Community-Created Health Care Solutions in Oregon

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Oregon Health Policy Commission

Community-Created Health Care Solutions in Oregon

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January 2006

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Background

The Oregon Health Policy Commission (OHPC) recognizes that there is no single viable model for ensuring access to needed health services in Oregon. Each community's optimal health care delivery system must be responsive to its unique environment, populations, and infrastructure. Consequently, the OHPC recruited a group of experts from throughout Oregon to investigate what can be done to support local or "community-created" solutions to improve access to health care within Oregon communities. This Local Delivery System Models Work Group aimed to:

- Identify viable community-created responses to ensuring access;
- Catalogue lessons learned and best practices;
- Disseminate findings to interested stakeholders.

Furthermore, the Work Group was convened to identify specific recommendations to the OHPC regarding:

- State policy changes that would create a more supportive environment for local health care solutions;
- Technical assistance needs of communities in the development of local health care solutions; and
- The type of assistance from state agencies that would be beneficial.

To begin to reach these objectives, the Local Delivery System Models Work Group conducted an initial survey of five Oregon communities currently developing local solutions to improve health care access for their residents. Local leaders of the identified community-created solutions were interviewed. These leaders were asked to (1) identify lessons learned from their collaborative efforts and (2) offer recommendations identifying ways the state can better support community health care access solutions. (See Appendix A for specific questions and summaries of replies.) The following is a summary of findings based on key informant interviews.

Overview

The difficulty in providing coverage and ensuring access to health services has reached critical proportions.

Each community's optimal health care delivery system must be responsive to its unique environment, populations, and infrastructure.

45.8 million people are without insurance in the United States. Nationally, between 2000 and 2004, the number of uninsured people in America increased by six million people.[1] Similarly, between the years of 2002 and 2004, the percentage of Oregonians lacking health insurance increased from 14% to 17%, with the number of uninsured in Oregon over 600,000.[2] This predicament is likely to grow, given the fiscal challenges of the state and the rising cost of health insurance for the government, private employers, and individuals. As a result of inadequate coverage and access to needed health services, many severe consequences can be identified, e.g., infection rates increase; people miss work and productivity declines, homelessness increases resulting in overburdened

[1] Cook, Alison. Holahan, John. Changes in Economic Conditions and Health Insurance Coverage 2000-2004. (2005) Market Watch, *Health Affairs.*

[2] Office for Oregon Health Policy and Research. *Rising Number of Uninsured in Oregon.* (2005).

social service agencies. In addition, as health insurance premiums soar, employers shift the cost of health insurance to their workers by reducing or dropping benefits altogether.[3] Yet, even as these and other challenges are being felt by more and more people, the demand for health services continues to increase.

Recognizing the lack of comprehensive policies at the state or federal level to ensure needed services, local leaders in Oregon are designing and implementing innovative ways to provide health services that will improve the health of their entire community. These community leaders are working with unlikely partners. They are doing business differently by reorganizing services at the local level. They are looking for savings within the current system by increasing communication and coordination. These local champions are exploring, designing, and implementing community-created solutions to the health care crisis.

Community-Created Solutions

The continued and growing challenges of providing health services have been identified by many as unsustainable. This crisis has motivated communities to seek different ways to operate and work with others. These community-created solutions feature broad efforts involving many stakeholders*, which coordinate resources, work, incentives and capacity. These solutions result in better access to health services for more people and often focus on prevention, primary care, and care management. These efforts tend to:

- Involve sharing the risks and rewards across stakeholders;
- Engage multiple, diverse public and private stakeholders;
- Need community leadership or "champions";
- Leverage financial commitments from stakeholders;
- Coordinate the process of delivering comprehensive health services;
- Offer significant stability to the local health care system; and
- Be politically challenging and time-consuming.

…local champions are exploring, designing, and implementing community-created solutions to the health care crisis.

It is worth noting what community-created solutions *are not*, for the purpose of this study. These local solutions are not designed and implemented by a lone organization. They are not targeted projects funded by a single source. Nor are they a specific service or program, unless it is the building block for a broader community-wide initiative to improve the delivery of health services.

Collaboration

Collaboration is the crux of building community-created solutions. Collaboration is a mutually beneficial and explicit relationship entered into by two or more organizations to achieve results they are more likely to achieve

[3] Castañares, Tina. Improving Health Care Access: Finding Solutions in a Time of Crisis. Collaborative Problem Solving for States and Communities. (2004). *National Policy Consensus Center.* 1-13, http://www.policyconsensus.org/publications/reports/docs/Healthcare.pdf.

* One who has a share or an interest, as in an enterprise, www.dictionary.reference.com

together rather than single-handedly.[4] Collaboration requires shared goals as well as values and vision, to which all stakeholders have a commitment. Collaboration embraces the tenets of shared decision making, ownership of outcomes, and risk to all participants.[5]

Collaboration, as a strategy for restructuring service delivery, is gaining momentum throughout the country. Several forces are propelling this development, among them:

- Emerging social policy issues for which there are no existing solutions;
- General agreement that fragmentation is unproductive and cooperation is a more efficient approach to service delivery;
- Shrinking of traditional funding sources, requiring organizations to address common issues jointly in order to conserve resources;
- Policies and programs which support the merging of existing and new resources to focus on commonly defined issues;
- Blurring of traditional boundaries between public and private roles; and
- Movement toward decentralization and an increasing shift of responsibility to the local level.[6]

Collaboration, while presently required by many funding agencies, is ultimately a commitment on the part of organizations and communities to invest in long-term and sustainable planning.

Survey Process

This report provides a survey of five of Oregon's community-created solutions to improve the delivery of needed health services. It documents the experiences of leaders involved in building and sustaining local collaborative efforts committed to increasing access to needed health services, reducing/controlling costs, and improving health care quality as well as the health outcomes of their entire communities. It shares lessons learned from local or regional health collaborations. It also identifies barriers and challenges to these and similar innovations. Furthermore, the report relays recommendations for policy makers and government officials on how best to support community innovation.

