
Summit on Streamlining the Health Care System: Action Options for Colorado

December 4, 2003

Summit Summary and Action Priorities

prepared by
Yondorf & Associates

for
Colorado Coalition for
the Medically Underserved

Funding provided by Caring for Colorado Foundation, The Colorado Trust,
COPIC, Exempla Healthcare, HealthONE, Colorado Association of Health Plans,
and Carol K. Gossard in memory of Dr. Abe Kauvar

Table of Contents

| | |
|---|----|
| Executive Summary | i |
| Introduction | 1 |
| Summit Opening | 1 |
| Session 1 – Streamlining the Health Care System: More on What Works | 1 |
| <i>Reengineering Colorado’s Health Care Delivery System—An Action Agenda</i> | 1 |
| <i>Preferred Drug Lists—Do They Really Save Money?</i> | 2 |
| <i>Stretching the Health Care Dollar—Leveraging and Program Consolidation Options</i> | 2 |
| Session 2 – Developing a Viable Strategy for Change: Ask the Experts | 3 |
| Participant Support for Streamlining Options—Results of Balloting | 5 |
| Session 3 – Small Group Discussions: Action Steps and Obstacles | 18 |
| Suggested Next Steps that CCMU Should Take | 10 |
| Summit Evaluation | 11 |
| Summit II Participants | 17 |

©2003, Colorado Coalition for the Medically Underserved. Permission is granted to reproduce this material, in whole or in part, for educational and non-profit purposes, with acknowledgement of copyright ownership.

Streamlining the Health Care System: Action Options for Colorado

CCMU Summit Part II, December 4, 2003

Executive Summary

On December 4, 2003, more than 50 Colorado business leaders, program directors, legislators, consumer and provider organization representatives, and federal and congressional office representatives met in Denver at a “Summit on Streamlining the Health Care System: Action Options for Colorado.” This was the second of a two-part summit on health care streamlining convened by the Colorado Coalition for the Medically Underserved; the first part was held November 3, 2003. The purpose of the second summit was to provide more in-depth information about streamlining options and their potential to free up dollars to expand access, and to develop an action agenda.

Participants heard from a panel of experts about three specific streamlining strategies about which attendees at the first summit had asked for more information. They included the chronic/planned care health delivery model, preferred drug lists based on evidence of effectiveness and cost, and fund leveraging and program consolidation strategies. A second panel offered advice on how to develop the political, public and special interest will to make the health care system more efficient and effective.

Midway through the summit, participants filled out a ballot asking about their support for, interest in, or opposition to a list of action steps designed to streamline the health care system. Participants received background information on each of the options before the summit in a white paper entitled, “Streamlining the Health Care System: Options for Colorado.” The ballot results showed:

- There was widespread support for and little or no opposition to:
 - ✓ Improving the management of emergency services by working with the provider community to extend the availability of after-hours and weekend primary and urgent care and doing more patient education on appropriate emergency room use.
 - ✓ Establishing a joint prescription drug purchasing program across state health care programs and/or with other state Medicaid programs.
 - ✓ Using an evidence-based preferred drug list (PDL) for Medicaid and CHP+.
 - ✓ Providing core benefits to healthy Medicaid and CHP+ children under the same plan.
- Almost all participants said they either supported or were interested in finding out more about:
 - ✓ Conducting a broad public awareness campaign about the need to streamline the health care system and the options under discussion.
 - ✓ Allowing people to apply for Medicaid and CHP+ coverage via the Internet.
 - ✓ Working with insurers to encourage them to promote/give preference to providers using the planned/chronic care model.

- ✓ Making small efficiency fixes to Medicaid and CHP+.
- ✓ Designing a standard benefit plan that would be available across all public and private programs.
- ✓ Working with employers to include planned care elements in quality report cards.
- ✓ Simplifying the Medicaid and CHP+ asset tests.
- ✓ Repealing TABOR to increase fiscal flexibility.
- ✓ Doing a more detailed analysis of all of the streamlining options under consideration to determine which ones could 1) yield the greatest streamlining savings, and 2) produce the most funds for use in expanding health care access.
- ✓ Providing preventive care for persons with severe disabilities.
- ✓ Encouraging Medicaid managed care contracting.
- ✓ Providing all Medicaid and CHP+ enrollees access to a 24-hour nurse advice line.
- ✓ Making it easier for those needing long-term care to access technology by streamlining the approval system for equipment that contributes to increased self-sufficiency.
- ✓ Requiring nursing homes to ask patients twice a year for their preferences for level of care in the event of an acute medical problem (e.g., pneumonia, stroke) in order to eliminate unwanted care.
- ✓ Establishing a universal coverage system along the lines of the Federal Employees Health Benefits Plan.
- ✓ Leveraging more funds for indigent care by collecting a hospital/provider tax, drawing down federal match, and returning money to providers via expanded Medicaid/CHP+ program or better reimbursement rates.

