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W. K. Kellogg Foundation

Program Information and Guidelines

"Windows of Opportunity"

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Windows of
Opportunity

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W. K. Kellogg Foundation

"Health Programming Information"

W.K. KELLOGG FOUNDATION

Health Programming Information

April 19, 1993

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

As the national debate over health care reform escalates, and the White House task force nears completion on the first phase of its work, we want you to know of the work supported by the Kellogg Foundation in the health field, and of the potential resources which might be mobilized in the next phase of the reform movement.

We recognize that there are powerful forces working to maintain the status quo, and that the only counterforce for the vested interests is that of the "voice of the people" -- the community.

For more than 63 years, we have made a substantial effort to join with a large variety of diverse, underserved communities throughout the United States and indeed around the world (through our work in Latin America, the Caribbean, and southern Africa) to understand health care problems from their perspective and to support problem-solving efforts identified by people in these communities.

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With more than $85 million currently invested in 100-plus community-based health projects, we have a rich reservoir of knowledge and lessons of what health care services and delivery systems work, and which do not.

We know that the health care issues of today cannot be addressed through traditional approaches, and that mobilizing and engaging people in maintaining their own health, and that of their families and communities, is an essential and critical component of any change process.

We also have substantial evidence that these individuals and their communities can make a difference in developing and implementing effective reform strategies. Here are some examples:

- Developing a network of church vans and drivers trained as health advocates has been successful in getting large numbers of expectant mothers into prenatal care in Detroit.
- In Chicago, health advocates bridge the communication and cultural gaps between traditional health care providers and people in communities and are making a powerful difference.

- Providing a network of community resources and volunteers in Evanston, Illinois, to assist people who wish to maintain elderly family members in their home settings is an effective way of reducing costs and enhancing quality of life for all. For $1800 per year in respite care services for persons eligible for Medicaid funding for nursing home care, these elderly can be maintained in their home settings, a savings of at least $40,000 per year per individual.

- Grandmothers in Bennetsville, South Carolina, engaged in teaching of young people, are an effective force in reducing adolescent pregnancy.

- Native American women on the reservations of South Dakota are improving the health of their families through a variety of approaches designed to increase their control over the circumstances that surround them.

These are but a few examples of the rich experiences that have been garnered over this extensive programming effort.

Community-based efforts that involve community members as active participants with the caregiving networks and inclusion of a full range of providers using their varied skills and expertise in providing health care are the key components of accessible, culturally sensitive and appropriate services at affordable cost for all.

In our home community of Battle Creek, a women's health service that initially was organized around the needs of underserved women now employs five nurse midwives and an obstetrician. Together, they deliver nearly 50 percent of the infants in the community. This cost-effective service has made a significant difference in reducing infant mortality and supporting the health of mothers. Mothers who delivered healthier infants then wanted the same options for pediatric care. Fifty percent of the children in Battle Creek never saw a physician outside of an emergency room. Based on this need, a pediatric care center was developed and staffed by pediatric nurse practitioners and pediatricians. At an average unit cost per visit of $35, high quality care is now available to all mothers and children within Battle Creek, and high-cost emergency room visits have been dramatically reduced.

From these experiences, a number of valuable lessons have been learned that may be useful in the current debate over health care.

- First, we do not have a health care system in this country. Instead, we have an expensive, highly fragmented, and inappropriate medical care system.

- Secondly, the current approaches to health care reform are addressing structural issues without addressing the fundamental issue of system change, which is essential if health care is to be accessible to all at affordable costs. These system changes must address:

  1) **comprehensiveness** of the system -- from preventive to curative and chronic care that is integrated and that works as a system;

Primary care → increased importance

Boston
E Tennesse
U of Hawaii
Michigan State
Morehouse
U of Texas El Paso
U of W Virginia

Public Health -

Univ of Washington
Johns Hopkins
U of Mich / Detroit
Univ of N. Car.
Emory
Univ of Mass.

2) **appropriate use of health personnel** organized to work collaboratively, drawing upon appropriate levels of expertise for different functions within an integrated system (i.e., use of nurse practitioners for health monitoring backed up by physicians expert in treatment of disease); and

3) **the needs of all people within the communities which it is designed to serve.** Communities need to be able to determine their health needs, and to govern a system that addresses and meets those needs. Communities need to assume the role of decision-maker.

That role is based on a partnership of citizens, business, labor, and civic leaders, government representatives, and providers. When a community controls its health care resources and understands the nature of its health problems, the performance of its health and human service providers, and the financial limitations of its payers, the community can then establish priorities and develop programs which can best expand access, control costs, improve quality, and maximize resident satisfaction.

While there will be transition costs in moving from our current medical care system to a coordinated, comprehensive health care system, we firmly believe that over a relatively short period, appropriate health care can be accessible for all at costs that are relatively stable, and perhaps will decline once the majority of problems are addressed at the preventive side of the equation rather than at health care crises.

Based on these convictions drawn from our community experiences, we have embarked upon three related initiatives designed to move communities toward fundamental reform of our health care system. These initiatives constitute a three-pronged approach toward fundamental reform.

* **Community Partnerships in Health Professions Education** aims to increase nationwide the number of primary caregivers who are committed to community-based approaches, with the emphasis on primary prevention, primary care, and working effectively in multidisciplinary settings.

  In 1991, the Foundation appropriated $47.5 million to create and support seven partnerships between communities and health professions education institutions. Now, only 18 months along, these seven projects are already demonstrating how medicine, nursing, and other health professions students can be educated cost-effectively in academic, but non-hospital community health settings.

* **Community-Based Public Health** (CBPH) is a national effort grounded in the belief that public health educators and students should become firmly linked -- once again -- with community-based organizations in underserved communities.

  The purpose of the CBPH initiative is to develop new models for partnership between local health departments and community-based organizations in underserved areas,

and to strengthen the way that future health professionals are educated and prepared for their lifework in community health problems.

* The **Comprehensive Community Health Models** (CCHM) initiative, a partnership between committed communities and the Kellogg Foundation, is intended to assist communities in building a more efficient health system through enhanced local control and system change. The program is designed to help communities:

  - Accurately assess the health status, risks, and needs of residents.
  - Create a health system which reflects the needs and priorities of the community and which is focused on maintaining and improving the health status of residents, while minimizing the impact of injuries and illness.
  - Enhance the technical expertise available to communities as they consider the feasibility, costs, and benefits of the different options to implement a locally-controlled health care system.
  - Serve as models which inform the nation's debate on health care reform.

The Foundation is working to identify three Michigan communities to join as partners with the Foundation in pursuing implementation of Comprehensive Community Health Models.

We appreciate your taking the time to learn more about the lessons from grass roots, community-based approaches in health care, and the Foundation's experiences of working with the poor, underserved, and the disenfranchised.

Enclosed is a more comprehensive explanation of many of the lessons learned over 63 years of working with community-based approaches. We would welcome the opportunity to meet with you to explore these issues more in-depth, and to provide you with other information that might help you as you formulate national health policies.

Sincerely,

Helen K. Grace, Ph.D.
Vice President - Program

Gloria R. Smith, Ph.D.
Program Director; Coordinator/Health

HKG/sld
Enclosure

W.K. KELLOGG FOUNDATION

Tues July 20 9:30

FACSIMILE TRANSMISSION

Send to (Name): Ms. Melanne Verveer

Total pages (including cover): 22

Organization: White House, Washington, DC

Number: 202/456/6244

Date: 6/17/93

From: Roslyn McCallister Brock

	MAIN NUMBER	2ND FLOOR	3RD FLOOR
Send Return FAX to:	(616) 968-0413	(616) 969-2188	XX (616) 969-2127

Other

SPECIAL INSTRUCTIONS:

Dear Ms. Verveer:

Please share this information with Mrs. Clinton. We hope that she will allow us to meet briefly with her to discuss our current health programming priorities. If this is not possible, we would appreciate receiving her comments regarding our efforts.

Thank you again for your personal response to my phone call.

Roslyn McCallister Brock
W.K. Kellogg Foundation

OFFICE USE ONLY (BOX 12)

Send now **Send after 11 p.m.** **Send:**

W. K. Kellogg Foundation, One Michigan Avenue East, Battle Creek, MI 49017-4058
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Lessons Learned in Community-Based Health Programming

Lessons Learned in Community-Based Health Programming

Introduction

There are many powerful lessons to be learned from grass-roots, community-based organizations in designing a health care delivery system that works for people at the community level.

Many of the lessons that can be shared with policymakers have come from the W.K. Kellogg Foundation's long and rich history of helping individuals and communities improve their health care and services.

Since its inception in 1930, the Foundation has been guided by its founder's principle of "helping people to help themselves."

At the root of every project and initiative that receives support is the belief that if individuals and communities are given the right tools — information, education, technical assistance, etc. — they will be able to assess their own needs and implement a course of action that meets those needs.

By building the capacity of individuals and communities, they will be able to change their health system to meet their needs and improve their lives and their community.

If individuals and communities are given the right tools they will be able to assess their own needs and implement a course of action that meets those needs.

Working toward health care reform

The Kellogg Foundation is very encouraged with the Administration's commitment to pursuing health care reform.

There is now significant evidence that communities can, on a larger scale and with the proper resources and authority, effectively identify and plan for their citizen's health needs,

allocate health care resources, and hold down health care costs, while at the same time safeguarding the quality of care.

As part of the current review being undertaken by the presidential task force headed by Hillary Rodham Clinton, we would hope the Administration would consider a viable role for communities in any health care reform strategy.

Although the focus currently is on the role to be played by governments and large regional purchasing consortia it is important to remember that *health is a local affair.* Health services are both delivered and received within the local community.

Therefore, communities have shown us that *system change needs to come at the community level.*

It is important to remember that health is a local affair.

The Lessons Learned

Based upon the lessons learned from more than 100 community-based health models, and from a wealth of knowledge which the Foundation has gathered over its 63-year history, the following observations can be made:

1. At the community level, delivery of health services has been fragmented, creating great waste and frustration for all parties.

   Most funding sources have been geared to meet the needs of health providers and agencies, not the needs of the people. Funding may come from a variety of sources with different rules for its use. This often means that communities are unable to comprehensively plan health services that meet their needs. Because of this, many community-based health models may not be able to sustain themselves and still remain grass-roots, community-based.

