RAINIER INSTITUTE

## Community and Public Health

**Proposal**

This proposal calls for strengthening the partnership between the community and public health to improve the health of citizens of Washington State - a partnership that recognizes and values the roles and responsibilities that each partner brings.

The commitment to public health is a commitment to the concept of a healthy community. Outside of reducing poverty, nothing else a community does affects the health of its people more than assuring that contagious diseases, environmental conditions, child health and behavioral risk factors are controlled. These interventions were developed by studying patterns of illness and death, assessing a variety of strategies to interrupt and prevent disease processes, and then applying these interventions broadly to the entire population.

The remarkable advancements in personal medical care in the past half-century have been distributed so far largely as commodities, as compensation for work or through public and private charity programs, like Shriners Hospitals and Medicaid. The time has come to apply a population based, public health logic to determining priorities for broad access to the full array of medical services. This will involve community dialogue to a) clarify community social values; b) determine community perceptions of health risks; c) review available information on patterns of illness and death and evidence on effective interventions to prevent and treat these risks and illnesses; and d) ultimately to develop a community definition of critical health services that will enjoy financial support for universal access.

To affect the connection between the community, public health, personal health, and local support for services appropriate for the community, we propose the creation and expansion of local entities to offer opportunities for local forums, support the assessment of needs, and work to ensure needed services are provided. There are a number of options available, but most communities need the following qualities:

1. An existing entity such as a hospital district or community health district that serves as the central organizing, sponsoring and controlling entity for a community. This entity could integrate and link payers, local citizens, local public health, and local health care services.

2. The ability to capture community assets already in the system and place control in the hands of the community.
    a. An opportunity for the community to be in charge of the governance of their system and make decisions about services to be available, benefit structure, funding mechanisms and allocation of resources.
    b. A way to subsidize care and services for uninsured people. This subsidy could be generated by a variety of sources including voluntary contributions from employers and individuals, organized donations of services and funds, and/or local taxes.
3. A partnership between the local public health jurisdiction and the community to ensure integration of services and priorities, as well as progress toward local population health improvements.
4. The ability for the local community entity to function similar to a local insurer or an "ensurer" of limited services already directly available in the community. Risk could be addressed based on scope of "benefits" and funding.
5. State-based public payers (HCA, DSHS, and DOH) to direct funding for local benefits into the community thus simplifying administration and facilitating coordination of services.
6. Quality improvement, chronic disease management, and community health interventions could be organized and prioritized by the local community entity – possibly using state and national standards and proven processes as needed. These interventions are already in place in many districts.
7. External support for a variety of functions like marketing, claims processing, utilization management, and development of effective and efficient administrative services - services that may not be available in the community.
8. Strong community leadership willing to spearhead and direct this effort.
9. Strong state leadership and true state partnerships that remove barriers and work with local initiatives.

## Background

People's health suffers when they do not have access to the individual health services they need. Communities suffer when these services are not available to significant numbers of their residents. The Washington State Board of Health (the Board) has a long-term interest in promoting access to health care for the residents of Washington State. Beginning in 1995 the Board began collaborating with the Public Health Improvement Partnership (PHIP) to improve access on the state and local level. By 2001, the Board and the PHIP adopted community-level standards for access to health care and began promoting a Menu of Recommended Critical Health Services for Washington State Residents (the Menu). The Menu is offered as a list of health services with proven benefit from which a community, through broad based dialogue, can select a core set of health services it believes are most critical to protect the public health within the context of their community's unique health risks, health assets, shared social values and available financial resources.

It is one thing for a community to identify a set of standards and a menu of critical health care services, but it is a much larger project to assure access to these critical health services in each community. Public health alone cannot accomplish this. Community organizing and involvement should be considered an integral part of any planning and development process. As much time needs to be put into mobilizing, educating and involving the community as goes into researching and identifying needs and gaps. The public health system can provide the leadership and the ideas, but the community is the key to making meaningful change happen. Communities, when trusted and empowered, can identify and embrace their own community health priority issues and bring about change. We need to be free enough in our thinking to let the community do its work. And we need to respect that community processes, which like law making, are a bit like making sausage. Community members are very capable of solving local problems if supported, with data and knowledge of local resources.