At the end of the summit, participants met in small groups to discuss the action steps described above, and to identify obstacles to change and strategies for overcoming them.

- Examples of identified obstacles included lack of leadership, lack of political will, conflict about the appropriate role of government, inconsistent messages, failure to align incentives with desired changes, and maintaining momentum.
- Suggested strategies for achieving change and overcoming obstacles included focusing on the marketing of social changes; getting everybody “on message;” supporting more demonstration projects; promoting greater system integration; developing more effective state-federal working relationships; establishing a strong collaborative process; and doing more public education and better advocacy.

In terms of next steps, summit attendees recommended that CCMU narrow down and advance one to three specific focused proposals, continue the dialogue, and build a coalition for change.

CCMU Summit on Streamlining the Health Care System: Action Options for Colorado

Introduction

On December 4, 2003, 50 Colorado leaders with an interest in health care gathered for the second part of a two-part summit on “Streamlining the Health Care System: Action Options for Colorado.”¹ The summit was convened by the Colorado Coalition for the Medically Underserved.² Funding for the summit was provided by **Caring for Colorado Foundation, The Colorado Trust, COPIC, Exempla Healthcare, HealthONE, Colorado Association of Health Plans, and Carol K. Gossard in memory of Dr. Abe Kauvar.**

The second summit was structured to respond to feedback from Summit I participants and to produce action-focused recommendations for consideration by policy makers and other health care constituents. In advance of the event, participants received an updated draft of a background paper describing 20 streamlining options that were the focus of the first summit.³

Summit Opening

Dr. Gary Vander Ark, Chair of the Colorado Coalition for the Medically Underserved and Director, Neurosurgery Residency Program at the University of Colorado Health Sciences Center, opened the summit. He noted that the November conference and summit on health care streamlining had provided provocative information and perspectives and generated considerable discussion about potential options for how we might achieve a better functioning health care system in Colorado. The purpose of Summit II is to start from where we left off. It is designed to respond to summit participants’ requests for additional information and to move a streamlining action agenda forward.

Session 1 - Streamlining the Health Care System: More on What Works

Presentations

Reengineering Colorado’s Health Care Delivery System - An Action Agenda

- Cory Sevin, RN, MSN, Vice President of Clinica Campesina, discussed the issues and challenges faced by providers and delivery systems in sustaining and expanding implementation of the chronic/planned care model. As a clinic serving a large number of the uninsured individuals, Clinica Campesina participated in a pilot to implement the chronic care model and is nationally recognized for demonstrated improvements in

¹ The first summit was held in Denver on November 3, 2003. For more on that event, see “Meeting Summary—Streamlining the Health Care System: Options for Colorado, November 3, 2003,” prepared by Yondorf & Associates for the Colorado Coalition for the Medically Underserved.

² The Colorado Coalition for the Medically Underserved is dedicated to improving care and coverage for Colorado’s underserved through a variety of public and private mechanisms. Founded in 1997, CCMU is an all inclusive, bipartisan effort. It is made up of a diverse group of organizations and individuals who share a commitment to access to quality, affordable health care for all of Colorado's citizens. Members of the Coalition include provider, business, insurance, consumer, government and foundation representatives.

³ See: Nellie Hester and Dann Milne, “Streamlining the Health Care System: Options for Colorado,” prepared by Yondorf & Associates for the Colorado Coalition for the Medically Underserved, 2003.

patient health status and cost savings. However, for the most part these savings have accrued to others – hospitals and health insurers. Ms. Sevin asserted that these entities don't recognize that they have these savings nor do they attribute these savings to their source. Ironically, these same entities, which have historically provided subsidies to Clinica Campesina as an indigent care provider, are now withdrawing these supports. Emphasizing that Clinica and other providers must be able to capture the efficiency savings from implementing planned care to sustain delivery system improvements, Ms. Sevin offered several recommendations necessary for successful delivery system streamlining including:

- Align incentives among systems of care;
- Strengthen Medicaid managed care; provide technical assistance, incentives, and rewards to providers and systems who implement planned care;
- Work with insurers and others to promote informatics and electronic medical records; and
- Incorporate implementation of planned care/chronic care model into standards for public quality reporting and contracting.

