Tools for Healthy Communities:
North Dakota’s 2nd Annual
100% Access Health Care Summit

October 26, 2006
Radisson Hotel, Bismarck, ND

SUMMIT REPORT

With support from:

Sponsored by Healthy North Dakota with the support of a HRSA State Planning Grant through the North Dakota Department of Health and a HRSA Technical Assistance Grant through Dakota Communities Access Program, Dakota Medical Foundation. Support also from Blue Cross Blue Shield of North Dakota, Community Healthcare Association of the Dakotas, North Dakota Healthcare Association, St. Alexius Medical Center, and Northland Healthcare Alliance.
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INTRODUCTION

“Tools for Healthy Communities”

North Dakota’s 2nd Annual 100% Access Health Care Summit was held in Bismarck, ND on Thursday, October 26, 2006. The purpose of this statewide event was to encourage the development and progress of local coalitions to develop community approaches to resolve the issue of those without health insurance. This one-day event was packed with wonderful speakers from our state as well as speakers from, DuPage County, IL and Muskegon, MI.

This statewide campaign brought together more than 65 healthcare professionals, elected officials, and local community members. The participants looked at health care access issues confronting North Dakota and identified potential community-based solutions that could be built into a powerful portfolio of activities to achieve 100% health care access.

The Summit was a highly interactive event with speakers and breakout sessions for the participants. The purpose of each of these sessions was to brainstorm ideas and solutions and to identify strategies to develop and implement these community-created ideas and solutions.

WELCOME

John R. Baird, M.D., Local Health Officer, opened the Summit with a welcome to all and a call to action. He gave a brief overview of the problem facing North Dakota and acknowledged the importance of convening this group to work on this growing problem.

Eric Monson, Novus, LLC, was the facilitator for the day’s event. He started by giving an overview of the agenda and encouraged the group to find action items in the day’s events that they could take back to their communities and implement.

ACCESS DUPAGE TOOL KIT

Richard Endress, President, Access DuPage, DuPage County, Illinois

Access DuPage is a collaboration among a number of healthcare providers and organizations. The program is open to residents in the county that have no insurance and have a household income 200% below the poverty level. Enrollees of the program are provided a primary care home and primary care physician services. Physicians agree to accept a defined number of members into their practice for free or small capitation fee. Specialty physicians agree to accept a defined number of pro bono referrals each year. Local government provides some funding. Access DuPage acts as a central hub to streamline the care of people without insurance and to distribute the load evenly throughout the medical community.

Please refer to PowerPoint presentation in Appendix.
Discussion groups made up of Local Coalitions

Question 1: Have we identified the uninsured in our area?

- If not, how can we accomplish?
- What tools do we need?

A. Healthcare providers know “who” their uninsured’s are.
(3)
B. Several studies provide data – not conclusive. (3)
C. County breakdown – Hipsa (2)
D. We can assume that percentage of uninsured is actually higher.
E. Manpower was stated as a barrier for identifying uninsured (to compile). In one area, there is only one physician to provide service.
F. Estimations for state done MA surveys; varying results, question reliability.
G. Has this population been well defined?
- poverty level
- voluntary decliners of insurance?
- IHS enrollees

Local community information.
Use 12 community health centers around state (community based solutions depend on community based data).
H. Free or reduced meal programs in schools.
I. Most seen as a problem:
  a. Mental health issues
  b. Farm families with ineligible transfer of assets – not eligible for MA (NH care)
J. Just starting to look at HCBS and continuum of care.
K. Tools:
  a. State data from Caring Program, Healthy Steps, etc.
  b. School lunch program
  c. Public Health
  d. Percentage of people at or below 200% poverty level
L. 10,000; 1,000 children (estimated uninsured)
M. How to market to them, esp. age 18-64, especially men?
N. Current efforts:
  a. St. Alexius/Primecare Task Force for Bismarck-Mandan Companies.
O. Each healthcare facility and each county has accurate estimate of uninsured. Previous surveys should provide.
P. Tony suggested tribes should provide health insurance for their members. Brenda referred Tony to Shakopee, MN for a program.
Q. Tony had one year grant to survey CCC College staff and students, estimating 68% uninsured.

