Integration of Safety Net Services: Opportunities and Benefits in Olmsted County, Minnesota

by

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Access to healthcare is an important determinant of health addressed by the Institute of Medicine report, *The Future of the Public’s Health in the 21st Century* (2003). Over 41 million Americans are uninsured and over 80% of those Americans live in working families. While lack of insurance is the most significant barrier to obtaining health care, many individuals who are insured, including those insured by Medicaid, often do not have coverage for preventive services, behavioral health care, and oral health care. Insurance programs with co-payments for preventive services and primary care have been shown to reduce use of preventive services and primary care for the poor (IOM, 2003, p. 223).

Uninsured and underinsured Americans have poorer overall health than insured Americans and tend to have no identified regular source of care. “Having a regular source of care improves preventive care and screening services and improves the management of chronic disease (IOM, 2003, p. 221).” Primary care is associated with better health outcomes, better preventive services, and lower total health care costs. Primary care is also associated with reduced disparities in health and nations that value primary care have lower mortality rates (IOM, 2003, p. 244). According to the Health Resources and Service Administration’s (HRSA) Bureau of Primary Care BPHC, “many of the uninsured and underinsured have no regular source of care and face serious financial and social barriers to receiving comprehensive, coordinated health services. As a result, these individuals are more likely to defer care, be hospitalized for avoidable or chronic health problems, and have difficulty securing needed medical care, even for serious conditions (HRSA, n.d.).”
Individuals without insurance or who are underinsured often seek healthcare from safety net providers. Safety net providers are “those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid and other vulnerable patients (IOM, 2000, p.21).” Community health centers or clinics funded by federal state and local governments, free clinics run by non-governmental charitable organizations with volunteer health care providers, and emergency departments providing non-reimbursed care are examples of safety net providers. Care in the safety net setting is generally based on acute care needs and not primary care continuing relationships with chronic disease management. Services are often fragmented between multiple providers who serve different purposes. The IOM states that “communication and collaboration between community organizations and health departments is often limited, leading to duplication of effort and inefficient use of resources. (IOM, 2000, p. 10) In most cases different missions, funding streams and constituencies of various providers have worked against effective collaboration. (IOM, 2000, p.211).

Health policies to improve access to care generally aim to expand health insurance coverage so that more people can access the current health care system or to strengthen and expand safety net services. At the community level, improving access to needed services for the uninsured and underinsured is most feasible by strengthening safety net services. The HRSA Bureau for Primary Care writes that “there is an urgent need for resources to address these infrastructure issues and provide uninsured and underinsured populations with entry into a comprehensive, integrated and coordinated system of care (HRSA, n.d.)”
Olmsted County, Minnesota has convened a Health Care Access Task Force to address the availability of adequate health care for the uninsured and underinsured members of our community. These needs are likely to grow in the coming years as rates of uninsurance continue to rise. The community has a strong foundation of health care resources yet there is a significant gap in health care for these vulnerable populations.

In Olmsted County, the need for a less fragmented, more coordinated system to provide equitable quality and safe care for patients is clear. A proposal solution to current gaps is to create a single integrated site for health care and health care related services where resources are pooled and gaps are filled. In this paper, I will present models to improve access to health care by integrating safety net services in the community, importance of chronic disease management which is lacking in current strategies for providing services to the underserved, and a strategy for successful implementation of such a models. I will discuss sustainability of such a program and the cost benefits and improved health outcomes that might be seen with chronic disease management in an integrated health system that serves the underserved.

