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"CHOICES" Florida's Version of Obamacare

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“CHOICES” FLORIDA’S VERSION

OF OBAMACARE

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Abstract

“CHOICES” Florida’s Version of ObamaCare

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“CHOICES” Florida’s version of ObamaCare was a unique case voted in by the public in Alachua County Florida. A mixed methods research design was utilized and provided context in which policy entrepreneurs operated, as well as an explanatory model of internal determinants. Social, economic and political factors were examined to determine the predictor variable in the adoption of the “CHOICES” health services program. The results revealed that voters 51 years of age and older had a greater probability of voting for the Alachua Referendum. “CHOICES” legality has not been under contention but its effectiveness has. This study found that “CHOICES” has been effective at providing comprehensive primary preventative care in a disjointed incremental system of healthcare by purposefully collaborating with all stakeholders involved. A model for purposeful collaboration is presented and is titled the policy adoption wheel of collaboration.

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Dedication

To Harold Dale Tobler

You are my mentor, I love and miss you.

Love your oldest Grandson

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CHAPTER 1

Setting the Stage for "CHOICES"

"Obama Care" a term used by the public refers to the Patient Protection and Affordable Care Act [PPACA] (2010) legislation signed into law by President Barack Obama March 23, 2010 and is evidence of the partisan tension that exists in politics regarding government participation in the United States disjointed incremental system of health care at the federal level. Further evidence of the tension created by partisan politics in health care is demonstrated by the 16 state attorney generals, four governors, and two private citizens who brought forth a law suit in Florida against the Federal government's attempted implementation of the PPACA (Dan). The number of states suing grew to a total of 27 states contesting the constitutionality of the individual mandate in the PPACA. Never in the history of the country have so many states united in a common grievance to sue the Federal government to repeal a law they believed to be unconstitutional.

Partisan tension among the two political parties exists when speaking about the PPACA and is present on the local level in Florida as well. Florida Republicans have coined the term "Florida's version of Obama Care" to refer to "CHOICES". "CHOICES" came into existence in 2004 when the voters approved a quarter cent sales tax by 88 votes; the program provides quality comprehensive preventative care to the underemployed who were uninsured legal residents of Alachua County Florida (Scicchitano, 2010). Unlike the PPACA, "CHOICES" was approved by the people of

Alachua County to allow local government to levy a quarter cent sales tax. However the tax sunset February 2011 and the program was in danger of collapsing.

The “CHOICES” program attempted to take the current disjointed incremental system of healthcare at the local level and purposefully collaborate with all stakeholders to provide comprehensive primary preventative care for legal Alachua County residents who are underemployed and uninsured and who do not qualify for other federal and/or state programs.

The stakeholders collaborating included citizens of Alachua County, local government, private for profit, and private nonprofit institutions. When we look at the past and present we see that no one group has been able to provide comprehensive primary preventative healthcare to all populations in need. Alachua County has recognized that they cannot be the providers of care, rather they can partner with the private nonprofit and private for profit sectors to provide care that “CHOICES” can subsidize for enrollees.

There is contention over whether or not “CHOICES” has been effective. If, however, an effectiveness measure is the number of people served, one could argue the program has not been effective. If effectiveness is related to the quality of care received by enrollees, then an argument could be made that the program has been effective. Regardless, policy implementation was successful at providing care to the population in need and required a careful process in order to be effective.

Policy implementation with regards to the PPACA may expand or contract the Federal government’s role in health care, specifically with regards to providing health

insurance. The PPACA is insurance reform those who look at the reform in this light consider it incremental reform. Still, others consider it to be a major change in health care policy (Baumgartner & Jones, 1999). Those who consider it a major change point to sections in the act, such as the community living assistance and support services (CLASS) section, as examples. This section discusses long term care and the need to provide long term care to the public at a reasonable cost.

Those who consider it an incremental change to federal health care policy can cite that a major change in health care policy would be the creation of a single payer system. Since the PPACA is insurance reform and not a single payer system, it is only an incremental change not a major change in health policy. Some scholars note that the incremental changes in the PPACA will continue and unless a major change takes place health insurance will be unaffordable for low to middle income Americans.

Punctuated equilibrium is a theory developed by Baumgartner and Jones. The theory explains change in the policy process it talks about incremental changes in the policy process and suggests that they lead to major changes (Baumgartner & Jones, 1999). All of the changes occur over time and are marked with significant events that occur to influence policy. When we look at health care policy we notice incremental as major changes that have taken place over time.

As incremental changes to health care policy continue to occur they will ultimately result in a major change taking place in health care policy. If Young's predictions come to fruition we could see those changes as early as 2033 (DeVoe & Young, 2012). This federal legislation and the political debate that surrounds it have set

the stage for a local discussion in Alachua County over their local health service program "CHOICES".

"CHOICES" a Local Health Service Program

Healthcare in the United States is a prevalent topic of conversation nationally because of the recent implementation and judicial review of the Patient Protection and Affordable Care Act. The PPACA is the federal government's attempt to reform health insurance. The impact that the PPACA will have on employers (Chirba, 2010) and what the quality of the healthcare delivery system will be after the implementation of the PPACA (Segal, 2010), and whether or not the PPACA can be used for a framework to eliminate health disparities (Majette, 2012) are all topics of conversation. The political debate surrounding the PPACA sets the stage for the adoption of local health service programs to fill the gap the gap left by the state government, federal government, private for profit and private nonprofit organizations.

Adoption of health service programs in the U.S. is important because of the disjointed incremental system of health care that relies heavily on purposeful collaboration between federal, state, local government, private nonprofits, and private for profit groups to provide access to care for American citizens. Even though purposeful collaboration occurs many Americans go without healthcare; our incremental system of health care does provide a safety net, when all participants purposefully collaborate.

Local government can purposefully collaborate by adopting effective health service programs which reimburse private for profit and private nonprofit providers. Healthcare can be expanded locally and purposefully to those who are presently without

access to care, as well as, those currently with care. Local Government in Alachua County Florida identified a need to increase access to care for the working uninsured population, and attempted to increase access for the population in need.

This research study examines one adopted health services program in Alachua County called “CHOICES”. “CHOICES” has been compared to the Patient Protection and Affordable Care Act by local Republicans who refer to it as “Florida’s version of ObamaCare” (Alachua County Republican Party eNews, 2011). The creation and implementation of the Alachua Referendum predated the PPACA by five years once the referendum was implemented it became “CHOICES”. “CHOICES” seeks to expand access to comprehensive primary preventative healthcare to the nonelderly, underemployed, uninsured population. One of the main differences between “CHOICES” and the patient protection and affordable care act is that “CHOICES” was voted on by the public as the Alachua Referendum during the 2004 primary election and has been on solid legal footing since its inception. “CHOICES” and the Alachua Referendum are one and the same, and will be used throughout this document to refer to the creation and implementation of the local health service program adopted by Alachua County residents.

The purpose of the study is to examine the policy adoption of Alachua Counties health service program “CHOICES” and evaluate the program’s effectiveness by analyzing the program evaluation conducted by the Florida Survey Research Center (Scicchitano, 2010). Adoption in this study refers to policy adoption by democratic government. If the program is determined to be effective or ineffective it will increase awareness through publication for other jurisdictions to avoid or replicate. “CHOICES” is

reported to be effective according to a program evaluation conducted by the Florida Survey Research Center (Scicchitano, 2010). Identifying political social and economic determinants leading to the policy adoption will be the focus of this study, and if found to be effective, replication will provide further evidence to support or refute the models ability to expand care. Public Policy entrepreneurs were instrumental in garnering support for the referendum and qualitative inquiry will be used to provide context about the environment in which they operated.

"CHOICES" is an innovative model in Alachua County Florida and when studying policy adoption it is important to look at the internal determinants. Internal determinants can be modeled using logistic regression to explain the significant factors, associated with policy adoption. In the case of the "CHOICES" health service program in Alachua County political, social and economic internal determinant factors can be examined much like Berry's (1994) examination of strategic planning. Internal determinants in the federal and local governments have not been studied as much as internal determinants in state governments, and adoption seems to be of less interest to researchers in federal and local governments, this could be due to the limited level of policy innovation in local municipalities.

When studying internal determinants of adoption of local level programs we can determine the factors which positively and negatively impact innovation, often before it has had time to diffuse to other counties, states, or the federal government. The laboratory for discovery of innovative programs becomes local government programs, and as they are replicated by governments their effectiveness can be compared.

“CHOICES” Background

Alachua County Florida had concerns about the rising emergency room costs in the county and wanted to develop a health services program to help alleviate the burden placed on hospitals as the primary source of care for the underinsured. “CHOICES” is a healthcare policy innovation at the local level in Alachua County Florida that provides comprehensive primary preventative care for the working uninsured who are underemployed. In March of 2003, the Director of Community Support Services in Alachua County presented what became the “CHOICES” program to the County Board. This was followed by an elected policy official championing a grassroots effort to place a referendum on the ballot that when implemented became “CHOICES”.

This policy official became a policy entrepreneur (Hakari, Koistinen, Lehto, Miettinen, & Tynkkynen, 2012) Policy entrepreneurs are individuals with the knowledge and opportunity to act to take advantages of windows of opportunity in the policy process. Policy entrepreneurs were instrumental in moving forward the agenda of the CHOICES program and are found in appointed as well as elected positions. The Alachua Referendum was successfully placed on the ballot; the choice given to the public was whether or not to adopt the referendum. After adoption on August 31, 2004 during the primary elections the Alachua Referendum was approved for implementation and shortly thereafter became the “CHOICES” health services program.

The Alachua County referendum passed with an extremely close margin during the election. It was on the ballot with a public defender, county commissioner seats, a state committee representative, precinct committee officials, a circuit judge, county

judges, and the school board. In March of 2004, six months before the primary election was held that contained the "CHOICES" referendum; elections were conducted for the Mayor, as well as, the primary for the president of the United States. Three months after the adoption of the tax that would fund "CHOICES", the general presidential election for the United States was conducted. This strategic placement of the referendum on the ballot, during a time that the general public had heightened attention regarding politics, worked in the favor of adopting the "CHOICES" health services program.

Healthcare Policy Environment

In the past ten years major health policy changes have not taken place. Before the great depression, Americans paid for health care out of pocket, and the cost of health care was much less than what it is today. Because of the threat of government expanding into health care during the Great Depression of 1929 the "Blues" were created (Blumenthal, 2006). This was a major change in health policy as it is the first time private insurance came into existence. Blue Cross and Blue Shield provided private insurance for individual purchase. For 50 cents a month, individuals could be covered by health insurance. This is worth five dollars and thirty four cents in 2011[1] Insurance made it no longer necessary to anticipate and save for possible future medical costs during the end of life (Sultz, 2010).

[1] As of Monday September 10, 2012 the deflator index for 1929 is 10.614 and for 2011 it is 113.327 suggesting that .50 cents in 1929 is worth $5.34 in 2011 Retrieved Monday September 10, 2012 from the World Wide Web http://stats.areppim.com/calc/calc_usdlrxdeflator.php

The history of health care in the United States identifies major stakeholders that include health care research organizations, alternative treatment providers, insurance companies, managed care groups (HMO & PPO), mental health providers, private nonprofit companies, lobbying groups/professional associations, long term care providers (both formal and informal), schools of health education, the public, employers, traditional healthcare providers, health care facilities, governments, and other health industry organizations (Sultz, 2010). The key macro groups include federal, state, local government, private for profit and private nonprofit groups.

Insurance came about because the cost of health care was so high during the Great Depression. For those that could not afford health insurance the government established Medicare and Medicaid in 1965 to cover the underserved populations of the aged and the extremely poor (Gunderson, 2012). Providers of health care services began to reap great financial benefits from the establishment of insurance companies and insurance companies began to charge rates that were higher than necessary given the care that was received (Sultz, 2010). Things have changed and physicians are now claiming they cannot profit from providing care to Medicare and Medicaid patients. They argue their provider compensation levels are falling (Biggs, 2010). For example insurance companies contract with managed care organizations who in turn contract with providers for reduced services for their enrollees. When enrollees choose to go to a provider who has a contract with a managed care company they pay less because they are charged in network fees. If enrollees opt to go to a provider who is out of network they pay higher rates and maximize both the benefit portion paid by the managed care company and the enrollee

quicker. However this system keeps insurance companies in check so they do not charge higher prices to consumers than is necessary. In the case of Medicare and Medicaid they contract directly with providers just like managed care, but many argue the rates Medicare and Medicaid contract with are too low and they cannot break even let alone make a profit (Isaacs & Jellinek, 2012).

Health Maintenance Organizations (HMO's) were created in 1973, by the Health Maintenance Organization Act of 1973 (Lobb, 2012). From 1992 to 1999 HMO's have grown rapidly (Sultz, 2010). One major problem for HMO participants is that they cannot choose a specialist without a referral recommendation from their primary care physician. This led to the creation of PPO's in 2001 by physicians and hospitals. PPO organizations allowed individuals to consult a specialist directly and provided better reimbursement rates for physicians (Sultz, 2010). Note, however, some PPO's require a primary care physician be assigned to a patient much like an HMO. By 2002, PPO's had captured more than 50 percent of the market for private insurance and appear to be the nation's preferred managed care option of choice (Feng, 2012).

The timeline of federal healthcare policy in Figure 1, when looking through the lens of punctuated equilibrium, created by Baumgartner and Jones (1999) shows that many incremental changes to health policy have been made over the years (Figure 1). Incremental and major changes to health policy have taken place throughout time. However there has not been a major change in health policy for the past 26 years. Major changes to health policy took place in 1910, 1929, 1973 and 1986. Nineteen years transpired between the first and second major change. Forty four years transpired

between the second and third major change. Thirteen years transpired between the third and fourth major change with an average of 27 years between major changes. Considering that it has been 26 years since the last major change we are due for a major change in health policy.

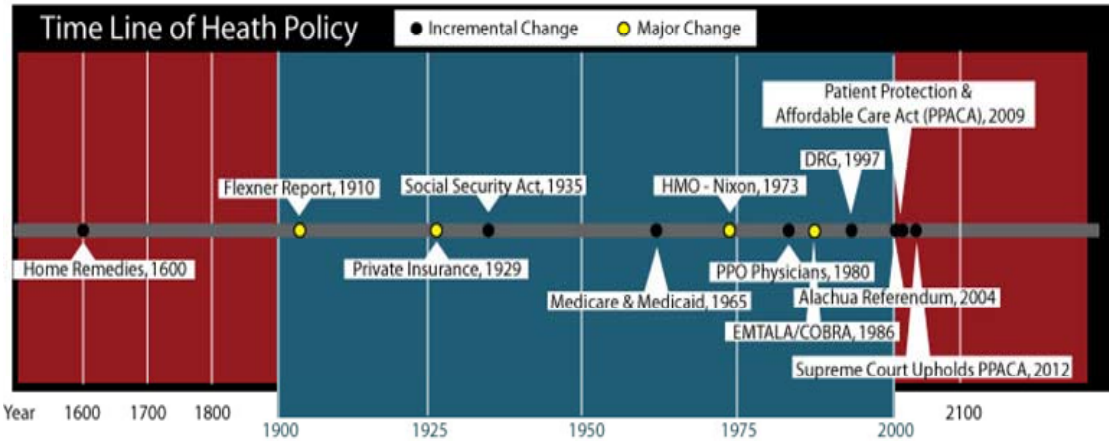


Figure 1. Time Line of Health Policy Key Changes

Healthcare Education and Nonprofit Donations

Physician education prior to the 19th century was not focused upon evidence based care. Care was typically provided by homemakers who learned herbal remedies, often by word of mouth (Sultz, 2010). Harvard was the first school to require four years of training, followed by Johns Hopkins. These institutions set the standard for all medical education. The Flexner Report (1910) was an accurate and searing description of abuses in medical schools.

Foundations and wealthy individuals supported medical schools through this early period in the history of medical education. Schools, who had more favorable reports, received the lion's share of the available funds. Most of the schools receiving funding were affiliated with Universities, this had a great deal of influence over medical educations present and future path towards the evidence based medicine model (Sultz, 2010).

The Flexner Report shifted the focus of healthcare education towards evidence based care, yet there were still many who could not afford care at all (Sultz, 2010). Insurance companies, like Blue Cross and Blue Shield, (Sultz, 2010) began refusing payments for procedures/ treatments they deemed unnecessary or were due to preexisting conditions. This in part led to the creation of Health Maintenance Organizations (HMO) in 1973. It was thought that they would hold down health care costs by changing the profit incentive from fee for service to promoting health and preventing illness (McGinnley, 1999). Not only did physicians see government involvement in healthcare in the form of Medicare and Medicaid they were being attacked by HMO's.

This led to the creation of the Preferred Provider Organizations (PPO) PPO's, which were organized by hospitals and physicians and were a direct result of the invasion of HMO's (Hurley & Strunk 2004). This incremental fragmentation of the healthcare system transformed the competition in regards to health insurance (Robinson, 2004). Now, instead of contracting directly with providers for care, insurance companies had to contract with managed care organizations. From 1910 to about 1973 physicians had a very lucrative career that did not involve invasive government intervention, or private

intervention. In fact when government threatened intervention in 1929, private insurance emerged (Blumenthal, 2006). However it only delayed the eventual intervention of government and private managed care organizations.

Managed care and insurance companies negotiate lower rates with providers. This raises questions about equity. What are the actual costs of procedures being performed? Why don't individuals have the same rights to negotiate better rates with providers like large managed care organizations? Myers (2009) reviewed the expansion of some market based state health care programs and stated when taken as a whole, they were successful in helping to bring about positive developmental effects for the U.S. states, despite the narrow focus (Myers, 2009). These positive developmental effects included liberal party strength, electoral competition, institutional capability and prior adoption (Barrilleaux, 2007).

Adoption of Policy Innovation

Much of the empirical research conducted in the United States concerning public agency innovation has been at the state level, suggesting more research is needed at the national, local/regional levels (Sabatier, 2007). Innovation can be explained as adoption of new programs based on internal determinants (Berry & Berry, 1990).

The internal determinants approach seems to be of less interest among policy researchers, thus creating a gap in the literature, with respect to innovation lead by local jurisdictions. While researching policy innovation 54 published articles were reviewed that were all related to Event History Analysis. This seems to be a popular method to use when studying adoption. The Mohr article published in 1969 was the first article that was

found in the research process that used logistic regression to study internal determinants of organizations. When we consider that counties are organizations this internal determinant method can be used to study the adoption process.

Factors included in internal determinant models predicting jurisdictional innovation include political, economic, and social characteristics internal to a particular geographic state or political sub-division (Berry & Berry, 1999). When motivation exceeds obstacles, adoption occurs (Berry & Berry, 1999; Mohr, 1969). Innovation is directly related to the motivation to innovate, inversely related to the strength of obstacles to innovation, and directly related to the availability of resources for overcoming such obstacles (Berry & Berry, 1999; Mohr, 1969). Thus when adoption occurs one can infer that motivation exceeded obstacles. Obstacles to innovation include "traditional" community norms, personal attitudes generally unfavorable to change, worker resistance to change, narrow organizational goals, lack of information, and mechanistic decision structures.

Factors Predicting Adoption

Factors that predict adoption in an organization are size, wealth, and availability of resources (Mohr, 1969). Wealth differs from the availability of resources in that there are resources other than money that may be contributing factors like access to healthcare facilities and providers or land. Organizations may be more likely to innovate when the environment is rapidly changing. Because, county governments are just larger organizations than these factors are relevant to the study, other contributing environmental factors include market conditions, technological changes, clientele needs

and demands, and the labor market (Berry & Berry, 1999; Mohr, 1969). Some predictors of innovation in the sense of readiness to adopt new patterns of behavior are organizational size and wealth (Mohr, 1969). However, public service agencies fail to take initiative and supply leadership in particular sectors of public affairs, and the public does not always have an opportunity to express their wants and needs (Mohr, 1969).

Public policy entrepreneurs can supply leadership in agencies and county government to help the public have a voice in policy decisions. Scholars, like Mintrom, agree that policy entrepreneurs are essential players at increasing the chances a policy will be adopted (Mintrom, 1997). Policy entrepreneurs constitute an identifiable class of political actors. Their presence and actions can significantly raise the probability of legislative consideration and approval of policy innovations (Mintrom, 1997). Mintrom employs a study using event history analysis to explain the importance of policy entrepreneurs in agenda setting and he concludes that policy entrepreneurs in 26 states who advocated for school choice raised the probability of adoption of school choice innovation. As policy entrepreneurs exploit windows of opportunity when the politics, policies and problems streams combine, policy innovations will occur (Kingdon, 1984).

Purpose of the Research Study

There were three specific aims of this research study: 1) To identify the factors that influenced the creation of the “CHOICES” program: 2) To describe the key role of public policy entrepreneurs who were part of the process of adoption: and 3) To provide researchers and government officials with a documented explanatory model of a purported effective comprehensive primary preventative care program.

1. The study will identify significant factors that influence the adoption of the “CHOICES” health services program voted into effect by Alachua County voters. We will examine the adoption of this comprehensive primary preventative care program by examining the influence of social, economic and political variables as internal determinants.

   Adoption is synonymous with innovation thus, “CHOICES” is a policy innovation. When studying adoption of policy innovations effectiveness is often lost. Adopting ineffective programs is of little use to the public. However, identifying the determinants responsible for adopting effective health service programs can be a great benefit to those communities, states, or federal agencies who decide to replicate effective programs.

2. Identifying and describing public policy entrepreneurs and the environment they operate in is an important qualitative piece because public policy entrepreneurs increase the probability adoption will occur. Public policy entrepreneurs are public servants the media, and/or elected officials. These entrepreneurs often have normative values that drive them to be motivated to overcome the obstacles associated with the adoption of innovation.

3. The final aim of this research is to provide government officials and scholars a descriptive document about the “CHOICES” Health Services Program, so that it might become adopted in other areas of the country that have need for innovation in this domain.

Adoption of an effective comprehensive primary care program can result in the nonelderly, underemployed, uninsured population having the opportunity to receive comprehensive primary preventative care. This can result in reduced emergency room visits for the communities adopting preventative programs. Emergency room care is the most costly form of care. Reducing emergency room visits could result in fewer taxes needed to fund emergency room stays in communities with safety net hospitals. Safety net hospitals provide care to those that cannot afford care, are uninsured or underinsured and are often supported by government funding.

Research Approach

A cross sectional analysis of internal determinant factors from 2004-2011 will be used to create a model that can test which variables are the significant factors related to the adoption of the purported effective health services program "CHOICES" by using logistic regression. Variables identified in the model creation will be based on a review of both the literature and public documents recording the events leading up to the creation and implementation of the "CHOICES" health services program. Public policy entrepreneurs who were responsible for setting the stage to adopt the "CHOICES" health services program in Alachua County Florida will be identified and context of the environment in which they operate will be presented.

The availability of resources for overcoming obstacles is the basis for the creation of the model. Mohr studied the determinants of innovation in public agencies and since the county government is just a larger organization this model can be used to investigate the significant factors that led to the adoption of the "CHOICES" health services

program. Mohr's model shows that when motivation exceeds obstacles adoption occurs. Since "CHOICES" was adopted the logical conclusion is that statistically significant factors will represent motivation.

