COMMUNITY HEALTH CARE CAPACITY PROJECT

REPORT AND RECOMMENDATIONS TO

Health Services Steering Committee
Citizens Health Advisory Council

La Plata County, Colorado
March 2010

INTRODUCTION

In La Plata County there is an effort among local business and organizations to "Think Local First." While this is typically used to remind citizens to shop and purchase services locally, it can also be applied to healthcare, specifically to a solution to health care access in La Plata County.

There is a tendency, in light of the ongoing and lengthy debate on health care reform at the national level, to "leave things for Washington or Denver to figure out." However, much of the research on health care solutions demonstrates that successful efforts are developed, implemented and supported locally.

This report and the recommendations included herein are the culmination of the Community Health Care Capacity Project. The Project is the result of an application for grant funding submitted by the Health Services Steering Committee (HSSC) to The Colorado Health Foundation, requesting financial assistance to assess access to primary care in La Plata County and provide recommendations and a strategic plan. This work is the continuation of years of foresight and effort by community members to address local health care needs and most recently supported by consultants from JSI Research and Training Institute, contracted by the Primary Health Care Community Coalition (a predecessor to the current Health Services Steering Committee) in 2007.

Specifically, the grant was provided to hire a project coordinator charged with "creating a comprehensive Health Services Plan for La Plata County to improve access, integration, quality and efficiency of health care in the county while supporting healthy lifestyle choices of its citizens."

BACKGROUND

For many years residents in La Plata County have been concerned about and involved in health care in the community. The ongoing efforts have produced a new regional hospital, a second surgical hospital, a nationally-recognized behavioral health organization, as well as successful recruitment of providers of numerous medical specialties. The community also supports a wide range of care providers in alternative approaches to traditional western medicine.

Recurring concerns about the number of primary care physicians in the community were heightened in 2006 when Valley-Wide Health Systems announced the closing of its Durango medical operations (Durango Primary Care and Southwest Children's Health Clinic) due to financial constraints, citing both the failure of an attempt to get La Plata County voter support for a Health Services Tax District and Valley-Wide's inability to obtain federal grant funding to subsidize the clinics. The clinics closed in March 2007.

As is typical in La Plata County, community resources were immediately mobilized. A number of local practices and organizations stepped up to do what they could, assuming the care of some of the patients left behind. The Health Services Clinic was established as a stop-gap solution by Mercy Regional Medical Center, with support from La Plata County and the City of Durango, opening in May 2007.

Later that year Governor Ritter approved La Plata County as a "Medically Underserved Population (MUP)." This, along with the county's designation as a "Health Professional Shortage Area (HPSA)" demonstrated the severity of the lack of primary care access in the area.

JSI Research and Training Institute (JSI) evaluated the local situation, recommended necessary actions, and reported their findings and recommendations in September 2007. The findings included confirmation of the primary care shortage in the county and the need for a "system-wide approach" in creating solutions. JSI elaborated that this would require county-wide involvement and should include an integrated operation, including behavioral health and public health to complement existing primary care providers. Sustainability, particularly in terms of financing, was also identified as an issue, with JSI reporting that solutions could lie in public financing.

Specific recommendations from the JSI report were (1) The Health Services Clinic should apply for Rural Health Center status, which would improve reimbursement for Medicare and Medicaid patients, (2) Recruit and retain primary care providers, (3) Build upon the current Health Services Clinic operations by recruiting additional providers, expanding services with behavioral and public health and outreach to communities outside of Durango. The final recommendation was to support Health Services Clinic operations through a variety of funding mechanisms, including patient fees, enhanced reimbursement from government sources and possibly an additional referendum on the Health Services Tax District.

To address these findings and follow-through on the JSI recommendations, the Health Services Steering Committee applied for and in January 2009 received grant funding from The Colorado Health Foundation for a more in-depth assessment of access to primary care in the county. This effort is the Community Health Care Capacity Project.

Through the course of this project, health care reform has been at the top of agendas for elected officials in Denver and Washington DC. National level discussions and proposals have created a high level of context for La Plata County's health care access situation.

Many of the issues facing the county are not unique to southwest Colorado. Knowing that other communities have similar problems is not necessarily reassuring, but it does present the opportunity to learn from the efforts in other locations.

At the state level much attention has been paid to the details of health care reform and which of the proposals would be meaningful to Colorado residents. Specific recommendations have been made to help address health care issues, and particularly access, in the state. The Blue Ribbon Commission for Health Care Reform published its "Recommendations for Health Care Reform in Colorado" in January 2008 which supported "interventions that respond to a variety of individual and community situations." While the recommendations were largely focused on insurance coverage for Colorado residents and helping people understand their insurance options and benefits, the report also included recommendations regarding quality and coordination of care, individual responsibility for health, expansion of telemedicine and funding for providers and public health delivery systems. Each of these is an important part of access to primary care.

Despite what some might say is a "long time coming," the Community Health Care Capacity Project is well-timed to take advantage of successes and solutions in other communities throughout Colorado and the nation. The national level focus on health care reform has brought with it an environment that offers almost unprecedented support of local community efforts to create healthier communities.

PROCESS

Project research began in April 2009. Interviews were conducted with 167 people and their feedback compiled in a database. Participants included local providers and representatives of organizations delivering health care services, insurers, municipal officials throughout La Plata County and county government, business owners, representatives from local school systems and local colleges, community members and individuals associated with non-profit organizations in La Plata County. Additional feedback was obtained in group settings where many additional participants offered valuable input in the form of comments and concerns regarding health care access in La Plata County, either as anecdotes or based on their personal experiences.

To put these comments into a framework, the concerns were grouped into three main categories:

1. Comments related to being accepted as a patient in a primary care provider practice (including providers of physical, mental or dental health care).
2. Comments related to cost of care, including cost or lack of insurance.
3. Comments related to gaps in care, including problems in communication which led to gaps or lower than expected levels of the quality of care (quality concerns).

Through the Fall of 2009, models of care delivery and solutions to service for the un- and under-insured were reviewed. Models in Colorado, the Southwest and throughout the nation were reviewed for potential implementation in La Plata County. Contacts were made at conferences within Colorado and outside the state. Site visits were made to Pueblo, Colorado and Grand Junction, Colorado. Discussions were held with and presentations were attended by representatives of multiple programs across the country, including the Vermont Blueprint for Health. Closer to home, conversations with the Northern Colorado Health Alliance in Greeley, Colorado, the Northwest Colorado Visiting Nurses Association in Steamboat Springs and Craig, Colorado and the Taos, New Mexico ECHO Kids Program provided details on how those communities have addressed access.