The Evidence for Collaboration and Integration

The IOM observed in 1988 that public health professionals often work on issues of public health without citizen participation or community participation (IOM, 1988). Approaches to improving the public’s health in which the community and its citizens were passive participants were often unsuccessful. Community-based partnerships with participation of various stakeholders are more effective and productive by “reducing duplication of effort and avoiding the imposition of solutions that are not congruent with
the local culture and needs (IOM, 2003, p. 184).” Collaborations with long term sustainability and institutionalization of effective programs improve health outcomes. (IOM, 2003, p. 186)

Lemak, et al. (2004) identified improved efficiency, shared resources, increasing legitimacy, acquisition of knowledge and governmental incentives and directives as reasons organizations enter into collaborative relationships. The potential benefits of reduced health care costs associated with community efforts that improve health status motivate for employers to be involved. Hospitals and health plans may participate because of the “community benefit” requirements for nonprofit organizations (IOM, 1997). By participating in ways to improve health care access, hospitals and health plans may also reduce costs of uncompensated care. The success of community health improvement projects requires shared values, congruence with community needs, political support and resources, including knowledge, skills, money, time and technical assistance (IOM, 203).

While collaborations can lead to integration, not all health improvement collaborations aim to integrate health services. Frequently coalitions of stakeholders are convened to identify gaps and plan for improvement or to pilot programs. These collaborations may include co-location of services but the separate organizations continue to own the services that they provide. An integrated health service model requires more formal relationships among stakeholders and centralization of clinical, administrative, information systems and finance. It also requires that patient populations are integrated. (NCIM, 2005; Wells, 2005). Examples of integration of health services include integration of primary care, specialty referrals, hospitalizations and prescription payment
sources or creation of a unified health system for the uninsured. Some integration efforts have been to create common diagnosis and treatment protocols among many clinics with assistance with support from such initiatives as the BPHC’s National Diabetes Collaborative.

Several governmental and non-governmental grant programs have provided funding to communities for programs that improve access to healthcare through community collaborations. The Communities Access Program administered by HRSA’s Bureau of Primary Health Care was established in 2000 to provide funding to assist communities and their safety net providers in “developing integrated health care delivery systems that serve the uninsured and underinsured with greater efficiency and improved quality of care (HRSA, n.d.).” In 2002, with the successful demonstration projects of CAP, the program was extended as the Health Communities Access Program. In order to receive funding from this program, communities must have at least one of each of the following participate in the consortia: a federally qualified health center, a hospital with a low-income utilization rate greater than 25 percent, a public health department, and a public- or private-sector healthcare provider or an organization that has traditionally served the medically uninsured and underserved. Expected results included coordinated care to underserved populations, increased access to primary care with reduction in hospitalizations, and elimination of duplication of efforts in service delivery and administration. An independent evaluation has not been completed to determine if these HCAP programs are effective and achieving results. The U.S. Office of Budget and Management and Federal Agencies (2005) cited the lack of evaluation, the presence of similar privately funded programs, and that the impact of many of the activities being
funded is not established as reasons for not funding this program for the fiscal year of 2006.

Turning Point, a grant program of the W.K. Kellogg and Robert Wood Johnson foundations, was a three year initiative “to strengthen the public health system in the United States to make the system more effective, more community-based and more collaborative.” Baxter summarized the key lessons from this project for public policy to include recognizing the need for direct and explicit support of partnerships, allow direct investment into community level capacity building based on community priorities, integrate partnerships into grant and funding strategies, increase skills of the public health workforce in communication and facilitation with non-governmental and non-health interests, and to model interagency and public-private integration at the federal and state levels (Baxter, 2002). These lessons learned have been used by the IOM to support their recommendations for health improvement efforts at the community level (IOM, 2003, p. 205)

Community Voices, an initiative of the W.K. Kellogg foundation, has a mission “to strengthen community support services and to help ensure the survival of safety net providers.” Community Voices sites have worked to fill in the service gap by providing direct services, to link people to coverage and care and to develop new community relationships and skills by, for example, forming integrated networks of providers. One example of integration in the Community Voices Initiative is the Voices of Detroit Initiative, which created an Integrated Services Delivery Network called the Uninsured Health System. In this “virtual HMO”, Detroit residents who meet a certain income requirement and do not qualify for Medicaid are enrolled and given a card to access a
network of providers. Services provided include primary care, dental, mental health and laboratory services at 15 clinics and 5 hospitals.