The unit of analysis is individual voters in Alachua County precincts. Logistic regression will be used to analyze the data collected for the model since the dependent variable is nominal. The dependent variable will be adoption of "CHOICES" coded 1=adopt and 0=not adopt. Independent variables will be collected to create a model that will assist in analyzing research questions found in Appendix A and B. Since "CHOICES" was adopted, the expectation would be that statistically significant variables would represent the significant motivation factors that overcame the obstacles.

Role of Policy Entrepreneurs

Public policy entrepreneurs play an important role in increasing the probability of adoption when the streams (problem, politics, policy) combine and windows of opportunity present themselves (Kingdon, 1984). Who public policy entrepreneurs are and what role they play in the agenda setting environment is an important determinant to identify and describe. Public entrepreneurs, much like their private sector counterparts, are considered leaders who advocate for change (Schneider, 1995). Some argue their activity can be systematically modeled (Schneider, 1995); others suggest the change they create is random (Cohen March & Olsen, 1972). Nevertheless, it is important to investigate the attributes of these individuals as they increase the probability that adoption of policies will occur.

Research Questions

The research question stemmed from an interest in the overall factors contributing to the adoption of the "CHOICES" health services program. The literature review identified social, economic, and political factors as significant variable groupings to predict the adoption of innovation, the "CHOICES" program (Mohr 1969, Sabatier 2007). Data was collected on 71 precincts for the logistic regression model and focused research questions were used in the model to further test the factors. Some precincts were combined by the supervisor of elections in Alachua County which reduced the number of precincts available in the analysis to 69.

The interest in this topic came from a lack of written material about adoption of local health services programs that were the direct result of a vote of the people governed. Appendix A contains the research question and associated hypothesis that began the inquiry into this topic. What are the factors associated with the adoption of the "CHOICES" health services program in Alachua County, Florida. The hypothesis is that social, economic, and political factors will be significant when predicting the adoption of the "CHOICES" health services program.

Appendix B presents the focused research questions and associated hypotheses that were created to structure the proposed study: The questions include: 1) Which political motivation factors have the strongest relationship with the adoption of innovation of the "CHOICES" health services program in Alachua County Florida? 2) Which economic motivation factors have the strongest relationship with the adoption of the "CHOICES" health services program in Alachua County, Florida? 3) Which social

motivation factors have the strongest relationship with the adoption of the “CHOICES” health services program in Alachua County, Florida? 4) How did the public express leadership in the creation of the “CHOICES” health services program? 5) What organizational factors have the strongest relationship with the adoption of the “CHOICES” health services program in Alachua County, Florida? and 6) What role will socioeconomic status and education play in the adoption of the “CHOICES” health services program? These questions provide a framework to analyze the results.

Appendix B includes the focused research hypotheses numbered to correlate with the focused research questions. The hypotheses include: 1) Precincts that have a majority of Democrats will be more likely to adopt “CHOICES”. 2) Precincts with higher home values will be more likely to adopt “CHOICES”, Precincts with higher household incomes will be more likely to adopt “CHOICES”, Precincts with more private businesses will be more likely to adopt “CHOICES”, 3) Precincts with a higher female populations will be more likely to vote to adopt the “CHOICES” health services program, precincts with larger non white populations will be more likely to vote to adopt the “CHOICES” health services program. 4) If the public has an opportunity to express their wants than leadership was supplied by the public. 5) Size of the precinct and wealth of the precinct will have the strongest relationship to adoption. 6) Precincts with higher education will be more likely to adopt.

Looking at public policy entrepreneurs is important to provide context to the quantitative measures discussed previously. This is necessary in order for us to understand public policy entrepreneur’s role. Qualitative measures were used to describe

the public policy entrepreneur's environment, roles, and how they contributed to the creation and implementation of the "CHOICES" health services program.

Appendix C describes the research questions that will be used to collect information to provide context that can confirm or refute the quantitative examination of the "CHOICES" health services program. Which individuals and groups advocated for the development and adoption of a comprehensive primary preventative care program targeting the nonelderly uninsured residents of Alachua County, Florida? What sources of information were used within the districts to guide policy entrepreneurs decisions about which preventative care program would be adopted? How do policy entrepreneurs impact the adoption of "CHOICES"? Why did policy entrepreneurs choose to become involved with the adoption of "CHOICES" What time constraints existed with the adoption of "CHOICES" who are the policy entrepreneurs associated with the adoption of "CHOICES".

This mixed methods study will explore the predictive factors that led to the adoption of "CHOICES", as well as, describe how policy entrepreneurs were involved in the creation and implementation of the "CHOICES" health services program. This provides a multidimensional overall structure for the research study that can triangulate interpretation of findings.

Structure of the Research Study

The dissertation will include five chapters. Chapter 1 will provide an overview of the study, the research problem, the purpose of the research, the approach to the research, and a structure for the written dissertation.

Chapter 2 includes a discussion of the role of government in health care, looks at federalism in healthcare policy, explores a history of federal state and local government healthcare, and looks at incremental changes in healthcare policy. It also examines a case of local government healthcare, looks at the history of "CHOICES" creation implementation and policy entrepreneurs, explores "CHOICES" background, the effectiveness of "CHOICES", who the "CHOICES" enrollees are, and what the "CHOICES" program goals are. Finally we explore vulnerable populations, models of policy change and policy innovation.

Chapter 3 will explain the mixed methods research study proposed, describe the sample setting, explain the research design, and explain why the internal determinant model was selected. The coding for each variable used in the statistical models will be explained. Additionally, there will be a discussion of the research questions, the dependent variable, as well as the categories for the independent variables. A more in depth discussion will be had as to which method of logistic regression was selected and why, and finally a discussion about policy entrepreneurs and the qualitative method selected will be explored.

Chapter 4 will begin with an introduction followed by a discussion regarding incremental change, windows of opportunity, and policy entrepreneurs. The binary logistic regression model will be presented followed by the variable categories. Then the hypotheses will be presented and the chapter will conclude with a discussion of the effectiveness of the "CHOICES" health services program. Chapter 5 will begin with qualitative reinforcement of "CHOICES" effectiveness. A policy analysis will be

presented along with an examination of “CHOICES” policy categories identified in the policy analysis. Observation from the literature will be presented followed by a discussion of the research study. The findings will be presented and the final theoretical framework will be presented.

CHAPTER 2

Role of Government in Health Care

In federal systems, power is divided between a central government and local, state or regional governments (DiIulio & Wilson, 2007). Both the central government and the constituent governments act directly upon the citizens. Two examples of federal government systems would be those in Canada and the United States, which are based on the adoption of a constitution (DiIulio & Wilson, 2007). In government that includes direct democracy. Citizens may act on government directly. Direct Democracy occurs when government is not able to meet citizen's expectations. Citizens and interest groups develop grassroots campaigns to place legislation on a ballot in states where this is permitted. The federalism lens, is not used as a primary focusing theory for this paper. However, it is important because it explains the different roles in levels of government. Federalism gives readers a way to understand how "CHOICES" could come to fruition in an American Federal system of governance. The Federalism lens does not explain the various micro levels of government at the local county, city or town level, but can be used to explain healthcare changes at the various macro levels of government as seen in (Figure2).

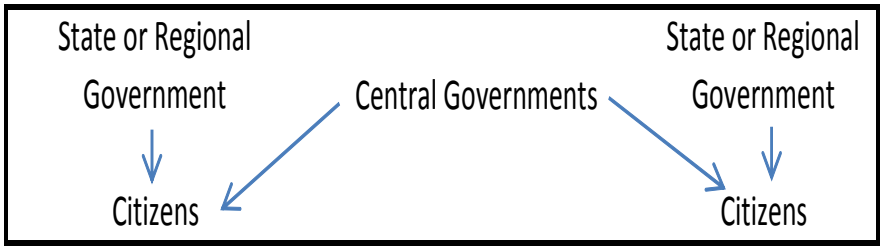


Figure 2 Wilson Depiction of Federalism (DiIulio & Wilson, 2007)

Researchers have used the Federalism lens to show how safety net hospitals in a federal system need financial support from local, state and federal government to continue providing care to the citizen base (Myers, 2009). Meyers concluded that safety net hospitals are doing the best possible job with the resources they have, but without funding from the government, they will likely collapse. However, when local government spends money on supporting a healthy population, it reduces the burden on county level safety net hospitals especially by reducing the number of emergency room visits. "CHOICES," a comprehensive primary preventive care program, provided evidence of this outcome by reducing the number of emergency room visits for enrollees in Alachua County (Scicchitano, 2010).

There has been much debate over the role of the federal government in health care as it relates to both spending and the federal budget. Since its creation in 1965, Medicaid enrollment rates have expanded, while states fiscal capacities have diminished (Weil, 2003). States financial futures are uncertain (Weil, 2003), especially with demands from the federal government to increase Medicaid programs, in order to continue receiving federal subsidies.

The PPACA requires states to increase Medicaid spending by one and a quarter percent above what was projected between 2014 and 2019 (Angeles & Broaddus, 2010). Beginning in 2014, the new health reform law will require states to expand coverage to those at 133 percent of the poverty level compared to the previous 235 percent of the poverty level. The Federal government is going to absorb 96 percent of the costs of the

Medicaid expansion over the next ten years, according to estimates from the Congressional Budget Office (Angeles & Broaddus, 2010).

The Patient Protection and Affordable Care Act (PPACA 2010) requires states to expand Medicaid to non elderly individuals whose income is 133 percent of the poverty level or roughly $29,000 annually for a family of four (Angeles & Broaddus, 2010). This will leave a gap in comprehensive primary preventative care coverage for working Americans who do not qualify for Medicare or Medicaid and are not gainfully employed a sufficient number of hours to be covered by their employer's insurance policies.

Medicaid pushed mentally ill and the disabled individuals out of state institutional care by the "Medicaidization" of the funding streams. The number of disabled beneficiaries doubled from 1997-2003 (Medicaid, 2003). Medicaidization refers to the process in which state mental health authorities gave up some of their responsibilities for regulating and managing local services in exchange for categorical funding. Categorical funding is distributed based on a formula based on the number of individuals served. Medicare's subsidy of Mental Health Medicaid represented 12 percent of spending in that sector in 1971, but grew to 20 percent by 1975. The "Medicaidization" of State mental health care has left some low-income groups without access to care (Medicaid, 2003). States were eager to participate in Medicaid because they could receive large financial subsidies from the Federal government. However this option still leaves out the working uninsured who may work multiple part time jobs.

Who is going to fill the gap in access to care? Alachua County has identified community needs and the voters in the county provided comprehensive primary

preventative care to residents in Alachua County. Health care policy makers, planners, administrators and medical care consumers continue to voice concerns that access to medical care should be improved.

Expansion of Medicaid and new premium credits for people with incomes that are too high to qualify is estimated to reduce the number of uninsured people by 32 million in 2019. According to the Congressional Budget Office there will be a one and a quarter percent increase in costs to states from 2014- 2019 as a result of the PPACA. Ninety six percent of the costs of the expansion over the next ten years will be borne by the federal government (Angeles & Broaddus, 2010).

Federalism in Healthcare Policy

Federalism in health care policy requires a dynamic balance between the goals of the federal government and the capacity of state and local governments to serve their constituents. In 2011 755 billion dollars were outlaid for Medicare and Medicaid. With the implementation of the Patient Protection and Affordable Care Act (PPACA) the federal government is requiring states to expand Medicaid programs by one and a quarter percent in order to receive matching federal dollars to maintain their programs. The current recession has made it more challenging for states to expand services while their budgets continue to shrink.

Even by expanding Medicaid coverage; there is a population that is being denied health care services. Alachua County Florida recognized the problem of the working uninsured populations, who are being denied health care services, and thus created “CHOICES” to help fill that gap. Policy entrepreneurs in Alachua County championed

grassroots efforts to involve the public in the decision making process and formed a collaboration between local government, private for profits and private nonprofit organizations to make comprehensive primary preventative care affordable for the uninsured in Alachua county Florida. A report by Michael J. Scicchitano purports that "CHOICES" has been effective. The program evaluation was conducted by the University of Florida's Survey Research Center. They collected data that showed "CHOICES" had been effective at reducing enrollee's emergency room visits. Results indicate that participants spent less on healthcare, which in turn gave them more disposable income that could improve their quality of life.

There is a "MICHIGAN CHOICES" that was looked at when creating Florida's "CHOICES" health services program. However the Michigan version is very different as it is an insurance program with a third paid by the participants, a third paid by enrollees, and a third paid by the county. Florida's "CHOICES" has not been replicated in any other counties; replication would allow comparison of achieved goals and affirm or refute the "CHOICES" model as a viable model for use throughout the country. Adoption involving the public requires a public decision making process important to gain legal credence and assure success.

Federal, State, and Local Government Healthcare History

The Health Insurance and Portability Act (HIPPA) signed into law in 1996 lead to the most current legislation in health care policy; the Patient Protection and Affordable Care Act (PPACA), which underwent judicial review. On June 28th 2012 the Supreme Court Ruled that the individual mandate in the case *National Federation of Independent*

Business, et al., v. Sebelius, Secretary of Health and Human Services, et al. could be thought of as a tax and because congress has the authority to levy taxes the individual mandate for all citizens to participate in the act was permissible.

The PPACA has been mandated by the federal government which makes it different from Alachua Counties "CHOICES" health services program. "CHOICES" was adopted because the taxpayers voted to create funding that ultimately became the "CHOICES" program. There has not been any litigation over the legitimacy of the "CHOICES" health services program. This distinguishes it from the PPACA which underwent judicial review. A timeline of health policy has been created to inform the reader of the past and present events and policies that created an environment where "CHOICES" could be created.

Incremental Changes in Healthcare Policy

Prior to 1910 healthcare was restricted to home remedies and individual choice. The Flexner report was issued in 1910 because evidence based medicine became highly sought after. However, 19 years passed before private insurance arrived. In 1935, the Social Security Act created national benefits for Americans over 65 years of age (Gunderson, 2012). It was not until 1965 that Medicare was established and implemented (Gunderson, 2012). Medicare is a federal single payer covering the elderly 65 and older and the disabled with health insurance. The system was expanded to include payments to states who had Medicaid programs who provided health care to poor Americans and those with disabilities. Both aforementioned groups were previously cared for in state institutions (Medicaid, 2003). This was followed by a series of modifications to

healthcare models. The Health Maintenance Organization (HMO) created under the Nixon administration provided enrollees with a range of medical services from approved providers and was followed by the creation of preferred provider organization (PPO) in 1980. In 1997 Diagnostic Related Groups (DRG's) were created to standardize compensation of hospitals. Finally 12 years later, the creation of the PPACA was adopted. Over time, four of the nine changes reviewed dealt with some type of insurance. If HMO's and PPO's are considered indirectly related, then six of the nine reforms have directly been related to insurance.

This is evidence that as a nation, the United States incrementally changed and in so doing complicated healthcare over time. Therefore we should at sometime anticipate a major change to take place (Baumgartner & Jones, 1999). It is possible that the PPACA has set the stage for a major change to take place if policy entrepreneurs act to exploit the window of opportunity that is currently available.

A Case of Local Government Health Care

Just like Alachua County Florida perceived a need for expanding access to primary preventative care for the working uninsured by purposefully collaborating, Clark County Nevada has an opportunity to purposefully collaborate. Clark County is still utilizing the disjointed incremental model that has slowly crept in over the years. Clark County provides most of their health services to the uninsured in the form of emergency room care offered at the local community hospital in Las Vegas.

Clark County Nevada's University Medical Center (UMC) is a case where the public expects local government to provide access to health care services for those who

cannot provide for themselves or for those who are without health insurance. However this hospital is not part of the university academic health programs. Clark County governs and financially supports the hospital while the Nevada System of Higher Education (NSHE) partners with UMC to contract for residents and fellows, who provide services and gain experience as part of their educational programs.

Merging the hospital with the Nevada System of Higher Education Health Science programs has been discussed. For example, an advantage would be government grants pursued by academic researchers this would subsidize hospitals costs; this partnership would indirectly provide resources for additional healthcare services to the community.

Rosenbaum (Blake, Hawkins, Rosenbaum, & Rosenbaum, 1998) suggested the federal government needed to provide significant funding to health center models of care, and states could continue to support these models. So during tough economic times the federal government should contribute additional financial support to make up for the states losses due to subsidies in medically underserved communities. Then care can be provided to those who do not have access

State and Local governments are bearing the burden of comprehensive indigent care (Rich & White, 1998). Local municipalities are much closer to the populous and know the needs of their respective geographic regions far better than the President or Congress. The federal government is far removed from the general population and cannot know the needs of every part of the nation. Emergency rooms, like the one in Clark County Nevada's University Medical Center, are providing medical and sometimes

dental care (Oral Surgery) to the working poor and the indigent. Looking into ways to provide comprehensive primary preventative care at the local level, may reduce health problems for enrollees and expenses for county taxpayers. “CHOICES” was shown to reduce emergency room visits in Alachua County, Florida and could have a similar impact in other counties (Scicchitano, 2010). By assessing a sales tax, tourists help support local health services programs and the burden is not only on the citizens of the local county.

At UMC, local government provides health care for the indigent and working poor in the form of a county hospital. This hospital is the only Level one trauma center in Southern Nevada, and houses the only burn care facility in a state that includes just over 2,700,000 residents. Currently, Nevada state government pushes the cost of healthcare down to the county. A blend of the NSHE and UMC in purposeful cooperative collaboration would strengthen opportunities for academics to apply for federal support through grants. This funding, if obtained, could assist in establishing a more secure financial footing. Furthermore it would establish the healthcare industry in the state as a leader in healthcare innovation.

Defining Comprehensive

A working definition for discussion in this document follows; comprehensive primary preventative health care is a system of care that includes primary medical services, dental benefits, and preventative care to its participants. It includes health coverage for primary/preventative care, prescription medication, dental care, vision, outpatient hospital services, physical therapy, immunizations, disease management,

durable medical equipment, family planning, chiropractic, occupational therapy, and speech therapy.

"CHOICES" History Creation, Implementation & Policy Entrepreneurs

In 2003 the board of county commissioners in Alachua County consisted of Rodney J. Long Chair, Mike Byerly Vice Chair, Cynthia Moore Chestnut, Lee Pinkoson, Penny Wheat, Randall Reid County Manager, and David Wagner County Attorney. The commission heard a presentation from Elmira K. Warren, Director of the Department of Community Support Services, in March of 2003. Cynthia Moore Chestnut took the lead on the commission and a group was formed called the Indigent Health Care Planning Group. Members of the planning group included Alachua County Medical Society, Area Health Education Center (AHEC), Shands HealthCare, University of Florida Colleges of Medicine and Dentistry, We Care, and Well Florida Council, Inc. The committee was to focus on the increasing number of uninsured and underinsured county resident's lack of affordable health

(Florida Health Insurance Study, 2004) The committee evaluated the report results from the 2004 Florida Health Insurance Study. The report stated rates in Florida's non-elderly uninsured working adults were 81.5 percent, and that 74.4 percent had incomes below 250 percent of the federal poverty level. The counties uninsured rate was at 13 percent and state statute 212 allowed the county to assess a sales tax of up to one percent to fund needed projects and initiatives (Section 216.0306 of the Florida Statutes governs the Local option food and beverage tax; procedure for levying; authorized uses; administration).

After hearing Elmira K. Warrens report about pharmaceuticals and social services costs being so high, Dr. Chestnut formed a Political Action Committee called "CHOICES". She went to her friends to ask for money to help support the campaign and this began her involvement as the mother of the "CHOICES" legislation.

A year later in 2004, the county commission consisted of Mike Byerly Chair, Cynthia Moore Chestnut Vice Chair, Rodney J. Long, Lee Pinkoson, Penny Wheat, Randall Reid County Manager and David Wagner County Attorney. Cynthia Moore Chestnut is widely recognized as the champion of the "CHOICES" program. She led a campaign to inform voters about an opportunity to levy a tax of a quarter cent to create a comprehensive primary preventative care program. The voters approved the tax by 88 votes. This was the beginning of "CHOICES". The department of Community and Support Services directed by Elmira K. Warren was the county department responsible to oversee "CHOICES". Community and Support Services also oversaw the Crisis Center, Social Services, Veteran Services, and Victim Services. "CHOICES" reports to Alachua County Health and Human Services, who in turn reports to the director of Alachua County Community and Support Services. Three top goals of the "CHOICES" program are 1) increase physical activity 2) improve dietary intake and 3) eliminate tobacco use (Alachua County, 2010). In fiscal year 2005-2006, there were 455 enrolled members of "CHOICES". Enrollment has steadily increased each fiscal year, but the percent increase of enrolled members has steadily declined since 2007. Appendix D shows the growth and decline of the program from 2005-2011. The program started with 455 members and in 2011 there were 3500 members. The program had $40 million dollars in its trust fund and

3500 members in 2011. It primarily funded care for the working uninsured but does fund some wellness and health programs that are open to all county residents (Gainsville.com, 2012). As of November 9, 2012 there were a total of 7500 members helped by the choices health services program, and 4200 active enrollees.

What could be the cause of the dropping percent increase in membership in 2010 and 2011? The county knew the population in need were those who were at or below 250 percent of the poverty level, but the "CHOICES" program was only instituted to cover those who were at or below 200 percent of the federal poverty level. 2010-2011 saw the lowest percent increase in enrollments when marketing and public relations efforts stopped because the county commission knew the program would sunset in 2011. February 1, 2011 the county commission voted to stop advertising the "CHOICES" program. They estimated there would be a savings of $75,000 to $80,000 a year. 2012 is the first fiscal year that expenditures outpaced revenues in the "CHOICES" program. It is estimated that expenditures would be $8,980,000 while revenues would be $8,750,000 (Gainsville.com, 2012).

The elimination of advertising and the steady decline of new enrollees made the future of the "CHOICES" program uncertain. Going forward the implementation of the PPACA may have a positive impact on funding for the program in fiscal years 2012-2013, since the act was upheld by the Supreme Court of the United States of America. If additional funding is found, advertising could be reinstated and access to care for Alachua counties poorest citizens could be expanded. This scenario seems unlikely to occur, unless a philanthropist with a large donation makes a charitable contribution. The

possibility of having a philanthropist make a large donation; in an economy that is going to tax the wealthy at a higher rate, because the Bush tax breaks for wealthy Americans sunset, makes finding a benefactor much more difficult. If the projections are on target it is possible wealthy Americans will begin to pay 50 percent or more of their income to the federal government. Additionally there is discussion about taxing charitable contributions as well. All these tax increases are meant for the wealthiest Americans making $200,000 or more.

At this time it appears that the "CHOICES" program is slowly declining and now that the PPACA is upheld the hope is that the changes in Federal health policy will take over where "CHOICES" left off. Unless a public entrepreneur steps up to help save the program it will probably completely vanish. Rodney J. Long opposed the reduction of the marketing expenditures at the county commission meeting. Unfortunately for the program he has since retired and the majority of the commission at the meeting wanted a detailed "exit strategy" put into place (Gainsville.com, 2012).

