
ACCESS TO QUALITY HEALTH SERVICES IN RURAL AREAS—INSURANCE

by Jane Bolin and Larry Gamm

SCOPE OF PROBLEM

- A total of 41.2 million people under age 65 are without health insurance, according to estimates using U.S. Census data.¹⁰ If the uninsured population continues to increase at the current rate (0.4 percentage increase between 2001 and 2002), 46 million working-age Americans will be uninsured by 2005.¹¹
- Persons living in nonmetropolitan areas are more likely to be uninsured than those in metropolitan areas—20 percent versus 17 percent.¹
- Access to health insurance has been identified by both national and state experts as a rural health priority.³²
- African Americans and especially Hispanics are more likely than whites to be uninsured.^{10, 33} Uninsured rates are also higher among the poor and chronically ill.^{2, 34}
- Health insurance is a critical factor in influencing timely access to health care. Persons without health insurance are less likely to have a “regular” or usual health provider, less likely to obtain preventive care, or to obtain needed tests and prescriptions.^{35, 36} The Department of Health and Human Services interagency workgroup has identified health insurance as one of the 10 “leading health indicators” and generally a reliable predictor of overall health status.^{37, 38}

GOALS AND OBJECTIVES

The goal of Healthy People 2010’s access to quality health services focus area is to improve access to comprehensive, high quality health care service.¹ Access to health insurance is critical to achieving this goal and the related Healthy People 2010 objectives:

- 1-1. Increase the proportion of persons with health insurance.
- 1-2. Increase the proportion of insured persons with coverage for clinical preventive services.

Health insurance is an important determinant of health and disability status, likelihood of physician use, and overall likelihood of health care treatment.² An important determinant of access and utilization of all aspects of health care services, including preventive services, health insurance has a strong influence on a person’s health.³⁻⁷

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According to a survey conducted by the Rural Healthy People 2010 team, access to quality health services (which includes access to insurance) was most frequently identified as a rural health priority. Approximately three-quarters of the respondents named access to quality health services as a priority.⁸ It was the most often selected priority among all four types of state and local rural health respondents in the survey and across all four geographic areas.

PREVALENCE

Persons living in nonmetropolitan areas are more likely to be uninsured than those in metropolitan areas—20 percent versus 17 percent.¹ The percentages of persons under 65 who are uninsured are higher in rural areas and large central metropolitan counties than in fringe counties in large metropolitan areas or in small metropolitan counties.⁹

Estimates using U.S. Census data show that those without health insurance under age 65 total 41.2 million—an increase of 1.4 million over the 14.2 percent uninsured in the previous year.¹⁰ If this annual increase of 0.4 percentage points between 2000 and 2001 in the percentage of uninsured continues at the same rate, 46 million working-age Americans will be uninsured by 2005.¹¹

Hispanics are more likely than other Americans under age 65 to be uninsured, and African Americans are more likely than whites to be uninsured.

Among racial and ethnic groups, Hispanics are more likely than other Americans under age 65 to be uninsured (36 percent), and African Americans (21 percent) are more likely than whites (14 percent) to be uninsured. Young adults 19-24 years of age are more likely to be uninsured (32 percent) as are those separated from their spouse (33 percent).¹² A total of 8.5 million children, or 11.7 percent of all children, are among the uninsured.¹⁰

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The majority (57 percent) of the uninsured are full-time workers, while 20 percent are part-time workers. Despite Medicaid programs, the

highest rates of uninsured are still in the poor and near poor—the two lowest—income groups.¹³ Several studies report that people living in the South and West have lower rates of private or job-based insurance.^{9, 10, 14}

IMPACT

Studies have shown that in rural areas where there are larger percentages of uninsured, a higher percentage of rural residents also report fair or poor health, no visit to a health professional in the prior year, and less confidence in getting needed health

care services.¹⁵ A lack of health insurance coverage is associated with lower utilization of preventive services such as cancer screening, and care for congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), oral and dental health, and mental health.^{16, 17}

Lower rates of preventive service utilization are documented for rural areas, although differences vary by service. For example, differences in mammogram screening may be more attributable to education or income rather than place of residence. Other preventive services are negatively correlated to rural status and to being uninsured.¹⁸ The uninsured are also more likely to be hospitalized for avoidable conditions, such as pneumonia and uncontrolled diabetes, and more likely to be diagnosed for cancer at later stages.¹⁹

BARRIERS

A number of studies report that working adults living in rural areas are less likely to be offered health insurance through their jobs, i.e., employer-sponsored insurance programs.^{20, 21} Most of this difference is associated with rural dependence on smaller firms and lower wage rates.²¹ Prior research shows that rural residents tend to have higher rates of private, self-purchased health insurance and are more likely to be uninsured.^{15, 21-25}