The Denver Health System is an example of an integrated public health system, where emergency (911) prehospitalization service, hospital, 10 community health centers 13 school-based clinics, the public health department, substance abuse and mental health treatment, a poison center, and advice line and a managed care insurance product are all linked (Gabow, 2003). Sources of funding include Medicaid, Medicare, CHIP, self-pay, insurance, managed care contracts, public health service grants, state indigent care funds, free drug programs, private foundations, CDC and many others. Benefits to the community include improved access to primary care, dental visits, specialty care. A single medical record is used by all clinics and the hospital so that care is efficient and safe. The system has been able to serve a larger percentage of uninsured patients due to subsidy from hospital revenue and the availability of hospital-related funding sources. The hospital has benefited from a decreased utilization of the emergency department for non-emergent care. The community health centers have improved access to funds. Employees have also benefited from higher than average salaries and improved benefit packages. Challenges of integration include administrative complexity. Sustainability is also challenged by growing costs of caring for the uninsured. Because this system was established in 1950, it has been able to grow in a coordinated way unlike many public health systems in the United States.

Project Access in Buncombe County, North Carolina has integrated health services to provide primary care to 15,000 uninsured residents. The Buncombe County Medical Society coordinates and staffs the project. Partners in the project include the
Buncombe County Health Center, Buncombe County Department of Social Services, area Hospitals, community based indigent care clinics, and area pharmacies. The project planning was funded by a Robert Wood Johnson Foundation community planning grant in 1994 and a three year implementation grant followed. Volunteer physicians see patients at existing public and philanthropic primary care clinics. Specialty referrals are coordinated and prevent recurrent visits because of unmet health needs. Hospitals provide lab, inpatient and outpatient services free of charge. Pharmacies provide medications at cost. Like the Detroit initiative, patients receive a card that gives them access to primary care and hospital services and prescription medications. Over $3.5 million in services are provided each year by physicians and other health care providers to uninsured community members. The county reallocated $600,000 from hospital emergency room care from the indigent to fund medications for uninsured residents and a computerized medical records system.

The benefits of this integrated system are seen by all participants. Physicians evenly share the burden and receive recognition from the community without becoming overwhelmed with patients calling for charity care. They also know that their time is well spent because patients get the needed medications, subspecialty referrals and diagnostic tests that they need. Hospitals have seen a downward trend in uncompensated care costs from $130,000 to $120,000 per month and decreased emergency department utilization. 80% of patients reported that their health was better or much better since enrolling in the program. Many of the patients reported that they were better able to work and subsequently became insured through new jobs.
Wells (2005) used the balanced scorecard to characterize benefits of integration. Based on previously published literature they constructed a scorecard that included the financial perspective (financial bottom line, asset utilization, leverage and public visibility), the customer perspective (patient acquisition/retention, morbidity and mortality, patient care quality, access to community health centers, access to other providers, and relationships with other providers), internal business process perspective (practice management, staff workload), and learning/growth perspective (capabilities of staff, collaborative skills and information systems, including benchmarking, consultative expertise, problem detection, motivation, empowerment, and alignment.) They analyzed these potential benefits at the clinical, managed care, and administrative level. In this study of 12 integrated functions across seven CHC-led networks around the United States, the authors identified a wide range of benefits to integration. Participants in this study felt that hospitals or states were benefiting from better primary care. Asset utilization was more efficient and staff time was freed for other purposes. Smaller organizations involved in integrated efforts commented on increased capacity. From the customer perspective, improved access was seen and patient care quality was improved but longer term outcomes such as reduced morbidity and mortality have yet to be studied. Administrative functions improved with integration decreasing staff workload and improving practice management. The learning and growing perspective showed the most benefit, likely because these integrative efforts are relatively new. In the Balanced Scorecard framework, it is the learning and growth that leads to improved internal business perspectives that leads to better service for customers, that then leads to improved financial outcomes. In order to be sustainable, outcomes of customer benefit
and financial benefit must be shown. Using this framework, integration efforts can be evaluated from a range of perspectives and evidence for processes that work may become more plentiful.