The community-created solutions survey process was conducted between the months of August and November, 2005. Five community initiatives were surveyed, comprising 34 key informants from fifteen Oregon counties. These communities were identified by the Local Delivery Systems Work Group as local public-private collaborative efforts at various stages of development. They also were selected due to their innovation, collaboration, and geographic diversity. Key informants included stakeholders actively involved in the community collaboration and representing multiple sectors, disciplines, and organizations. The five community-created solution initiatives were:

- 100% Access Coalition, comprising Lane county - Appendix B
- Central Oregon Health Care Collaborative, comprising Crook,

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[4] Winer, Michael. Ray, Karen. (2000). Collaboration Handbook: Creating, Sustaining and Enjoying the Journey, Wilder Publishing Center. http://www.wilder.org/pubs/pubcatlg.html#collabh

[5] Graham John R., Barter, Ken. (1999). Collaboration: A Social Work Practice Method. *Families in Society.* Vol. 80 (1) 6-13.

[6] Community Based Collaboration: Community Wellness Multiplied. Chandler Center for Community Leadership. http://crs.uvm.edu/nnco/collab/wellness.html

Deschutes, and Jefferson counties - Appendix C
- Northeast Oregon Network-NEON, comprising Baker, Union and Wallowa counties - Appendix D
- Samaritan Health Services, comprising Benton, Lincoln and Linn counties - Appendix E
- Tri-County Safety Net Enterprise, comprising Clackamas, Multnomah and Washington counties – Appendix F

Lessons Learned

Lesson 1
Community collaborative efforts require sharing risks and rewards

Collaboration, as noted above, requires each member to be actively engaged - both in terms of creative problem solving and in the sharing of financial risks and rewards. Several of those interviewed indicated that sharing risk is a barrier to further and more meaningful collaboration. They acknowledge the challenges of moving from competition to consensus building, from working alone to including others from diverse fields and sectors, from thinking mostly about activities and services to also thinking about larger results and strategies, and from focusing on short-term accomplishments to demanding long-term results.[7] Despite these challenges and changes, there is broad agreement that business must be conducted differently. Having identified that the health system is not as efficient and effective as it could be, those interviewed recognized these collaborative efforts as opportunities to utilize existing resources more efficiently. Furthermore, some communities have used their collaborative effort as a platform for bringing additional resources into their community.
Many discussed the potential of their collaboration to address the perceived inequities of care among the provider/practitioner communities. Others cited the possibility of being able to better influence policy makers and/or leverage new funding, by strengthening their voice and numbers.

Lesson 2
Successful collaborations require the participation of diverse stakeholders

In order for collaborative efforts to be effective, a widely diverse group of stakeholders need to be actively involved. Many of those interviewed agreed that local communities must embrace access to health care as a community-wide concern and not one limited to hospitals and practitioners. Many of those interviewed suggested the importance of going beyond “the usual suspects” when building collaborations. Hospitals, safety net clinics, and other private providers must be involved. However, insurers, local health departments, social service agencies, the business community, academic institutions, and labor and faith-based organizations are valuable and needed partners. Many of those interviewed expressed that the broader the representation within a collaborative effort, the deeper the resource pool in terms of skills, funding, and creative problem-solving capacity. Many have involved the broader community through

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These collaborative efforts are opportunities to utilize existing resources more efficiently.

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[7] Winer, Michael. Ray, Karen. (2000). Collaboration Handbook: Creating, Sustaining and Enjoying the Journey, Wilder Publishing Center. http://www.wilder.org/pubs/pubcatlg.html#collabh

pubic forums, kick-off events, interactive summits and conferences, key-informant interviews, and media/press releases. Galvanizing the entire community to "buy in" to the importance of healthy people and health care is seen as an important task of these collaborations.

Lesson 3
Community leadership or "champions" are fundamental

The need for community leadership was identified as a key component to achieving improved access and healthy communities. Leaders who are tenacious in their commitment to making positive change and who share a vision of what that change should look like are essential to successful collaboration.

Leadership and trust among leaders should not be underestimated when developing community-created solutions.

According to those interviewed, little to no positive outcomes can occur without on-going leadership dedicated to the collaboration. These leaders tend to include public health and health provider administrators, academics, researchers, practitioners, government officials, and representatives from faith-based, business and philanthropic organizations. These leaders possess many diverse traits, however an identified theme among them is their authority to make institutional changes and allocate resources to the collaborative effort. It is worth noting that no consumer or advocacy voices were identified as leaders or champions of these local efforts.

It also was noted that trust among leaders is necessary for a collaborative effort to be successful. Building this trust is often challenging due to a lack of prior experience with working together or to these leaders' historically competitive roles. Leadership and trust among leaders should not be underestimated when developing community-created solutions.

Lesson 4
Stakeholders must be willing to make financial commitments to the effort

Particularly as community-created solutions evolve, it is important that each stakeholder bring something tangible to the table in the way of resources. As stated above, collaborative efforts involve pooling resources to meet objectives that an individual organization could not reach as easily. The survey responses pertaining to financial commitments were most often framed in terms of the prospect for pooling resources and reducing inefficiencies, rather than implying a need for additional dollars. Seed money, donated staff time, facilities, and technical equipment were mentioned as concrete contributions to community collaborations. All of the communities surveyed see the need for skilled and extensive staffing in order to sustain their collaborative efforts. Although each community recognizes the importance of dedicated staff and infrastructure to support and sustain their community-created collaboration, those interviewed commented on the lack of on-going funding for such vital roles.

Lesson 5
Community-created solutions seek to provide coordinated, comprehensive health care services

Stakeholders in each community expressed that presently, the health care system – both the financing and delivery of services - is in a state of fragmentation. There is no comprehensive policy at the federal or state level ensuring that the basic health

needs of all people are met. As a result of this fragmentation, there are both unnecessary duplications of services as well as large gaps in service. Delivery of health services is local by its very nature; many of those interviewed stressed that their communities are the natural environment for developing solutions. Although developing and implementing strategies for mitigating fragmentation and enhancing the overall coordination of service delivery was identified as laborious and challenging, interviewees believed such improvements necessary. Consequently, communities are seeking to better coordinate services in many ways. For example: (a) building on the efforts of existing health care safety net clinics, (b) developing information system capacity for sharing health data across institutions, (c) improving communication among providers and other community partners, (d) further coordinating preventive, primary, secondary and tertiary care, and (e) integrating services such as public health, medical care, and behavioral health.

