

**Access HealthColumbus  
Coordinated Medical Home Network Preliminary Feasibility Study  
Sample of Key Informant interview responses**

1. *Describe your understanding of the existing primary care “safety net” delivery system for vulnerable people in Franklin County.*

- *Is it an organized system that providers and consumers understand and can easily navigate?*
- *Does it provide timely, well-organized care?*
- *Is there enough capacity to meet vulnerable patients’ needs?*
- *Does it promote preventive health services, and continuous coordinated chronic disease care?*
- *What do you think are the largest gaps in this “system”?*

- It’s not organized at all in my opinion. People in general, who are uninsured don’t have much of a clue how to access these services.

Access to specialty care does not exist] in any kind of effective way. It exists in that, by hook or by crook, knowledgeable primary care sites can figure out how to get people into specialty care, but in terms of it being seamless or well coordinated – no.

[The largest gaps in the system are] care coordination, capacity for medical homes, and specialty referral/specialty care.

- The safety net systems in Franklin County are fragmented. Although fragmented, they provide great opportunities for access to primary care services on a continuous basis. When you look at the overall providers that are involved, what you see is that you have multiple levels of service delivery, which really constitute access points and again, my take on that is that they are not coordinated, although entry is accessible.

If you look at behavioral health and mental health services, which don’t even figure into the conversation most of the time, as well as access to specialized services for treatment of addiction, rehabilitation, etc you start seeing that within this vulnerable population, you have subsets of individuals who are even more vulnerable.

- I view primary care as [being] local, neighborhood-based...The safety net that we described tends to be in a few neighborhoods, not multiple neighborhoods. Whereas poverty or lack of insurance exists throughout the community.

Gaps we have to mention [are] dental, and I would add behavioral health and other behavioral services as really major, major holes... [There are also] language barriers. With the huge growing Somali and Hispanic/Latino populations in Columbus, we’re tremendously challenged to keep up with [the need for] interpreters in our centers.

- I don't see any connection, or at least any type of coordinated response to make sure we have a full net that doesn't have any holes [that people] can fall through.

I think there are a lot of gaps... [O]ur neighborhood health centers are not able to serve more than 15,000 to 20,000 people. That's a drop in the bucket [compared] to the 100 plus thousand [people who] are uninsured.

- I really don't think we have a system, per se. I think we have a variety of different aspects of care that are not integrated or well-coordinated.

We have been lacking for an awful long time a financial safety net for this vulnerable population... Some states have a pretty good financial safety net for people who are uninsurable. Ohio is not one of them.

A lot of people are not getting good preventive care, because primary care doctors aren't being reimbursed very well for preventive services. Whether the patient is insured or not, the insurance payers have stopped paying for ...evaluation and management codes.

- When I hear the term "safety net," I often think episodic care rather than ongoing care... If you think of low-income folks who are accessing care, they often access it in a time of sickness and it's often wherever they can get in most quickly.

- In order to be a system, there would have to be a clear point of entry, and a clear service delivery model in place to get specific needs met within the system. There is no entry point. There is no organized system of care. It's highly fractured.

My sense is that we are collectively spending enough on healthcare in this community, that if we spent it more wisely we could cover vulnerable populations... But you'd have to redirect all of the resources, not just the safety net resources. There is a shortage of resources for vulnerable populations, but it's about redirecting resources.

I know that the wait lists are long at Columbus Neighborhood Health Centers' clinics. I know that it's very long to get in to see a counselor for any of the ADAM system agencies. But I don't know if that's a system issue or just because people don't know who to call.

- Vulnerable people show up in emergency rooms...and they see that as their primary safety net for medical care. That is horribly inefficient and horribly expensive, and just about the worst way that a safety net could be designed.
- Do I think there's enough capacity? Absolutely not. Not yet. We're getting there, we're moving. And if we move in a uniform way, that will truly be to the benefit of the community, the hospitals, and the FQHCs.
- It's impossible to say right now whether [the safety net] has capacity or whether it's full. Inefficiencies mask a lot of things. So if coordination, scheduling, continuum of care are all

disrupted in this net, there's no way to know whether there's capacity. [We] have to get at the first to answer the second.

- It's certainly not organized in the sense of a system in any logical way... "System" is an absolute misnomer ... We may have organizational entities that have system attributes, but we don't have a healthcare [system]. We don't have a network of providers and or insurers that are integrated in any way, [even] loosely.