Ms. Sevin referred participants to the background paper “Promoting the Planned Care Model, Action Options” prepared by conference consultant staff for additional discussion of action options.

Preferred Drug Lists – Do They Really Save Money and What About Special Situations?

- Richard Cauchi, Program Manager, Health Care Program of the National Conference of State Legislatures, offered a detailed look at the use of preferred drug lists (PDLs) in Medicaid and the pros and cons of state Medicaid PDLs. He defined a PDL as a formal list of specific drug products, both preferred and non-preferred, that constitute a drug benefit. A significant feature of PDLs is that they are generally based on both medical effectiveness as well as cost-effectiveness. Mr. Cauchi acknowledged that use of PDLs in Medicaid requires attention to legal requirements, state plan features, and other design details such as exception processes. Trends indicate that:
 - Slightly over a third of states currently operate with PDLs;
 - Most have some type of exception policy;
 - Mental health drugs are increasingly included; and
 - States are implementing a variety of cost containment strategies, such as supplemental manufacturer rebates.

Citing one example of a state-based collaborative initiative, Mr. Cauchi described the national Multi-State Pooling Initiative, where participating states will purchase jointly, use a PDL list, and negotiate supplemental rebates for Medicaid.

Supplemental materials provided as handouts included a compilation of information on state use of state preferred drug lists, and a sample PDL from Illinois Medicaid and SeniorCare.

Stretching the Health Care Dollar – Leveraging and Program Consolidation Possibilities

- Barbara Yondorf, President, Yondorf & Associates, Health Policy Consultants, challenged summit participants to consider the implications of leveraging federal funds

through investment of public and private health care funds. She provided an overview of current state expenditures drawn from her analysis, “Colorado Health Care Spending on the Uninsured Medically Indigent.” (She discussed three options for leveraging private and state-only expenditures:

- Collect unmatched indigent care funds via provider taxes, which can then be returned to providers in the form of expanded Medicaid/CHP+ programs and/or higher reimbursement rates.
- Consider an individual pay-or-play approach, requiring individuals to either demonstrate proof of coverage or pay a small income tax surcharge or uninsured service fee, as a way to leverage out-of-pocket expenditures by the uninsured.
- Take advantage of additional opportunities for refinancing, for example by using unmatched tobacco settlement funds for comprehensive primary and preventive care grants, and using unmatched state funds for intervention services for 0-3 year old children through Developmental Disabilities Services.

Ms. Yondorf also addressed opportunities to consolidate programs with similar functions to achieve economies of scale. Highlighting other states as examples, she discussed:

- Covering healthy Medicaid and CHP+ children under the same program in order to: keep seamless coverage for children when parent’s income changes and during transitions to private coverage; facilitate an employer buy-in program; and tailor benefits for a population of healthy children.
- Consolidating state purchasing, considering that the state is a major health care purchaser for state employees, Medicaid, CHP+, indigent, prisoners, uninsurable, etc.

Panel - Audience Discussion

Following these presentations, the three experts responded to audience questions. Topics of discussion included:

- Concern over whether the chronic care model promotes or potentially disrupts links between individuals, their clinical care provider, and community resources;
- Realities of administering preferred drug lists; and
- Whether leveraging Medicaid dollars in Colorado can include receiving a match for case management expenditures.

Session 2 - Developing a Viable Strategy for Change: Ask the Experts

A distinguished panel of experts offered advice and answered questions about the politics, challenges and opportunities to achieve real change. Panelists included:

- Eric Anderson, President, Sonderman E-Squared (public policy communications)
- Travis Berry, Vice President, Dutko Group (lobbying)
- Rosario C de Baca, Health Coordinator for LARASA (grassroots/community organizing)
- Sharon Sherman, Managing Principal, GBSM (communications)
- Jay Want, MD, President, Physician Health Partners (physician practice management)

Panelists offered the following points in response to two questions:

Panel on Developing a Viable Strategy for Change: Ask the Experts

Question #1: What major piece of advice do you have for achieving the kinds of systemic streamlining change under discussion?

