

ACCESS TO CARE

Introduction

BACKGROUND

Health and social service providers and concerned individuals have been working for years to improve access to health care for people with no insurance and for those insured through Medicaid. The Adams County Health Department's PATCH (Planned Approach to Community Health) initiative focused on this problem as early as 1991. A number of community initiatives grew from the PATCH process, including the Blessing Hospital Community Outreach Clinic which provides ongoing care to individuals with chronic illnesses, the Adams County Dental Clinic, and the MedAssist program, which connects people with prescription drugs.

Despite these efforts, concerns about readily-available, on-going access to physician services for these populations continued. In 2002, a feasibility analysis to determine the viability of a Federally Qualified Health Center (FQHC) was initiated. That process identified the potential benefits of an FQHC (medical home with comprehensive primary and preventive services, assistance with enrollment in other services, care management, enhanced Medicaid reimbursements), but the financial analysis demonstrated that the ratio of potential Medicaid clients to uninsured clients meant the concept was not viable here.

In the spring of 2005, the Adams County Health Department received a Network Planning Grant from the federal government to support the assessment of our access to care issues and planning for improved access to care. Specifically, the grant objectives were:

- Assess the scope of the problem, the needs of these populations, and how this problem is being addressed in other communities
- Develop a plan to address the issues we uncover
- Develop a system and structure to implement the plan

A planning committee was formed (see attached) and a work plan was developed in the late spring of 2005. The planning committee developed a health leadership list (also attached) to ensure that the work of the committee would be communicated to and connected with people outside the committee who were concerned about health care and who had potential impact on how this issue was ultimately addressed.

ALLIANCE FOR BUILDING COMMUNITY PARTNERSHIP

The Health Care Access Planning Committee formally affiliated with the Alliance for Building Community to assess, implement strategies and assist in evaluation efforts of the community goal of: Residents have access to health and social services. Four indicators are identified to measure this goal including: percentage of children without health insurance, percentage of adults without health insurance, percentage of population who did not access health care services due to cost in the last year, and measure of access to mental health services.

ASSESSMENT RESULTS

The results of the assessment phase were shared at a meeting on October 17, 2005. Health and social service providers, employers and others (see attached list) heard and discussed the

key issues uncovered through the assessment process, which was conducted by the Medical Foundation, a health and social services research organization that has done other research in our community. Both quantitative and qualitative research results were reported:

- The consequences of poor access to health care are significant
 - 19% of uninsured use the ER as usual source of care (vs. 3% of insured)
 - 35% of uninsured don't seek care when needed (vs. 9% of insured)
 - Avoidable hospitalizations are 50 % higher among uninsured
 - The estimated lost economic value is \$2000 per individual
- Adams County has less favorable measures (vs. Illinois overall) on several variables known to influence access to care
 - Education
 - Income
 - Usual source of care/personal doctor
 - Percentage of doctors in primary care
- Adams County has less favorable measures on several health care access outcome variables
 - No medical physical in past 2 years
 - Births to women under 18
 - We lacked data on the cost of inappropriate, uncompensated care (ER for primary care, inpatient for ambulatory care sensitive conditions)
- We have quantified the number of people in the target populations
 - 6558 people in Adams Co. are below the poverty level (10% vs. 10.7% in IL)
 - 10894 people are enrolled in Medicaid (16.1% vs. 12.6% in IL)
 - 6177 have no insurance (12.2% vs. 15.2% in IL)
 - 3830 of these people are employed (62.0% vs. 64.4% in IL)
 - 1143 of the uninsured are under the age of 18
 - After subtracting the children from the total uninsured, it is estimated that as much as 75% of the adult uninsured population is employed
- Consumers and providers have opinions on what needs to change
 - Increase and improve coordination of care
 - Improve provider staff respect for individuals and develop patient-sensitive payment plans
 - Expand the number of people covered under insurance
 - Improve patient education and information
 - Educate patients on best use of system
 - Expand the number of Medicaid providers; providers adjust their availability for Medicaid patients regularly, based on patient load/mix
 - Expand the number of providers accepting the uninsured
- Other communities have developed successful approaches to expand the number of employers offering health insurance
 - 3-share models use employer, employee and community funding

- Criteria for which employers can offer the 3-share plan include low average wage, not offering insurance in prior 12 months
- Care management (designated PCP's, case managers, care coordination, disease management) improves efficiency and effectiveness
- Communities have also developed formalized networks of providers willing to see uninsured patients
 - Patients are enrolled in network
 - Providers use sliding scale
 - Use care management (designated PCP's, case managers, care coordination, disease management) to improve efficiency and effectiveness
 - Make sure people are enrolled in all available, applicable programs
- The state of Illinois has several innovative pilot approaches
 - St. Clair County is developing a 3-share model
 - A community consortium designed the benefit package and selected a carrier
 - Not-for-profit entity established to manage the program
 - Public share via combination of Certified Public Expenditures and cost-based reimbursement to the health department
 - State working on small employer reinsurance pool

MEASUREABLE OUTCOMES

At the conclusion of the assessment phase, we had identified and quantified issues related to access to care for our target populations, and had gained knowledge about some potential program solutions to consider. As we moved into the planning phase of the project, we had a number of potential indicators to use in the future as measures of our success, including:

- Percentage of individuals with health insurance coverage
- Percentage of individuals with usual source of care
- Percentage of individuals with medical physical in last two years
- Percentage of individuals seeing provider in last 12 months
- Uncompensated care in ER for primary care
- Uncompensated inpatient care of ambulatory care sensitive conditions

HEALTH CARE ACCESS PLANNING COMMITTEE

Diane Campbell	Department of Human Services
Kathy Fauble	AHEC
Patty Loeffler	Blessing Hospital
Shirley Longlett	SIU Quincy Family Practice Center
Nephtali Matta	Quincy Medical Group (later replaced by Carol Lewis)
Debra Phillips MD	SIU Quincy Family Practice Center
Mark Schmitz	Transitions
Julie Shepard	Adams County Health Department
Kurt Stuckman	Catholic Charities (later replaced by Amanda Lewis)
Dan Stupavsky	United Way
Ellen Vonderheide	Adams County Health Department
Cathy Meckes	Project Consultant

HEALTH CARE LEADERSHIP LIST

Brad Billings	Blessing Hospital
Nancy Bluhm	Adams County Health Department
Zig Brown	Blessing Hospital
Patty Douglas	Salvation Army
Carrie Edgar	University of Illinois Extension
Dan Evans MD	Quincy Medical Group
Jerry Jackson	Blessing Hospital
Maureen Kahn	Blessing Hospital
Jerry Kruse MD	SIU Quincy Family Practice Center
Peter Leffman MD	Chair, Riverview Health Services Board
Mike Rein	Transitions
Claire Robinson	United Way
Kurt Stuckman	Catholic Charities
Cheryl Waterman	United Way
Major Carol Wertz	Salvation Army

ATTENDEES AT ASSESSMENT REPORT MEETING, OCTOBER 17, 2005

Anne Forbes	Alliance for Building Community
Carrie Edgar	University of Illinois Extension
Sandy Trusewych	West Central Illinois Center for Independent Living
Bev Rossmiller	Tri-State Health Care Coalition
Barb Dietrich	Sunset Home
Sylvia Miller	Quincy Medical Group
Debra Phillips MD	SIU School of Medicine Quincy Family Practice Center
Shirley Longlett	SIU School of Medicine Quincy Family Practice Center
Mark Schmitz	Transitions
Patty Loeffler	Blessing Hospital
Zig Brown	Blessing Hospital
Michael Gilpin	Blessing Corporate Services
Virlene Miklich	Blessing Physician Services
Susan Downey	The Medical Foundation
Kathy Fauble	AHEC
Roger Leenerts	H&B Quality Tooling
Maureen Kahn	Blessing Hospital

Peter Leffman
Cheryl Waterman
Diane Campbell
Claire Robinson
Tony Oakley
Amy Looten
Jessica Ebbing
Amy Morrell
Patty Douglas
Jeannie Martin
Chuck Scholz
Jill Blickhan

Riverview Health Services
United Way
Department of Human Services
United Way
Good News
Quincy Area Chamber of Commerce
SIUE student nurse
Adams County Health Department
Salvation Army
Quincy Public Schools
Attorney
Community Foundation of the Quincy Area

ACCESS TO CARE

From Assessment to Planning

GOAL

To use the results of the assessment phase and the resources available to us through the grant to develop a concept of and planning for a system to support access to care for uninsured and Medicaid insured individuals.