Lesson 6
The long-term goal of community-created solutions is to create stable, sustainable local health care systems

Each community solution is intended to build a stronger, more efficient and more effective way to conduct business. However, all but one community-created solution included in the survey is in an early stage of development. Those interviewed identified several key factors to building and sustaining community created solutions: (a) committed and trusted leadership; (b) time; (c) identifiable short- and long-term outcomes; and (d) shared vision and understanding of challenges, problems, and opportunities; and (e) clear and on-going relationships with both public and private sector leaders. A number of those interviewed expressed concern regarding the ability to sustain their community-created solutions. Although many share the commitment to the community collaboration and have invested time and resources to move the work forward, more assistance and time is needed to deliver meaningful outcomes. Those interviewed continue to try to collaborate with more and different partners to help assure the sustainability of their efforts. However, with limited local resources and reductions in technical and fiscal support from the federal and state governments, community-created solutions are often jeopardized.

Lesson 7
Developing collaborative relationships is time-consuming and politically challenging

The most often-cited challenge in forming these relationships is politics, turf and fairness issues, followed closely by busy schedules. Conflict will occur and must effectively be resolved. Nurturing unlikely partnerships is the "bricks and mortar" of building and sustaining a meaningful collaboration.

Delivery of health services is local by its very nature; many of those interviewed stressed that their communities are the natural environment for developing solutions.

Communities must be willing to take the time that is needed (and it will be different for each community) to germinate and nurture new or fragile relationships, to cultivate a shared vision, and to plan strategically. Not only must the collaboration involve diverse stakeholders, a case must be made for how each stakeholder can expect to

benefit and why organizations must be willing to stretch beyond their core missions. State and federal regulations and bureaucracies are often a barrier to successful community-created solutions. Confusion and the lack of relationships with government officials/employees make it challenging to overcome these bureaucratic barriers. In order to attend to the political challenges of community collaborative efforts, committed and skilled staffing is needed. Staff must be responsible for ensuring concrete and timely products or “deliverables”. Stakeholders, including the broader community, must employ a high degree of patience and a broad interpretation of success, when evaluating staff and their community-created solutions, especially in the early stages of the collaborative.

Recommendations for State Support

Those interviewed were asked to offer specific recommendations relating to ways the state could better support community-created solutions that are intended to improve access to needed health services and improve health outcomes within their community. Six general recommendations on how state policy-makers, government officials, and state employees can better support communities build and sustain such innovative efforts were identified.

View and recognize communities as equal and unique partners

- Recognize the important role of communities in improving the delivery of health care;
- Learn from innovations at the local level;
- Involve community stakeholders in a meaningful and on-going fashion;
- “*One size doesn’t fit all*.” Create and support state and local programs that adapt to the differences in how a community provides health services;
- Realize and support the time and expertise needed to build and sustain community-created solutions that ensure health services; and
- Permit and actively support the development of community-created solutions to providing health services.

Support and strengthen the health care safety net

- Establish and support policies, programs, and services specifically supporting health care safety net providers and populations; the health care safety net is a community’s response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
- Further strengthen infrastructure responsible for supporting Oregon’s safety net;
- Devote adequate funding and staffing for efforts that support safety net development and involvement;
- Encourage the growth of health care safety net providers in underserved communities; and
- Provide information, referral, and technical assistance to communities relating to how/if to pursue the development of a health care safety net clinic.

Provide the “connective tissue” between communities

- Share information and data relating to best practices, lessons learned, and opportunities to receive technical and funding support; and
- Provide opportunities/venues for communities to learn from one another and gain important exposure to innovative outside ideas.

Ensure technical assistance is offered to interested communities

- Help build a common health information system to improve communication and coordination among local/regional providers;
- Gather health data at the local/regional level with community stakeholders;
- Help communities interpret the findings of data;
- Translate data with communities into responsive strategies;
- Assist communities in their efforts to apply for grants;
- Assist with evaluating community-created solutions;
- Assist with identifying appropriate/desired outcomes;
- Provide consultation relating to how to build and sustain community-created solutions; and
- Support and expand the Office of Rural Health's Community Health Improvement Partnership program, which provides technical support in order to improve local health care systems in rural/frontier Oregon.

Create flexible and supportive policies

- Seek ways to individualize approaches and remove barriers experienced at the local level;
- Provide flexible state policies and regulations to support local solutions to delivering and financing health services;
- Ensure adequate supporting and funding for prevention/public health and chronic care management; and
- See Appendices A-F for *Key Informant Interview Summaries* and Appendix G for further information.

Make financial investments in community innovation

- Stabilize publicly funded programs;
- Provide "seed money" to help collaborations get off the ground; and
- Target grant funding for promising collaborations improving access to needed health services and health outcomes.

A "one size fits all" approach to addressing the fragmentation and inefficiencies of the health system was reiterated as being both unrealistic and inappropriate.

Conclusion

According to those interviewed, policy makers and government officials have an important role to play in promoting and sustaining innovative solutions that help ensure healthy Oregon communities. Possible and appropriate roles for the state were reiterated from leaders in the Willamette Valley, the Tri-County area, as well as Central, Northeastern, and Coastal Oregon communities. While many shared perspectives were evident among the responses of key informant interviews, a "one size fits all" approach to addressing the fragmentation and inefficiencies of the health system was reiterated as being both unrealistic and inappropriate.[8] Consequently, state leaders, policies, and programs are asked to support community-created solutions if health outcomes for Oregonians are to improve.