Bob Bailey the "CHOICES" program director is hopeful that the program will be able to survive until 2014 when the PPACA takes effect (Gainsville,com, 2012). The PPACA requires states to implement the expansion of Medicaid in order to keep and enhance funding from the federal government. Bailey believes that the additional funding from the Federal government through the PPACA may be a way to extend the life of the "CHOICES" program. However; Mr. Bailey acknowledges that the PPACA is a wild card with a "big question mark on it" effect (Gainsville,com, 2012). Another factor causing "CHOICES" to struggle financially is a county ordinance requiring "CHOICES"

to maintain a spending plan that keeps administrative costs at 15 percent of revenues in a given fiscal year. Bob Bailey does not believe the program can be effectively operated when tax revenues disappear. In order to meet the requirement of the ordinance, administrative expenses would have to drop by $73,210 in fiscal year 2012-2013. (Gainsville,com, 2012). Bailey believes that to fix the problem, this ordinance should tie administration costs to expenditures and not revenues. On May 24, 2011 the county commission voted to keep the current plan that serves around 3700 poor residents of Alachua County. The decision was to use the remaining $40 million dollars raised by the quarter cent sales tax to keep the program going until December 2013.

Another explanation for the declining enrollment - is the heated partisan politics associated with the creation, implementation and impending demise of the "CHOICES" program. Conservative Republicans adamantly oppose the program, calling it Florida's version of Obama Care "kind of". Comparing "CHOICES" to Obama Care is a weak comparison when you consider that the public voted in the tax that funded the "CHOICES" program Retrieved Alachua County Republican Party eNews (2011, August).

Political posturing on the left and right can be observed within the county commission. Susan Baird, a Republican on the Alachua County Commission, was a vocal critic of the program, and Rodney J. Long, a Democrat, spoke up against reducing the marketing expenditures for the program. The leadership exercised by Mr. Long was short lived. In a county news release, Monday June, 13th 2011, Rodney Long announced that

he would not seek reelection and planned to retire. This meant that “CHOICES” lost an advocate on the county commission.

The main argument to eliminate “CHOICES” is that it has not provided primary preventative healthcare for as many citizens as were thought it would serve and the cost per enrollee is too high. It cost on average $2500 per member per year (Alachua County, 2011). The program has an unspent balance and only served 3500 enrollees in 2011. This is a small number when compared to the estimated 15,000 that are in need. Supporters of “CHOICES” have suggested expanding the eligibility requirements by lowering the number of working hours, reducing the requirements on salary, and easing eligibility in order to increase access to “CHOICES” care for more Alachua County residents.

Since the program only covered those who are underemployed and working 20 hours or less, it did not capture those who work multiple part time jobs to support their families. The quarter cent sales tax approved by Alachua County voters included all precincts. There were 18,743 votes cast in favor of “CHOICES” and 18,655 Against “CHOICES”.

Since the American disjointed incremental system of health care relies on employers providing insurance to the populous, those who are underemployed go without coverage (Davis & Rowland 1983). A comparison of the rate of nonelderly, uninsured Americans from 1987 to 1996 revealed the uninsured population is growing. The uninsured are less likely to use preventative care and more likely to pay for preventative care out of pocket (Cohen, Machlin & Taylor, 2001). It is projected the nonelderly,

uninsured American population will continue to expand from 45 million in 2003 to 56 million by 2013 (Gilmer & Kronick, 2005).

The incremental disjointed healthcare system in the United States relies heavily on employers to provide employees with health insurance and is often taken for granted by those who have health coverage (Davis & Rowland, 1983). A large section of the population in the United States goes without healthcare because they just cannot afford it (Davis & Rowland, 1983). Because the uninsured go without coverage, by the time they receive treatment, it most often occurs in hospital emergency rooms. If they had access to comprehensive primary preventative care it would reduce the use of emergency rooms as the uninsured and the underinsured's primary form of health care (Bindman, Keane, & Grumbach, 1993).

Background Alachua County "CHOICES"

Why have the voters in Alachua County Florida created the "CHOICES" program? How does the "CHOICES" program benefit Alachua County Florida residents? Has the "CHOICES" program been effective in filling the gap left by Medicare and Medicaid? Two unique aspects of the "CHOICES" program are that it provides comprehensive primary preventative health care to those who qualify for the program at the county level and that it expands coverage to the working poor who do not qualify for Medicare, Medicaid or private health insurance through an employer.

At face value "CHOICES" seems to be filling a gap in the current health care system by providing comprehensive primary preventative health care coverage to those that do not qualify for existing Federal or State programs. Gaps in coverage for the

nonelderly working poor existed in 1980's (Davis & Rowland 1983) and still exists today even in Massachusetts who instituted statewide health reform (Long Shulman & Stockley, 2011). Massachusetts was able to increase insurance coverage to 97 percent for women and coverage for men is rising (Long, Shulman, & Stockley, 2011). Health reform in Massachusetts has covered more individuals, but those earning $25,000 and less tend to go without screening for cancer and cardiovascular disease (Clark & Govindarajulu, 2011). The state of Massachusetts state based insurance system expansion still contains gaps in coverage for those making $25,000 or less. The Massachusetts experience is that by increasing coverage you reduce cost of uncompensated care. In 2009 three percent were uninsured whereas in 2007 six percent were uninsured. The Federal single payer system Medicare and the state based Medicaid programs have gaps that the PPACA legislation as well as some local governments like Alachua County Florida are attempting to fill.

Alachua County Florida is different from other counties and the PPACA because; it is the only county that voted to create comprehensive primary preventative care for the uninsured who are underemployed. Medicaid is attempting to expand coverage to some of this population through the Patient Protection and Affordable Care act. Some consider the requirement to expand Medicaid by one and a quarter percent an unfunded, unconstitutional mandate imposed by the Federal Government (Obama).

Increasing coverage does not necessarily ensure access to care, as the cost of care can still be a barrier (Long Shulman & Stockley, 2011). It is expected that increases in coverage due to the Federal Governments passage of the PPACA will help narrow the

gap which presently exists, even in Massachusetts (Long Shulman & Stockley, 2011), but to really make a difference an intentional collaboration needs to be formed between the federal government (Medicare), state government (Medicaid), county government ("CHOICES"), private for profits (Blue Cross Blue Shield), and private nonprofits (Health Centers) to create structured focused cooperative collaborations. These collaborations have the potential to help reduce or eliminate gaps in the current health care system. No one entity can solve the problem surrounding improving access, quality, and cost control, on their own, especially in this complex disjointed incremental system of healthcare that has evolved slowly over time. "CHOICES" is an example of a local government trying to purposefully collaborate with nonprofit organizations in order to address the problem of providing comprehensive primary preventative care to the nonelderly, employed who are underinsured. Further expanding their program by partnering with the state and federal government would allow them to provide comprehensive primary preventative care to even more enrollees.

Under the Regan administration Americans learned that states were willing to step up and provide health care to their citizenry, (Rich & White, 1998) when the federal government cut funding to healthcare. The desire of the States to participate and provide healthcare for the public was an unintended consequence that the Regan administration did not foresee. They had incorrectly predicted the private sector would fill the gap they had intentionally created in the healthcare system (Rich & White, 1998) Now with the "CHOICES" program, we see local government coming forward to provide financial

assistance for healthcare by partnering with the private nonprofit and private for profit sectors to provide care to populations in need.

This leads us to some important questions:

1. What impact has local support at the precinct level in Alachua County had on the implementation of “CHOICES”?
2. Has the overall health of Alachua County residents improved?
3. Can the “CHOICES” case study be used to create an innovation framework that can provide a useful lens for future research at the county level in regards to adoption

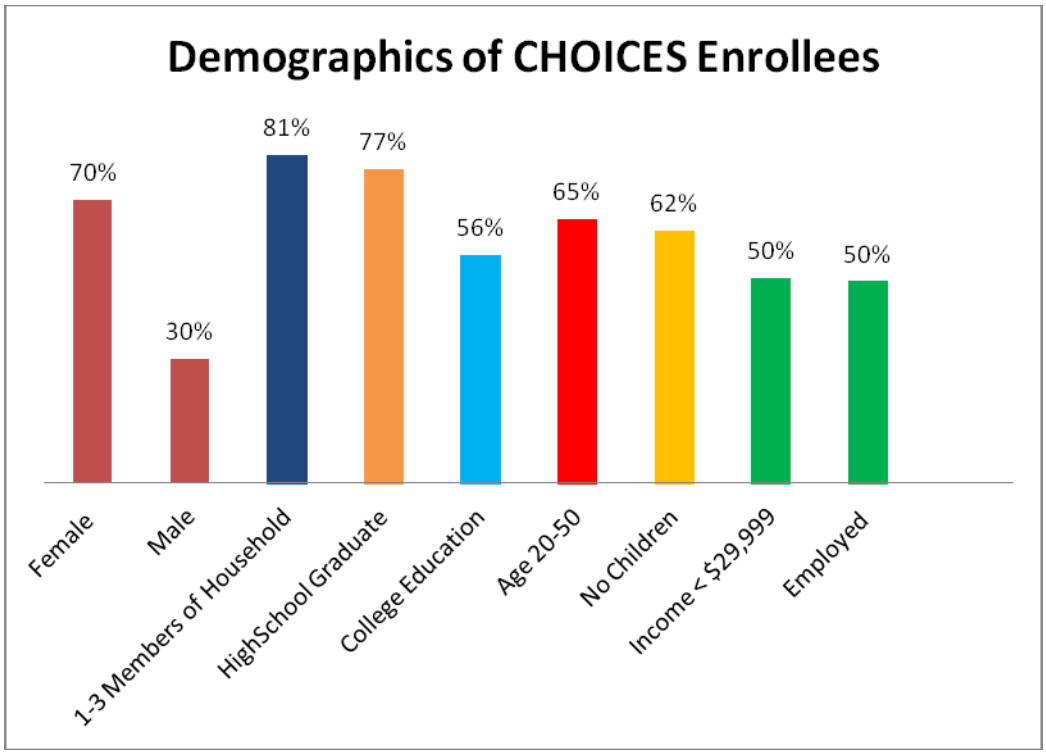


Figure 3. Enrollee Demographics

"CHOICES" affordability.

Affordability of health care for Alachua County residents enrolled in "CHOICES" did improve. According to enrollees Seventy two percent delayed primary care from a physician before enrollment compared to only 5.9% after enrollment. Sixty eight percent delayed medical care before enrollment compared to 9.4% after enrollment. Over Thirty nine percent (39.5) of enrollees spent $100 dollars or less on health care before compared to 64.3% after. Sixty six percent stated they could not afford prescription medication before compared to 8.3% after. Over sixty-seven percent (67.3) did not receive needed

medical tests because of limited coverage before enrollment compared to only 10 percent after. Thirty three percent delayed costs because the wait was too long compared to only 8% after. Fifty three percent did not have insurance because they could not afford it and 80.6% never had health insurance or had been without coverage for a minimum of one year. Seventy-two percent were without insurance because they could not afford it. See Appendix E for affordability chart.

"CHOICES" healthiness.

Fifty percent of enrollees did not go to the emergency room for care compared to 74.9% after enrollment in the "CHOICES" health services program. Forty four percent were admitted between one and five times before enrollment compared to only 22.7% after enrollment. Thirty two percent had between one and five visits to urgent care before enrollment compared to 13.6% after. Forty two percent never missed a day of work before "CHOICES" enrollment compared to 62.5% after enrollment. Eighty eight percent stated they had excellent, good or fair health before "CHOICES" and 97.7% stated they had excellent good or fair health after "CHOICES". Twelve percent stated they had overall health poor compared to 2.4% claiming their health to be poor after. See Appendix F for increased health chart.

"CHOICES" increased health coverage.

Fifty three percent of enrollees were without health coverage for more than two years. Forty six percent had healthcare from an employer prior to qualifying for "CHOICES". Fifty two percent were enrolled in "CHOICES" less than 12 months, and

56.5% spent less on healthcare. See Appendix G for increased health coverage costs. So what does this mean?

On average residents of Alachua County have a five percent unemployment rate compared to the state unemployment rate of seven percent. So if residents are spending less on health care after enrollment than there disposable income is going up. When we look at the trend in hospital bed usage we see Alachua County staying consistent at 319,000 to 320,000 from 2004 to 2011 compared to the states average during that time period of 589,000 beds. Alachua County overall seems healthier compared to the state of Florida. There is a trend in Medicaid enrollment from 2004 to the present of fewer enrollments in Medicaid from Alachua County residents. We know from the survey data that residents are missing less days of work being more productive and are no longer in need of the Medicaid services for their children.

American Health & Disease

Americans are living longer but not necessarily healthier lives due to chronic disease (Coburn Lundblad MacKinney Mcbride Mueller & Watson 2012). Many Americans will suffer chronic diseases in their lives (Tang, 2003). Seventy-three percent of patients with terminally ill diseases in an inner London health authority wanted to die at home according to a study conducted by Karlsen; however, only 58% in the study conducted by Karlsen actually had the opportunity to die at home (Addington-Hall & Karlsen, 1998). The study surveyed a random sample of 229 people. Acute diseases were the cause of most Americans deaths prior to the 1920's, advances in medical technology have extended the life expectancy of Americans. Very few die from acute illnesses like

pneumonia or appendicitis, Americans will always demand quality healthcare that is provided both efficiently and effectively. Nationally 60 percent of Americans died in hospitals and only 20 percent died at home (Fennell, Mor, Teno, & Weitzen, 2003).

Models for collaboration have been created to demonstrate how the United States could more effectively use resources to care for the chronically ill (Hirsch, Homer, Minniti, & Pierson, 2004). Who should provide care to the indigent and working poor? Is it the proper role of government in society to take care of those who cannot take care of themselves?

Chronic diseases have overcome acute diseases as the leading cause of death in people in the world as they age (Gould, Hawkes, Hofman, & Yach, 2004). Most people who utilize modern technology advancements in medicine will live to the age of 80, and most will experience some form of chronic disease in their lifetime. Technology advancements include more effective prescription medication, radiographs taken from machines that reduce exposure to x-rays, and nanobiothecnology. Researchers in nanobiotechnology are attempting to provide treatments for diseases that will only attack non healthy cells. These advancements will continue to be important as the baby boomer generation is rapidly approaching 80 years of age and healthcare will continue to be a topic of concern for all stakeholders

The need for health care and the demand for services from all health care stakeholders will increase, especially as the population ages. As a result, some stakeholder groups may experience growth, while others may phase out when policy and technology changes how services are provided. The needs of the baby boomer generation

to receive healthcare at a reasonable cost will become more of an issue. As costs for services continue to fluctuate and current technology becomes old, it will be replaced with newer technologies. This increase in cost is not in the best interest of any stakeholders. It could lead to demand being greater than the supply of new healthcare technologies.

Advances in technology have increased the cost of health care from what it was in the past (Fennell et al., 2003), and so has information technology. Information technology has driven up the costs of health care as the demand for insurance has expanded what consumers require insurance companies to cover (Weisbrod, 1991). For example when modern Computed tomography (CT) scans are not the cutting edge in technology, will they become more affordable? The cost of a CT scan in Japan is much more affordable than in the U.S. due to economies of scale. Perhaps as CT scans become more affordable we could see a reduction in health care costs over time, if insurance companies reimburse providers at a higher rate for less expensive CT scan.

Vulnerable Populations

Some of the populations in need in the current disjointed system of health care include: the underemployed, children, elderly and adolescent populations. Children, the elderly and the unemployed have mechanisms to access comprehensive primary preventative care services through federal and state programs. The underemployed however are at a great disadvantage when it comes to obtaining comprehensive primary preventative care. “CHOICES” is a unique program because it was voted in by the people to provide services for the underemployed population.

Children Population of Need

Disparities in dental service related to income exist for children especially those in lower income families who have the greatest need for dental services and receive treatment less often than those with larger incomes (Edelstein, 2002). These low income children experience more pain due to tooth decay and dental carries and miss school more often than those who have dental care (Edelstein, 2002). This is another reason "CHOICES" is unique as it provides comprehensive primary preventative care which includes dental care.

State governments are typically aware of the needs of children within their states and Medicaid programs are designed to cover their health care needs. Expanding state funding for services reaches the Medicaid population that primarily consists of children, but leaves out the working poor, a population who desperately needs primary preventative health care services (Rich & White, 1998). Focused purposeful collaboration with federal, state, county government, private for profit and private nonprofits is needed, to ensure the uninsured underemployed American population receives comprehensive primary preventative care.

Adolescent Population of Need

On a federal level, it is very difficult to understand what is happening and the needs of local communities. States and counties will have better ideas about the needs of their respective areas of responsibility in terms of healthcare. Access to care for adolescents is not shrinking (Brindis, Cart, Irwin, Marchi, & Newacheck, 1999). However, a disparity still exists among financially low income adolescents who are

uninsured, and those who are non-white (Corey, Freeman, Hayward, Shapiro, & Wood, 1990). Private health insurance for adolescents is eroding. Providing insurance for these adolescents is vital (Brindis et al., 1999).

Programs like the state children's health insurance program (SCHIP) and Medicaid have become even more important when trying to expand insurance to the adolescent population. Many adolescents do not qualify for federal programs, and increasing the ability of adolescents to qualify needs to be addressed. We also need to look at the problem of medical providers willingness to accept patients from these programs (Davidson, 1982).

A flaw in the Medicaid system is that there are many providers who refuse to treat patients under these programs because they cannot cover their costs. Factors like limitations on coverage, arbitrary and rigid definition of service, short term eligibility, frequent changes in program characteristics, cumbersome claims form procedures, unpredictable payment, low rates of compensation, burdensome accountability forms and procedures; and brusque disinterested employees (Davidson, 1982).

The more provider reimbursements fall, the more likely service levels will be reduced (Rich & White, 1998). In Michigan, one million people qualified for dental care but only 250,000 actually received treatment for their oral health (Lang & Weintraub, 1986).

Elderly Population of Need

For the elderly, two types of care are provided, informal care and formal care (Cremer, Pestieau, & Ponthiere, 2012). Informal care is typically provided by family

members, this trend is changing as the nature of the workforce has changed and families have no time to care for their aging parents (Cremer et al., 2012). Some are opting to place parents in institutional care. Those individuals who choose to work and provide community based care for their elderly parents are classified into two groups: 1) employed, and 2) non working. Both groups provide assistance with shopping, household chores, transportation, money management, emotional support and service arrangements (Brody & Schoonover, 1986).

Working caregivers provide less personal care and home cooked meals than their non-working counterparts. Their inability to provide those services, however are offset by their ability to hire care givers to assist in the home with their aged parents (Brody & Schoonover, 1986). One downfall of federal state and/or local programs is that they do not provide a means of compensating informal caregivers. The PPACA does include in CLASS a section that allows individuals to save money for home care throughout their life. However; The CLASS program does not allow benefits to be used for long-term institutional care (Protection, 2010).

One great advantage of the “CHOICES” program is it allows those who do not have family caregivers to receive medical, dental, and preventative care needed through formal systems of care. However, extended institutional care is not covered in the “CHOICES” program. Nor is reimbursement for those who might provide home care to their aging parents. “CHOICES” is trying to provide comprehensive primary preventative and acute care. It is not designed to provide long term or home based care. This is a

problem because as Americans live longer with chronic diseases like diabetes and cancer they are going to need long term care.

Models of Policy Change

The literature contains many models of policy change that help to explain the policy process. Understanding these models allows for the creation of a framework that can be used to analyze the adoption of the "CHOICES" health services program. Some of the models build on each other but all models ultimately lead to policy change. The change can be in the favor of some groups and not others, but ultimately change does take place.

Garbage Can

Cohen (1972) posits that the decision making process is messy and decisions are not made in an organized linear fashion. Choices are made when shifting combinations of problems, solutions and decision makers happen to make action possible (Cohen, March, & Olsen, 1972). The process described by Cohen is messy and suggests that there is no order to the policy process. In contrast Kingdon (1984) posits that policy making occurs in multiple streams (MS) and acknowledges that policy making occurs under conditions of ambiguity. He describes ambiguity as being related to ambivalence, as opposed to uncertainty, which could be described as ignorance or imprecision (Sabatier, 2007). However, Kingdon's Model (1984) provides us with three streams that operate independently and when they converge a window of opportunity opens.

Multiple Streams

The (MS) theory came about when Kingdon was considering the garbage can model created by Cohen, March and Olsen (Kingdon, 1984). Kingdon's MS theory states that, windows of opportunity, occur when the streams converge. A good theory of choice provides answers to three questions: 1) How is attention rationed?, 2) How and where is the search for alternatives conducted?, and 3) How is selection biased? (Kingdon, 1984).

The adoption of specific alternatives depends on when policies are made, and then by proposing a theory of political manipulation. The three streams that flow through the policy system are the problem stream, policies stream and the politics stream. When these streams converge due to the creativity of policy entrepreneurs, a window of opportunity exists for policy adoption to occur (Kingdon, 1984). Policy entrepreneurs who have been waiting for the opportunity to act take advantage of the window to move the policy forward. When public policy entrepreneur's show leadership, and take action during narrow windows of opportunity, changes are more likely to occur as motivation exceeds obstacles (Kingdon, 1984).

Kingdon's adaptation of the garbage can model to policy output by the U.S. federal government is conceptualized as an organized anarchy with rampant ambiguity characterized by three general properties: 1) fluid participation, 2) problematic preferences, and 3) unclear technology. Even though this theory was applied to the U.S. federal government, it is conceivable that the model could be used at various levels of government to explain policy formation (agenda setting and decision making) (Sabatier, 2007).

The MS theory makes three assumptions: 1) Individual attention or processing is serial, and systemic attention or processing is parallel; 2) Policy makers operate under significant time constraints; 3) The streams flowing through the system are independent (Kingdon, 1984). Alachua County's adoption of the "CHOICES" program can be viewed according to these assumptions. Because Alachua County is a system each stream can be conceptualized as having a life of its own, running parallel to the other streams. It is important to mention the streams and know that they exist even though the main focus of the study is on internal determinants and adoption of the CHOICES health services program.

The streams.

The problem stream includes concerns of individuals inside and outside of Alachua County. It contains the variables indicators, focusing events, feedback and load. The policies stream is the solution stream, and are people's products, and is usually generated in narrow policy communities (Kingdon, 1984; Sabatier 2007). Values, acceptability, technical feasibility, access mode size and capacity integration are all examples of variables in the policy stream. The politics stream refers to the broader political discourse within which policy is made, and actors include legislators and parties, as well as the national mood/climate of opinion (Kingdon, 1984; Sabatier, 2007).

The window.

When these three streams converge they open brief windows of opportunity that policy entrepreneurs, who are permanently ready, can exploit through the agenda setting process and grassroots campaigning. Additionally, MS recognizes the existence of

stakeholders (media, civil servants, politicians, specialists) and highlights their roles and actions, particularly those of policy entrepreneurs, within the problem, political and policy processes. The overall purpose of this study of the "CHOICES" health services program is to study adoption of internal determinants.