STRATEGY

Our planning strategy was to use a broad base of community input, as well as the consulting resources available to us through the Georgia Health Policy Center (GHPC) at Georgia State University, to develop program concepts to address the issues we had identified. We committed to developing the concepts as fully as possible within the parameters of the Network Planning Grant which funded our efforts.

STRATEGIC PLANNING DAY

We convened a strategic planning day in early December of 2005 and included participants from health care providers, social service agencies, community organizations, employers and business representatives, as well as elected officials and consumers. The planning process was facilitated for us by Catherine Liehmon from the GHPC. After a review of the output of the assessment phase, the group discussed:

- What is our highest priority access to care need?
- What resources are available to address the needs?
- What obstacles must we overcome to develop and implement a solution?
- How will we measure our success?

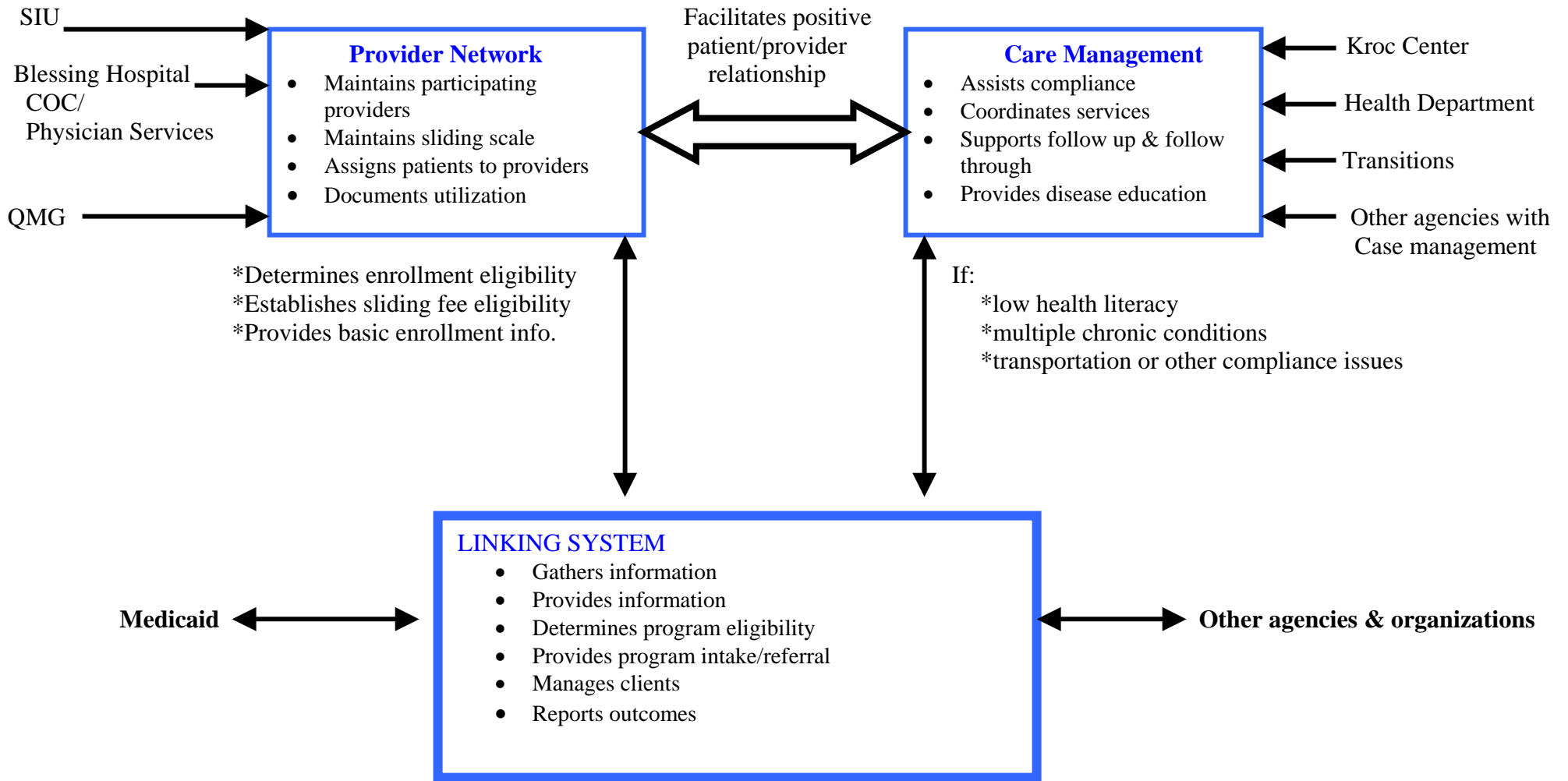
With this group discussion as input, the large group was divided into two smaller groups to develop a concept for what each considered the highest priority need. Both groups decided to develop concepts for the same need: better connection to and coordination of health and social services. Based on this interest in what we called a “Linking System” our consultant shared with us some examples of what other communities had developed. At the conclusion of the day, we agreed that development of a linking system that incorporated care management capabilities would be our top priority, while we continued to investigate and develop concepts for a provider network for the uninsured and a three-share insurance model.

PLANNING STRUCTURE

In January of 2006, we organized a linking system work group to address the priority need identified through the strategic planning process. In subsequent months, we also met with case managers from local agencies to develop a concept for care management, with providers to discuss the provider network concept and with business organizations and employers to discuss employer health insurance issues. We also surveyed 20% of the small employers in Adams County. The output of these efforts and recommendations for moving from planning to implementation are described in the following sections.