I don't think there is enough capacity. I think the intriguing thing that we're going to confront over the next couple of years is whether the number of providers increases but the capacity doesn't ... I believe what we're seeing is that for a multitude of reasons as the older providers leave the profession, the younger providers are not as anxious or willing...to lead the same kind of lifestyle and so it's almost as if it's taking two to replace one.

- A number of hospital systems and FQHCs are well intentioned... They're doing the best they can in their own individual systems, but it's disjointed. They try to work together, but there isn't a coordinated system of primary care in the city and county... There isn't centralized scheduling, there isn't overflow for overcapacity of clinic X, Y and Z. And there isn't coordination between primary care physicians and other health providers that are outside of the hospital systems or the FQHCs.
- Much of the primary care safety net is never accessed because there's not enough capacity. [By the time a patient presents], it's no longer a primary care [issue],...it's secondary, tertiary, even quaternary care by the time the safety net is accessed...The holes are way too big on the primary care side, so the problem is caught later, when it is much more significant.
- Is it organized? I would say absolutely not. There is no coordination of care or intentionality of care across the free clinics, to the residency programs to the FQHCs... Does it provide timely, well organized care? That depends on what particular entity you're talking about, but the overall answer is no. There is certainly not enough capacity. The need for services is far greater than the existing safety net organizations can provide.

The biggest gaps in the system [are that] we don't have the capacity... that there is not good coordination or communication... and from the perspective of someone trying to use the system, I think it's very hard for them to navigate and know where to go.

- There is incongruence in service delivery, and there is incongruence in the definition of services that are provided.

In terms of prevention...I think there is information provided on how to do self-maintenance, but in terms of healthcare literacy, I think that's a growing need in this community (at multiple levels, not just the most vulnerable). "Healthcare literacy" meaning what your body is telling you, understanding what you can do to respond to that, understanding what system to go to in response to your concern.

2. *Among the variety of issues that currently face the Franklin County community (employment, education, homelessness, etc.) do you consider expanded access to medical home services to be important enough to develop a community-wide solution? If [yes/no], why?*

- [In Franklin County,] there are systems for education. We have a fairly decent system for homelessness. There are systems around employment. It feels to me like healthcare is left to the free market in some respects, rather than how we've developed systems around some of these other things. But [these issues are] embedded in each other and you can't untangle them, and health is a huge part of it, especially mental health.
- If you look at employment and education, if a person isn't healthy they can't go to work and we know when our kids are not healthy they don't go to school, so I think health is... very important for the other things to be viable.
- There's a groundswell that's mounting as it relates to health care because it's coming closer to home. There are a lot of people who are "middle class" who are now struggling with the same issues that the poor have to struggle with. And because of that change in economic status, it's getting greater illumination. As those economic changes – like a wave in the community – peak, that's when [community issues] get more attention.
- When people lose their health, they lose their ability to be productive... People go from bad to worse and eventually, unless there's a concerted effort to address health and health-related conditions, people become less and less productive. From an employer's perspective, [we] end up spending as much on lost productivity as we do on healthcare.
- I think primary care is a critical issue for the community. There are already so many dollars spent on it that are misspent, that it seems you could solve healthcare issues in our community simply by using the resources that are there more effectively.
- I believe that healthcare is a basic community [service], and should be a national service. I also want to say that it's really important that [expanded access to medical homes] be considered in the context of health policy, which is much more than access to care. It relates to employment policy, living wage issues, having employment that is linked to coverage, linked to education, and housing policy.
- Well, right now I think the economy is on everyone's mind as the top priority... A year ago, a year and a half ago, [access to medical home services] probably would have been the number one issue. Right now, it would probably be second.
- To the extent that [expanded access] includes preventive care, I would put it among the top items.

- I rank it high because it has an impact on stability within the home, employment, and education... It warrants a community wide solution for middle class or lower middle class workers.
- It's difficult to say which one is more important than the other. There's a relationship, especially between education and employment and access to ongoing, preventive, medical home services. If you don't have good health that you can build and maintain in the medical home, then you can't get the job. And if you can't get the job, then you may not have the money to pay for the medical home. If you don't have the education, you may not be able to get the job. They are all interwoven.
- It ought to rank number one because it touches and impacts all those other things mentioned... I don't think the county is really going to find a good mechanism of truly impacting those other problems if they don't address this problem.
- Having a job and having access to healthcare are two primary needs. So I put both of those right up there with education... This whole concept of a medical home, this whole concept of preventative healthcare, is something that we need to make a priority in this community.