   Ultimately, the issues surrounding sustainability must be addressed at the policy funding level. Many community-based health projects have had major

difficulty in continuing their services because of *fragmentation of funding at the community level, multiple and conflicting policies, and funding priorities that are directed toward paying for illness care rather than health promotion and prevention.* In building their own capacity, individuals and communities have been able to use these funds in more flexible ways to meet community needs.

2. When individuals and communities are provided with the information and background on health issues, they gain the capacity to exercise their power and influence to effect change/health care reform. With the right tools (new information, understanding, technical assistance, etc.), they become new, significant players at the table, and not token representatives.

3. Holistic approaches aimed at meeting the health and human service needs of people have been the most effective. This often meant that the definition of health became broadened and intertwined with other community-development issues, such as housing and economic development. Serious problems arise when health services are separated from human services, although our society's method of financing forces this separation.

4. There are large gulfs between the views/perspectives of health care providers and the people they are supposed to serve. Representatives from all parts of the community (consumers and purchasers of these services) need to be at the table (included) where the community's health needs are determined, and service delivery is planned.

At the same time, those providing health services need to reflect the diversity represented in the community.

For too long, health professionals have gone into communities to provide services without understanding the people or their needs, or allowing them to become involved in solving their own health problems.

Holistic approaches aimed at meeting the health and human service needs of people have been the most effective.

5. Bridging cultural and value gaps between communities and health care providers is essential at all levels. Community members in a variety of roles can be effective in bridging these gaps.
6. Community-based approaches to health have been a powerful force in building the capacity of people to have greater control over their lives and those of their families.
7. Communities often do not follow local, county, or state geographic boundaries on a map. Therefore, they need to have the authority to identify and establish boundaries that define their community.
8. Consensus among these widely differing stakeholders can be built with carefully crafted collaboration.
9. Organizational capacity (community infrastructure) is necessary for sustainability.

Bridging cultural and value gaps between communities and health care providers is essential at all levels.

W.K. Kellogg Foundation experiences

With its experiences in community-based health, the next steps were to support efforts to refocus health professions education and target two critical areas — increasing the number of primary caregivers committed to community approaches, and helping public health educators and students to become firmly linked with communities. WKKF has two major initiatives in this area:

- **Community Partnerships in Health Professions Education** aims to increase nationwide the number of primary caregivers who are committed to community-based approaches, with the emphasis on primary prevention, primary care, and working effectively in multidisciplinary settings.

In 1991, the Foundation appropriated $47.5 million to create and support seven partnerships between communities and health professions education institutions. Now, only 18 months along, these seven projects are already demonstrating how medicine, nursing, and other health professions students can be educated cost-effectively in academic, but non-hospital community health settings. Such settings are well under way in West Virginia, Boston, Michigan, Georgia, Hawaii, El Paso, and Tennessee.

These students are working and learning together in teams. Each is governed by a new organizational partnership between academic institutions and communities. Communities are influencing, by mutual agreement, the curriculum, research, and patient care of these new academic community health settings. Hundreds of students will be trained in rural and urban communities.

The key issues in refocusing health professions education are money and models — more financial support for undergraduate and graduate education occurring in non-hospital, academic, community environments and educational models that demonstrate how high-quality, community-based education and care can be conducted in such non-hospital settings.

As good as these models are, and the better they will become, *they will not survive under the existing system of paying for graduate medical education.* Virtually no funds are available for medical education or medical specialty training outside of hospitals. The federal government expends $5.2 billion in Medicare funds via hospitals (1992); $600 million in Veterans Administration funds are expended in hospitals; $5.6 billion in basic and clinical research funds (mostly from NIH) are expended on subspecialty research that affects the nature of medical education. A difficult situation is made even worse by

The key issues in refocusing health professions education are money and models.

states expending more than $2 billion on hospital-based graduate medical education and the medical practices income of medical schools adds up to a national total of $6.6 billion.

Therefore, we recommend the following to support academic, community-linked, non-hospital health professions education to increase the number of primary care practitioners:

Redirecting funding to support academic, community-linked, non-hospital health professions education to increase the number of primary care practitioners.

1. Allocate a proportion of both direct and indirect Medicare graduate medical education support for non-hospital, primary care education of physicians, nurses, and other health professionals. This could be achieved by (a) eliminating from direct medical education (DME) and indirect medical education (IME) subsidies that residents receive beyond the limits imposed by Comprehensive Omnibus Budget Reconciliation Act (COBRA) (eligibility for initial board certification plus one year, to a maximum of 5 years); (b) setting aside a certain portion (for example, 25 percent) of the DME and IME payments made on behalf of all residents, specifically for residents in the primary-care specialties (family practice, internal medicine, and pediatrics) for education in academic, non-hospital, comprehensive care settings; and (c) increasing the funding from the savings from (a) to the Health Resources and Services Administration, to develop grant proposals to create community-based academic health centers (CBAHCs), in HPSAs, for graduate education in an ambulatory setting of primary care physicians, nurses, and other health professionals.
2. Directly allocate funds for the non-hospital education of primary care practitioners to incorporated community and academic partnerships that are governed by representatives of the non-provider

community, community health centers, and health professions schools.

3. Change area health education legislation so that such community/institutional partnerships as indicated above could be the direct recipients of funding rather than through medical schools; significantly increase the funding for such redefined community partnership AHECs.

With a grant from the Kellogg Foundation, the Alliance for Health Reform, chaired by Senator John Rockefeller, is producing a series of policy options for increasing the number of primary care practitioners. The Alliance for Health Reform's proposals will address issues of student loans and debts, Medicare funding of graduate medical education, and the nature of health professions education.

- **The Community-Based Public Health** (CBPH) initiative is a national effort grounded in the belief that public health educators and students should become firmly linked — once again — with community-based organizations in underserved communities.

The Foundation believes that public health educators and practitioners should become firmly linked with community-based organizations in underserved areas if needed changes in the discipline are to be achieved and if these changes are to be responsive to society's greatest needs. Since all health concepts must ultimately have local relevance, there is a need for public health professionals — as well as for political, human services, and community leaders — to understand clearly the social, economic, and cultural conditions which determine health status, and the manners by which these effect lifestyle, behavior, and community decision-making.

The purpose of the CBPH initiative is to develop new models for partnership between local health departments

Public health educators and practitioners should become firmly linked with community-based organizations in underserved areas if needed changes in the discipline are to be achieved.

Public health practice needs to recognize the social, economic, and cultural differences of local communities, emphasize community capacity-building, use commuinty networks, and enter into a partnership of shared responsibility to improve community health and well-being.

and community-based organizations in underserved areas, and to strengthen the way that future health professionals are educated and prepared for their lifework in community health problems.

CBPH is now in its first year of a four-year Implementation Phase, following a one-year Model and Leadership Development Phase. Seven consortia were selected in the final competitive process; more than 100 applicants from around the nation submitted proposals to participate in the program.

Each approved consortium contains a school of public health, at least one other health professions school, one or more local health agencies, and representative community-based organizations in an area where model health services and programs are to be demonstrated.

Each of these seven consortia contains the following elements:

- A model community site, urban or rural, in which consortium partners provide community-based public health services;
- A form of public health practice that recognizes the social, economic, and cultural differences of local communities, emphasizes community capacity-building, makes use of community networks, and enters into a partnership of shared responsibility to improve community health and well-being;
- An approach that uses the core public health functions to understand and address local community priorities;
- A plan for upward mobility of community youth into the "helping professions" through recruitment, education, training, and mentoring;
- An approach for continuing education and leadership training for current health workers and for community laypersons;

- An educational system which reduces disciplinary fragmentation, that emphasizes teamwork in developing the values and skills that are pertinent to public health, and that links with members of the other health professions in an effort to make system improvements; and
- A model for learning the profession that emphasizes the relevance of community input and control into health decision-making that welcomes that input into the educational process, and that values the local health agency as an important site for scholarship, education, and research.

Community is at the core of system change

At all phases of these initiatives, the community has been at the core of developing innovative models aimed at systems change.

However, all these efforts targeted only pieces of the health care crisis. The next logical step was to ask the question: If one could wipe the slate clean, what would a health care system — envisioned by the community and controlled at the local level — look like?

This led to the development of a plan to work with select communities in Michigan that want to create a coordinated, comprehensive health system.

The Comprehensive Community Health Models initiative

Based upon lessons learned from more than 80 community-based health service projects, the Foundation strongly supports a community-based health care reform strategy and has recently funded a new initiative for total health care reform through established partnerships with three Michigan communities.

Comprehensive Community Health Models — building a more efficient health system through enhanced local control and system restructuring.

Key elements of a Comprehensive Community Health Model.

The **Comprehensive Community Health Models** (CCHM) initiative, a partnership between committed communities and the Kellogg Foundation, is intended to assist communities in building a more efficient health system through enhanced local control and system restructuring. The program is designed to help communities:

- Accurately assess the health status, risks, and needs of residents.
- Create a health system which reflects the needs and priorities of the community and which is focused on maintaining and improving the health status of residents, while minimizing the impact of injuries and illness.
- Enhance the technical expertise available to communities as they consider the feasibility, costs, and benefits of the different options to implement a locally-controlled health care system.
- Serve as models which inform the nation's debate on health care reform.

The Foundation is working to identify three Michigan communities to join as partners with the Foundation in pursuing implementation of Comprehensive Community Health Models.

Five key structural elements are identified as critical issues for developing effective models at the community level.

1. A **Community Governing Board** responsible for establishing local priorities and allocating health resources.
2. A **Uniform Administrative Structure** which allows communities to create a single set of rules and regulations, reduce system fragmentation, and monitor the system's performance.
3. An integrated financing system to provide **Community-Wide Coverage** so that all residents will be eligible for

health benefits and have access to appropriate, quality health care resources and services.

4. A **Comprehensive Integrated Delivery System** placing emphasis on health promotion, disease prevention, and primary care. Each community's health system will link health and human service providers into an integrated system to help achieve the primary goals of health care reform.

5. And **Full Financial Responsibility and Authority** for distributing health care resources to support health system reform.

Through this approach, it is envisioned that participating communities will be able to control all health resources flowing into the community. Thus, the successes achieved in approaches where resource control was limited to hospital revenues only, such as those tested in Rochester, N.Y., will be magnified in the CCHM communities.

The most important aspect of CCHM is the central role of the community. That role is based on a partnership of citizens, business, labor, and civic leaders, government representatives, and providers. When a community controls its health care resources and understands the nature of its health problems, the performance of its health and human service providers, and the financial limitations of its payers, the community can then establish priorities and develop programs which can best expand access, control costs, improve quality, and maximize resident satisfaction.