Policy makers and government officials have extremely complex roles to play and challenging choices to make – life

[8] This was also a theme of the 2002 study, Small Market Communities: Challenges and Opportunities in Serving OHP Enrollees and the Uninsured. *Office for Oregon Health Policy and Research.*

and death choices. So do local communities, where the delivery of health services actually occurs. These communities cannot afford to continue to do business in the same way. They are no longer willing to allow their neighbors to go without adequate access to quality and needed services. They are building collaborative efforts in order to re-evaluate and re-design how health services are delivered. These communities are convening diverse stakeholders from both public and private sectors. They are bringing time, resources, creative problem solving and tenacious energy to the table. However, these community innovations face many challenges, barriers, and confusion. Consequently, these communities acknowledge that they cannot do all they need without government assistance and supportive public policies.

Appendix A

Survey Summary

Question 1: Innovation of project (Do you see anything about this project that you would identify as innovative and if so, what do you think it is?)

Range of Responses:	*Incidence:*
Collaboration (the breadth and/or depth of skill, key players/diversity)	(12)
Structure of collaborative	(5)
Scope of the project	(4)
Tenacity of core leaders	(4)
Over-arching shared sense of purpose among leadership and staff	(4)

Question 2: Timing of project (What contributed to this project being undertaken now?)

Range of Responses:	*Incidence:*
Consensus around health care crisis	(11)
Financial imperative	(4)
Vision shared by key leaders	(3)
"Stars aligned"	(2)
Collaborative efforts provided credibility by earlier successes	(2)

Question 3: Project goals

Range of Responses:	*Incidence:*
Increase access for uninsured/underinsured	(8)
Achieve 100% Access	(6)
Relationship building	(5)
Shore up existing safety net clinics	(5)
Integrate system/include schools, social service etc.	(5)
Achieving fairness/equity	(4)
Increase efficiency/decrease cost	(4)
Improve measurement tools/capacity	(4)
Provide education/added value to community	(4)
Influence policy	(3)
Project should be replicable	(2)

Appendix A continued

Question 4: Methods/strategies to reach goals

Range of Responses:	*Incidence:*
Relationship building	(12)
Begin with winnable tasks (“low hanging fruit”)	(8)
Recruit key people	(5)
Network/info-share with others around state/country	(5)
Get provider “buy-in”	(4)
Cultivate ability to share health information	(4)
Partners need to commit tangible resources	(4)
Use of workgroups for targeted issues	(4)
Focus on prevention	(3)
Use of professional facilitation	(2)
Reduce # of medical errors	(1)
Position project to influence funders	(1)
Reduce unnecessary medical care	(1)

Question 5: Sources of project funding and/or projected funding issues

Range of Responses:	*Incidence:*
Will need FTE designated to project (to maintain)	(6)
Have or will apply for grant funding	(6)
Have utilized donated resources	(3)
Need seed money in order to move project forward	(3)
Need to stabilize funding of project	(1)

Question 6: Desired/achieved outcomes (How will you know if you’ve impacted access, how will service delivery be different?)

Range of Responses:	*Incidence:*
Track statistical data (E.D. use, immunization rates, surveys etc)	(13)
Improved trust among partners	(6)
Evidence of increased access	(6)
Improved/increased community dialogue	(5)
Increased visibility of project	(3)
Achieve 100% Access	(2)
Improved efficiency/decreased costs	(3)
Better understanding of how to measure projects developmentally	(2)
Sustainability	(1)
Project expands	(2)

Appendix A continued

Question 7: Significant challenges and/or barriers facing project

Range of Responses:	*Incidence:*
Politics/turf issues	(18)
Fairness/equity issues	(8)
Busy schedules	(7)
Getting provider community on board	(7)
Distance between communities (geographically and/or culturally)	(6)
Project concept hard to grasp/too vague-what are the "products"	(7)
Project too overwhelming/maintaining momentum	(5)
Insufficient data-especially re: unserved/underserved	(6)
Path unclear for undertaking a project of this type	(6)
Scarce number of doctors/recruiting challenges	(4)
Burden of mental health needs	(4)
Risk of becoming a "beacon city"	(4)
Lack of consumer or broader community voice	(4)
Instability of state funding	(4)
Lack of ability to share health information across systems	(4)
Managing inclusiveness	(3)
Cost of medications	(3)
Burden of dental needs	(2)

Question 8: Strategies considered or implemented to attempt to address challenges and/or barriers

Range of Responses:	*Incidence:*
Honest communication	(9)
Individualize strategies to meet needs of specific community/population	(8)
Focus on building relationships	(6)
Recruit/maintain those participants who are dedicated and optimistic	(5)
Focus on the development process of building the collaborative	(5)
Include a diversity of participants	(4)
Use outside consultants	(3)
Must be willing to give something up	(2)
Invest in electronic health records system	(2)
Use of mediation	(2)
Use of professional facilitators	(2)

Appendix A continued

Question 9: Lessons learned that might be helpful to other communities

Range of Responses:	*Incidence:*
Investing in the *process* is key	(15)
Be inclusive	(7)
Build a winning team of principal players	(5)
Build in the public health system	(4)
Get the provider community on board	(4)
Do what is best for patients and communities	(3)
A non-profit is a good convener	(2)
Marketing of the concept is very important	(3)
Use of targeted workgroups is beneficial	(2)
Organizations must be willing to stretch beyond their core missions	(2)

Question 10: What can the state do to assist this project (In the form of policy, technical or agency assistance?)

Range of Responses:	*Incidence:*
Provide technical assistance (consultation re: data, grant writing etc.).	(15)
Provide "connective tissue" between communities and other models.	(11)
Value that communities have an important role and that each is different.	(10)
Provide seed $ for project start up/fund promising pilots/programs.	(8)

Appendix B

100% Access Coalition

Lane County - Community Profile

Number of interviews conducted: 11

Lane County's 100% Access initiative was conceptualized by a small group of core leaders from United Way, PacificSource Health Plans, Lane Individual Practice Association (LIPA), and the offices of Congressman Peter Defazio and U.S. Senator Ron Wyden. The leaders were struck by the profound needs relating to health care among all sectors of their community as identified by United Way of Lane County's 2004 community needs assessment. Consequently, the United Way convened a small planning workgroup, which resulted in inviting and recruiting community leaders from the public and private sectors to a meeting. At this meeting, leaders were asked the question: "Can we do better with our own resources?" The majority of those in attendance believed that Lane County could do better.