As the models were reviewed it was apparent that no single model held the entire solution for La Plata County. Individual aspects of multiple models appeared to apply to specific issues here.

Preliminary options were reviewed in sessions held with the Citizens Health Advisory Council, the Health Services Steering Committee, the Tribal Council of the Southern Ute Tribe, and management of the City of Durango and La Plata County. These groups discussed how some of these models might fit in La Plata County and feedback was incorporated into the study.

Subsequent to these sessions, recommendations were formed and fine-tuned, based on the valuable feedback obtained. These recommendations are presented further in the text of this document. (See Appendix A for a Logic Model of the Project Process.)

DATA

Volumes of data were reviewed during the course of this project. The compilation included here is broken into three sections: Data, an Asset Inventory for La Plata County, and a SWOT (Strengths, Weaknesses, Opportunities and Threats) Analysis. It is not the intent that any of these sections be a complete and exhaustive listing. Any attempt to compile an accurate asset inventory is bound to unintentionally overlook a new program or include a program which has since been discontinued. Rather, included below are a few selected statistics that are particularly pertinent and abridged listings, culling applicable information from months of research, feedback and study. An Asset Inventory is categorized by age groups. The SWOT analysis includes highlights of the strengths, weaknesses, opportunities and threats in the La Plata County health care environment.

Please see Appendix C for references and resources that will provide additional information. It is important to keep in mind that many reports must use data that is 1-2 years old or even older due to the time frame needed to gather, analyze and report the information. Using older data results in projections based on past results. These types of forecasts can be inaccurate now, in light of the changes in the economy from late 2008 to the present. Also, many analyses are based on household surveys and contact for these

surveys is made by land-line telephone calls. Households without phones or using only cell phones will not be included. This could be especially relevant in La Plata County.

STATISTICS

National statistics for Federal Poverty Level (FPL) (2009) (see http://aspe.hhs.gov)

	100%	200%	300%	400%
Family size: 1	$10,830	21,660	32,490	43,320
2	14,570	29,140	43,710	58,280
3	18,310	36,620	54,930	73,240
4	22,050	44,100	66,150	88,200
5	26,790	51,580	77,370	103,160
6	29,530	59,060	88,590	118,120

Colorado statistics:
In 2007 approximately 2 million homes in CO have family incomes below 300% of Federal Poverty Level (see http://www.coloradohealthinstitute.org)

Families living below 400% of Federal Poverty Level cannot afford health insurance without a substantial subsidy. This is usually received through employer-sponsored health insurance where the employer pays a substantial portion of the premium. (Colorado Voices for Coverage, May 2009)

The typical family can afford to spend about 5% of the household income on health care. Some programs providing "affordable" options expect families to contribute up to 12%. (Joan Henneberry, Executive Director, Colorado Department of Health Care Policy and Financing – presentation September 21, 2009)

The Colorado State Scorecard compiled by The Commonwealth Fund ("A private foundation working towards a high performance health system") reports Colorado ranks 40th out of the 50 states in Access to Care. Other rankings are:
43/50 for the percent of children who are insured (actual data: 87.3%)
31/50 for the percent of non-elderly adults (18-64) who are insured (actual data: 80.3%)
45/50 for percent of at-risk adults who have visited a doctor for a routine check-up in the past 2 years. (Actual data: 78.98%) (see www.commonwealthfund.org)

La Plata County statistics: (Population statistics taken from Colorado Health Institute at http://www.coloradohealthinstitute.org unless otherwise noted)

Population of county =50,700 (2008)
Projection of 2010 population = 54,800
Projections for 2020 = 68,4000

Current breakdown in age groups (2008)
0-17: 20.3%
18-64: 68.3%
65+: 11.3%

Projected breakdown in age groups for 2020
0-17: 20.9%
18-64: 61.3%
65+: 17.7%

Income breakdown for La Plata County:
10.9% of population at or below 100% FPL (CO average = 18.9%)
33.7% at or below 200% FPL (CO = 40.5%)

Unemployment in La Plata was 4.7% in the third quarter 2009 (Colorado = 7.2%, U.S. = 9.6%) (see https://edis.commerce.state.nc/docs/countyProfile/CO/08067)

La Plata County's uninsurance rate 18.5%
2/3 of those who are uninsured are employed,
11.8% of La Plata County's population ages 18-64 is uninsured and living at or below 250% of FPL

Full-Time Equivalents of primary care providers (based on 2008 data from Mercy Regional Medical Center):
-OB/Gyn: 6 FTEs (8 physicians)
-Pediatrics: 6.4 FTEs (8 physicians)
-Family Medicine: 16.3 FTEs (22 physicians)
TOTAL: 28.7 FTEs (38 physicians) = an average practice of .75 FTE (3/4 time)

30.5% of those surveyed in Region 9 reported visiting a hospital emergency department in the past year
87.4% visited their primary care provider in the last year
6.6% of people in Region 9 reported that the hospital emergency department was their usual source of care (CO average is 4.8%)

The two hospitals in the county report many of the patients presenting in their emergency departments are uninsured. At Mercy Regional Medical Center just under 50% of the patients presenting for care are either uninsured or self-paying.

Of people who deferred medical care, 12.8% were insured but still deferred because of out-of-pocket costs
38.4% deferred medical care because they were uninsured

Mercy Regional Medical Center's Emergency Department is the only provider in La Plata County in the Colorado Indigent Care Program

ASSET INVENTORY

Age 0-17:
San Juan Basin Health Department provides a number of programs to meet the needs of special pediatric populations, including pre-natal services. In addition the Integrated Child Health Program is a model program working with local pediatric practices providing navigator services for children ages 0-5 and their families.

The Early Childhood Council creates community partnerships and training opportunities with programs for pre-school aged children including in-home care providers, Headstart, and Community Connections.

Pediatric patients are well served by the pediatric practices in the county. The state of Colorado has recently expanded CHP+ and Medicaid coverage and practices do see these patients. There are adequate numbers of obstetricians and Certified Nurse Midwives to provide prenatal care.

The School-based Clinic at Durango High School provides a broad spectrum of services for students at the high school. The majority of their services connect students with behavioral health and contraceptive resources, although basic health care services are also available.