3. *With respect to the [medical home services model presented], what do you consider to be the necessary, or essential, healthcare components of a “medical home” system for vulnerable people in Franklin County? Based on household income only, how would you define a “vulnerable person” in Franklin County?*

### **Necessary components of a medical home system**

- I think that this [list of services] fairly represents a relatively comprehensive medical home. I think probably implied in this but not stated explicitly is medical education, health education, patient education. What I don't see explicitly talked about here is the preventive services.

What kind of personal responsibility standards do you build into a model like this? There probably needs to be some “carrots and sticks” in [the model] – incentives for people to both get the kinds of tests they need and then follow through, and “sticks” [for people] who don't.

- Just saying that we have primary care services, that we have mental health, affordable drugs and we coordinate care – to me, this is a listing of services...an elementary start. You need to say how you're going to deal with chronic disease. Because when you look at adults, especially unemployed, underinsured adults, they come in with any variety [of diseases], and usually have at least two chronic diseases. This would be a great acute care model where you have somebody who's primarily healthy that does not need access to chronic care.

- Electronic medical records should be listed here.

Having the [medical home] be accessible, which means geography, wait times, interpreter services, etc, which aren't medical services, but if you don't have that, you often can't access what you need from this list.

- What jumps out at me is a missing theme around prevention and health education, which could be provided at all of these different levels.

The issue of nutrition is also not addressed. The reason we want to address nutrition in this community is because of the obesity epidemic and the correlation between chronic diseases and diet.

Does the definition of behavioral health services include substance abuse treatment?

- All of us who have worked with vulnerable people know that they often don't have the skill set to access services that are provided...This population is very transient...I want to make sure this isn't a system that's been set up with a vision that you and I have – a system that works for us. Because we really don't know what it's like to be a vulnerable, disadvantaged person.

- There's a certain amount of education related to financing healthcare. It's like [teaching] financial literacy...which I think vulnerable populations – whether they're employed or not – really need help with. That would really help give people options that they don't even realize they have.
- I know that some people are currently in the middle of just trying to survive, that preventive [health] is something that doesn't readily come to their attention. But as we help individuals gain control over what's happening to their bodies, when do we introduce the notion of prevention and responsibility?
- It still needs to be grounded more in wellness and prevention. I think the whole concept of wellness – the idea is that the emphasis is on health and not sick care.  
And because of all of the issues around obesity and diabetes, nutrition should be prominent here.
- I'm not sure what is essential, and what is "extra." For me, it's about: how can we meet basic needs so that we're not just in a reactive situation, but have a proactive, wellness approach?
- One part that's missing, but it may be implied, is the ability to get people into the system. How to you get people in the front door? I wonder about the outreach, the engagement, having multiple doors and windows for people to get through.

### **Definition of a vulnerable person based on household income**

- I think it's correct to think that income is probably the driver. I think that paying attention to certain disabilities is probably also part of what needs to be understood in the context of vulnerable.
- Income alone does not drive whether somebody's vulnerable. A lot of it depends on what issues a person is dealing with and what opportunities they have to crawl outside of their box.  
Clearly up to 200% of poverty is going to be easy to do. [Above that], it will depend on age and the number of morbidities and chronic disease problems you have, because at our income levels, if you have one sick person, and you have one partner who suddenly loses his job and can't work, life becomes very, very difficult if you have a sick child, or a sick parent.
- There are a lot of people up to the 400% with good jobs, decent jobs and things, but still can't afford to purchase the insurance coverage. So we've got to figure something out for that group as well. That's why it's difficult to go by just this criteria because people at 300% and 400% are working. Some have insurance, some do not.

- At 200%, we leave a lot of the working poor out. 300% is probably needed more than we know. And 400% may be also, but I think we can make a case for 300%....We can draw the line at 300% and feel like we are really doing more than just the unemployed, the indigent and so forth. We are hitting the working poor which need this more than ever.
- For the most part, I think the group up to 400% of poverty is “potentially vulnerable” and the people at the other end are “extremely vulnerable.”
- Up to 400% of the federal poverty level looks like a big number, but there’s really a small amount [of money] that you can actually make decisions with, since so much of that is taken up by other expenses like housing, transportation, education, and child care.