The most important aspect of CCHM is the central role of the community.

Key elements of community control

To exercise appropriate control, however, a community must be provided with the appropriate resources and requisite authority.

The following authorities and resources are considered

important in strengthening the ability of communities to effectively govern their health care systems. The list should be viewed as illustrative, to encourage additional discussion.

Authorities

Recognizing local governance structures.

1. Federal law should recognize local governance structures and provide flexibility in the allocation of health and human service dollars to community governance structures to meet local priorities. Such structures can be established by voluntary action (i.e., as a private, non-profit corporation) or as a local governmental agency by formal legislative action either at the state or federal level. In either case, they need to be specific legal entities which are assigned specific responsibilities. If the entity is to be eligible to receive and disburse state and federal funds, formal recognition (established in law) by the federal and/or state governments is required. Depending upon the powers that need to be given to the governing board, appropriate state and federal laws may need to be changed.

2. It is anticipated that each community would identify a governing board as part of its formal governance structure. The following issues will have to be addressed as part of this process:

- **Board Composition** — Although some specification may be necessary, any prescriptive mandate for representation should be broad and flexible. Most of the board members should represent the major public and private purchasers of health services in the community, as well as the residents in the community. Provider representation should be limited.

  By giving purchasers and patients a strong, majority voice, we increase the likelihood that the board's decisions will more closely attempt to realign the health care system with the needs of the community. However, given the ineffectiveness of

previous attempts to over-specify composition for community health efforts (e.g., our history with health planning), the federal government should consider limiting its requirements to a few general categories. For example, 40 percent of the board might represent major public and private purchasers, 40 percent residents (who reflect the demographic mix of the community), and 20 percent providers.

3. A mechanism for establishing the geographic area and population base falling under the authority of the community governing board. Any federal law in this area should not be prescriptive, but should provide options which support the ability of communities to engage in some level of self identification.

4. A mechanism for allowing the governing board to levy taxes or fees to finance health coverage for the un- and underinsured in the community might also be considered. If so, it would have to be decided whether the financing approach would be taxes, assessments, donations, etc. In all cases, only a government entity with financing authority could impose these types of assessments.

5. Authority for selecting, employing and monitoring the work of staff, selecting and monitoring the work of an administrative agent.

6. Authority to periodically conduct community-wide needs assessments, which would incorporate surveying the population and surveying providers is also required to assure that the necessary data are available to plan for community needs.

   Authority will also be required to allow the governing entity to access information on health care transactions (related both to payment and medical encounters) to monitor the quality of the care provided.

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Communities need to be able to foster or approve linkages among providers for the purpose of achieving efficiencies and promoting provider collaboration.

7. Authority to establish a standard benefit package, to establish the minimum categories of services and the services to be provided within those categories; and to specify co-pays, deductibles, and co-insurance requirements. The authority must also be empowered to develop supplemental benefit packages.

8. Authority to negotiate a reimbursement rate with providers and authority to negotiate with insurers and benefit plans (HMO's, PPO's, Blue Cross, etc.) regarding premium rates for the standard benefit plan and for any supplemental insurance plans that would be offered by insurers in the community.

9. Authority to impose standards of practice on insurers selling health coverage within the community.

10. Authority to regulate the acquisition and diffusion of technology within the community.

11. Authority to foster or approve linkages among providers for the purpose of achieving efficiencies and promoting provider collaboration. (This will be especially important in communities having more than one hospital to avoid anti-trust litigation.)

12. Authority to define the patient participation: Defining mechanisms for patient's selection of primary care teams; patient appeal and grievance procedures; and options for transfer or dis-enrollment.

13. Authority to regulate provider participation: Establishing enrollment criteria; identifying the conditions of participation, grounds for termination, and appeal mechanisms; identifying performance evaluation standards and data requirements; use of cost or utilization targets; and quality assurance.

14. Authority to establish reimbursement policy: Identifying the reimbursement methodologies (including the

authority to establish global budget and capitation arrangements) to be applied to: HMOs, hospitals (acute short-term community and mental health), nursing homes, physicians, nurses, pharmaceuticals, durable medical goods, and other institutions, practitioners, and vendors of health care goods and services.

15. Authority to establish financing policy for the provision of health coverage: Determining financing sources and collection procedures; addressing maintenance of effort issues; and addressing individuals/entities unable to pay.

Resources

Very few communities have the requisite resources and expertise to implement meaningful health care reform strategies. However, it is clear that communities can assume these responsibilities once they have been empowered to do so. To accomplish this, the following are required:

Educating the governing board and the community.

- A formal educational process for the community board. Such a process would have several objectives. First, board members need to be educated about the problems with the existing health care system. This is important because any effort that proposes to provide an alternative to the existing health care system has to offer a clear picture of the existing system: its strengths, its weaknesses, and its promise. Within this framework, the alternative model has to demonstrate that it can preserve the good while correcting basic problems. Second, leadership development must also be undertaken. Such a process is necessary if we are to ensure that key constituencies — often not part of the communities leadership structure — are to have meaningful input into the deliberations of the governance structure. Third, the community's advisory body members must gain skills in the art of negotiation

and compromise so that board deliberations will result in the ability to come to consensus and initiate appropriate action.

- Communities must be provided with the funds and technical assistance necessary to adopt and/or develop a battery of measures and indicators that will assess the health status of residents and the performances of a community's delivery system. This assessment will provide benchmarks for monitoring the impact of change in the community.
- Communities will also need to have access to technical assistance to assist them in implementing any health care reform strategy. Examples of the kinds of expertise communities will need to be able to draw on include ethics, administration, financing and reimbursement, legal, and delivery system reform.

  Communities will need to have access to ongoing operational support, both fiscal and technical, to creatively manage the development and delivery of health services in their jurisdiction.

The success of communities in any reform strategy will depend to a large extent on their ability to manage the detailed policy and procedural questions that will arise as they move through implementation.

The success of communities in any reform strategy will depend to a large extent on their ability to manage the detailed policy and procedural questions that will arise as they move through implementation. Although the long range goal is to build internal capacity, in the short run, communities must be able to access outside technical assistance in resolving these issues.

Lessons Learned in Community-Based Health Programming

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Introduction

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Many of the lessons that can be shared with policymakers have come from the W.K. Kellogg Foundation's long and rich history of helping individuals and communities improve their health care and services.

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The Kellogg Foundation is very encouraged with the Administration's commitment to pursuing health care reform.

There is now significant evidence that communities can, on a larger scale and with the proper resources and authority, effectively identify and plan for their citizen's health needs,

allocate health care resources, and hold down health care costs, while at the same time safeguarding the quality of care.

As part of the current review being undertaken by the presidential task force headed by Hillary Rodham Clinton, we would hope the Administration would consider a viable role for communities in any health care reform strategy.

Although the focus currently is on the role to be played by governments and large regional purchasing consortia it is important to remember that *health is a local affair.* Health services are both delivered and received within the local community.

Therefore, communities have shown us that *system change needs to come at the community level.*

It is important to remember that health is a local affair.

The Lessons Learned

Based upon the lessons learned from more than 100 community-based health models, and from a wealth of knowledge which the Foundation has gathered over its 63-year history, the following observations can be made:

1. At the community level, delivery of health services has been fragmented, creating great waste and frustration for all parties.

   Most funding sources have been geared to meet the needs of health providers and agencies, not the needs of the people. Funding may come from a variety of sources with different rules for its use. This often means that communities are unable to comprehensively plan health services that meet their needs. Because of this, many community-based health models may not be able to sustain themselves and still remain grass-roots, community-based.

   Ultimately, the issues surrounding sustainability must be addressed at the policy funding level. Many community-based health projects have had major

difficulty in continuing their services because of *fragmentation of funding at the community level, multiple and conflicting policies, and funding priorities that are directed toward paying for illness care rather than health promotion and prevention.* In building their own capacity, individuals and communities have been able to use these funds in more flexible ways to meet community needs.

2. When individuals and communities are provided with the information and background on health issues, they gain the capacity to exercise their power and influence to effect change/health care reform. With the right tools (new information, understanding, technical assistance, etc.), they become new, significant players at the table, and not token representatives.

3. Holistic approaches aimed at meeting the health and human service needs of people have been the most effective. This often meant that the definition of health became broadened and intertwined with other community-development issues, such as housing and economic development. Serious problems arise when health services are separated from human services, although our society's method of financing forces this separation.

4. There are large gulfs between the views/perspectives of health care providers and the people they are supposed to serve. Representatives from all parts of the community (consumers and purchasers of these services) need to be at the table (included) where the community's health needs are determined, and service delivery is planned.

At the same time, those providing health services need to reflect the diversity represented in the community.

For too long, health professionals have gone into communities to provide services without understanding the people or their needs, or allowing them to become involved in solving their own health problems.

Holistic approaches aimed at meeting the health and human service needs of people have been the most effective.

5. Bridging cultural and value gaps between communities and health care providers is essential at all levels. Community members in a variety of roles can be effective in bridging these gaps.
6. Community-based approaches to health have been a powerful force in building the capacity of people to have greater control over their lives and those of their families.
7. Communities often do not follow local, county, or state geographic boundaries on a map. Therefore, they need to have the authority to identify and establish boundaries that define their community.
8. Consensus among these widely differing stakeholders can be built with carefully crafted collaboration.
9. Organizational capacity (community infrastructure) is necessary for sustainability.

Bridging cultural and value gaps between communities and health care providers is essential at all levels.

W.K. Kellogg Foundation experiences

With its experiences in community-based health, the next steps were to support efforts to refocus health professions education and target two critical areas — increasing the number of primary caregivers committed to community approaches, and helping public health educators and students to become firmly linked with communities. WKKF has two major initiatives in this area:

- **Community Partnerships in Health Professions Education** aims to increase nationwide the number of primary caregivers who are committed to community-based approaches, with the emphasis on primary prevention, primary care, and working effectively in multidisciplinary settings.

In 1991, the Foundation appropriated $47.5 million to create and support seven partnerships between communities and health professions education institutions. Now, only 18 months along, these seven projects are already demonstrating how medicine, nursing, and other health professions students can be educated cost-effectively in academic, but non-hospital community health settings. Such settings are well under way in West Virginia, Boston, Michigan, Georgia, Hawaii, El Paso, and Tennessee.

These students are working and learning together in teams. Each is governed by a new organizational partnership between academic institutions and communities. Communities are influencing, by mutual agreement, the curriculum, research, and patient care of these new academic community health settings. Hundreds of students will be trained in rural and urban communities.

