physicians on a fee-for-service basis for services provided to its members. As a result, patients are receiving better treatment than they otherwise might, says Simmons. Another innovation was that Care*Link* asked its primary care physicians to help develop the program's schedule of benefits.

And finally, Care*Link* has been very active in providing preventive services, screenings, outreach and education to its members. Upon enrollment, each member is provided a "medical home" and receives a health risk profile. Care*Link* provides a smoking cessation program and education about asthma and diabetes. Members are offered screenings for prostate, colorectal and breast cancer, as well as flu shots and other vaccines.

As a result of all of these strategies, the program has been able to improve care for patients at a very affordable price, says Care*Link*'s medical director, Gary McWilliams, MD. According to Dr. McWilliams, Care*Link* is able to care for its patients – many of whom are "the sickest of the sick" – for about $150 per member per month. By comparison, health plans in Bexar County receive $653 per member per month for patients enrolled in a Medicare HMO.

One of the cost containment measures implement by Care*Link* has been the development of a drug formulary, which has reduced the program's drug costs by about 10% per year during each of the last four years. In addition, Care*Link* has been active in connecting its patients with drug companies' Patient Assistance Programs, which offer prescription drugs free of charge to eligible patients. Under these programs, Care*Link* members received about $13 million worth of free pharmaceuticals in 2003, says Dr. McWilliams.

Most recently, Care*Link* has begun working more closely with the Center for Health Care Services (CHCS), which provides mental and behavioral health services for residents of Bexar County. CHCS case workers help eligible patients enroll in Care*Link*, which ensures that not only do they receive the mental health services they need, but also physical health services. "It's been a very successful relationship," says Simmons.

For more information,, please contact Juanita Simmons, Care*Link*, at jmsimmons@university-health-sys.com.

Organizing physicians in response to the needs of a diverse patient population

Multicultural Primary Physician Medical Group
San Diego, California

In the late 1980s and early 1990s, Rodney Hood, MD, was concerned that he and other private-practice physicians in San Diego County were not well prepared for the increasing prevalence of managed care in the marketplace. "It was clear to me and a group of other doctors that if we wanted to survive, we needed to organize ourselves and become more knowledgeable and more political," he recalls. So in the mid-1990s they formed the Multicultural Primary Physician Medical Group, an Independent Physician Association (IPA) that provides primary and specialty care.

"Our purpose, as individual physicians, was to gain more negotiating power so that we could keep not only an appropriate level of compensation, but more importantly, keep the patients we already had," says Dr. Hood. The patients that he and the other physicians in the group were seeing were mostly African-Americans, Hispanics and Asian-Americans, many of them without health insurance. "But many of our patients were covered [by health insurance], and we were afraid of losing them," he says.

The doctors formed the IPA not only out of concern about losing their patients. They were also motivated by the conviction that patients are better served if they have access to private-practice physicians who both reflect the diversity of the community and are located within the community. San Diego is highly multicultural and so are the group's physicians, who have typically been about one-quarter African-American, one-quarter Hispanic, one-quarter Asian-American, and one-quarter white.

Dr. Hood is Past President of the National Medical Association, which represents more than 28,000 African-American physicians. He is convinced that one of the advantages of IPAs is that they allow traditional providers to maintain their relationships with patients, which can be especially beneficial for patients of color. "There is evidence to suggest that managed care sometimes fractures the patient-physician relationship, which is part of the problem with health disparities," says Dr. Hood. "Hopefully, [IPAs] will create a scenario where health disparities can be reduced."

He notes that research still needs to be done on how IPAs affect patient outcomes, particularly in the area of health disparities. "We have a strong interest in doing that," he says, especially in light of the Institute of Medicine report which shows a high incidence of cancer, diabetes and other diseases in communities of color. "We've been talking with health plans about using us as a model to collect that data."

The Multicultural Primary Physician Medical Group has also been active in efforts to improve access to health care for patients who are medically underserved. In the mid-1990s, the group applied for a grant from The Robert Wood Johnson Foundation under a program called "Reach Out: Physicians' Initiative to Expand Care to Underserved Americans." The program awards grants to physician-led projects designed to increase access for uninsured and underinsured patients. "'Reach Out' was ahead of the curve" with the concept, says Dr. Hood.

The group was awarded a 3-year, $300,000 grant, which they used to put together a network of physicians that would see patients for free or at reduced cost. They began with the IPA's doctors and then extended the network to physicians outside the IPA. While doing that, they developed a relationship with the San Diego County Medical Society, which assisted in recruiting not only doctors to the effort but also labs and other entities.

The grant was designed so that the network would have to be self-sustaining after 3 years. At that point, the IPA created a foundation through which to continue funding the physician network project. "The network struggled for a few years, but they were referring 2,000 patients a year to specialists and other entities," says Dr. Hood. In 2002 the San Diego County Medical Society agreed to spearhead the project and founded a 501c3 organization to house the effort.

After 5 or 6 years of financial struggle, the IPA underwent a transition in 2004. They condensed their size and hired a new management group to market them and negotiate their contracts. As a result, says Dr. Hood, "we went from debt to positive case flow in 6 months."

Dr. Hood says it's still too early to start bragging about how the group is doing, "but I think the IPA is a positive and pragmatic response to many of the concerns physicians have about dealing with managed care." More than anything else, it shows that "when physicians organize they can improve their negotiating power and maintain their contracts at a more acceptable level, and more importantly, keep their patient base."

For more information, contact Rodney G. Hood, MD, Careview Medical Group, at rghood@cox.net.

Using a case management model to serve nursing-home-eligible Medicaid recipients

FlexCare
Salt Lake City, Utah

Under most state Medicaid programs, patients who need long-term care are at risk of losing their benefits if they move out of nursing homes. But in Utah, the state health department initiated a five-year managed care demonstration project in 2000 that provides Medicaid patients the option of living in alternative settings that offer greater independence.

Called FlexCare, the program allows people with long-term care needs to move out of nursing homes into less restrictive environments such as assisted living, residential care, or their own home. FlexCare also lets patients move seamlessly among different levels of care as their medical needs change over time.

While other states have opened up assisted living options to Medicaid patients with long-term-care needs, FlexCare is "pretty unique" in the country because it not only offers patients a full array of living situations, it also provides intensive case management, says project director Don Fennimore.

Each FlexCare enrollee is paired with a case management team consisting of a nurse and a social worker, and each team carries an average caseload of only 35 patients, which allows them to keep close track of their patients' needs, says Fennimore.

The team coordinates services with the patient's primary care physicians, specialists, home health, mental health and other providers. The nurse typically accompanies the patient to doctor visits, while the social worker communicates with the patient and his/her family and assists with financial and other needs. Together they serve as advocates for the patient as the patient's needs and living arrangements change over time.

FlexCare is currently open to eligible adults in Salt Lake, Davis or Tooele counties. To qualify, enrollees must be either in a nursing home for at least 90 days and medically eligible for long-term-care services under Medicaid; in a nursing home on a Medicare stay and medically eligible for long-term-care services under Medicaid; or hospitalized and medically eligible for long-term-care services under Medicaid upon discharge.

About 360 patients – or roughly 18% of the nursing-home-eligible Medicaid population in the three counties – are enrolled in FlexCare. The target penetration rate is about 30%-35%, says Fennimore.

FlexCare is essentially a long-term-care HMO under Medicaid in Utah. Through its case management model, the program is able to offer enrollees a full range of services and living arrangements at a cost that is about 5% lower than the average nursing home rate, says Fennimore. The program pays FlexCare a daily rate for each enrollee and FlexCare becomes the payer for all services provided to that enrollee, including their room-and-board, case management, home health services, physical therapy, mental health services, durable medical equipment, etc.

FlexCare is run by a division of Valley Mental Health, a public, nonprofit corporation that is the Medicaid mental health provider for Salt Lake County. The small profit margin Valley Mental Health reaps from FlexCare is reinvested in the program's infrastructure, says Fennimore.