**Goal of the Partnership**

We want to support and promote the development of community environments and social support systems that enhance the quality of life and individual health of citizens.

We want to build a system of community behaviors and services that:

1. Promote healthy individual behaviors;
2. Prevent disease;
3. Treat illnesses effectively and in a timely manner;
4. Offer more social integrated options for end of life care;
5. Provide the most cost-effective mix of community environments, health information, health promoting resources and medical services for the funds available to each community.

Public Health brings to the partnership:

- Data to assess and monitor a community's health status;
- Leadership in how to address major health problems;
- Education about what is healthy behavior – best practices models;
- Strategies for changing a community's physical and social environments in ways that promote, facilitate and reward healthy personal choices;
- Some access to state and federal funding; and
- A vision for health that includes environmental health, workplace health, reducing morbidity and mortality.

The Community's contributions include:

- Ability to raise awareness about health issues and problems including cost of care in the community;
- Ability to make health care a top local and state priority;
- An opportunity to test alternative financing methods;

- ♦ Support and assistance in implementing best practices designed to improve health status;
- ♦ Creativity for addressing and reaching hard to reach populations;
- ♦ Creativity in developing solutions to local health care problems; and
- ♦ Access to new and different resources.

**How can we do this?**

The Public Health Improvement Partnership has developed standards for the operation of state and local public health agencies in our state to advance the commonality of community and public health working in tandem to improve community health in this way. Specifically, the following recommendations advance this policy approach:

The standards call for local public health agencies to

- convene community forums to familiarize community members with their patterns of health risk, morbidity and mortality;
- complete and share inventories of available services to address these risks
- act as an information and referral source for access to available services, and
- Convene interested communities groups so that those groups might develop programs and other strategies to fill gaps in critical health services.

To help advance a statewide dialogue in support of this approach, the state Board of Health has recommended that the PHIP create a new statewide Committee on Access to Critical Health Service, and involve new partners such as health foundations and professional associations in the committee's work.

Passing along the work of public health into the community may involve:

- ♦ The identification and leadership of a widely trusted and well-informed community leader.
- ♦ Local health jurisdictions improving their connections with their communities and improving their understandings of the power of the community.
- ♦ Working with public purchasers to educate them about the importance of expanding their use of the Board's menu and other evidence-based approaches to guide "value-based" purchasing.
- ♦ Collaborating with public and private community entities to develop a network under which each entity takes specific responsibility for some aspect of planning, organizing, directing, financing or delivering critical health services. (Entities may include: public hospital districts, private health care service providers, business, United Way and other charities, churches, service organizations and others.)

- Allowing public dollars from DSHS and DOH funding streams to flow directly to the communities to produce measurable improvement in population wide health status or public health protection.
- Seeking new state and federal dollars and support to directly support community systems and the health of local residents. (E.g. Special designation such as critical access hospital.)
- Working with designers of benefit packages so that equal weight is given to evidence about the efficacy and public health value of mental health, addiction treatment, and dental health services.
- Exploring the creation of a community organizing, sponsoring and controlling entity like a community health district or building on the public hospital district for a community. An advantage of using a hospital district is that the district already has an infrastructure, enabling legislation, public accountability, specific geographic definition and population served/taxed, and is often the central focus of health care services in rural communities.
    A. If necessary, the public hospital district laws would be amended so that this local governmental entity could expand its role to serve as the organizing focus for the health care system.
    B. The governance of the system could be controlled by the local community through the hospital districts and their publicly elected officials. As elected officials, hospital district boards have clearly defined public accountability.
    C. Broad business, citizen and provider participation could be fostered through the creation of an advisory group that would assist elected hospital district officials in making decisions on services to be available, benefit structure, funding mechanisms and allocation of resources.
    D. A consideration for generating a subsidy for care and services for uninsured people might be to augment the local taxing authority of the hospital district.
    E. One option for bringing the local public health jurisdiction into partnership with the local hospital district might be to include amending laws to require an elected member of the local Board of Health be added as public hospital district commissioner.