I think it’s pretty easy for folks to see how up to 250% of the federal poverty level should be included in the vulnerable person definition. But once we start getting [above that], I think it starts getting more difficult for people. I don’t think that they recognize how quickly ... money gets whittled down to zero or to a negative number just with the things that a person “has” to pay for.

- It’s important to recognize that it’s not just the [economic] situation, but also the actual health care condition of the family member...an economic situation may have an impact – it may tip the balance, but there’s another dimension that is very specific to health care, and that is if they have any chronic health condition or disability. I think that’s what puts people in a vulnerable situation.
- More and more you’re seeing studies that talk about up to 400%, or even beyond that if you’re in a family situation where you’re making it today and things are going fine, but you have one major medical episode and then become uninsurable, you find yourself in a very different situation in terms of trying to pay for the cost of health care.
- The statistic should be not income, but: how many are being served, and how many aren’t. And for X more money, how many more people can we serve? A service delivery measurement matters more than an income measurement.
- We are drawing lines here where there are no lines to be drawn, in reality.
- Certainly [the poverty level should be ] well above 100 percent, but I am not sure after that.... I certainly would not want to exclude the working poor. Someone making \$20,000 or \$25,000 thousand dollars a year who does not have health insurance is certainly the kind of person I would want to help.
- I think, quite honestly, the average resident out there would not be as comfortable taking care of folks up to 400% of poverty. Just looking at federal programs, looking at the salaries, it’s like we can’t take care of the very poorest right now, why are we going to set ourselves up for

disappointment? I'd rather take care of everybody at the lower end first, and then grow from there.

4. *If tomorrow, the Franklin County community collectively decided to expand access to coordinated medical home services to vulnerable people (at any of the income levels outlined above), the next question for the community to consider would be how to finance it ...*
- *Of the following listed funding sources, which one(s) do you consider to be most feasible, the most appropriate, or the most probable for the Franklin County community to consider? Why is that?*
  - *Which funding mechanism(s) do you consider to be the least feasible, the most inappropriate, or the least probable? Why?*
  - *Are there other funding mechanisms you would consider, not listed here?*
- A local tax levy isn't going to happen without having hospitals contribute a percent of net revenue. This community will not support a levy, knowing the hospital systems made \$240 million last year ... If [the hospitals] were going to put up X number of dollars to get a levy passed, there would probably be some expectation that those medical homes that were being funded were going to help to decrease the penetration into the hospital systems.
  - Unless you have [a strong] level of funding and political support from the city, you're not going to have the investment in the infrastructure that will allow this to happen.  
You've got to look at local health systems [as a source of funding.] They say they give their share of charity care, and I understand that they do, but that care is not [used] to build a coordinated system.
  - I think it's worth a stab at trying to do a local levy. I think it's a big enough issue, and it's one that we have not tried to do in this community  
My guess is that the [hospital systems] will say they're already losing millions of dollars in their emergency programs ... Plus they're all not-for-profits and they would all say that any money they make, they reinvest in people, they hire more nurses, they add new facilities, etc.  
Foundation funding...would need to be a coordinated effort and you would have to have moneys coming into a central pot. But I think it would be hard as heck trying to get all those guys to agree on something to fund.
  - I think you're going to have to have all of these on the list to put together the puzzle that works – the combination that works.  
There would be foundation funding to provide seed money [and] to help leverage other dollars.
  - I think we've seen some creative funding models in this county. In affordable housing, for example, we made a breakthrough. Half of the real estate transfer fee goes to the Community Shelter Board....No one feels it, there's no pain to it, and it's the right thing to do....It's something that doesn't need to be debated every year and isn't subject to the will

power of your elected officials...Somewhere, in some of these mundane transactions that have some relationship to the health of our community, we need to be taking small dollars [from] each of these types of transactions and designate that to building our war chest, our safety net for our community.