The key issues in refocusing health professions education are money and models — more financial support for undergraduate and graduate education occurring in non-hospital, academic, community environments and educational models that demonstrate how high-quality, community-based education and care can be conducted in such non-hospital settings.

As good as these models are, and the better they will become, *they will not survive under the existing system of paying for graduate medical education.* Virtually no funds are available for medical education or medical specialty training outside of hospitals. The federal government expends $5.2 billion in Medicare funds via hospitals (1992); $600 million in Veterans Administration funds are expended in hospitals; $5.6 billion in basic and clinical research funds (mostly from NIH) are expended on subspecialty research that affects the nature of medical education. A difficult situation is made even worse by

The key issues in refocusing health professions education are money and models.

states expending more than $2 billion on hospital-based graduate medical education and the medical practices income of medical schools adds up to a national total of $6.6 billion.

Therefore, we recommend the following to support academic, community-linked, non-hospital health professions education to increase the number of primary care practitioners:

Redirecting funding to support academic, community-linked, non-hospital health professions education to increase the number of primary care practitioners.

1. Allocate a proportion of both direct and indirect Medicare graduate medical education support for non-hospital, primary care education of physicians, nurses, and other health professionals. This could be achieved by (a) eliminating from direct medical education (DME) and indirect medical education (IME) subsidies that residents receive beyond the limits imposed by Comprehensive Omnibus Budget Reconciliation Act (COBRA) (eligibility for initial board certification plus one year, to a maximum of 5 years); (b) setting aside a certain portion (for example, 25 percent) of the DME and IME payments made on behalf of all residents, specifically for residents in the primary-care specialties (family practice, internal medicine, and pediatrics) for education in academic, non-hospital, comprehensive care settings; and (c) increasing the funding from the savings from (a) to the Health Resources and Services Administration, to develop grant proposals to create community-based academic health centers (CBAHCs), in HPSAs, for graduate education in an ambulatory setting of primary care physicians, nurses, and other health professionals.
2. Directly allocate funds for the non-hospital education of primary care practitioners to incorporated community and academic partnerships that are governed by representatives of the non-provider

community, community health centers, and health professions schools.

3. Change area health education legislation so that such community/institutional partnerships as indicated above could be the direct recipients of funding rather than through medical schools; significantly increase the funding for such redefined community partnership AHECs.

With a grant from the Kellogg Foundation, the Alliance for Health Reform, chaired by Senator John Rockefeller, is producing a series of policy options for increasing the number of primary care practitioners. The Alliance for Health Reform's proposals will address issues of student loans and debts, Medicare funding of graduate medical education, and the nature of health professions education.

- **The Community-Based Public Health** (CBPH) initiative is a national effort grounded in the belief that public health educators and students should become firmly linked — once again — with community-based organizations in underserved communities.

The Foundation believes that public health educators and practitioners should become firmly linked with community-based organizations in underserved areas if needed changes in the discipline are to be achieved and if these changes are to be responsive to society's greatest needs. Since all health concepts must ultimately have local relevance, there is a need for public health professionals — as well as for political, human services, and community leaders — to understand clearly the social, economic, and cultural conditions which determine health status, and the manners by which these effect lifestyle, behavior, and community decision-making.

The purpose of the CBPH initiative is to develop new models for partnership between local health departments

Public health educators and practitioners should become firmly linked with community-based organizations in underserved areas if needed changes in the discipline are to be achieved.

Public health practice needs to recognize the social, economic, and cultural differences of local communities, emphasize community capacity-building, use commuinty networks, and enter into a partnership of shared responsibility to improve community health and well-being.

and community-based organizations in underserved areas, and to strengthen the way that future health professionals are educated and prepared for their lifework in community health problems.

CBPH is now in its first year of a four-year Implementation Phase, following a one-year Model and Leadership Development Phase. Seven consortia were selected in the final competitive process; more than 100 applicants from around the nation submitted proposals to participate in the program.

Each approved consortium contains a school of public health, at least one other health professions school, one or more local health agencies, and representative community-based organizations in an area where model health services and programs are to be demonstrated.

Each of these seven consortia contains the following elements:

- A model community site, urban or rural, in which consortium partners provide community-based public health services;
- A form of public health practice that recognizes the social, economic, and cultural differences of local communities, emphasizes community capacity-building, makes use of community networks, and enters into a partnership of shared responsibility to improve community health and well-being;
- An approach that uses the core public health functions to understand and address local community priorities;
- A plan for upward mobility of community youth into the "helping professions" through recruitment, education, training, and mentoring;
- An approach for continuing education and leadership training for current health workers and for community laypersons;

- An educational system which reduces disciplinary fragmentation, that emphasizes teamwork in developing the values and skills that are pertinent to public health, and that links with members of the other health professions in an effort to make system improvements; and
- A model for learning the profession that emphasizes the relevance of community input and control into health decision-making that welcomes that input into the educational process, and that values the local health agency as an important site for scholarship, education, and research.

Community is at the core of system change

At all phases of these initiatives, the community has been at the core of developing innovative models aimed at systems change.

However, all these efforts targeted only pieces of the health care crisis. The next logical step was to ask the question: If one could wipe the slate clean, what would a health care system — envisioned by the community and controlled at the local level — look like?

This led to the development of a plan to work with select communities in Michigan that want to create a coordinated, comprehensive health system.

The Comprehensive Community Health Models initiative

Based upon lessons learned from more than 80 community-based health service projects, the Foundation strongly supports a community-based health care reform strategy and has recently funded a new initiative for total health care reform through established partnerships with three Michigan communities.

Comprehensive Community Health Models — building a more efficient health system through enhanced local control and system restructuring.

Key elements of a Comprehensive Community Health Model.

The **Comprehensive Community Health Models** (CCHM) initiative, a partnership between committed communities and the Kellogg Foundation, is intended to assist communities in building a more efficient health system through enhanced local control and system restructuring. The program is designed to help communities:

- Accurately assess the health status, risks, and needs of residents.
- Create a health system which reflects the needs and priorities of the community and which is focused on maintaining and improving the health status of residents, while minimizing the impact of injuries and illness.
- Enhance the technical expertise available to communities as they consider the feasibility, costs, and benefits of the different options to implement a locally-controlled health care system.
- Serve as models which inform the nation's debate on health care reform.

The Foundation is working to identify three Michigan communities to join as partners with the Foundation in pursuing implementation of Comprehensive Community Health Models.

Five key structural elements are identified as critical issues for developing effective models at the community level.

1. A **Community Governing Board** responsible for establishing local priorities and allocating health resources.
2. A **Uniform Administrative Structure** which allows communities to create a single set of rules and regulations, reduce system fragmentation, and monitor the system's performance.
3. An integrated financing system to provide **Community-Wide Coverage** so that all residents will be eligible for

health benefits and have access to appropriate, quality health care resources and services.

4. A **Comprehensive Integrated Delivery System** placing emphasis on health promotion, disease prevention, and primary care. Each community's health system will link health and human service providers into an integrated system to help achieve the primary goals of health care reform.

5. And **Full Financial Responsibility and Authority** for distributing health care resources to support health system reform.

Through this approach, it is envisioned that participating communities will be able to control all health resources flowing into the community. Thus, the successes achieved in approaches where resource control was limited to hospital revenues only, such as those tested in Rochester, N.Y., will be magnified in the CCHM communities.

The most important aspect of CCHM is the central role of the community. That role is based on a partnership of citizens, business, labor, and civic leaders, government representatives, and providers. When a community controls its health care resources and understands the nature of its health problems, the performance of its health and human service providers, and the financial limitations of its payers, the community can then establish priorities and develop programs which can best expand access, control costs, improve quality, and maximize resident satisfaction.

The most important aspect of CCHM is the central role of the community.

Key elements of community control

To exercise appropriate control, however, a community must be provided with the appropriate resources and requisite authority.

The following authorities and resources are considered

important in strengthening the ability of communities to effectively govern their health care systems. The list should be viewed as illustrative, to encourage additional discussion.

Authorities

Recognizing local governance structures.

1. Federal law should recognize local governance structures and provide flexibility in the allocation of health and human service dollars to community governance structures to meet local priorities. Such structures can be established by voluntary action (i.e., as a private, non-profit corporation) or as a local governmental agency by formal legislative action either at the state or federal level. In either case, they need to be specific legal entities which are assigned specific responsibilities. If the entity is to be eligible to receive and disburse state and federal funds, formal recognition (established in law) by the federal and/or state governments is required. Depending upon the powers that need to be given to the governing board, appropriate state and federal laws may need to be changed.

2. It is anticipated that each community would identify a governing board as part of its formal governance structure. The following issues will have to be addressed as part of this process:

   - **Board Composition** — Although some specification may be necessary, any prescriptive mandate for representation should be broad and flexible. Most of the board members should represent the major public and private purchasers of health services in the community, as well as the residents in the community. Provider representation should be limited.

     By giving purchasers and patients a strong, majority voice, we increase the likelihood that the board's decisions will more closely attempt to realign the health care system with the needs of the community. However, given the ineffectiveness of

previous attempts to over-specify composition for community health efforts (e.g., our history with health planning), the federal government should consider limiting its requirements to a few general categories. For example, 40 percent of the board might represent major public and private purchasers, 40 percent residents (who reflect the demographic mix of the community), and 20 percent providers.

3. A mechanism for establishing the geographic area and population base falling under the authority of the community governing board. Any federal law in this area should not be prescriptive, but should provide options which support the ability of communities to engage in some level of self identification.

4. A mechanism for allowing the governing board to levy taxes or fees to finance health coverage for the un- and underinsured in the community might also be considered. If so, it would have to be decided whether the financing approach would be taxes, assessments, donations, etc. In all cases, only a government entity with financing authority could impose these types of assessments.

5. Authority for selecting, employing and monitoring the work of staff, selecting and monitoring the work of an administrative agent.

6. Authority to periodically conduct community-wide needs assessments, which would incorporate surveying the population and surveying providers is also required to assure that the necessary data are available to plan for community needs.

   Authority will also be required to allow the governing entity to access information on health care transactions (related both to payment and medical encounters) to monitor the quality of the care provided.

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Communities need to be able to foster or approve linkages among providers for the purpose of achieving efficiencies and promoting provider collaboration.

7. Authority to establish a standard benefit package, to establish the minimum categories of services and the services to be provided within those categories; and to specify co-pays, deductibles, and co-insurance requirements. The authority must also be empowered to develop supplemental benefit packages.