Rural areas tend to have smaller businesses, resulting in higher premium costs for employer-based insurance spread across fewer employees. Combined with higher premiums for such occupations as farming, mining, logging, and fishing, many families may not be able to afford insurance.²⁶ Although only 20 percent of the overall American workforce is employed in firms with less than 25 employees, workers from these small firms account for 42 percent of the uninsured workers in the country.²⁷

During difficult economic times, food and basic necessities are purchased before health insurance, and health insurance is more likely to be dropped or deferred.²⁸ Since persons living in rural areas are more likely to have seasonal work and lower

incomes, they are the most at-risk group of being both uninsured and living below federal poverty levels.^{6, 7, 29}

There is a direct correlation between the percentage of those with incomes at or below the federal poverty level and degree of rurality. Twenty-two percent of the population in rural counties away from metropolitan areas have incomes at or below the federal poverty level compared to 13.8 percent for residents of metropolitan counties, and 15.8 percent among rural counties adjacent to metropolitan areas.¹⁵ Higher poverty rates and overall lower wages in rural areas magnify the problem of a lack of employer-based health insurance coverage or coverage that is more costly to workers.

Prior research shows that rural residents tend to have higher rates of private, self-purchased health insurance and are more likely to be uninsured.^{15, 21-25}

PROPOSED SOLUTIONS

Among the proposed solutions are tax incentives and some regulatory protection for developing MEWAs (Multiple Employer Welfare Associations) or health insurance purchasing cooperatives for smaller employer organizations in some regions of the country. Medicaid extensions and waivers and expansion of the State Children’s Health Insurance Program (SCHIP) are also proposed for persons who are near poverty but Medicaid ineligible. The current economic downturn and state budget shortfalls are likely to restrict these options for addressing the needs of more of the uninsured, at least in the near future.³⁰

A number of communities, led principally by provider groups, have established special health plans or programs for the uninsured. These programs emphasize the provision of key preventive and other

primary health services often associated with reducing demands upon very expensive emergency room services or acute care facilities where such admissions might be prevented by timely primary care.

An important step in community efforts to address the problem of the uninsured is the development of reasonably accurate estimates of the number of uninsured locally. A guide has been developed to support the efforts of community groups to arrive at such estimates.³¹

SUMMARY AND CONCLUSIONS

Rural populations in the U.S. tend to face a number of barriers and challenges in accessing affordable health insurance; these may be greater for some populations than others. Existing research shows significant differences in access to insurance between rural and non-rural populations and that these differences are amplified for racial and ethnic minorities.

The relatively larger proportions of small businesses and lower-paying jobs in rural areas are reflected in fewer employers offering health insurance, fewer choices, and less attractive provisions among employer-sponsored plans. At the same time, both poverty and higher incidence of chronic conditions reflect an increased need for care.

Although there is evidence of some success in certain states in reaching more of the uninsured via extending Medicaid program eligibility and enrolling more previously uninsured children in SCHIPs, current budget cutbacks in most states threaten to reverse this progress. There is evidence, too, of innovative community efforts sponsored by local providers to extend coverage or services to the uninsured. Although providers in many rural areas continue to make major efforts to maintain “safety net” services for the uninsured, it is unclear how long they will be able to maintain them in the face of growing economic challenges to rural populations and providers.

MODELS FOR PRACTICE

The following models for practice are examples of programs utilized to address this rural health issue.