In December 2004, an even broader spectrum of community stakeholders convened to further explore the health of Lane County and begin to identify action steps that would move them toward 100% access. This meeting resulted in five workgroups responsible for exploring and developing strategies related to: medical home, chronic illness/prevention, mental health, medications and insurance/enrollment. These work groups were supported by skilled staff. Each group had a professional facilitator who volunteered their services as well as workgroup champion(s) who were notable for their content expertise and/or their community visibility. Workgroup members were recruited from diverse disciplines. Each workgroup received administrative support donated from numerous coalition organizations.

In May 2005, the five workgroups shared priorities and strategies to move their work forward at a public forum. Several "promising opportunities" were endorsed[1] and workgroups agreed to continue to meet and refine their work plans. In addition to the five original workgroup, a metrics group has been established to address measurement and documentation needs.

Initial seed money was provided by several of the core organizations. This funding contributed to the hiring of a 100% Access Coalition Director/Coordinator and other infrastructure needs. Additionally, the coalition applied for, and received a federal grant, "Healthy Communities Access Program," HCAP. Although many participants expressed the need for a permanent FTE position, there was also a shared perspective that planning should

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[1] Promising opportunities defined: All opportunities should result in improved access to health care in Lane County. Other criteria for selecting promising opportunities include: doable locally, leadership momentum exists, immediacy of the opportunity and constituent readiness. Opportunities may utilize resources differently, or may require the development of new resources and systems.
100% Access: A United Way of Lane County Healthcare Initiative.

be done without the expectation of any additional resources. This was identified by some informants as a strategic method for keeping participants invested and engaged in the collaborative without being dependent on external or additional funding.

100% Access is coordinated by a steering committee of approximately 20 members. The steering committee reports back to the United Way board. Workgroup members report to the steering committee.

Those interviewed attribute "the convergence of need and willingness" among community stakeholders as key to the development of the collaborative. Furthermore, the breadth and depth of stakeholders and the commitment from leaders who have the authority to allocate resources and make organizational changes were identified as vital to developing the collaborative. The 100% Access Coalition has successfully recruited participants from the provider/practitioner community, hospitals, social service, insurance, business, governmental leaders at the local and the national level, safety net providers and more. One key informant stated the 100% Coalition is the result of "the right people, in the right place, at the right time, talking about the right things".

Upcoming strategies for improving access

- Establish a community-wide charity care standard.
- Develop, test and implement a health care outreach, eligibility and screening, enrollment, and assignment partnership
- Create, test and implement a Medical Assistance Program Care (MAP Card) Network
- Develop a Volunteer Physicians Network support by the MAP System Navigators, Mental Health Champion and MIS
- Expand availability and enrollment in chronic condition self management groups
- Establish a Coordinated Lane County Pharmacy Program with a unified Prescription Assistance Program (PAP) and 340B program linked to MAP Card eligibility/membership
- Provide earlier, non-institutionalized mental health interventions for uninsured and underinsured individuals through development of 24/7 referral and scheduling capacity, linkage with the MAP Network, and the expansion, coordination and mobilization of lay and professional behavioral health resources
- Develop and pilot a low cost insurance product for non-profit employees with potential application to the small business market

Appendix B continued

100% Access Coalition Members

Organization	Type	Contact
United Way	Human Service/ Non-profit	Priscilla Gould
PacificSource	Insurer	Ken Provencher
U.S. Congressman DeFazio	Elected public official	Libby Page
U.S. Senator Wyden	Elected public official	June Chada
Direction Service	Human Service/ Non-profit	Marshall Peter
PeaceHealth	Hospital	Loren Barlow MD
PeaceHealth	Hospital	Thomas Jefferson MD
LIPA	Insurer	Rhonda Busek
LIPA	Insurer	Terry Coplin
Kathleen Howard Consultants	Private Consultant	Kathleen Howard
St. Vincent de Paul	Human Service/ Non-profit	Terry McDonald
Lane County	Local Government	Steve Manela
Lane County	Local Government	Rob Rockstroh
Temple Beth Israel	Faith	Rabbi Husbands-Han
Oregon Medical Group	Medical Practitioner	Leo Cytrnbaum MD
KidSports	Non-profit Child Recreation Organization	Jim Torrey
Sacred Heart Medical Center	Hospital/Faith	Sister Barbara Haase
McKenzie Willamette	Hospital	Roy Orr
The Ulum Group	Private consultant	Jenny Ulum
Dept of Human Services Health Systems Planning	State government	Laura Brennan

Appendix C

Central Oregon Health Care Collaborative

Crook, Deschutes, Jefferson Counties - Community Profile

Number of interviews conducted: 4

Core leaders of the Central Oregon Health Care Collaborative (COHCC) describe this initiative as being in the earliest of developmental stages. Three key leaders, representing Deschutes County Public Health, Volunteers in Medicine, and Clear Choice Health Plans are responsible for generating interest in a central Oregon collaborative and for doing the research and networking necessary to begin moving the conversation out to the broader community.

The COHCC leadership prepared a "concept paper" focusing on the health care crisis and opportunities for addressing cost, quality and access at the local level. These leaders are now selectively distributing the concept paper among key community stakeholders to gauge interest.