ATTENDEES AT STRATEGIC PLANNING DAY

Bev Rossmiller	Tri-State Health Care Coalition
Dr. Debra Phillips	SIU/Quincy Family Practice
Jim Mentesi	GREDF
John Spring	City of Quincy, Mayor
Major Carol Wurtz	Salvation Army
Janet Enroth	Quincy Public Schools
Amy Looten	Quincy Chamber of Commerce
Carol Lewis	Quincy Medical Group
Chad Hine	Quincy Medical Group
Sylvia Miller	Quincy Medical Group
Marla Ferguson	Quanada
Jean Buckley	Tracy Family Foundation
Zig Brown	Blessing Hospital
Cindy Brink	General Assistance
Mark Schmitz	Transitions
Sandra Trusewych	WCILCIL
Kathy Ridder	JK Creative Printer
Dr. Tom Miller	SIU/Quincy Family Practice
Chuck Fitch	SIU/Quincy Family Practice
Carrie Edgar	University of Illinois Extension
Shirley Longlett	SIU/Quincy Family Practice
Patty Douglas	Salvation Army
Kathy Fauble	Western Illinois AHEC
Peter Leffman	Riverview Health Services
Anne Forbes	Alliance for Building Community
Denise Mewes	Consumer
Kimi Yuchs	Sunset Home
Susan Douglas	Quincy Housing Authority
Sylvia Miller	Quincy Medical Group
Patty Lieurance	Department of Human Services
Mary Anne Dollman	Quincy Catholic Charities
Barb Baker Chapin	Transitions of Western Illinois
Teresa Meyers	SIU/Quincy Family Practice



ONE COMMUNITY SYSTEM:

Connections Coordination Care

ACCESS TO CARE Linking System

GOAL

The goal of a community linking system is to have a community-wide information and intake system that facilitates social and health services needs identification, referral, enrollment and management, while minimizing the need for multiple client inquiries and referrals. A community linking system was identified by the access to care strategic planning process as the highest priority program element to put in place to form the basis of a system to improve access.

STRATEGY

The recommendation to put this system in place was based on issues uncovered during the assessment phase of this project and the experience and expertise of the dozens of individuals, including health care providers, social service providers, employers and consumers who participated in the strategic planning process. These issues include:

- There are many services available in our community that could improve access to care and help people access care more effectively, but it's not always easy to make the necessary connections
- Research among our health care providers indicates providers would be willing to accept more uninsured or Medicaid insured patients if those patients were connected to existing services that helped them use the system more effectively
- Providers and social service agencies do not have an efficient system for connecting people to services, documenting those efforts, eliminating duplicate efforts, etc.

Additionally, as the recommended elements of an access to care system were further researched and developed, it became clear that there is a need for software to connect people to other elements of the system (care management, provider network). Linking systems have the potential to address all these issues.

SYSTEM REQUIREMENTS

Input from representatives of social service and health providers who formed a linking system work group (see attached list) and also from written surveys (25 health and social service agencies responded) identified the requirements for the system:

- **Collect** demographic information and program eligibility information from clients
- **Document** benefits and programs already in use, barriers to access, needs and interests and appropriate consents
- **Provide** eligibility matching, program information, referrals, enrollment instructions, and enrollment, including providing this function for other elements of the access to care system (care management, provider network)
- **Document and report** contacts, referrals, system utilization and outcomes
- **Include** support, upgrades, customization

The group of agency and provider representatives working on this aspect of the project identified six essential functions for the system: Intake/information gathering, eligibility matching, referral/enrollment, support for care management, network management,

reporting/analysis. An information technology consultant engaged by the project helped us identify requirements for security and confidentiality, since HIPAA compliance is an important requirement as well.

ANALYSIS

With the assistance of our consultant from the Georgia Health Policy Center, we identified six systems to review. Later an additional system was identified and reviewed. Three of the systems presented enough evidence of meeting our requirements to warrant further review and demonstrations were held for each of these. The consensus was that one system, CHASSIS, from Network Sciences, based in Austin, TX, presented the best match for our needs. After a second demonstration, the group agreed that this was the system to focus on for implementation in our community. (See attached information about CHASSIS).

ISSUES

Three key issues have been identified as potentially problematic for the implementation of a linking system in Adams County.

- Funding is a major hurdle. These systems are expensive and while the strategic planning participants clearly identified this as the highest priority access to care element for the community, its value to any one agency is hard to estimate prior to implementation. Although it is possible to see the potential for much less duplication of effort and streamlining of meeting complex client needs, that's probably not enough to justify agency financial support initially.
- There is concern over duplication of information and referral services. The United Way has already invested in information and referral software. Though much less comprehensive than the linking systems we reviewed, it was a substantial investment for the agency. Also, the United Way is preparing to meet the requirements for "211" systems, a concept still not fully developed in the state of Illinois. We've had extensive discussions with the United Way staff and have agreed that the development of the linking system and the further development of information and referral services/211 in this area need to be connected as we move forward. Even with a linking system, where potentially any linked agency can provide multiple program information and referrals, there is a need for a neutral telephone based information and referral resource connected to the linking system.
- This effort needs to be a collaboration among agencies, rather than a program of a particular agency. All the systems we reviewed are web-based systems hosted by the vendor. In other words, the system is potentially available to every authorized employee at all of our county's health and social service providers. It is intended to be a vehicle for efficiently expanding access to program eligibility determination and enrollment, so that as many residents as possible are connected to all available programs.

IMPLEMENTATION

We are recommending a phased implementation of the Linking System, since not all agencies are in a position to participate immediately and that gives us an opportunity to learn and modify as needed. Implementation steps could include:

- Identifying five or six key agencies willing to participate first

- Work together to finalize the deal with the selected vendor
- Develop and load program eligibility information
- Design the elements of the assessment feature
- Begin to utilize the system and modify as needed
- Add additional users as feasible

LINKING SYSTEM WORK GROUP

Barb Baker-Chapin	Transitions
Cindy Brink	General Assistance
Joby Brown	First Christian Church
Diane Campbell	Department of Human Services
Glenda Clark	YWCA
Patty Douglas	Salvation Army
Carrie Edgar	University of Illinois Extension
Kathy Fauble	AHEC
Lois Hendrickson	Adams County Health Department
Carol Lewis	Quincy Medical Group
Patty Loeffler	Blessing Hospital
Shirley Longlett	SIU Quincy Family Practice Center
Candee Musgrove	Adams County Health Department
Debra Phillips MD	SIU Quincy Family Practice Center
Claire Robinson	United Way
Bev Rossmiller	Tri-State Health Care Coalition
Mark Schmitz	Transitions
Todd Shackelford	Area Agency on Aging
Kurt Stuckman	Catholic Charities
Major Carol Wertz	Salvation Army

CHASSIS (Community Health and Social Services Information System)

- Developed by Network Sciences, Austin TX, to support efficient and effective connection between uninsured/needy and health/social services
- Serves as information system for Austin indigent care collaborative, and as information system to support similar initiatives in other Texas locations and in Palm Beach County, FL
- Original component (Medicaider) is fast, accurate health care payment program eligibility determination tool
- Additional modules provider linking system features:
 - Single point of entry to match clients with programs
 - Generates referrals and facilitates enrollments
 - Creates client records for shared access for other users with appropriate clearance
 - Tracks, stores and reports contacts, referrals, enrollments, etc
- Has care management component that helps care manager support clients with chronic illness, track history of services, treatments, prescriptions, etc; and provides reminders for follow-up actions
- Eligibility tool can be used to determine eligibility and enroll people in local provider network
- 100% web-based and supported by Network Sciences
- Each user has individual username and password
 - “Rights” can be assigned by username so certain parts of system are only available to appropriate individuals
 - HIPAA compliant
 - Up-to-date security features
- Continuously updated with immediate access to latest version and information

ACCESS TO CARE Care Management Program

GOAL

To assist screened and referred individuals with their appropriate and effective use of the health care system through the provision of care management services. Care management includes helping individuals make appointments with their health care provider; assisting with transportation to appointments; talking to clients after appointments to help them follow their provider's plan of treatment; providing appointment reminders; providing disease education; serving as an advocate for the client when needed; making sure they are connected to all appropriate health and support programs.

STRATEGY

We would like to use existing case management capability from within several agencies, instead of setting up a separate care management program. We have identified almost a dozen agencies with case management capability. Six of those have provided additional information about the services available, eligibility criteria, funding sources/levels and whether or not the elements of care management could be provided to eligible individuals under their existing funding agreements. That information is summarized in a table below.