- [Regarding cost sharing with consumers] You have to be wary of unintended consequences, as fair as it might seem. It's hard enough to get people to take their meds when they feel well. If you're diabetic or pre-diabetic, hypertensive or pre-hypertensive (and those are the biggies), and you feel well, you might not take your meds because you have a \$20 or a \$10 co-pay or something. I would be very careful about that.
- I believe that the individual has some responsibility. So does the health care system, and employers. I think hospitals need to continue to work on cost containment, that pharmacy manufacturers need to work on cost containment, and that we should demand that they find ways to reduce the cost of pharmaceuticals. There also needs to be some role that the federal government plays in the process, as well as the state.
- All health care is paid for by the individual, in one way or another. I say that because there are ways that [all of] these sources impact individuals.

There are too many requests on foundations and community charities for funds, and they're supporting too much health and human service programming already; I think a lot of them are getting tapped out.

- Employers didn't go into business to manage employees' healthcare, but that's what they're being asked to do, or else be viewed as bad employers. They are looking for alternatives; they just want to believe in what they see...The ability for an employer to participate in something that's a better deal, a better way of doing things from a health perspective, and ultimately leads to healthier employees makes sense.
- Most cities the size of Columbus have a public hospital system, or they have a tax. Columbus doesn't have either. I wonder if that model is still working for us. Healthcare costs have changed so dramatically, the population has expanded and migrated out to the suburbs. Does the model still work? I'm not sure it does.
- A tax levy should be about creating conditions in which every person would be healthy. It's a broader take on public health, preventive services, and primary care. I'm concerned about having [those dollars] sucked up by hospitals to pay for their usual community obligations.
- Let's say there was a levy in place... I'm thinking of some sort of endowment that's created, that organizations could contribute to that would help offset the costs of some of the care.

That would be a great thing for foundations to have, actually – a donor advised fund that they could solicit funds for. Maybe that becomes the community endowment.

- The first priority has to be creating a coordinated, efficient model, then figure out the funding source. Don't pump funding and then back into a coordinated model. There's a sequence that has to happen here, clearly.
- Yes, it's about taxation, because I think we'll eventually end up there. That's got to be the source of the funds. But maybe the taxes that we already collect are sufficient. So one question is "what is the tax?" and the other is "is the tax sufficient?" and are we really talking about a reallocation of available dollars?
- What may be feasible is some kind of a tax or fee on all hospital charges (hospital revenues) where funds are generated to first, cover the costs [of providing indigent care], but also to equalize or redistribute revenue to those providers who are providing the most indigent care. So in effect you have the health systems generating revenue by taxing all of the hospitals, but then reimbursing the hospitals based on the level of indigent care they were providing. That way it's more equitable within the system.

I don't think it would be fair to expect employers to pick up these costs. That's not a sensible solution. There would be a tremendous political battle if we asked the business community to pay for this problem. This is a society issue, not just a business community issue.

- If there is a decision to go after the local providers, which may not be a bad way to go, you've got to get everybody. It can't just be the health care systems because they're already doing a lot...You can't exacerbate the problem by incenting more people not to take care of it. If you only go after the big health systems you're encouraging providers in that system not to be there, and go off and do their own thing.

5. *If the Franklin County community collectively decided to expand access to coordinated medical home services, and the source of funding for that expansion were decided and approved ...*

*What entity should be charged with overseeing the administration and distribution of those funds in a way that is transparent to the public?*

- *Is it an existing entity? If yes, who?*
  - *Should a new entity be established? If yes, should it be a public entity or private entity? How should it be structured?*
- We need a different vision of what can happen with public health in this state. [We need] a combination of public health, academic, private, and community entities in order to have a different discussion... It's bigger than Franklin County. We really need to have the state health department, and Job and Family Services. We need to have different conceptions, because otherwise, we will put together structures that are founded on shifting sand.
  - Access HealthColumbus is a possible entity. Much like the Shelter Board in this community, as the place where resources come for homeless services, I can imagine Access being a similar kind of entity.
  - I'm of the mind that we should really have much more visibility for our public health officials. It saddens me to think how we've marginalized the role of public health. Too often it's thought of as emergency preparedness and response teams and that kind of stuff. I think we need to move away from that notion, and get them more involved in overall population health management. But they'd have to learn some new skills and be willing to reach out more proactively. It would seem like an expanded role for them... We would have to broaden the definition of what they're doing and how they do it and who they do it for.
  - [The entity should] have a profit motive. There should be incentives to drive better and better results, in terms of quality of care, access, health outcomes, and cost. They should enjoy some upside from the model... It would act as an incentive for that entity to do really good work.
  - I wouldn't put taxpayers dollars into a private, for-profit entity to make decisions. If the bulk of the dollars are public and charitable dollars, non-profit dollars, I'm not sure I'd want somebody making a huge sum of money from it.
  - We would really like Access HealthColumbus to be a catalyst for something bigger, but how big will this need to be? What level of sophistication will we need to be far reaching?
  - This assumes that there's a system set up that someone needs to administer – I would suggest that we focus on capacity and efficiency before we build something new. And if we don't take

our learnings from things like CNHC, like look-alike, like the VCN, how are they doing? If we don't take some of those and fix those first, it doesn't make sense to me to build something new.