- Appeal to bottom line self-interests of different groups within a range of good policy options. (Anderson)
- Speak the language of different constituencies, not abstract public policy concepts. (Anderson)
- Craft a specific proposal--identify 1 or 2 things and put them on paper, to be a roadmap. (Berry)
- Identify your coalition. You need to have a base of people who you can count on to really want what you want, because not everyone can be with you--there will be winners and losers. (Berry)
- Figure out how to mobilize people to action who may not realize or want themselves to be part of the change (e.g. Ceasar Chavez). (C.de Baca)
- People have to find a way to be connected to an idea for change – you have to start with what does health and health care really mean to different types of people. (C.de Baca)
- You have to confront what business you are in – the business of marketing social change. You need to delve into what works and what doesn't. (Sherman)
- The accomplishments of the Conservative Right illustrate the type of strategic investment that can significantly change public dialogue including: money on message, getting message out (created own media), scholarships to create a whole ideological generation, and unfettered relationships with major funders to support long term investments. (Sherman)
- To influence physicians, you need to form a coalition that mimics the influence of dominant payers (e.g. 30-50% of physician office traffic). Need a coherent “voice.” (Want)
- Set one consistent set of performance standards and create incentives (Want)

Question #2: How can CCMU make sure that savings from streamlining are used to expand health care access and not, for example, road construction, insurance company stockholder dividends, or other legislative interests?

- The first challenge is quantifying savings when we have most often really been talking about constraining costs. (Anderson)
- Key to communication is don't promise if you can't show at the end. When crafting the message, state expectations for what can be delivered, then you can maintain accountability. (Sherman)
- There needs to be a tangible return on investment for doctors. There are philosophical issues about who profits from preventive care and quality improvement--benefits from quality improvement need to derive to anyone. This conference is a remarkable coalition of people under the tent – needs to be the kind of basis for discussion about these issues.
- It's difficult on the public side. On the private side, entities can stabilize more effectively. It seems like they are achieving goals de facto if they individually look like they perform well. (Berry)
- We need to understand health in a broader context e.g. costs of prisons, lack of an effective mental health system. (C de Baca)
- Messages for populations differ. Vulnerable populations with more complicated needs fear they would lose from the chronic care model.

- continued -

| |
|--|
| Panel on Developing a Viable Strategy for Change <i>(continued)</i> |
| <i>Question #2 (continued)</i> |
| <ul style="list-style-type: none"> • We need to look more broadly at health care solutions, such as spreading costs more reasonably, not just at containing costs. • When people don't get what they should, it drives costs in many places. How do you sell "better for all" when it is hard to put specific ROI in everybody's pocket? • An example of selling this kind of thing is the effort by the Culture and Scientific District initiative that went after a theme of "what matters to us" targeting older Americans. • The health care system is distrusted. We have to get back to an ethic of "we have to care for each other." |
| <i>Points Made During Question and Answer Period</i> |
| <ul style="list-style-type: none"> • Campaigns that succeed are focused: people see what it will do. • We have to cut things down to bite size chunks. Successful examples include the Search Institute and Assets for Youth. • You have to have a sense of deserving victory: "Never, never, never quit." We need to replace statistics with stories e.g. the local news story of Oscar the boy with cancer. • The question is often asked, why aren't people crying out more? We need to look at who is feeling the sense of crisis. How do you make the case to the people at the food court at Park Meadows mall? • The provider shortage is a complex problem. How do we keep a message with this in mind? • We have a spirit of generosity, but we need to put things in context so that we can feel that what we do will make a difference. Medical economist Uwe Reinhardt has said that the reason we don't have universal health care is because Americans are mean-spirited people. We are statistically mean in that we have the lowest tax rate of any country in the world and we make the least contribution to the world from our GNP (gross national product). • We need to reduce cognitive dissonance. Americans will always do the right thing after they exhaust all other options. We maintain convenient delusions. • There is lack of cultural competency. The state has not prepared its infrastructure, its professional schools, to deliver to its constituents. We need to develop skilled professionals with the skills needed given our particular citizens. |

Participant Support for Streamlining Options—Results of Balloting

Before breaking up into small group discussion sessions, participants were asked to fill out a Streamlining Options Action Ballot. For each of 31 action steps, they were asked to check one of the following: "Support;" "Interested but need more information;" "Oppose;" or "Don't know/No opinion." The ballots were tabulated and an average score was calculated for each action step using the following weighting: Support = 10 points; Interested = 7; Oppose = 0; Don't know = 5. The results are shown in the table that follows.