Policy Innovation

When should a government program be termed new? Policy innovation literature defines new government programs as: a new program the adopting government has not previously adopted (Sabatier, 2007). Policy invention is the process by which original policy ideas are formulated and implemented (Sabatier, 2007). This contrasts slightly from policy innovation which replicates programs that have been adopted by other jurisdictions. Theories about policy innovation and invention share much in common with models that explain organizational innovation (Sabatier, 2007). Sabatier gives examples of cross national government innovation studies that investigate how nations develop new programs and how the programs diffuse across countries (Brooks 2005; Elkins & Simmons, 2004; Gilardi 2005; Meseguer 2005a, 2005b; Simmons, 2000; Weyland 2004). Studies focusing on policy innovation at the local and regional level include (Lubell, Mete, Schneider, & Scholz, 2002), as well as one study of regional government in a foreign nation (Ito, 2001). Most of the empirical research has been conducted in the United States Federal system at the state level, and most of the models explain policy innovation at the state level (Sabatier, 2007). More research is needed on the county and local level.

When explaining adoption of new programs by states, internal determinants are used to identify significant factors (Berry & Berry, 1990). The factors in internal determinants models that predict jurisdictional innovation include political, economic, and social characteristics internal to the state (Sabatier, 2007). Policy Scholars are familiar with adoption studies and many agree that when looking at the internal determinants model to explain innovation it is important to look at more than just internal determinants to explain the policy change (Sabatier, 2007). However when a policy has not diffused a researcher can only look at internal determinants for prediction and the policy entrepreneurs who championed the initiatives. The Multiple Streams theory suggests that windows of opportunity open for short periods, that policy entrepreneurs take advantage of when the problems, policies, and politics streams converge to create windows of opportunity.

CHAPTER 3

Chapter 3 presents the method selected for the study. It discusses the effectiveness of the "CHOICES" health services program. It presents the sample setting, research design, and the utilization of the internal determinant model. It discusses public policy entrepreneurs then presents the variables used in the correlation model, as well as, the research questions and hypotheses. The chapter concludes with a discussion about the variable categories.

Mixed Methods Research Study

In Order to evaluate and study internal determinants of policy adoption for "CHOICES" a single health service program in a county government. It is important to be aware of the significance public policy entrepreneur's play in adoption studies? Internal determinants were analyzed by collecting precinct data to determine which precincts voted for and which precincts voted against the "CHOICES" program. Creating the internal determinant model used to evaluate the adoption of the "CHOICES" program; which operates in a government utilizing federalism, where policy was formed in multiple streams, was the method used to explain the significant factors related to program adoption.

This mixed methods study looked at the effectiveness of the "CHOICES" health services program, quantitatively at internal determinants, and qualitatively at public policy entrepreneurs in order to provide context. Demographic data and data on social, economic, and political factors was collected systematically at the precinct level to be used as independent variables in the correlation and logistic regression models. A

structured systematic procedure seen in figure 4 was used to collect quantitative data. Since public policy entrepreneurs could not be looked at quantitatively, a qualitative method was used to explore data to provide context regarding the role of public policy entrepreneurs in the policy adoption process.

Procedure	Source
Collect Statement of Votes for the Alachua County Referendum August 31, 2004	http://elections.alachua.fl.us/index.php?id=33&spanish=N
↓ Input Data into a Spreadsheet ↓ Match Precincts in the Spreadsheet to Zip Codes in Alachua County Florida (for those that can not be found online look up in the yellow pages)	http://elections.alachua.fl.us/?id=7
↓ Locate Covariates by Zip Code	http://www.zipareacode.net/zip-code-32605.htm
↓ Type in Each Zip Code to locate Covariate data and enter into the spreadsheet. ↓ Collect Partisan Data for Each Precinct and socioeconomic data	Email Alachua County Elections Department and request Data go to Buereau of Labor Statistics website for socio economic data by county and collect data
↓ For Missing Covariates Select the Best Method to Impute Values ↓ Run Correlations in Statistical Package ↓ Prepare Data for Logistic Regression Model ↓ Import Data into SPSS and Analyze Results of Logistic Regression	
↓ Analyze Political, Social and Economic Variables	

Figure 4 Quantitative Procedure

The qualitative study data was collected from websites, newspapers, and government documents in an attempt to find vivid explanations for the qualitative research questions posed in Appendix C. This research helped us understand qualitatively what happened in Alachua County Florida during the creation of the Alachua Referendum, which after adoption became the “CHOICES” health services program. The analysis provided us with the context of the setting in which policy entrepreneurs operated to create public health policy.

“CHOICES” Effectiveness

A debate existed about the effectiveness of “CHOICES”. In this analysis we argue the program has been effective. No, it has not covered 15,000 enrollees, but it has met the goals that were set for the program. 7500 enrollees have benefited from the “CHOICES” health services program since its creation. More will benefit from the program, until the doors are closed, because revenue is not being generated to maintain operations due to the tax sunset in 2011.

According to the “CHOICES” program evaluation, emergency room care was the most expensive form of health care in Alachua County. Reducing the use of hospital emergency rooms has two benefits for communities, a healthier population, and more profitable and less crowded hospital emergency rooms. When county hospitals are factored into the equation, less crowded emergency rooms filled with people who cannot pay, means a healthier population which lowers the taxes necessary, to keep a county safety net hospital functioning.

A debate exists about preventative vs. emergency care (Menzel, 2011) the debate centers around the issues created by the Federal Emergency Medical Treatment and Labor Act (EMTALA). EMTALA prohibits hospitals from refusing acute care to those who cannot afford to pay (Menzel, 2011). EMTALA was implemented in 1986 with the creation of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and was an attempt to establish a moral right to health care for all who reside within the borders of the United States. Hospitals choosing to accept Medicare funds cannot refuse acute care. They absorb the costs when individuals cannot pay for services and pass them on to the consumers who can pay, or the public absorbs the costs in the form of taxes to support local hospitals. When the hospital is a county hospital, those expenses are passed on to the public in the form of taxes assessed by the county. Veterans and Shriners hospitals are the only hospitals identified that this act does not apply to. EMTALA is Section 1867(a) of the Social Security Act, within the section of the U.S. Code which governs Medicare.

Those who are insured are more satisfied with medical care, they use emergency services less often and are more likely to frequent preventative care options (Choi, 2011). Those who do not utilize preventative care services tend to get sick more often; since they do not have access to primary care providers, and preventative healthcare services the length and frequency of hospital stays increase (Scicchitano, 2010). Finding ways to cover these underserved populations is important.

“CHOICES” Enrollees

Who are the ”CHOICES” enrollees and has the program met its goals. The demographics of the “CHOICES” enrollees are shown in figure 3. It shows the majority of enrollees have graduated high school, over half are college educated 70% are female and they span from 20 to 50 years in age. This group is without coverage and “CHOICES” is providing access to care for enrollees of the program. The outcomes of the program evaluation can be located in Appendices E, F, and G.

“CHOICES” Program Goals

“CHOICES” program goals are: 1) To help the uninsured residents of Alachua County to stay healthy and 2) To provide access to services working uninsured residents need but have put off due to a lack of adequate health coverage. 3) Reduce emergency room visits and increasing the utilization of primary preventative care services. The hope is to provide quality healthcare options for the medically underserved, and help Alachua County overall become a healthier place.

provider problems.

Some Problems did occur in the beginning of “CHOICES” for providers. However, none of the providers said that informing them of new “CHOICES” members was “not successful at all”. None of the providers said that the “CHOICES” program was “not successful at all” in providing them with contact information for new enrollees. Four percent of providers said that timely and accurate reimbursement was “not successful at all” (Scicchitano, 2010). Fifty two percent of providers stated that they had not

encountered any problems as a “CHOICES” provider. Ninety percent of providers stated that they had encountered only one problem.

enrollees.

In the beginning of “CHOICES” there were some problems with enrollee’s. Applications not being processed quickly, but the problems were resolved. Ninety two percent of enrollees selected their own primary care physician (Scicchitano, 2010). Sixty nine percent of those who did not select their own physician stated the process to change primary care physicians was “very easy”. These results suggest that Alachua County is improving access to care for the working underinsured population. The top four ways individuals found out about “CHOICES” was: through friends and family 39.2 percent, healthcare providers or clinics 15 percent, television ads 14.7 percent, and employers 12.4 percent. Eighteen percent of Americans between the age of 18 and 64 who are employed in the labor force do not have insurance.

How is “CHOICES” doing at reducing emergency room visits and hospitalization, and increasing the use of preventative care? According to Appendix E they are doing a fantastic job for enrollees. “CHOICES” has been successful at reducing emergency room visits and increasing the utilization of primary preventative care services which was a goal set by the program. Additionally, the program improved the physical and dental health of enrollees.

Furthermore 98.9 percent of “CHOICES” disenrollees felt that they had “excellent, good, or fair” overall health when in enrolled in “CHOICES” compared to 90.4 percent of disenrollees who feel their overall health is “excellent, good, or fair” now

(Scicchitano, 2010). The final questions remaining are: 1) Has the "CHOICES" program provided quality health care for the medically underserved and 2) Has Alachua County indeed become a healthier place? Survey participants were asked to rate their overall health before and after "CHOICES." Eighty eight percent rated their health as "excellent, good or fair" compared to 97.7% who rated their health "excellent, good or fair" after, see Appendix F. Twelve percent rated their health as poor before enrollment in "CHOICES" compared to only 2.4% after enrollment. The average rating on a 4 point scale increased from 2.67 to 3.10 (Scicchitano, 2010). This was a significant increase and suggested the "CHOICES" participants did indeed feel healthier. They perceive they are, in fact, being provided quality comprehensive primary preventative care.

"CHOICES" sought to enhance the quality of life of enrollees by reducing healthcare expenditures this allowed enrollees disposable income to increase. Before joining "CHOICES" 39.5% of enrollees spent $100 or less on health services, after joining, that number increased to 64.3%, suggesting "CHOICES" has been successful at increasing disposable income for enrollees. 56.5% of surveyed enrollees spent less on health care allowing them to increase their disposable income (Scicchitano, 2010) see Appendix G. Enrollees have had their quality of life improved, disposable income has increased, they missed fewer work days, had fewer emergency room visits, providers received accurate timely payments, enrollment was quick and changing providers was simple, but most importantly those who have not previously qualified for comprehensive primary preventative care now qualify for health benefits. Fifty three percent of "CHOICES" enrollees had been without health coverage for more than two years. Fifty

two percent of survey respondents reported that they are enrolled in the program for less than 12 months (Scicchitano, 2010). This means that they come into the program and leave when they find gainful employment. This is further supported by the data collected on unemployment rates on average Alachua County has lower unemployment rates than the state in general.

Sample Setting

Alachua County Florida through the Alachua referendum of 2004 tried to increase access to care. The 2004 population in Alachua County was 235,731[2] of that population 127,133 were registered to vote, according to the supervisor of county elections in Alachua and the official statement of votes cast in the August 31, 2004 primary election (http://elections.alachua.fl.us/index.php?id=33&spanish=N). Of those who voted 50.12 percent voted for the Alachua referendum and 49.88 percent voted against the Alachua referendum.

This study looked at 69 precincts in Alachua County that voted on the referendum. The sample included all registered voters in each of the 69 precincts in Alachua County Florida. A model was created where each precinct became a case representing the rows and the columns contained political, social and economic internal determinants. Because the dependent variable was dichotomous logistic regression was used to determine the significant factors associated with the adoption of "CHOICES" at

[2] According to a U.S. Census Bureau the 2011 population in Alachua County was 249,000 which was a .008 percent increase from the previous year. If was assume the same increase that would place the 2004 population in Alachua County at 235,731

the precinct level (Mohr, 1969). Logit was selected because the data was not normally distributed. The model predicted which internal determinant factors were positively or negatively related to a vote for adoption and which factors played the strongest role in voters choice to adopt the "CHOICES" health services program. Because quantitative measures cannot tell us the impact of public policy entrepreneurs we will look at them through a qualitative lens discussed later in this chapter.

Research Design

The research design was a mixed methods design using both qualitative and quantitative methods to describe and answer the research questions. The qualitative piece explored the aforementioned qualitative research questions in Appendix C and provided context about the environment in Alachua County during the creation and implementation of the Alachua Referendum as it related to public policy entrepreneurs and confirmed the predictor variable in the quantitative model.

The qualitative portion of the research project required data collection to explain who the policy entrepreneurs were and what role they played in the adoption of the "CHOICES" health services program. Data was collected to examine the sources of information policy entrepreneurs used to make their decision on which preventative care program to adopt. Data was collected to examine the impact that policy entrepreneurs had in the adoption of the Alachua Referendum, and why policy entrepreneurs chose to become involved in the adoption of the referendum. Finally, data was collected to understand the time constraints that existed with the adoption of the Alachua Referendum.

The quantitative analysis explained the significant internal determinants used in the model to answer the quantitative research questions. The method chosen to analyze the data was logistic regression. Additional data was collected for the independent variables in the quantitative analysis to form a model using social, economic and political factors in order to determine which motivation factors were positively or negatively related and statistically significant. Since policy adoption is the area of interest and the dependent variable is a dichotomous variable logistic regression was chosen to analyze the constructed model.

Utilization of the Internal Determinant Model

Internal determinant factors that predict adoption in organizations are size, wealth, and availability of resources (Mohr, 1969). Organizations are more likely to innovate when they are large and when the environment is rapidly changing. Alachua County has a population of over 230,000 and can be considered a large organization with diverse groups of people who have a common interest. The unit of analysis for this study will be individual voters in Alachua County.

By thinking of Alachua County as a large organization comprised of unique individuals the environment would be rapidly changing and innovative. One innovation is bringing the voters into the policy creation process by voting on the Alachua Referendum, this makes Alachua County unique from other counties. The quarter cent sales tax that became “CHOICES” provided the necessary revenue stream to allow the county to increase health services for the working uninsured. Some predictors of innovation in the sense of readiness to adopt new patterns of behavior are organizational

size and wealth, the larger the bureaucratic organization the greater the chance that they will innovate (Rogers 2004; Cohen & Klepper 1996). Economic determinants in the model will be collected to analyze “CHOICES” and we suspect they will play a very significant role in the adoption of the “CHOICES” health services program. Figure 5 depicts the general theoretical model that will be further explored.

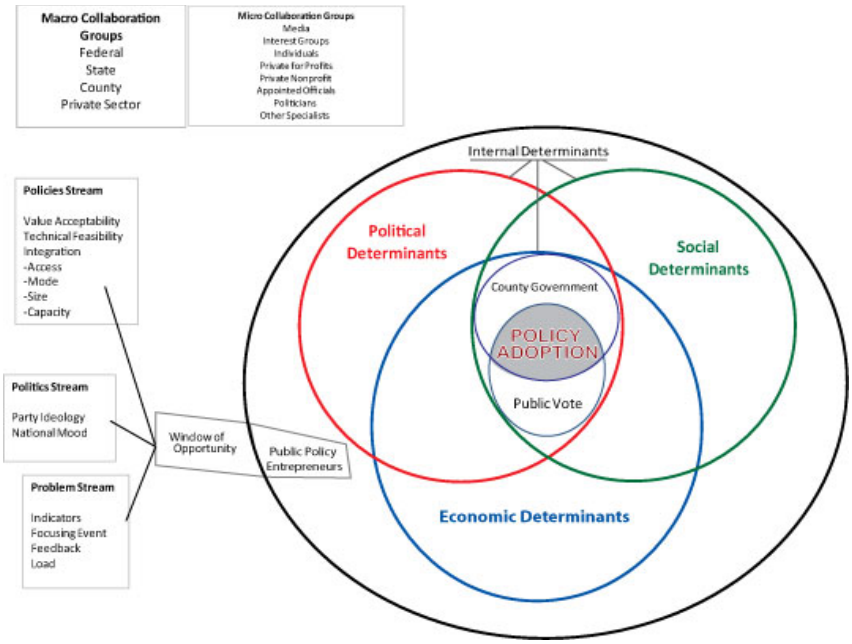


Figure 5 General Theoretical Model

Public Policy Entrepreneurs

Although they cannot be included in the quantitative analysis it is important to look at the role of public policy entrepreneurs in the creation and implementation of the "CHOICES" health services program. They did have an impact on increasing the probability that the adoption of the "CHOICES" health service program would come to fruition. The related questions that we chose to explore are contained in Appendix C and the model is depicted in figure 5.

Many public servant agencies fail to take initiative and supply leadership when innovating in public affairs. The public is not given opportunities to express their wants and needs by voting (Mohr, 1969). Alachua County gave citizens the opportunity to vote and have their wants and needs expressed. This makes the case very unique when compared to other regions. In Alachua County the public policy entrepreneurs communicated the problem and supplied leadership in government agencies. Scholars like Mintrom agree that policy entrepreneurs are essential players when it comes to increasing the chances policies become adopted (Mintrom, 1997). Through their expert knowledge of public policy systems entrepreneurs are able to exploit windows of opportunity that result in policy change, and in the case of "CHOICES" adoption.

Additionally, the literature revealed that community support for policy entrepreneurs can be measured using the comparative local tax rate. When local tax rates are high, in relation to other communities, opportunities can present themselves for public entrepreneurs to innovate. Public policy entrepreneurs innovate by increasing the efficiency of local services, limiting expenditures and redirecting patterns of growth that

residents associate with the higher taxes (Schneider, 1995). In the case of “CHOICES” we will hypothesize that policy entrepreneurs will advocate to increase the efficiency of the “CHOICES” health services programs.

Furthermore the theory of innovation and diffusion leads us to understand that adoption of a policy is an innovation, so Alachua Counties adoption of the “CHOICES” program would make the county and the voter’s policy innovators (Schneider, 1995). Overall we would expect to see Alachua County with a higher tax base and a higher overall tax rate thus increasing the probability of the emergence of a policy entrepreneur.

Finally budgetary factors discussed in the literature reviewed included: redeploying local budgets to achieve policy goals. This factor is divided into three categories developmental, allocational, and redistributive (Peterson, 1981) the domain in which local political entrepreneurs have the most control is the allocational (Schneider, 1995). When there are high allocational expenditures slack resources can be used to reallocate resources to a more preferred policy. In this case we consider slack resources to be resources that are not necessary to the operation of the “CHOICES” health services program. If there is a large surplus from a tax we would expect politicians who control the funding to attempt to reallocate those resources to other areas (Schneider, 1995). In Alachua County we would expect to observe politicians attempting to reallocate funds that were not exhausted as part of the operational costs in the “CHOICES” health services program due to the presence of slack resources.

Variables in Correlation Model

The bivariate correlation model includes the dependent variable and selected independent variables which helped determine whether and which variables were statistically significant. The model was run with only the statistically significant variables in an attempt to narrow down the model to the variables that were included in the predictive internal determinant model that was analyzed.

Collected Variables Research Questions and Hypotheses

Forty-six variables were collected, sources of the data included the Alachua County Supervisor of Elections, the yellow pages, and www.areacode.net/zip-code-32605.htm, and the bureau of labor statistics. See Appendix O for the list of coded variables. The variables were coded as follows.

Legally cast ballots (LegCasBal) is a variable stands for precincts submitting legally cast ballots. A consecutive numeric number was assigned beginning with one and ending with 69. This allowed us to identify that out of the 71 precincts only 69 reported votes to the Alachua County Supervisor of Elections. Precincts 50 and 53 were missing from the analysis and were assumed to not be legally cast votes. A phone call to the Alachua County Supervisor of Elections revealed that the precincts were combined with other precincts in the past and that all votes were legally cast. They did not have data tracking which precincts were combined.

Precinct (PRCT) is the actual numeral assigned to the voting precinct in Alachua County. Precinct name (PRCTName) is the name of the precinct where voting occurred. Precinct location (PRCTLOC) is the actual address of the precinct, were voting took

place. City (CTY) is the city affiliated with the precinct where voting took place. State is the state where voting took place. Zip is the zip code where voting took place.

Current Voting Population (CrntVotPop) is the total available voting population it is an interval level variable that was coded 1=GT1500 0=LT1500 1 is the voting population greater than 1500 and 0 is the voting population less than 1500. Demographic variables were included White population (WhtPop) is an interval level variable and includes White males and females, Non white population (NonWhtPop) is an interval level variable and includes Non White males and females and are coded the same as current voting population (CrntVotPop), Black population (BlckPop), Hispanic Population (HisPop), and Other population (OthrPop) all are interval level variables and include Black, Hispanic, and other males and females and are coded the same as current voting population (CrntVotPop). White male population (WhtMalPop) includes all White males and other male population (OthrMalPop) includes all Non-White males they are interval level variables and are coded the same as current voting population (CrntVotPop). White female population (WhtFeMalPop) includes all White females and other female population (OthrFeMalPop) includes all Non-White females they are interval level variables and are coded the same as current voting population (CrntVotPop). Sex unspecified (SexUnspec) is sex unspecified and is an interval level variable coded the same as current voting population (CrntVotPop). There could be some multicollinearity issues if current voting population (CrntVotPop) is used in the analysis with the other specified variables since the count of all the demographic variables should

total to the count of the current voting population (CrntVotPop) they could be explaining the same variance in the dependent variable.

Age 18 to 50 (Age18_50) includes all men, women, sex unspecified and all ethnicities who are eligible to vote. The variable is interval and the coding is 1=GT800 and 0=LT800. 1=greater than 800 votes and 0=less than 800 votes. Age 51 and up (Age51up) includes all men, women, sex unspecified and all ethnicities who are eligible to vote and is coded the same as Age 18 to 50.

Households is an interval level variable and is coded 1=GT1500 and 0=LT1500. 1=greater than 1500 households 0=less than 1500 households. Average house size (AvgHousSiz) is an interval level variable and is coded 0=LT.5 1=GT.5. 0=less than .5 live in the household and 1=more than .5 live in the household. Average house value (AvgHousVal) means average house value and is a ratio variable coded 1=GT20,000 and 0=LT20,000. 1=greater than $20,000 and 0=less than $20,000 in house value. Average house income (AvgHousInco) is a ratio level variable and is coded 1=GT10,000 and 0=LT10,000. Average house income stands for average household income.

Number of businesses (NumBus) is an interval level variable it is coded 1=GT90 and 0=LT90 it stands for the number of businesses in a precinct. 1=greater than 90 businesses and 0=less than90 businesses. Number of Employees (NumEmp) is an interval level variable and is coded 1=GT1300 employees and 0=LT1300 employees. It stands for the number of employed persons in each precinct. 1=greater than 1300 employees and 0=less than 1300 employees. Annual Payroll (AnnPay) stands for the annual payroll of

businesses in each precinct and is coded 1=GT25mil and 0=LT25mil. 1=greater than $25million dollars in payroll and 0=less than $25million dollars in payroll.

LandArea is the total land area occupied by the precinct and is an interval level variable and is coded 1=GT 200 and 0=LT200. It stands for the land area in each precinct. 1=greater than 200 square miles and 0=less than 200 square miles. Water area is the total water area occupied by the precinct is an interval level variable and is coded 1=GT.3 and 0=LT.3. It stands for the water area in each precinct. 1=greater than .3 square miles and 0=less than .3 square miles of available water area.

Number of registered voters (NumRegVot) is an interval level variable and is coded 1=GT1800 and 0=LT1800. It stands for the number of registered voters in each precinct that participated in the voting process. There could be some multicollinearity with regards to the variable coded current voting population (CrntVotPop) and only one of the variables should be included in the model. Number of registered voters (NumRegVot) stands for 1=greater than 1800 individuals voted and 0=LT1800 individuals voted. Times Counted (TimCount) is an interval level variable coded 1=GT400 0=LT400 and stands for the number of times the Alachua County Supervisor of Elections recorded each vote.