Question 2: What tools do we need?

A. Answer – somewhat! More collaboration and communication would be beneficial. (2)
B. Community leaders probably not. (2)
C. Healthcare providers more so.
D. Huge financial toll on medical centers.
E. Overuse of high-cost care such as emergency room.
F. The eligibility guidelines of coverage programs are not widely known – many families aren’t aware.
G. North Dakota has very few programs and services for adults.
H. Yes
I. Majority, No
J. 75% of what is done in Harvey is Medicare.
K. Until we advocate for them we will not be aware.
L. Decision makers feel everyone has access and has adequate income – don’t want to talk about this.
M. Inter-generational farming situations – land belongs to parents; need LTC; younger generation suffers.
N. A concern is those individuals who are fragile medically but haven’t qualified for disability yet.
O. Primary Care Physicians – not fully supportive of services for uninsured.
P. Legislators – premium rates of small businesses are too high, and they must pay for uninsured.
a. Some younger uninsured do not take
Q. Only on a small scale. Actual documentation from facilities and statistics needed.

Question 3: Does the Access DuPage Program offer a framework for us?

A. Liked the idea of shared care.
B. Non-threatening
C. MN state law prohibits sharing of information without consent – ND okay to share for taxes.
D. Seeing less “rule out” diagnosis
E. Need to get ND support
F. Need community coalitions
G. Somewhat, but modification is needed. We do not have the number of physicians, etc.
Maggie Anderson, Director of Medical Services for the North Dakota Department of Human Services. Maggie’s presentation included what is currently going on in areas of disease management, managed care, and the initial impact of Deficit Reduction Act (DRA). In the future, the Department will be waiting for final legislative decision about the Medicaid Management Information System and will continue to work on the impact of the DRA.

Kim Randell, Director of Caring for Children, presented “Healthy Steps, Caring Program.” Kim represents the private side of a public/private partnership. This partnership is made possible by a Robert Wood Johnson grant. The grant allowed for one toll free helpline for all three programs: Medicaid, Healthy Steps and Caring for Children. It also means one application and one computerized eligibility system for all three programs. This includes outreach strategies that were put into place in schools, clinics and in partnerships. Caring for Children provides medical, dental, mental health care services to uninsured children from birth to 19 who do not qualify for government-funded program. Yet their families cannot afford private insurance. The program started in 1989 by Blue Cross Blue Shield in an effort to provide primary and preventative care to uninsured children. Kim described Caring for Children as a 3-legged stool. Participating providers agree to accept 50% of usual rate, BCBS pays all administration costs and contributors donate funds to pay premiums of enrolled children. All 3 legs are vital for this program to stand.

Sharon Ericson, CEO of Valley Community Healthcare Centers, Northwood, ND presented, “Community Health Centers: New Tools in an Old Box”. Her presentation described Community Health Centers (CHC’) and how Valley Community Health Centers have benefited from being a federally funded CHC. CHC’s must serve a medically underserved population, providing comprehensive primary and preventive healthcare. They must be governed by a community based board of directors, with the majority of the board members being users. The comprehensive primary care must include some access to pharmacy and outreach transportation services. A federal grant assists the management and finance of the facility. She then described Valley Community Health Centers including the barriers to access that it must overcome, the disparities that they treat, the accountability that they must produce, the collaboration and the disease management tools they use.

Please refer to PowerPoint presentation in Appendix.