Leadership agrees that COHCC is about more than improved access. In other words, access does not improve health in and of itself. COHCC aims to look at the gross inefficiencies within the health care system and begin to examine how to provide access, contain costs, and provide quality health care in a way that is sustainable over time. COHCC asserts that "with its unique geographic location, collaborative medical community, responsive business leaders, and dedicated citizens, Central Oregon can build upon its solid foundation to launch a successful health care initiative that would *reform* health care."[2]

The core group is working at broadening its stakeholder involvement and actively in the recruiting. Focus is presently being spent on recruiting the key players with the expectation that they will help to shape the goals and objectives of the collaborative. Recruitment goals for COHCC focus on maintaining a manageable number of partners and enlisting people who have both the time to invest as well as the willingness to commit concrete resources. The group hopes to host a community panel within the next couple months, as well as a summit-type event in the spring. The group is receiving consultation from the Lane County 100% Access coalition and is actively networking with communities across the state and nation who are undertaking or have implemented similar projects.

COHCC seeks start up funding to be able to organize the initial panel as well as coordinate and host the summit in the spring. Concern was expressed over whether this small group can maintain the momentum needed to promote the collaboration during this critical period of development. All members of the leadership group see this project as one that requires a long-term vision and commitment.

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[2] DRAFT White Paper. Central Oregon Health Care Collaborative. September, 2005.

Appendix C continued

Upcoming strategies for improving access

- Disseminate concept paper to key stakeholders
- Host a key-leaders community meeting/panel to build coalition and develop specific strategies
- Host a community summit

COHCC Core Leadership

Organization	Type	Contact
Clear Choice Health Plans	Insurer	Mike Bonetto
Volunteers in Medicine	Safety Net Provider	Christine Winters
Deschutes County	Public Health/ Local Government	Dan Peddycord

Appendix D

Northeast Oregon Network, NEON

Baker, Union, Wallowa Counties - Community Profile

Number of interviews conducted: 5

The Northeast Oregon Network (NEON), is a collaborative effort between Wallowa, Union and Baker counties, and was established in August, 2004. NEON was originally led by a small group of individuals who had discussed and recognized the value of a community collaboration to ensure needed and quality health services are provided in an efficient fashion.

NEON is an entirely rural/frontier collaboration led, in large part, by public health and human service organizations. NEON is **not** centered on the direct provision of health care. It is focused on the coordination and efficiency of needed services.

Recruited in part around the prospect of applying for a Rural Health Development Planning grant from the federal Health Resources and Services Administration (HRSA), key stakeholders from the three counties were drawn together to discuss the potential for building a community-created solution to address mutual concerns related to access and health care. Attendance at this initial meeting was much larger than expected. Eleven of the participating organizations wanted to pursue the NEON collaboration whether grant funding was received, or not. Although NEON did not receive the HRSA funding initially, a small group of these leaders continued to meet and plan, with no financial support, throughout this past year.

NEON seeks to create an integrated health care network. To build a strong and sustainable network, key informants stressed the need to (a) involve diverse stakeholders, (b) prepare and follow a strategic plan, and (c) influence local, state and national rural health policies.

NEON is committed to including diverse stakeholders, which includes both public and private partners. Recruiting the provider/practitioner community however, has been a challenge for NEON. Practitioners in rural and frontier areas are stretched extremely thin, as are all NEON members. The distance between each community compounds these challenges further; travel time and unmet expenses have made recruitment difficult. Marketing the concept has also been somewhat challenging, as some stakeholders have found the project amorphous and difficult to grasp. When it was learned that the HRSA grant had not been initially awarded the numbers of those actively participating in the Network, dwindled substantially.

Collaboration is a familiar way to do business throughout northeast Oregon. Nevertheless, recruiting key stakeholders, laying the foundation and infrastructure for NEON, and “nurturing alliances” each require a great deal of time and must be done with the utmost care. Key informants pointed out that each stakeholder involved in NEON wears “multiple hats” in their rural communities. According to some key informants, “You don’t often get a second chance in rural communities if you mess it up the first time.” NEON members stated that adequate time and

skilled staff specifically dedicated to the collaborative are important to achieve positive outcomes.

NEON members see the potential for NEON to facilitate innovative services tailored to specific areas and to create meaningful system changes. Members of the NEON recognize the importance of timely concrete outcomes, and yet anticipate tangible outcomes may take one or two years.

In September 2005, HRSA informed NEON that there were funds left over from the previous grant cycle. Consequently, NEON was awarded $72,000 to plan their collaborative. This incentive provided an important outcome for NEON, and allows the Network to hire .3 FTE staff. NEON submitted another federal government grant application to assist in the considerable planning and development necessary to move the collaborative forward.

Upcoming strategies to improve access

- Reconvene earlier partners
- Actively recruit provider/practitioner community
- Hire Kristen West from CHOICE Regional Health Network/Communities Joined in Action to assist in strategic planning
- Hire consultant to help set-up and train NEON members in using GIS
- Hire a consultant to help conduct a tri-county feasibility study relating to a Federally Qualified Health Center (FQHC)
- Hire FTE to assist in the administration of NEON
- Evaluate potential projects for most promising opportunities

Some Additional Potential Strategies are:

- Integrated Mobile Access Teams
- Development of Traumatic Brain Injury Resources
- Dental Services for uninsured patients
- Expanded Community Resource Team (CRT) Model
- Access to Free Medication Assistance Program
- Prescription Drug Abuse Screening Protocol

Appendix D continued

Northeast Oregon Network Members

Organization	Type	Contact
Center for Human Development Inc.	Non-profit/ Public health	Lisa Ladendorf
Elgin Health Clinic (OHSU)	Safety Net/ Public Teaching Hospital	Ginny Elder
Grande Ronde Hospital	Hospital	Vicki Hill Brown
Union County Commission on Children and Families	Human Services/ Local Government	Vicki Brogoitti
Wallowa County Commission on Children and Families	Human Services/ Local Government	Ann Gill
Wallowa County	Public Health/ Local Government	Laina Fisher
Wallowa Memorial Hospital	Hospital	Tami Perrin
Wallowa Valley Mental Health Center	Human Services/ Non-profit	Stephen Kliewer
Mountain Valley Mental Health Programs Inc.	Human Services/ Non-profit	Tim Mahoney
Baker County Commission on Children and Families	Human Services/ Local Government	Judy Barzee
Baker County	Public Health/ Local Government	Debbie Hoopes
Seniors and People with Disabilities	Human Services/ State Government	Libby Goben
School of Nursing (OHSU)	University	Jeannie Bowden
State House District 57	Elected Official	Representative Greg Smith