Total Votes (TotVotes) is an interval level variable and is coded 1=GT400 and 0=LT400. It represents the number of voters in each precinct voting on the Alachua Referendum. 1=greater than 400 votes and 0=less than 400 votes. Votes for the Alachua Referendum (VoteFor) is an interval level variable and is coded1=GT180 and 0=LT180. It represents the number of people voting for the Alachua Referendum. 1=greater than180

people voted for the referendum 0=less than 180 people voted for the referendum. Dependent is the dependent variable and stands for the number of precincts that vote for the Alachua Referendum. 1=precinct voted for and 0=precinct voted against the referendum.

Full time city manager (FullCtyMgr) was coded 1=part time city manager and 0=full time city manager. Full Mayor was coded 1=full time mayor and 0=part time mayor. Council versus strong mayor type of government (Council_StMay) 1=council manager style of local government 0=strong mayor style of local government. Website was a nominal value collected to be able to quickly navigate to the websites of the local municipalities.

Majority democract (MajDem) is a nominal variable coded 1=majority of the precinct is Democrat and 0 the majority of the precinct is not Democrat. Dem was coded 1=GT700 and 0=LT700 it is an interval level variable standing for the number of democrats voting on the Alachua Referendum. 1=greater than 700 democrats voted 0=less than 700 democrats voted. The variables Republican (REP), Non Partisan (NPA), Other Party, Libertarian (Liber) and Green are all coded the same as the Democrat (Dem) variable. Majority Republican (MajRep) is a nominal variable and is coded 1=majority of the precinct is Republican and 0=majority of the precinct is not republican.

Socioeconomic variables were collected from the bureau of labor statistics website and were not found to be significant. This could be due to the fact that the unit of analysis is individual voters in Alachua County precincts and the lowest level of data that could be obtained was zip code data in Alachua County.

The main research question was what are the factors associated with the adoption of the "CHOICES" health services program in Alachua County, Florida? The general hypothesis was that social, economic and political factors will be significant in predicting the adoption of the "CHOICES" health services program. This research question can be found in Appendix A, and the focused research questions can be found in Appendix B. The following hypotheses are associated with the research questions.

Although, we do not expect social variables to explain as much of the variance in the dependent variable as economic and political variables, we do expect some will be statistically significant. Research has shown women prefer larger government's roles, which led the researcher to hypothesize precincts with higher female populations will be more likely to adopt government growth (Cavalcanti & Tavares 2011). Additionally, black women tend to see the most pressing issues in society as education, healthcare, economic development, and employment (Barrett, 1995). This leads us to hypothesize precincts with higher minority populations will be more likely to vote to adopt "CHOICES". Another reality is that the less educated benefit substantially less from contemporary health care than do other Americans (Dougherty, 1988). If the less educated benefit less from contemporary health care than other Americans than we would expect that those who are more educated would understand that, and want to provide comprehensive primary care for those who are without care. This lead the researcher to hypothesize, those who are more educated would be more likely to vote for "CHOICES".

H1: 1) Precincts that have a majority of democrats will be more likely to adopt "CHOICES". One of the internal determinants discussed by Mohr is the political

determinant (Mohr, 1969). In the American two party system, Republicans and Democrats are the two major parties, with the passage of the PPACA Democrats tended to favor health reform in contrast to Republicans who tended to oppose the legislation (Oberlander, 2010). Democrats learned from previous mistakes in trying to pass health reform and were successful at creating incremental reform to our current health insurance system in the form of the PPACA (Oberlander, 2010). Democrats nationally tend to favor health reform so the expectation is that local Democrats will act in the same manner by supporting "CHOICES". The expectation is Democrats will have a positive view of health care reforms and be more likely to vote for the adoption of the "CHOICES" health services program.

H2: 1) Precincts with higher home values will be more likely to adopt "CHOICES". We expect that precincts with higher home values will have more educated residents and there will be a positive relationship to the dependent variable. They will tend to vote for adoption of the "CHOICES" health services program. 2) Precincts with higher household incomes will be more likely to adopt "CHOICES". 3) Precincts with more private businesses will be more likely to adopt "CHOICES". These are all economic variables, which is another category of internal determinants discussed by Mohr (1969). Dougherty stated that the less educated benefit substantially less from contemporary health care (Dougherty, 1988). If this is true we would expect those who are less educated not to have gainful employment which in turn would lead to a lack of benefits. We would expect those who are more educated to understand this and want to provide comprehensive primary preventative care for those who can not afford it. Thus,

we would expect there to be a positive relationship to the dependent variable from the economic variables. The expectation is that economic determinants will be the most significant when explaining which internal determinants predict adoption on the local level. Adoption occurs when motivation exceeds obstacles (Berry & Berry, 1999) thus we would expect to see precincts that are more privileged to be more likely to adopt.

H3: 1) Precincts with higher female populations will be more likely to vote to adopt the "CHOICES" health services program. The policy entrepreneurs associated with the implementation of the "CHOICES" health services program are non white and they formed a political action committee called "CHOICES" to solicit funds to bring the initiative forward for the ballot. We would expect there to be a positive relationship to the adoption of "CHOICES" 2) Precincts with larger non white populations will be more likely to vote to adopt "CHOICES" health services program. The policy entrepreneur who was instrumental in the creation and adoption of "CHOICES" is a non white female, and in an interview she stated that the first place she went to garner financial support for the referendum was to her friends and family. We would expect to see a positive relationship to the adoption of "CHOICES" for non white females. 3) Precincts with higher median education will be more likely to adopt. We would expect precincts with higher education to have more businesses and a higher payroll then precincts without higher education. We would expect there to be a positive relationship to the variable annual payroll of businesses (AnnPay) and the dependent variable.

H4: If the public has an opportunity to express their wants than leadership was supplied by the public. This question seems qualitative but can be measured and is

important to the study. This is the dependent variable and is what set the "CHOICES" health services program apart from all other healthcare programs including the PPACA. This program was taken to the people to decide whether or not it should be implemented. Mintrom's discussion surrounding policy entrepreneurs stated that often the public does not get a chance to express their opinions in the policy process (Mintrom, 1997). In the case of "CHOICES", precincts either received an opportunity to vote or they did not. Participation in the policy process can be coded as 1=yes opportunity to vote and 0=no opportunity to vote. We would expect there to be a positive relationship to the independent variables included in the model and the probability of adopting the "CHOICES" health services program.

H5: 1) Size of the precinct and wealth of the precinct will have the strongest relationship to adoption. This is an economic indicator and the expectation is that these variables will have a positive relationship to the dependent variable and that some will be predictor variables.

H6: 1) Precincts with higher education will be more likely to adopt. As stated before, the reality is the less educated benefit substantially less from contemporary health care than do other Americans (Dougherty, 1988). This leads us to hypothesize that those who are more educated will be more likely to vote for "CHOICES". The thought behind this is that those who are more educated will feel inclined to help those who are less educated by increasing access to care for those who go without. It is thought that there will be a positive relationship between the variables annual payroll of businesses

(AnnPay) and average household income (AvgHousInco) and that they will be statistically significant predictor variables.

Variable Categories

It is important for the reader to understand the categories the variables fall into. This will aid the researcher when presenting the results to apply them to the model created, and the reader to understand what inferences are being made with regards to the results. Since this is a mixed methods study both quantitative as well as qualitative methods were employed. This section will conclude with a brief discussion about each category of variables. It will start with a discussion of the dependent variable and then look at the categories of all the independent variables: social, economic and political.

Dependent Variables

The dependent variable is defined as: the probability that precincts will choose to adopt or not to adopt the Alachua referendum. Prior to 1990, most researchers used the states as a dependent variable and innovativeness was defined by the rapidness with which states adopted new policies (Sabatier, 2007). For this study, we will use the voters in the precincts probability of adoption as the unit of analysis. Researchers have measured variables at the interval level using year of adoption, the ordinal level by ranking states in their order of adoption (Baum & Canon 1981; Glick 1981; Gray 1973a; Walker 1969) and dichotomous variables showing whether a state has adopted a policy by a specific date (Filer Moak & Uze 1988; Glick 1981; Regens 1980). Researchers are now using the probability of a state to adopt a policy; the analysis is empirical and

pooled, it can be cross sectional or time series when states are viewed over a number of years (Berry & Berry 1990, 1992; Glick & Hays 1997; Mintrom 1997).

There are two main dependent variables used in the internal determinant models 1) earliness of adoption and 2) probability of adoption (Sabatier, 2007). Earliness of adoption does not come into play because Alachua County is the first county where the voters upheld the implementation of a tax to support the "CHOICES" program in order to provide comprehensive primary preventative care to the working underemployed who were uninsured. Thus the dependent variable is the precincts probability of adoption.

Social Variables

The literature was reviewed on social factors and it was found that social variables play a role in the probability an entrepreneur will emerge in a community. One important variable affecting the ease of with which entrepreneurs can organize the citizenry into collective action is the stake individual citizens have in local tax and service issues (Schneider, 1995). If social variables are significant we would expect to see the presences of a public policy entrepreneur in Alachua County. Public policy entrepreneurs tend to be more educated. If they are more educated then we would expect them to have more wealth. If they have more wealth then we would expect them to have homeownership.

Communities that have greater concentrations of renters, where individuals do not have a specific investment in property, are harder to organize than communities with larger concentrations of more firmly anchored homeowners (Cox, 1982). When applied

to the case of “CHOICES” we would expect precincts with more homeowners to be more likely to vote for “CHOICES” and less likely to vote against “CHOICES”.

Another theory in the literature, social bias theory, links social status with political skills and economic resources in order to facilitate mobilization against development (Donovan & Neiman, 1992). The best predictor of antigrowth policies among Northern California city planning agencies is the percentage of white collar population and not relative community status or social homogeneity (Baldassare & Protash, 1982). Social Bias theory hypothesizes that policy entrepreneurs have more access to economic resources because of their social status in the community. In the case of “CHOICES” we hypothesize the policy entrepreneurs have a more elevated social status then the average citizen.

Baldassare disputes social bias theory by using the Geni coefficient to determine that the percentage of residents in white collar jobs is a more significant factor when determining which city planning agencies choose to adopt growth control policies. Using Baldassare’s thinking the hypothesis would be that a negative relationship will exist between precincts with a higher percentage of residents with white collar jobs and their support for “CHOICES”. Precincts with more white collar jobs will be more likely to vote for “CHOICES”. The social variables that will be collected for use in the model include households, average household size, average household value, and average household income, Alachua County employment and wages, and Florida unemployment rate.

Economic Variables

The literature revealed budgetary factors like the size of the tax base are important to consider as the larger the tax base the easier it is to provide a service at a reasonable rate. The stronger the tax base the more likely it is that the tax will be smaller to provide needed services to a community. Communities with a strong tax base can provide good services at a moderate tax rate and moderate services at a low tax rate (Schneider 1982) this strong tax base provides public entrepreneurs a powerful resource that can be used to further their vision (Schneider, 1995). In the case of "CHOICES" we would hypothesize that a small tax assessed on the public would be the result of a large tax base. The economic variables that will be collected for use in the model include number of businesses, number of employees, annual payroll, land area square miles and water area square miles.

Political Variables

Political Factors include cost and benefit of entrepreneurship in the local market for public goods, electoral conditions, and the structure of the chief political executive. Three categories of the structural factor include the offices of city manager and mayor, the nature of local system representation and the adoption of non partisan elections. The office of mayor tends to be a critical institutional position for local entrepreneurs, when the office is full time it tends to be even more critical (Schneider, 1995). In the case of "CHOICES" the policy entrepreneurs are the public servant making the presentation to the Alachua County Commission and the County Commissioner who championed the grassroots campaign to educate the public on the issue.

Schneider is concerned with the local system of representation his belief is that collective action problems are easier to overcome in smaller constituencies than in larger ones. This suggests that cities with district elections as opposed to at large elections are more likely to provide organizational opportunities for anti growth entrepreneurs. In the case of "CHOICES" this would mean that district elections would have a positive relationship to the emergence of a pro growth entrepreneur and a large election would have a negative relationship to a pro growth entrepreneur. The political variables that will be collected include the number of registered voters, times counted, total votes, votes for the Alachua Referendum, percent of votes for the Alachua Referendum, votes against the Alachua Referendum, percent of votes against the Alachua Referendum, democrats, republicans, non-partisan, other party, libertarian, green, full time city manager, full time mayor, majority democrat, and majority republican.

Logistic Regression

Multinomial logistic regression cannot be used because the dependent variable does not have more than two outcomes (Elliott & Woodward, 2007). Ordinal logistic regression cannot be used because the dependent variable does not have two or more ordered categories (Elliott & Woodward, 2007). This analysis is concerned with the probability that states will choose to adopt or not to adopt the Alachua referendum which became the "CHOICES" health services program. The dependent variable is dichotomous, either voters voted for the Alachua referendum or they did not, thus binary logistic regression becomes the method of choice to analyze the constructed model (Elliott & Woodward, 2007).

The independent variables used in logistic regression models can be binary or quantitative. In our analysis we will standardize the values by subtracting the mean and dividing by the standard deviation, to aid in comparing the odds ratio from the output provided by our statistical software. Variables with a significance of p=.10 will be included in the model. If it appears that there is more than one model that could be used to explain the relationship between the independent and dependent variables they will be compared using the log likelihood the model with the lower log likelihood value will be selected as the model that best fits. Once the classification table is produced the cut value will be analyzed to determine if a different cut value would yield a better prediction whichever cut value provides the best prediction is the model that will be used when reporting the results (Elliott & Woodward, 2007).

CHAPTER 4

Introduction

The main purpose of this study was to examine the strength and direction of the social, economic, and political variables in Alachua County precincts who voted on the Alachua Referendum, while acknowledging the importance of policy entrepreneurs in the policy creation and implementation process. The previous chapters have discussed the importance of using a mixed methods approach to analyze the adoption of the "CHOICES" health services program.

Additionally, this chapter will describe the policy entrepreneurs who were involved in the creation and implementation of the "CHOICES" health services program and the operational environment. It will examine the results of the quantitative binary correlation analysis and logistic regression, as well as, evaluate the hypotheses associated with the models, and present the results of the analysis. Furthermore, the "CHOICES" health services program evaluation conducted by the Florida Survey Research center about the program's effectiveness will be analyzed.

Precinct Description

Descriptive statistics were computed to help understand the data that was collected. There was a mean of 3188 votes of all precincts in the current voting population under study, of that population on average 2363 voters were white, 424 were black, 105 were Hispanic, 296 were classified as other. On average there were 1082 votes per precinct from white males and 287 from non white males. There were on average 1260 votes from white females and 440 votes from non white females. Those who did not

specify sex averaged 122 votes per precinct. Appendix H shows the distribution of the raw data and that the data is not normally distributed.

Voters 18-50 on average turned out to vote 2060 times in each precinct. While voters 51 and up averaged 1154 times in each precinct. There were on average 7494 households in each precinct with an average household size of 2.3. The average home value was $91,864 and the average household income was $33,007. On average there were 441businesses per precinct who employ on average 6,504 people with an average payroll of $150,192,879 dollars. Precincts on average occupy 2796 square miles and have on average they occupy 1 square mile of water area.

Each precinct averaged 1843 registered voters and the votes by precinct on average were counted 450 times. Total average votes in each precinct was 441 and on average precincts cast 217 votes for and 223 votes against the Alachua Referendum. On Average Each Precinct had 839 democrats, 469 republicans, 272 non partisan, 27 declared as other party, 6 libertarians, and 4 members of the green party. Appendix H demonstrates the descriptive data before it was coded for binary logistic regression and clearly shows that the data is not normally distributed. Appendix I presents the results of the Pearson Correlation analysis of the statistically significant variables that were included in the logistic regression model. Appendix J shows the statistically significant descriptive data after coding for the binary logistic regression model.

Correlation

In previous chapters. we suspected that number of registered voters (NumRegVot) and current voting population (CrntVotPop) could have some multicollinearity issues.

The first step in the analysis was to run bivariate correlations between number of registered voters (NumRegVot) and current voting population (CrntVotPop) there was a Pearson correlation of .957 that was significant at the .01 level in a two tailed test suggesting that the two variables were highly correlated with one another when analyzing the raw data. When the analysis was run on the coded data the result yielded a strong person correlation of .8. Since both variables were not necessary to keep in the model number of registered voters (NumRegVot) was selected. Appendix I includes the Pearson Correlation table of variables included in the model.

Number of registered voters (NumRegVot) is a more accurate variable to measure precincts who voted on the referendum it was selected for use in the model, because it includes the actual number of voters who voted on the Alachua Referendum in 2004. Bivariate correlations were run again on all the raw data collected and it was determined that there are many multicollinearity issues. This is not surprising because the data was not collected randomly and is not generalizable to the population at large. This study is only meant to explain the internal determinants associated with the policy adoption of the "CHOICES" health services program. Statistically significant variables that were included in the binary logistic regression model include. The dependent variable probability of voting for the Alachua Referendum (ProbVtFor). The independent variables include: Zip code (Zip2), other female population (OthrFeMalPop), age 18 to 50 (Age18_50), age 51 and up (Age51up), households, average house size (AvgHousSiz), average house value (AvgHousVal), average house income (AvgHousInco), annual payroll of businesses (AnnPay), LandArea, WaterArea, number

of registered voters (NumRegVot), Full time city manager (FullCtyMgr), council or strong mayor (Council_Stmay), Democrat (Dem), and non partisan (NPA). Appendix J includes the standardized means and standard deviation of the variables included in the logistic regression model.

Incremental Change, the Window of Opportunity & Policy Entrepreneurs

This study was centered on local county government and the participation of the voting public in the policy process. Specifically, the interest was centered in how public policy entrepreneurs impacted the process and what internal determinant factors led to the adoption of the "CHOICES" health services program. In order to understand the environment that policy entrepreneurs operated in, it is important to understand the previous polices that preceded the adoption of "CHOICES". In the 1600's prior to the publication of the Flexner report in 1910, which shifted the focus of medical education to evidence based care, healthcare was typically provided through home remedies passed down from previous generations. This major change in healthcare to move towards evidence based care increased the cost of health education, and caused healthcare professionals to become well respected highly educated members of their communities.

Although, providers were well respected they were burdened with high tuition and as technology became more expensive healthcare costs increased. The expense is shared by the consumer in the form of higher fees for the services offered by providers. This resulted in the poor not being able to pay for care. The inability of the poor to pay for care resulted in the creation of health insurance which allowed more people to afford

care. Because insurance companies bore the lion's share of health care costs it eliminated the need for the public to save for future anticipated healthcare expenditures.

The next major change came from the creation of the social security act in 1935 which began the federal government's involvement more directly in the lives of citizens of the United States. In 1965 Medicare and Medicaid were implemented to expand the healthcare safety net that up until then primarily consisted of private insurance. Insurance companies driven by profit began denying coverage, charging higher rates to consumers, and compensating providers less due to the decentralized nature of the healthcare industry. The variation in expenditures from region to region led to the variation in provider reimbursements. The creation of HMO's in 1973 was to help manage the costs associated with health care. HMO's enter into direct contracts with insurance companies on behalf of their participants. PPO's created by hospitals and physicians followed shortly thereafter in 1980 and were a direct outgrowth of the creation of HMO's. In 1997 Diagnostic related groups were implemented and changed the way in which hospitals were reimbursed by government for care provided. All of these policies preceded the 2009 passage of the PPACA and the discussion preceding the act set the stage for the political debate that ultimately led to the creation and implementation of the Alachua Referendum.

The political debate that surrounded Obama Care resulted in Florida Republicans calling the Alachua Referendum Florida's version of Obama Care. This perfect storm allowed public policy entrepreneurs to step forward and take advantage of a window of opportunity in Florida to create and implement a primary preventative care program that

was approved by the citizens of Florida to help the working uninsured receive comprehensive primary preventative care services in hopes that it would reduce the burden on local hospitals who had become the indirect primary care providers. "CHOICES" is not insurance it is a method of compensation for local providers who opt into the program to receive reimbursement from the funds raised to pay for the working uninsured's primary care needs.

"CHOICES" Environment

The first policy entrepreneur that stepped forward in the creation of the Alachua Referendum was Elmira K. Warren. Elmira K. Warren was the Director of the Department of Community and Support Services and made a presentation to the Alachua County Commission. The 2004 study presented concluded health insurance in Florida is a complex issue, affected by a wide range of factors, including economic fluctuation and cultural traditions. This report set the stage for Cynthia Moore Chestnut to come forward and champion the Alachua Referendum. Without the Alachua Referendum "CHOICES" would not have been created or implemented. Cynthia Moore Chestnut is the true policy entrepreneur and is the reason the program was successful.

Q1:Which individuals and groups advocated for the development and adoption of a comprehensive primary preventive care program targeting the non-elderly uninsured residents of Alachua County, Florida? Elmira K. Warren Director of the Department of Community Support Services was instrumental in bringing knowledge to the Alachua County Commission that resulted in the grassroots campaign that led to the implementation of the "CHOICES" health services program. Cynthia Moore Chestnut

was the county commissioner who championed the effort by leading the campaign and creating a PAC that put the Alachua Referendum on the primary ballot for a vote of the people. Rodney J. Long was a strong advocate of the program while he served on the Alachua County Commission.

The Alachua County Republican Party opposed the implementation of "CHOICES" stating that it was "a solution to a non existing problem" Retrieved June 30,' 2011 from the World Wide Web: http://www.votedifferently.com/choices.html That Democrats and county leadership pushed the program onto Alachua Citizens by placing the referendum on a ballot during a primary election and that Democrats were not happy with the "CHOICES" health services program Retrieved June 30,' 2011 from the World Wide Web: http://www.votedifferently.com/choices.html

Q2: What sources of information were used within the districts to guide policy entrepreneurs decisions about which preventive care program would be adopted? County commissioners heard from the Director of Community and Support Services. County commissioners advocated their positions to the precincts, in an attempt to garner support for the Alachua Referendum. A 2004 Florida Health Insurance Study report concluded that, "clearly there are many different reasons that people are without health insurance. No one number or percentage tells the whole story. Indeed, more thorough, multivariate analyses of these data and several subsequent reports will emerge over the coming months. In collaboration with AHCA and Health Management Associates, the additional survey findings will be combined with information obtained in focus groups and reviews of action taken in other states, all intended to help understand the

complicated reality of why and how people obtain health insurance coverage (or not)." All of these reason's guided policy decisions within districts.

Q3: How do policy entrepreneurs impact the adoption of "CHOICES"? Why did policy entrepreneurs choose to become involved with the adoption of "CHOICES"? What time constraints existed with the adoption of "CHOICES"? Who are the policy entrepreneurs associated with the adoption of "CHOICES"? It is clear that policy entrepreneurs impact the adoption of policy decisions. Cynthia Moore Chestnut was contacted and interviewed she offered some insight into these questions.

How do policy entrepreneurs impact the adoption of "CHOICES"? Senator Chestnut who was a county commissioner at the time sat on the National Association of Counties and found the Michigan "CHOICES" plan. However this plan was insurance that had a shared responsibility of one third government, one third enrollees, and one third insurance. Without Cynthia Moore Chestnut the political action committee "CHOICES" would not have been created and the referendum would not have been placed on the ballot. Her previous experience as a state senator was instrumental for her to understand the problem on the local as well as the state level and she took action to make change in her community.