8. Authority to negotiate a reimbursement rate with providers and authority to negotiate with insurers and benefit plans (HMO's, PPO's, Blue Cross, etc.) regarding premium rates for the standard benefit plan and for any supplemental insurance plans that would be offered by insurers in the community.

9. Authority to impose standards of practice on insurers selling health coverage within the community.

10. Authority to regulate the acquisition and diffusion of technology within the community.

11. Authority to foster or approve linkages among providers for the purpose of achieving efficiencies and promoting provider collaboration. (This will be especially important in communities having more than one hospital to avoid anti-trust litigation.)

12. Authority to define the patient participation: Defining mechanisms for patient's selection of primary care teams; patient appeal and grievance procedures; and options for transfer or dis-enrollment.

13. Authority to regulate provider participation: Establishing enrollment criteria; identifying the conditions of participation, grounds for termination, and appeal mechanisms; identifying performance evaluation standards and data requirements; use of cost or utilization targets; and quality assurance.

14. Authority to establish reimbursement policy: Identifying the reimbursement methodologies (including the

authority to establish global budget and capitation arrangements) to be applied to: HMOs, hospitals (acute short-term community and mental health), nursing homes, physicians, nurses, pharmaceuticals, durable medical goods, and other institutions, practitioners, and vendors of health care goods and services.

15. Authority to establish financing policy for the provision of health coverage: Determining financing sources and collection procedures; addressing maintenance of effort issues; and addressing individuals/entities unable to pay.

Resources

Very few communities have the requisite resources and expertise to implement meaningful health care reform strategies. However, it is clear that communities can assume these responsibilities once they have been empowered to do so. To accomplish this, the following are required:

Educating the governing board and the community.

- A formal educational process for the community board. Such a process would have several objectives. First, board members need to be educated about the problems with the existing health care system. This is important because any effort that proposes to provide an alternative to the existing health care system has to offer a clear picture of the existing system: its strengths, its weaknesses, and its promise. Within this framework, the alternative model has to demonstrate that it can preserve the good while correcting basic problems. Second, leadership development must also be undertaken. Such a process is necessary if we are to ensure that key constituencies — often not part of the communities leadership structure — are to have meaningful input into the deliberations of the governance structure. Third, the community's advisory body members must gain skills in the art of negotiation

and compromise so that board deliberations will result in the ability to come to consensus and initiate appropriate action.

- Communities must be provided with the funds and technical assistance necessary to adopt and/or develop a battery of measures and indicators that will assess the health status of residents and the performances of a community's delivery system. This assessment will provide benchmarks for monitoring the impact of change in the community.
- Communities will also need to have access to technical assistance to assist them in implementing any health care reform strategy. Examples of the kinds of expertise communities will need to be able to draw on include ethics, administration, financing and reimbursement, legal, and delivery system reform.

  Communities will need to have access to ongoing operational support, both fiscal and technical, to creatively manage the development and delivery of health services in their jurisdiction.

The success of communities in any reform strategy will depend to a large extent on their ability to manage the detailed policy and procedural questions that will arise as they move through implementation.

The success of communities in any reform strategy will depend to a large extent on their ability to manage the detailed policy and procedural questions that will arise as they move through implementation. Although the long range goal is to build internal capacity, in the short run, communities must be able to access outside technical assistance in resolving these issues.

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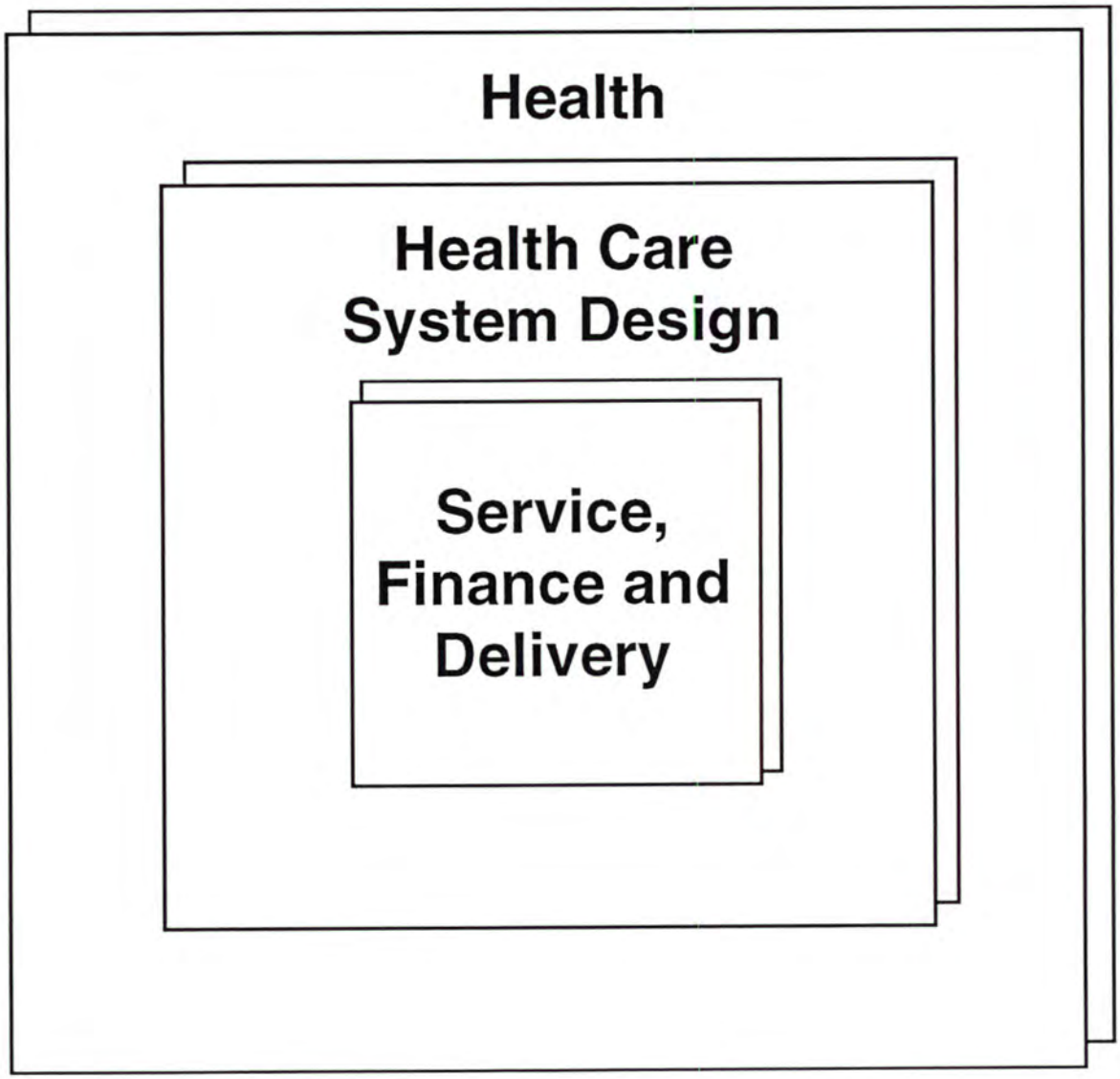
For the application of knowledge to the problems of people