For example, FlexCare created a psychiatric assisted-living facility for patients who need both psychiatric services and some level of custodial care but prefer more independence than they would have in a nursing home. In the FlexCare facility, "they're getting focused psychiatric care, which they're not going to get in a nursing home," says Fennimore. "And it's designed to maximize their independence and privacy."

FlexCare has also developed specialty housing units for younger physically handicapped patients. The housing units provide a handicapped-accessible cooking area and a roll-in shower in each apartment, a pool of personal care attendants, and a peer group for residents. The level of care in these facilities can be tailored to the needs of each individual resident, which is not the case in nursing homes.

Given the success of FlexCare, others areas of Utah are considering, or have begun implementing, similar case management programs for long-term care Medicaid patients. Weber County, north of Salt Lake City, started a program in October 2003. Also, a similar project may get started in a five-county area of southern Utah.

For more information, contact: Don Fennimore, Valley Mental Health, at DonF@vmh.com.

A community-based coalition improves end-of-life care

Project Compassion
Chapel Hill, North Carolina

In the fall of 2000, PBS stations around the country aired "On Our Own Terms," a landmark television series about issues involved in providing humane care for people when they are dying. The series, which was watched by some 22 million people nationwide, was accompanied by a community campaign designed to stimulate dialogue and action on the multitude of issues surrounding end-of-life care.

Around the same time that the PBS series was aired, community leaders in the North Carolina counties of Durham, Orange and Chatham began meeting to discuss people's unmet needs at the end of life. Recognizing the need for an independent, collaborative forum to address end-of-life care issues in their counties, these organizers launched Project Compassion – a community-based organization that provides education, advocacy and support for all people as they deal with serious illness, death, and grief.

The force that really brought the coalition together was its passionate founder Mary Meyer, says Project Compassion's executive director, James Brooks. "Mary does not come from a health care background – she's a CPA," says Brooks. "But she came to the work as the result of a deep personal experience." Meyer's close friend had recently died of breast cancer, leaving behind a 5-year-old child. "By watching what her friend went through and struggled with, Mary came to a personal understanding that all of us need care at the end of life," says Brooks.

As a first step, Meyer met with and interviewed community leaders who in some way were connected with end-of-life issues. She met with officials from hospitals at Duke and the University of North Carolina (UNC) – both of which operate their own hospices. Bringing together these and other partners to form an end-of-life coalition took some finessing. "It is a very competitive environment, and a lot of folks don't cross party lies," says Brooks. "But Mary began to pull together these people and to introduce them to each other – some for the first time."

Under Meyer's leadership, the group quickly organized itself and secured 501(c)3 status by November 2001. Because of the existing polarization, it was decided that the best approach was to create an independent organization that would truly be community-based, says Brooks. "It was important that the organization be seen as being on the side of the whole community."

By the time Project Compassion became a 501(c)3, it had secured funding from a local private donor for strategic planning and a consultant. The group had also linked up with Last Acts Partnership – The Robert Wood Johnson Foundation's end-of-life care initiative – and with The Carolinas Center for Hospice and End of Life Care. Brooks, who was formerly a clinical manager for a hospice in Florida, met Meyers at a support team leadership conference in 2001 and was subsequently hired to head Project Compassion.

"We've been very local in our prioritizing and what we're chosen to do," says Brooks. "There are literally hundreds of ways to do this work, so the challenge is to figure out how to do this work in a way that meets the needs of the community and can also be accomplished."

Among the coalition members are more than 50 local groups and organizations, including UNC Hospital and UNC Hospice, Carolina Meadows Retirement Community, Carol Woods Retirement Community, Shepherd House Assisted Living, Hope Valley Garden Club, Duke Community Home Care, the North Carolina chapter of AARP, and more than 30 diverse faith communities. The coalition also includes "a lot of community people who just have a passion for this," says Brooks.

One of Project Compassion's main projects is the Support Team Initiative. Under this initiative, volunteer support teams provide practical, emotional and spiritual support for people who need help with care giving. This team approach to care giving uses a model that was created within the AIDS hospice community in the 1980s and 1990s, says Brooks. Using a team approach, community volunteers pool their talents, creativity and time to offer much more support than one volunteer can provide alone.

"Support teams are appealing because most folks who have been involved in caring for someone who is dying know that it can be an overwhelming position to be in if you are the person doing it," says Brooks. By volunteering in groups of 6-12 people, caregivers can provide more comprehensive care to the recipient as well as offer needed support to each other.

During 2003, Project Compassion launched 42 of these volunteer support teams with 425 volunteers who provided 6,400 hours of care giving support for 145 people. In 2004, Project Compassion planned to create 50 more support teams. This care giving service is offered at no cost to the recipients. In 2003, the network was recognized as 1 of 3 model programs in the U.S. by RWJF's Last Acts Partnership. In 2004, the National Council on Aging recognized the network nationally as 1 of 8 Wisdom Works programs.

In its other community initiatives, Project Compassion helps people access the information they need by offering public forums, workshops, and symposia on a range of topics to help people with care giving, end-of-life issues, and grief. It also offers the community a resource center, a printed resource guide, and a website with extensive information and resources.

In addition, Project Compassion supports a network of 125 trained Advance Care Planning facilitators and offers printed resources, planning guides, and educational events to help people understand and plan for end of life wishes.

For more information, contact James Brooks, Project Compassion, at james@project-compassion.org.

Removing barriers that hinder disabled residents from full community participation

Littleton Model Community Project
Littleton, New Hampshire

In 2001, the Bush administration announced the New Freedom Initiative, which was designed to assist communities in expanding education and employment opportunities for persons with disabilities and removing barriers that prevent these individuals from taking part in community life. The initiative was intended to aid in implementation of the U.S. Supreme Court decision L.C. v Olmstead, which found that communities have an obligation to provide support to individuals who are disabled so that they may live independently if they are able.

As a result of the New Freedom Initiative, the Centers for Medicare and Medicaid Services (CMS) awarded a Facilitating Lifespan Excellence (FLEX) grant in early 2002 to the New Hampshire Department of Health & Human Services and the University of New Hampshire's Institute on Disabilities. Upon receiving the FLEX grant award, these two entities put out a Request For Proposals (RFP) to communities in New Hampshire, inviting them to apply for part of the grant money. The initiative was called the Real Choice Systems Change Initiative.

The Town of Littleton was the only town that was chosen to receive an award. Nestled in the White Mountains of New Hampshire's North Country, Littleton is a scenic town of about 6,000 residents. It was tapped for an award because of its strong local government, high level of civic participation, history of collaboration among health and social service providers, and its reputation as a "destination community".

Under the Real Choice Systems Change Initiative, Littleton received a three-year grant of just under $300,000 to create its Model Community Project. New Hampshire is actually one of only six states in the country that is currently carrying out a Model Community project to develop and maintain strategies to encourage seniors and other persons with disabilities to fully participate in community life.

The Model Community grant cycle for Littleton began in June 2002 and will end in June 2005. The town is using the money to develop mechanisms that are supportive of older people and people with disabilities, says Nicole Lapointe, project manager for the Littleton Model Community Project.

Before receiving the grant, Littleton was "about par for the course among towns of its size, in terms of community supports for people with disabilities," says LaPointe. "But now we hope to be ahead of the game" by implementing improvements that will make it possible for anyone in the community to access local facilities and programs, and to get needed information.

Littleton is certainly ahead of the curve in recognizing the importance of removing barriers for people with disabilities, who make up a growing percentage of Americans as the nation's population ages. In New Hampshire, people over the age of 65 currently represent 12% of the population. But that figure will grow to an estimated 26% of the population by the year 2025. In Littleton today, nearly 45 percent of people over age 65 have some form of disability. So changes are clearly needed if this growing segment of the population is to continue to fully participate in community life.

The Town of Littleton has been working collaboratively with local partners to determine what it means to be an inclusive community, to identify and inventory community assets and capacity, and to enhance, coordinate and develop supports for people in the community. These partners include the North Country Health Consortium, Inc. – an organization that facilitates collaboration among health and human service providers to address common issues – as well as local businesses, and education and social service organizations.