Results of Balloting on Action Steps to Streamline Colorado's Health Care System

Background: Summit participants were given a ballot with 31 choices of action steps to streamline Colorado's health care system. The action steps included strategies aimed at streamlining the delivery and organization of care, health care financing and payment, and benefits, eligibility determination and enrollment. For each action step, participants were asked to check one of the following: "Support," "Interested but need more information," "Oppose," or "Don't know/no opinion." The ballots were tabulated and an average score was calculated for each action step using the following weighting: Support = 10 points; Interested = 7; Oppose = 0; Don't know = 5.

Action Steps with an Average Score of 9.0 to 9.4 (the highest score):

- Do more patient education on appropriate/inappropriate use of the ER.
- Work with the provider community to extend the availability of after-hours and weekend primary and urgent care in order to reduce unnecessary utilization of the emergency room.
- Do joint prescription drug purchasing across state health care programs and/or with other state Medicaid programs.
- Use an evidence-based preferred drug list (PDL) for Medicaid and CHP+.
- Provide core benefits to healthy Medicaid and CHP+ children under the same plan.

Action Steps with an Average Score of 8.0 to 8.9:

- Conduct a broad public awareness campaign about the need and the options under discussion.
- Allow people to apply for Medicaid and CHP+ on the Internet.
- Work with insurers to encourage them to promote/give preference to providers using the chronic care/planned care model.
- Make small efficiency fixes to Medicaid and CHP+. (See page 22 of white paper, "Streamlining the Health Care System: Options for Colorado.")
- Design a standard benefit plan that would be available across all public and private programs.
- Work with employers to include planned care elements in quality report cards.
- Simplify the Medicaid and CHP+ asset tests.
- Repeal TABOR to increase fiscal flexibility.
- Do a more detailed analysis of all of the options to determine which ones could 1) yield the greatest streamlining savings and 2) could produce the most funds for use in expanding health care access.
- Provide preventive care for persons with severe disabilities.

- continued -

Results of Balloting on Action Steps to Streamline Colorado's Health Care System *(continued)*

Action Steps with an Average Score of 8.0 to 8.9 (continued):

- Encourage Medicaid managed care contracting, which allows plans to internally redirect funds to front-end, planned care from back-end, high cost care.
- Improve the management of emergency care services by providing all Medicaid and CHP+ enrollees access to a 24-hour nurse advice line.
- Make it easier to access technology by streamlining the approval system for equipment that contributes to increased self-sufficiency.
- Require nursing homes to ask patients twice a year for their preferences for level of care in the event of an acute medical problem (e.g., pneumonia, stroke) in order to eliminate unwanted care.
- Establish a Federal Employees Health Benefits Plan (FEHBP)-like universal coverage system.
- Leverage more funds for indigent care by collecting a hospital/provider tax, drawing down federal match, and returning money to providers via expanded Medicaid/CHP+ or better reimbursement rates.

Action Steps with an Average Score of 7.0 to 7.9:

- Use a multi-faceted strategy that includes a number of different options.
- Increase Medicaid's outreach and training efforts regarding the existing consumer-directed, personal care attendant services program.
- Allow for self-declaration of income and income deductions for those applying for Medicaid and CHP+.
- Expand the consumer-directed care option for those needing personal care attendant services to other populations (e.g., individuals with developmental disabilities).
- Where it is convenient for Medicaid recipients, require/encourage them to get their prescriptions filled at clinics that get public health pricing for drugs.
- Provide specific provider incentives, such as tax credits for investments in reengineering physician and clinic practices or higher reimbursement rates for practices that use the chronic care/planned care model.
- Eliminate the asset test for Medicaid and CHP+.

Action Steps with an Average Score of 4.2 (lowest score) to 6.9:

- Require Colorado employers to either provide employer-sponsored health insurance or pay into a fund to help subsidize coverage for their employees (the "employer pay-or-play option).
- Provide a high-deductible standard plan for everyone, make deductible expenditures nontaxable, allow consumer choice of insurers, and subsidize the deductible for those with low incomes.
- Establish a Canadian style single payer system.