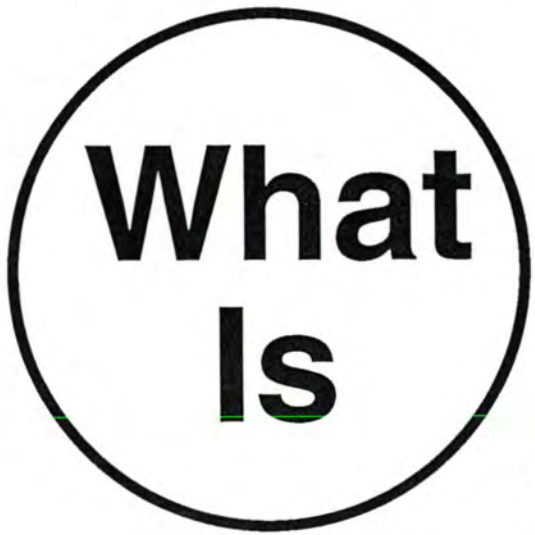
7/16/93

Comprehensive **C**ommunity **H**ealth **M**odels of Michigan

KELLOGG FOUNDATION

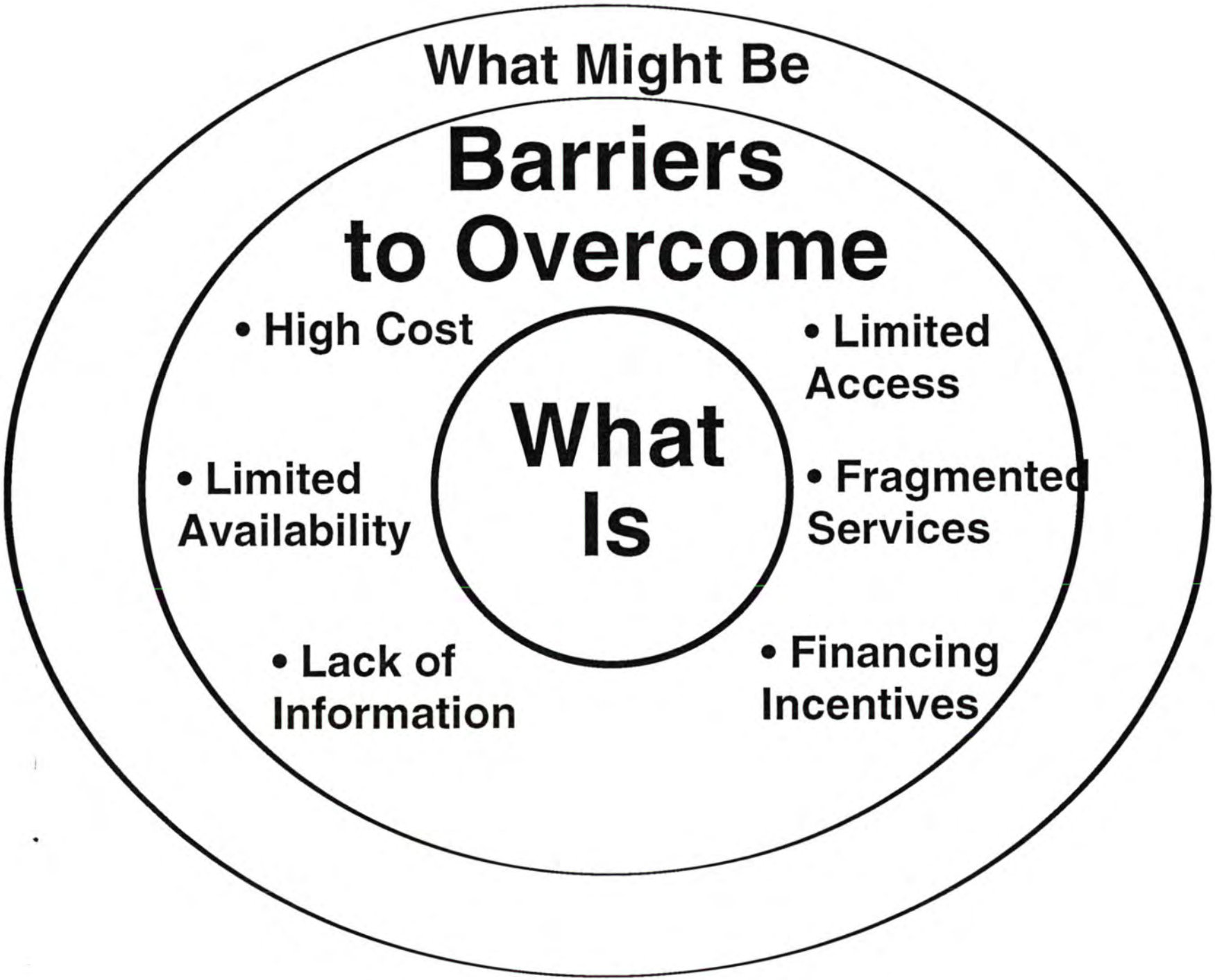


Source: The Belmont Vision — Health Care in America.



Fragmented Medical Care System


What Might Be
Coordinated, Comprehensive
Community Health System
What
Is
A Health Care System
That Is Responsive to Community
Needs and Managed by
The Community


What Might Be
Barriers to Overcome
• High Cost
• Limited Access
What Is
• Limited Availability
• Fragmented Services
• Lack of Information
• Financing Incentives

The Goal

To improve and maintain health

The Process

Assist communities in:

- Identifying needs
- Setting priorities
- Managing resources
- Developing coordinated, comprehensive health delivery systems
- Establishing integrated information systems

The Approach

- Identify up to three moderately-sized (75,000 to 200,000 population) Michigan communities committed to comprehensive change.
- Establish a partnership between these communities and the Foundation to pursue health system reform.
- Provide these communities with resources and technical expertise necessary to achieve reform.
- Pursue appropriate changes in the financing and delivery systems.

The Benefits

Community

- Enhanced health status of residents
- Improved quality of life
- Improved attractiveness for economic development

The Benefits

Consumers

- Increased access to primary care and comprehensive health services
- Increased emphasis on maintaining health
- No fear of losing coverage
- Improved quality of health services
- Support from a health and human services network
- Increased satisfaction

The Benefits

Purchasers

- Controlled cost increases
- Increased employee satisfaction
- Increased access to information
- Increased system efficiency
- Improved value per dollar expended

The Benefits

Providers

- Increased time for clinical practice
- Enhanced linkages to community support services
- Reduced paperwork and third-party micromanagement
- Enhanced job satisfaction
- Increased malpractice protection

CCHM Components

- Community-Wide Governing Board
- Integrated Administrative Structure
- Community-Wide Coverage
- Integrated Health Delivery System Organized Around Primary Prevention and Primary Care
- A Community-Based Information System to:
  - — Enhance Decision-Making
  - — Monitor Quality of Care
  - — Assess Consumer Satisfaction Costs
  - — Streamline Information Flow

Key Community Decision Points

- Community Agency/Foundation agrees to serve as the facilitator
- Community elects to develop a partnership with WKKF to develop a Comprehensive Community Health Model
- Community identifies a CCHM Advisory Board

Key Community Decision Points

- Community develops a budget, approach, and timetable for completing the Community Health Investment Plan
- Community completes the Community Health Investment Plan
- Community moves to implementation

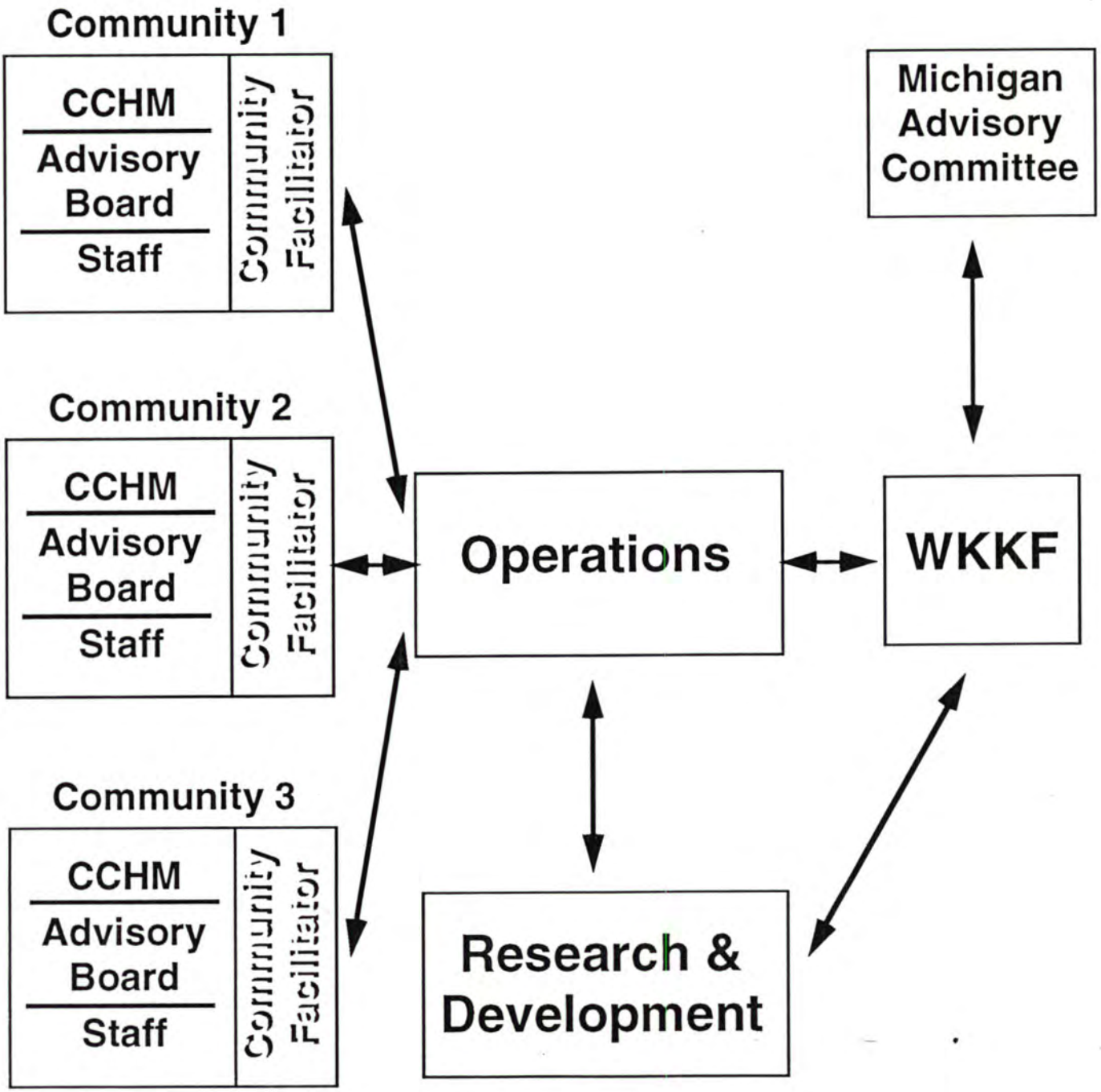
Key Responsibilities of Community Facilitator

- Coordinating community decision-making regarding CCHM participation
- Coordinating the identification of individuals to serve on the CCHM Advisory Board
- Notifying WKKF of the community's intent

Key Responsibilities of Community Facilitator

- Assisting in identifying community's key leadership
- Making initial contact, scheduling, and participating in community leadership interviews
- Making initial contact, scheduling, and participating in community focus groups
- Scheduling and hosting three symposia

Community Structure for Planning Phase



An Invitation to Become a Partner in

Comprehensive
Community **H**ealth **M**odels
of Michigan

An Invitation to Become a Partner in

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Community **H**ealth **M**odels
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*A Health Care System Out of Sync

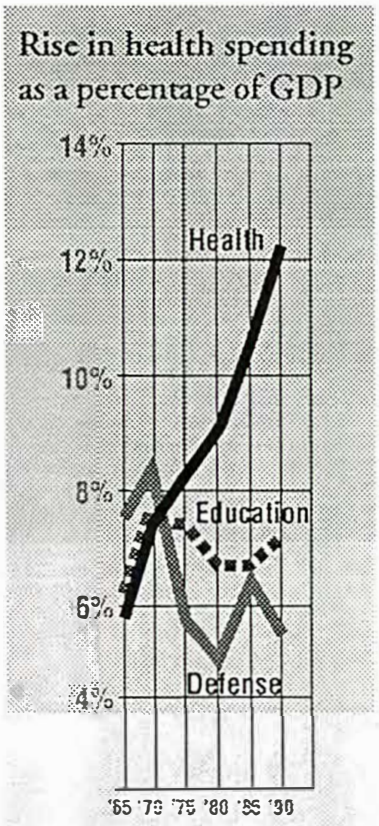
Rising health care costs, decreased access to health care, and a growing fear among all Americans — those insured and uninsured — about their ability to pay for and gain access to health care if they get ill has fueled the national debate over restructuring the medical care system.

National health reform appears imminent. While the rhetoric has escalated and several states are rolling out unique proposals, most of the proposed solutions focus on alternative approaches to financing and organizing the *medical delivery system.*

The national health care debate, however, provides this country with a historic opportunity to expand its vision of what it means to maintain and serve a healthy society, and to emphasize the primary functions of a *community's health care delivery system.*

Medical care costs are going out of sight. Access to medical care increasingly is a problem, whether or not you have health insurance. However, we need to remember that costs and access are symptoms of a much larger problem. We all feel the cost pinch daily. However, access is just as important an issue.