Among the improvements made in Littleton have been facility upgrades to make sure public buildings are in compliance with the American's with Disabilities Act. Some of the facility upgrades, such as those that need to be made to old parks and recreation buildings, are quite costly, and the project is seeking additional funding to complete those. But the project has been able to tackle other types of upgrades that have been identified as readily achievable. For example, Littleton is changing all of the door knobs on public facilities from small, round knobs to the level door handles that can be opened with a closed fist. The town has also updated its signage to appropriately mark entrances that are handicap-accessible.

In addition, the town has installed software in the town office that provides a built-in text magnifier for people who come to the office to read public information about zoning ordinances, property sales or tax regulations. The software can also translate written text into voice for those whose eyesight is too poor to read even magnified text.

Littleton recognizes that older people and people with disabilities are vital to the community, says Lapointe. She notes that conservative estimates put the unemployment rate among people with disabilities in New Hampshire at about 40%. "We want to continue to engage these people and to encourage them to stay in the workforce," says Lapointe. "We are concerned about this as a quality of life issue for people who want to work and cannot find employment, and as an economic development issue in a community with an overall unemployment rate that is below the state average."

As part of the grant award, the Model Community Project is providing local employers with the information and assistance they need to feel comfortable hiring older people and people with disabilities. The project is also providing incentive grants to employers – such as grants to help them make facility upgrades to improve accessibility – as well as free marketing opportunities and technical assistance.

Transportation is also a significant focus of the Model Community Project. People with disabilities need reliable transportation to be connected with services, programs and other people in the community. A coalition of health care providers and transportation service providers have been working together for three years to start a fixed bus route that would connect Littleton with the nearby city of Lancaster and with the two hospitals in the area, says Lapointe. Another goal is to start a fixed bus route within Littleton. The coalition is continuing to seek funding to implement their vision of an improved transportation system for residents with disabilities.

With the grant for the Model Community project coming to an end in 2005, the town is taking the issue of sustainability funding very seriously. “We’re trying to get people to think about why this is important,” says Lapointe. Part of the message to residents and local businesses, she says, is that “as Littleton is promoting itself as a tourism and retail destination, we want to be a community that is safe and comfortable for everyone, and that includes people with disabilities.”

For more information, contact Nicole Lapointe, Littleton Model Community Project, at nlapointe@nchin.org.

Improving coordination of transportation for elderly residents in rural New Mexico

Senior Transport Program
Sandoval County, New Mexico

Sandoval County is a mostly rural area northwest of Albuquerque where a growing number of frail elderly residents are choosing to stay in their homes rather than move into assisted living facilities or to urban areas where services are more accessible. Many of these residents rely on the county for transportation to health care and social services that are 50 or more miles from where they live.

For these elderly residents, the county operates a Senior Transport Program that takes them to local senior centers for meals and to medical providers in Albuquerque. As the demand for transportation has grown, the need to better coordinate the Senior Transport Program became more urgent, says Gino Rinaldi, the county’s senior program administrator.

In the past, there was no coordination of transportation. An elderly resident would simply call their local senior center to request a ride and a staff person would go pick them up. If another elderly person called for a ride while that staff member was out driving, another staff member would have to go pick up the second person. Due to lack of coordination, several staff members could be out driving at the same time, leaving the senior centers virtually without staff, which often led to problems.

Not only was it inefficient, it was also costly, says Rinaldi. In 2001, the county faced a budget deficit and was trying to figure out ways to cut costs. “So we were faced with having to eliminate medical transportation altogether, or doing it smarter.”

The county decided to implement a coordinated system of transporting seniors so that one full-time driver could handle all of the transportation for four of the County’s seven Centers. The county also combined the Senior Transport Program with the county’s maternal/child health transportation system. “It’s been working well,” says Rinaldi. “We now have a full schedule every day into Albuquerque and Rio Rancho.”

Initially, some clients were unhappy with the changes. A lot of seniors had gotten used to the individual attention they'd received under the old system. Understandably, they were afraid to lose that. "If someone – particularly a frail elderly person – who lives 50 miles from Albuquerque has to see a doctor, it's a major ordeal," says Rinaldi. "It takes a lot out of them to go, and often they don't want to go, especially when they don't feel good."

But now, most of the seniors are satisfied with the new system, he says, and they still get individualized attention. The driver, who is bilingual in English and Spanish, often serves as translator between patient and provider. This is important, says Rinaldi. "As people become more frail, they often prefer to speak in their native language." The driver can also make sure that the appropriate prescriptions are picked up.

Although the county does not have an estimate of the money saved under the new system of senior transport, there has been a big pay-off in terms of efficiency. "Things run more smoothly," both in the transport program and the senior centers, says Rinaldi. "The customer satisfaction is there and the staff is able to maintain a presence in the senior centers."

For more information, contact Gino Rinaldi, Sandoval County Senior Program, at rinaldigino@hotmail.com.

FOSTERING COLLABORATION AMONG DIVERSE PARTNERS

Bringing together diverse interests to address community well-being

Health Improvement Partnership
Spokane, Washington

The Health Improvement Partnership (HIP) is a non-profit organization in Spokane, Washington, whose mission is to pull together diverse interests to collaborate on efforts to improve overall community health and well-being.

"We look for issues that are not getting solved by other entities," says Dan Baumgarten, HIP's executive director since 1997. HIP employs a broad definition of "community health" to identify and address community needs. In addition to its work to improve access to health care for uninsured residents, HIP addresses issues such as employment for people with disabilities and early child care.

Baumgarten says HIP has carved out a unique role as a neutral convener that brings together diverse – and often competing – sectors to address community needs. "We ask people who might not normally work together to 'think big' and imagine new possibilities," he says. "We try to hold that together through facilitation and sometimes even implementation, and to bring in resources."

Spokane's two major hospital systems and the Spokane Regional Health District established HIP as a non-profit organization in 1996. The impetus for creating HIP was the growing awareness in Spokane that most determinants of population health are not connected to medical intervention, but to broader community issues such as housing, education, and employment.

The hospitals funded HIP during its first four years through Inland Northwest Health Services. Hospital funding was phased out at the end of 2001 and HIP developed new sources of funding. "Now we're independent, and we're much better off now because we're seen as a neutral convener," says Baumgarten. "You have to be perceived as everybody's ally, and that takes a lot of work."

HIP adheres to three principles in carrying out its mission as a neutral convener: create an atmosphere of civility, maximize communication, and put purpose before identity.

"You have to create an environment where enemies will shake hands with each other," says Baumgarten. In addition, "you have to keep your eyes on the purpose," he says. "You can't be concerned about who will get the funding and who will get the credit."

HIP has found success by trusting partnerships and collaborations to define its role in relation to a particular community improvement issue. For example, HIP often looks to its community partners to determine what, if any, role HIP should play in implementing new collaborative plans. "We found that partners often want us to be involved," says Baumgarten. "By being willing to defer to the interests of the partnership, you actually get energy by giving it away." The organization also earns more trust from its partners by demonstrating that it is not simply another competitor for funding.

In fact, HIP has been highly successful in attracting funding from regional and national sources for community-wide efforts at collaboration and innovation. Since its founding, HIP has brought about $12 million in new funding into the Spokane region.

HIP has also seen its own annual budget grow from approximately $200,000 in 1996 to $2.3 million in 2003. To date, HIP has partnered with over 500 organizations on projects that range from small neighborhood improvement projects to statewide system change initiatives.

Among its achievements, HIP has helped 17,000 uninsured residents of eastern Washington gain health care coverage. HIP is currently educating small employers who cannot afford the full cost of coverage for their workers to tap into new vehicles that will help employees gain coverage. HIP has also helped launch mental health services in the context of primary care for low-income patients.

Baumgarten brings to HIP his extensive experience as a consultant who has assisted organizations large and small in their efforts to adapt to accelerating change. "Sticking to your knitting does not work as well in an environment of accelerating change," he says. "The world keeps presenting you new and unexpected situations, so there is a premium on adapting and being innovative."

Communities have tremendous untapped capacity to link needs and resources, says Baumgarten. For example, on the issue of health care access, "most communities have the resources to make everyone as healthy as possible, but there is tremendous inefficiency in mobilizing those resources – the incentives don't get organized."