Three Share Plan

Gary Packingham, Vice President of the Community Health Ventures, a wholly owned subsidiary of the Muskegon Community Health Project, Muskegon, MI

Gary presented a talk after lunch on multishare health coverage. He began his discussion with a description of the uninsured population in North Dakota and the cost shifting that takes place to pay for costs of that population. This included impact on business and government. He then described a community solution to expand health care coverage, which can be called a three share or a multishare product. Access Health in Muskegon, MI is an example of such a model; it includes public subsidy and member contribution. There is community governance of the program and a care management model. This includes clinical providers as well as community resources. An example was given of the financing of their multishare program which includes one-third share of the cost contributed by the employer, one-third by the employee and one-third by the community. In his example, it was $50 for the employer, $50 for the employee and $65 for the community share for a monthly cost per person of a $165. He then gave examples of their health coverage benefits that are provided and the co-pay that is expected and the medical claims that they have encountered on a per member per month basis for 2004 and 2005.

Please refer to PowerPoint presentation in Appendix.
Community Engagement

Terry Dwelle, North Dakota Health Officer

Dr. Dwelle gave a stimulating presentation on the principles of community engagement, basing the process on community needs. The community owns the process which makes it sustainable and comprehensive which should be culturally appropriate. It can be facilitated by outsiders but should rely on community members to identify their needs and the projects they wish to work on. He described training that has been available through Healthy North Dakota for community engagement facilitators and welcomes interested parties to contact himself or Melissa Olson, Director of Healthy North Dakota.

Discussion groups made up of Local Coalitions

**Question 1: Does the Three Share program from Muskegon, MI offer any possible solutions for us?**

A. There is some merit in the concept.
   - Employer
   - Employee
   - Providers
B. We would consider some local government funding as a four-share model.
C. Would work well to put money into a shared pool.
D. Receive some slow pays instead of none.
E. Some source of some income.
F. How does 3 share work for the farmer? Farmer would contribute.
G. Yes. It does offer possible solutions. However, may need to be more flexible with qualifying criteria, i.e., farmers – good crop and good income one year, no income the next, they would not qualify to apply.
H. Creative approach to cost sharing for insurance – example: Hettinger farmers joined together to get insurance where farmers/health community/? Share cost of insurance.
I. We are not sure? What are DISH dollars and who in our state would be the 3rd player/payor?
J. Raise awareness of current health insurance premiums -- dollars used to cover uninsured.
K. Targeting adults 18 – 64
L. Premium as affordable as possible.
M. Engages the business community.
N. 2 programs – 1) homeless/uninsured – 2) non-homeless/uninsured
O. We are a dynamic community – not too many closures.
P. Lower cost services are incentivized.
Q. Can transfer between employers (?)
R. Funding, was it started through a grant?
S. Following years funding three businesses.
T. Possibility of working in our community, may or may not work or would the area say they have their own health care system, do we need to provide a system such as the Native American community, they are a nation in their own.
U. Casino was started to benefit Native Americans.
   - Idea stated to have premiums paid by tribes for health care insurance premiums.
V. More of a state-wide subsidy, because we are so rural in ND.

**Question 2: What steps should we take to engage our community/communities within the influence of our coalition?**

A. Raise level of awareness of “need”. Utilize faith community, medical community, media campaigns. (4)
B. Connect eligible families to coverage programs that already exist.
C. Put a “face” to problem. Use real stories of representative folks.
D. Increase levels of eligibility to provide options for a broader group.
E. Investigate funding options to cover costs of education, coverage.
F. Have a vision and educate (2)
G. Find a champion to stick their neck out (some communities have clinic and hospital and are not willing to get together and discuss healthcare).
   - Retiree champion: for example – Dick Tschider, other highly visible former business representatives.
   - Identifying small business that are interested.
   - Primary care physicians, dentists, opticians, need to be engaged.
   - Dick Hedahl = business rep/champion. Also is good example of preventive care.
   - Meet with community leaders.
H. Agree to disagree.
I. Sharing information/best practices.
J. Discuss change and prove to business or boards what financial benefits will be – “what’s in it for me?”
K. Town hall type meetings.
L. Major employers have insurance coverage here.
M. Considered “personal problem” by many.
N. Surveys – UW, St. Alexius, CH – indicate that “uninsured” is a priority health issue.
O. Read Greater North Dakota chamber of commerce news to see their perspective on legislative issues.
P. Chronic disease management – representatives needed on task forces.
Q. Ask them about a tri-share option.
R. Rural areas with the lack of health care providers, need to combine as a community and define the need.
S. ND is an aging population, they feel like everyone should earn their own way.
T. Impact Foundation in Fargo, possibly an area to draw that pool of monies. Improve dental, nutrition.
U. Need to improve Native American population health care, possibly through casino dollars.