Having access to appropriate, affordable health care is much more than having an insurance card. Access is having a team of health care providers available and willing to treat you 24 hours a day — outside of an expensive hospital emergency room.



Source: HCFA, National Center for Education Statistics, Statistical Abstract of the U.S.

Health care, as a share of the nation's Gross Domestic Product, is rising dramatically compared to other uses of national income.

Michigan state government's health care and medical insurance expenditures:
FY 1981 - 1991

Fiscal year	Total health care and medical insurance expenditures	Health expenditures as percent of total state expenditures
1981	$2,038.1	20.8%
1985	2,824.6	22.7
1991 est.	4,680.6	26.1

Source: HFA calculations from Department of Management and Budget comprehensive annual financial reports: Division of Accounting data: Dept. of Civil Service - Employee Benefits Div.: Annual Report of the Michigan State Employees Retirement Section.

In Michigan, health care is consuming a growing share of total state expenditures, paid for by our tax dollars.

In addition, access to appropriate, affordable health care requires having providers who understand the context in which people live.

And comprehensive health care allows individuals, families, and communities to learn how they may participate in maintaining their health.

Our nation has lost sight of the mission of our health care delivery system. We must refocus our energy and resources on the opportunities available to *improve our health*, rather than the problems that confront the current system of medical care.

The Opportunity — Change at the Community Level

The W.K. Kellogg Foundation, based on its long history of working with community-based health services, has learned that a community's health care delivery system needs to:

- Be managed by the community so that it reflects the community's needs and priorities.

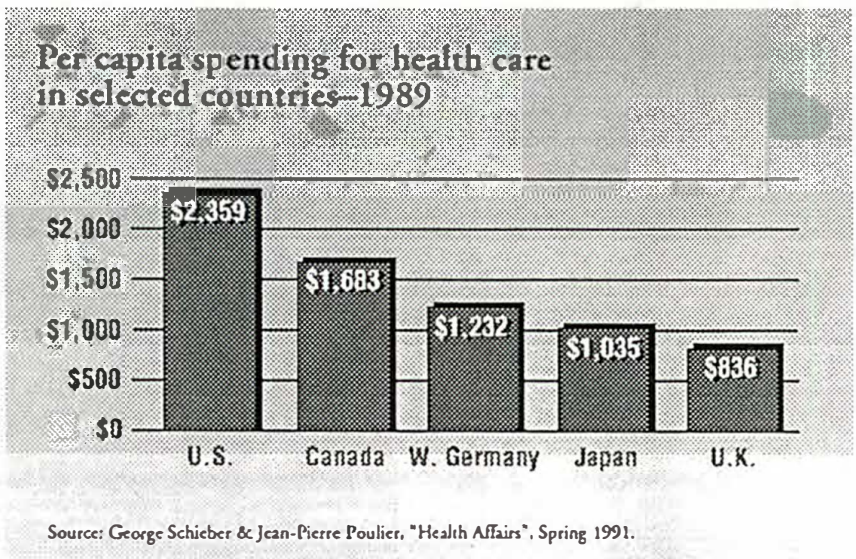
- Maintain and improve the health status of its people by reducing their morbidity (e.g., chronic illnesses, etc.) and increasing their length of life. To achieve these goals, health promotion, primary prevention, and primary care must play leading roles in a community's health care system.

- Minimize the impact and costs of an injury, acute illness, or chronic illness through early diagnosis and treatment.

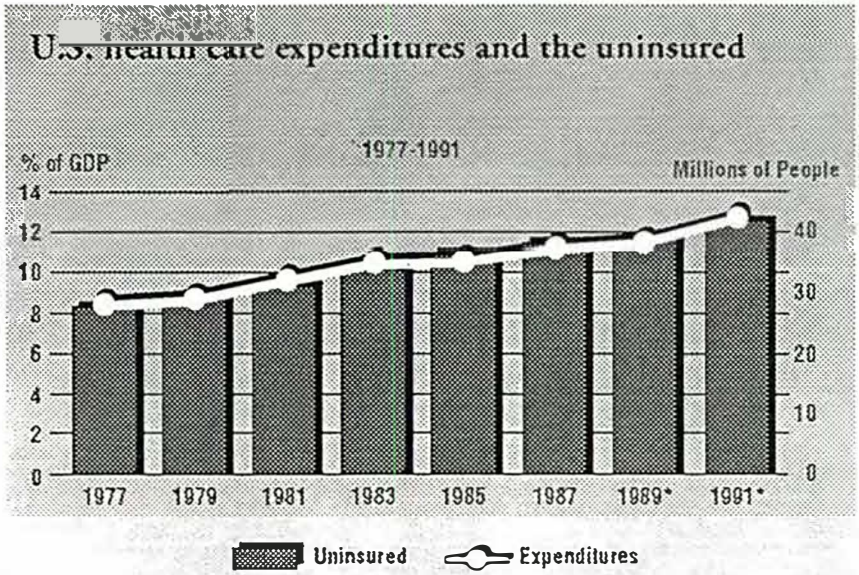
America's health care system is going to change — it has to for all of us. The uncertainty appears to be exactly how and from which level that change will come — national, state, or the community.

We all have an opportunity to help shape that change.

Communities need to be able to determine their health needs, and to manage a system that addresses and meets those needs. Communities — consumers, payers, and providers of health care — need to assume the joint role of decision-maker for their health care delivery system.



Our health expenditures per person exceed those of other developed nations, yet we may not be getting the best value for our money.



As health care expenditures rise, more and more people are becoming uninsured.

That role is based on a *partnership* of citizens, business, labor, and civic leaders, government, and providers.

When a community manages its health care resources and understands the nature of its health care problems, how its health and human service providers perform, and the financial limitation of its payers, the community can then establish priorities and develop programs that can best expand access, control costs, improve quality, and maximize consumer and payer satisfaction.

Purpose of the Invitation

Comprehensive Community Health Models of Michigan (CCHM), a partnership of interested communities and the Kellogg Foundation, is intended to assist communities in building a more efficient and effective health care system by strengthening local control and restructuring how services are delivered.

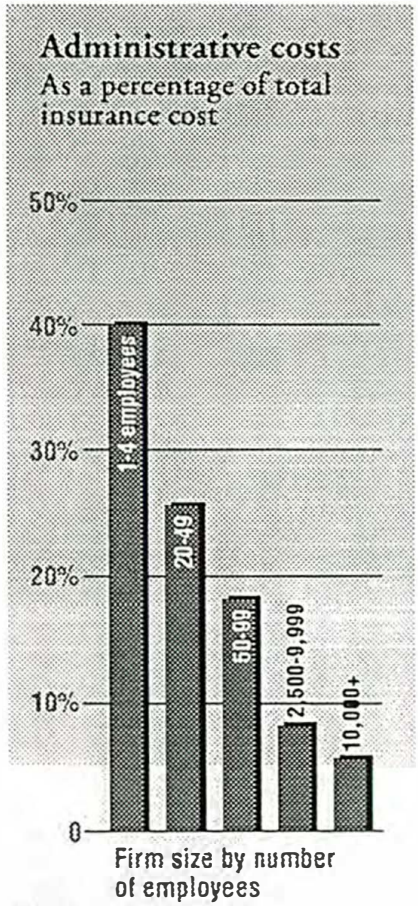
The CCHM initiative is one potential vehicle for reforming a community's health care delivery system.

It is an invitation to communities to bring all players to the table — citizens, business, labor, and civic leaders, government representatives, and providers.

From there, members of this Representative, Community-Wide Advisory Board will create a vision of a health care delivery system that will meet the needs of their community by assessing their current systems, and deciding how they might want to improve them.

The initiative is designed to help communities:

- Accurately assess the health status, risks, and needs of residents.
- Enhance their technical expertise and knowledge as they consider the feasibility, costs, and benefits of the different options available to restructure their health care delivery system.
- Create a health care delivery system that reflects the needs and priorities of the community, and which is focused on maintaining and improving the health status of citizens, while minimizing the impact of injuries and illness.
- Serve as models for other communities, regions, and states exploring health care reform.



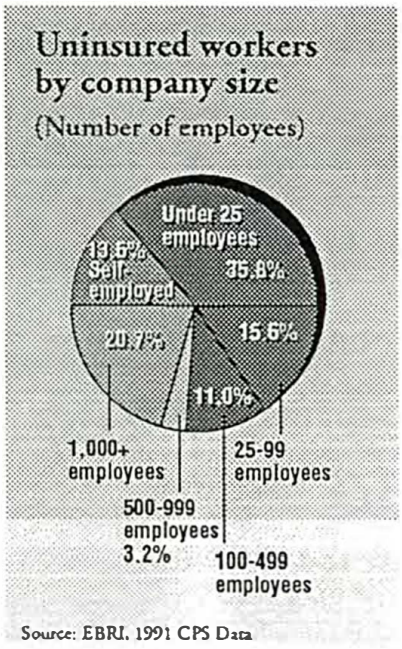
Source: U.S. General Accounting Office

The administrative costs of our current health insurance system vary with the size of the employer – suggesting that smaller firms are at a significant disadvantage.

The Initiative

The Kellogg Foundation proposes to establish partnerships with three Michigan communities that want to pursue health systems reform.

The communities will have between 75,000 and 200,000 residents, several major corporations, a union presence, an underserved population, and signs that their local health care system is experiencing serious problems.



Most uninsured workers are employed by small firms – firms that provide most of the employment in our nation.

Another critical element is that the community have a *representative leadership* that is committed to fundamental change, and is willing to enter into a partnership in pursuit of that change.

The Foundation will respond to requests from these communities for selected resources and the technical assistance needed to achieve fundamental change. The Foundation also will help to facilitate this change by joining with communities in pursuing necessary local, state, and federal approvals.

These partnerships will explore the development of a Comprehensive Community Health Model within the participating communities. To be successful, communities will want to develop a *new vision of health care* that reinforces and emphasizes maintaining the health of their citizens, rather than treating illnesses.

While each community may decide to take different paths to achieve reform, each community needs to be committed to working toward a comprehensive health care system that addresses the following five key elements:

1. A Community Governing Board, which would be responsible for establishing local priorities and allocating health resources. Community control is essential to assure that individuals who own the problems also *manage the resources* necessary to resolve them.