An alternative strategy for providing care management would be to hire care managers who would be dedicated to providing care management to clients referred through the Linking System. This would require finding new funding sources, but would allow the care managers to specialize in the health care-related needs of the clients. The preference in our planning discussions to date has been to try to use existing case management capability, but the final determination of the best way to provide this service needs to be addressed during implementation.

CLIENT IDENTIFICATION

Clients who would benefit from care coordination will be identified through the linking system or by a medical provider. Within the Linking System, care management eligibility criteria will be available just as it will be for many other programs. Criteria will need to be finalized by the agencies providing the care management resources, but might include no insurance or Medicaid plus any one of the following criteria:

- Multiple chronic medical conditions
- Problematic transportation to provider appointments
- Low health literacy as determined by screening questions*
- Health care compliance issues as determined by screening questions*

*The Nursing Diagnoses, Outcomes and Interventions Classification System might provide standardized scales for documenting health literacy, compliance or other factors that could be included in the criteria for case management

Health care providers who believe an uninsured or Medicaid patient would benefit from care management can refer that person to the Linking System for care management eligibility screening.

CARE MANAGER ASSIGNMENT

An individual screened, determined to meet criteria for care management and willing to participate will be matched with a care manager based on the specific eligibility criteria of agencies participating in the care management program. The table below shows what we know so far about case management capacity in local agencies.

Eligibility	Agency	Program Name	Program Description/funding	Comments
Low-income (200% of poverty level or less) and pregnant or infant	Adams County Health Department	Family Case Management	Promotes wellness and healthy lifestyle; funded by state grant	Program has limited ability to support additional client contacts; can't transport
HIV/AIDS diagnosis and financial criteria	Adams County Health Department	West Central Illinois Care Consortia	Assistance with food, finances, medical and medications; state and federal grants	Program can assist financially with health care
Not provided	Township of Quincy	General Assistance	Help with rent, utilities, food, household and medical; funded by township	Case management resources are limited; can't transport
Severe mental illness	Transitions	MI Case Management Support Services	Case management for persons with severe, persistent mental illness; Medicaid, private insurance, sliding scale	Can provide care management under this program
Children with developmental delay or risk factors for delay	Transitions	Infant and Toddler Services	Case management for child and family from birth to age three; United way, IL Board of Education and Title XX	Can provide care management under this program
Developmental disability	Transitions	Client & Family Support/DTP	Day programming and case management for adults with developmental disability; United way, Adams County Board, DHS	Can provide care management under this program
Low income and in crisis	Salvation Army	Family Service	Building self-sufficient, health families; donations, United Way, FEMA	Can provide care management but staff is not currently available to expand program.
Income at 70% of local poverty or Food Stamps or TANF	Two Rivers	Workforce Investment Act Adult	Preparation for workplace; US Dept. of Labor through IL DCEO	Caseworkers can only serve people who qualify for program.
Out of work due to plant closings, layoffs	Two Rivers	Workforce Investment Act Dislocated Workers	Services to transition to new employment; federal and state grants	See above
150% of poverty	Two Rivers	Low Income Home Energy Assistance Program	Assists household in paying utility bills; state and federal grants	This staff not in a position to handle additional casework.
125% of poverty level	Two Rivers	Community Services Block Grant	Assists with emergency needs, shelter, food pantries, rent assistance; federal grants	Case managers get involved with broad set of issues. General suggestion is that funding not tied to customer eligibility for particular program would

				be appropriate to pay for additional case management.
Disability	West Central Illinois Center for Independent Living	Independent Living Skills Training	Promote skills re: health care, budget mgt, employment, personal skills, home mgt, mobility and transportation; Dept of Human Services, State and Federal Grants, private donations	Services must be requested by consumer, not provider or family. Consumers set own goals and case managers assist in reaching them. Services are free.
Disability	West Central Illinois Center for Independent Living	Advocacy	Educate re: rights, advise on benefits, services they are entitled to; Dept of Human Services, State and Federal Grants, private donations	Services must be requested by consumer, not provider or family. Consumers set own goals and case managers assist in reaching them. Services are free.

Other agencies with case management capability include: United Way, Division of Specialized Care for Children, Child and Family Connections, the Area Agency on Aging and the Quincy Housing Authority.

CARE MANAGEMENT EXPECTATIONS

The expectation of the Access to Care program is that the assigned care manager would include in their typical client assessment elements to identify the particular needs of the client relative to appropriate interaction with the health care system. Based on that assessment, the management/support plan will include specific goals relating to the health system, as well as interventions and activities to help the client achieve the goals. Information about the client's interaction with the health care system will be documented within appropriate modules of the Linking System. Periodic reports on the achievement of the stated goals will be entered into the system as well.

IMPLEMENTATION

Suggested implementation steps include some immediate actions to provide an increased level of care management even before implementation of the linking system.

- Interested agencies should agree upon criteria for care management referral
- We should complete the identification and description of all available care management resources
- The availability and use of these resources should be promoted to medical providers and social service agencies
- Agencies providing care management should document the care management they provide and its impact on the goals identified for each client
- Communication between the care manager and the medical provider should be encouraged and documented
- Once the Linking System is available, even on a pilot basis, the care management program should be integrated into it

CARE MANAGEMENT

Barb Baker-Chapin
Cindy Brink
Candee Musgrove
Nancy Bluhm
Patty Douglas
Carol Wertz
Larry Markway
Susan Douglas
Sandy Trusewych
Karla Richmond
Claire Robinson
Susan Douglas
Robin Mahnken

WORK GROUP

Transitions
General Assistance
Adams County Health Dept.
Adams County Health Dept.
Salvation Army
Salvation Army
Two Rivers Council
Quincy Housing Authority
Independent Living Center
Child/Family Connections
United Way
Quincy Housing Authority
Division of Specialized Care for Children

ACCESS TO CARE Provider Network Program

GOAL

To establish a network of health care providers willing to accept an agreed-upon number of uninsured patients, who will pay for services on a sliding fee scale. By having an established relationship with a primary care provider and having access to specialist and hospital care when needed, more people will receive the preventive services they need and the amount of inappropriate uncompensated care provided by the hospital will be reduced. In addition, uninsured patients will be distributed in an equitable and manageable way among providers. The program will gather outcome data to demonstrate overall reduction in costs for the community and improved health outcomes for program participants.

STRATEGY

By formalizing a network of providers for the uninsured, people who qualify for use of the network can have an identified entry point for the system and distribution of patients can be sensitive to the capacity of participating providers. There are many such networks in operation around the country, some of which share information and ideas under the American Project Access Network (APAN) banner. APAN and other projects have developed program models, including information, policies, procedures and forms, which can be replicated in other communities. The model programs are entitled Access and the community name- for example: Access Adams County.

NETWORK DEVELOPMENT

Provider networks are developed by first establishing a sliding fee scale so that the fee that will be collected at the time of service is known to the patient and to the office staff. Not only does this eliminate the inefficiencies inherent in trying to collect more money than a network enrollee has the demonstrated ability to pay, it is sensitive to the patient's desire to be treated like any other patient. Placement of the patient on the sliding scale is done in advance of the first appointment via the network enrollment process.

The successful sliding fee scale networks are physician lead and include participation by all providers. The benefit of broad participation is fair and reasonable distribution of patients. In the development phase, providers are asked how many patients they can accept, so that distribution of patients can also be sensitive to a provider's capacity. Providers in other communities have found this sort of system preferable to having these patients use the emergency room for primary care and then be assigned to the next doctor on the list if follow-up care is required.