Because national focus has only recently turned to integration of health services to improve access, little in the way of empirical evidence regarding outcomes such as cost savings, improvement in quality of care, and improvement in health outcomes as been published. More research is needed to demonstrate those efforts that provide the most quality and access with the most cost savings. Sustainability needs to be demonstrated as well.

**The Chronic Care Model and Chronic Disease Management**

Improving Chronic Illness Care (ICIC) is a national program supported by The Robert Wood Johnson Foundation with direction and technical assistance provided by Group Health Cooperative's MacColl Institute for Healthcare Innovation. The Chronic Care Model was developed by the ICIC with input from national experts. In this framework, the community and its resources and policies and the health care system interact to improve health and functional outcomes. Patients are empowered and prepared to manage their own health care with internal and community resources organized to support them. The delivery system effective and efficient, supportive of evidence-based care, provides clinical case management for patients with complex needs and is culturally and linguistically competent. Decision support is given to providers in the form of practice guidelines and integrating subspecialty expertise with primary care. Clinical information systems are used to organize patient and population data to facilitate efficient and effective care. (Have asked permission for using the picture)
Disease management programs within insurance plans and used by many workplaces have less of the community emphasis of the chronic care model. The Disease Management Association of America (DMAA) defines disease management as a system of coordinated health systems which focus on chronic health conditions by supporting patient self-management and supporting the practitioner with evidence-based practice guidelines in order to improve quality of care. They emphasize prevention of exacerbations and complications. Components of disease management programs include population identification processes, evidence-based practice guidelines, collaborative practice models, patient education for primary prevention, behavior modification and compliance/surveillance, process and outcomes measurement, and routine reporting/feedback loop. Disease management is recommended for disease with high prevalence and for which well established practice guidelines exist, gaps in therapy are widely known, measurable outcomes exist, and cost savings can be demonstrated in a relatively short period of time ("Fact Sheet", n.d.). A review of recent published literature and results of an America’s Health Insurance Plan (AHIP) survey by Bayer et al. (2004) showed benefits of disease management programs in decreasing emergency department utilization, hospitalizations and, thereby, decreasing costs.

Disease management programs require collaboration from many service providers. Risk assessment generally determines need for case management, periodicity of practitioner visits, and education needs. Education can be done individually or with groups of high risk individuals by a health educator, nurse or dietician depending on needs or with printed educational materials. Models might include home visits for high risk individuals, a nurse advice line and follow-up phone calls after emergency
department visits or hospitalizations. Providers generally receive education regarding practice guidelines and are given feedback regarding their patients’ utilization of services and their management of certain chronic diseases, for example whether asthma severity was classified or prescription of controller medications in asthma. Information systems that ease communication between providers (i.e. computerized medical record), track and schedule patient appointments, remind patients of appointments, identify patients in need of disease management are also important.

The Chronic Care Model adds community resources and policies to the disease management strategy of most health care systems. Patients are encouraged to use effective community programs and partnerships with community organizations are encouraged to fill needed gaps in services. Disease management in community collaborations to provide health services will ensure quality and cost-effective care.

Changing Demographics and Health Care Access in Olmsted County

From the Olmsted County Community Health Assessment (2003), the population of Olmsted County grew from 106,470 to 124,277 or 16.7% from the 1990 census to the 2000 census and growth continues at a fast pace. The Rochester-Olmsted Planning Department projects that the population will grow to 170,530 by the year 2030. Racial and ethnic minorities make up a large proportion of population growth with a 180% increase the minority population from 1990-2000. Minorities now make up about 11% of the total population. 9% of children enrolled in Rochester public schools are enrolled in ESOL programs, with 58 countries of origin represented. During the 1990’s, employment in Olmsted County increased 50% faster than the national rate. While household incomes
in Olmsted County exceed national and state median incomes, poverty affects 6.4% of the population. Estimates of minority children living in poverty are as high as 28%.