Appendix E

Samaritan Health Services

Benton, Lincoln and Linn Counties - Community Profile

Number of interviews conducted: 7

Samaritan Health Services (SHS) is a non-profit organization, serving approximately 250,000 residents throughout Linn, Benton, and Lincoln counties as well as in portions of Polk and Marion counties. SHS is locally owned and directed by leaders from each of its five hospitals, physicians, and community representatives from throughout the region. Samaritan Health has over 150 affiliated physician primary care clinics and an independent/assisted living facility. SHS offers several insurance related services. SHS self-insures its employee and their dependents and has a Medicare product for eligible beneficiaries living in Linn, Benton and Lincoln counties. As an option for external employers, SHS offers Third Party Administration (TPA) to self insured groups. Within the upcoming year SHS will launch an insurance product for the Public Employees Benefit Board (PEBB). Furthermore, SHS has a managed care plan under contract with the state of Oregon to administer the Oregon Health Plan in Linn and Benton counties known as the InterCommunity Health Network (IHN). IHN was founded in 1993 by Albany General, Good Samaritan and Lebanon Community hospitals, and serves 16,000 Oregon Health Plan members in Linn and Benton counties. Although IHN's contract with the state of Oregon is not exclusive, it is currently the only managed care organization (MCO) in Linn and Benton counties that administers the Oregon Health Plan.

The early leaders of SHS and its partnering organizations came together around a very cohesive vision which has since been translated and embraced by the larger community throughout the region. Periods of distrust among partners in the developing stages of the collaborative existed. Key informants indicated the importance of a clear vision, tenacious leadership, and nurturing relationships were significant to the success of SHS.

Key informants identified several reasons for the achievements of SHS. Agreement was expressed that SHS's vision and commitment to "patient–centric" and community-based care contribute to it being an effective collaborative. In the early period of consolidation, SHS went to a model of equal pay for equal work. This has evidently engendered genuine buy-in from the practitioner community whose level of engagement and coordination with the regional hospitals is extremely high. Another innovative element is SHS's Social Accountability Budget or "institutional tithing". SHS allocates up to 10% of the previous years net revenue to support a variety of community health initiatives. These initiatives focus on unmet community needs and collaboration, prioritize prevention, measure and disseminate progress results throughout the wider community, plan for self-sufficiency, and operate efficiently.

SHS supports safety net clinics in East Linn, Corvallis, Albany, and in Lincoln City through financial contributions, sharing lab technologies, and providing free medications through a limited generic formulary. In addition, SHS has developed the Samaritan Health Medical Assistance Program which takes patients with complex conditions who require brand name pharmaceuticals and helps them to apply for pharmacy assistance programs.

Some concern was expressed that SHS's value of turning no patient away may result in the region becoming a "beacon" for people who are low-income or uninsured. Eligibility criteria may be needed to manage demand from people outside of the service area. In addition, because much of the decision-making is consensus driven, it takes more time. There is a strong value for communication across and between systems and as a result, SHS is moving toward developing the capacity to share electronic health records. This is seen as a concrete and needed step toward better coordination and access, yet is extremely complex and time consuming.

Community partners involved with SHS indicated many benefits of working collaboratively. While there was acknowledgement that SHS is "the only show in town" due to the size and scope of its consolidation, most informants expressed appreciation and benefit in SHS's willingness to bring needed resources on the table. Others note that SHS is in a position to spearhead certain kinds of initiatives that other public or private/non-profits would be less able to undertake due to differing mandates, resources and level of political persuasiveness. There was a sense among some that nurturing the relationship between SHS and local health departments is still an area which requires growth. There have however, been several successful joint partnerships between local health departments and SHS including maternal child health services, emergency preparedness and community health planning in Lincoln county.

Upcoming strategies to improve access

- Develop electronic health records capacity
- Develop broader partnerships with the business community
- Further develop partnership with county health departments
- Undertake a systematic assessment of community resources/gaps to promote greater coordination

Appendix F

Tri-County Safety Net Enterprise

Clackamas, Multnomah, Washington - Community Profile

Number of interviews conducted: 7

The Tri-County Safety Net Enterprise (SNE) is the result of an intergovernmental agreement between Multnomah, Clackamas and Washington Counties. The three Counties created the Enterprise to align public and private access efforts for low income and uninsured residents into a cohesive regional approach. Its major objectives are to (a) create community ownership and accountability for the health care safety net, (b) assure all underserved residents have access to affordable and appropriate medical care, and (c) improve the environment for those caring for low income and the uninsured.

The Enterprise formed as a result of the Robert Wood Johnson's Communities in Charge project, a 3-year planning and development grant. After 3 years of relationship and trust building, researching best practices, and strategically planning, the Enterprise was developed in 2004. This intergovernmental structure is the only one of its kind focused on health care issues in the state. The mission of the Enterprise is to support and improve healthcare access in the three counties.

In creating the Enterprise, the three Counties also created an independent board. The board is comprised of three county commissioners (one from each county), three hospital administrators, three safety net providers, three public health directors, a member from the Oregon Primary Care Association, an Oregon government official, and one consumer. Some key informants identified that a more diverse board may assist the Enterprise in moving forward with its objectives. For example, including business, insurers, faith, and other sectors could broaden resources and expertise. Although an independent board, the Enterprise is still a public entity. Washington, Multnomah and Clackamas are very different counties, with varied governance structures, diverse demographics, and significantly different socio-political cultures. It was noted that these differences must be understood and appreciated while moving forward with any and all collaborative efforts.

The Enterprise is funded by a Healthy Communities Access Program (HCAP) grant from the federal government. Enterprise stakeholders acknowledge that seeking long-term sustainable funding for the collaboration is one of the essential next steps. There is not yet consensus on how the Enterprise should be funded.