REFERENCES

1. U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.
2. Broyles, R.W.; McAuley, W.J.; and Baird-Holmes, D. The medically vulnerable: Their health risks, health status, and use of physician care. *Journal of Health Care for the Poor and Underserved* 10(2):186-200, 1999.
3. National Center for Health Statistics. *Health, United States, 2001 with Urban and Rural Health Chartbook 2001*. Hyattsville, MD: National Center for Health Statistics, 2001.
4. Hoffman, C., and Schlobohm, A. *Uninsured in America: A chart book*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 1998.
5. Lurie, N.; Ward, N.B.; Shapiro, M.F.; et al. Termination from Medi-Cal—does it affect health? *New England Journal of Medicine* 311:480-484, 1984.
6. Hagdrup, N.A.; Simoes, E.J.; and Brownson, R.C. Health care coverage: Traditional and preventive measures and associations with chronic disease risk factors. *Journal of Community Health* 22:387-399, 1997.
7. Casey, M.M.; Call, K.T.; and Klinger, J. The influence of rural residence on the use of preventive health care services. Working Paper #34. Rural Health Research Center, Division of Health Services Research and Policy, School of Public Health, University of Minnesota, 2000.
8. Gamm, L.; Hutchison, L.; Bellamy, G.; et al. Rural healthy people 2010: Identifying rural health priorities and models for practice. *Journal of Rural Health* 18(1):9-14, 2002.
9. Eberhardt, M.; Ingram, D.; Makuc, D.; et al. Urban and Rural Health Chartbook, *Health, United States, 2001*. Hyattsville, MD: National Center for Health Statistics, 2001.
10. Mills, R.J. Health insurance coverage: 2001. *Current Population Reports*, U.S. Census Bureau, September 2002.
11. Employee Benefits Research Institute (EBRI). Brief Executive Summary No. 252. 2002. <<http://www.ebri.org/ibex/ib252.htm>>January 18, 2003.
12. Rhoades, J., and Chu, M. Health insurance status of the civilian noninstitutionalized population: 1999. *2000 MEPS Research Finding No. 14, AHRQ Pub No. 01-0011*. Rockville, MD: Agency for Healthcare Research and Quality, 2000.
13. Blumberg, L., and Liska, D.W. *The uninsured in the United States: A status report*. Washington, DC: The Urban Institute, 1996.
14. Rhoades, J.; Brown, E.; and Vistnes, J. Health insurance status of the civilian noninstitutionalized population: 1998. *MEPS Research Finding No. 11, AHRQ Pub. No. 00-0023*. Rockville, MD: Agency for Healthcare Research and Quality, 2000.
15. Ormond, B.A.; Zuckerman, S.; and Lhila, A. Rural/urban differences in health care are not uniform across states. *New Federalism Series: National Survey of America's Families* Number B-11, Washington, DC: The Urban Institute, 2000.
16. Faulkner, L.A., and Schauffler, H.H. The effect of health insurance coverage on the appropriate use of recommended clinical preventive services. *American Journal of Preventive Medicine* 13(6):453-458, 1997.

17. Strickland, J., and Strickland, D.L. Barriers to preventive health services for minority households in the rural south. *Journal of Rural Health* 12(3):206-217, 1996.
18. Zhang, P.; Tao, G.; and Irwin, K.L. Utilization of preventive medical services in the United States: A comparison between rural and urban populations. *Journal of Rural Health* 16(4):349-356, 2000.
19. Kaiser Commission on Medicaid and the Uninsured. *The uninsured and their access to health care*. Washington, DC: Henry J. Kaiser Family Foundation, 2000.
20. Frenzen, P.D. Fewer rural than urban workers receive employment fringe benefits. *Rural Conditions and Trends* 6(1):22-25, 1995.
21. Coburn, A.F.; Kilbreth, E.H.; Long, S.H.; et al. Urban-rural differences in employer-based health insurance coverage of workers. *Medical Care Research and Review* 55(4):484-496, 1998.
22. Coward, R.T.; Clarke, L.L.; and Seccombe, K. Predicting the receipt of employer-sponsored health insurance: The role of residence and other personal and workplace characteristics. *Journal of Rural Health* 9(4):281-292, 1993.
23. Hartley, D.; Quam, L.; and Lurie, N. Urban and rural differences in health insurance and access to care. *Journal of Rural Health* 10(2):98-108, 1994.
24. Mueller, K.J.; Patil, K.; and Ullrich, F. Lengthening spells of uninsurance and their consequences. *Journal of Rural Health* 13(1):29-37, 1997.
25. Yen, W. Health insurance coverage of Washington's non-elderly population. *Washington State Population Survey*, Research Brief No. 6. Olympia, WA: Washington State Office of Financial Management, 1999.
26. Mintzer, C.L.; Culp, J.; and Puskin, D.S. Health care reform: What it means for rural America. A working paper for the National Advisory Committee on Rural Health, Office of Rural Health Policy, 1992.
27. Garrett, B.; Nichols, L.M.; and Greenman, E. *Workers without health insurance: Who are they and how can policy reach them?* Washington, DC: The Urban Institute and the W.K. Kellogg Foundation, 2001.
28. Elder, G.H. Jr.; Tobertson, E.B.; and Ardel, M. Families under economic pressure. In Conger, R.D., and Elder, G.H., Jr., eds. *Families in Troubled Times: Adapting to Change in Rural America*. New York: Aldine De Gruyter, 1994, 79-104.
29. Anonymous. Access to health care for the uninsured in rural and frontier America. National Rural Health Association Issue Paper, 1999. <www.nrharural.org/dc/issuepapers/ipaper15.html>December 10, 2001.
30. Hurley, R.E.; Crawford, H.; and Praeger, S. Medicaid and rural health care. *Journal of Rural Health* 18 Suppl:164-175, 2002.
31. Sochowitzky, E., and Turnbull, N. How many uninsured: A resource guide for community estimates, 1999. Boston MA: The Access Project, Brandeis University. <<http://www.accessproject.org/downloads/uninsured.pdf>>2002.
32. Gamm, L., and Bell, S. Identifying rural health priorities within Healthy People 2010: A report on the results of the Rural Healthy People 2010 survey 1. Dallas, TX: National Rural Health Association Conference, 2001. See introduction in Volume 1, Table 2.
33. Hargraves, J.L. The insurance gap and minority health care, 1997-2001. Center for Studying Health Systems Change, *Tracking Report* No. 2:1-4, 2002.
34. Stroupe, K.T.; Kinney, E.D.; and Kniesner, T.J.J. Does chronic illness affect the adequacy of health insurance coverage? *Journal of Health Politics, Policy, and Law* 25(2):309-341, 2000.