To implement this program in Adams County, we recommend that an advisory council of providers be established to help set up the program structure.

ENROLLMENT IN NETWORK

Individuals are screened for enrollment in the network via an intake process facilitated by the Linking System. Eligibility criteria can include having no insurance, not being eligible for Medicaid or Medicare and meeting an established income level. Another variable that could be required to participate in the program is that the participant must have been a resident of Adams County for at least 90 days. If individuals are found to be eligible for Medicaid or

Medicare, they are directed to enrollment in those programs. The screening criteria would be developed with the advisory council.

Eligible individuals are typically enrolled for a period of one-year, at which time eligibility must be re-established. Patients sign a “Patient Responsibility Agreement” that includes things like keeping scheduled appointment, complying with treatment plans, reporting changes in income, and applying for other benefits for which they might be eligible. Failure to comply with these is grounds for termination from the program.

PATIENT BILLING

Patients are billed for services by the practices based on the level of pay determined when they enroll. Each patient is assigned a patient ID number, which is displayed on an ID card. This number contains a letter that corresponds to the fee codes established for different levels of income. This is how the provider offices know how to adjust each patient’s fee. In the Access Emmanuel (GA) program, patients must pay their fee at the time of services. Some provider network programs ask the providers to generate a HCFA form to forward to network management so that the number of patients served and the nature of services can be tracked and reported.

CARE MANAGEMENT

People enrolled in the network who meet certain criteria (multiple chronic conditions; no transportation; other compliance issues, etc.) will be referred to care managers. The role of the care manager is to assist that person’s appropriate interaction with the health care system, via provision of transportation, health education, compliance support, linking to other needed programs, such as prescription assistance, and other support services. The purpose of this referral is to help the patient participate as effectively as possible with the provider in improving and maintaining good health.

IMPLEMENTATION

We do not anticipate full implementation of this program until after the community-wide Linking System is established. The information system we are considering has functions that will support screening for program eligibility and enrollment with a provider. More important, the system will screen for and match people with other health and social service programs, so that enrollees will be connected with other needed services before their appointment with a network provider.

Knowing that providers are already accepting uninsured patients, we would consider some immediate actions to improve the way uninsured individuals access services now, while we work on a broader implementation after the community-wide linking system is available. Implementation steps could include:

- Formalize a list of providers immediately available to accept uninsured patients and establish an advisory council.
- Establish and agree to the policies and procedures by which the network will operate and set up the sliding fee scales.
- Establish an individual to maintain the list of providers and to distribute patients among those providers.

- Have agencies refer uninsured patients to this resource to be assigned systematically to the participating providers.
- Develop a structure or engage an existing structure of physicians who are willing to help promote the program to other physicians to solicit their participation.
- Set up more providers in the network.
- Actively work with providers to meet their needs and ensure continued participation.
- Educate the office staff members in participating provider's offices about the program and how it functions.
- Begin to expand the number of patients enrolled in the network.
- As the Linking System is established, use its features to manage the provider network, patient enrollment and referral, and outcomes reporting.

PROVIDER NETWORK PROGRAM INPUT

Blessing Hospital

Brad Billings
Larry Swearingen
Maureen Kahn
Zig Brown

SIU Quincy Family Practice Center

Debra Phillips MD
Jerry Kruse MD
Tom Miller MD
Shirley Longlett

Quincy Medical Group

Chad Hine
Les Clemmer
Dan Evans MD
Carol Lewis
Kathy Harmon
Ruth Gray
Dick Schlepphorst MD
Ken Blum
Sylvia Miller

ACCESS TO CARE Three-Share Insurance

GOAL

With the primary source of insurance for adults in the United States being their employer, a goal of access to care initiatives has to be to expand the number of individuals with employer-based coverage. Since almost 75% of the uninsured adults in Adams County are employed, expanding the number of people insured at work is a priority.

STRATEGY

Other communities around the country have experienced success with an approach called “Three-Share” or “Multi-share” coverage. This approach uses a basic benefit design and an employer-employee-community premium share to make health coverage affordable for employers to offer and employees to purchase. The viability of the approach depends on a number of factors, key among them determining the qualifiers for participation and securing the community premium contribution. In Illinois, there is one active program, in Winnebago County, and five other programs, covering seven counties, waiting on approval of a state Medicaid amendment that would certify unreimbursed tax-funded costs of services as state Medicaid expenditures for the purposes of securing additional federal money that becomes the community match. Other potential sources of the community match are local donations or private and federal grants. The key to securing local community support for the third share of the premium is to understand that the community is already paying for inappropriate emergency and inpatient hospital care for people who do not have access to primary and preventive services. In our community, even just a portion of the cost of uncompensated inappropriate care (estimated to be over \$1,000,000 annually) would fund a third of a basic benefit insurance plan for a portion of our uninsured working adults.

THREE-SHARE EXAMPLES

In Carbondale and Springfield, the three-share plans will use plans from Unicare. In one example, the monthly premium for individual coverage is \$195 per month (or \$65 per share). The plan has a \$1000 in-network deductible and a \$5000 maximum annual out-of-pocket for in-network utilization. Preventive services are covered 100% up to \$200 maximum with no deductible (after that the deductible applies); in-network office visits require a co-pay, and hospitalizations and most other services are covered at 60%. The plan in Macoupin County, which will use a different Unicare plan, has about 85 small employers committed to offering the plan.

In St. Clair County, the plan will be offered through American Life. It has fixed benefits: \$60 per office visit up to \$600 per year; \$1000 per inpatient hospital day, etc. The premium is \$150 (or \$50 per share) per year for individual coverage. The criteria an employer must meet to offer this plan are being located in St. Clair County, not having offered insurance for a period of at least one-year and employees whose median hourly wages are no more than \$15 per hour.

The three-share concept got its start in Michigan, where state regulations allow counties to develop county health plans that are exempt from state insurance law. In Muskegon County, the program is allowed to draw Disproportionate Share Hospital dollars from Medicaid, which are matched at the federal level, returned to the local hospitals and turned over to the program to serve as the community match. In order to offer the plan, businesses must be

located in Muskegon County, have not offered insurance for the previous 12 months and pay a median hourly wage of \$11.50 or less. The total premium is about \$150 per month for individuals.

SMALL EMPLOYER HEALTH INSURANCE IN ADAMS COUNTY

Meetings held with three organizations that represent employer interests (Great River Economic Development Foundation, Quincy Area Chamber of Commerce and Tri-State Health Care Coalition) indicated employer interest in investigating the three-share approach. At the suggestion of this group we obtained information about small employers in Adams County. Adams County has 2000+ employers with fewer than 50 employees. We surveyed 400 of these businesses about health insurance. A summary of the results of the survey is attached. Of 62 responding companies who completed the survey, a little over half do not offer insurance, either because it's too expensive or because employees are covered under a spouse's plan. The comments from companies offering insurance and those not offering were similar, that offering health insurance is or is becoming too expensive for employers and employees.

It is interesting to compare responses between employers offering insurance and those that do not. The average wage for businesses not offering insurance is \$10.51 per hour; for those offering, it is \$12.56 per hour. Both groups of employers largely rate an employee monthly premium of \$40-\$80 as affordable. Amounts above that are considered not affordable by employers not offering insurance. More of the employers offering insurance considered higher employee premiums affordable. When asked to rate the affordability of the employer portion of the premium, the businesses not offering insurance responded the same way: \$40-\$80 was affordable. For the employers offering insurance, a significant number included \$80-\$120 in the affordable category. Currently, these employers report an employee monthly premium of \$172.83 and an employer monthly premium of \$294.60.