Question 3: What tools and information do we need to accomplish community engagement?

A. Trained facilitators. (2)
B. Community Champion.
C. Gather community agencies together, develop a main goal.
D. Cooperation of community.
E. Utilize community leaders that have third generation linkage.
F. Resources to spend time in each “community”, i.e., University (UND community development students).
G. Understanding of the process.
H. Ground Rules.
I. More time and funding.
J. Ask Gary Garland about employer (esp. small business) survey results?

Governor’s Perspective

Duane Houdek, Health Policy Advisor and General Council for the Governor

Mr. Houdek brought greetings from the Governor. He described the governor’s office support for our activities and their interest in seeing preventive and affordable healthcare for North Dakota.

State Legislative Panel

The Legislative Panel consisted of: Senator Tom Fischer (R) Fargo – District 46; Senator Larry Robinson (D) Fargo – District 24; Representative Clara Sue Price (R) Minot – District 40

Each Legislator provided their views on access to healthcare and issues that may rise in the upcoming legislative session. They answered questions from the audience.

Healthy North Dakota

Melissa Olson, Director of Healthy North Dakota

Melissa described Healthy North Dakota as an initiative that was begun by Governor John Hoeven. It now represents a large group of people from around North Dakota working in a number of priority areas, under various committees, coalitions and focus area groups. The North Dakota Department of Health provides liaisons to the various committees. Some links that could develop between those interested in 100 percent healthcare access could be with committees such as the Healthy North Dakota Community engagement committee, Health Disparities committee, Worksite wellness committee, and the new group that is being facilitated by Healthy North Dakota looking at the healthcare delivery system in North Dakota.
Discussion groups made up of Local Coalitions

Question 1: What Healthcare issues to be addressed legislatively might help our local/regional coalition?

A. More coverage for preventative screenings.
B. Need mental health care in schools.
C. Education at early age in grade school.
D. New emphasis on prevention.
E. Increased access to addition counseling – not enough LAC’s in the state - ? incentives.
F. Phone bank of all resources within a community.
G. Increased funding for preventive services – education to the public.
H. Collaboration efforts – support at local level.
I. Single point of entry
J. Very young children’s health:
   – legislative priority – example: health training – day care providers = license required
K. Pro bono reg. legislate.
L. Addiction and Meth education/prevention provided at our schools (elementary).
   • Also alcohol, gambling

Question 2: How might Healthy ND help our local/regional coalition?

A. Providing dollars.
B. Not sure what they are, sorry. Tell us more.
C. Offer a facilitator to come into our communities to help with engagement.
D. Create a plan that can be used in all communities.
E. Diabetic educators.
F. Fund Women’s Way.
G. “It is us” = reciprocal help – information/distribution
H. Increased access to addiction counseling:
   – not enough LAC’s in the state - ? incentives
I. Phone bank of all resources within a community.
J. Increased funding for preventive services:
   – education to the public.

Question 3: What three steps should we take to strengthen or initiate development of our coalition when we get back home?

A. Reconvene group:
   • Prepare to be a resource for local communities.
   • Communicate -- by January.
   • Identify and bring in new players.
   • Identify community within the coalition.
   • Talk to others about the information shared here.
   • Designate persons within our organizations to serve on coalition.
   • Identify meeting dates for coalition.
   • Coalition meeting: Brochure, next steps, business champions, add members.
   • Find a facilitator to coordinate event and generate enthusiasm, etc.
B. Evaluate the assets available and existing data.
C. Define the problem and suggest.
   i. Potential solutions
   ii. Prioritize solutions
D. Encourage local communities to address these issues.
E. Need a strategic plan.
F. Is there some direction/guidance?
G. UW – basic needs
H. Chamber of Commerce involvement.
I. June’s ideas/experience – what can they teach us?
J. Get MD, dentist, optometrist
K. Increase community education.
L. Identifying an interest group.
M. Conduct survey for additional interest in community/area.