Southwest Colorado Mental Health Center has a broad range of services for children and their families.

Dental Services to pediatric patients, particularly those with no or little dental insurance are provided by San Juan Basin Health Department's Smile Makers program as well as by several area dental practices.

Age 18-64:
La Plata County is served by a wide range of medical specialists and two hospitals. Medical resources in the county are far beyond what could be expected in a rural county with 50,000 people.

Mercy Regional Medical Center has a faith-based corporate sponsor and provides services to all patients, regardless of ability to pay.

Mercy's Health Services Clinic has been certified as a Rural Health Center and serves un- and under-insured residents. As of the writing of this report, the clinic is financially supported by Mercy, the city of Durango and La Plata County.

Southwest Colorado Mental Health Center provides a full array of behavioral health services, including acute inpatient treatment. Support for certain programs comes from La Plata County and the city of Durango.

San Juan Basin Health Department provides a number of programs for prenatal care and other women's health services (cancer screenings), communicable disease prevention, nutrition and home health.

Planned Parenthood provides contraceptive services and is the only area provider of pregnancy termination services.

Most of the medical practices in the community offer some form of discounted fees for patients with limited ability to pay.

The Southern Ute Tribe has been meeting the needs of its members and recently changed its affiliation with Indian Health Services. In light of this change, the tribe is working to rebuild its tribal clinic.

San Juan Basin Health Department's Promoviendo la Salud Program provides outreach focused on prevention for La Plata County's Latino population.

The 9 Health Fair provides low-cost screenings to between 1300-1600 individuals each year. Regional fairs serve an additional 250-500.

Fort Lewis College serves its students with a Student Health Center and Counseling Center, which are staffed with providers and which are connected to the local community via relationships with community-based providers.

Durango is fortunate to have a more than adequate number of dentists and dental hygienists.

Non-traditional medical practices are available from a wide variety of providers in the county, most notably in Durango.

The City of Durango and other municipalities throughout the county are focusing on healthy lifestyles and healthy communities.

Transportation services, operated by Durango Transit and Road Runner (through the Southern Ute Community Action Program) are available within the city of Durango, out to the Mercy medical campus and between the communities of Durango, Bayfield and Ignacio.

The county has a fully-staffed Veterans Administration clinic located in Durango providing primary care services.

<u>Age 65+</u>
Many of the assets listed above apply to La Plata County's elderly population. In addition:

La Plata County Senior Services and San Juan Basin Health Department are collaborating to provide outreach nursing services.

Four Corners Health Center provides long-term care in Durango.

Hospice services are available locally at Hospice of Mercy, a partnership with Centura Health at Home.

SWOT (STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS) ANALYSIS

STRENGTHS

The state of Colorado is, by some measures, one of the healthiest states in the nation. This is certainly evident in La Plata County where many of the county's residents regularly exercise, have access to locally grown, healthy foods, maintain a reasonably healthy diet and have active lifestyles.

La Plata County has medical providers in a much wider range of specialties than could be expected in a rural area of approximately 50,000 people. There are many providers, organizations and programs and two excellent hospitals currently addressing the medical, behavioral and dental health needs of many of the county residents.

La Plata County has 3.24 active practicing physicians for every 1000 residents. This compares favorably with the Colorado average (3.1/1000) and the national average (3.2/1000).

Many community organizations, including La Plata County itself, are concerned about access to primary care, particularly for residents who are either uninsured or covered by one of the government-sponsored insurance plans. These groups are invested in working towards solutions.

The Durango Network is a resource for medical practitioners in their negotiations for reimbursement rates from insurance companies. The Network is taking an active role in developing electronic communication and quality of care strategies among its members.

La Plata County has been certified as both a Health Professional Shortage Area (HPSA) and a Medically Underserved Population (MUP). Both of these designations can be effective tools in recruiting primary care providers.

WEAKNESSES

Physician groups have been slow to come to the table to address access issues. Individual practices make their own, often admirable, efforts, but don't see the whole picture. Reimbursement levels from both commercial and government-paid insurance plans hold

practices hostage and force difficult business decisions. None of the physician practices in La Plata County accepts the Colorado Indigent Care Program.

While La Plata County has a typical ratio of physicians to the population, the number of physicians practicing in primary care is substantially below the typical 50-50 split. Of the limited number of primary care practices, only a few accept new patients covered by Medicare or Medicaid. While La Plata County has more than enough dentists to cover its population, only a few see Medicaid-covered patients.

La Plata County has an adequate number of providers of prenatal care however many members of the county's Hispanic community are not receiving care until the third trimester.

Few of La Plata County's dentists accept adult Medicaid patients.

La Plata County is a rural county and transportation to/from health care providers can be difficult, even more so during the winter months.

La Plata County does not have a fully-developed IT infrastructure, nor is data exchanged between and among care providers occurring in a way that is timely and supportive of quality care.

The employment base in the county is predominantly small employers (more than 80% of the members of the local Chamber of Commerce have 5 or fewer employees). Many of these businesses can no longer afford to provide a health insurance benefit to their employees. Many of the employed uninsured are in entry level positions with wages that make it extremely difficult for employees to purchase health insurance on their own.

There is a population of undocumented residents in La Plata County. They work locally yet few residents acknowledge their existence in the area or the health care needs of their families.

The practice environment in Colorado makes it more difficult for Nurse Practitioners and Physician Assistants to establish a primary care practice in Colorado than in the surrounding states. These states are aggressively pursuing these providers with attractive recruitment packages.

Slightly over one-fourth of the practicing physicians in La Plata County are at or near retirement age.

In today's economy there are no guarantees of funding that will be sustainable forever. State and National support and reimbursement rates will be challenged by budgets. Foundations will have limited resources and will have to restrict the projects in which they invest. Charitable donations will be limited by individual financial circumstances.

OPPORTUNITIES

There is a role for the La Plata County faith-based community. In many areas these groups are an important part of support for the community health centers.

Partnering with local colleges helps in developing and enhancing training programs for nurses and other health care staff. It could also help in developing cooperative programs with other training institutions for rural outreach or training sites. These can be a successful recruitment tool. Student nurse programs and primary care residency outreach sites are 2 examples. These programs can provide an economical option for increased staffing for local offices.

The community can come together to create a recruitment committee which includes businesses, schools, recreational and volunteer organizations – to recruit a provider's entire family.