HIP is trying to tap the tremendous potential in Spokane by facilitating collaboration and innovation among diverse interests, but there has been resistance, says Baumgarten. "Despite our success, a lot of people don't necessarily understand our approach. We try to educate community members about the potential for creative collaborations and our role as a catalyst."

On the other hand, HIP has built a track record of being able to get people to work together to accomplish significant improvements in community well-being. Through its commitment to finding ideas that can inspire partnership, building trust, and putting purpose ahead of acclaim, HIP has made a real difference – both in substance and style – to the quality of life in Spokane.

"People have to feel that things are possible," says Baumgarten, "when before they might not have seemed possible."

For more information, contact Dan Baumgarten, Health Improvement Partnership, at danb@hipspokane.org.

Using multi-county collaboration to address the needs of uninsured, rural residents

The Wellness Coalition
Lordsburg, New Mexico

The four counties in rural southwest New Mexico are a thinly populated, often marginalized area of the state. The local economy, never very strong, has worsened in the last few years, and the area has long had among the highest rates of unemployment in New Mexico.

With the recent closing of the area's copper mines, unemployment has shot up even further, along with the number of people who lack health insurance, says Nikki Zeuner, executive director of The Wellness Coalition, a nonprofit association that includes the County Community Health Councils, consumers and providers in the four counties.

Lack of access to health care –including substance abuse treatment and mental health services – is a major problem in this part of New Mexico. Nor has been there been much help from the state, says Zeuner. "Funding never makes it down here."

Given the significant barriers to accessing health care in this rural area, health care workers in these four counties – Grant, Luna, Hidalgo and Catron – decided in 2001 to come together to form a coalition that would collaborate in setting health care priorities and identifying funding sources.

Under the leadership of a large community health center called Hidalgo Medical Services, The Wellness Coalition partners created a board in 2001 that includes representatives of local agencies and service providers as well as health center staff.

Many of the members of the board did not previously have a history of collaborating, says Zeuner. "But now we're actually giving them money and staff time," which has increased some board members' interest and participation in the coalition's work.

The board quickly produced a strategic plan that included applying for a three-year, $200,000 "networking grant" from the federal Bureau of Primary Health Care. That application was successful and the funding the Coalition received has been applied toward joint efforts to integrate the systems of care for uninsured residents in the four counties.

Building on its first successful grant application, the Coalition applied for an even larger Community Access Program (CAP) grant from the Health Resources and Services Administration. Once again, the Coalition was successful and received a grant of more than $900,000 in September 2003. The Coalition plans to use the three-year CAP grant to expand its efforts to better integrate systems of care throughout the four-county area.

Among the goals the Coalition has set is the streamlining of enrollment procedures across all providers and creation of a joint information system that allows staff at all providers to have convenient access to patients' eligibility information and referral history.

The Coalition intends to give uninsured patients a "swipe card" for them to present at any point-of-care in the region. The card will act as a form of identification that brings up the patient's status of eligibility for subsidized care as well as their referral and service utilization history. The Coalition hopes to have this system operational by 2005, says Zeuner.

The Coalition is also using the CAP grant funds to increase health education and preventive services.

Recognizing that the CAP grant will end within three years, there need to be some cost savings realized that can than be used to continue the Coalition's progress toward creating more integrated and effective systems of care for uninsured residents, says Zeuner. For example, one of the goals is to reduce unnecessary use of emergency rooms. The Wellness Coalition is planning to put a community health worker in every emergency room to help patients with non-emergency conditions get signed up for subsidized health care, if they qualify, and direct them to community health centers and other more appropriate and less costly settings for primary care.

For more information, contact Nikki Zeuner, The Wellness Coalition, at nzeuner@wellnesscoalition.org.

Multi-stakeholder collaboration encourages residents to adopt a healthy lifestyle

Bexar County Community Health Collaborative
San Antonio, Texas

In 1997, the healthcare systems in Bexar County, Texas, were faced with a new state law mandating that they each complete a community health needs assessment. In response, executives at five competing health systems decided to undertake a joint assessment in their community. They also pulled in other health care stakeholders to make the process as comprehensive as possible.

The assessment was completed in 1998, and the experience gained by cooperating with each other set the stage for the creation of the Bexar County Community Health Collaborative, says Executive Director Joan Miller. Through the experience, leaders of participating health care organizations "learned their counterparts did not, in fact, have horns and a tail," Miller says. "Actually, they liked each other and decided to keep working together to find areas where they could cooperate in improving residents' health status."

The organizations that came together to sponsor the Health Collaborative include Baptist Health System, Bexar County Medical Society, Christus Santa Rosa Healthcare Corp., Community First Health Plans, Methodist Healthcare Ministries, Methodist Healthcare System, San Antonio Metropolitan Health District, Southwest General Hospital, and University Health System. These member organizations pay dues that help fund the Collaborative's $500,000 annual operating budget.

When they formed the Health Collaborative, these organizations decided to tackle pressing public health issues facing San Antonio, such as improving residents' levels of fitness and nutrition, addressing youth depression, and advocating for fluoride in local drinking water.

Sponsors were particularly concerned about the challenge of obesity in their community. "We knew we had a problem when we compared [San Antonio] data to state data, and certainly when we compared it to goals set by the Centers for Disease Control & Prevention," says Miller.

So the Health Collaborative commissioned research on the "best practices" that were being used by communities around the country to reduce obesity rates. They wanted to find comprehensive, community-wide strategies that were being employed to prevent and treat obesity. "But we came up with a big fat zero," says Miller. All they found were piecemeal efforts, such as local fitness programs and diet centers, but nothing that tied these efforts together in a community-wide program.

So the Health Collaborative decided to chart its own course. In 1999, the organization established Fit City/Fit Schools – a citywide program that works to raise awareness among San Antonio residents about the need to adopt a healthy lifestyle.

One of Fit City/Fit Schools' ongoing initiatives is Walk San Antonio (WSA), which is designed to get San Antonians moving for 30 minutes a day at least five days a week. By mid 2004, nearly 11,000 San Antonians were enrolled in the program, and the goal is to add another 5,000 members by the end of the year. WSA participants keep track of the minutes they walk, the pounds they've lost, and the reduction in their body mass index (BMI).

Fit City/Fit Schools receives financial and in-kind support from an array of businesses and civic organizations, including The Junior League of San Antonio, Inc., the YMCA, Humana, and even the Texas Beef Council. The program has also received a grant from the CDC and a grant administered through the county health system, although there is no city or county money that goes into the program.

Another Fit City/Fit Schools project is the Healthy Vending Initiative. In early 2003 the initiative developed science-based nutrition standards for snacks and beverages. Staff and volunteers trained some 20 vending companies on use of the standards and expanded healthy vending sites in hospitals, schools, government offices and businesses.

The Health Collaborative is also helping employers improve the fitness and nutrition habits of their employees by establishing the Fit City Corporate Wellness Program. It includes a customized Walk San Antonio program, monthly employee wellness data reports, nutritional seminars and cooking demonstrations, the Healthy Vending Program, and copies of the *Fit City Today* quarterly newsletter and Fit City Monthly Messages on fitness and nutrition to distribute to employees.

In trying to get San Antonians to adopt healthy habits, the Health Collaborative's biggest challenge is the behavioral barriers, says Miller. "You can provide information and rewards, but it has to be the individual's decision to adopt healthier behavior, and that's something we don't have control over."

A second challenge is fundraising. Getting employers to invest $10 per employee per year in wellness can be a pretty tough sell. "People are investing in hopes," says Miller. The Health Collaborative provides employers data on enrollees' exercise time and their BMI reduction to try to demonstrate progress. “But it’s a delayed return on investment, and human nature tends toward wanting quick fixes,” she says.

The Health Collaborative tries to overcome these challenges by continually telling the story of what they’re trying to accomplish. From the beginning, its board has been committed to raising and maintaining its visibility in an effort to secure its sustainability. As a result, Fit City/Fit Schools has received widespread attention in the media, at both the local and national levels.