**Barriers that need to be overcome:**

- A statewide insurance support arrangement to provide catastrophic coverage or to assume the significant risk that could arise from adverse selection and costly community care if communities.
- Legal, regulatory and technological changes to allow public medical care purchasing agencies such as HCA, DSHS and DOH to pass dollars directly to communities so long as certain population wide health status improvement or public health protection objectives were met.
- Technical and legal support in developing new community models of service delivery.

- Access for local communities to shared purchasing arrangements for purposes of securing bulk pricing. I.e. pharmaceuticals, durable medical goods.
- The ability to pool public and private dollars to create accountable transparent methods to expand health care coverage.
- Resolve malpractice coverage issues for local providers – i.e. Physicians, clinics, hospitals, family planning agencies.
- Provide stable and secure government financing and clear legal direction needed for the key elements of the public health system to assure that it will perform its roles in promoting access to critical health services.

**Examples of Current Washington Efforts**

Given the current health care environment, communities, local public health jurisdictions and local philanthropists have stepped to the table to begin the process of implementing this approach. These current efforts can serve as models and testing sites for future partnerships.

A. Local health jurisdictions around the state have partnered with the Humanlinks Foundation and the Washington Health Foundation to host community forums and citizen meetings to discuss access issues in their community. These meetings have engaged local community leaders and citizens in dialogue to identify problems and solutions for our current health care system.

B. Local health jurisdictions have built local coalitions around access issues with local health providers and area businesses in a number of counties. (See examples below: Jefferson access project, Health Improvement Partnership and Choice.)

**Local efforts to address access**

**Health Improvement Partnership (HIP)**

Faced with rising health care costs in the early 1990s, Spokane County's four major hospitals worked with the Spokane Regional Health District to begin an initiative to improve overall community health and well being, not only in prevention and treatment of illness, but in areas they saw as interrelated and crucial to the community's wellness, such as education, childcare, economic development, and safety. Recognizing that they could not invest this broadly in community development without the partnership of the community itself, they convened a yearlong planning process that involved the leaders of more than seventy organizations from all sectors of community life. From this year of planning in 1995, the Health Improvement Partnership was born.

**Healthcare Access Initiative**

For five years, an Eastern Washington coalition organized by the Spokane, Washington-based Health Improvement Partnership (HIP) has been organizing an improved regional healthcare access system. Finding the existing system full of gaps and instabilities that leave many people without access to timely, affordable healthcare, HIP has partnered with over 200 regional healthcare organizations. HIP's goal, which echoes its organizational value statements, has been to act as a *neutral convener*, a *catalyst,* and to *strengthen others' capacity to do their work.* In other words, HIP has been fostering the efficiency and coordination—and, in some arenas, the *development*—of a regional healthcare delivery system that reaches toward 100% access / zero disparities.

The results so far include more than 31,000 individual contacts with uninsured/underserved citizens across an eleven-county Eastern Washington region—via HIP's new Health for All (HFA) information, referral, and enrollment service. More than 17,000 previously uninsured people have been enrolled on affordable, sustainable health care coverage through these efforts.

*Key Elements of the Healthcare Access Initiative:*

- *Health for All*: This program has three key components. It enrolls uninsured and underinsured into available health care options (state insurance programs such as Medicaid and Basic Health, other insurance options; affordable primary, preventive and specialty care; resource and referral information); provides targeted outreach for underrepresented populations via Multi-Cultural Outreach Workers; and through its *Advocate,* also provides care coordination services for individuals with chronic disease or multiple access barriers.