Involving the municipalities in the county adds depth to County efforts. Communities throughout the county have opportunities to support healthy lifestyles. The City of Durango is actively pursuing opportunities for citizens to become healthier. The healthier people are, the fewer health care providers the community needs. Transportation for people to/from health care providers is also an important contribution.

Communication and sharing of appropriate patient information between and among providers, hospitals, pharmacies, public health, etc. will result in lower costs of care and higher quality of care. Feedback with comparison data motivates providers to change behavior and has been shown to improve quality of care in communities like Grand Junction. Aligned incentives encourage medical providers to focus on the needs of the entire community. Insurers are considering incentive payments for quality, especially in primary care. There is a current study involving five of Colorado's largest insurers (Aetna, Anthem, Cigna, Humana and United). These insurance companies are participating in a pilot with the Colorado Clinical Guidelines Collaborative and 17 practices in Colorado to research the impact of reimbursement based on achievement of quality measures.

Telemedicine can provide access to specialties not available in the community and allow patients to receive some care without having to travel longer distances.

There are 199 physicians with active licenses living in La Plata County. Active practices are maintained by 162 of them, leaving 37 physicians in the area who are no longer working in an office. Some of these could be interested in donating their services to provide care at a community health center.

Funding has been increased and criteria have been met for eligibility for Federally Qualified Health Center designation. La Plata County could identify an entity to develop a proforma and apply for an FQHC-status community health center. An FQHC could develop an outreach program and be a resource to communities throughout the county.

Centralized eligibility determination would save overhead costs for many organizations and provide a patient-friendly approach.

Members of both the Citizens Health Advisory Council and the Health Services Steering Committee are the latest, yet separate, iterations of community efforts to address health care needs in La Plata County. Forming a single group to address ongoing and future needs (such as provider recruitment or long-term care needs as the population of the county ages) could bring together any and all organizations involved in community health and create a forum with a specific role and identity in the community.

La Plata County has a strong public health partner in San Juan Basin Health Department. There are multiple opportunities for public health-private health partnerships to meet the needs of patients beyond the provider's office (for example, home visits).

Changes in IRS rules for non-profit organizations will require them to demonstrate planning and specifics around investments they might make in community benefit activities. This could be an opportunity for combining energy and resources towards common community goals related to health care.

THREATS

If we do get meaningful health care reform at the national level, the county could have more individuals covered with health insurance. This could create an exponential growth in demand for services.

There is a continued low number of medical students choosing primary care residencies. All workforce projections point to a crisis in the availability of primary care physicians. To meet the need, the preferred model for providing care in the future will be an interdisciplinary team of physician and non-physician providers. This model is not strongly supported by the Colorado licensing regulations.

Fewer and fewer employers will be able to provide health insurance benefits if costs continue to increase.

The increasing number of retirees being drawn to Southwest Colorado will strain current resources in primary care providers and will increase the numbers of Medicare-covered patients in the county.

All successful models involve buy-in and agreement among all parties including medical staff, and recognition of their role in reaching the goal of a healthy community. Leadership will be needed from all stakeholder groups.

DISCUSSION OF POSSIBLE MODELS

There are numerous examples of models to address access to care, both inside Colorado and across the nation. Many communities have local initiatives in place. Across the country community leaders agree that local programs are effective in increasing access to health care. Despite the unique aspects of each specific plan, often tailored to fit a wide variety of different local communities, these approaches fall into a relatively small number of categories. Each has advantages and disadvantages that may be more or less meaningful in a community. Each has different issues in terms of financial sustainability.

There are initial, basic approaches which every community should begin with. These are the foundation upon which other models can build. They include obtaining designation as a Health Professional Shortage Area (HPSA) and/or as a Medically Underserved Population (MUP), having a Certified Rural Health Clinic, and establishing a school-based health center. La Plata County has done a good job of undertaking many of these. There are other basic methods that can be considered, most notably applying for a Federally Qualified Health Center (FQHC) and establishing a volunteer provider/donated care program.

Beyond these initial efforts there are additional ways to address access to care. Many of these require a high degree of cooperation among members of the health care community. These include multi-share programs that offer health benefit packages (as opposed to health insurance), community partnerships in the form of alliances, public and private health partnerships, health service tax districts, and city or county mandates for employer coverage requirements.

The keys to success in all of these efforts lie in several areas: engaged leadership, cooperation among often competitive parties, and financial sustainability.

Models that could be applicable in La Plata County include an FQHC, a volunteer/donated care program, an alliance of community organizations with a stake in community health, a partnership between public health and private health care offices, a multi-share program for small employers, and a voucher program to facilitate services for specific population of county residents. Each of these is discussed in further detail below.

FEDERALLY QUALIFIED HEALTH CENTER

A Federally Qualified Health Center is the basic building block of most communities' approach to access to health care for low income, government insured, or uninsured people. An FQHC is a government designation that verifies that a community health center provides a certain level of services, accepts all patients and is governed with patient input. A sizeable increase in funding for new FQHCs is included in the health care reform bill which is currently being developed by Congress. January 2010 estimates are that the requests for applications for new FQHCs could open in April 2010. While an application is no guarantee of approval and funding, there is an increased interest by the current administration in approaching access to care through FQHCs. It is a necessary

process for entering the queue for future opportunities, should an application not be successful in the first attempt.

There are a number of advantages of a Federally Qualified Health Center for both patients and the center itself. For patients an FQHC must offer a wide variety of services including physical, behavioral, dental and vision health to patients of all ages. It must accept patients covered by government insurance plans and offer a sliding fee scale. The federal government requires that at least 51% of the members of an FQHC board of directors be users of the FQHC's services. For the health center, there are increases in reimbursement from the government and an initial grant of $650,000 which is guaranteed for the first 3 years of operation. Often there are state grants for which the FQHC is eligible. The federal government provides liability coverage, so the clinic saves the cost of private malpractice insurance for its employed health professionals. FQHCs are also eligible to participate in federal buying programs which limit the cost of some supplies, particularly drugs. These benefits, along with changes in reimbursement and eligibility for ongoing federal grants make the difference in helping FQHCs reach financial stability.