35. Taylor, A.; Cohen, J.; and Machlin, S. Being uninsured in 1996 compared to 1987: How has the experience of the uninsured changed over time? *Health Services Research* 36:16-31, 2001.

36. Weinick, R.; Zuvekas, S.; and Drilea, S. Access to health care—sources and barriers, 1996. *1997 MEPS Research Findings No.3, AHCPR Pub. No. 98-001*. Rockville, MD: Agency for Health Care Policy and Research, 1997.

37. Centers for Disease Control and Prevention. Leading Health Indicators at a Glance. <<http://wonder.cdc.gov/data2010/lhi.htm>>2002.

38. U.S. Department of Health and Human Services. Leading Health Indicators. <<http://www.healthypeople.gov/LHI/>>2002.

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MODELS FOR PRACTICE

FOCUS AREA: ACCESS (INSURANCE)

Program Name: CHOICE Regional Health Network Regional Access

Location: Olympia, Washington

Problem Addressed: Access to Insurance

Healthy People 2010 Objective: 1-4, 1-5

Web Address: <http://www.choicenet.org>

SNAPSHOT

The mission of the CHOICE Regional Health Network, a nonprofit consortium of rural and urban providers, is to “improve the health of our community.” That “community” represents five counties in central western Washington State, with four being rural counties.

RAP improves access to primary care and other medical services by connecting eligible residents to a medical home and providing guidance on available sources of health insurance.

The Regional Access Program (RAP) serves the uninsured and underinsured at or below the 250 percent federal poverty level in the five county service areas. RAP improves access to primary care and other medical services by connecting eligible residents to a medical home and providing guidance on available sources of health insurance.

THE MODEL

Blueprint: CHOICE Regional Health Network Regional Access Program was created in 1996 to provide intensive outreach to low-income individuals and families. Access coordinators partner with schools, providers, daycare providers, state agencies, hospitals, and other community-based organizations to reach children and adults who are without health insurance.

Access coordinators meet individually with clients to explain the various programs for which they are eligible, help them complete the necessary paperwork, and serve as advocates. In 2002, CHOICE helped enroll more than 3,000 people in public insurance. Since the program began, CHOICE has assisted more than 14,000 people in the region to access needed health care services.

The services provided by RAP include:

- outreach to community-based organizations;
- provide a toll-free phone number that connects to a person who prescreens and schedules appointments;

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- provide application assistance to complete necessary paperwork and provide follow-up; offer Spanish translation and interpretive services through a toll-free, dedicated Spanish phone line and through four bilingual staff;
 - perform enrollment case management when appropriate;
 - serve as a liaison between state agencies and clients to facilitate enrollment or to resolve problems;
 - educate consumers by explaining benefits and helping clients choose an affordable health plan and primary care physician;
 - connect residents to available social services and programs for which they may be eligible;
 - produce and distribute marketing materials to reach the target population; and
 - provide information to consumers about being informed and responsible health care users, with a focus on primary care.

Making a Difference: The program conducts annual surveys of providers and patients to assess the effectiveness of the program. The impacts of the program for 2001 include:

- reduced the number of uninsured in the region by 3,331;
- decreased the insurance disenrollment rate of CHOICE clients from 30 percent to 10 percent;
- saved the providers in the region \$4.5 million in uncompensated care; and
- reduced hospital bad debt and charity care by 14 percent.

Beginnings: The CHOICE Regional Health Network is a nonprofit consortium begun in 1996. Network membership includes public and non-profit hospitals, local health departments, family practice residency programs, practitioners, schools, and community members.