Why did policy entrepreneurs choose to become involved with the adoption of "CHOICES"? Cynthia Moore Chestnut confirmed that the reason she became involved was because of the presentation from Elmira K. Warren at the Alachua County Commission meeting in which Ms. Warren presented information on high healthcare costs being borne by the county. The idea was to charge a sales tax that tourists as well as

residents would pay. Since the University of Florida is in the county they reap the benefits of tourism during football games and thus tourists end up paying for the "CHOICES" health services program.

What time constraints existed with the adoption of "CHOICES"? Elmira K. Warrens presentation was in March of 2003 and a 75 word initiative had to be turned into the Supervisor of Election by June of 2003 in order to be on the ballot in 2004. It was worded in such a way that the county commission could not use the funds for something other than the intended purpose. If Dr. Chestnut had created an insurance plan it would have needed approval of the state legislature. Alachua County was the second county in Florida to pass legislation on healthcare. Presently Dr. Chestnut sits on the advisory board for "CHOICES" until the PPACA kicks in and hopefully takes over where "CHOICES" left off.

Who are the policy entrepreneurs associated with the adoption of "CHOICES"? Senator Chestnut is clearly the Mother of the referendum which led to the creation of the "CHOICES" health services program. There were not a lot of resources available for Dr. Chestnut when she formed the political action committee and she went to her friends for donations. The county commission did not want to promote or educate the public on the program, so she enlisted the support of senior groups, social services groups, and health agencies. She approached some businesses but they were not interested in the referendum even though they have benefited greatly from the implementation of the program.

Binary Logistic Regression Model

The preceding variables were included in the binary logistic regression model. According to the model 36 precincts voted against the passage of the Alachua Referendum and 33 precincts voted for the passage. The null model is that every precinct voted for the Alachua Referendum. The probability that some precincts vote for the Alachua Referendum is 52.2 percent. We have to accept the null hypothesis that there is an equal probability that a precinct will vote for the Alachua Referendum. There is however, an eight percent chance a precinct will not vote for the Alachua Referendum.

The classification table in the predicted model increased to 78.3 percent from 52.2 percent of the null model. The model correctly predicted 72.2 percent of the time the probability that a precinct would vote against the Alachua Referendum and correctly predicted 84.8 percent of the time that a precinct would vote for the Alachua Referendum.

We can be confident that there is something happening in the model and that the model has some predictive capacity because there was a Chi Square value of .000 that is statistically significant. However Chi Square is extremely sensitive to sample size and the small sample size of n=69 is a factor to take into consideration. A larger sample size would allow us greater confidence that something is happening in the model that will provide some predictive capacity.

The Nagelkerke R Square which is a pseudo R Squared Value suggests that 67.1 percent of the variability in the dependent variable is accounted for in the independent variables used in the model. Nagelkerke R Square value is on a scale of 0 to 1.0. The

Hosmer and Lemeshow Test was not utilized because of the small sample size of only 69 precincts, and an observation of at least 400 would be needed in order to use this test. The nagelkerke pseudo R Square value .617.

The results from the variables listed in the equation including logit scores and odds ratios can be found in Appendix K. It was found that variable Age 51 and up (Age51up) is statistically significant and that when a one unit increase in the variable Age 51 and up (Age51up) from 0 to 1 occurs there is a .134 times greater likelihood of voting for the Alachua Referendum controlling for all the other independent variables in the model.

Coding of Variable Categories

The variables were broken down into three categories social, economic, and political. It was thought that the economic variables would be the most significant, but when we look at the variables that are included in the model we see four political variables number of registered voters (NumRegVot), full time city manager (FullCtyMgr), Democrat (Dem), and non partisan (NPA). Two economic variables annual payroll of businesses (AnnPay), and Water area, and three social variables households, average house size (AvgHousSiz), average house income (AvgHousInco). Additionally, there were demographic variables collected for use in the model. The significant demographic variables included in the model are other female population (OthrFeMalPop), age 18 to 50 (Age18_50), and age 51 and up (Age51up).

Social Variables

The social variables that were collected for use in the model included households, average household size, average household value, average household income, Alachua County employment and wages (AL_EMP) and Florida unemployment (FL_EMP). The statistically significant variables included in the model were households, average household size, and average household income. All of the variables have positive relationships to the dependent variable probability of voting for the Alachua Referendum. None of the variables were predictor variables according to the odds ratio.

Economic Variables

The economic variables collected for use in the model included number of businesses, number of employees, annual payroll, land area square miles and water area square miles. The statistically significant variables included in the model were annual payroll and water area square miles. All of the variables have a positive relationship to the predictor variable and none of the variables were predictor variables according to the odds ratio.

Political Variables

The political variables collected included: number of registered voters, times counted, total votes, votes for the Alachua Referendum, percent of votes for the Alachua Referendum, votes against the Alachua Referendum, percent of votes against the Alachua Referendum, democrats, republicans, non-partisan, other party, libertarian, green, full time city manager, full time mayor, majority Democrat, and majority Republican. The statistically significant political variables included in the model are number of registered

voters (NumRegVot), full city manager (FullCtyMgr), Democrat (Dem), and non partisan (NPA). All the variables have a positive relationship with the dependent variable and none of the variables are statistically significant.

Demographic and Identifying Variables

These variables were included in the model to help explain the types of populations that the "CHOICES" health services program serves. It was thought that the demographic variables would differ from one another. The variables collected include legally cast ballots (LegCasBal), precinct (PRCT), precinct name (PRCTName), precinct location (PRCTLoc), city (CTY), state, zip code (Zip2), current voting population (CrntVotPop), White voting population (WhtPop), Black voting population (BlckPop), Hispanic voting population (HisPop), other voting population (OthrPop), White male population (WhtMalPop), other male population (OthrMalPop), White female population (WhtFeMalPop), other female population (OthrFeMalPop), sex unspecified (SexUnspec), Age 18 to 50 (Age18_50), and Age 51 and up (Age51up). All variables contain a positive relationship and only Age 51 and up (Age51up) is a statistically significant predictor variable, thus allowing us to interpret the odds ratio for that variable. A 1 unit increase from 0 to 1 in Age 51 and up (Age51up) is .134 times more likely to vote for the Alachua Referendum controlling for the individual differences in the other independent variables. Appendix L includes the variable relationships observed to the dependent variable.

Hypotheses

The general hypothesis was: H1: Social, economic and political factors will be significant in predicting the adoption of the CHOICES health services program. This turned out to be partially true. Social, economic and political factors were significant in creating the model. However, they did not become predictors in the model. All significant factors had a positive relationship to the dependent variable probability of voting for the Alachua Referendum.

The first of the focused hypothesis was: H1: 1) Precincts that have a majority of Democrats will be more likely to adopt CHOICES. Precincts with more Democrats were a significant factor in the model and there is a positive relationship between being a democrat and being more likely to vote for the Alachua Referendum however it is not a predictor variable so we can not state the probability of adoption associated with this variable.

The second focused hypothesis is: H2: 1) Precincts with higher home values will be more likely to adopt CHOICES. 2) Precincts with higher household incomes will be more likely to adopt CHOICES. 3) Precincts with more private businesses will be more likely to adopt CHOICES. Home values were not statistically significant and were not included in the logistic regression model. Higher household incomes were included in the model and there is a positive relationship with the dependent variable, but it is not a predictor variable and we can not interpret the odds ratio. Number of businesses was not included in the model because it was not statistically significant. However; annual payroll

of businesses was included in the model, but it is not a predictor variable and we cannot interpret the odds ratio.

The third focused hypothesis is: H3: 1) Precincts with higher female populations will be more likely to vote to adopt the CHOICES health services program. 2) Precincts with larger non white populations will be more likely to vote to adopt the "CHOICES" health services program. 3) Precincts with higher median education will be more likely to adopt. Nonwhite female populations were significant and were included in the model. However it was not a statistically significant predictor variable and the odds ratio cannot be interpreted. Race and gender were only significant in regards to non white females. Males, nonwhite males, and White females did not have a statistically significant relationship for inclusion in the logistic regression model. Education is correlated with higher income and although there was not an education variable the thought was that precincts with higher annual payrolls would be more educated and more likely to adopt. Annual payroll of Businesses (AnnPay) was statistically significant and was included in the logistic regression model. However it is not a predictor variable and the odds ration cannot be interpreted.

The fourth focused hypothesis is H4: If the public has an opportunity to express their wants than leadership was supplied by the public. This variable is the dependent variable probability of voting for the Alachua Referendum (PrbVtFor) and has a statistical relationship with the demographic variable Age 51 and older (Age51up). It was included in the model because it is unique to have public participation as a vote in the creation of health services programs.

The fifth focused hypothesis is H5: 1) Size of the precinct and wealth of the precinct will have the strongest relationship to adoption. Size of the precinct and wealth of the precinct were measured using average house size (AvgHousSiz) and average house income (AvgHousIncom) both had a positive relationship with the dependent variable however neither was a predictor variable so the odds ratio cannot be interpreted.

The final focused hypothesis is H6: 1) Precincts with higher education will be more likely to adopt. Education is correlated with higher income and although there was not an education variable the thought was that precincts with higher annual payrolls would be more educated and more likely to adopt. Annual payroll of businesses (AnnPay) was statistically significant and was included in the logistic regression model. However it is not a predictor variable and the odds ration cannot be interpreted.

Effectiveness of "CHOICES"

The first two years of the "CHOICES" program are marked by rapid growth in enrollment followed by a steady decline of new enrollees see Appendix D. When looking at the data keep in mind you are only looking at current enrollees n=3500. A total of 7500 enrollees have actually received health benefits at some time during the creation of "CHOICES". "CHOICES" was effective at increasing access to care for employed uninsured residents of Alachua County Florida. The surveyed enrollees tended to be predominantly female, had between one and three members living in the household. Over half were college educated and nearly 80% had graduated from high school. Sixty five percent were between the age of 20-50 and 62% did not have children, and over half of enrollees incomes were less than $29,000. Now we know that voters age51up were a

statistically significant predictor in the adoption of the “CHOICES” health services program. This is interesting because the majority of the services are being provided to the demographic of 20-50 see figure 3.

“CHOICES” has made healthcare for enrollees more affordable. Fewer enrollees delay medical care from a specialist due to cost and fewer delay medical care from a primary care physician due to cost. Fewer are unable to purchase their prescription medications, and fewer don’t receive needed medical tests because of limited coverage. Fewer delay coverage because the wait in the provider’s office was too long. More enrollees that have gone without health coverage are now covered by “CHOICES” see Appendix E.

Before “CHOICES” enrollees spent more time in emergency rooms seeking care. After enrollment their attendance in emergency rooms and urgent care dropped. Fewer miss days at work and an increasing percentage feel they are healthier after enrollment see Appendix F. Enrollees spend less on health care see Appendix G. “CHOICES” has been effective ,the perception of the enrollees in regards to affordability of health care, healthiness, and disposable income are all positive. “CHOICES” was meant to cover 15,000 enrollees and since its inception it has covered 7500 no one ever placed a time limit on when the population had to be served in order to be effective, given a few more years “CHOICES” will reach the goal of 15,000 enrollees.

Local programs like “CHOICES” can help those who do not qualify for federal or state assistance to receive treatment. Reimbursement rates For “CHOICES” providers were acceptable to most providers and of those who had problems with the program most

did not have a second incident. “CHOICES” has a greater success rate than Medicaid of properly paying providers for the care they provide enrollees utilizing the program (Scicchitano, 2010).

CHAPTER 5

Qualitative Reinforcement of "CHOICES" Effectiveness

"The real, honest to God truth is I would not have dental, medical, or any other kind of coverage if I didn't have this program. Plain and simple, I would not be able to afford it. I would have teeth falling out of my head. I wouldn't be able to cover my medicines; I wouldn't have my allergy medicines; I wouldn't have vision. This is saving me from that, plain and simple. I can try to pay my bills and hopefully be able to get off the program and give back to it within the next couple of years. " (Scicchitano, 2010).

"I went a long time not having any insurance at all – just a wing and a prayer that I didn't break a leg… but, it's "CHOICES" definitely a lot of peace of mind that if I have to go to the doctor, that I can go and get it. I won't have to basically go into a whole bund of debt just to go and get something basic done. "(Scicchitano, 2010).

"We're living in a healthier county as a result of ["CHOICES" coverage]. People are less angry and hostile. They're not going to be upset because they know that they're going to be taken care of by their county. And, people are appreciative of the County Commissioners and the people who – we have a generous county to actually make this happen. It makes me thankful to my fellow citizens. " (Scicchitano, 2010).

"It was a life saver" (Scicchitano, 2010).

How do we measure the importance of a diabetic's insulin medication, the ability to not stress about the costs associated with medical visits to the emergency room, healthcare professional, or hospital. Some might argue that this program has not been

effective I would argue that it is and the effectiveness lies in the ability of the stakeholders to purposefully collaborate to provide increased access to care for citizens who tend to go without care.

Policy Analysis "CHOICES

The three goals of the "CHOICES" health services program are: 1) To help the uninsured residents of Alachua County to stay healthy 2) Provide access to services working uninsured residents need but have put off due to a lack of adequate health coverage and 3) Reduce emergency room visits and increase the utilization of primary preventative care services. The first part of the policy analysis was to identify the policy categories. Nine categories were identified to provide information about the three goals. The nine categories are missed work, prescription medication, overall health, insurance, medical tests, emergency room visits, urgent care visits, visit to primary care physician, and visit to specialist.

Help Stay Healthy

Presently, enrollees in "CHOICES" report missing work less often. When "CHOICES" is eliminated enrollees not covered by the patient protection and affordable care act, who choose not to purchase insurance, will miss more work days due to health related issues. Continuing the program will allow those not covered by the PPACA to continue coverage under the "CHOICES" health services program. "CHOICES" enrollees have the prescription medications they need because they can afford to purchase those medications. Enrollees not covered by the PPACA and those choosing not to purchase insurance will be without needed prescription medications. Continuing the

program will allow those not covered by the PPACA and those choosing not to purchase health insurance to continue purchasing needed prescription medications.

Enrollees stated that there overall health after enrolling in “CHOICES’ is better than before they were enrolled. When “CHOICES” is eliminated those not covered by the PPACA and those choosing not to purchase insurance will see a decline in their overall health. Continuing the program will allow the population that the PPACA is not covering to continue to maintain their overall health.

Provide Access to Services

The PPACA requires all American citizens to have health insurance. “CHOICES” increases the disposable income of enrollees to be able to better afford insurance; however, enrollees who have insurance do not qualify for the “CHOICES” health services program. Enrollees that choose not to purchase insurance and to not qualify for the PPACA will not have access to health benefits. Reinstating “CHOICES” would allow enrollees to have more disposable income; however, if they cannot use it to purchase health insurance at the end of the year they will be taxed to make up for the fact that there were not covered.

Enrollees in “CHOICES” will continue to receive medical tests they need in order to maintain their health. Once “CHOICES” is eliminated unless the qualify for benefits under the PPACA or pay for health insurance they will be without the medical tests they need in order to know how to properly take care of themselves. Reinstating “CHOICES” will cover the population the PPACA does not, the population between 133 percent and 200 percent of the poverty level.

Reduce Emergency Care Increase Primary Care

Under “CHOICES” emergency room visits have gone down. Once eliminated we would expect to see these visits for those not covered by the PPACA to go up, if reinstated we would expect the visits to stay constant or decrease. We would expect to see the same result for urgent care visits as well. “CHOICES” enrollees visit their primary care a specialist physicians more often. We would expect to see these visits decline when the program is eliminated for those not participating in the PPACA. If “CHOICES” is reinstated we would expect to see the visits hold constant or increase.

Examination of “CHOICES” Policy Categories

What percent increase or decrease of enrollees missed work after enrollment in “CHOICES”? Sixty three percent reported that they missed fewer days of work, this was a 50% decrease in the number of enrollees missing work for health related issues. What percent increase or decrease of enrollees could not purchase prescription medications after enrollment in “CHOICES” eight percent could not afford to purchase medications after enrollment. This was an 87% increase in the number of people who can now afford to purchase medications after enrollment.

What percent increase or decrease of enrollees thought their health was better after enrollment in “CHOICES”. Ninety eight percent thought their health was better after enrollment in “CHOICES” this was an 11% increase from before they were enrolled. Overall employees missed less work, purchased needed medications more frequently, and overall they felt healthier. “CHOICES” is meeting the goal of helping the uninsured residents of Alachua County to stay healthy.

What percentage of enrollees spend less on healthcare? Sixty four percent of enrollees felt they spent less on health care after enrollment in “CHOICES”. This was a 63% increase in the number of enrollees who felt they spent less on health care services. Spending less on health care services means that there is more income available to be used in other areas for enrollees. What percent increase or decrease is there in the number of enrollees not receiving needed medical tests? Ten percent of enrollees did not receive needed medical tests this was an 85% increase in the number of enrollees receiving needed medical tests. Overall “CHOICES” is providing access to services working uninsured residents need but have put off due to a lack of adequate health coverage.

What percent increase or decrease was there for enrollees in “CHOICES” in regards to emergency room visits? There was a 49% decrease in emergency room visits for enrollees in Alachua County. Seventy five percent of enrollees did not go to the emergency room after enrollment. What percent increase or decrease was there for enrollees in “CHOICES” in relation to urgent care visits? Urgent care visits had a 28% decrease, 83% of enrollees did not ever go to urgent care after enrollment. What percent increase or decrease was associated with delaying care from a primary care physician? Six percent of enrollees delayed care from a primary care physician after enrollment. This was a 92% increase in the number of enrollees who received primary care. What percent increase or decrease was associated with delaying specialist care? Nine percent of enrollees delayed care from a specialist after joining “CHOICES”. This was an 86% increase in the number of enrollees who visited a specialist. Overall emergency room visits for enrollees is down, urgent care visits are down, and primary and specialist care is

up. “CHOICES” has been effective at reducing emergency room visits and increasing the utilization of primary preventative care. See Appendix M for the policy analysis matrix and Appendix N for the policy category examination.

Observations in the Literature

Causes of innovativeness at the individual level included greater socioeconomic status, higher levels of education, income, and wealth (Sabatier, 2007). Individuals who meet the preceding criteria are more likely to innovate than those who do not meet the criteria. This would suggest in the case of “CHOICES” the policy entrepreneur would have a higher socioeconomic status, more education and greater income and wealth than the population. High levels of education provide recipients with a more open mind and increased access to knowledge about innovative practices (Sabatier, 2007). Often innovation costs money and involves financial risk for those who adopt them. Increased wealth and income provide the tools necessary for individuals to assume risk (Sabatier, 2007). The literature on organizations posits similar hypotheses (Berry 1994; Rogers & Shoemaker 1983) and Walker (1969) suggests that states operate in the same way.

Mohr proposes that the probability an organization is willing to innovate is inversely related to the strength of obstacles to innovation; and directly related to 1) motivation to innovate and 2) availability of resources for overcoming the obstacles (Mohr, 1969). We would expect that if states operate the same way as individuals that counties would operate the same way as states. We would expect to see an inverse relationship to the obstacles fighting against the passage of “CHOICES” and the willingness of the county commission to implement the program. Other useful factors

include looking at citizen and elite ideology (Berry & Berry 1992; Lee & Mooney 1995; Sapat 2004). However; their influence is not seen as a factor that should be included in internal determinants models because ideology is perceived to influence routine or incremental policy (Anderson Hill & Leighly 1995; Clingermayer & Wood 1995). Since our model will be looking at internal determinants we will not consider factors that are unrelated to the study of internal determinants. However we will include citizen and elite ideology as they are a useful unit of analysis in our discussion of policy formation so the reader will understand who the players in the policy process are and how they interact with one another.

Wealth, income and slack resources for organizations, as well as, individuals high level of education and large size for organizations reflect the capabilities of individuals and organizations to innovate and adopt new policies, we can compare it to government in that similar capabilities are needed in order to achieve innovation (Sabatier, 2007).

One major factor that merits consideration is that of the policy entrepreneur, Mintrom points out the importance of policy entrepreneurs in facilitating the adoption of school choice initiatives in the states (Mintrom, 1997). However, without a perceived severe problem and a motivated public official these measures are still at jeopardy of falling short of innovation. Problem severity is an important determinant of motivation to innovate. The more severe the problem the more likely state officials will be motivated to fix or address it (Sabatier, 2007). In the case of Alachua County we see the public entrepreneur using problem severity to convince voters to vote for the creation of a tax that would be used to provide comprehensive primary care to the working

underemployed who are uninsured. Presently, we see county commissioners using the campaigned perceived problem severity and the lack of outcomes to attempt to eliminate the program.

Other factors like electoral security also play a vital role when determining problem severity (Sabatier, 2007). The more secure public officials feel the more likely they are not to adopt new policies that are popular with the electorate, and the more unsecure they are the less likely they are to adopt similar policies (Sabatier, 2007). This suggests that the policy entrepreneur in the case of "CHOICES" was secure enough in their position to choose to lead the grassroots effort to implement a tax to provide comprehensive primary preventative care for the working uninsured.

Additional factors like poor economic conditions contributed to the adoption of Mother's Aid programs by increasing the "demand and need for assistance" (Allard, 2004). Poor economic conditions in Alachua County could be a factor contributing to the demand and need for comprehensive primary preventative care programs. We would expect to see a positive relationship between poor economic conditions and adoption of "CHOICES".

Stream suggests that the rate of un-insurance among a state's population influences the likelihood that the state will adopt a set of health insurance reforms (Stream, 1999). In the case of "CHOICES" we would expect to see a positive relationship between the Alachua County un-insurance rate and adoption of "CHOICES". "The greater the ratio of state education funding to local funding, the more likely that a state legislature will consider systemic reform like school choice" (Mintrom & Vergari 1996).

If we apply the same rational to health reform we would expect the opposite to be true as well. The greater the ratio of local funding for education compared to state funding we would expect to see "systemic reform at the local level." In the case of "CHOICES" we would expect to see local funding to be higher than state funding thus adding an additional factor to consider when explaining why "CHOICES" was adopted.

Walker takes the position that politicians anticipating closely contested elections are especially likely to embrace new programs in order to broaden their electoral support, and politicians with less time to a new election are more likely to adopt a new popular program then they are to adopt one that is highly controversial (Walker, 1969). Evidence to this theory can be found in the highly popular state lotteries (Berry & Berry, 1990) and the unpopular mandatory taxes (Berry & Berry 1992) as well as the controversial school choice initiatives (Mintrom 1997). "CHOICES" was highly controversial therefore we would expect to see a closely contested election between the policy entrepreneur and her opponent.

Discussion of the Research Study

The purpose of this study was to examine the creation, implementation, and adoption of the "CHOICES" health services program. The specific aims were threefold: 1) To identify the factors that influenced the creation of the "CHOICES" program: 2) To describe the key role of public policy entrepreneurs who were part of the process of adoption: and 3) To provide researchers and government officials with a documented explanatory model of a purported effective comprehensive primary preventative care program.

Specific Aims of the Study

Specific aims of the study included: 1) The study identified internal determinants that were categorized into three areas social, economic and political that influenced the adoption of the "CHOICES" health services program voted into effect by Alachua County voters. 2) The study identified and described public policy entrepreneurs and the environment they operated in. 3) The final aim of this research was to provide government officials and scholars a descriptive document about the "CHOICES" Health Services Program, so that it might become adopted in other areas of the country that have need for innovation in this domain.