DONATED CARE

There are numerous examples of volunteer or donated care ("Project Access" programs) across the country. I counted close to 50 separate websites for programs. Most of them can trace their beginnings to Project Access in Buncombe County, North Carolina which began in the mid-1990's. Members of the Buncombe County Medical Society felt that the efforts individual practices were making to address care of the medically indigent were not enough. They created a centralized administrative operation which processes eligibility, maintains a patient database and seeks out medical provider volunteers to donate care to a specific number of patients each year. This program also schedules appointments for the enrolled patients and provides a reminder system to help patients with follow-through.

Scaled down versions of this program differ in the array of services they provide. This typically minimizes the clerical staffing in the program and focuses simply on getting providers to donate care to a specific number of eligible patients. Some utilize eligibility determinations made by other health care entities in their communities.

One variation of a donated care program is the Marillac Clinic in Grand Junction. Marillac sees only uninsured patients and provides them with primary care services (fully integrated medical, behavioral, dental and vision care) through its employed and volunteer providers. Medical and surgical specialists in the community donate their care to see all referrals from the clinic. Community support of the clinic, particularly from the faith-based community, has been critical to the clinic's ongoing success. This support takes the form of financial contributions and volunteer efforts.

Donated care programs are advantageous in that they serve a specific population whose medical needs often are unmet. The Buncombe County program's criterion was uninsured individuals whose income was at or below 200% of Federal Poverty Level.

The program is relatively low cost, supported first by grants from foundations with ongoing funding from state and federal programs. Assisting patients with follow-through and compliance has in turn reduced inappropriate use of local hospital emergency departments. The administrative program can also link applicants with existing programs for which they might be eligible. The Buncombe County program has 85% participation by physicians in the county and so has spread the financial burden of caring for these patients across many practices. It also provides a known point of financial commitment, around which private practices can budget and plan.

There are minimal disadvantages to this program. Provider participation is crucial. Once projections are made to determine number of eligible participants, further calculations on provider participation and numbers of patients to be seen in each primary care office can be made. If a formalized "office" for the program is developed, there are staffing and other overhead costs.

A key factor in the success of donated care programs is physician leadership. Individuals who truly believe in the program are necessary to recruit participating colleagues. Attributes of successful leaders for this program include a sense of service to the community, including acknowledgement of the necessity of addressing the health care needs of all community members. Powers of persuasion are also helpful. Buncombe County found that physicians close to or just beyond retirement age were willing volunteers.

HEALTH INFORMATION EXCHANGE

Grand Junction, Colorado's system of providing care in Mesa County has been the focus of much investigation as elected officials and their advisors attempt to find a solution to health care delivery in the U.S. The model of care delivery there involves every aspect of the community's health care resources and has been decades in the making. It is not the intent of this paper to present an in-depth analysis of that model. There are, however, highlights which are applicable for consideration in La Plata County.

The success in Grand Junction is multi-factorial and due to closely aligned incentives and goals. The medical community is close-knit and almost all are members of the local physician network. This network had the foresight to recognize the value of communication of health information among and between practices. Their creation of the Quality Health Network (QHN) has allowed for communication to take place among medical offices which in turn has allowed for some of the highest quality health care being delivered at some of the lowest costs in the country. Sharing of appropriate patient information between providers has prevented delays in care and eliminated duplication of services. The data passing through QHN can be used by insurers to review patterns of care for specific diagnoses, factors surrounding readmissions to hospitals and costs for episodes of care. Insurance companies can report this information out to providers who can review how their treatment of patients compares with that of their colleagues.

The Grand Junction providers have a partner in Rocky Mountain Health Plans (RMHP). RMHP is also a leader, recognizing that it is in the interest of patients, providers and

insurers that patients are treated with the highest quality, most effective measures while making sure that treatments provided are necessary, not duplicative and the most reasonably-priced option to adequately address the medical concern at hand. RMHP rewards providers by reimbursing them based on these behaviors.

In addition to providing incentives for quality care, RMHP also brings a rather unique book of business to the model. Rocky Mountain Health Plans is the fiscal intermediary for both Medicare and Medicaid on the western slope. Added together with RMHP's commercial business, they cover over 80% of the patients in Mesa County. Developed as a tool to ease the administrative burden of managing their many insurance coverage plans, RMHP made the decision to reimburse Medicare, Medicaid and RMHP commercial plans at similar rates. The consequence of this was the burden of payer mix reimbursement differences was essentially eliminated for the medical practices. Medical offices no longer had to try to balance how many Medicare or Medicaid patients they could afford to have in their practices.

A very important piece of the Grand Junction model is the Marillac Clinic. The Marillac Clinic serves the area's uninsured patients. Local medical practices refer uninsured patients to Marillac where programs meeting their medical, behavioral, dental, and social needs can be addressed by the clinic's integrated program. Marillac has many more resources for its patients than a typical medical practice could offer.

The final piece in the model is their approach to end of life care. An active hospice program enrolls patients very early, at an average of over 100 days in 2009 vs. the typical enrollment which in La Plata County ranges from 3-50 days. Enrolling patients earlier creates an environment for important discussions and decisions and, in the experience of the Grand Junction model, reduces the costs and dependence on extraordinary measures in the last weeks of life.

It is improbable that the entire Grand Junction model can be duplicated in La Plata County, at least at this point in time. However, pieces of the model can be further considered and will be addressed in the Recommendations.

MULTI-SHARE PROGRAM

Being uninsured means delaying or foregoing care for many people. Two-thirds of the uninsured population in La Plata County is actually employed. This is not for a lack of caring or concern on the part of La Plata County employers, but rather cruel proof of the current out of control costs for small businesses to provide health insurance benefits. Right now in Colorado, only 38% of small businesses (those with less than 50 employees) are able to afford to provide health insurance for their employees.

Pueblo County, Colorado was concerned about the inability of local small businesses to hire enough employees. Research revealed that the lack of health insurance benefits was a big part of the problem. In the San Luis Valley they had a similar problem – a large number of uninsured residents whose employers could not afford to provide them with health insurance benefits. The answer in these two communities was to create a "multi-

share plan" of health benefits. Multi-share programs do not provide health insurance. Instead a package of health care benefits is put together and the cost of that package is shared by 3 parties: the employer (who pays a cost/month for each enrolled employee), the employee (who pays his/her share each month) and a third party. In Pueblo the third share is paid for by the county. In Alamosa a local community foundation is covering the third portion.

It is important to stress that this is NOT a health INSURANCE plan. Employees enrolled in this program are not insured for coverage of any and all episodes of care. It is a package of specific benefits which are available to employers and employees who meet very strict criteria. Although it is not insurance, the benefits package is so similar to actual insurance that the State of Colorado must pass legislation that grants statutory authority to operate the program and provide specific limitations and protection for consumers.