The CHOICE Regional Health Network takes on new and/or expands existing programs based on an assessment of factors that reflect their mission and vision. The questions asked as criteria for program selection for the Regional Access Program are:

- Does this initiative make sense regionally?
- Is the problem important and in the long-term interests of the community?
- Does it address a coordination, quality, access, or health status objective?

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- Is it a step toward better distribution of health resources?
 - Is it a prudent investment in a cost-conscious market?

Challenges and Solutions: To address social and cultural issues, case management services were created to connect people to other needed services (e.g., food). Bilingual staff were hired to address language and cultural issues. Special materials were developed to assist clients from other cultures to understand the concepts of insurance, medical home, and managed care. Recently, CHOICE partnered with the Crisis Clinic to manage an Internet-based Regional Resource Directory.

Ongoing funding for the network comes from membership dues that are paid by the six public and non-profit hospitals (member sponsors). This funding is supplemented with state contracts and grants. For example, the Statewide Health Insurance Benefit Advisor (SHIBA) Program was folded into the RAP program. Savings from reductions in uncompensated care are reinvested back into the program. In 2001, the program received a Community Access Program (CAP) grant from the Health Resources and Services Administration. Expanded funding over the last five years allows the program to increase its service population, adding children, the underinsured, and additional counties (from one to five).

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MODELS FOR PRACTICE

FOCUS AREA: ACCESS (INSURANCE)

Program Name: Inland Northwest in Charge – coordinated by the Health Improvement Partnership

Location: Spokane, Washington

Problem Addressed: Access to Insurance

Healthy People 2010 Objective: 7

Web Address: www.hispokane.org

SNAPSHOT

Inland Northwest in Charge (INIC) is a collaborative project providing services aimed at improving health care access for the uninsured and underinsured spanning all age groups and ethnic groups in 11 rural and urban counties in eastern Washington State. INIC utilizes a variety of community strategies to deliver outreach and training services.

INIC seeks to improve health care access for the uninsured and underserved, including outreach and enrollment efforts for state-sponsored health care.

THE MODEL

Blueprint: Inland Northwest in Charge is a collaborative project coordinated by the Health Improvement Partnership (HIP), a 501(c)(3) nonprofit organization involving representatives from over 200 organizations. INIC seeks to improve health care access for the uninsured and underserved, including outreach and enrollment efforts for state-sponsored health care, referrals to primary and specialty/chronic disease care, designing and implementing an affordable insurance product (which combines public and private dollars) for the working uninsured, and access to additional health-related resources (e.g., affordable pharmaceuticals).

HIP serves uninsured children in Washington State through the Healthy Kids Now! project and serves the uninsured/underserved in an 11-county region of eastern Washington through several projects (Health for All, Covering Kids and Families, and other targeted INIC programs). Most of the counties are rural. Of the 556,540 people in the catchment area, 35 percent live in rural counties. The other 65 percent live in Spokane County, a rural/urban county. Several programs serve rural and tribal communities, children under the age of 19, and uninsured adults and pregnant women. INIC also implements specialized outreach to multicultural communities. INIC interventions take place throughout the community through a variety of partners such as clinics, physician offices, hospitals, health plans, employers, schools, and human services agencies.

INIC provides marketing and outreach services, a staffed hotline for client application assistance, training and technical assistance on state-sponsored health care for community professionals and outreach workers, one-on-one outreach in rural and tribal areas, coalition building, assistance to community partners in program and resource development, and capacity building for outreach and health care access in rural communities. Program coordinators at the Health Improvement Partnership work with diverse community stakeholders to define priorities and workplans. Internal staff, consultants, and contracted workers finalize action plans and implement activities.

Making a Difference: INIC tracks the number of people reached, served, and connected with health insurance and/or primary care. Over 16,000 individuals have been enrolled in coverage or directed to primary care since 1999. Surveys are given to clients regarding their coverage retention and satisfaction with the services. INIC works to build more outcome measures to assess the effectiveness of the programs. Base-line data are gathered on hospital charity/uncompensated care levels, emergency room primary care usage, and unnecessary admits to measure the long-term impact the programs have on these indicators.

Beginnings: INIC began in November 1998 and was fully implemented in January 1999. INIC first received funding from a contract with the Department of Social and Health Services' Medical Assistance Administration for designing and conducting Medicaid outreach. Additional significant funding was subsequently received from a Robert Wood Johnson Foundation grant and a Health Resources and Services Administration Community Access Program grant. INIC draws upon a mix of local, regional, state, and national funds.