- Under the Shelter Board concept, you see this umbrella kind of organization that oversees things in a way that works. So you could take the existing neighborhood health centers...the free clinics... would all still be a part of this, and create an umbrella organization that represents, based on its funding streams, cross-sections of the community.
- I think it's important that the private non-profit is required to operate in public domain as if it were a public entity...very transparently. I think it could be compelled to be transparent as a private entity, but not be as constrained as a public entity would be constrained by the politics of things.
- It cannot be a public entity. I don't think the city or the county on their own could oversee this. I also don't know that a totally private entity could – so it's going to have to be a blend between public and private. And I think everyone that has a vested interest is somehow going to have to have a voice. So that would mean people involved in sharing the funding burden would have a voice, as well as the people involved in the actual delivery of care.
- There has to be checks and balances and the organization has to be designed in such a way that it can handle very large dollar amounts and a lot of contact with individuals if they need service. When people have grievances, they end up going back to who's holding the purse strings.

I can't imagine an organization that is partially governmental, partially private, but that would be a really neat model. I don't know if that exists anywhere. To have an organization that is a hybrid of government and private – that would be wonderful.

6. *If the Franklin County community collectively decided to expand access to coordinated medical home services, the source of funding were secured, and the entity charged with the distribution of funds were in place ...*

- *How should the funds be distributed to the providers of primary care coordinated medical home services?*
- *Are there other payment systems you consider feasible?*

- When we talk linking pay for performance to preventive services, a unique angle would be to think about what incentive we should give to physicians that are good at keeping their patients well...It's interesting to think about what dynamics would change if there were some benefit to a practice for keeping people well.
- Fee for service has created such a mess that I certainly wouldn't go there, not for medical home services...We pay more for high-tech and specialty care and less and less for primary care and preventive services, to the point where we're paying almost nothing for preventive services because they're so hard to measure. We've sort of pushed the provider community into specialty care...and the more money [that specialty providers] make, it seems, the less money primary care doctors make, and the less integrated healthcare is.

Probably the best way would be capitation. But that assumes that the doctor's office is prepared to do it...And until there's enough volume, if you will, to make the capitation worthwhile, it's hard to imagine that they would do it.

- My hope would be that whatever the payment process, that it give providers get a fair return (so they don't have to donate their services), but that it incentivize wellness wherever possible. I think many of the current payment practices disincentivize wellness. Whatever is the best way to get towards wellness and optimal disease management would be what we'd want to incentivize.
- I think pay-for-performance is kind of an umbrella of the other [payment models]. Because pay-for-performance starts to bring the incentive into the equation, that focuses on quality of care and not just seeing people...To get started, I think it's a combination of pay-for-performance and fee-for-service...because the whole system's engineered around fee for service and the feds are bringing pay for performance into the Medicare arena.
- Providers will say one thing, and systems will say another. I could see a capitation model, with some incentives for preventative services and improved health outcomes for patients.
- Fee for service is probably a good way to pay for [services], but that still doesn't make it appropriate.

7. *If the Franklin County community collectively decided to fund expanded access to coordinated medical home services, how would you – as a member of the community, as a stakeholder, or as a casual observer – define and measure the impact of that investment?*

- *What outcomes would you expect?*
- *What measurements, instruments, or methodologies should be integral to the process, in order to measure whether those outcomes were achieved?*
- *At what stages of implementation should these measurements occur?*
- *How long should they continue?*
- *Will the type of measurement(s) change over time?*

- We have to look at the integration of some population-based measures that the system is held accountable to. Clinical indicators, for example, that are part of the Uniform Data Set performing structure. The integration of clinical measures that speak to changes in population based health care is going to be critical.

We have to be able to look not only at the individual level – does that individual patient have access – but also, what does it mean? Are we really making a difference? Yes, they can get in the door. Yes, we can serve them quickly. But ultimately, did we really make those people healthier?