The health benefits provided in the multi-share program are developed locally by a committee of providers, hospital representatives, employers and employees who would be enrolled in the plan. There is a focus on preventive care and wellness but primary care visits and referrals to specialists are included as is hospitalization. Co-pays and preauthorizations are required for some services. Some services have benefit limits.

Criteria for eligible employers include the business being located in the community and meeting the local definition for "small business" (typically 2-50 employees). Eligible employees in the two current pilots in Colorado must work a minimum of 15 hrs/week and make less than $15/hour. Further details are available on the websites for these two programs which are listed in Appendix C.

Multi-share programs address a population in many communities that is often uninsured: the working uninsured. With careful actuarial planning the model has proven to be a successful approach to addressing access to and cost of care for this population. The monthly share is an amount much lower than the costs for either an employer or employee to purchase group health insurance. Benefits obviously are a factor in determining share costs. In Pueblo the shares have been near $60/month/share over the first several years of their program. The San Luis Valley Health Access program has monthly share costs under $50/share. Another multi-share program in Muskegon, Michigan, reviewed for this project, has a $30/month/share cost. The major drawbacks of the approach are the need for careful financial projections and commitment of contributions from the party providing the third share. Another consideration is the need for a successful marketing and enrollment program to reach the "critical mass" of members. The program in Pueblo now has its own organization, "Health Access Pueblo" to manage day-to-day operations. At a minimum, a contractual relationship with a third-party administrator is necessary.

VOUCHER PROGRAM

Communities across the country, particularly in southern and western states have quietly created non-profit organizations with voucher programs to help undocumented residents receive care. Many times people go without health care for fear of reprisal and deportation, only showing up in local emergency departments when things have progressed to life-threatening circumstances. Private donations are accepted to help fund vouchers which are exchanged for health care visits. The reimbursement via the voucher is negotiated with the health care provider, typically at Medicaid rates.

In Taos, New Mexico the ECHO Kids program was started to help children who were not receiving care. It was only after implementation that the program realized that 70% of the children they were helping were children in families of undocumented residents. The program covers well-child visits and the occasional sick child visit. It has been expanded to cover pre-natal care for qualifying mothers as well. In its first year the program issued 175 vouchers, converting $48,000 in donations into $150, 000 worth of care.

The advantage of a voucher program is that it specifically states what the donations will be used for. People who disagree with sponsorship or support of the effort simply do not have to participate. The non-profit does not accept federal or foundation dollars that could not be used to care for this population. Medical practices receive an agreed-upon rate of reimbursement vs. the typical small payment that this population of patients can afford (although it is noteworthy that this population, like many low-income, uninsured patients is insistent on paying something towards their care). The care made possible by these voucher systems contributes towards overall healthier communities.

COMMUNITY CARE TEAMS

Many states have considered options for making their populations healthier, working on "healthy lifestyle" programs over the last several years. More recently, states have faced financial pressures as the limitations of current state budgets require cost savings. As state offices have reviewed the costs of health care, it has become obvious to many that population health and chronic health conditions are driving higher and higher state expenditures. While many states have developed programs to address these concerns, Vermont is rapidly gaining recognition for its efforts and its partnerships.

The Vermont Blueprint for Health is a detailed, state-wide program addressing many issues, with the goal of improving the lives of individuals. The program has many approaches, and collaboration plays an important role in all of them. This report is focusing specifically on the Community Care Team (CCT) development and its impact on access to and cost of care.

Community Care Teams are a multidisciplinary approach, bringing together public health and private health care providers to provide care support for people outside of their medical office interactions. Vermont recognized that even under the best of circumstances, socioeconomic and behavioral barriers exist for patients and adherence to prescribed treatment is rarely optimal. CCTs can facilitate access to care and other needed services and by doing so improve health status and reduce the cost of care. Each

team is unique, its staffing determined by local needs. Teams can include resources such as social workers, dieticians, and community health workers. Each is led by a public health nurse. The CCT teams work closely with the patients' primary care providers. The community care model is a home visit/outreach/case management model, taking the team to patients' homes, identifying and addressing social issues which could affect the patient's response to medical treatment or compliance with treatment protocols. Visits at the patient's home before or after scheduled medical appointments can assess the patient's understanding and follow-through. Communication between the CCT and the medical provider result in better care since all the parties have the most accurate information. Use of Community Care Teams is helping Vermont primary care providers operate their practices as medical homes. The focus of the care teams is not on disease-specific care. It is focused on health maintenance and prevention. The goal is facilitated access, whatever the patient's needs. It can include enrollment assistance, referral to community programs, or patient education among many types of support. Patients are referred to CCTs in a number of ways, through provider referral, self-referral and identification by community-based services. In the Vermont pilot the assumption was made that a single CCT could serve a community with a population of approximately 20,000 people.

In Vermont, the cost of the Community Care Teams is being shared by the top five insurers in the state. In the pilot locations approximately 5 full-time positions were added to existing resources for each CCT. The annual cost of $350,000 equals an additional expense of $1.46 per person per month (for a community of 20,000). The return on this investment was much more than just recouping the cost of the staff. Improved coordination leads to improved care which leads to a reduction in health care expenses, most notably reductions in unnecessary emergency department visits and hospitalizations. Financial savings have exceeded the initial project costs. The insurers involved are supporting expansion. Program enrollment and expansion of Community Care Teams throughout the state is planned to double in year 3 and grow six times over by year 5.

The Community Care Teams are only one part of Vermont's larger "blueprint." Assessing the impact of the CCT on population health status and rewarding improved health with increased reimbursement from insurers are also an important part of the success of this project. The scope of this report does not permit an in-depth description of the entire program design, implementation and analysis. However, the reallocation and collaboration in the roles of public and private health described in this model, and the resulting progress in facilitating access and improved health status are important. This model integrates the traditionally distinct cultures of public health and private health care delivery.

Colorado is currently the site of a similar, multi-payer pilot project studying a continuous, comprehensive, coordinated care approach with patients and integrated personal health care teams. The project is even described as creating an "integrated health care neighborhood." Sixteen practices with 17 sites across Colorado's front range are participating. Once the practices have met requirements for "Medical Home" designation, they will receive additional payments from participating insurers including

Anthem, United, Humana, Aetna, Cigna, Colorado Medicaid and Colorado Access. Funding for the project is being provided by the Commonwealth Fund and the Colorado Trust. The project will be used to evaluate the multi-disciplinary approach to health care, its impact on quality of care and health status and also demonstrate savings from unnecessary care.