It is evident that partisan politics played are role in the framing of the agenda for the adoption of the "CHOICES" health services program. The agenda was framed by public policy entrepreneurs who were instrumental in facilitating adoption. Change in healthcare policy tends to be incremental, and stakeholders include the federal government, state government, local government, private for profit companies, private nonprofit companies, citizens, patients and providers.

Via cooperative collective collaboration from all stakeholders, access to healthcare providers can be available to everyone in the American disjointed incremental system of healthcare. This study focused on how Alachua County participated in the healthcare process by providing financial assistance for enrollees to receive comprehensive primary preventative care from local providers.

Findings

The most striking finding in the study is that a demographic variable collected became the predictor variable for the model. The variable was voters age 51 and up and the interpretation of the predictor variable is. A one unit increase from zero to one in Age51up is .134 times more likely to vote for the Alachua Referendum controlling for the individual differences in the other independent variables. There is a positive relationship between Age51up and the dependent variable. The model that was created eliminated the inclusion of non white males, white males, and white females as they were not statistically significant variables. The model did however include non white females. Two of the public policy entrepreneurs were non white females, and included the mother of the referendum who was the policy entrepreneur who was instrumental in the creation and implementation of the "CHOICES" health services program. Both nonwhite females and individuals age 51 and up were significant factors in the adoption model.

Another important finding is that this program was voted in by the people during a primary election. The closeness of the race and the fact that it was voted on during a primary election and not a general election makes us ask the question, what would have happened in a general election? According to Southwell (2000) voter turnout in primary elections is less than in all other types of elections. However, according to our predictor variable if the turnout was mainly voters 51 and up the probability would be .134 times more likely that they would vote for the Alachua Referendum.

Frameworks

The general theoretical model in figure 5 came from thinking about Mohr's (1969) article discussing internal determinants, Berry & Berry's (1999) article discussing policy innovations, Mintom's (1997) work about policy entrepreneurs, and Sabatier's (2007) work on theories of the policy process. Sabatier's work included Kingdon's (1984) work on agenda setting which helped in understanding the importance of policy entrepreneurs in setting the stage for policy change to take place. Baumgartner Jones & True's (1999) work on punctuated equilibrium helped us understand the health policy change process and that over time incremental and major changes in health policy have taken place. However, for the last 39 years there has not been a major change in the current disjointed incremental health care system.

General Theoretical Model

The general theoretical model helped frame the role of policy entrepreneurs in Alachua County by recognizing a window of opportunity that had opened and that the time was right to advocate for policy change. The framework identified the significance of public policy entrepreneurs, and the role they played in facilitating policy change. Policy change took place due to their availability, knowledge, skills, abilities and resources which allowed them to act. When policy entrepreneurs exploit windows of opportunity social, economic, and political factors play an important role in understanding why policies are adopted. Understanding those factors can assist policy entrepreneurs in choosing where to spend their time during grassroots campaigns when trying to garner support for policy innovation.

Proposed Policy Adoption Wheel of Collaboration

It became apparent in the research that collaboration is needed in the policy adoption process and in healthcare in general. The problem is that many working uninsured go without care and it is only by working together in the current disjointed incremental system of care that we can improve access to care for Americans. Through purposeful collective cooperative collaboration we can increase access to healthcare for all Americans. When we achieve unity and consensus then policy adoptions will occur that won't be contended as to their legality.

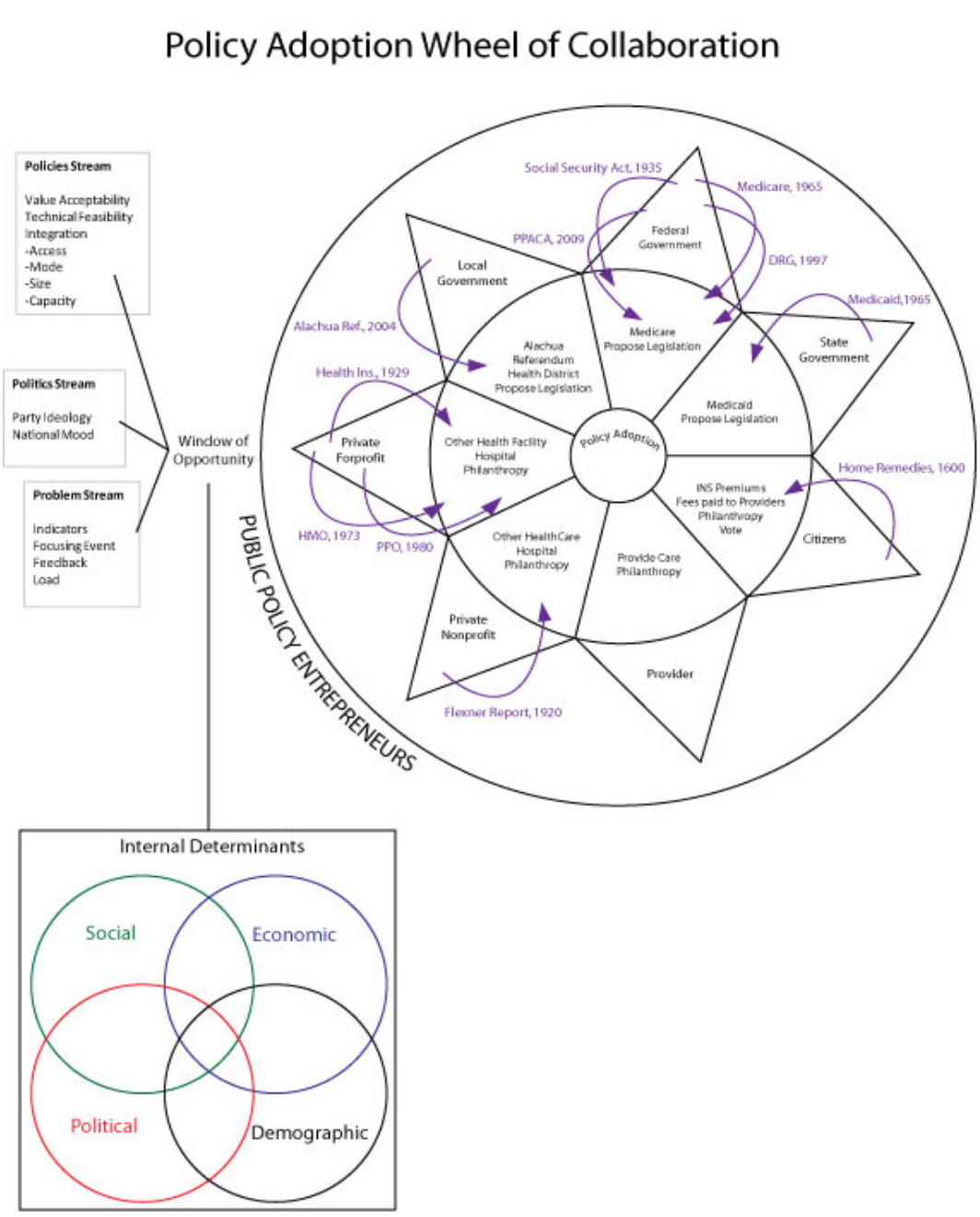


Figure 6 Policy Adoption Wheel of Collaboration

The preceding model takes into account the influence of policy entrepreneurs who operate in federalism to exploit windows of opportunity which will allow them to facilitate policy change. Facilitating policy change in Alachua County required knowledge of the external as well as the internal environment. Understanding the external environment provided context for local policy entrepreneurs to frame a grassroots campaign to facilitate policy change. Understanding the internal environment helped policy entrepreneurs make sure that once the policy change was adopted it could be implemented. In the future if another vote is taken to the people the primary focus of the grassroots campaign should be to target the demographic of 51 and up that would allow a larger margin of victory for future legislation if the voter turnout was predominantly the target age group.

Internal Determinant Factors

A cross sectional analysis of internal determinant factors from 2004-2011 was used to create a model that was tested to determine which variables were significant factors related to the adoption of the "CHOICES" health services program using logistic regression. Variables identified in the model creation were based on a review of both the literature and public documents recording the events leading up to the creation and implementation of the "CHOICES" health services program. Public policy entrepreneurs were responsible for setting the stage to adopt the "CHOICES" health services program in Alachua County Florida and are identified.

The availability of resources for overcoming obstacles was the basis for the creation of the model. Mohr studied the determinants of innovation in public agencies

and since the county government is a larger organization this model was used to investigate the significant factors that led to the adoption of the "CHOICES" health services program. Mohr's (1969) model showed that when motivation exceeded obstacles adoption occurred. Since "CHOICES" was adopted the logical conclusion is that statistically significant factors did represent motivation.

Social, Economic, Political and Demographic Factors

Social factors that were included in the final predictive model were households, average household size, and average household income. Neither the economic nor the political factors were predictors. The economic variables were annual payroll of businesses and water area sq miles. The political variables included in the model were NumRegVot, FullCtyMgr, Dem and NPA. They were important to include in the model so that the statistically significant demographic predictor variable Age51up could be interpreted. All of the variables in the model had a positive relationship to the dependent variable ProbVotFor.

Public Policy Entrepreneur Factor

Who are public policy entrepreneurs much like the private sector they are leaders who perceive opportunities to make political/policy changes by advocating their position to alter and transform political arenas (Schneider, 1995). Some argue that the change created by policy entrepreneurs is random and that policies are essentially thrown together in a garbage can and dumped out again (Cohen March & Olsen, 1972), other scholars believe in a more structured process where agenda setting plays a key role in the decision making process (Baumgartner 2009; Elder 1984; Milward 1990).

Game theory considers political entrepreneurs to be “embedded” in a system that they are trying to change (Shepsle, 1979), this view is endogenous and structured, and it is believed that entrepreneurial activity can be systematically modeled (Schneider, 1995). “Entrepreneurial profit seeking is often a game worth winning, but frequently not a game worth playing” (Pasour, 1989).

The benefits to society can be significant when policy entrepreneurs get involved we see evidence of this when we look at “CHOICES” the program expanded comprehensive primary preventative care to the non elderly who are uninsured and underemployed a population that is frequently overlooked by our current disjointed incremental system of health care. James Q. Wilson believes that studies of innovative leadership show that the personalities and actions of individual executives are critical when explaining innovative public servant change (Wilson 1995).

“CHOICES” is an innovation where we see that leadership was shown by the actions of policy entrepreneurs who were civil servants and members of the county commission. Cynthia Moore Chestnut championed the grassroots effort that resulted in a quarter cent sales tax to implement “CHOICES”. Her leadership resulted in the successful adoption of the Alachua Referendum which became the “CHOICES” health services program.

Economists have studied policy entrepreneurs for many decades however they have not developed a theory regarding emergence of policy entrepreneurs and or their impact on markets (Schneider, 1995). Kingdon’s agenda setting literature (Kingdon, 1984), the theory on the origins of policy from Laid & Milward (1990), innovation and

policy diffusion literature (Berry & Berry; Gray 1973; Polsby 1985; Walker 1969) all provide evidence for policy entrepreneurial actors to make change; however they do not agree on the characteristics of policy entrepreneurship, except that policy entrepreneurship is important and critical.

Without a policy entrepreneur "CHOICES" would not have been adopted. Whether or not the passage of the Alachua Referendum and whether or not the creation of "CHOICES" was an incremental or major change locally can be debated, but without the presence of Cynthia Moore Chestnut this program would not have come to fruition. The fact that the program was adopted in a county that had not previously had comprehensive primary health care services for the underinsured is a strong argument that this is a major change for Alachua County.

Predicting change when public entrepreneurs are involved has not yet been accomplished (Schneider, 1995) and models need to be developed to predict and explain non-incremental change (Schneider, 1995). Policy entrepreneurs are very successful at organizing and facilitating change both incremental and dramatic; however, models need to be developed to help us understand how policy entrepreneurs create dramatic change (Schneider, 1995). One thing is evident that the introduction of public policy entrepreneurs into the policy process does raise the chances that policies will be adopted.

Healthcare Public Policy Entrepreneurs

Theodore Roosevelt was one of the first presidents to attempt to pass comprehensive health care reform. His intent was to provide health insurance coverage for all Americans (Kingdon, 1984). The Truman, Nixon Carter and Clinton Administrations all pushed for some form of national health insurance, and under the Johnson administration Medicare and Medicaid were implemented (Kingdon, 1984). Both the Clinton and the Obama administrations recognized a need to cover the 15 percent of the American population who were without health insurance, but only the Obama administration was successful in setting the agenda for the policy discussion to take place (Kingdon, 1984). The Clinton Administration had very little agreement on what policies should be pursued. Some pushed for a single payer national health insurance, others wanted managed competition and still others wanted a more incremental approach (Kingdon, 1984). The secret task force created by the Clinton administration did come up with a complex proposal just before the 1994 elections that was untested and ultimately too late because the policy window closed, and a new administration was elected (Kingdon, 1984).

During the Obama administration the major players in health care reform had unified their positions and decided the best approach was to keep the current system in place with one major change the creation of the individual mandate. This was thought at the time to be a bipartisan compromise. Democrats were pushing the idea of a single payer system and Republicans had brought forth the idea of the individual mandate in a competitive market (Kingdon, 1984).

Limitations

Limitations of this study are that it focused on one health services program in Alachua County Florida that was adopted by a vote of the people. The study will not be able to be generalized to other county health service programs. However replication of a similar program using “CHOICES” as a benchmark would allow a comparative program evaluation to be conducted to further examine the effectiveness of the health service program. Also this paper presents a framework that can be tested by future researchers to see if it can hold true to the questions in the policy adoption process.

Another limitation is the sample size of the data collected is 69 precincts in Alachua County Florida. This limits the analysis that can be performed when looking at the data and the tests that can be used to interpret the models. There was variation in some of the data collected and an average was inserted which may further exacerbates the non normality of the data that was collected. Another limitation of the study is that a random sample of voters was not collected however with a larger sample size a random number generator could be used to randomly select data from the population. However, with such a small sample size it was more important to use all the data that we had.

Implications of this research are: 1) When the funds that support “CHOICES” run out, and if citizens want to reinstitute the “CHOICES” health services program, then they will be able to target the campaign on the age group that tends to support “CHOICES”. Another limitation of this study is that it did not take into account why the cost of health care is so expensive and what could be done to bring down those costs. It also does not address the problem of providing health care to the rural populations. This is a real

problem in America that needs to be addressed if we are to improve the access of health care for all Americans.

Future Research

Future research could focus on the costs of healthcare and how we could bring those costs down so providers would choose to practice in rural areas of the country. It could also include a collaboration study to see how well the federal government, state government, local government, private for profits, private nonprofits, providers, and citizens collaborate with one another in the policy adoption process. A survey could be administered to all zip codes in the United States to collect the data that could be analyzed and generalized to the nation. An implementation study on the "CHOICES" health service program could be completed to further provide more information for those interested in this unique case.

Education and Physician Shortages in Rurals

There is a global shortage of health care professionals in society (Clark & Stewart 2006). They are moving from the least developed countries to developed countries where they can earn better wages. Within developed countries, like the United States they are moving from rural to urban areas (Ricketts 2000). Healthcare educators in the United States are attempting to address this problem of shortages in rural areas, but the complexity of the U.S. healthcare system and health education systems are difficult to maneuver. Researchers have identified factors that both attract and detract healthcare professionals from entering rural practice. Opportunities to practice in an established group, improved hospital facilities, reasonable working conditions, spousal factors, and

other variables have been identified as reasons that physicians enter or leave rural practices (Rourke, 1993).

Education of health care providers is available at public and private for profit schools, and private nonprofit educational facilities. These facilities can be large complex organizations or small independent focused colleges and universities. When we compare dentistry with the complexity of medical specializations offered we note that the dental profession is less complex and much more decentralized. Specialty practices like endodontics, orthodontics, pediatrics, prosthodontics, periodontics, public health and oral surgery are more prone to decentralization. For the most part Dentist's practice in small private offices making them available to locate their practices in small communities unlike some of the physicians who practice in large hospitals.

Medicine is much more complex and centralized when it comes to specializations by offering specialties like immunology, anesthesiology, colon and rectal surgery, dermatology, emergency medicine, family medicine, internal medicine, medical genetics, neurological surgery, nuclear medicine, obstetrics/gynecology, ophthalmology, orthopaedic surgery, otolaryngology, pathology, pediatrics, physical medicine and rehabilitation, plastic surgery, preventative medicine, psychiatry and neurology, radiology, surgery, thoracic surgery, and urology and they tend to be more centralized when giving care (Coburn Lundblad MacKinney Mcbride Mueller & Watson 2012). Much of the care is administered in hospitals and not local physician's offices.

Appendices P and Q illustrate the complexities of specialties in Dentistry and Medicine. One argument regarding the centralized nature of the medical profession is that

there is a need for more qualified general practitioners in rural areas, practitioners who have specialized knowledge broad enough to treat the rural populations (Johns 2001). Other researchers talk about decentralizing specialist training, like psychiatric services, to rural communities to allow underserviced areas to have psychiatric services in their community (Adlaf, Cooke, Hodges, Rubin, & Parker 2006).

In dentistry, all predoctoral students graduate with a degree in general dentistry and have the ability to treat patients in most specialties if they have honed those skills. Once a dentist specializes they are restricted to practicing in that specialty if they want to charge specialist rates. Healthcare education is further complicated by adding separate accrediting bodies for each discipline and specialty within the discipline. All of this specialization has resulted in the loss of skilled generalists (Coburn Lundblad MacKinney Mcbride Mueller & Watson 2012).

Collaboration in Health Care

There is a large body of literature on the need for healthcare professionals to collaborate in interdisciplinary practices. Collaboration opportunities exist presently for nursing and dentists to address oral health needs among the elderly (Coleman, 2005). Models for collaboration exist for how system dynamics helped communities organize cost-effective care for chronic illnesses (Hirsch Homer Minniti & Pierson, 2004). Researchers have also addressed disparities through dental & medical collaborations (Berg, Mouradian, Somerman 2003).

It is very apparent that collaboration is necessary and needed now and in the future of health care (Fuchs, 1996). Comprehensive government control is not the answer

when it comes to health care (Fuchs, 1996). Even governments like England and Sweden who have high government involvement in financing health care take the precautions necessary to give physicians a great deal of autonomy (Fuchs, 1996).

Market competition can be a problem as well if corporations are strictly concerned with maximizing profits. However; by giving physicians the ability to lead the system and generate good but not excessive profits they will collaborate with all participants in the system for the good of the patient (Fuchs, 1996). The need for collaboration among health care professionals is even greater now because of the increased complexity of health care and health care education systems.

Leathard points out that collaboration is necessary in complex systems like healthcare and social services on an international level (Leathard, 2003). It would seem that the increasing complexity in the United States, disjointed, health care system and complex healthcare higher education systems would require collaboration among professionals in health, social services and education to become more efficient and effective. As healthcare professionals work with one another for the best interest of the patient's health this could result in more efficient quality healthcare. When health care professionals concern themselves with values and collaborate with all stakeholders the patient will receive personalized attention and concern from a provider that will result in more informed patient who works cooperatively with the provider to better their health (Fuchs, 1996).

The model the school-linked health center (SLHC) created by (Ballard & Fothergill 1998) addresses the adolescent population. The model does provide

comprehensive care to adolescents. It does not fit the "CHOICES" model. SLHC's receive public and private funding, (62 percent) of their funding from Medicaid, (14 percent) from state services, and (19 percent) from local services.

Implementing SLHC may be a way for local and state governments to capture more Federal funding as was recommended by (Blake, Hawkins, Rosenbaum E. & Rosenbaum S., 1998). Creative partnerships with State and Local government and non-profit entities may be a way to improve the health care in local municipalities and states that have serious disparities in their health care systems. However future research to assess long term effectiveness is needed.

Conclusions

Although this was a small n study of only one health service program in a local Florida county and the results can only be generalized to that county. This case demonstrates what can be done to help eliminate contention over legality that stems from implementing programs without a vote from the people on the local level.

By bringing voters into the policy creation process contention over whether or not the program was legal was eliminated. There is still an argument in Alachua County over the effectiveness of the program and that is a lesson to be learned for current and future policy entrepreneurs in Alachua County when garnering support. A clear definition of how health service programs will be evaluated should be included in the development of the programs.

The following questions were asked in previous chapters: What impact has local support at the precinct level in Alachua County had on the implementation of

"CHOICES"? Because the public voted for "CHOICES" Alachua County was able to increase access to care for enrollees, they increased the healthiness of the enrollees, and they increased the disposable income of enrollees. 2) Has the overall health of Alachua County residents improved? Yes, the overall health of Alachua County enrollees in the "CHOICES" health service program has improved. And 3) Can the "CHOICES" case study be used to create an innovation framework that can provide a useful lens for future research at the county level in regards to adoption? Yes this case study can be used to educate public officials about a health service program in a local jurisdiction that was effective. A framework has been developed that can be used for future research. 4) Has the "CHOICES" program provided quality health care for the medically underserved? Quality is difficult to determine, but they did increase access for the uninsured to receive primary preventative care.

Who should provide care to the indigent and working poor? The role of government is not to become providers for everyone the role of government is to collaborate and help fill in gaps when they are identified. Is it the proper role of government in society to take care of those who cannot take care of themselves? This is a question about values and what values society holds dear. One way to determine what society wants is to allow them to vote on questions to tell elected officials what to do and what societies values are.

Summary

The purpose of this study when it began was to examine the creation, implementation, and adoption of the "CHOICES" health services program. The specific aims were threefold: 1) Identify the factors that influenced the creation of the "CHOICES" program: 2) Describe the key role of public policy entrepreneurs who were part of the process of adoption: and 3) Provide researchers and government officials with a documented explanatory model of a purported effective comprehensive primary preventative care program.

The social, economic, political and demographic factors were analyzed and the predictor variable was identified. Public policy entrepreneurs were a significant part of the policy adoption process in Alachua County and without them the chances of adoption occurring would have been less. This research will provide researchers, elected officials, appointed officials and those interested in this topic with a documented explanatory model of the creation and implementation of the Alachua Referendum which became the "CHOICES" health services program. It can be used by current public policy officials in Alachua County to answer some questions about the "CHOICES" health services program and the closeness of the race in the primary election.

Appendix A. General Research Question

Fiscal Year Number Enrolled Members	Percent Increase
Q1: What are the factors associated with the adoption of the “CHOICES” health services program in Alachua County, Florida?	H1: Social, economic and political factors will be significant in predicting the adoption of the “CHOICES” health services program.