Challenges and Solutions: Challenges include maintaining enough ongoing funds to test and fully implement new methodologies for serving the population; having adequate time, staffing, and resources to balance both the planning and implementation sides of the programs; and retaining the ongoing involvement of community partners. INIC addresses these challenges in a variety of ways, including:

- pursuing a “cooperative financing” plan with a variety of community partners in which each partner contributes a certain percentage toward sustaining or enhancing health care access strategies;
- working extensively with state and local policymakers to explore partnership opportunities that may allow for more regional tailoring of state-based funding;
- writing grants;
- seeking corporate support; and
- tapping into existing state and federal dollars that support the mission.

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MODELS FOR PRACTICE

FOCUS AREA: ACCESS (INSURANCE)

Program Name: Lake Plains Community Care Initiative

Location: Batavia, New York

Problem Addressed: Access to Insurance

Healthy People 2010 Objective: 1-4, 1-6

Web Address: None

SNAPSHOT

The Lake Plains Community Care Network (LPCCN) is a not-for-profit corporation formed in 1997 from a network of employers, providers, and community service groups and organizations that have collaborated since 1993. The network addresses rising costs of health care and the dwindling choices of health care services in rural areas. The Lake Plains Community Care Initiative is one of several community-oriented programs under LPCCN.

The Lake Plains Community Care Initiative seeks to better coordinate and strengthen the local health delivery system while at the same time promoting additional competitively priced health insurance options to the communities.

THE MODEL

Blueprint: The Lake Plains Community Care Initiative is a local response strategy that targets growing concerns over access to and affordability of quality health care and health insurance coverage for the area residents. LPCCN exists as a three-county, rural health network located in upstate Western New York. It is a not-for-profit corporation comprised of representatives from three hospitals, three public health departments, area health practitioners, and community/governmental business representatives. The corporation has 13 governing board members with an approximate 25-member community advisory council. A part-time CEO, full-time associate director, full-time care management coordinator, and limited support personnel staff the project.

As a rural health network, LPCCN seeks to offer open-ended service support to all 150,000 individuals residing within the catchment area. Insurance efforts are directed toward offering support to uninsured and underinsured adults and their families. The targets are individuals who are typically self-employed or employed in small group environments (organizations with 50 employees or less). Many of these individuals are employed in agribusiness, retail, or the service industry. The Lake Plains Community Care Initiative seeks to better coordinate and strengthen the local health delivery system while at the same time promoting additional competitively priced health insurance options to the communities. This is accomplished by two methods. First, LPCCN established a three hospital, 160 physician, messenger model

(a type of preferred provider organization [PPO] that was established by the Federal Trade Commission to allow physicians to negotiate reimbursements) to coordinate and strengthen the overall delivery system. Gradually, the PPO will be enhanced through the provision of local support features or functions such as local medical management, case management, community care management, and utilization review efforts. Second, LPCCN attempted to reach local self-insured organizations, employment-sector trusts, and a third party commercial carrier to contract with the PPO and actively take advantage of the enhancements being provided.

Making a Difference: The Lake Plains Community Care Initiative covers approximately 2,400 lives by servicing health insurance plans. The Initiative expects to add 1,000 more covered lives in 2002.

Beginnings: LPCCN was incorporated in 1997, and the first service contract took effect in July 2000. The problem was noticed beginning in the early 1990s when the provider system began losing market share and experienced increasing difficulties in meeting financial objectives and attracting new practitioners to the communities. The numerous insurance carriers decreased as well as the consumer responsiveness of those that remained. As Lake Plains gained in local prominence and stature, LPCCN commissioned a market analysis through the University of Buffalo, School of Medicine and Biomedical Sciences. The results of this study only put numbers to what was known and experienced on a day-to-day basis by businesses and health care consumers alike. It revealed that premiums were too high for the actual utilization, and fewer choices and less customer service was made available.

Challenges and Solutions: Lake Plains Community Care Initiative has experienced varied challenges over the past several years. All health insurance activities in New York State are complex and highly regulated. Finding locally controllable response options that are prudent and fiscally affordable have proven very difficult. The program leaders realize that one strategy is clearly not right for all. An array of strategies (such as self-funded insurance plans, specific trust plans, and an innovative partnership with a large commercial insurance carrier) is needed to effectively get the job done. Another major challenge is the continued pursuit for new options while also seeking to refine those already in place.

LPCCN has been funded as a New York State Rural Health Network since 1997 and has also benefited from a federal rural network development grant, Kellogg Foundation grant award, and member organization contributions. The organization anticipates becoming self-sufficient by 2004 as the revenue stream grows from increased utilization of PPO services within the community.