Session 3 - Small Group Discussions: Action Steps and Obstacles

Participants broke into six small groups, each including diverse representation of various sectors and perspectives in attendance, for facilitated discussion of how to move forward strategically with streamlining actions. Each roundtable responded to three questions, exploring strategies to achieve streamlining of the delivery system, benefits and eligibility and enrollment, or financing and payment.

| Key Points from Roundtable Discussions about Action Steps |
|--|
| <i>Suggested Specific Next Steps</i> |
| <ul style="list-style-type: none"> • Need leadership and credible, neutral clearinghouse of information to facilitate bringing evidence-based information/practices to the forefront, promote shared learning, bring out information about delivery system changes that work, promote benchmarking, enhance collaboration, decrease fragmentation of efforts. • Develop more effective working state-federal efforts. Centers for Medicare and Medicaid Services could be more of a resource rather than just an oversight entity. • Multidisciplinary involvement and collaboration – everyone must be at the table to best meet needs/address delivery system changes. Promote effective collaborations among agencies, programs, providers and consumers; find natural partners to develop innovative approaches. • Identify focused areas for collaborative work. • Provide education and advocacy, demystify. • Reduce multiple standards, duplication of efforts. • Do better outreach for involvement of specific populations (i.e. Latinos, mental health). |

| Major Obstacles and Strategies to Overcome Them | |
|---|---|
| <i>Obstacle/Challenge</i> | <i>Strategies</i> |
| <ul style="list-style-type: none"> • Achieving political will. | <ul style="list-style-type: none"> • Need to break down the work appropriately, stay focused, use demonstration projects. |
| <ul style="list-style-type: none"> • Lack of leadership. | <ul style="list-style-type: none"> • Need more healthcare involvement by legislature and governor. |
| <ul style="list-style-type: none"> • Conflict about the role of government: should it be smaller versus it is government’s role to fix the problem. | <ul style="list-style-type: none"> • Need to address fundamental social policy issues including whether health care is a right or privilege. |
| <ul style="list-style-type: none"> • Perceptions. Need to change attitudes that change = more costs, that we are just rearranging the deck chairs on the Titanic without a real shift in direction. Not enough people really believe that there is a serious problem | <ul style="list-style-type: none"> • Use strategies suggested by expert panel on developing viable strategies for change. |

- continued on next page -

| Major Obstacles and Strategies to Overcome Them (continued) | |
|---|--|
| <i>Obstacle/Challenge</i> | <i>Strategies</i> |
| <ul style="list-style-type: none"> • Inconsistent and incorrect focus of messages (i.e., choice rather than accountability, quality). | <ul style="list-style-type: none"> • Need to categorize different ideas and solutions, find the best ways to implement, then target the right messages to the right people; change message from “costs” to “health” and “quality health care.” |
| <ul style="list-style-type: none"> • Silos are a challenge. You can’t streamline a fragmented system. | <ul style="list-style-type: none"> • Need to integrate efforts (i.e. mental and physical health care). How many silos should we have (e.g., all government programs in one, all private programs in another?) |
| <ul style="list-style-type: none"> • The health care delivery system is outmoded, a hospital-based system that is the most expensive type of care | <ul style="list-style-type: none"> • Need to reorient priorities, provide support for models that work, focus on promoting the health of individuals and populations. An urgent care system is needed to ensure follow up. Need to change reimbursement, decrease revisits to ERs--the most expensive option. |
| <ul style="list-style-type: none"> • Failure to align incentives. | <ul style="list-style-type: none"> • Must look at reimbursement issues, consider how we can promote healthy behaviors and what we penalize via premiums. Does insurance really work as a concept for health care (i.e. versus life insurance)? Need to look for efficiencies across programs and providers, streamline administration, look for providers outside the safety net willing to be part of the work to address the uninsured. |
| <ul style="list-style-type: none"> • Need to think outside the box: what we are doing isn’t working. | <ul style="list-style-type: none"> • Need to acknowledge the need for a redefined, tiered system of coverage, then focus education and efforts to achieve this. Need to confront our myths about Medicaid coverage and costs such as the assets test: does it make sense? Think about new structures like creating health districts. |
| <ul style="list-style-type: none"> • Resources, especially for recruitment and retention of rural providers/systems, education (given state budgets), technology infrastructure. | <ul style="list-style-type: none"> • Need to collaboratively pool resources, spread availability, prioritize concrete things like electronic eligibility technology. |
| <ul style="list-style-type: none"> • National versus state points of leverage, achieving state level changes when major sources of influence are national i.e. health plans, agencies. | <ul style="list-style-type: none"> • Look at strategies like a “standardized health plan” rather than a “single payer.” Creatively engage federal congressional delegation, agencies (i.e. CMS), resources like NCSL. |
| <ul style="list-style-type: none"> • Focusing the work. | <ul style="list-style-type: none"> • Need a tiered action agenda, ability to pick low hanging fruit, cultivate other ideas work toward achieving and perceived successes |
| <ul style="list-style-type: none"> • Putting faces on who really needs the services, acknowledging that we can’t solve problems by ignoring the facts of who needs the services. | <ul style="list-style-type: none"> • Getting the right people in the room, include real consumers with diverse needs and perspectives in the work. |
| <ul style="list-style-type: none"> • Maintaining momentum. | <ul style="list-style-type: none"> • Effective coalition building. |