Appendix B. Focused Research Questions

Fiscal Year Number Enrolled Members	Percent Increase
Q1: Which political motivation factors have the strongest relationship with the adoption of innovation the “CHOICES” health services program in Alachua County, Florida?	H1: Precincts that have a majority of Democrats will be more likely to adopt “CHOICES”
Q2: Which economic motivation factors have the strongest relationship with the adoption of the “CHOICES” health services program in Alachua County Florida?	H2: 1) Precincts with higher home values will be more likely to adopt “CHOICES”. 2) Precincts with higher household incomes will be more likely to adopt “CHOICES” 3) Precincts with more private businesses will be more likely to adopt “CHOICES”
Q3: Which social motivation factors have the strongest relationship with the adoption of the “CHOICES” health services program in Alachua County, Florida?	H3: 1) Precincts with higher female populations will be more likely to vote to adopt the “CHOICES” health service program. 2) Precincts with larger non white populations will be more likely to vote to adopt the “CHOICES” health services program. 3) Precincts with higher median education will be more likely to adopt the “CHOICES” health services program

Q4: How did the public express leadership in the creation of the “CHOICES” health services program?	H4: If the public has an opportunity to express their wants than leadership was supplied by the public.
Q5: What organizational factors have the strongest relationship with the adoption of the “CHOICES” health services program in Alachua County, Florida?	H5: 1)Size of the precinct and wealth of the precinct will have the strongest relationship to adoption.
Q6: What role will socioeconomic status and education play in the adoption of the “CHOICES” health services program?	H6: 1) Precincts with higher education will be more likely to adopt.

Appendix C. Qualitative Research Questions

Fiscal Year Number Enrolled Members	Percent Increase
Q1: Which individuals and groups advocated for the development and adoption of a comprehensive primary preventative care program targeting the non-elderly uninsured residents of Alachua County, Florida? Q2: What sources of information were used within the districts to guide policy entrepreneurs decisions about which preventative care program would be adopted? Q3: How do policy entrepreneurs impact the adoption of “CHOICES”? Why did policy entrepreneurs choose to become involved with the adoption of “CHOICES”? What time constraints existed with the adoption of “CHOICES”? Who are the policy entrepreneurs associated with the adoption of “CHOICES”?	

Appendix D. “CHOICES” Membership by Fiscal Year and Percent Increase

Fiscal Year	Number Enrolled Members	Percent Increase
2005-2006	455	100%
2006-2007	1141	151%
2007-2008	1826	60%
2008-2009	2671	46%
2009-2010	3340	25%
2010-2011	3500	5%

Note. Alachua County, 2010-2011

Appendix E. “CHOICES” Enrollee Affordability

	Before Enrollment in “CHOICES”	After Enrollment in “CHOICES”
Percent Enrollees Delay Medical Care because of cost with Physician	72%	5.9%
Percent Enrollees Delay Medical Care because of cost with Specialist Care Physician	68.4%	9.4%
Can't Afford Prescriptions	66.1%	8.3%
Enrollees spending $100 or less on Health Care Before	39.5%	64.3%
Didn’t Receive Needed Treatment or Medical Tests Because of Limited Coverage	67.3%	10.0%
Delayed Medical Care Because the Wait Was too Long to See a Doctor	32.5%	8.0%
Did not Have Insurance Because they Could not Afford it.	53.1	80.6
Those Without Insurance Stated the major Reason “could not afford it”	72	
Americans Between 18 & 64 who are	18.1%	

Employed and do not have insurance U.S.

Census

Appendix F. "CHOICES" Enrollee Healthiness

	Before Enrollment in "CHOICES"	After Enrollment in "CHOICES"
Did not Go to Emergency Room	50.4%	74.9%
Admitted 1-5 Times Emergency Room	44.3%	22.7%
1-5 Visits to Urgent Care	32.2%	13.6%
Never Missed Day of Work Before	41.6%	62.5%
Overall Health Excellent Good or Fair	88.2%	97.7%
Overall health "poor"	11.8%	2.4%

Appendix G. “CHOICES” Enrollee Increase in Health Coverage

	Health Coverage Before Enrollment in “CHOICES”
1) Without Coverage for more than 2 years	53.1%
2) Enrollees who had coverage before “CHOICES” received benefits from employer	45.9%
3) Percent Spending Less on Health Care Increasing Disposable Income	56.5%
4) Enrolled in “CHOICES” less than 12 months	52.3%

Appendix H. Mean, Standard Deviation, and Standard Error Raw Descriptive Data

Descriptive Statistics				
	N	Mean	Std. Error	Std.Deviation
Current_Voting_Population	70	3188.4571	1573.12920	13161.74315
White_Population	70	2362.8286	1166.16684	9756.85177
Black_Population	70	423.8571	210.97791	1765.16786
Hispanic_Population	70	105.3429	52.38485	438.28311
Other_	70	296.4286	147.17835	1231.38246
White_Male_Population	70	1082.0571	534.06561	4468.31343
Other_Male_Population	70	287.2857	142.06884	1188.63322
White_Female_Population	70	1259.6000	621.67531	5201.30884
Other_Female_Population	70	439.8286	217.93655	1823.38800
Sex_Unspecified	70	122.4571	61.35409	513.32516
@1850_Years_of_Age	70	2059.8857	1017.55911	8513.51034
@51_Years_of_Age_Up	70	1153.9714	569.77808	4767.10546
Households	39	7494.3846	705.66206	4406.85813
Average_Houshold_Size	39	2.3510	.03516	.21957
Average_House_Value	39	$91,864.102564	$4,206.2072362	$26,267.7557711
Average_Household_Income	39	$33,007.000000	$2,265.5580345	$14,148.4053909
Number_of_Businesses_	39	441.0000	46.12928	288.07729
Number_of_Employees	39	6504.3846	758.76293	4738.47301
Annual_Payroll	39	$150,192,879.179487	$19,477,135.6270581	$121,634,673.0055120
Land_Area_sq_miles	39	2795.7001	2761.25103	17244.00713
Water_Area_sq_miles	39	.9806	.35702	2.22957
Number_Registered_Voters	69	1842.5072	82.19338	682.74949
Times_Counted	69	450.4203	25.19196	209.26014
Total_Votes	69	440.5797	24.75646	205.64257
VoteFor	69	217.2029	13.09225	108.75236
VotesAgainst	69	223.3768	15.09248	125.36759
Dem	69	839.3913	38.63631	320.93729
Rep	69	468.9565	31.26858	259.73632
NPA	69	272.0725	23.51010	195.28955
Other_1	69	26.7391	1.98488	16.48765
Liber_	69	6.3043	.53692	4.45997
Green	69	3.8696	.52145	4.33153
Valid N (listwise)	39			

Appendix I. Results Pearson Correlation

Variable	Pearson r	p-value
Zip2	69	.000**
OthrFeMalPop	69	.017*
Age18_50	69	.060
Age51up	69	.027*
Households	69	.000**
AvgHousSiz	69	.000**
AvgHousVal	69	.000**
AvgHousIncom	69	.000**
AnnPay	69	.026*
LandArea	69	.000**
WaterArea	69	.014*
NumRegVot	69	.041*
FullCityMngr	69	.049*
Council_StMay	69	.049*
Dem	69	.054
NPA	69	.032*

Note. *p<0.05; **p<0.01

Appendix J. Mean, Standard Deviation, and Standard Error of Coded Descriptive Data

Descriptive Statistics				
	N	Mean	Std. Error	Std. Deviation
Zip2	69	.74	.053	.442
OthrFeMalPop	69	.12	.039	.323
Age18_50	69	.58	.060	.497
Age51up	69	.20	.049	.405
Households	69	.84	.044	.369
AvgHousSiz	69	.25	.052	.434
AvgHousVal	69	.25	.052	.434
AvgHousIncom	69	.19	.047	.394
AnnPay	69	.07	.031	.261
LandArea	69	.75	.052	.434
WaterArea	69	.09	.034	.284
NumRegVot	69	.51	.061	.504
FullCityMngr	69	.94	.028	.235
Council_StMay	69	.94	.028	.235
Dem	69	.61	.059	.492
NPA	69	.06	.028	.235
Valid N (listwise)	69			

Appendix K. Results Logistic Regression

Variables	B	S.E.	Wald	df	Sig.	Exp(B)
Zip2	-21.087	40193	0	1	1	0
OthrFeMalPop	18.702	10869.05	0	1	0.999	1.33E+08
Age18_50	-0.536	1.215	0.195	1	0.659	0.585
Age51up	-2.009	0.942	4.549	1	0.033	0.134
Households	1.269	40639.07	0	1	1	3.557
AvgHousSiz	-41.159	60295.79	0	1	0.999	0
AvgHousInco	-2.417	43005.43	0	1	1	0.089
AnnPay	-13.41	42931.01	0	1	1	0
WaterArea	0.722	36588.79	0	1	1	2.058
NumRegVot	0.138	1.18	0.014	1	0.907	1.148
FullCtyMgr	-1.753	27216.06	0	1	1	0.173
Dem	1.444	1.04	1.929	1	0.165	4.238
NPA	18.367	17403.57	0	1	0.999	94768272
Constant	21.687	60730.95	0	1	1	2.62E+09

Appendix L

Variable Relationship Model

	Independent Variables						
	*Statistically Significant Predictor Variable						
	Zip2	OthrFeMalPop	*Age18_50	Age51up	Households	AvgHousSiz	AvgHousInco
Relationship to Dependent Variable	+	+	+	+	+	+	+
	AnnPay	WaterArea	NumRegVot	FullCtyMgr	Dem	NPA	
Relationship to Dependent Variable	+	+	+	+	+	+	

Appendix M

Policy Analysis

Goals & Deductive Questions	Impact Category	Policy Alternatives		
		Keep "CHOICES"	Eliminate "CHOICES"	Reinstate "CHOICES"
Help the uninsured residents of Alachua County to stay healthy: 1) What percent increase or decrease of enrollees missed work after enrollment in "CHOICES"? 2) What percent increase or decrease of enrollees could not purchase prescription medications afte	Missed Work	Presently Enrollees report missing fewer days of work	Enrollees who are not covered by the PPACA will be without primary preventative care and will miss more work	Continuing the program will allow the population that the PPACA does not cover to maintain primary preventative care
	Prescription Medication	Presently Enrollees have the prescription medications they need because they can afford to purchase them thanks to "CHOICES"	Enrollees who are not covered by the PPACA will be without prescription medications	Continuing the program will allow the population that the PPACA does not cover to continue purchasing their prescription medications
	Overall Health	Presently Enrollees state their overall health is better after enrollment in "CHOICES"	Enrollee Health will begin to decline for those not covered by the PPACA	Continuing the program will allow the population that the PPACA does not cover to maintain their overall health
Provide access to services working uninsured residents need but have put off due to a lack of adequate health coverage: 1) What percent increase or decrease of enrollees spend less on healthcare? 2) What percent increase or decrease of enrollees did not r	Insurance	The PPACA requires all enrollees to pay for insurance "CHOICES" increases the disposable income of enrollees to help them to afford this expense	Enrollees will miss more work have less disposable income and still be required to purchase health insurance	This will allow enrollees to have more disposable income to purchase health insurance
	Medical Tests	Enrollees will continue to receive the medical tests they need to maintain health	Unless covered by the PPACA enrollees will not receive the medical tests they need to maintain health	This will allow enrollees to receive the medical tests they need to maintain health
Reduce emergency room visits and increasing the utilization of primary preventative care services: 1)What percent increase or decrease was there for enrollees in "CHOICES" in regards to emergency room visits? 2) What percent increase or decrease was there	Emergency Room Visits	Enrollee Emergency Room Visits went down	Enrollees not covered by the PPACA will have an increase in emergency room visits	Enrollee Emergency Room Visits will decrease or stay constant depending on enrollment
	Visit Primary Care Doctor	Enrollees visit the primary care physician	Enrollees not covered by the PPACA will not see the primary care physician and will wait until they need emergency services	Enrollees not covered by the PPACA will continue to see their primary care physicians
	Visit Specialist	Enrollees visit specialists	Enrollees not covered by the PPACA will not see the specialist and will wait until they need emergency services	Enrollees not covered by the PPACA will continue to see their specialists
	Urgent Care Visits	Enrollee Urgent Care Visits went down	Enrollees not covered by the PPACA will have an increase in Urgent Care visits	Enrollee Urgent Care Visits will decrease or stay constant depending on enrollment

Appendix N

Analysis of Policy Categories

Goals & Deductive Questions	Impact Category	Increase or Decrease in "CHOICES" Policy Categories				
		Keep "CHOICES"	Percentage	Percent Increase or -Decrease	Before	After
Help the uninsured residents of Alachua County to stay healthy: 1) What percent increase or decrease of enrollees missed work after enrollment in "CHOICES"? 2) What percent increase or decrease of enrollees could not purchase prescription medications afte	Missed Work	Presently Enrollees report missing fewer days of work	63%	-50%	42%	63%
	Prescription Medication	Presently Enrollees have the prescription medications they need because they can afford to purchase them thanks to "CHOICES"	8%	87%	66%	8%
	Overall Health	Presently Enrollees state their overall health is better after enrollment in "CHOICES"	97.7% (28.3% Excellent, 56.1% Good, 13.3% Fair, 2.4% poor)	11%	88%	98%
Provide access to services working uninsured residents need but have put off due to a lack of adequate health coverage: 1) What percent increase or decrease of enrollees spend less on healthcare? 2) What percent increase or decrease of enrollees did not r	Insurance	The PPACA requires all enrollees to pay for insurance "CHOICES" increases the disposable income of enrollees to help them to afford this expense	64%	63%	40%	64%
	Medical Tests	Enrollees will continue to receive the medical tests they need to maintain health	10%	85%	67%	10%
Reduce emergency room visits and increasing the utilization of primary preventative care services: 1)What percent increase or decrease was there for enrollees in "CHOICES" in regards to emergency room visits? 2) What percent increase or decrease	Emergency Room Visits	Enrollee Emergency Room Visits went down	75%	-49%	50%	75%
	Visit Primary Care Doctor	Enrollees visit the primary care physician	6%	92%	72%	6%
	Visit Specialist	Enrollees visit specialists	9%	86%	68%	9%
	Urgent Care Visits	Enrollee Urgent Care Visits went down	83%	-28%	65%	83%

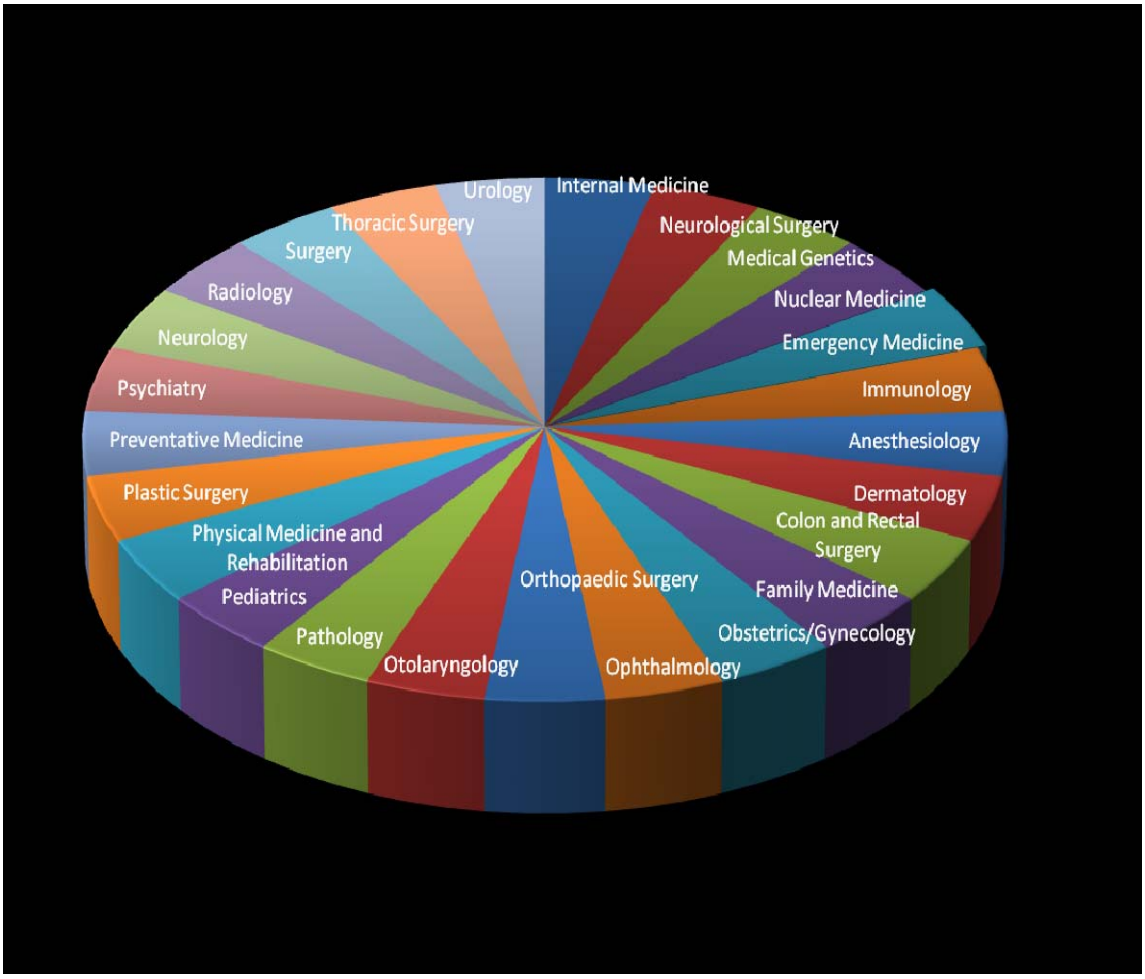
Appendix O

List of Coded Variables

LegCasBal	PRCT	PRCT Name	PRCTLocation	City	State	Zip
Nominal	Interval	Nominal	Nominal	Nominal	Nominal	Interval
Current Voting Population	**White Population**	**NonWhite Population**	**Black Population**	**Hispanic Population**	**Other**	**White Male Population**
Interval GT1500 0=LT1500 1=GT1500	Interval GT1500 0=LT1500 1=GT1501	Interval GT1500 0=LT1500 1=GT1502	Interval GT1500 0=LT1500 1=GT1502	Interval GT1500 0=LT1500 1=GT1503	Interval GT1500 0=LT1500 1=GT1504	Interval LT500=0 GT500=1
Other Male Population	**White Female Population**	**Other Female Population**	**Sex Unspecified**	**18-50 Years of Age**	**51 Years of Age Up**	**Households**
Interval LT500=0 GT500=2	Interval LT500=0 GT500=3	Interval LT500=0 GT500=4	Interval LT500=0 GT500=5	Interval LT800=0 GT800=1	Interval LT800=0 GT800=2	Interval LT1500=0 GT1500=1
Average Houshold Size	**Average House Value**	**Average Household Income**	**Number of Businesses**	**Number of Employees**	**Annual Payroll**	**Land Area sq miles**
Interval LT.5=0 GT.5=1	Interval LT<20,000=0 GT20,000=1	Interval LT10,000=0 GT10,000=1	Interval LT90=0 GT90=1	Interval 0=LT1300 1=GT1300	Interval LT25mil=0 GT25mil=1	Interval LT200=0 GT200=1
Water Area sq miles	**Number Registered Voters**	**Times Counted**	**Total Votes**	**VoteFor**	**>50%VtFor**	**FullCtyMgr**
Interval LT.3=0 GT.3=1	Interval LT1800=0 GT1800=1	Interval LT400=0 GT400=1	Interval LT400=0 GT400=1	Interval LT180=0 GT180=1	GT50%=1 For- LT50%=0 Against	1=Full 0=Part
FullMayor	**Council/StrMay**	**Website**	**MajDem**	**Dem**	**Rep**	**MajRep**
1=Full 0=Part	1=Council 0=Strong	Nominal	Nominal 1=Majority Democrat 0=Mjority not Democrat	Interval LT 700=0 GT 700=1	Interval LT700=0 GT700=1	Nominal 1=Majority Republican 0=Majority not Republican
NPA	**Other**	**Liber**	**Green**	**AL_EMP**	**FL_EMP**	
Interval LT700=0 GT700=1	Interval LT700=0 GT700=2	Interval LT700=0 GT700=3	Interval LT700=0 GT700=4	LT6.7=0 GT6.7=1	LT6.7=0 GT6.7=1	

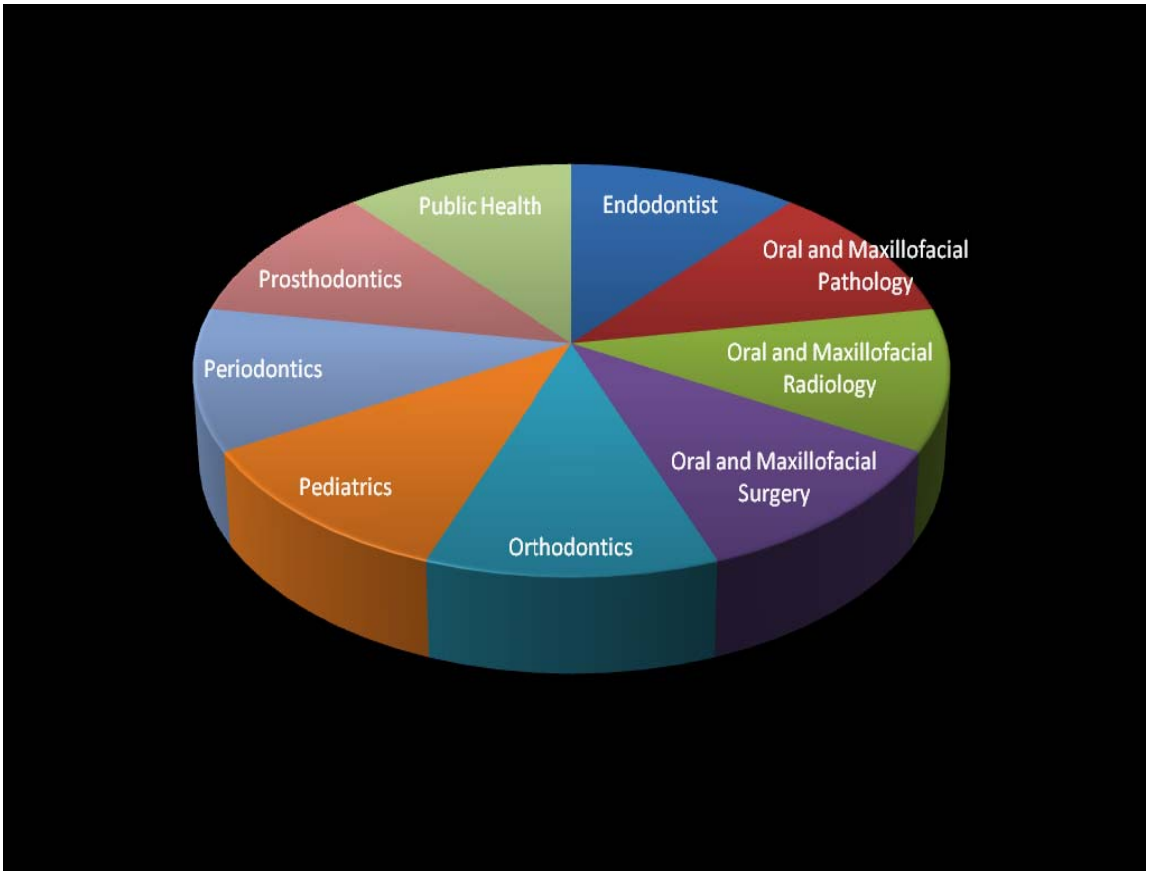
Appendix P

Physician Specialties



Appendix Q

Dental Specialties



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