For more information, contact Joan Miller, Bexar County Community Health Collaborative, at jmmiller@healthcollaborative.net.

Bringing stakeholders together to discuss problems, develop consensus on solutions

Vermont Health Policy Roundtable
Vermont

In early 2002, Vermont Association of Hospitals & Health Systems President and CEO Bea Grause and then-Secretary of Health Services Jane Kitchel wanted to figure out why the sickest 10% of Vermont’s population used 73% of its health care resources. They brought together a diverse group of the state’s health care stakeholders to discuss the issue. This group came to be known as “The Sickest Ten.”

The group they brought together included the state’s health commissioner and commissioner of the Department of Aging and Disabilities as well as top-level state Medicaid officials, leaders of the state medical society, the state home health association and two major health plans, and academics from the University of Vermont Medical School.

The group soon found that the 10% of Vermont’s population who were using 73% of its health care resources were, indeed, severely ill and injured. They included people who were quadriplegic or severely brain injured, or those who had suffered spinal cord injuries. “We found that those people were extremely well case-managed,” says Grause. They were heavy users of the health care system, but there was no reason to think their care could be delivered in a less costly fashion.

“It was the next 20% of the population, in terms of claims, that we needed to look at,” says Grause. This section of the patient population was made up mostly of people who had diabetes, cancer or congestive heart failure. The group picked diabetes out of those diagnoses and looked around at projects in Vermont designed to address diabetes. For about a year the group considered whether they would initiate a collaborative project.

Ultimately, the group decided that it would not carry out a project. “We realized we had no funding or ability to do a project,” says Grause. “But we found that there was value in just sitting down together, talking about policy, and thinking about solutions.”

“The Sickest Ten” became a strategic thinking group that in 2003 was renamed the Vermont Health Policy Roundtable. The goal of the group became talking about the stakeholders’ collective vision for health care reform, says Grause. “We want to see if we can get past the political barriers to see where our principles are aligned. This is a vehicle for the cross-pollination of ideas.”

By fall 2003, the group found they could agree on several principles, such as the need to eliminate cost-shifting and under-reimbursement by Medicare and Medicaid, and support for evidence-based medicine. The group reached a consensus in support of the Chronic Care Model developed by Dr. Ed Wagner of the Improving Chronic Illness Care program in Seattle, Washington. With the group's encouragement, the state of Vermont announced in October 2003 that it planned to implement the Chronic Care Model statewide.

Health care stakeholders are motivated to participate in the Roundtable group because they see it as "a safe place to share ideas," even when there is disagreement, says Grause. The issue of pay-for-performance, for example, continues to be a difficult topic on which to reach consensus.

For more information, contact Bea Grause, Vermont Association of Hospitals and Health Systems, at bea@vahhs.org.

Bringing diverse partners together to collaborate on county health planning

Broward Regional Health Planning Council, Inc.
Broward County, Florida

Throughout the state of Florida, eleven regional health planning councils are responsible for carrying out health planning and implementation activities designed to raise the quality of life for local residents. The largest of these health planning councils is in Broward County. A private, non-profit organization, the Broward Regional Health Planning Council, Inc. (BRHPC), operates with an annual budget of about $10 million and more than 90 staff members.

Although county health departments provide health services, in Florida they don't have planning functions, says BRPHC CEO John Werner. "I think it's a unique system compared to other states." Instead, it is up to the regional health planning councils – functioning as public-private partnerships – to carry out the role of local health planning.

BRHPC operates under the direction of a 12-member board of directors. According to state statute, the boards of directors of regional health planning councils must be composed of health care providers, purchasers, and nongovernmental consumers. Board members are chosen by Broward County Commissioners to serve a two-year term. A majority of board members must represent purchasers and consumers.

Through this structure – a board that represents all different interests in health care, both public and private – there has been important progress toward health care improvement goals in Broward County, says Werner. "Over the years, we have been able to get different providers in the community – both public and private – to work together and knock down barriers to access."

One example of this success was the development of a coordinated primary care system in Broward County. "Back in the 1980s it was a very fragmented system," says Werner. "But the providers got together and decided they wanted our Council to develop a primary care plan that would improve access to care." As a result, the Council was able to co-locate many primary care services in the county and to persuade the hospitals to take over the primary care system, which resulted in improved access.

In a more recent undertaking, BRHPC has been the lead agency on a three-year Community Access Program (CAP) grant of nearly $1 million that the federal Health Resources and Services Administration awarded to Broward County in 2001. The goals of the Broward County Community Access Program are: improved access to health care services through development of a centralized eligibility and referral system and increased awareness of existing resources, improved data management and case tracking for the uninsured population through an enhanced information management system, and improved care for the uninsured through better case management for patients with diabetes, asthma and AIDS. “It’s proven to be a very effective program,” says Werner.

BRHPC is the umbrella for other organizations such as the Broward County HIV Health Services Planning Council, which is the designated planning body for Ryan White C.A.R.E Act Title I services, including HIV outpatient health and support services, case management and comprehensive treatment services.

BRHPC is also the umbrella organization for the Healthy Start Coalition, a program that helps women get the support services they need to have a healthy pregnancy and a healthy baby.

A current focus for BRHPC is the improvement of the behavioral health system in Broward County. “Behavioral health is an area we’re getting ready to move into because it’s been neglected,” says Werner. In the fall of 2004, the Council was entering into a planning mode on the issue of behavioral health services, which will involve looking at the existing resources and setting improvement goals and strategies.

For more information, contact John Werner, Broward Regional Health Planning Council, Inc., at jwerner@brhpc.org.

APPENDIX A: SELECTED OPINION-EDITORIALS FROM THE COMMUNITIES

"Finally, straight talk on health-care crisis"

Editorial
Spokane Journal of Business
December 11, 2003

We were glad to see the Spokane Regional Chamber of Commerce join forces with the Wye River Group on Healthcare, which conducted community-forum meetings here last week on the nation's health-care crisis after having held such discussions in 10 other U.S. cities.

By seeking the opinions of leaders and residents here and elsewhere on health-care issues, the Washington, D.C.-based nonprofit Wye River Group is doing something that badly needs to be done—taking the temperature of the health-care system at the local level to see how sick it really is.

Though health care is one of the most vexing issues confronting Americans and U.S. businesses, it is getting little meaningful debate either in Washington, D.C., or in the state capitals. When legislation such as the recent Medicare prescription bill is taken up, there's so much log rolling by special interests that the final bill is as much a tally of industry lobbyists' power as anything else.

Besides, our failing system partly is a creation of Washington, D.C., where there appears to be little stomach for the kind of effort that it will take to find a cure. It's time for a bottom-up approach, rather than the top-down planning that has gotten us where we are.

The Wye River Group's goal is to stimulate conversations in communities that will jump-start a national dialogue about the fundamental values and principles Americans want to see observed as future health-care policy is developed. In its community roundtable discussions, the Wye River Group doesn't ask leaders for their views on specific policy issues. Rather, it asks more fundamental questions, such as whether there is, or should be, a social contract for health care in the U.S. It has challenged participants to define the attributes of a well-functioning system and the role each sector would play in creating and maintaining such a system.

In the first phase of its effort, the Wye River Group found most community leaders agree that the country hasn't developed a social contract in health care, as it has in other areas of public policy, such as education. In such a contract, the link between two parties, say the taxpayers and the users of the public schools, is clear, and both sides know what to expect. Because there is no social contract between society and its members when it comes to health care, most Americans don't know what to expect from the health-care system. Nor do they understand their responsibility to contribute to the health-care system as consumers, and the public's expectations are out of line with what the health-care system is able to deliver.

The group says community leaders generally agree that the most important step in moving forward with health-system change might be a re-examination of the way consumers function in the system. It says the health-care market is evolving toward giving consumers more choices, but also more responsibility for the economic consequences of their health-care decisions.

In the second phase of the group's project, which it's beginning now, its intent is to engage these leaders in activities designed to bridge the gap between local concerns and national policy. Yet, the Wye River Group says, many elected officials don't seem to grasp the magnitude of the challenges that must be faced to fix the health-care system or the urgent need to address them. It says an effort is needed to educate and engage citizens and policymakers on health-care issues, and little progress can be made without political leadership and public pressure.