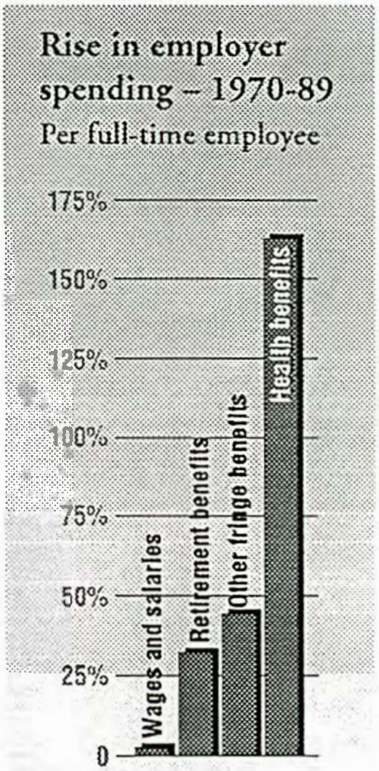
2. An Integrated Administrative Structure, which allows communities to create a single set of rules and regulations, reduce fragmentation in the system, and monitor the system's performance. These structures will reduce the

enormous administrative burden in the current health care system, and *improve the community's capacity to monitor the performance of its health care system.*

3. Integrated methods of financing health, ensuring **Community-Wide Coverage** so that all residents will be eligible for health benefits and have access to appropriate, affordable, quality health care resources and services. Community-Wide Coverage assures that no one is left exposed to the hazards of being uninsured. It also reduces the unfair financial burden imposed on individuals and businesses whose medical bills are inflated to cover the cost of care provided to the uninsured and public clients.

4. A **Comprehensive, Integrated Delivery System** that emphasizes health promotion, disease prevention, and primary care. Communities will be encouraged to base the design of the delivery system on the health status of residents, and to build the medical care system around preventive and primary care by using new organizational arrangements and financing incentives. Communities also will be encouraged to explore ways of linking human service providers with preventive, primary, and medical care.

5. A **Health Information System** to enhance the Community Governing Board's decision-making ability, and to monitor quality of care, its costs and benefits, and consumer satisfaction. The Health Information System would enhance the flow of information among providers, which would improve medical decision-making and strengthen the linkages between health and human service providers. In addition, such a system would reduce costly paperwork and service duplication, since the information would follow the patient from provider to provider.



Source: Alliance for Health Reform, EBRI Data

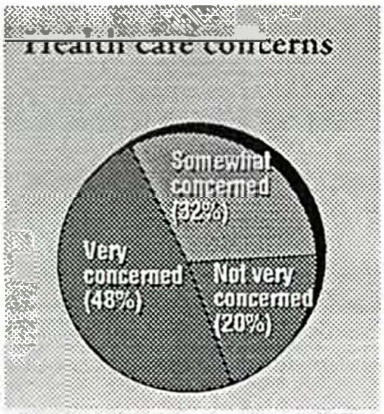
Paying for ever-increasing health care costs per employee has made U.S. employers less competitive internationally.

The Benefits

CCHM offers communities, consumers, purchasers, and providers significant benefits.

For the Community

The health status of residents is enhanced, the quality of life is improved, and economic development becomes more attractive.



Source: Public Sector Consultants of Lansing

Michigan residents also are concerned about their continued ability to maintain their health benefits.

For Consumers

Consumers will be more satisfied by increased access to primary care and comprehensive health services, increased emphasis on maintaining health, no fear of losing coverage, improved quality of health services, and continuous support from a health and human services network.

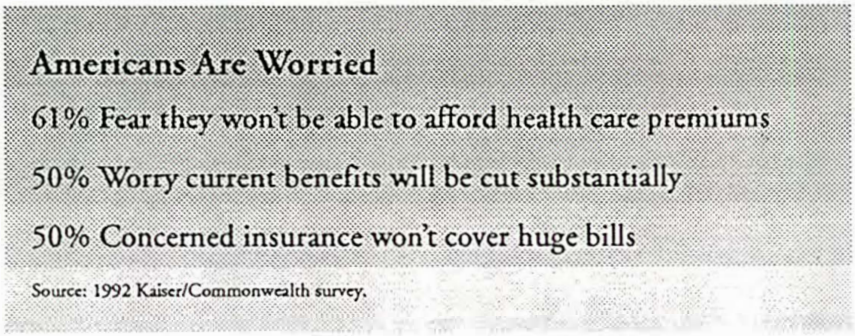
For Purchasers

Individuals, small and large businesses, and government will see cost increases for health care controlled, more satisfied workers, increased access to information, a more efficient health care system, less paperwork, and a better value from each dollar expended.

For Providers

By reducing paperwork and third-party micromanagement, providers will be able to devote more time to clinical practice, enhancing their job satisfaction. In addition, linkages to community support services would be enhanced, and their malpractice protection increased.

Unless the CCHM elements are in place, communities will not be able to deal effectively with the costs and access problems that plague the current system.



A majority of Americans are worried about the cost of health insurance and their ability to maintain their health benefits.

Breaking Down the Pieces

The CCHM initiative is divided into two phases. The first is a development phase, during which the community will:

1. convene a Representative, Community-Wide Advisory Board, and

2. develop a Community Health Investment Plan (CHIP), which will describe how the community will implement its version of a Comprehensive Community Health Model.

During the second phase, the community will implement the elements of its Community Health Investment Plan.

Foundation Assistance

Grants will be awarded in two stages to communities that have the capacity to reform their health care delivery system, and are committed to that change.

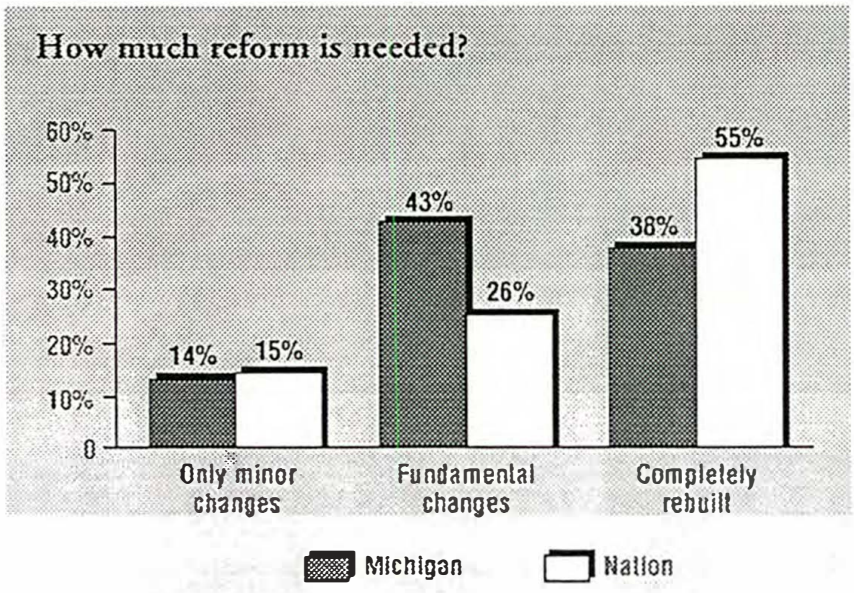
Phase I

The first grant is for the developmental phase, during which participating communities will plan their health care reform strategies.

The Foundation will assist communities in the developmental phase in the following ways:

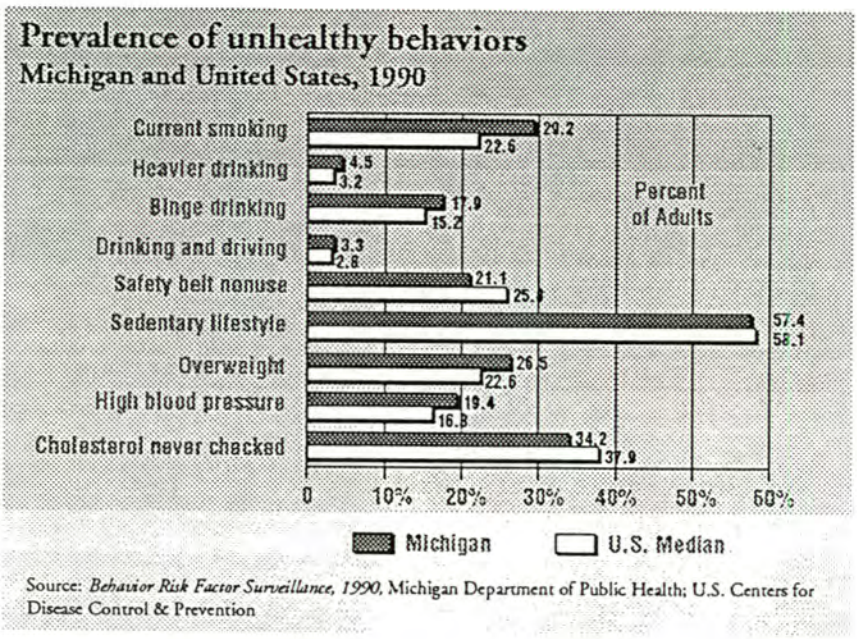
1. It will offer to a Representative, Community-Wide Advisory Board funding for a 12- to 18-month period to support Board activities related to developing a Community Health Investment Plan.

2. It will provide funding to assist communities in formally assessing the health status and health needs of residents, as well as the status and performance of the community's current health and human service systems.



Source: Public Sector Consultants of Lansing

Michigan residents also strongly agree that the health care system must be significantly reformed if it is to truly address health needs.



Michigan residents show markedly higher rates for unhealthy behavior in a variety of categories compared with the national average.

3. It will assist Board members in developing an effective, community-based model to implement CCHM's key elements, and enhance community participation by providing workbooks and offering seminars on selected health care topics.

4. It will provide technical assistance in the areas of law, finance, medical delivery systems, administration, ethics, and governance as communities work to develop their Community Health Investment Plans.

5. It will support communities in pursuing requests for local, state, and federal approvals needed to implement their Community Health Investment Plans.

Phase II

Support from the Foundation to assist communities in implementing their reform strategies will depend on a variety of factors. These will include the quality of the Community Health Investment Plan, whether there is a very high potential that the plan will significantly increase and improve access to health care, and the degree to which the plan will improve the health status in the community.

This grant also will be contingent upon the participating communities' receiving any local, state, and federal approvals necessary for implementation.

Obtaining Additional Information

If community residents are interested in obtaining more information on this initiative, the Foundation is willing to conduct workshops and community forums to assure that residents and community groups have a thorough understanding of the scope and intent of this initiative.

For more information, please contact:

0715932MEPI

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W.K. Kellogg Foundation

1992 Annual Report

Windows of Opportunity