There are several variations on the "community care team" approach. Many people will be familiar with the terms "case management" and "outreach," maybe even "care navigators" or "care coordinators." Ohio has the Pathways Project's Community Health Access Project-Ohio with community health workers. Texas has created a certification program for their home outreach navigators called "Gateway to Care." Wisconsin has "Wraparound Milwaukee" bringing families that may use multiple social and health care resources together with a single caseworker.

ELIGIBILITY DETERMINATION

Almost every agency that provides any type of health-care related service has responded to the un- and under-insured by offering reductions in its fees. Most often this is done by establishing criteria under which the discounts are extended. An application process is necessary. It is sad, but true, that some ineligible individuals will try to take advantage of programs and reduce the resources available to others. Processes to determine who is eligible can be cumbersome for both the organization and the patient. At its worst the process is inconvenient, embarrassing and demeaning for the patient.

In Northwestern Colorado, the Northwest Colorado Visiting Nurses Association has found a way to make things better. What started out as an effort for the local community health center grew until they worked with their local agencies, organizations and health care practices to create a single-source eligibility determination process. A taskforce staffed by representatives from each of the interested parties created a single list of eligibility criteria acceptable to all of them. The group did not insist on a single discount formula, but left it to the individual entities to apply their specific sliding fee scale. Having a single office responsible for this process eliminates duplication since the same family isn't reapplying at several different medical practices. The actual number of people processed was reduced as each family was processed only once. This meant that a smaller number of resources were needed to meet the need. With a centralized process, the other organizations could eliminate overhead and reassign staff to other areas or eliminate positions. The single source eligibility process also has been able to identify individuals who are eligible for other government programs and facilitate enrollment.

Eligible people are categorized in one of five levels, based on the established criteria and are given a card which displays information for the entire family – much like a family plan health insurance card. Eligibility is good for one year.

Collaborating and combining resources has allowed an economy of scale. Participating organizations support the service. The cost of the service is considerably lower than the internal costs many of these organizations were carrying to run their own programs.

The advantages of this program are its patient-oriented approach. The application process is relatively simple and it minimizes the need to travel to different locations and repeat the same information at each new stop. It also facilitates enrollment in other programs. There are also advantages to the local organizations which have reduced overhead costs. The biggest advantage to health care businesses is that they do not have to change their individual fee schedules.

The biggest hurdle is having a group willing and able to assume the responsibilities. Resistance to a single set of eligibility criteria can be reduced if the effort piggybacks on some of the already established criteria available at the state level, such as those for the Colorado Indigent Care Program.

COMMUNITY ALLIANCE

Reading about these models might lead to the question – "and how do we get all this done?" The need for a community-wide effort is obvious. The people in northern Colorado faced the same question at one time and found the answer in the creation of the Northern Colorado Health Alliance (NCHA) in Greeley.

In Greeley people were frustrated with the lack of success from a previous, large community group effort. They identified that the right people, the decision-makers of organizations whose work touched health care, needed to be the ones at the table. In creating the Alliance, community leaders designed a non-profit corporation with a goal that "all underserved residents will have access to appropriate, affordable, comprehensive quality care." NCHA is led by a working board of directors which is responsible for strategic health planning and action through leadership, collaboration and integration. Members of the alliance include representatives from medical, behavioral and dental clinics (including representation from the Family Medicine residency program and Sunrise Community Health Center), hospitals, public health, Weld County, United Way, the county Medical Society and local colleges. This group recognizes that competition exists between members yet they have identified common interests among the alliance's members. This recognition of overlapping interests has allowed the group to have a shared vision in meeting the community's health needs.

The Alliance is organized into three main areas of focus: primary health care needs (including medical, dental and behavioral health), workforce development and infrastructure. It serves as an "integrator" of health services in Weld County, working to identify projects that will provide a greater benefit if approached collectively.

Financial stability for the Alliance and its projects comes from several sources. The members of the Alliance pay dues, based on their own organization's annual budget. This amounts to approximately $250,000/year and is used to pay for administration, which was added after the initial start-up. Much of their work is accomplished using funds already in the community and from the member organizations' existing programs and financial budgets. The Alliance has done local fundraising for specific projects (i.e. they

raised $6 million for development of their community health center) and occasionally seeks grants for targeted projects.

The focus of the Alliance is on patients and families as a first priority. This means the primary advantage of the Alliance is the collaborative effort of many, often competing, entities towards a common goal. Combining efforts brings maximum resources to an issue, coordinating an approach to a problem and eliminating duplicative, less successful programs. However, it is important to realize that building a successful alliance requires time (and the right projects) to build trust among members. The success of NCHA has also depends on having leaders at the table who are the decision-makers for their organizations. The Alliance needs to be able to make its own decisions and commitments without a lengthy process of members returning to their own organizations to ask for permission, financial support, etc.

FINANCIAL CONSIDERATIONS

This project was charged with assuring financial stability of its recommendations. The challenge of doing that in 2010 cannot be understated. Financing mechanisms that were thought to be a "sure thing" have disappeared in the dust of the diminishing economy. Foundations are more carefully distributing the reduced donations they receive. National, state and local budgets are challenged to meet standing obligations. Every organization struggles to create a reasonable budget.

However, the availability of dedicated, stable funding is one of the most important factors in any effort's viability and sustainability. Despite the difficult economic realities, there are ways to fund efforts to expand health care options. As challenging as state and national budgets are, there is a renewed interest in community-based solutions to health care access and this interest is providing new funding opportunities. Foundations, seeking to find the "best use" of their funding, are investing more than ever in health care projects. No one source of funding can provide the entire solution. Successful efforts are creative and take advantage of any and all financial resources

GOVERNMENT PROGRAMS CAN BE A MAJOR SOURCE OF FUNDING:

Medicaid and CHP+ offer enhanced reimbursement to practices serving a qualified level of medically underserved patients. Physicians can receive an additional $10 per checkup for kids under age 4 and an additional $40 per checkup for kids five and older. If a school-based health center has an FQHC as its medical sponsor it is eligible for enhanced Medicaid and CHP+ reimbursement. The Colorado Indigent Care Program provides reimbursement for participating practices for uncompensated care provided to medically underserved patients.