We found the Wye River Group's findings to be insightful. We know that its efforts are only a start on a long road to resolution of the issue, but we thank both it and the Spokane Regional Chamber for their efforts.

"Begin national dialogue now on health care"

Op-ed by Ollye B. Shirley, PhD
The Jackson Clarion-Ledger
December 12, 2003

With the election of a new governor here in Mississippi and the 2004 presidential campaign heating up around the country, now is the time for all of us to begin talking about one of the most serious issues we face as a state and a nation: the failures of our health care system.

The problem of the uninsured, in particular, is crying out for urgent attention. The number of Americans without health insurance jumped to nearly 44 million people last year — 2.4 million more than the year before, according to the U.S. Census Bureau.

Mississippians affected

Here in Mississippi, the percentage of our citizens without health insurance rose by 1.6 percentage points, to 16.5 percent. Insurance coverage is not the only issue: Too many Mississippians continue to face real problems getting access to basic health care services.

This should be a wake-up call to anyone who cares about our shared quality of life. Our new governor and the health care community in this state should feel a sense of urgency about addressing the many problems in health care.

The Mississippi NAACP has undertaken a major new initiative designed to assist people in our state who have difficulty getting access to health care services and information.

At our state convention earlier this month, delegates voted overwhelmingly to establish a lay health educator in each branch office throughout the state. Each of these health educators will be chosen from the local community and trained by health care professionals provided by the Jackson Medical Mall. Our hope is that, through this initiative, we can increase people's knowledge of how to use the health care system when they need care, and what they can do to help themselves stay healthy.

We are in this together, and that is the principle that should guide us — as a community, a state and a nation — in our efforts to improve our health care system. We want to make it work for everybody.

Broad solutions sought

With this goal in mind, the Mississippi NAACP is part of an effort to bring together a broad spectrum of health care and community leaders in Mississippi to talk about common-ground solutions to our health care problems. We discovered we still need to do a lot of work to develop consensus on basic issues such as whether all Americans should have a right to health care.

We need to start talking about these fundamental questions. And we can't just leave it to the health care "experts" and our political leaders to figure it out for us. All of us who depend on the health care system – – and we all will at some point in our lives – have an interest in moving our society toward a better health care system.

Our most recent discussion, held two months ago in Jackson, was encouraging. But we need more people to get involved.

Similar discussions are taking place in other communities around the country. This larger effort, which includes a total of 10 communities, is called "Communities Shaping a Vision for America's 21st Century Health and Healthcare." It is a unique attempt to understand how members of the public and health care stakeholders view the values and principles underlying our health care system.

Wye River Group on Healthcare, a national non-profit health care organization, pioneered this approach with the support of more than 300 community and health care leaders in 10 communities, including Mississippi. The goal is to start conversations at the community level that could lead to a

long-overdue national dialogue on what Americans want from their health care system and what they are willing to support.
Isn't it time we start talking?

Ollye B. Shirley, PhD, chairs the Mississippi NAACP's Education Committee.

"First steps toward improving health care"

Op-ed by Robert Jackson, EdD

Raleigh News & Observer

January 27, 2004

Heading into the 2004 president election, voters face an array of pressing domestic and foreign policy issues to consider in their choice of candidate, from the economy and employment to the ongoing war against terrorism. But certainly, the continuing healthcare problems in our community, our state and our nation must be among voters' top considerations.

The U.S. Census Bureau recently reported that the number of uninsured Americans climbed to nearly 44 million people last year, an increase of 2.4 million more than the year before. Our state had among the highest growth in uninsured. The percentage of North Carolinians who lack health insurance grew by 1.6 percentage points, to 15.6 percent.

In a state rich in top-quality medical schools and other health resources, access to healthcare remains a challenge for many. Across the country, middle-class families and their employers are feeling the strain of health insurance costs, which jumped an average of nearly 14 percent between 2002 and 2003.

Healthcare leaders in North Carolina and other communities recognize there is an urgent need to address our nation's healthcare challenges. For that reason, a broad spectrum of physicians, hospital and health insurance executives, consumer advocates, public health officials and others have joined together in an initiative designed to generate solutions to some of these problems at both the community and national levels.

This project, called "**Communities Shaping a Vision for America's 21st Century Health and Healthcare,**" is an unprecedented effort to understand how healthcare stakeholders and consumers view the values and principles underlying our healthcare system – and what they think those values and principles should be. Community-based discussions were held in Raleigh/Durham and nine other communities across the *country over the last year to explore these issues, while setting aside the politics and sector competition that have shaped so much of our healthcare policy in this country.*

The aim of the project was to start conversations in various communities that could lead to a long-overdue national dialogue about the fundamental values and principles that Americans want to guide United States healthcare policy into the future. Wye River Group on Healthcare, comprised of bi-partisan, public and private healthcare stakeholders, pioneered this broad-based effort with the active participation and support of more than 300 healthcare leaders in the ten communities.

Among their findings is that many Americans do not know what they can and should expect from their healthcare system. Nor do they understand their responsibility to contribute to the healthcare system. Over the years, our country has developed an effective social contract in other areas of public policy, such as education. But most community healthcare leaders agree that our country has not developed a social contract for healthcare that is well-articulated and broadly understood.

We know that Washington, D.C., is in chronic gridlock over the direction of healthcare policy. But in our own North Carolina communities, where the care is actually delivered, important progress is being made. For example, in Bladen County, a homegrown healthcare outreach and education organization has had a major impact on the health of county residents, particularly in the areas of diabetes and obesity. Called "Bladen Healthwatch," the organization has created a number of initiatives, including the "Healthwatchers at School" program that started walking campaigns to encourage students to walk during the day near their home, school or church. Schools set up designated walking trails and gave incentives to both teachers and students to participate.

But major changes in healthcare will require substantial public input and engagement. We hope that the people of North Carolina and our elected officials will join us in a dialogue about where we as a community, a state and a nation want to go with the healthcare system on which we all depend. We recognize that this type of effort is an enormous undertaking, but we think the effort must be made. Our current circumstances require it and Americans deserve the best healthcare system we can design.

For action to be possible, the conversation must move beyond the battleground of special interests that have so often stood in the way of change. There will have to be articulate leadership that generates respect for the process and encourages stakeholders to put aside self-interested agendas that stand as obstacles of constructive change. There will also have to be broad-based support from the public. Healthcare is for the people and should be by the people. It is truly the American way.

Robert Jackson is state director of AARP North Carolina.

"Rebuilding healthcare from the ground up"

Op-ed by John H. Warner, Jr.
The San Diego Union-Tribune
January 29, 2004

Californians decisively recalled the election of one governor and voted in a new one, as the nation's attention remained riveted, yet again, on the volatile and colorful politics of our great state. Fixing a crippled economy was the focus of most of the political debate between the candidates and 83 percent of the voters agreed, citing the state's multi-billion dollar deficit as the critical issue in this election.

The budget and associated ballot initiatives continue to occupy the news. With all the emphasis on the deficit and reducing the state budget, one would think the budget-busting item of healthcare and the state of quality and access in California might have surfaced more loudly during and after this campaign. Healthcare has been front-page news because the escalating cost of employer health care benefits and the degree of cost shifting to employees is a major issue in the ongoing strike at many of our grocery stores over the past months.

Though it was missing from the recent political debate, California health care leaders out in the communities are keeping discussions of the most difficult and complicated health care issues alive as part of a national dialogue percolating across the United States. It is clear that many of our elected officials need to gain a better grasp of the magnitude of these challenges and the urgent need to address them.

We cannot fix California's economy without drastically restructuring our health care system. Therefore, there has to be increasing efforts to educate and engage citizens and policy-makers on healthcare issues. Progress can be made only with political leadership and strong public interest and pressure.

The Wye River Group on Healthcare, a forum for collaboration and open exchange with broad participation and sponsorship from many individuals and organizations, initiated a project in July 2002 that included holding a series of Health Care Leadership Roundtables, or "listening sessions," in 10 diverse communities around the country, including San Diego. The aim of the project was to start conversations in various communities that could jump-start a national dialogue about the fundamental values and principles that Americans want to guide U.S. healthcare policy into the future.