The Enterprise continues to clarify its role in the community, its relationship with other access efforts, continues to interpret its mandate, and align its leaders around a shared vision. Key informants identified the importance of, and time involved in, building relationships and trust in order to produce positive outcomes. The Enterprise was recognized as playing a significant role in bringing the three distinctly different counties and county governments into an alliance

around health care. It has supported or led community efforts such as the Maternal Newborn Care Access Workgroup, which aims to develop a coordinated system of health care access for all pregnant women in the region, and the continuing effort to expand coverage for uninsured pregnant women statewide. The Enterprise is also working to further identify the highest access needs within the three counties by working with OHSU to create a complete picture of what is happening in community emergency departments. However, some informants expressed the need for immediate and more tangible outcomes to sustain the collaborative.

In 2005-2006, the Enterprise plans to work more effectively in the community to (a) build community relationships, (b) provide partner organizations with technical assistance, and (c) represent the regional health care safety net, and (d) convene a broad advisory group to develop community involvement and accountability for health care access.

Upcoming strategies to improve access

- Build on a pilot project completed in partnership with the Medical Society of Metropolitan Portland and the Coalition of Community Clinics, introduce and implement 'Project Access" across the region
- Expand pharmacy services to safety net clinics
- Based on what is learned from regional emergency department utilization information, identify and implement focused primary care access strategies, such as siting and opening new service delivery sites
- Participate in/support hospital charity care discussions

Appendix F continued

Tri-County Safety Net Enterprise Board

Organization	Type	Contact
Multnomah County Commissioner	Elected Official	Serena Cruz
Providence Milwaukie Hospital	Hospital	Jacquelyn Gaines
Department Human Services	State government	Bruce Goldberg, M.D.
	Consumer	Bill Hancock
Oregon Primary Care Association	Safety net	Craig Hostetler
Washington County	Human Services/ Public Health/ Local government	Susan Irwin
Virginia Garcia Memorial Health Center	Safety Net	Gil Muñoz
OHSU	Public Teaching Hospital	Peter Rapp
Washington County Commissioner	Elected Official	Dick Schouten
Clackamas County Commissioner	Elected Official	Martha Schrader
Multnomah County	Public Health/ Local government	Lillian Shirley
Clackamas County Safety Net	Public Health	Alan Melnick, M.D.
Clackamas County	Public Health/ Local government	Maryna Thompson
Native American Rehabilitation Assoc. of the Northwest, Inc.	Safety net	Jackie Mercer
Tuality Healthcare	Hospital	Dick Stenson

Appendix G

Policy and Program Recommendations for State Government
Selected Responses from Key Informants[Π]

View and recognize communities as equal and unique partners

- Ensure that public and private sectors are being treated with fairness and equitably, note economies of scale.
- Measure successes thru outputs and "products" *as well as* the value of community development.
- Regard that local collaborations require time and plenty of "feeding and watering" as they develop.
- Invest in piloting innovation at the local level ("low-risk").
- Share information about community collaborations into "layman's" terms so legislators and other state decision makers can better comprehend and address the issues with communities.
- Tailor policies and programs to reflect the specific benefits and challenges of rural/frontier communities, e.g., grant programs which impose population requirements that are too steep for many rural communities, funding requirements which do not allow for reimbursement of travel time/expenses, physician recruitment regulations which do not make it plausible for new doctors to locate in rural communities i.e. the 40 hours per week direct service requirement).

Support and strengthen the health care safety net

- Stabilize the Oregon Health Plan and develop legislative priorities which place value on health, education and well-being.
- Require every licensed provider see Medicare and Medicaid patients.
- Ensure capitation payments to Medicaid managed care plans are ensuring access to care for patients (medical, dental, and mental health).
- Encourage communities to apply to be Federally Qualified Health Centers (FQHC).
- Require Medicaid managed care plans contract with FQHC's and other qualified safety net providers.
- Ensure reimbursement for safety net clinics and other primary care providers for behavioral health services (integration of primary and mental health care).
- Make licensing of out-of-state doctors easier in Oregon to promote volunteering in safety net clinics.
- Emphasize and pay adequately for prevention services.

[Π] Recommendations may fall into one or more category, however for brevity they are only listed once.

Appendix G continued[Π]

- Utilize certificate of need programs more often and effectively.

Provide the "connective tissue" between communities

- Provide better coordination and communication between public and private health services.
- Create venues for communicating and learning from local and national community leaders.
- Provide information relating to stability, grants, and best practices.
- Sponsor forums such as the Oregon-Washington 100% Access Summit.

Ensure technical assistance is offered to interested communities

- Work with communities that want to do something different around obtaining Medicaid waivers.
- Promote inter-operability between systems through monitoring, evaluating and helping to shape the public will.
- Embrace/employ *Communities Joined in Action* assistance around measurement and best practices to improve health care access at the local level (Return on Community Investment principles).
- Provide consumer data on quality that looks at the variations of health care opportunities around the state and analyze why those variations exist. State can highlight and mitigate (if necessary) these variations.
- Offer technical assistance, e.g., evaluation, grant writing, infrastructure development.

Create flexible and supportive policies

- Ensure a health policy expert/advocate within the Governor's office, who can be the point person for community efforts around health care.
- Un-encumber or de-categorize money.
- Reduce the bureaucratic requirements ("for every hour of clinical service there is 35 minutes of supporting paperwork").
- Pursue Medicaid presumptive eligibility policy for homeless people.
- Create anti-trust "safety zones" around collaborative efforts.
- Reinvest the health care premium dollars into prevention programs.
- Tort reform.
- Disconnect the health care dollar from the individual-pursue a demonstration project through the Medicaid waiver.

[Π] Recommendations may fall into one or more category, however for brevity they are only listed once.

Appendix G continued[Π]

Make financial investments in community innovation

- Engage in more public/private partnerships with foundations to support communities.
- Offer seed funding for community-created solutions.
- Connect economic development and health status.
- Replicate electronic health records capability and interoperability at the local level throughout the state.

[Π] Recommendations may fall into one or more category, however for brevity they are only listed once.