The Chamber of Commerce sponsored a focus group lunch at which small employers provided additional insights into health insurance issues. They provided reasons that employees might not take coverage even when it's offered: a perception that taking insurance will remove their kids from Medicaid; some employees (particularly young and healthy ones) don't see the value; the premium is too high. The consensus of this group was that an employee premium of about \$80 per month was affordable for small business employees. Research conducted for the state of Illinois identified about \$90 a month as an affordable premium for the targeted employers.

In a discussion of the three-share concept, employers were concerned about eligibility criteria and the need to design criteria so that employers don't drop existing coverage to participate in a three-share plan. The employers were receptive to the idea of designing coverage criteria so that the availability was targeted to low-wage employees who cannot afford coverage even if it's currently offered. They also suggested that support for a three-share program here should be broad-based, including providers, employers and the community at large.

We asked the National Federation of Independent Businesses (NFIB) to also sponsor a focus group for us, but the state director declined. Their organization is focusing on insurance reform as their key strategy for improving the affordability of health insurance for small employers.

POTENTIAL IMPACT

We think there is sufficient need and interest among small employers to warrant continued development of the three-share concept. Although the potential availability of federal Medicaid dollars to fund the community share should not be ignored (and we should track recently introduced federal legislation-HR 5171- which would make federal grants available for start-up three-share programs), there is a case to be made for local support of the third share. Although a very difficult statistic to develop, Blessing Hospital has estimated that the cost of avoidable hospital care for uninsured patients is over \$1.3 million annually. Half of that amount, or \$650,000, would fund one-third of the Unicare plan for 900 or almost 25% of our working uninsureds. This is money that the community is already paying for care that might not have been necessary in the first place. Funding primary and preventive care would be a much better community use of those dollars.

IMPLEMENTATION

Most of the counties, which have already designed their three-share programs, received state health planning grant money to pay for consultants who specialize in the design and implementation of these programs, at \$80,000 to \$100,000 per project. With the work by these other counties and the availability of insurers already participating in these plans, we expect the development cost to come down, which might make the engagement of a three-share consultant more affordable. Likely implementation steps include:

- Identify a potential insurance partner with a plan that fits our needs
- Determine the plan provisions and resulting premium and secure the community share of the premium for a pilot program
- Confirm the marketability of the plan with small employers
- Engage local brokers in the initial marketing to a pilot-sized market

EMPLOYER FOCUS GROUP PARTICIPANTS

Kurtis Carlson	20/20 Eyecare
Tony Crane	Architechnics, Inc.
Debbie Fasano	Care Net Pregnancy Services
Tom Darnell	Darnell Home Improvement Services
Katherine Thomas	ETC Computer Solutions
Rodney Heimer	Heimer and Assoc., Inc.
Mike Nobis	JK Creative Printers and Mailing
Pam McNelly	Northwestern Mutual Financial Network
Monica Hinkamper	Quincy Racquet Club
Cheryl Esselman	Esselman Counseling
Karen Points	West Central Child Care Connection
Marla Willard	West Central Child Care Connection
Cara Spalding	The Crossing
Deb Aamoth	Allstate Insurance
Jack Freiburg	Freiburg Insurance
Rene Ingraham	Ingraham and Ingraham

EMPLOYER INSURANCE SURVEY SUMMARY

Out of the 400 Employer Insurance Surveys mailed out, 67 were returned. Of those, 29 employers offered insurance while 33 did not (Figure 1). Five other surveys were returned because they were either no longer in business or only had volunteers.

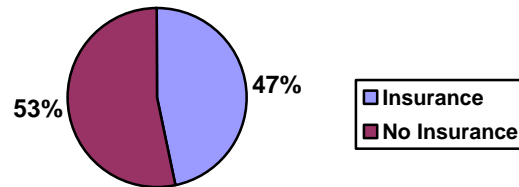


Figure 1. Insurance coverage provided by employers.

SECTION 1

Of the employers offering insurance: 351 employees were eligible for coverage, although a total of 403 full-time employees was reported by employers offering insurance. Only 233 employees currently take the offered coverage. Out of the 29 employers offering insurance, 24 offered family coverage, while 4 do not and 1 employer did not respond. The number of employees taking family coverage is 123. For all their employees who have satisfied any applicable waiting period, 25 employers reported their employees are eligible. Only 1 employer reported not all employees were eligible, while 3 did not respond. The average premium/month for employee only/single coverage is \$172.83 (Table 1). The average premium/month for family coverage is \$436.46 (Table 1). The five-number summary for both single and family coverage provides the best picture of the range of employee premiums per month (Table 2).

Table 1. Average Employee Premium/Month

Employee Only/Single Coverage	\$172.83
Family Coverage	\$436.46

Table 2. Five-number Summary

Employee Only/Single Coverage		Family Coverage	
Minimum	\$11.56	Minimum	\$98.76
First Quartile (25%)	\$53.00	First Quartile (25%)	\$184.59
Median	\$94.46	Median	\$325.00
Third Quartile (75%)	\$263.00	Third Quartile (75%)	\$740.00
Maximum	\$750.00	Maximum	\$1,044.00

SECTION 2

This section was only pertinent to those employers offering insurance. On average, the employer pays \$294.60/month for the employee only/single coverage on a per employee basis (Table 3). For family coverage, on average the employer pays \$540.90/month (Table 3). The five-number summary best shows the range of amounts the employers pay per month (Table 4).

Table 3. Average Amount Employer Pays/Month

Employee Only/Single Coverage	\$294.60
Family Coverage	\$540.90

Table 4. Five-number Summary

Employee Only/Single Coverage		Family Coverage	
Minimum	\$50.00	Minimum	\$50.00
First Quartile (25%)	\$128.00	First Quartile (25%)	\$184.59
Median	\$229.16	Median	\$509.50
Third Quartile (75%)	\$409.00	Third Quartile (75%)	\$850.00
Maximum	\$700.00	Maximum	\$1,325.44

The number one reason why employees declined the coverage offered was because they have coverage through a spouse or parent with 19 employers ranking that reason (Fig. 2). Being ranked by 10 employers, the next reason was the employee share was too expensive. The next two reasons, in order, are they don't think they need it and then the benefits are not attractive enough. Only 7 employers even ranked those two options.

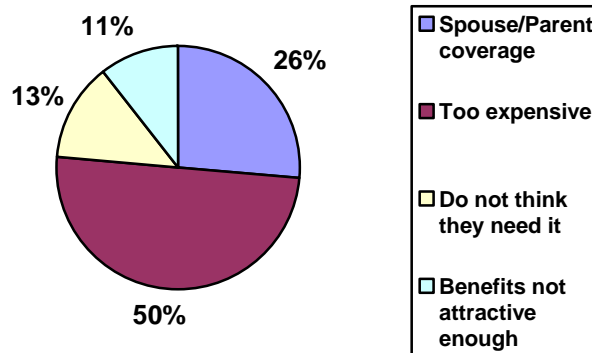


Figure 2. Reasons eligible employees decline the coverage offered.

SECTION 3

This section was only pertinent to those employers who did not offer insurance. The majority of employers, 21 out of 33, do not offer insurance because it is too expensive, while 18 also ranked employees being covered elsewhere as another reason they do not

offer insurance (Fig. 3). Only 2 employers responded employees would rather have higher wages than health care benefits. Only 5 employers responded to the year in which they last offered health insurance. One employer never has, while one last offered insurance twenty years ago in 1986, with the most recent year being 2003.