- When you get started, you've got to track activity first. Then you track effectiveness. It's a journey that, whatever entity leads this, will have to take us on. But with the community's feedback about what we should be monitoring. We need to ask: "What is it that will make us feel comfortable that we're doing something, and that we're getting something for the dollars that we're putting in?"
- I'd want to know some of the output type measures: the number of people served, the services, the standard output measures. On the results side, it would be useful to know whether there was decreased utilization of high cost things like ERs or inappropriate urgent care use, and wellness measures that show certain folks got healthier.
- [I'd like to see the] business case model for why, if we spend \$1 now, it ends up saving us \$10 down the road. I'd be interested to know whether that actually holds weight. If it did, we might actually get people to tax themselves in order to continue it and support it.
- The key for employers, like with any other customer, is to think like they think. What are they thinking right now? Health care costs are killing them. What are you going to do that's going to help their bottom line? It's about the value proposition. How is this going to help my company? And if it helps my company and the community too, that's great.

- The other thing you'd want to do is make sure that there are measures that are widely understandable when you want to go back to the broader community and say here's what we've done and here's how we can tell you what we've done. It's good to do that in terms that are easily understandable.
- I want to see that the system is sustainable and that it includes a robust emphasis on prevention. If we're going to create something new, we all talk about the importance of prevention, so we should carve that out in the beginning. There should also be minimal gaps in terms of who's being served. We want to make certain we've created a system that is an efficient and effective one for these vulnerable people that don't know how to take advantage of systems.
- Over time, one of the measurements that I hope we would be able to see as an impact of doing this is, for instance, fewer ambulatory care sensitive conditions being reported in the hospitals – both in terms of admissions, and also deaths related to ambulatory care sensitive conditions. So, it's about morbidity and mortality, but it's also simply about the cost to our system from people having to have hospital stays for preventable conditions.
- Measuring over time the number of new medical homes that are successfully created and the number of new users that are successfully engaging in the increased capacity. Also, there needs to be some look at how cost effective it is, and so the cost per visit needs to be tracked. And then, hopefully, there would be decreased emergency room use, decreased admissions to the hospitals, decreased health disparities, and decreased overall public health costs.
- I see three kinds of broad measures: One would be a financial one – so some type of trending on volume to cost, total cost to visits... benchmarked over time; the other is an access measure, and that can be based on the number of patients seen, wait times, the catchment that these sites begin to draw from, etc; and then obviously a quality measure – outcomes data, improved health, repeat visits, everything down to whether they're following care plans (which is probably farther down the road). I'd set those up from day one, with probably the recognition that you change them in 6 months once you get going.

8. *What do you perceive to be the individual (patient-based) quality-of-life benefits of improved health for vulnerable persons?*

- [Benefits include] access to educational services and better parenting and family relationships, which are enhanced in the presence of health... Depression and anxiety are also major components of [health]. People who are in a healthy state are also free of those impediments, which impact all of their relationships and their ability to be successful in general.
- [Poor health] results in all kinds of side effects that cause stress, which deteriorates your quality of life. But having access – having the assurance that you can get [health] issues addressed, have the follow-up care that goes with it, and have someone to go down this road with – that’s huge. It’s a system that says we care. In the end we’re all better for it.
- If the medical home provides a truly integrated health care program, where physical as well as psychiatric and behavioral health needs are met, patients will have better outcomes. Some of the worst chronic diseases that we manage are mental illnesses. Individuals could benefit if a medical home comprehensively met their needs in a more integrated format.
- If someone’s healthier, they’re a better mother, father, husband, wife, etc. It can be looked at from multiple levels.
- The opportunity for more hope, more happiness, self-fulfillment, and productivity.
- More stability in having real, rather than hoped-for healthcare.
- I would hope that they live longer and are more productive. Fewer lost days from work, and they’re happier because they’re not worried about how they’re going to pay for service X, Y, and Z, which takes a lot of stress off of people.
- Improved health...longevity...feeling better at work. Preventing small things from growing into big things.
- You aren’t living life in pain. You aren’t living life unable to walk up and down the stairs...You may be living life with a concern about some illness that you have to manage. If you have improved health, hopefully you’re spending less time and energy managing illness and you’re spending more time just living life.
- They’re going to be better able to work, so the gain for them will be greater. Longer life expectancy...family improvement...the ability for adults to care for their family, so stress would be less. Maybe there would be a generational change in terms of valuing healthcare. If

they start to gain a benefit from it, then their children would see it. And the value behind that is that we would begin to care about and value prevention.