Wrap Up

A leader’s coalition will continue to meet periodically in the next year. Anyone is welcome to join the group. Potential legislation will be considered by that group. Local coalitions will be encouraged to continue their work.
## PowerPoint Presentations

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- **“ReTooling” Medicaid** – Maggie Anderson, Director of Medical Services for the North Department of Human Services  
  16-20

- **“Community Health Centers – New Tools in an Old Box”** – Sharon Ericson, CEO of Valley Community Healthcare Centers, Northwood, ND  
  21-29

- **Multi-Share Health Coverage** – Gary Packingham, Vice President of the Community Health Ventures  
  30-37

- **“Community Engagement Concepts”** – Terry Dwelle, North Dakota Health Officer  
  38-43

- **“Healthy North Dakota”** – Melissa Olson, Director, Healthy North Dakota  
  44-51
Finishing North Dakota’s Health Care System: The Gaps in Access, Health Status & Quality

John R. Baird, M.D.
State Medical Officer

October 18, 2005

Access
Percentage and number of the uninsured in North Dakota

- 8.2% of North Dakotans are uninsured
- 51,920 people
  - Similar to the population of Bismarck

North Dakota Household Survey – Feb-Mar 2004
By UND Center for Rural Health funded by HRSA State Planning Grant
Health Insurance Status by Gender

<table>
<thead>
<tr>
<th></th>
<th>Insured</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>90.4%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Female</td>
<td>93.2%</td>
<td>6.8%</td>
</tr>
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Health Insurance Status by Age Group

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<thead>
<tr>
<th>Age</th>
<th>Insured</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>91.9%</td>
<td>8.1%</td>
</tr>
<tr>
<td>18-24</td>
<td>84.1%</td>
<td>15.9%</td>
</tr>
<tr>
<td>25-34</td>
<td>90.6%</td>
<td>9.4%</td>
</tr>
<tr>
<td>35-44</td>
<td>91.5%</td>
<td>8.5%</td>
</tr>
<tr>
<td>45-54</td>
<td>91.1%</td>
<td>8.9%</td>
</tr>
<tr>
<td>55-64</td>
<td>92.8%</td>
<td>7.2%</td>
</tr>
<tr>
<td>&gt;64</td>
<td>98.6%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
Health Insurance Status by Race/Ethnicity

- Caucasian: Insured 93.1%, Uninsured 6.9%
- Native American: Insured 68.3%, Uninsured 31.7%
- Other: Insured 83.3%

* IHS is not considered an insurance, rather a provider of last resort

Health Insurance Status by Marital Status

- Widowed: Insured 4.8%, Uninsured 95.2%
- Separated: Insured 24.1%, Uninsured 75.9%
- Divorced: Insured 15.7%, Uninsured 84.3%
- Living with Partner: Insured 21.9%, Uninsured 78.1%
- Married: Insured 5.1%, Uninsured 94.9%
- Single: Insured 16.0%, Uninsured 84.0%
Health Insurance in North Dakota

Employment Status

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Uninsured</th>
<th>Insured</th>
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<tbody>
<tr>
<td>Self Employed</td>
<td>3.8%</td>
<td>96.2%</td>
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<tr>
<td>Employed by Someone</td>
<td>6.7%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Homemaker</td>
<td>6.0%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Full-time Student</td>
<td>6.4%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Retired</td>
<td>10.6%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>21.3%</td>
<td>78.7%</td>
</tr>
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</table>

Health Insurance Status by Size of Firm (those employed)