Asked to participate in these discussions was a diverse cross-section of public and private stakeholders with detailed knowledge of health and healthcare. They included physician leaders, hospital and health system executives, community and public health officials, pharmaceutical and pharmacy representatives, business executives, consumer representatives, and government officials. This type of broad representation was evident in the San Diego session.

One of the many important developments to emerge from this initial effort was a compilation of 40 case studies showcasing community-based partnerships and innovations to address key healthcare challenges at the local level.

One of the case studies highlighted was San Diego's effort to form groundbreaking collaboration that assesses local health needs and supports community efforts to expand access to medically underserved populations.

In response to a 1994 law mandating that hospitals prepare a community health needs assessment every three years, representatives from 25 health-related organizations came together to collaborate on completing the new and arduous requirement. Nine years later, the new coalition, named Community Health Improvement Partners, or CHIP, has expanded its priorities to improving access by removing barriers to the largely Latino population, which is disproportionately uninsured and medically underserved. The collaborative effort has become a model of what public-private cooperation can achieve, even in a highly competitive healthcare environment such as our county.

However, much more needs to be done. The first step we need to take, as a nation, state or county is to recognize that our health care system is facing enormous challenges that we need to address. In many areas of the country, healthcare – especially the safety net – is crumbling; employers and consumers are facing skyrocketing healthcare costs; many patients are not getting the quality health care services they need; and health care organizations are facing serious financial problems while physicians and other health care professionals face these as well as morale problems.

Throughout 2004, WRGH will continue to work with the local health care leaders in the pilot communities, including San Diego, to identify potential demonstration projects that may build upon an existing community success or tackle a still unaddressed or growing problem.

Further, the local business community also is actively involved in promoting discussions on this important topic. The San Diego Regional Chamber of Commerce, representing many small and large businesses, has completed a comprehensive briefing, available to community organizations, that describes the healthcare environment we face and presents recommended actions for federal, state and local government, for employers, large and small, and for the public.

John H. Warner, Jr., is corporate executive vice president and director of SAIC, San Diego.

"KidCare debate shows need for dialogue on commitment"

Op-ed by Ron Levant, EdD
Ft. Lauderdale Sun-Sentinel
March 22, 2004

Do we mean it when we say that children are our future? If so, we need to ask ourselves what kind of future we are creating by denying poor children access to a doctor when they need one. Florida's current approach — expanding eligibility for KidCare one year and restricting it the next; making children wait for coverage they are qualified to receive — does not indicate a strong commitment to children's health.

Our country has not yet developed a social contract for health care as we have for education. Americans understand that it is in everyone's interest to fund public education. We want to raise intelligent citizens and workers. But don't we also want to raise healthy ones?

A national conversation on this issue is long past due. It is time for Americans to talk about a national vision for health care that includes guaranteed health care for children.

A lot of health care providers and community leaders in South Florida believe there is an urgent need to address our nation's mounting health care problems, including the 44 million Americans — adults and children — who are uninsured. The first step is to start talking about them in a way that is grounded in our values and principles as a community and as a nation.

For that reason, a broad group of psychologists, physicians, hospital and health insurance executives, consumer advocates, public health officials and others in the Fort Lauderdale area have joined a national initiative designed to generate solutions to some of these problems at both the community and national levels.

This project, sponsored by the Wye River Group on Health Care, is a unique effort to understand how health care stakeholders and consumers view the values and principles underlying our health care system. The goal is to start conversations in various communities that could lead to an overdue national dialogue about health care policy.

To move the conversation forward, we have developed a list of 10 questions on health care that we are asking political candidates to answer. The first question asks candidates how they would go about developing a shared vision for health care. The second asks them if they think health care is a right that should be guaranteed for all, or a privilege.

We, as citizens, need to start asking these questions of our elected officials. And it's time that we get better answers.

Dr. Ron Levant of Fort Lauderdale is president-elect of the American Psychological Association.

Election Over, It's Time to Move Forward on Health Care

Op ed by Jon R. Comola and Marcia L. Comstock, MD MPH

Muncie Star Press

December 2004

With the 2004 presidential election behind us, it's clear that the nation is sharply divided over a number of important issues. But surely there are some problems that our elected officials can come together to solve during the next four years. As President Bush has said, "A new term is a new opportunity to reach out to the whole nation."

Health care is certainly one area where we could use more bipartisan cooperation. Our country faces a mounting health care crisis, and both Republicans and Democrats know it. Seventy percent of voters who were polled on Election Day said they were "very concerned" about the cost and availability of health care.

Americans have good reason to be worried. Annual double-digit increases in the cost of health insurance are pricing many people out of the market. Here in Delaware County, nearly one in five people is now without health insurance. Nationally, the number of uninsured has risen to 45 million.

The problems are clear; the question is what to do about them. Wye River Group on Healthcare has been working with communities for more than 2 years to advance practical solutions to health care challenges. A not-for-profit, non-partisan organization, we've traveled to communities throughout the country, including Muncie, to talk with local leaders about the problems in health care and to listen to their perspectives.

We think communities are an appropriate place to seek workable ideas that can be brought to Washington. After all, communities are where health care is delivered – not on Capitol Hill. And it is community leaders who see and understand how policy decisions made in Washington actually affect their friends and neighbors.

That was certainly clear in Muncie, where we held a roundtable discussion in late September that involved about 30 local leaders representing health care, government, non-profit organizations, philanthropies and businesses, as well as the pastor of a local congregation.

We learned a lot from them about health care in Delaware County – both the challenges and the opportunities. For a community its size, Muncie clearly has tremendous assets in health care in addition to its academic resources and strong tradition of philanthropy. However, we heard that these assets could be better utilized if they were more coordinated and more directly connected to people in the communities they serve.

Local leaders seem well aware of the deficiencies that need to be addressed. We detected a strong commitment on their part to work with each other on finding solutions to specific health care issues, such as improving patients' access to health care resources and eliminating disparities based on race, gender and age.

Significant efforts are already underway. Among the most notable are Cardinal Access, a ground-breaking collaboration led by the BMF Foundation to provide discounted health care services to low-income, uninsured residents, as well as an initiative by Partners for Community Impact to identify gaps in county health and human services. TEAMwork for Quality Living continues to do impressive work, especially in its efforts to improve county residents' heart health.

These are excellent examples of how the unique assets of a community can be used to address the specific challenges facing that community. But Muncie leaders said they're not satisfied with what they've achieved so far; they want to go further. As a result of Wye River Group's encouragement of increased collaboration, they have committed to creating a Community Health Council. Convened by the BMH Foundation, the Council's mission is to improve collaboration among health care providers, service agencies, non-profits and other organizations. We applaud this decision.

Now the aim of our organization is to create momentum in Washington for health care reform. As part of that effort, we are working to create a "blueprint" for improving health care that will be presented to the Bush administration within the next two months.

The blueprint is based on work with dozens of community and health care leaders around the country, including several in Muncie. We were fortunate to receive input from Deputy Mayor Phyllis Amburn, BMH Foundation President Kelly Stanley, Partners for Community Impact's managing director, Allison Bell Imel, and its chairman, Mike Ellis.

We find it encouraging that so many leaders in Delaware County recognize the importance of moving forward on local health care improvements as well as on national health care reform. We are committed *to sharing the blueprint with your community, once it is complete, and continuing our work with you to make this a healthier nation. Together, let's move forward.*

Jon R. Comola and Dr. Marcia L. Comstock are CEO and COO, respectively, of the Wye River Group on Healthcare.