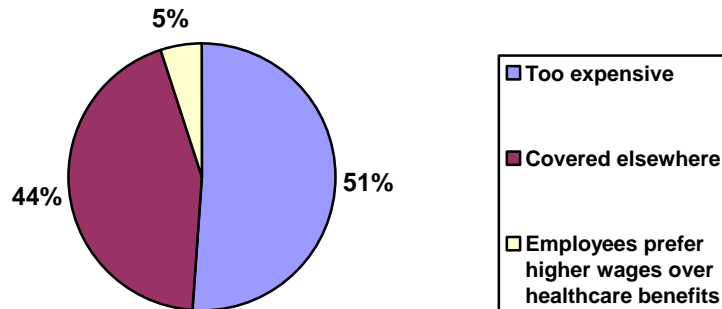


Figure 3. Reasons employers do not offer health insurance.

SECTION 4

The biggest difference in the employer’s surveys is the perceived affordability of insurance premiums (Table 5). For each employer premium option, the majority of employers, offering insurance, ranked them as affordable. With the exception of the lowest premium range, the majority of employers not offering insurance viewed the other options as maybe affordable and even more likely as not affordable.

Table 5. Employer’s perceived affordability of employer premiums.

Affordability	Employer Premium \$40 - 60			Employer Premium \$60-80			Employer Premium \$80-100			Employer Premium \$100-120		
	Affordable	Maybe	Not	Affordable	Maybe	Not	Affordable	Maybe	Not	Affordable	Maybe	Not
Insurance	19	1	0	16	4	0	12	6	1	16	1	5
No Insurance	15	5	0	7	8	0	1	9	10	2	2	17

For the employee premium options, both sets of employers viewed the lowest premium range as affordable (Table 6). While the other ranges gradually became viewed as less affordable options all the way to not even affordable for the employees. The majority of employers offering insurance ranked the first three ranges as affordable, as opposed to their counterparts, not offering insurance, who ranked most options as maybe affordable or not even affordable. Ultimately, with both the employer and employee premiums, the employers who do not offer insurance found many more options less affordable than their counterparts who currently offer insurance coverage.

Table 6. Employer's perceived affordability of employee premiums.

Affordability	Employee Premium \$40 - 60			Employee Premium \$60-80			Employee Premium \$80-100			Employee Premium \$100-120		
	Affordable	Maybe	Not	Affordable	Maybe	Not	Affordable	Maybe	Not	Affordable	Maybe	Not
Insurance	20	2	0	11	9	1	6	9	3	6	4	8
No Insurance	17	4	4	8	7	7	2	5	14	2	1	18

There were a total of 536 full-time employees reported by employers. Of those 536 employees, 133 are working for employers who do not offer insurance coverage. There are 85 full-time employees working for employers who do not offer insurance coverage. The average hourly wage for employees who were not offered insurance was \$10.51. While the average hourly wage for employees who were offered insurance was \$2.00 higher, at \$12.56.

Overall, the majority of the surveys returned were from employers who do not offer insurance coverage to their employees. The reasons for employers not offering insurance and employees declining insurance were very similar. The top two reasons were because it was too expensive or there is insurance coverage provided by a spouse. Regardless of whether or not they offered insurance coverage, employers agreed it is becoming more difficult to provide insurance due to the ever-increasing costs. Most employers who do not offer insurance could not afford to do so. Both sets of employers recognize the problem with providing insurance for their employees, especially among small business owners. Several employers, from each group, cited this problem and suggested forming groups to help lower the costs for them in order to provide insurance for their employees. Even though a little over half of the employers do not offer insurance coverage, both sets of employees face the same problems when it comes to providing insurance coverage for their employees.

ACCESS TO CARE Organization and Structure

GOAL

To ensure that measurable improvements in access to health care in Adams County are achieved and sustained, through the establishment of a community-supported structure to implement the recommendations from the assessment and planning project.

STRATEGY

We are recommending the use of an existing but inactive organizational structure to house the implementation and ongoing management of access to care programs in Adams County. When it was determined that a Federally Qualified Health Center (FQHC) was not a financially viable access to care model in our county, the board of Riverview Health Services, Inc. agreed to keep the organization intact but inactive in the event that other access to care initiatives would need such a structure. A general review of the Articles of Incorporation and the By-Laws did not reveal any major inconsistencies between the purpose and objectives of Riverview and an organization to support the implementation of the access to care initiatives. The purpose of Riverview is to “improve access to quality health services in Quincy and the surrounding area.” Some of the specific purposes and objectives listed may need to be modified or deleted since they reflect Riverview being a provider of direct services, but there is substantial consistency between the overall goal of Riverview and the access to care goals.

BENEFITS OF STRUCTURE

While we recognize the costs and complications associated with establishing a separate entity, there are numerous benefits as well:

- A high level individual will be needed to oversee the implementation and ongoing management of the access to care system and it’s not clear what existing organization could hire this individual
- The organization will need to enter into contracts for the implementation and support of its programs (for example, contracts for system software, insurance program consulting, insurance program administration, etc.).
- There are potential liabilities associated with managing access to care programs that existing organizations may not want to assume
- Although other organizations may be asked to play a lead role in promoting a particular access to care program, the overall initiative needs to be viewed as independent of any particular agency or organization
- The successful programs we’ve looked at in other parts of the country use independent structures to oversee access to care initiatives
- An independent structure can serve as the Alliance for Building Communities (ABC) partner for the many health-related objectives in the ABC plan

BOARD STRUCTURE

The Riverview board has 16 members, including four officers who serve as the Executive Committee. An FQHC board is required to have as a majority of the directors people who represent the center’s target service populations. While it would be good to have broad consumer representation on the access to care structure board as well, consumers would not have to constitute a majority. This structure would benefit from good provider and business

community representation as well. The special needs and interests of the provider community could be addressed through the establishment of formal “appointing authority” or reserving a certain number of board seats.

The committee structure established for Riverview would be applicable to the access to care structure: Finance, Fund Raising, Planning, Nominating and Training and Quality Improvement. Also, the committee structure would provide a way for representatives of the many agencies and organizations with an interest in health care access to continue to participate in this initiative.

COSTS ASSOCIATED WITH IMPLEMENTATION AND MANAGEMENT

We have estimated costs associated with the initial establishment of a structure to implement the recommended access to care initiatives. Start-up costs would include the initial investment in the software system; consulting assistance associated with implementation of the access to care initiative, such as assistance from the American Project Access Network (APAN), insurance; program consulting, etc.; legal services; office equipment; and training and development. Ongoing operational costs would include personnel (full-time executive and part-time clerical); office operations; communications materials; office space; and program operations. A draft budget is attached.

FUNDING SOURCES

Access to care programs are typically funded with a combination of federal, state and local resources. There are a number of grant opportunities for funds to establish access to care initiatives, which are listed on an attachment. The programs active around the country generally continue to rely on grants and donations for the bulk of their funding for subsequent operations. The justification for ongoing funding, particularly locally-generated, lies in the community benefits documented, including reduction in inappropriate uncompensated hospital care (which reduces the cost of care for the community) and improved efficiency and effectiveness of social service agencies using the Linking System. Although the actual dollars associated with inappropriate uncompensated care are difficult to estimate, Blessing Hospital has estimated that the cost of inappropriate emergency and inpatient services provided to uninsured individuals is about \$1.3 million. Less tangible benefits are improved productivity from a healthier community, improved school performance attributable to healthier families and the overall improvement in quality of life, which in our community can be documented through the Alliance for Building Community (ABC) outcomes measurement system.