<table>
<thead>
<tr>
<th># of Employees in Firm</th>
<th>Uninsured</th>
<th>Insured</th>
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<tr>
<td>1</td>
<td>21.3%</td>
<td>78.7%</td>
</tr>
<tr>
<td>2 to 10</td>
<td>10.6%</td>
<td>89.4%</td>
</tr>
<tr>
<td>11 to 50</td>
<td>6.4%</td>
<td>93.6%</td>
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<tr>
<td>51 to 100</td>
<td>6.0%</td>
<td>94.0%</td>
</tr>
<tr>
<td>101 to 500</td>
<td>6.7%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Over 500</td>
<td>8.6%</td>
<td>96.2%</td>
</tr>
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</table>
Are you offered health insurance through employer or union?

- Yes: 15%
- No: 52%
- Don't Know: 4%
- Not Applicable: 29%

Do you have access to health insurance through your spouse?

- Yes: 10%
- No spouse: 40%
- Spouse not employed: 4%
- Uninsured: 46%
3 Geographic population groups

- Urban (greater than 16,718)
  - Bismarck, Fargo, Grand Forks & Minot
- Large Rural (5,000 to 16,717)
  - Devils Lake, Dickinson, Jamestown, Minot
  - AFB, Valley City, Wahpeton, & Williston
- Small Rural (under 5,000)
  - Remainder of the state

Where do the uninsured reside?

- Urban: 18,498 - 36%
- Large Rural: 10,303 - 20%
- Small Rural: 23,120 - 44%
Uninsured by Age/Geographic Area

<table>
<thead>
<tr>
<th>Age</th>
<th>Small Rural</th>
<th>Large Rural</th>
<th>Urban</th>
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</thead>
<tbody>
<tr>
<td>0-17</td>
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<td>3177</td>
<td>183</td>
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<td>18-24</td>
<td>2614</td>
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<td>25-34</td>
<td>3303</td>
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<td>35-44</td>
<td>4993</td>
<td>1407</td>
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<td>45-54</td>
<td>3587</td>
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<tr>
<td>&gt;64</td>
<td>1040</td>
<td>1,154</td>
<td>1,154</td>
</tr>
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Why not buy insurance on your own?

- Do not need: 5%
- Could not afford: 76%
- Rarely sick: 2%
- Other: 17%
How many miles do you travel to receive health care services?

- 58.3%: 5 or less
- 11.5%: 6 to 10
- 9.2%: 11 to 20
- 12.6%: 21 to 50
- 6.4%: 51 to 100
- 2.0%: 100 or more

All respondents

Health Status
Health Status Consequences - Uninsured

- Worse clinical outcomes for chronic diseases
  Diabetes, CV disease, Mental illness
- Decreased life expectancy

Source: Insuring Americas Health, Principles and Recommendations, IOM 2004

Perceived Health by Insurance Status

![Bar chart showing perceived health by insurance status](chart.png)
Consequences - Uninsured

- Receive fewer services or no care at all
- Less likely to receive preventive services
- Medical bills - a factor in half of bankruptcies
- Uncompensated care – $35 billion annually

Source: Insuring Americas Health, Principles and Recommendations, IOM 2004
North Dakotans Indicating a Regular Place for Health Care

Are you confident that you can get health care when you need it?

North Dakota Department of Health
Uninsured

- 8.2% - 51,920
- 31.7% of Native Americans
- Male, not married
- Young adults & children
- Lower income
- Employed (71.7% of uninsured)
  - small firms
- Poorer health status
- Lower quality care
Health Insurance in North Dakota

October 18, 2005

North Dakota Department of Health

Patchwork of Healthcare Coverage
North Dakota

FPL
300%
200%
140%
133%
50%

Caring Program

Healthy Steps - SCHIP

Medicaid

Pregnant Women, Children (Age 0-5)

Medicaid

Children (Age 6-19)

Medicaid

Non-pregnant Adults

Medicaid & Medicare

Aged, Blind, Disabled

Medicare Only

MediGap

Comments are welcome. Contact:

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701-777-3848
http://medicine.nodak.edu/crh
One Community’s Journey
Reaching 100% Access
In
Muskegon County, Michigan
The good news....