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MODELS FOR PRACTICE

FOCUS AREA: ACCESS (INSURANCE)

Program Name: Southeast Kentucky Community Access Program

Location: Harlan, Perry, Leslie, and Knott Counties, Kentucky

Problem Addressed: Access to Health Care, Housing, Education, and Public Safety

Healthy People 2010 Objective: 1-4, 1-6

Web Address: http://www.mc.uky.edu/ruralhealth/community_programs/skycap.htm

SKYCAP is a collaborative demonstration program designed to improve access to health care, social services, and housing for the underinsured and uninsured residents of Harlan and Perry Counties, and most recently through funding from the Good Samaritan Foundation, Inc., Leslie and Knott Counties.

SNAPSHOT

The Southeast Kentucky Community Access Program (SKYCAP) is a rural demonstration and evaluation program funded by the Health Resources and Services Administration, U.S. Department of Health and Human Services, and launched on September 1, 2000. The purpose of SKYCAP is to identify collaborative partners in rural communities in southeast Kentucky to demonstrate ways to develop sustainable health care programs for the medically indigent. The overall SKYCAP goal is 100 percent access and zero disparities. Although it is a rural demonstration program, SKYCAP hopes to become an ongoing program.

THE MODEL

Blueprint: SKYCAP is a collaborative demonstration program designed to improve access to health care, social services, and housing for the underinsured and uninsured residents of Harlan and Perry Counties, and most recently through funding from the Good Samaritan Foundation, Inc., Leslie and Knott Counties. Services provided include, but are not limited to:

- emergency medication access,
- dental care,
- eye care,
- primary providers,
- home visitation,
- education,
- transportation, and
- eligibility for pharmaceutical programs for the indigent.

SKYCAP also takes referrals from different agencies. Delivery of services is achieved by deploying family health navigators (FHNs) in 11 community sites as community health advisors to assist eligible clients with ambulatory care sensitive diseases (asthma, cardiovascular disease, diabetes, hypertension, or severe mental illness) to receive care in the most appropriate settings.

FHNs serve the uninsured and underinsured population by conducting home visits, performing assessments of clients and family needs, and providing referral information to clients and their families. The family health navigators also act as liaisons between clients and their families as well as mental health and health and human service providers. FHNs report to network members the specific characteristics or conditions that impede clients from obtaining available services. In addition, FHNs work with multidisciplinary teams to establish action plans for clients and families. They assure that action plans are carried out, link clients with all needed services, connect clients to support groups, and provide emotional and educational support for clients and their families.

SKYCAP is a community partnership with the University of Kentucky Center for Rural Health in Hazard; Harlan Countians for a Healthy Community, Inc.; Hazard Perry County Community Ministries, Inc.; and Data Futures, Inc. These community partners bring together over 50 other partners and organizations, such as health departments, local hospitals, pharmacies, and mental health centers.

It is estimated that 24 to 45.4 percent of the population in these counties lives in poverty (compared to Kentucky's state average of 15.8 percent). The median household income in these counties ranges from \$15,805 to \$23,318, compared to a state average of \$33,672. Only 49.2 to 58.7 percent have completed high school (compared to the state average of 74.1 percent). While only about 1 percent of the nation's population lives without indoor plumbing, more than 6 percent of Harlan and 7 percent of Perry County's citizens are without running water. Kentucky has the highest smoking rate in the nation (30 percent) and southeastern Kentucky has the highest rate in the state (33 percent). The overall mortality rate per 100,000 in the 45–64 age group is 145 percent higher than in the nation; mortality rates for heart disease, late stage breast cancer and lung cancer are 160–250 percent higher than national rates. The state ties for second place nationally in the percentage of obese adults (33), and the rate in southeastern Kentucky is even higher. The goals of Healthy People 2010 cannot be achieved unless special populations, such as Appalachians, have effective solutions to their health care crisis.

Although Medicare covers 26 percent of the people in these counties, and most children have some sort of public or private insurance, about 12,000 people are still medically indigent. In addition, approximately 10,000 people

are Medicaid recipients, of which the majority are otherwise uninsured. The greatest need in this two-county area is access to pharmaceuticals.

Making a Difference: The SKYCAP program formed a baseline of medical/social care utilization for the following diseases: asthma, diabetes, heart disease, hypertension, and mental illness. By the end of 2001, SKYCAP received over 5,000 referrals from different agencies and provided a total of 13,000 services. These are services that otherwise would probably be unavailable to these people due to being uninsured or underinsured.

Beginnings: The SKYCAP program was fully implemented in December 2000 and provided services to Harlan and Perry Counties. It received one of the original 23 Community Access Program (CAP) grants in September 2000.