Suggested Next Steps that CCMU Should Take

Summit participants were asked to write down their suggestions for specific next steps that the Colorado Coalition for the Medically Underserved should take as a result of the summit. Their responses are shown below:

| Participant Recommendations for CCMU Next Steps |
|--|
| <ul style="list-style-type: none">• “Be the glue to pull stakeholders together.”• “Continue on to develop options.”• “Continue dialogue.”• “White paper to analyze how to pull down federal match dollars.”• “Leveraging federal funds through provider taxes.”• “Narrow down and advance specific, focused proposals. Build coalition, do public education campaign. Remember Sharon Sherman: People can do what’s right if reminded of the need and alternative.”• “Public education. Send information about recommendations/reports to CANPO, United Way and similar networks of consumer-based organizations.”• “Identify specific streamlining mechanisms.”• “Get some \$ sponsors (industry/coalitions) to help demonstrate ideas and spread messages.”• “Create agenda of 1-3 items. Strategy to implement.”• “Take leadership role on specific issues, gather data, craft message, lobby to make change.”• “Develop a plan with members. Get organizations to buy into, support and expend political capital on.”• “Move forward with promoting chronic care model in collaborative way.”• “Work with local elected officials, then progress to federal level.”• “Medicaid/CHP+ enrollment. Legislate that money saved stay in health care.”• “Collect the hard data. Long-term proposal.”• “Share best practices such as some done with CRHC between rural communities, etc.”• “Support DHCPF proposal to combine Medicaid and CHP+ healthy kids. Chronic disease management. Medicaid rx program. Colorado rx clearinghouse.”• “Make decision and make it happen.”• “Keep in public forum.” |

Summit Evaluation

Overall summit evaluation:

- On a scale from 1 (poor) to 5 (excellent), participants gave the summit an average score of **4.4 out of 5**.

What people liked best about the summit:

- “Panel on *Developing a Viable Strategy for Change: Ask the Experts* – 3
- “Very good information from panelists. Second [viable change] panel gave great stimulating thoughts.”
- “2nd [viable change] panel was particularly good.”
- “Communications/PR [viable change] panel was one of best I’ve seen.”
- “Panel discussions.”
- “Good dialogue.”
- “The fact you are bringing leaders together.”
- “Quality of participants.”
- “The people who attended.”
- “More interactive; lots of networking.”
- “All.”
- “Small group discussions was great. Our small group with a wide variety of organizations found very common lines and ways to collaborate.”
- “Small group discussions” – 4
- “Good discussions”
- “Focused discussion. Diversity of participants. Diversity of speakers.”
- “Good speakers, focus on identifying action steps.”
- “Getting more specific/focused ideas.”
- “Desire to get to decisions to act.”
- “Great for building possibilities.”
- “The discussions and the learning.”
- “Great topics, speakers.”

What people liked least about the summit:⁴

- “Limiting the group discussion to just one small piece (our piece was tough because many of us felt we don’t directly affect or make these decisions).”
- “Needed more time for small group discussion.”
- “I need more in-depth information on some of the specific action options to make a decision of support.”
- “(Decisions are never easy!)”
- “Not enough time or structure to create agenda.”
- “Wanted to get to a group focus.”
- “Venue.”
- “Not enough time.”
- “A little more preparation by the moderator of the first panel would have been appropriate.”

⁴ 40% of respondents either did not list anything under “least” or said everything about the summit was good.

- “Left feeling like there is so much to do!!”
- “Need for more diverse opinions to actually speak up.”
- “Speakers not enough time.”
- “Too short.”
- “A lot of info—must be sure to follow-up so this momentum doesn’t disappear. Need more time to complete blue ballot.”
- “Cross disabilities coalition disruption.”
- “Disruptions by Julie.”
- “Don’t meet enough—this group can solve the problem we just need to keep focused and never, never, never surrender.”