The world is not flat;
There are no sea monsters;
It is still possible.....
to be a pioneer
COLLABORATIVE DECISION MAKING

- Over 800 volunteers since inception
- Groups come and go
- Manage up to 14 planning groups in a year
- Community identifies the issue - not top down!
- Board of Directors maintains governance
- Endorsing Organization: 100% Access/0 Disparity

Muskegon’s Medical Homes
100% access for low income populations

- Working Uninsured
- Unemployed
- Uninsured
- Medicaid
- Indigent

30% of Poverty

- County 3-Share Plan
- FQHCs
- County Indigent Plan
It is difficult, if not impossible to persuade and motivate people to solve a problem if they do not know they are unhealthy or how poorly their health compares to all state residents…EPIC/MRA REPORT ‘96

THE ENVIRONMENT WE FOUND

• Hospital merger creates two camps of competition
• Weak medical societies
• Two hospital affiliated clinics
• No marketing for decision making
• Opposition from stakeholders
What We Learned in 1997 - Muskegon Values Coverage

Determine strength of political will ....

97% All children should have access to care
92% All people should have insurance or coverage
81% Any reform effort should include health coverage

Identify Economic Self Interest

76% If affordable health coverage is available, more businesses will locate here.

69% If health care costs too much, businesses won’t locate here.

67% Businesses are less likely to come here if we have a higher sickness or disease rate.
Four Strategies for Change

- Enrollment Maximization
- Capacity Expansion
- New Programs
- Health Improvement

Staff and volunteers maintain community visibility through outreach and event participation -

- Healthy People 2010
Enrollment and Access to Care

Single Door Enrollment Assistance

- Medicaid enrollment
- MIChild/Healthy Kids - Ranked Fourth
- Maternity Outpatient Medical Services Program
- Food Stamp Assistance Program – 3 counties
- Diabetes Retinopathy Program
- Renew Student Vision Program
- Translation Support

Capacity Expansion

- 2 – FQHC’s – 30,000 visits
  - Primary Care
- Oral Health Clinics –
  - 20 operatories
  - 100 people a day
Dental Coalition outcomes:
- Triple dental capacity
- U-M Partnership
- Head Start compliance
- County Coordinator
- Miles of Smiles
- Regional Expansion
- New focus populations

Access Health
Business Coverage & Muskegon Care
Muskegon’s Community Plans

Access Health, Inc.

Community Governance

Provider Contracts

3-Share Access Health

I-Net

Muskegon Care

Muskegon Community

HEALTH PROJECT

Access Health Market

- 500 local businesses
- Full and part-time employees
- Children ages 19 – 23
- Identify government coverage
  - Medicaid (Healthy Kids)
  - SCHIP (MIChild)
- 3-5 applications per week
Eligible Businesses

- Located in Muskegon county
- No health insurance for 12 months
- Median wage of $11.50 per hour

Access Health Accomplishments

- 1,500 people served in ’04 – over 430 businesses
- 97% of all local physicians participate
- 38% of market penetration (eligible businesses)
- $2.3 million generated annually for health providers
- Hundreds of children identified and enrolled in SCHIP/Medicaid
Muskegon Care

**Low Utilization**
50% of members are typically short-termed unemployed

**Moderate Utilization**
30% are generally longer termed unemployed

**High Utilization**
20% are chronically diseased and unemployable

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**Muskegon Community HEALTH PROJECT**

**Muskegon Care**

**PLAN DEMOGRAPHICS**
- Annual plan enrollment of about 2200
- 20% are chronically ill members
- 50% of costs are for pharmaceuticals
- 10% of patients costs 67% of all drug expenses
Going Beyond the HMO Finance Model

Community Ownership Benefits

**Financial Benefits**
- Control of eligibility
- Medical utilization control
- Drug utilization control
- Lower-cost community health service partnerships
- Reduced admin cost
- Lower claims payment costs