Challenges and Solutions: By collaborating across the mountains, SKYCAP attempts to create a comprehensive network for this most distressed area. It supports integrated programming to increase access to health care for the target populations. The program seeks to expand a CAP network of safety net providers that will serve this Appalachian region and can be easily replicated throughout Appalachia in its entirety. The University of Kentucky Center for Rural Health is the bridge that ties the groups together and brings the necessary infrastructures that each group would have difficulty sustaining individually in the present state of rural health care decline. The greatest challenge is building the new networks and infrastructures before losing the safety net providers.

PROGRAM CONTACT INFORMATION

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MODELS FOR PRACTICE

FOCUS AREA: ACCESS (INSURANCE)

Program Name: Vermont Coalition of Clinics for the Uninsured

Location: Middlebury, Vermont

Problem Addressed: Access to Insurance

Healthy People 2010 Objective: 1-4, 1-6

Web Address: <http://http://www.vccu.net/>

SNAPSHOT

The Vermont Coalition of Clinics for the Uninsured (VCCU) is a group of free health care clinics and one dental clinic in Vermont that work together to provide a safety net of primary care services to individuals whose household incomes fall below 200 percent of the federal poverty level (FPL) and who either lack health insurance entirely or are underinsured (e.g., high deductibles). The nine member clinics are distributed around the state, and although each has its own board of directors, each clinic maintains its own policies and does its own fundraising. Some funding (from the State of Vermont and private foundations) comes through the coalition. The coalition developed software for uniform data collection, acts as a clearing-house for problem solving, and actively advocates for its constituents.

VCCU is comprised of free health care clinics and one dental clinic that provide safety-net primary care services to uninsured and underinsured individuals.

THE MODEL

Blueprint: VCCU is comprised of free health care clinics and one dental clinic that provide safety-net primary care services to uninsured and underinsured individuals who fall below 200 percent of the poverty level. It specifically serves the low-income uninsured and underinsured between the ages of 18 and 65. Few children need the clinics since Vermont has a state Medicaid extension program that provides insurance to children under 18 years of age in families with incomes at 300 percent of the federal poverty level. Although most programs have income guidelines that go to 200 percent of the FPL, some programs have extended the guideline to 300 percent of the FPL.

The majority of the member clinics operate as freestanding health care facilities and are staffed by medical volunteers. These clinics provide services based on the traditional free clinic model, which means that services are provided on a weekly to tri-weekly basis in the evenings. The remainder of the clinics operate through local hospitals and local medical care practices to incorporate their clients into the mainstream provision of health care services. This method is known as the incorporated model. The success of VCCU relies heavily on the over 500 volunteers who include

physicians, nurses, allied health professionals, and administrative assistants. Examples of free services provided by the clinics include primary health care, referral for testing and specialty care, enrollment in social services and Medicaid extension programs, prescription medications, and case management. The clinics developed a case management model to ensure continuity of care.

Making a Difference: The clinics now serve about 20 percent of the state's uninsured population. Their constituents are the unemployed and working poor. About 60 percent are women, and most clients fall into the 30 to 45 age category. Most are high school graduates and are employed. In fact, there is a trend in the client base toward multiple jobs. Of those with some insurance, 68 percent have insurance with deductibles of \$250 or more. According to these data, there are an increasing number of underemployed clients who are also underinsured.

Beginnings: The VCCU program began in 1994 and was fully implemented by 1995. Each clinic was developed by a grassroots effort within that community, and each program works closely with its local hospital and medical community. VCCU offers support to any community wishing to start a free clinic and provides technical assistance to that community. VCCU grew from an informal group of five clinics to a 501(c)(3) organization with nine clinics after receiving funding from the Rural Health Outreach Program of the Federal Office of Rural Health Policy. At the end of that three year funding period, the State of Vermont stepped in and provided funding that exceeded that of the Rural Outreach Program that supports the VCCU office staffed by 1.4 full-time employees and provides partial financial support to the nine free clinics. Each individual clinic is also supported by direct financial support from its local hospital, community contributions, and private foundation contributions.

Challenges and Solutions: The health care situation in Vermont is now in a state of flux and is showing contradictory trends. While employment is up, so too is the cost of medical insurance (a 20 percent cost increase was anticipated in 2001). The state has increased the number of Vermonters covered by Medicaid and Medicaid extension programs by 16 percent, yet the free clinics have seen a steady increase in the number of clients served. Reimbursement to providers from state programs is low, and clients cannot find care in some areas even when services are covered. Clearly, many Vermonters fall through the gaps in private and state programs.

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