Strengths of the community identified by the assessment included a strong economic base, low unemployment, excellent medical services and good public infrastructure. The key informant survey identified significant unmet needs to be medical and dental services for those low income residents as well as services for the working poor. Barriers to residents and agencies include language, religious and cultural barriers and lack of funding for important services and programs.

From 2001 to 2004 uninsurance in Minnesota increased from 5.7% to 7.4%. 11.2% of Minnesotans were uninsured for some part of the year in 2004. Disparities in health coverage by ethnicity exist and the uninsurance rate of Hispanic/Latino Minnesotans grew significantly over this time period. In southeast Minnesota, over the same time period, group insurance rates decreased 2%, public insurance rates increased 2% and uninsurance rates increased by 2%. Uninsurance rates are much higher for lower income individuals than for those with higher incomes. (10.2% vs 3.2%) and are also higher among 18 – 34 year olds than older adults (15.6% vs. 6%). While these numbers are small when compared to national uninsurance rates, the trend is likely to continue as unemployment rates increase and people are increasingly employed by mid-size employers who do not offer health insurance because of rising healthcare costs.

Olmsted County Safety Net Integration
Health care access issues in Olmsted County are small relative to many communities in the United State but are very real to many residents. Current trends of rising uninsurance rates, disparities in economic prosperity of minority populations, and population growth at rates that may exceed economic growth mean that Olmsted County must build infrastructure and capacity to support the changing needs of our community now.

In Olmsted County, safety net services in the community include the Good Samaritan Dental and Medical Clinics organized by Salvation Army, the Hawthorne Education Center, Olmsted County Public Health Clinics, IMAA (Intercultural Mutual Assistance Association) Community Health Worker Program and Chemical Dependent Prevention Program, Office of Diversity, and Migrant Health. These organizations have missions to provide services for vulnerable populations, but generally have significant limitations to what they can offer. For instance, the dental needs met by the Good Samaritan Dental Clinic are not preventative and the Good Samaritan Medical Clinic is only able to provide limited services for chronic diseases such as hypertension and diabetes. The populations served by clinics may also be limited by missions to treat specific segments of the underserved. The Olmsted Medical Center and Mayo Clinic hospitals and emergency departments are important stakeholders in the Olmsted County safety net as they provide non-reimbursed medical care to vulnerable populations.
The framework for community collaborative action put forth by Fawcett and colleagues in 2000 is made up of five key components (see Figure 1). The components of this process do not always occur sequentially as depicted in the diagram. In the case of Olmsted County, health care access for vulnerable populations has been identified as a priority health issue. The Health Care Access Task Force is in the planning phases of identifying actions to improve access. An integrated single site for health care and health care related services is the proposed model for improving access. Implementation of such an action would clearly occur in parallel with changing community conditions and systems, which involves changing aspects of the social, organizational and political environments that contribute to health problems. (page 194) Once such a site is established with multiple collaborating partners, the behaviors of those seeking care and the risk factors associated with poor health outcomes in vulnerable populations would be changed. Finally, the community's health would improve.

At the center of the proposed integrated system for delivering health care to the underserved in Olmsted County is a single site community health care center. Within this center, patients will have access to primary care and chronic disease management, mental health services and oral health services. All community organizations currently providing safety net services to the under- and un-insured will be invited to provide services within this center. Health service related activities including assistance with
applying for state insurance programs and disability benefits based on eligibility will also
be offered. Uninsured individuals will periodically be reassessed for eligibility for
governmental insurance programs. The center will address barriers to access such as
transportation, language barriers and health literacy. Chronic disease management and
primary care will be provided by the many health care providers employed by Mayo
Clinic and Olmsted Medical Center. The site will serve as a portal of entry into
secondary and tertiary care at Mayo Clinic. While a single integrated site may meet
community access needs now, it is likely that a community-wide network of sites may
eventually be needed as health care access needs of the community are growing. As with
the Denver Health System, infrastructure building now will make continued coordination
and integration possible over time.