**Health Benefits**
- Intensive case management of chronically ill patients
- Identification of disabled for Federal Medicaid enrollment
- Improved diagnostic tools
- Quality of Life monitoring

Muskegon Community
HEALTH PROJECT

Muskegon *i-Net* Software

- Internet-based case management
- Local claims payment service
- Community-based treatment
- Tracks utilization and costs
- Health improvement evaluation
**Health Improvement – Education and Screening**

- Stanford Chronic Disease Self Management Program
- Oral Health Screening
- School and Community Tobacco Health Education
- Pulmonary Screening
- School and Community Asthma Screening
- Diabetes Screening and Supplies
- African American Prostate Screening
- Stay Active Muskegon – pedometer program

**Diabetes Network outcomes:**

- 12,000 screened in community
- Common protocols developed
- Community education
- African American intervention
- Pharmacy partnership
- Annual Walk for Diabetes
- Annual African American Conference
Muskegon’s Building Blocks to Coverage

<table>
<thead>
<tr>
<th>Program</th>
<th>Income Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access Health</strong></td>
<td>300% of FPL (federal poverty level)</td>
<td>Muskegon’s 3-share health coverage program targets working uninsured individuals and area small businesses. 420 businesses - 38% market penetration; 1,500 people served. $2.3 million back to providers.</td>
</tr>
<tr>
<td><strong>Muskegon Community Health Project: MIChild/Enrollment Maximization</strong></td>
<td>200% of FPL</td>
<td>Enrollment program to maximize coverage of children eligible for the MIChild (SCHIP). Children enrolled via Access Health, MCHIP single door, presumptive eligibility w/schools. Ranked 4th in state for online assistance.</td>
</tr>
<tr>
<td><strong>Muskegon Community Health Project: Medicaid/Enrollment Maximization</strong></td>
<td>Low-income adults @ 150% and Children@ 185% of FPL</td>
<td>Single door review and enrollment/referral at Muskegon Community Health Project; Medicaid now 20% of county population. Direct referral to FQHC &amp; private physicians. Concurrent Bridge Card screening.</td>
</tr>
<tr>
<td><strong>Community Health Centers: Hackley Community Care &amp; Muskegon Family Care</strong></td>
<td>150% of FPL &amp; below</td>
<td>2 FQHC’s with combined capacity of 30,000. Medical care for Medicaid, uninsured and indigent people. 20 oral health operatories. 340B &amp; hospital pharmacy programs. Enrollment partnership.</td>
</tr>
<tr>
<td><strong>Muskegon Care</strong></td>
<td>30% of FPL</td>
<td>Indigent individuals meeting state income requirements – single adults. Approximately 3,000 in County. Case managed with membership card for service. $66/pm pm</td>
</tr>
</tbody>
</table>
Collaboration – What Worked for Us

• Measure “political will” – qualitative & quantitative
• Understand the importance of an “early win”
• Be willing to allow conflict
• Find ways to expand participation – on/off the table
• Don’t disband the group
• Don’t let money define the debate
• Trust builds commitment
• Good public policy should not be partisan

Vondie Woodbury, Exec. Director

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North Dakota Medicaid

Maggie Anderson
Medical Services
Department of
Human Services

Celebrating Medicaid

- 40th Anniversary of Medicaid
- Excellent coverage of optional services
- 53,000 North Dakota recipients
- 2992 children covered through SCHIP
- 1371 children receive services through CSHS
Medical Services – Continuing to Evolve…..

- Medicaid Waiver Applications
- PACE (Program of All Inclusive Care for the Elderly)
- Changes in SCHIP
- Personal Care – now in State Plan
- Attending State Coverage Initiative meeting
- Collaboration within DHS regarding coverage for kids
- Expanding Managed Care
- Partnership Programs for Long Term Care

Areas of Interest and Effort

- Dental Access
- Pharmacy Reimbursement Changes
- Medicare Part D Implementation
- PACE
- Pay for Performance
- 3-share programs