- *Strategies for the Employed Uninsured*: Solutions to increase access for the working uninsured (75% of Spokane's uninsured are employed) include: A public/private campaign at the state level to allow the blending of private dollars from small employers with public dollars from the Washington State Basic Health Plan (BH) for the development of an affordable new "Expanded Choice" coverage; and a partnership with the Spokane Regional Child Care Initiative to offer new health care access options to child care industry employers, employees and the families they serve.

- *Coordination and Integration of the Existing Community Health System Providers and Services*: This component involves development of new referral protocols between hospital emergency departments and community health centers for high-risk uninsured seeking primary care in the hospital emergency departments without a regular doctor. It includes system infrastructure development to increase the capacity of Community Health Centers and other safety net providers to provide quality healthcare to the

uninsured and implementation of a project to co-locate primary care and behavioral health at Spokane Falls Family Clinic.

**Healthcare Access Initiative Community Involvement**

Through funding from a Robert Wood Johnson Foundation Communities in Charge grant, HIP convened individuals representing over 200 organizations in various coalitions, committees and focus groups in 2000 to design a community-driven, coordinated system of care for Eastern Washington's uninsured that would begin implementation in 2001. Representatives from all sectors of the health care system (safety net providers, hospitals, other providers, health plans, public health and local and state health care policy makers) came together in the design and implementation processes. HIP also sought input and participation from non-traditional health care access stakeholders such as employers, social services, advocates, insurance brokers, state policy makers, and other community groups. HIP also partnered with other communities across Washington State also working toward 100% Access/Zero Disparities on policy strategies that would empower local solutions to improved access.

Today the Healthcare Access Initiative continues to be driven by collaboration. This involves ongoing input and guidance from an Advisory Committee for the overall project, and targeted advisory bodies for specific project elements such as Expanded Choice. It also involves ongoing needs assessment and input from uninsured and underinsured consumers via HIP's Health for All program which communicates daily with individuals seeking access in urban and rural regions of Eastern Washington.

**CHOICE Regional Health Network**

CHOICE Regional Health Network is a nonprofit consortium of rural and urban providers and other partners dedicated to improving the health of their region**.** They achieve their purpose by collaborating to:

- Improve **access to services,** particularly for the low-income;
- Improve **quality and value of care** provided;
- Give people the information and **tools** to improve their health; and
- **Plan** among separately owned organizations **for a better future.**

CHOICE was created in January1996, and serves the five county region including Grays Harbor, Lewis, Mason, Pacific, and Thurston through a network of providers as indicated in the chart below.

Number of Provider FTEs

| **County** | **Primary Care** | **Specialist** | **Population per PCP** |
|---|---|---|---|
| Grays Harbor | 44.6 | 21.7 | 1570 |
| Lewis | 43.2 | 19.3 | 1597 |
| Mason | 22.4 | 8.6 | 2232 |
| Pacific | 7.1 | .5 | 1831 |

| | | | |
|---|---|---|---|
| Thurston | 118.3 | 116.4 | 1758 |

The original nucleus of support for this effort came from both the public and not – for-profit hospitals in the service area. As CHOICE evolved, it added public health departments and area practitioners to the network and most recently has begun a multifaceted strategy for involving community-at-large in their work. Today public health representatives serve on the Sustainable Health Care Access Council and in some counties, serve as the "geographic team" lead for the project's work. CHOICE also embraces ongoing and active participation each day by low income consumers in their service area who utilize the CHOICE Regional Access Program, and by involving consumers in volunteer service on community advisory councils staffed by CHOICE. In addition, the project conducts ongoing citizen/consumer meetings, surveys and interviews.

This five-county collaboration faces a number of challenges in their efforts to better meet the needs of their constituents. These challenges include the reality that many residents are:

- Sicker and poorer than elsewhere in Washington State;
- Increasingly limited English Proficient (LEP) Spanish speakers;
- Employed in low wage jobs that don't offer insurance; and
- Proud, independent and innovative in the face of adversity.

Yet despite these hurdles, CHOICE has become an effective and essential health link for its service area. Each month CHOICE staff and volunteers successfully:

- Find 308 people a medical home and connect 231 working adults to needed services.

**Six Principles for Achieving 100% Access**

1. Stabilize the safety-net.
    - RHC and CHC expansion
    - Organize, acknowledge and enhance underpaid services
2. Get small employers participating.
3. Deliver evidence-based and patient-focused care through health teams.
    - IS development
    - Language access
    - Lay worker models
4. Enroll people with limited incomes in a medical home.
    - No one uninsured
    - Start with children
5. Reduce costs and redirect savings to cover more people.
6. Purchase services of greater value to the community.
    - Blend funds and programs
    - Community MSA for primary care and prevention
    - Linked to catastrophic coverage
    - New methods to finance what's in the "middle"
    - Public health accountabilities
    - Greater percent of expenditures for primary care and prevention over time

1. Guide resources to local activity.
2. Protect the vision.
3. Are in action campaign mode:
    - Create abundance through offers and requests;
    - Be clear about the what and let go of the how; and
    - Don't let criticism veto action.
4. Boost local champions.
5. Renew leadership.
6. Inspire other communities to join them in action.
7. Generate political will at the grass roots level.
8. Phase-in over 5-7 years

**Jefferson Access Project**

East Jefferson County, with a population of about 26,000 residents, is a rural area located in the northeast corner of the Olympic Peninsula. When the local board of health composition was expanded in 1997, new seats were created for a public hospital district commissioner, a Port Townsend City Councilperson and two consumers. Since that time, Jefferson General Hospital and Jefferson County Health and Human Services have engaged in a number of activities to improve access to health services. Much of this work has been conducted under the guidance of their "Joint Board" which meets together 2-4 times a year.

The fundamental problem confronting the Jefferson Access Project is "how can a rural community organize services and financing in a way that improves access, supports and stabilizes local health providers and at the same time actually improves the health of the community?" After a set of desired goals for the local health system were developed, initial efforts focused on researching and discussing options that might consolidate and coordinate health funding at the local level. Many community leaders who attended a daylong Summit in May of 2001 supported this idea. However, without strong partnership with and support from state health programs, the task was determined to be infeasible. Efforts focusing on smaller initiatives and more immediate issues have continued. Jefferson General Hospital was able to gain Critical Access Hospital designation, which alleviated some of the under-reimbursement issues for the hospital, and the primary care physicians they employ. As a result, both primary and hospital care is available to uninsured residents on a sliding fee scale. The Health Department engaged the community in a comprehensive effort to find out more about the health of residents through a Behavioral Risk Factor (BRFSS) survey. The hospital and health departments have also coordinated a variety of services including vaccinations, health education and support programs, maternity support services, and the Breast and Cervical Health Program. The most recent "Civic Engagement" project used the State Board of Health's Critical Health Services Menu to identify information available to measure gaps as well as amend the list and prioritize areas for focus in Jefferson County. The initial results of this project will be the focus of the next Joint Board meeting,

Community involvement has been described as “grass tips” rather than grassroots. Participation has included business, chamber of commerce, charitable organizations, ministerial associations and major community human services agencies. Because of the structure of the Joint Boards, local elected officials from the county, city and hospital district have formed the backbone of the effort. As in many rural areas, these community leaders are also involved in a wide range of community and statewide groups and represent a broad cross section of interests and views.

Public Health is involved as an equal partner in this work. With limited resources and complimentary organizational missions, the hospital and health departments have recognized the importance of each other’s role. Even in small communities, this partnership between public and personal health services requires a significant amount of work and time to build the necessary knowledge and trust. Because of this unique relationship in Jefferson County, there is a solid understanding of and commitment to including public health as an integral part of community health services.

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