MEASUREABLE RESULTS

Part of the Network Planning Grant that has funded this assessment and planning phase has been reserved to develop an evaluation system to document the measurable impacts of the programs implemented. In addition to the ABC indicators and the indicators identified in the assessment process (see Introduction), the planning process has also identified other potential measurable indicators:

- Number of non-provider points of entry into services supporting health access
- Number of overall service referrals and connections
- Distribution of uninsured and Medicaid clients accessing through system
- Fewer no-show appointments

AGENCY PARTNERS

The complexity of the problems we are addressing and the need for a collaborative approach support the need to work closely with key agencies and organizations on all aspects of the implementation process. It is very important for other groups to feel ownership in these programs as they are developed. The United Way is certainly a key to successful implementation of the linking system, as are other agencies that provide an information and referral function, such as the Area Agency on Aging. For the provider network, other communities and the American Project Access Network (APAN) recommend provider “ownership” of the solution. Although we may be successful in using existing case management programs to provide care management in the system, the Salvation Army and the Kroc Center are important partners for care management.

IMPLEMENTATION

There are several implementation steps that can be addressed immediately:

- Determine the steps required to establish the support structure in the Riverview corporation
- Reactivate and modify as needed the board membership and structure
- Secure start-up/three-year grant funding from a combination of sources, including local support

JOB DESCRIPTION

DRAFT

Job Title: Executive Director of the Adams County Health Care Access System

Education Required: Minimum qualifications include a bachelor's degree

Experience Required: Minimum of 5-8 years of experience in a health-related field. Relevant work experience includes an administrative position with a provider or in managed care. Skills desired include the ability to interface with medical providers as well as social service agencies and excellent communication skills.

Licensure Required: None.

Description of Job Activities:

- Facilitates effective working relationships with access to care partners.
- Fund development for access to care projects.
- Grant writing to support access to care projects.
- Public promotion and education of access to care projects.
- Serve as contact person for facilitation of the community linkage system for community agencies and contracted vendor.
- Enrollment and facilitation of the provider network for the uninsured population.
- Assign case managers from provider agencies to appropriate participants.
- Work with consultant to facilitate community 3-share program.

ACCESS TO CARE BUDGET DRAFT

CATEGORY	START-UP	ANNUAL	
SALARY		75,000	
Executive Dir. (1.0 FTE)			
Assistant (.5 FTE)		15,000	
BENEFITS			
Executive Dir. at 30%		22,250	
Assistant at 15%		2,250	
SUBTOTAL		114,500	
OPERATIONS			
Supplies, phone, etc.		7,000	Potential in-kind donation
Marketing/communications		3,000	
Travel		1,000	
Legal, Accounting	2,000	1,000	
Meetings		2,000	
Training		1,000	
Equipment		3,000	Potential in-kind donation
Insurance		1,500	
Rent		5,000	Potential in-kind donation
SUBTOTAL	2,000	24,500	
PURCHASED SERV.			
Software system	30,000	25,000	*
Program consulting	70,000	20,000	
SUBTOTAL	100,000	45,000	
TOTAL	102,000	184,000	

*These are estimated costs which will ultimately be determined by the system configuration purchased. Annual costs will likely decline by about half in subsequent years

Access to Healthcare Program
Potential Grant Funding Sources

Grant Name	Grant Source	Application Due Date	Program Date	Grant Amount	Grant Purpose	Status of local activity (As of June 9, 2006)
1. Network Outreach Grant	HRSA- Office of Rural Health Policy	September, 2006	May 1, 2007- April 30, 2010 (3 year grant period)	First year- 150,000 Second year-\$125,000 Third year- \$100,000	Development of new and innovative health care delivery systems in rural communities that lack essential health care services	
2. Local Initiative Funding Partners Potential local partners could include: Salvation Army, Tracy Family Foundation, Blessing Hospital Foundation, Community Foundation of the Quincy Area, Oakley-Lindsay Foundation, United Way of Adams County and local community corporations	Robert Wood Johnson Foundation	Stage I- June, 2006 Stage II- November 9, 2006	July 1, 2007- June 30, 2010 or June 30, 2011 (3 or 4 year grant period)	\$200,000-\$500,000-TOTAL throughout grant period Equal local dollar match required	Partnership between RWJF and local grantmakers to fund promising, original projects to improve significantly the health of vulnerable people in their communities.	Have had a meeting with local funders and Blessing Affiliates Board. Are working to identify a nominating agency
3. Marion Gardner Jackson Charitable Trust	Marion Gardner Jackson Charitable Trust	July, 2006	January 1, 2007- December 31, 2010 (3 year grant period for program grant) May request a specific time frame for capital grant requests	\$25,000 each year Match required For program grant No request amount limit for capital grant request	Aid religious, charitable. Scientific, literary and educational organizations in the Quincy, Illinois area.	Attended the bidder's conference. Talking with the technical assistant consultant to determine application strategy

4. Grants to develop community based primary care centers	Illinois Department of Public Health	June 9, 2006	July 1, 2006- June 30, 2010 (4 year grant period)	\$75,000 each year	Provides grants to support the development and operation of projects that establish new or enhance existing services to meet the primary health care needs or rural areas and downstate designated shortage areas.	Grant submitted June 9, 2006 requesting \$75,000 each year for four years. Funds requested for salary and linkage system start-up.
5. HCAP	HRSA	This grant is not available this year, however we can watch to see if it is funded in future years			Assist communities and consortia of health care providers and others to develop or strengthen integrated community health care delivery systems that coordinate health care services for individuals who are uninsured or underinsured and for activities related to coordinated care for individuals with chronic conditions who are un or underinsured.	
6. Building System Capacity- expanding access to targeted health services	Illinois Children's Healthcare Foundation	June 30, 2006	October 31, 2006 1-year grant period	\$50,000-\$500,000	Increase access to health care through an expansion of services in clinical settings. Priority consideration will be given to organizations that operate as medical homes for underserved children in Illinois.	Talking with consultant regarding our program plan and its' appropriateness to the grant program.

7. Fresh ideas: Community-based approaches to improve care for vulnerable populations	Robert Wood Johnson Foundation	Any time-brief proposal first and if invited full proposal	Any time	\$300,000	Looking for fresh ideas to represent new approaches to the health and health care problems that affect vulnerable people. Projects to expand or continue existing programs or services will not be considered. Especially interested in support to organizations outside the formal network of health care programs.
8. Communities Building Access Act	Legislation introduced by Rep. Pete Hoekstra (R-Holland, MI)	H.R. 5171. Co-sponsors are being added to the legislation.		\$45 million in federal grants over seven years	support “multi-share” coverage programs, volunteer specialty provider networks and to establish a national center to support community programs
9. Aligning Forces for Quality: The Regional Market Project	Robert Wood Johnson Foundation	September 7, 2006	July 14, 2006- Applicant registration deadline September 7, 2006- Full proposals due November 15- December 13, 2006- Site visits of finalist communities	\$600,000 over three years	To help communities dramatically improve the quality of health care they provide for chronic diseases in ambulatory settings.

The grants listed on the chart provide information regarding potential grants that we can apply for to implement the activities identified by the Access to Healthcare project. We realize that we cannot rely upon grant funding alone and that we need to develop a plan to leverage other funding sources for the project.