APPENDIX B: SUPPORTERS OF WRGH/FAHCL INITIATIVES

ENDORSERS OF THE 10 QUESTIONS FOR POLITICAL CANDIDATES

CALIFORNIA

Healthcare Association of San Diego and Imperial Counties – Steve Escoboza, President & CEO

Sharp Hospital – Dan Gross, CEO

Sharp Community Medical Group – John E. Jenrette, MD, Chief Medical Officer

San Ysidro Health Center – Ed Martinez, CEO

Murray N. Ross, PhD

California Health Decisions – Ellen B. Severoni, President

Scripps Health – Chris Van Gorder, President and CEO

FLORIDA

Broward County Medical Association – Linda Cox, MD, President

AvMed Health Plans – Douglas G. Cueny, Executive Vice President

Nova Southeastern University Department of Rural Medicine – James Howell, MD, Chair

Nova Southeastern University Center for Psychological Studies – Ron Levant, EdD, Professor and Dean; President, American Psychological Association

Florida International University Center on Aging – Max B. Rothman, Executive Director

Broward County Medical Association – Alan S. Routman, MD, Immediate Past President

South Florida Hospital & Healthcare Association, Inc. – Linda S. Quick, President

ILLINOIS

American Cancer Society Illinois Division – Ermilo Barrera, Jr., MD, Vice President; Chief of Surgery, Glenbrook Hospital

Illinois Psychological Association – Terrence Koller, PhD, Executive Director

Rush University Medical Center and Associates in Cardiology, Ltd. – Joseph V. Messer, MD

Northwestern University Institute for Health Services Research and Policy Studies – Michael L. Millenson, Visiting Scholar

Mt. Sinai Community Foundation – Robert Parker, MD, CEO

Finch University Board of Trustees – Herb Sohn, MD, Vice Chair; Strauss Surgical Group

MISSISSIPPI

Mississippi Health Services Coalition – Rims & Judy Barber

Mississippi Hospital Association – Sam W.Cameron, President & CEO
Tutwiler Clinic, Inc. – Sister Anne Brooks, DO
University of Southern Mississippi College of Health – Joan Exline, PhD, Dean
St. Dominic Counseling Center – W. Criss Lott, PhD, Clinical Director
North Central Mississippi Council on Aging – Alfio Rausa, MD, President
United Healthcare – Jack Wickens, Regional President

NEW HAMPSHIRE & VERMONT

Maxine N. Brandenburg & Richard G. Brandenburg, Burlington, VT
Vermont Medical Society – Paul Harrington, Executive Vice President
Littleton Model Community Project – Nicole LaPointe, Director
Anthem Blue Cross Blue Shield of New Hampshire – John H. Robinson, MD, Medical Director
The Center for Evaluative Clinical Services, Dartmouth Medical School – John E. Wennberg, MD, Director

NEW MEXICO

Children's Hospital of New Mexico – Javier Aceves, MD, Medical Director
Sandoval County Health Alliance – Nicola Baptiste, Administrator
Delta Dental Plan of New Mexico, Inc. – Walter S. Bolic, President & CEO
New Mexico Hospital & Health Systems Association – Maureen Boshier, President & CEO
New Mexico AARP – Mike Donnelly, Assistant Director for Advocacy
El Pueblo Health Services – Alan Firestone, MD
New Mexico Department of Economic Development – William E. Garcia, Former Cabinet Secretary; Private Investor; Retired – Intel, US West
Lovelace Clinic Foundation – Maggie J. Gunter, PhD, President and Executive Director
Lovelace Clinic Foundation – Martin Hickey, MD; former CEO, Lovelace Health Systems
New Mexico AARP – Ophelia Rinaldi, Representative
UNM School of Medicine – David Sklar, MD, Senior Associate Dean for Clinical Affairs
Paul Sowards

NORTH CAROLINA

North Carolina Area Health Education Centers Program – Thomas J. Bacon, DrPH, Director
Duke University Department of Family and Community Medicine – E. Harvey Estes, Jr., MD, Professor Emeritus

Blue Cross Blue Shield of North Carolina – Robert J. Greczyn, Jr., President
Robert Hartley, MD
Robeson Health Care Corporation – Jinnie Lowery, President and CEO
York Properties – Smedes York, President

OREGON

Oregon Health Care Quality Corporation – Vickie Gates, Executive Director
Oregon Coalition of Health Care Purchasers – D'Anne Turner Gilmore, Executive Director
Oregon State Pharmacy Association – Tom Holt, Executive Director
GreenField Health – Charles M. Kilo, MD MPH, CEO; Fellow, Institute for Healthcare Improvement
Foundation for Accountability – David Lansky, PhD, President
Oregon Health and Science University Center for Research on Occupational and Environmental Toxicology – Gary Rischitelli, MD, Assistant Scientist

TEXAS

Kelsey-Seybold Clinic – Valerie Bergeron, CEO
Scott and White Health Plan – Allan Einboden, Director of Administrative Operations
Center for Health Care Services – Leon Evans, Executive Director
Don Gilbert, Former Texas HHS Commissioner
Community First Health Plans – Charles Kight, President and CEO
Texas Healthcare & Bioscience Institute – Tom Kowalski, President
Center for Health Care Services – Ron Lewis, Director, MR Essential Services
Greater San Antonio Hospital Council – Bill Rasco, President and CEO
Health Care Summit Commission – Bill Thornton, DDS, Chair
University of Texas Health Sciences Center – Harold Timboe, MD MPH, Associate VP for Administration

UTAH

University of Utah Family & Preventive Medicine – Marc Babitz, MD, Associate Professor
University of Utah College of Nursing – Penny Brooke, Professor and Director of Outreach
Valley Mental Health – David Dangerfield, CEO
Scott Leckman, MD
American Medical Association – John Nelson, MD, President-elect and Board of Trustees Member; LDS Hospital

MountainStar Healthcare Network – Deb Reiner, Community Relations Director

Katherine Sheehan

University of Utah – Richard Sperry, MD PhD, Associate Vice President for Health Sciences

Deseret Mutual Benefit Administrators – Michael Stapley, CEO

Central Valley Medical Center – Mark R. Stoddard, CEO

WASHINGTON

Providence Healthcare – Ryland "Skip" Davis, President and CEO

Inland Northwest Health Services – Tom Fritz, CEO

Spokane Regional Chamber of Commerce – Rich Hadley, President and CEO

Premera Blue Cross – Gail Keeling, Vice President & General Manager Eastern Washington

Empire Health Services – Garman Lutz, President and CEO

MARSH – Curtis Taylor, Managing Director

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Tufts University School of Medicine – Harris A. Berman, MD, Professor and Chair, Dept. of Family Medicine and Community Health

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Massachusetts Medical Society – Jack T. Evjy, MD, Past President; Past Member, Board of Directors, American Cancer Society New England Division

Last Acts Partnership – Dr. Karen O. Kaplan, President & CEO

American Medical Group Association – Sanford Kurtz, MD, Chair; Chief Operating Officer, Lahey Clinic

American Medical Group Association – Samuel Lin, MD PhD, Consultant for Medical Affairs

Wyeth Pharmaceuticals – Lucinda Long, Vice President for Global Public Policy/Global Public Affairs

American Psychological Association – Russ Newman, PhD, Executive Director for Professional Practice

U.S. Chamber of Commerce – Kate Sullivan, Health Care Policy Director

Ochsner Clinic Foundation – Warner Thomas, Chief Administrative Officer & Chief Operating Officer

National Association of Manufacturers – Neil Trautwein, Director of Employment Policy

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Don Balfour, MD	San Diego, CA
Ross Becker	(Retired) Director, Long-Term Care Division, Aging and Long-Term Care Department, State of New Mexico, Santa Fe, NM
Harris Berman, MD	Professor and Chair, Department of Family Medicine and Community Health, Tufts University School of Medicine, Boston, MA
Walt Bolic	President and CEO, Delta Dental Plan of New Mexico, Albuquerque, NM
Maureen Boshier	President and CEO, New Mexico Hospital & Health Systems Association, Albuquerque, NM
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Maxine Brandenburg	(Retired) President & CEO, Vermont Business Roundtable, Burlington, VT
Sally Cameron	Executive Director, North Carolina Psychological Association, Raleigh, NC
Sam W. Cameron	President and CEO, Mississippi Hospital Association, Jackson, MS
A**nn Carson, PhD**	Psychologist, San Diego, CA
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Robert Hartley, MD	Rocky Mount, NC
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