- If you don't have your health, it's hard to improve your status in life. Education, employment, parenting, it's all those social determinants that health impacts. And the economic side ties into that. If you want to be a good part of our society, a contributing part of society, you have to have your health because working is a big part of contributing to society. Being a good parent is part of contributing to society. Educating yourself and advancing yourself intellectually is a part of contributing to society. And it's hard to do all those things if you're unhealthy.

9. *What do you perceive to be the individual (patient-based) economic benefits of improved health for vulnerable persons?*

- [A benefit is] not having to worry so much about healthcare cost as a huge piece of a person's budget. And maybe that person is more responsible with their healthcare dollars and their healthcare expenditures when they move out of this system, because they will have learned something about preventative care, and regular treatment, and staying on your drugs, and all the good things that this system would provide.
- People who are healthier have better work performance, which affects their ability to acquire and retain employment.
- You might have people needing to take fewer sick days. As we know, there are significant numbers of employees who don't have paid sick days, so if they're out sick they lose income. Or if they have to be out for a family member, if they're a caregiver for a family member, if there are fewer episodes where somebody has to take time off of work, then that could give them an economic benefit. Plus there's an economic benefit to having some subsidy for healthcare, to give a family resources to spend on other things.
- I think the economic benefits are significant in terms of the ability to get to work consistently and to have, when they're at work, better wellness and less anxiety about how they're going to get their healthcare needs met for their kids. It would seem it should also contribute to the kids being able to stay in school, which could have greater benefits down the road, particularly if there's an impact on reducing teen pregnancies and some of the things that cause kids to drop out of school.
- Skill building and being a productive member of our community translates to receiving a living wage, which translates into the ability to purchase goods and to live the life you want to live.
- For the individual, being able to get in [to see a doctor], for a sliding fee or a low flat fee – think about a family's planning mechanism, not having to be forced to make very, very difficult choices. Do I go to the doctor, or pay the rent, or pay the bills? It's that type of thing. It's got to relieve a family's economic burden, and I think that's huge.

10. *What do you perceive to be the economic benefits to the Franklin County community of improved health of vulnerable persons?*

- If we do things right – preventive care initiatives and timely visits, coupled with appropriate management and compliance of chronic disease – we ought to be able to demonstrate, not by the individual but by aggregate, that in fact, healthcare costs are less because we’re seeing people at the right time.

We ought to be able to demonstrate that we’re spending less money on the government-sponsored side, and we ought to be able to demonstrate, from the employer’s perspective, that illness, absenteeism, or the new term “presenteeism,” are less costly in terms of benefits packages.

- When you talk about economic impact, unemployment rates, and lost time, it’s hard to separate education from healthcare. Because a lot of these go hand in hand. Improving the healthcare system without improving the education system, how much impact will you really have? It will be marginal. They really need to go together to have an impact on the economy.
- I think it would be cool to say that Franklin County is the first county in the United States to have all of its residents with access to routine healthcare, preventive healthcare, etc.
- One might assume there would be less need for uncompensated care and less use of more expensive alternatives, like emergency rooms. There would also be less time off of work, which has a deleterious effect on the business community.
- We would have a more productive local economy because ultimately we would pay less into the healthcare system and more into productive wages that turn a profit for area businesses, which can be turned right back into improving this community’s infrastructure– arts and human services, other aspects of health, recreational programming, etc.
- People are leaving, and they’re leaving in droves. We’ve got a brain drain going on. We’ve got to give folks a reason to stay. When you’re down, you get creative. We’re down now. We need to get creative, and do some things that make people want to live here.
- A healthy community is a good (inaudible) investment from out of town businesses, other entities would like to come here if the community’s healthy. We’ve got magazines about healthy communities that (inaudible) those are really good places to live. Our community’s economic health would be enhanced if that was our reputation nationally.
- People who are currently unemployed, who receive other kinds of public benefits, would not have to... Healthy communities attract investment from out of town businesses. Other

entities would like to come here if the community were known as a healthy community. Our community's economic health would be enhanced if that was our reputation nationally.