Other participant comments:

- “Stay focused, act.”
- “Need a strategy for maintaining the momentum.”
- “More speakers from other states about what has worked.”
- “Look forward to the next summit.”
- “Value comes from action. We need to chip away at the issue by implementing some of the ideas. Choose low hanging fruit to demonstrate success.”
- “Where to from here? How to capitalize on this momentum and effect change for the better.”
- “A really tightly run conference!”
- “I can’t wait to see what will come out of this working group’s tireless efforts!”
- “Great job to Barb and team!”
- “Great job bringing a great group together.”
- “Thank you.” - 2

Summit II Participants

Chris Adams, President
The Adams Group

Eric Anderson, President
SE2

Ruth Benton, Chief Executive Officer
New West Physicians, P.C.

Travis Berry, Vice President
The Dutko Group

Donna Boucher, President
The Bates Group, Inc.

Betty Boyd, State Representative
Colorado House of Representatives

Peg Brown, Executive Director
Colorado Association of Health Plans

Jerome Buckley, MD, Chairman/CEO
COPIC Insurance Co.

Rosario C de Baca, Program Coordinator
LARASA

Richard Cauchi, Program Manager, Health Care
Program, National Conference of State Legislatures

Kevin Cosens, Financial Analyst
University of Colorado Hospital

Mark Earnest, MD, Associate Professor of Medicine
University of Colorado Health Sciences Center

Patricia Gabow, MD, CEO/Medical Director
Denver Health

Kim Hacker, Project Manager
Hot Issues in Health Care

Don Hall, President/CEO
Colorado Access

Sue Hall, Director of Health Care Policy
Colorado Family Physicians

Pamela Hanes, PhD, President/CEO
Colorado Health Institute

David Herr, MD, Associate Medical Director
Rocky Mountain Health Plans

Joseph Hoffman, Chief Actuary
Anthem BlueCross and BlueShield

Larry Kieft, MD, Clinical Director
Poudre Valley Prenatal Program

Barbara Ladon, Director, Child Health Plan Plus
CO Department Health Care Policy & Financing

Carrie Lucas, Law Enforcement Clerk
Colorado Cross-Disability Coalition

Barry Martin, MD, Chief Medical Officer
Metro Community Provider Network

Andy McElhany, State Senator
Colorado State Senate

Jennifer Miles, Government Relations Consultant
Colorado Community Health Network

Stacey Moody, Program Coordinator
Children's Health Matters, Catholic Charities

Gerry Niederman, Attorney
Faegre & Benson LLP

Barbara O'Brien, President
Colorado Children's Campaign

Lorri Park, State Coordinator
Family Voices of Colorado

Ralph Pollock, AP Group and Chair, CACI Business
Council on Healthcare Competition

Tony Prado-Gutierrez, Executive Director
Commission on Family Medicine

Julie Reiskin, Executive Director
Colorado Cross-Disability

Andrea Richard, Area Representative
Office of U.S. Senator Wayne Allard

Michael Robinson, Senior Administrator
University of Colorado Hospital

Nancy Schoyer, Executive Director, Colorado
Coalition for the Medically Underserved

Cory Sevin, RN, MSN, Vice President
Clinica Campesina

- continued on next page -

Chet Seward, Director, Division of Health Policy
Colorado Medical Society

Sharon Sherman, Managing Principal
GBSM

Gary Smith, CEO
Physician/Hospital Services LLC

Jim Tatten, Director, State Advocacy
Catholic Health Initiatives

Courtney Thomas, Nurse Consultant
Invest in Kids

Lois Tochtrop, Minority Whip
Colorado House of Representatives

Alex Trujillo, Regional Administrator
Centers for Medicare and Medicaid Services

Gary Vander Ark, MD, Chair, CCMU&
Director, Neurosurgery Residency Program, UCHSC

Jay Want, MD, CEO
Physician Health Partners

Debbie Welle-Powell, Vice President, Managed Care
Exempla Health Care

Chris Wiant, President/CEO
Caring for Colorado Foundation

Annie Wohlgenant, Senior Program Officer
Rose Community Foundation

Larry Wolk, MD, Vice President
CIGNA Healthcare

CONSULTING STAFF

Lynn Dierker
Consulting Staff

Karmen Hanson
Consulting Staff

Dann Milne
Consulting Staff

Barbara Yondorf
President
Yondorf & Associates

Lana Hake
Consulting Staff

Nellie Hester
Consulting Staff

Doug Mitchell
Yondorf & Associates