Integration requires an integrated workforce and integration of the patients served
by the system. Partnering organizations will contribute to the program in their respective
areas of expertise. However, so that efforts are not duplicated within the system,
workforce training may be necessary to broaden scopes of contributions. Similarly,
organizations will no longer be providing services to a designated segment of the
community but may provide services to all underserved segments. For instance,
Hispanic/Latino migrant workers may be cared for by those that have traditionally cared
for Somali refugees. Integration requires that the fragmented system come together into a
better whole.

Financially, this system of integrated safety net services is most viable if funding
streams are largely local. As with CAP/HCAP, funding from the government in times of
financial stress is not reliable. Program planning and implementation grants may help get
the program started but sustainability will rely on community resources. Mayo Clinic, the county’s largest employer and health care provider, and Olmsted Medical Center would benefit by contributing to this system for many of the reasons stated earlier, including a healthy community and decreased uncompensated care costs. Those private nongovernmental organizations that provide free care will benefit by contributing as they will be able to offer more comprehensive services for the patients that they serve. The county and its health department will benefit by contributing funds as improved care for the indigent means a stronger, healthier community. As a goal of the clinic will be to get people insured either through the workplace or through public programs, insurance will also be a source of funding.

Within the community health improvement framework, accountability and shared responsibility are paramount. All stakeholders involved in the improvement process share responsibility for improving the health of the community’s population. Stakeholders must recognize their function in the larger system as performance monitoring is planned. Accountability of the organization to the community may be ascribed to its leadership. A Community Advisory Board might be established to make recommendations for improvement and to review performance of the organization. The Agency for Healthcare Research and Quality (AHRQ) has collaborated with physician organizations and health insurance plan representatives as the Ambulatory Quality Alliance to create performance measures that will inform consumers regarding health care quality and will improve health outcomes. Other measures from the National Healthcare Disparities Report could be used to monitor access to care within the community.
Challenges that Public-Private Partnerships

Weiner (1998) identified key challenges to governance of public-private partnerships based on the experiences of 25 community health public-private partnerships participating in the Community Care Network (CCN). Community stakeholders involved in these partnerships included hospitals, local health departments, clinics, physician groups, churches, insurers, schools, social service agencies and community service groups. Three issues emerged from interviews and focus groups: managing turf issues among partner organizations, defining and incorporating community accountability, and coping with partnership growth and development.

According to Weiner, partnership governing bodies rely on mutual benefit and reciprocity to achieve coordination and benefits must be mutual to the partner and the partnership. Participation levels of partnering organizations vary with level of effort and resource commitment. Challenges to managing turf issues were addressed by adopting a shared vision and requiring credible commitments. Some partnerships chose projects so carefully in order to prevent turf issues based on diverging interests. However, this strategy may prevent the most efficient and socially beneficial project. Conflicts were dealt with using interpersonal trust and accommodation which can lead to perception of favoritism and can prevent the partnership from achieving its mission and goals.

Community accountability is a second issue of governance addressed by Weiner. The partnership must know what community voices truly represent the needs of the community. Decision-making becomes less efficient as more opportunities are made for community members to be heard. The partnership must remain responsive and
accountable to the community but must make decisions to move forward in a timely manner.

Weiner also addressed growth and development in terms of how partnerships formulate policies, define roles and responsibilities, create identity and establish legitimacy. A formal governing board structure by organizing partnership as a corporation was the most common way to accomplish these growth and development issues in CCN partnerships. Problems seen with more formal organization of partnerships included incorporating the community's voice into issues of governance and less flexibility and openness. Sustained collaboration of partners with diverse interests "requires establishing a working context that preserves and respects individual differences in organizational perspectives, culture, and competencies, yet also promotes a sense of unity or coherence in the partnership (Weiner, 1998)."
References:


