

Colorado Coalition for the Medically Underserved

1999 Community Discussion Group Summary Report

I n f o r m
E d u c a t e
E n g a g e
M o b i l i z e

**Resulting Strategies
and
Opportunities for Change**

Statement of Values

The members of the Colorado Coalition for the Medically Underserved are united by a shared commitment to the following vision:

Nearly 600,000 Coloradans do not have health insurance coverage. A similar number of our citizens are estimated to be underinsured, exposing them to economic calamity if they experience a catastrophic illness or injury. Most of the uninsured and underinsured are employed. Most did not choose their uninsured status. Yet they face the very real prospect of not being able to obtain medical care when they need it. The result is that the uninsured get inadequate or insufficient health care and their health suffers as a result. The lack of health insurance, independent of income or social class, has become a predictor of ill health.

The Colorado Coalition for the Medically Underserved views this state of affairs as unacceptable. Colorado's resources and its community values make it possible to institute a better approach to meeting the health care needs of our citizens. The Coalition believes that all Coloradans can and should have access to quality health care and prevention programs. The Coalition believes that it is critical that Colorado achieves health insurance coverage for all of its citizens. We seek to make this vision become a reality.

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Colorado Coalition for the Medically Underserved

1999 Community Discussion Group Summary Report

Resulting Strategies and Opportunities for Change

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Background

The Colorado Coalition for the Medically Underserved (CCMU) and the Colorado Community Health Network (CCHN) facilitated a series of community meetings on access to health care and health insurance coverage in four Colorado communities (Adams, Delta, Pueblo and Routt counties) in August and September 1999.

The purpose of the community discussion was to help the Colorado Coalition for the Medically Underserved understand local realities and how they relate to the Coalition's goal of achieving health insurance coverage and access for all Coloradan's by the year 2007.

The Coalition selected communities to participate in the discussion group process based on a set of criteria established by the Coalition and CCHN. Criteria included geographic, economic and racial/ethnic diversity, and the extent to which the community was underserved (estimated by the percent of persons in poverty, and the percent of the population that is uninsured).

The community discussion groups were organized to meet objectives and action steps outlined in *A Plan for Colorado*. The Coalition suggested gathering input through "town hall meetings" from the medically underserved, health care providers, the business community, and consumers/the general public. The community discussion group process effectively gathered input from these various constituencies, in varying degrees from each community. The findings will inform the Coalition's efforts to:

- Educate the public and raise awareness about the problems and needs of the underserved.
- Gather public input to help support and direct efforts to achieve health insurance coverage for all Coloradans.
- Secure commitments from other groups to implement the ideas in the plan.

This report includes:

- **Findings on access, financing and service delivery** for the Coalition to consider in implementing its Plan.
- **Opportunities** for the Coalition to implement strategies with communities to advance goals and objectives outlined in *A Plan for Colorado*. The community discussion group strategy created a relationship with four communities in the state that can be leveraged to achieve the Coalition's goals and to support the community's goals.
- **Themes, challenges and strategies** for each community.

The Colorado Coalition for the Medically Underserved is a group of more than 100 professional and health provider organizations, state agencies, legislators, individuals, foundations and consumer and business groups with a mission to secure insurance coverage and access to care across the state by 2007.

The Colorado Community Health Network (CCHN) is Colorado's primary care association, representing community, migrant, homeless and Indian Health centers across the state. CCHN is committed to achieving 100% access to health care and 0% health disparities in communities across Colorado.

Lessons Learned

INSURANCE COVERAGE

- **Health insurance as a resource that helps people and families to cope with changes in their life, and, in some cases, transition to a more stable situation.** Communities consistently expressed the desire for a health service delivery and insurance coverage system that works across the life-span, and takes into account fluctuations in income, family structure, geographic location and eligibility.
- **Private and public systems are inexorably linked.** The numbers of people in a community who obtain services through safety net providers increases as the commercial infrastructure weakens in communities.
- **Insurance coverage does not automatically ensure access to health care,** especially when there is a shortage of providers, or where there are not enough providers serving the low income, uninsured or Medicaid/CHP+/Medicare insured persons. To achieve meaningful access to health care, strategies must support the safety net infrastructure and extend public and private insurance coverage to the maximum number of persons. State level efforts to increase the number and types of services covered by public programs, or to expand eligibility, must be coordinated with the community providers who are addressing the needs of increasing numbers of people.

CCMU Goal 1: Achieve health insurance coverage for all Coloradans through a variety of public and private mechanisms by 2007.

AFFORDABLE COVERAGE FOR THE UNDERSERVED

- **The “underserved” is a broad and diverse group of individuals that is perceived to be growing in each community.** As communities began to list the groups they consider to be underserved, they expressed surprise and concern at the large proportion of persons that fall into this category.

CCMU Goal 2: Take interim steps to optimally meet the needs of the underserved and phase in affordable coverage solutions for those most in need.

The underserved in these communities include:

- undocumented, seasonal and migrant workers;
- the currently uninsured;
- insured persons and families with deductibles and/or co-payments that are too high for their incomes;
- older persons with low fixed incomes not yet on Medicare, or unable to afford Medicare premiums;
- persons who cannot obtain prescription coverage, or for whom prescription co-pays are not affordable.

Existing Systems. As the potential number of persons who need safety net providers increases, communities will need to make conscious decisions about how to best offer services in order to maximize community resources. Communities suggested continuing and expanding support for existing safety net providers.

- **“Being covered” by insurance can be as much a matter of perception as it is actual enrollment in a program.** For example, many privately insured people would say they are “uninsured” if they have deductibles of \$1000 or more, and/or co-payments for services that they cannot afford. These individuals experience the same lack of routine care and preventive services that might characterize the experience of the uninsured.
- **The development of new commercial or public insurance products in the state would be most welcomed by the smaller businesses.** Across discussions and communities, premium costs to the employer for employee health insurance have been increasing in the double digits for the past two years (e.g., 18-20%) in Colorado, and employers are beginning to pass more of the cost of insurance on to employees. While insurance coverage may be available to individuals, it may not be affordable for some families. Similarly, many services that community members consider “the basics” are no longer covered by – or adequately covered by – insurance, particularly dental care, mental health services, prescriptions, and vision care. Among employed people, there is a general willingness to pay for an employer-sponsored plan, but the payment must be perceived as “affordable”. Local insurance programs are being initiated as one strategy to both support local providers and provide increased coverage for the population in some communities.

COALITION GOALS AS PUBLIC POLICY PRIORITIES

Communities indicated the desire for a partnership with the Coalition beyond the community discussion group process.

Communities see the Coalition as:

- *An important advocate at the federal and state level with policy makers;*
- *A source of good information to communities and best practices;*
- *A source for facilitation or planning assistance to help communities “take the next step.”*

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| CCMU Goal 3: Ensure that achieving these goals remains a public policy priority. |
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Continued involvement with the communities who participated in this process also paves the way for the Coalition to secure commitments from groups and institutions at the local level as they become committed to strategies that enhance access to care and increased insurance coverage for the population.

The follow-up strategies proposed for each community are opportunities for the Coalition to further define its roles in supporting communities that desire to implement aspects of *A Plan for Colorado*.

Detailed Findings Regarding Insurance Coverage*

Discussion group participants voiced the need for continued efforts to monitor and encourage enrollment in existing public and private insurance programs. They cited a lack of program coordination in the system at the point of eligibility determination and enrollment. Participants argued that this lack of coordination in programs must be addressed and overcome to maximize enrollment in public programs.

Specific Suggestions

- Communities strongly recommended an investment of additional resources into education and enrollment activities for both public (Medicaid, CHP+, CACP, CUHIP) and private health insurance programs.
- The enrollment process for Medicaid, CHP+, welfare and other public assistance programs is often seen as demeaning and humiliating. More sensitive and culturally appropriate enrollment processes are needed. One approach would be to uncouple the application for welfare or other assistance from the application for any type of medical assistance or insurance programs.
- Existing programs are not well coordinated. For instance, referral from the Medicaid eligibility process to the CHP+ program is not happening smoothly in many communities.
- Small communities need adequate administrative support from the state or other programs for enrollment activities. The infrastructure demands for doing effective outreach and enrollment place a particular burden on programs and staff in smaller communities that may not be able to distribute additional responsibilities for these tasks.

The community discussion groups highlighted the challenges within the existing insurance infrastructure in the state, as well as opportunities for improvements. These findings by insurance “type” are summarized below.

Private insurance- The type and extent of commercial insurance programs available to a community are directly related to the community’s economy and employment base. Insurance offered by businesses in communities experiencing slow economic growth or setbacks have high deductibles and higher co-payments than those offered elsewhere. Similarly, families are increasingly unable to afford monthly premiums and co-payments required at the time of service. Safety net providers shared that many insured patients consider themselves uninsured if they cannot afford these deductibles or co-pays. In several communities, employees of schools, health departments and county/city governments cannot afford insurance. Ironically, these people are responsible for the enrollment of other community members in existing public insurance programs. In all communities, small businesses are struggling with the affordability of insurance for their employees.

Medicaid- Medicaid reimbursement continues to be the main support for safety net providers in communities, including hospitals. The Medicaid program also continues to be a mainstay for families and individuals who are transitioning from welfare to full time work.

* A full report regarding public and private insurance programs in the communities is available upon request from CCHN.

Community members suggested that Medicaid coverage be extended to all family members for one year after welfare benefits end, regardless of earnings, to encourage self-sufficiency.

The asset test in the Medicaid eligibility process is problematic, barring many low-income families from coverage. Community members suggested that if the asset test remains, it should be modified to account for how the assets are used (e.g., a school loan for continuing education or a car for transportation to school). A shortage of dentists who accept Medicaid, and therefore, a lack of access to dental care for Medicaid insured children and adults, was a common theme. Communities suggested that Medicaid dental reimbursement be increased to 85% of usual and customary reimbursement.

Child Health Plan Plus-The CHP+ program is a welcome resource in communities. However, there are specific challenges to maximizing the enrollment in the program. First, families are not consistently referred to CHP+ if they are ineligible for Medicaid. This is often a communication breakdown at the local level between county offices that perform enrollment in Medicaid and other assistance programs, and those responsible for CHP+ enrollment.

Second, communities and the state are still searching for an effective way to market CHP+. It was suggested that young mothers with children who are eligible for the program could be involved in the design of marketing materials. The approach implemented by Colorado Access to inform all providers about how its program would work and what challenges could be anticipated was discussed as a successful model that could be considered by the CHP+ program to inform all safety net providers across the state.

Third, an insurance premium paid monthly regardless of services utilized is hard for many eligible families to understand or afford. Providers and consumers alike discussed alternatives to paying for the program, such as an annual fee, payment at the time of service, or a monthly bill for services that could be budgeted with other bills.

A final challenge to maximizing CHP+ enrollment especially in rural or small communities is the lack of infrastructure available to devote or divert to this effort. Communities suggested deploying an enrollment team to these communities around the state that can help existing staff to reach families and get children enrolled.

Colorado Indigent Care Program (CICP)- The CICP program is an important resource for adults and children who do not qualify for other programs, and for safety net providers. The use of this program varies based on the knowledge and experience that hospitals and other providers have of the program, and their ability to obtain adequate reimbursement for services provided through other programs. For some providers, the paperwork and effort required by CICP outweigh the benefit of participating. Some providers would rather arrange for a low cost cash transaction with patients. Safety net providers in some areas have used the CICP program for both their uninsured patients and to supplement patients from low-income families who cannot afford their insurance plan's high deductible payments.

The primary challenge for consumers using the program is that participation in CICP by physicians and hospitals varies greatly, affecting continuity of care. In most communities, physicians (particularly specialists) are less likely to participate in the program than hospital facilities. In other communities where primary care providers such as community health centers participate in the program, it is sometimes difficult to find specialists who will accept referrals for CICP patients. Patients may not understand that physicians who treat them in the hospital, or specialists they are referred to for care, do not participate in the

program and will bill them for services – despite the fact that the hospital or community health center that refers them participates in the CICP program.

Medicare- Senior citizens in communities expressed fear and concern about the changes occurring in the Medicare program, particularly in the Medicare + Choice program. In areas of the state that may not be profitable for plans, senior citizens are disenrolled from their plan, and sent a letter informing them of this change. Medicare enrollees are aware that providers in urban and populated areas of the state are paid more under Medicare + Choice than providers in rural areas of the state. The confusion and uncertainty of finding a provider who will accept Medicare are stressful for these elderly persons. Providers and consumers in communities described scenarios where physicians may be closing their practices to the Medicare insured because of these unstable payment practices by HMOs. Additionally, as patients with managed care plans fill an increasing proportion of physicians' practices, physicians may limit the number of Medicare enrollees in their practice because they require more time to manage and treat.

Seniors also expressed concern about the inequity of the system. For example, seniors who held lower paying jobs during their working years have weaker retirement and social security benefits. Medicare premiums and deductibles consume a relatively higher proportion of their retirement income.

Opportunities for Coalition Involvement in Community Follow-Up Strategies

Strategies to improve access were developed with each community that participated in the discussion group process. Across all four communities, strategies generally fell into the following categories:

- Strategies to maintain and expand existing programs and safety net providers;
- Strategies to increase enrollment in existing insurance plans and programs that can pay for or provide health care;
- Strategies to increase the availability of health services.

The Coalition has the opportunity to continue its partnership with CCHN in follow-up strategies. Opportunities for Coalition involvement in these strategies are described briefly in this section.

Maintain and expand existing programs and safety net providers

- Incorporate stories and strategies that are working in communities into Coalition publications, as well as in educational materials that publicize successful strategies.
- Provide information to communities about charity care, community benefit and how to measure and understand this resource in their environment.
- Work with communities to develop creative strategies that can leverage the benefit provided by the medical system with others (business, philanthropy).
- Help communities assemble data needed to communicate the “extent of the problem.”
- Help communities determine what if any policy changes need to be made or “flexed” for innovative ideas to be implemented.
- Involve legislators from the four communities in follow up strategies.
- Develop advocacy and information strategies for the Coalition to support at the state level using anecdotes and stories from the four communities.
- Develop advocacy strategy for the Coalition for the federal Safety Net Preservation Act.
- State level support and advocacy from the Coalition can help ensure these programs are implemented and accommodate the needs of the currently uninsured and underserved.

Increase enrollment in existing insurance products and payment programs

- Use pilot communities as a resource to develop and test the educational messages of the Coalition.
- Support community meetings and “Health Summit” ideas with materials.
- Assist with the development of materials with a message that works for the business community about sharing in responsibility for insurance coverage.
- Examine barriers to obtaining affordable group coverage.
- Use pilot communities as a resource to test financing system scenarios. Gather feedback from community and health system leaders in follow up meetings.
- Investigate models or examples in communities where community benefit and charity care dollars have been applied to insurance or payment programs.
- Advocate for tobacco dollars to be used for CHP+ premiums or marketing and enrollment support in small communities.
- Conduct a session with legislators to have them “mock” enroll in programs as an educational process.

Increase the availability of health services, particularly for the underserved

- Acknowledge and recognize providers (primary care, specialty care and others) already serving the underserved. Leverage for increased response in the broader community.
- Secure information for pilot communities on the size of the access problem (number of uninsured, provider information).
- Provide information to communities about upcoming legislation that will impact service availability.

The Colorado Community Health Network (CCHN) can play a coordinating role with the communities in these follow up strategies. Staff from CCHN worked with community members to establish the community meetings, and have developed a connection and relationship to these communities. Specifically in follow up, CCHN has become involved with local partnership efforts that communities have put in motion to respond to the issues and opportunities raised during the community discussions.

CCHN can also provide linkages with the CHP+ and CACP program, and information on resources available for communities to improve access, such as the National Health Service Corps program. The legislative advocacy strategies requested by communities in the discussion group process can also be folded into CCHN's advocacy strategies at the state level, and the training and support CCHN offers to advocates from underserved communities has been extended to representatives from the four counties as well.

Community Specific Findings

The full report from each community can be obtained by contacting staff at the Colorado Coalition for the Medically Underserved.

Adams County

Discussion group dates August 5 and 6; September 22, 1999

Number of participants 30

Meetings 6

Community Organizations and Individuals Serving as Conveners

Lynn Trefren, Tri County Health Department
 Pete Leibig and Peggy Leitner, Clinica Campesina
 Christine Begley, The Covering Kids Initiative
 Reverend Jane Riecke, Thornton United Methodist Church
 Carol O'Dowd, City of Thornton
 Mary Ann Martinez Gofigan, Salud Family Health Center

Basic demographics

| Indicators | Adams |
|---|---|
| Geographic description | Partially rural, and suburban |
| Population (1993) | 281,134 |
| % Hispanic (1990) | 18.6 |
| Dominant industries and top employers | Local government and schools Health services Information Scientific industry Mining and agriculture |
| % Uninsured | 15 |
| % Population <200% of the Federal Poverty Level | 28 |
| Eligible children enrolled in CHP+ | 27% of a total of 6,545 eligible children enrolled as of June 1999 |
| % Population enrolled in/eligible for Medicaid | 8 |

(Note: Data are for the county as a whole, unless otherwise indicated)

Issues and Themes

- County residents identify with their city or neighborhood. The growth rate and expanse of Adams County requires strategies to be focused at the city or neighborhood level to be effective.
- Growth in Adams County has resulted in isolation between programs, health care providers and people. As the population grows, this situation will be exacerbated. The dispersion of services has led to the rise of informal leaders who walk people through the maze of programs and services available.
- Existing public transportation services focus on serving the Denver-metro area, and do not effectively link residential areas with medical and social service centers within the county.
- Access to primary health care and dental care for low-income residents is sorely inadequate, because the capacity of the local system is maximized. This is evidenced by the waiting times and lack of available appointments at safety net providers. Through recent assessment efforts of the Thornton Partnerships for Community Health, Thornton residents specifically identified health care access, dental and mental health care, vision impairment and teen pregnancy as key health concerns.
- Insurance coverage would not necessarily equate to improved access for underserved populations in Adams County. However, improved insurance coverage in the population would provide a stronger funding stream for safety net providers, which would help services to be maintained.
- The uninsured are a diverse group that includes undocumented persons. It is difficult for uninsured individuals to get appointments and pay for specialty care services, despite the referral mechanisms that primary care safety net providers have put in place.
- Various members of a family may have different sources (and degrees) of insurance coverage. Safety net providers try to enroll underserved persons in insurance programs, and simultaneously encourage them to take responsibility for their health.
- Since the meetings were held, safety net providers have reported that there are no secure “backup” arrangements for hospital obstetric services needed by low-income pregnant women delivering in hospitals in the western part of Adams County.

Challenges

Poor or underserved persons often have difficulty arranging for transportation, and public transportation systems do not adequately link residential areas with health and human service resources located in the county. The mobility of persons and families within and between communities, particularly the undocumented negatively affects continuity of care.

Uninsured individuals have inadequate access to specialty care, and their access is often dependent on informal agreements between safety net providers and specialty providers.

The number of families and individuals who use safety net providers will increase as the county population continues to grow. However, safety net providers in Adams County are currently operating at capacity, with limited ability to see additional underserved persons.

Proposed Strategies

Improve access to primary health care—This is a critical need in the county, and Thornton has a unique opportunity to address that need immediately. Clinica Campesina has recently received federal funding to open a primary health care site in Adams County, allowing it to

provide approximately 3,000 additional visits a year. This would meet the needs of approximately two out of five medically underserved individuals in the area.

Thornton Partnerships for Community Health is actively mobilizing the community to address critical health needs. The City of Thornton and broader community can begin to develop a long-term solution to health care needs by committing Community Development Block Grant dollars or other funds to the clinic, and supporting a capital campaign that will allow Clinica Campesina to build a permanent site in Thornton. The development of this site, along with Thornton Partnership efforts, could serve as a springboard for addressing other health needs identified by the community, such as the need for dental care.

Strengthen partnerships among health care providers (hospitals, clinics, health department)—Disseminating information about available services -- which might increase knowledge and referrals between organizations -- was one suggestion provided during the community. Thornton Partnerships for Community Health is including such a proposal in its Town Meeting on Community Health. A dissemination strategy could be expanded to include the whole county, and to identify resources in the broader Denver metropolitan region that are available to residents.

Additional strategies for strengthening partnerships included the following:

- Incorporate the Greater Westminster Quality of Life Effort in follow-up strategies in Adams County.
- Link the Sheriff's Department Community Policing effort with Clinica Campesina to do some creative outreach into the communities immediately surrounding the clinic.
- Support the work of the Brighton Community Health Improvement Project.
- Involve and support school nurses in their coordinating role in schools. Nurses were mentioned as linkages to students for the Child Health Insurance Plan. In partnership with other community health providers, nurses can be used to reach families and children with existing insurance products, and providers can in turn support nurses as they seek to continue to find referral sources for students who need health services.

Acknowledge the contribution of physicians who provide support services to the underserved and leverage additional support—Aurora-Adams County Medical Society and the Colorado Medical Society could acknowledge the contribution of specialty physicians who provide services to the underserved and uninsured. The general surgery group in Brighton, who receives referrals from Salud Family Health Care Center, is a good example. Acknowledging these specialists may help to mobilize participation in care for the underserved in those areas of the county where such participation is weak. The current contribution of physicians may be leveraged to create a partnership of businesses and other community organizations in support of care for the underserved. For example, a current and critical area of concern is the lack of a secure backup system for providing hospital-based obstetrical services to low-income women who are served by safety net providers.

Advance the involvement of businesses in supporting the safety net—One idea was to present case studies through the MetroNorth Chamber of Commerce for how a business' bottom line is influenced by the extent of the uninsured and underserved in a community, and the impact of poor employee health on business productivity.

Engage interested local providers legislative advocacy efforts at the state and local level—CCHN and the Coalition could develop methods for linking local communities with the

state legislative process and the Coalition's efforts to address health care issues across the state. Ideas for legislative advocacy included convening legislators from communities visited in Adams County to go through an exercise that highlights the consumer experience in obtaining health and social services, the tight budgets faced by families and the programs that serve them, and the role of safety net and other providers in maintaining the health of the population.

Delta County

Discussion group dates September 23, 1999
Number of participants 45 (including about 20 migrant farm workers)
Meetings 7

Community Organizations and Individuals Serving as Conveners

Sally Kane and Bonnie Koehler, Delta County Health Department
 Mary Jane Place and Noemi Kelley, Migrant Farmworker Health Program
 Judy Wiesbroad, Delta County Chamber of Commerce
 Pat Malone, Ministerial Alliance

Basic demographics

| Indicators | Delta |
|---|--|
| Geographic description | Rural/Frontier |
| Population (1993) | 23,141 |
| % Hispanic (1990) | 9.1 |
| Dominant industries and top employers | Local government and schools Agriculture Mining |
| % Uninsured | 37 (1997 BRFS) |
| % Population <200% of the Federal Poverty Level | 48 |
| Eligible children enrolled in CHP+ | 55% of a total of 495 eligible children enrolled as of June 1999 |
| % Population enrolled in/eligible for Medicaid | 11 |

(Note: Data are for the county as a whole, unless otherwise indicated)

Issues and Themes

- Delta County is older and poorer than other counties in Colorado, on average. County representatives shared that it is an increasing challenge for the middle, working-class to support the needs of “both ends of the spectrum”— the young and old low-income residents of the community.
- The safety net is very fragile and experiencing financial stress. Almost half of the Delta County Hospital budget is for uncompensated or charity care. Medicare and Medicaid payments to health care providers are declining, weakening their ability to provide uncompensated care. Community members shared that Medicare plans are disenrolling seniors from the area due to lack of profitability.
- Despite financial challenges, *all* providers in Delta County provide care to the medically underserved, and are therefore part of the safety net. Local physicians and the hospital do not turn patients away who are unable to pay for services, and all physicians in the community accept Medicaid payment for services.

- Employment based health insurance is a challenge to support in an agricultural economy. Most farm-workers, who may also be migrant workers, are paid cash for their labor and are not offered benefits. The Chamber of Commerce indicated that many businesses in Delta County do not have a large enough operating budget to cover health insurance costs for their employees. Due to these and other factors, forty percent (40%) of Delta County is uninsured.
- Access to dental health services is a challenge for uninsured and elderly adults, as well as all Medicaid insured persons.
- There is approximately a three-week wait for mental health services in Delta County and like other specialty care, services must often be obtained in Grand Junction, CO.
- Things get done in Delta County through informal networks. The formal infrastructure is often too stretched to take advantage of available programs or to implement new ideas. The county has a single school district, hospital, and health department. While county resources are lean, ideas can be coordinated more easily among entities in the county because of this simplified structure.
- Economic development issues are a priority in Delta County.

Challenges

There are multiple challenges to improving access to health services in Delta County. There are relatively few people available in the county to accomplish any project or to implement ideas. Service providers talked about the need for a champion to “sacrifice themselves” in the short term in order to tackle new ideas.

The safety net, which involves all health care providers in this community, is very fragile. Reimbursement for services from Medicare, Medicaid and private insurers is decreasing, which is having a significant financial impact on Delta County Hospital and all service providers. The level of uninsured persons in the county means constrained resources in general for the health system.

The community established a federally funded community health center (Tres Rios Clinic) in May 1995. However the clinic closed in June 1996. This experience may impact the desire of community leaders and members to examine similar strategies for improving access in the future.

A final challenge is that relationships among the current leadership in the county (Health Department, School District, hospital, business community) at the time of the community meetings were tenuous or newly developing. Clearly there is the opportunity to move forward on collaborative projects that address health as these relationships further develop.

Proposed Strategies

Recognition for the efforts and success of local physicians commitment to service—Community members wanted to recognize local physician willingness to accept everyone into their practices, regardless of payment or insurance status, such as through a community meeting, is one strategy that can be organized in follow up to the initial community meetings. Additionally, the Coalition and the state could formally recognize Delta County for its success in enrolling children in the CHP+ program. The county can be promoted as a model to other small communities for the CHP+ enrollment process.

Develop a stronger connection to the state legislature and other policy makers through the Coalition and CCHN—Distributing to community representatives information and updates on current federal and state bills or initiatives that impact access to health services would allow the community to be more proactive. For example, CCHN distributes periodic “Action Alerts” to communities and safety net providers on legislation that impacts access

to services, financing or other policies concerning safety net providers. The Delta County Health Department and others participating in the community discussion process in September will be added to the CCHN "Action Alert" distribution list. Additionally, CCHN provides an annual training and advocacy class for members of the Association, and participation may be extended to members of the Delta County community. The annual legislative agenda with key dates, as well as lobbying strategies are provided as part of this training. Representatives from Delta County also requested that CCHN and the Coalition use the community in their legislative advocacy as a source of anecdotes about challenges in maintaining health services on the Western Slope of the state.

Improve access to dental care—As of September 1999, the Federal Register designated Delta County as a Health Professional Shortage Area (HPSA). (The Department of Health and Human Services through the Bureau of Primary Health Care designates the HPSA, and it is published in the Federal Register.) A HPSA designation specifically indicating a shortage of dental providers might improve access by connecting the community with the National Health Service Corps (NHSC) program, which can help communities to recruit dental health professionals.

Dentists and other professionals could also increase their involvement as volunteers in the Montrose County Dental Clinic, which would increase the number of days that dental services are available for residents of the two-county region.

Create a linkage with economic development efforts that are being advanced in Delta County— Discussion group participants shared that the Colorado Governor's Office has been to Delta County twice in the summer of 1999 as part of learning about economic development possibilities in the Western Slope. A next step might be to craft a joint letter from CCHN, the Coalition, and the community to the Governor, which summarizes findings from this report and their implications for economic development. As economic development strategies unfold in Delta County, CCHN and CMU can advocate with community representatives for the role of health services in economic development at the state level. At the local level, community health providers could meet with the Chamber of Commerce and community leaders to discuss the findings of this report, and become integral parts of any economic development plans.

Pueblo County

Discussion group dates September 20 and 21, 1999

Number of participants 100

Meetings 7

Community Organizations and Individuals Serving as Conveners

Sponsoring Organizations:

Healthy Pueblo Communities 2010 Task Force

Latino Chamber of Commerce

Parkview Medical Center

Pueblo Chamber of Commerce

Pueblo City-County Health Department

Pueblo Community Health Center, Inc.

Pueblo County Dental Society

Pueblo County Medical Society

Pueblo Hispanic Education Foundation

S.E.T. of Pueblo

St. Mary-Corwin Medical Center

Note: A group of community leaders invited community leaders, providers and health care consumers to participate in the discussions. The leaders participated in one or more of the sponsoring organizations listed above.

Basic demographics

| Indicators | Pueblo |
|---|--|
| Geographic description | Small city in a rural region |
| Population (1993) | 125,505 |
| % Hispanic (1990) | 35.8 |
| Dominant industries and top employers | Local government and schools, universities Hospitals/medical centers Telemarketing |
| % Uninsured | 19 (Pueblo city estimate) |
| % Population <200% of the Federal Poverty Level | 43 |
| Eligible children enrolled in CHP+ | 17% of a total of 2,415 eligible children enrolled as of June 1999 |
| % Population enrolled in/eligible for Medicaid | 16 (1992-1993 estimate, consistent with current community estimates) |

(Note: Data are for the county as a whole, unless otherwise indicated)

Issues and Themes

- The Pueblo community has “done it for themselves,” out of the shadow of Denver. The community desires equality in attention and resources in the state through a continued partnership with the Coalition and CCHN.
- Many persons fall into the category of underserved in Pueblo. There are 25,000 uninsured persons. Approximately 29,000 community residents are seniors experiencing difficulties with Medicare coverage and living on fixed incomes; 20,000

are veterans; and 20,000 Medicaid insured persons. Each group is experiencing access challenges. Additionally, salaries in Pueblo are low enough so that insurance coverage may not be affordable.

- Difficulties obtaining prescription medications, dental health services, and mental health services were frequently mentioned in the community discussions.
- The process for determining eligibility for the Child Health Plan Plus and Medicaid is critical. The success of these programs rests in the interaction between applicants and eligibility workers at the local level. Improved communication and sensitivity on both sides are needed to improve the effectiveness of these programs.
- Health and human service providers are successfully demonstrating the relationship between the strength and quality of their services, and the potential for economic development in the community. Parity in funding for health and human services with other city and county functions is being advocated at the local level.
- Legislative and political advocacy is an aspect of many strategies in Pueblo and its surrounding counties.
- The community is ready to set priorities and targets for health improvement. Leaders shared that outside facilitation or assistance to focus efforts would be beneficial in this process.

Challenges

There are some challenges to access to health services in Pueblo County. One barrier to patient access is a lack of information in languages other than English and a lack of translation services, particularly for Spanish-speaking individuals. Some health care providers, such as the school based wellness centers, require a more sophisticated infrastructure to be able to bill for services and collect payment. In an underserved area, the payment recovered may not cover the cost of establishing this capability. Families have also been significantly affected by welfare reform, particularly young mothers with children who are working or going to college. Their income (and the assets necessary to work or go to school, such as a car or student loans) causes a loss of Medicaid and other support services. In one woman's words: "You feel you have to lie to keep your benefits so you can continue to improve yourself."

Agencies that provide services in Pueblo face challenges in the annual budget process. Perennial tax cut proposals (like the recently defeated proposition 2B that would have effectively cut \$100 million from the city budget over the next 12 years) may have negative consequences for safety net service providers that rely on the city and county for financial support.

There is a great deal of volunteerism in Pueblo. Service providers discussed that even on the job, however, it is necessary to "go the extra mile" to make things happen. It is challenging to reach out and involve "new faces" in community efforts. Specifically, community members discussed the need to increase the involvement of both Hispanics and youth in strategies. Service providers also shared that the business community is a necessary and sometimes missing element from community efforts to address health and access to care.

Proposed Strategies

Advance the work of existing community efforts by establishing goals for health improvement in Pueblo—One proposal for arriving at these goals was to organize a Health Summit. The summit can be a forum to discuss and prioritize community health issues, and propose goals for health improvement. Based on information from the community

discussions, goals around healthy lifestyles (e.g., exercise, nutrition, weight) might be relevant in Pueblo. Data collected by Healthy Pueblo 2010 or other community coalitions can be used to inform summit participants and set reasonable goals for the future. The Human Investment Plan/Healthy Pueblo 2010 could then adopt or advance these goals and implement strategies to meet them.

Improve the eligibility determination and enrollment process for medical and other public assistance program—These improvements would extend Medicaid and the Child Health Plan Plus (CHP+) insurance programs to more eligible persons in the community. Community members who were recipients of both programs described the enrollment process as demeaning, disrespectful, and confusing. One suggestion was to emphasize the importance of sensitivity and respect in the enrollment process to the Department of Social Services, and to investigate the reasons why some eligible families are not referred to the CHP+ program when denied enrollment in Medicaid. Another suggestion was to separate the process for enrolling in public insurance programs from the enrollment process for welfare or other types of assistance. This would potentially remove the stigma associated with “welfare” from programs that connect low-income persons with health insurance. To support this type of strategy, the Coalition and CCHN can support state policies that allow Medicaid eligibility to be done at community locations other than a “welfare” office, such as churches and schools (particularly through the school wellness centers).

Increase enrollment of eligible children in CHP+—Community members suggested talking directly with local legislators regarding the administrative and financial barriers to enrolling eligible children in the CHP+ program was one suggestion, as these barriers have led to lower than expected enrollment in the state. Another suggestion was to help families with the paperwork and forms required to enroll in the CHP+ program, through volunteers who could spend the time to walk families through the forms. The Department of Social Services would be important to have as a partner in implementing any of these strategies because of their experience with the administrative problems associated with CHP+. Community members requested an invitation to state level meetings on CHP+ so they can be better informed about the program, and share their experiences with the state.

Political advocacy in partnership with CCHN and the Coalition for the Medically Underserved at the federal, state and local level—The Health Committee of Action 22 (a coalition of 22 counties in southern Colorado) could be a forum to share issues from the community meetings in Pueblo that require advocacy and policy change. Issues raised in these discussions include lack of prescription assistance for low-income persons, Medicare “insurance dumping,” and elimination of the asset test for Medicaid eligibility. Community members also recommended that the Coalition develop a strategy for supporting federal safety net legislation.

Routt County

Discussion group dates August 2 and 3, 1999

Number of participants 45

Meetings 6

Community Organizations and Individuals Serving as Conveners

Sue Birch, Northwest Colorado VNA

Frank May, Routt Memorial Hospital

Sandy Evans, Steamboat Springs Chamber Resort Association

Gary Mielke, Yampa Valley Health Plan

David Bonfiglio, Pharmacist

Basic demographics

| Indicators | Routt |
|---|---|
| Geographic description | Rural |
| Population (1993) | 15,553 |
| % Hispanic (1990) | 2.5 |
| Dominant industries and top employers | Ski and resort establishments Eating/drinking establishments Construction-special trade companies |
| % Uninsured | 15 (Steamboat estimate) |
| % Population <200% of the Federal Poverty Level | 29 |
| Eligible children enrolled in CHP+ | 21% of a total of 310 eligible children enrolled as of June 1999 |
| % Population enrolled in/eligible for Medicaid | 2 |

(Note: Data are for the county as a whole, unless otherwise indicated)

Issues and Themes

- Citizen participation is a valued aspect of community life.
- Flexibility and local control is a shared value among service providers and community leaders.
- Routt County and Steamboat Springs have retained a sense of “community,” despite an influx of workers every year to meet the needs of tourists, and other changes over time that have occurred in the economy of the community. There has been a shift from ranching to tourism over time, although ranching is still an important local industry.
- One challenge for the county is developing programs and services to meet the needs of a relatively small, disperse population base. Collaboration with other counties has occurred in the past and does help Routt County to show the “numbers” needed for some programs; however, the distance between cities and towns from one county to another often prohibits effective collaboration around service delivery.
- Communities in Routt County outside of Steamboat Springs have more difficulty accessing health services, largely because of distance and lack of transportation.
- Existing public and private insurance programs could be utilized more extensively in the community. Lack of knowledge about the existence of some programs, and the stigma attached to Medicaid prevents use of existing programs.

- The pool of uninsured persons is perceived to be growing. Local health providers are feeling the pressure of offering uncompensated services when there are fewer persons paying for those services each year.

Challenges

The ability to acquire federal, state and even local resources was presented as a challenge for Routt County. Federal and state funds or grants often require a “sizeable” problem or a diverse population to qualify. Routt County may not have the population size or diversity based on race and ethnicity to demonstrate “need.” At the local level, individuals with the time and expertise to apply for grants and other resources are scarce, even to local funders such as the United Way.

The county’s population is dispersed over a large area. Delivery of services in the most *effective* way for the population, such as through outreach and home health visits, may not be the most *efficient* way given the geography of the county.

Current health providers perceive that health and human services are not adequately funded, and “stretching” to provide and expand services with current payment levels often makes the strain on providers worse, despite the availability of new programs.

Community involvement was identified as a strength in Routt County; however, community members may work 2-3 jobs, leaving limited time for involvement in other community activities. This presents a challenge to developing community-based solutions to issues with a cross section of individuals.

Proposed Strategies

There were several strategy suggestions around improving access or addressing health issues offered by discussion group participants during the community meetings. These suggestions follow a general theme of rising to the challenge, and finding a solution and a system that provides quality accessible health care for the entire community. In the words of some providers, “If you can get the resources to the local entities that can solve the problems, we will do it.”

Encourage and develop innovative ideas around expanding insurance coverage–

- The Yampa Valley Health Plan presents an opportunity to extend coverage to the currently uninsured persons in the community. The plan is currently seeking a risk partner that can support the insurance product. Once implemented, the plan might consider incorporating a buy-in option that is affordable for low-income families and individuals in the community who are not eligible for other public insurance programs.
- All employers recognize the extent of part-time, multiple-jobs in the community. Employer collaboration for health insurance coverage for “shared” part-time employees could be explored as a strategy to expand insurance coverage in the county. The Coalition for the Medically Underserved could identify potential models as well as federal and state resources that can support the development of unique approaches to insure the uninsured. Coalition committees are working on financing models and scenarios to expand coverage, and models for a “shared employee” health insurance option can be shared with the community. Discussion group participants suggested that the Coalition and CCHN advocate for the development of a state health insurance pool or program that part time or seasonal employees could buy into regardless of their location or employer within the state.

- Pilot projects that demonstrate the value of local control are a familiar strategy for health and human service providers in Routt County. Specifically around insurance coverage, community members proposed a pilot project that would increase the flexibility and amount of CHP+ funding to the community, but expand eligibility to include the parents of enrolled children who are also uninsured. The state of Colorado is looking for communities interested in expanding CHP+ coverage; CCHN and the Coalition could advocate for Routt County to serve as a demonstration site for this idea.
- An educational effort may help to maximize enrollment in public and private insurance programs. Sessions for community members could be organized in a format that allows individuals and families to have one on one meetings with insurance program representatives. A session at Routt Memorial Hospital for service providers that presents the full range of insurance and payment programs available would also be beneficial. For example, service providers participating in the discussions specifically requested information on the Colorado Indigent Care Program, and the Colorado Uninsurable Health Insurance Program (CUHIP). *Steamboat Cares*, and other organizations that supply health education materials for the county, could disseminate information on existing insurance programs to support this effort.

Improve access in underserved parts of the county—South Routt County is designated as a health professional shortage area (HPSA). The communities of south Routt (such as Oak Creek) had a “small town/big city” relationship with Steamboat Springs in the past, but current leadership in the public and private sector have expressed interest and opportunity in understanding and meeting the needs of *all* communities of Routt County. Specific ways to improve access in South Routt as described by residents could include the following strategies:

- Recruit a physician or other mid-level provider for the community through the National Health Service Corps, which would also provide residents with a primary care provider regardless of their ability to pay for services.
- Build on local resources already available (South Routt Medical Center, pharmacy, EMTs, mid-level health professionals who live in the community) to assure access to basic services for the communities in south Routt County. One suggestion was to create an informal “health team” composed of local people with health knowledge or training that can “triage” needs locally as well as monitor the health of chronically ill people (such as those with diabetes or hypertension). Another suggestion was to find creative ways to financially assist EMTs who are residents of the community to go through training to achieve Level III, which is a licensed paramedic.

Improve access to mental health services—There is both national and state attention on access to behavioral/mental health services in the United States and in Colorado. The recent report from the Surgeon General on the mental health status of the country, and the state’s issuance of an RFP to provide managed mental health services for Medicaid enrollees, are both evidence of the attention being placed on behavioral health. Service providers in Routt County perceive an insufficient network of prevention and treatment (e.g, alcohol and drug detoxification units) services based on the needs that exist. Service providers also described the difficulties of maintaining behavioral health programs for a population that is largely uninsured for this care and dispersed over a large area.

There are some opportunities for the community to explore ways to improve the amount and types of behavioral health services. Community members could collaborate in the compilation of a grant request to the Substance and Mental Health Services Administration

(SAMHSA) for the year 2000 to build infrastructure in the community. The community may also qualify as a Mental Health – Health Professional Shortage Area (HPSA), which would provide access to the National Health Service Corps program, which can help communities recruit and retain a range of mental health professionals.

Strengthen safety net providers—Community members suggested convening the Northwest Colorado VNA, Routt Memorial Hospital, employers, doctors, all social service providers and representatives from insurance plans in the community to discuss strategies for strengthening safety net providers, and assuring their existence as the number of uninsured residents increases over time. This meeting could be convened based on a directive from the County Commissioners for the community to find ways to assure services for the entire population, by preserving the safety net for the future.

Appendix

Methods

Once the communities were selected, Coalition members were asked to supply the following for each community:

- the names and contact information for persons who could serve as “conveners” for a series of community discussions;
- key individuals and organizations that should be invited to participate in discussions on access and insurance coverage;
- information about or copies of studies and reports that would contribute background knowledge about the health and health system of each community.

Names and contact information for potential conveners in each community were compiled from the suggestions of Coalition members. Elena Thomas, Community Development Coordinator at CCHN, and Chet Seward, staff member for the Coalition, contacted these conveners and provided them with background information on Coalition efforts in the state, and with the community’s opportunity to participate in a series of discussions that would both highlight access issues as well as potential solutions. Communities were provided with *A Plan for Colorado*, and were asked, through their participation in a series of community discussions, to assist the Coalition in honing its work and the plan.

A sample of the agenda used to inform, recruit and solidify the role of these community conveners is shown below:

Agenda for Conference Call of Community Discussion Group Conveners

Introductions (all participants)

Background information on the Coalition for the Medically Underserved and the proposed Community Discussion Process (Chet Seward and Elena Thomas)

- Purpose of the community discussions: to gather feedback and advice and to identify any existing gaps/needs in primary care for the underserved
- Discussion Group questions
- Coalition participants
- What will be done with the information collected?

Community Discussion Group set-up process (Community leader/convenor)

- What is the area of interest: the county, city or a region?
- Dates for site visit
- Community participants (see suggestions in the proposed schedule, and suggestions from Coalition members) Who/what groups are missing from the list of contacts? How do we reach them?
- Proposed meeting schedule (see sample/proposed schedule)
- Role of community conveners: tasks, timelines

Next steps and update process as we prepare for the community discussions?

Once community conveners agreed to participate in the process, they were given materials to help organize the community meetings and invite representatives from key constituencies to the meetings: community members, business leaders, the faith community, health and human service providers, as well as other representatives they felt were critical to the discussions.

A sample of the materials provided to the conveners to assist them in the process is shown in Figure 1.

Figure 1-Community Discussion Group Background

The Coalition for the Medically Underserved is a consortium of state and community based providers of health care, businesses, and consumer advocacy groups and other organizations that is advocating for insurance coverage and access to health care for all Coloradans.

To that end, the Coalition has teamed up with organizations like the Colorado Community Health Network, that are promoting a national campaign for “100% Access and 0% Health Disparities.” We need your help to achieve the Coalition’s goals and ensure that all Coloradans have access to affordable, quality health care, and health insurance coverage by 2007.

The key to any successful effort is a community perspective – you are the expert. We seek your thoughts and advice: What would you do to address problems involving access to health care? What does your community think about insurance coverage? We want to listen to what local leaders, health care providers, businesses and residents have to say! In exchange, we commit to follow-up with you and your community. We will do this by sharing a report with all of the information we collect in the process, and by asking your community to partner with us on strategies that might help improve access to health care or insurance coverage for everyone.

A team of Coalition members would like to visit Delta in August or September. During that visit, we would like to have a series of meetings with community leaders, health care providers, and other community members. Suggested times, participants and places for those meetings are attached to this letter, in a “schedule” for your consideration.

We are asking for help organizing the community meetings that are part of the site visit. This involves inviting guests via letter or phone call to “town-hall” style discussions, keeping track of RSVPs, and arranging for meeting places. We can provide help with these tasks:

- Attached are a task description and a draft letter of invitation that can be used to invite community members and organizations to meetings. [Attendees should be invited 2-3 weeks before the community meetings. Our goal is to have 20-30 participants at each meeting.]
- Coalition members may have some suggestions and recommendations for invitees to the meetings.
- Everyone comes to meetings if there is food; we can provide you with monetary support for community meeting refreshments or meals, if you can make the arrangements.

What benefits are there for you and your organization in this process?

- **Exposure** -- local and state press are being contacted to cover this community process.
- **Input** – to a state Coalition that is working to understand how it can address access to health care and health insurance coverage in Colorado.
- **Opportunity** -- To partner with a state and a national effort to address access to health care and health insurance coverage in the community. The Colorado Community Health Network and Coalition Members are committed to helping communities move forward with ideas and strategies that come from community discussions. For example, we could share strategies for increasing enrollment in the Children’s Health Plan + and other public health insurance programs, or we could help a community develop a plan for increasing access to primary care.

The community discussions were facilitated using a series of open-ended questions. Following introductions, during which participants in the discussion were asked to share something about why they live in the community, these questions were asked:

- Define or describe your community. What kind of community do you want to live in (how do you want your community to look), and how does health care fit into your *vision* of community?
- How are things now in relation to health care services in this community? What is going on? What is working? Who has challenges and why? What services do community members have problems getting access to?
- What needs to happen to move toward the *vision* you have for your community? Is it insurance coverage? If so, what would progress “look” like? How would you make sure that people use it?
- What resources are currently being used to help address this community’s health care needs? Are there other efforts being developed or other resources that could be called upon?
- What can each of us do to move toward the vision you have for health care in this community? What advice would this community give to a group of people who are interested in improving access to health services and/or health insurance coverage?

Information was recorded at the time of the discussion on a flip chart at the front of the room, and on a laptop computer. Reports to each community were drafted based on this information and the input of Coalition and CCHN members provided at the community discussion groups and in follow-up meetings.



Acknowledgements

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