Grant funding is available through the Comprehensive Primary and Preventive Care Program and the Primary Care Fund to maintain or expand existing health services in practices that meet state requirements.

Health Information Exchange will be required of medical practices within five years. The definition of "meaningful use" of electronic health records (EHR – also known as electronic medical records or EMR) and the exchange of information to coordinate quality patient care is being debated as we read this. Large amounts of grant money are available through the American Recovery and Reinvestment Act (otherwise known as "stimulus funds") to install and implement electronic health records and health information exchange. Additionally, incentive payments from Medicare and Medicaid will be made for "EHR-certified" practices that meet other criteria. Once certified, a medical practice may receive a maximum of $44,000 over five years from Medicare. Beginning in 2015 practices that do not quality will be subject to penalties. Medicaid incentive payments will be based on the cost of the initial implementation or upgrade of the practice's EHR, up to $21,250 for the first year and $8,500 in up to the 5 subsequent years.

Federally Qualified Health Centers bring additional funding beyond that available to community health centers and rural health clinics through Section 330 Public Health Service Grants. Enhanced reimbursement is based on actual operating costs and subject to a higher cap than any other health center. Added funding (up to $650,000) is available in the form of federal grants for start-up operations. These funds are guaranteed for the first 3 years of operations and can be renewed in subsequent years if qualifying criteria continue to be met. Professional liability insurance for contracted providers is provided by the federal government for FQHCs – a substantial savings in overhead costs.

PARTNERS ARE AVAILABLE:

Across the state organizations have grant funding opportunities. Colorado Rural Health Center is currently offering grants up to $50,000 for efforts to improve health services in rural Colorado.

Volunteer provider programs bring considerable "in kind" financial resources to programs in salaries not paid. Professional liability coverage costs will be an issue for physicians not currently in practice. There are opportunities with COPIC Insurance (a company providing professional liability insurance for health care) for coverage and with the State of Colorado to investigate potential legislative changes to minimize the financial risk for providers caring for the medically underserved.

Insurers are an important part of the financial environment. The Grand Junction model has demonstrated the success of reimbursing for achievement of quality measures. The current pilot projects in the Colorado Clinical Guidelines Medical Home project can reinforce this with major insurers. Practices designated as Medical Homes are eligible for enhanced reimbursement from Medicaid and CHP+. In Vermont, insurers are funding

pilot projects of community care teams. There are financial opportunities to seek partnership with one or more insurers.

Communities often contribute to financial sustainability through County-funded support or through local community foundation support of specific projects. In Pueblo the County supports the local Health Access small employer health benefits program. La Plata County supports a number of health care programs and efforts including support of San Juan Basin Health Department and Southwest Colorado Mental Health and services to indigent residents. In Colorado taxpayers can vote to support health care through health assurance districts or health service districts. Demonstration of community involvement and commitment in terms of financial contributions may be an important part of receiving funding from other sources.

Groups within communities can offer additional financial resources. In Grand Junction the faith-based community provides substantial support for the Marillac Clinic which serves the uninsured. Employer groups or local chambers of commerce can support programs for small businesses designed to maintain or expand access or coverage by contributing their portion in a multi-share program. Local hospitals contribute to community benefit programs. Mercy Regional Medical Center's contribution towards the Health Services Clinic is an obvious example of this. United Way can also support community health care efforts. Pharmacies and nursing homes can provide donations of supplies to help decrease costs in some programs, particularly pharmaceuticals.

FOUNDATIONS IN COLORADO:

Although foundation funding can be viewed as temporary and as such not truly contributing to sustainability, foundation funding can help with start-up costs, bridging gaps until a program becomes fully operational. Foundation funding can cover the costs of special efforts, such as a needs assessment or community survey so that those costs do not have to come out of otherwise limited budgets. Foundations continue to generously support access and coverage initiatives in Colorado. (See Appendix C for a partial listing.)

PATIENT PAYMENTS:

It is important not to overlook the contribution that patient fees bring to overall financial performance of some programs. Even in clinics serving the uninsured, patient revenues bring in from 10-30% of total revenues.

In other projects, it might be typical to include financial projections with each of these potential funding sources. Because of the nature of the recommendations being made in this report, and the many alternatives to meet those recommendations, specific implementation plans will be necessary before financial proformas can be developed.

RECOMMENDATIONS:

Access to care is really two separate issues: having enough providers to see the patients and having care available at a cost that patients can afford. For many people the "cost" factor is a combination of affordable health care insurance coverage as well as the actual fee for the health care service. The relationship between health insurance status and access to and use of health care services has been established by a number of different research studies.

The recommendations in this report are made to address the premises of the original project proposal made to The Colorado Health Foundation. The project was intended to "address four priority needs: a) a lack of primary care physicians per capita in La Plata County; b) a lack of access to medical care for the uninsured, the under-insured and those individuals receiving Medicare and Medicaid; c) a lack of a culturally competent, integrated, quality health care system that connects patients, providers, and regional hospital services across all levels of primary care, mental health care, and preventive/wellness care; and d) the absence of a sustainable funding stream for local health care priorities."

There are eight specific recommendations in this report. They are listed below along with the rationale for their inclusion. Many of them address more than one of the priorities listed above. Appendix B is a summary matrix demonstrating which priorities of the project are addressed by each recommendation.

Recommendations alone do not solve health care access problems. All people must have their basic needs (food, water, sleep-and a safe place to do it) met first before they can think about their health. In La Plata County one-third of the population is living at less than 200% of the federal poverty level. As our communities address poverty and housing, healthy lifestyles and environments, they are setting the groundwork for addressing community health. When people can walk or ride a bike instead of driving, have access to natural foods and clean water, then they can lead healthier lives. Healthy lives mean people have fewer reasons to see medical care providers. This, above all else, is the solution to the number of providers needed in La Plata County.

Getting and keeping ourselves healthy is a goal – and the most important one worth pursuing. It is the responsibility of each individual and the community as a whole. As we work to make that possible for all residents of La Plata County, we can focus on making sure that everyone can see a medical care provider when they want or need one.

RECOMMENDATION 1: Form a regional health care alliance.

The single-most effective method to address health care issues in La Plata County is the formation of a county-wide health alliance. A "Southwest Colorado Health Alliance," patterned on the Northern Colorado Health Alliance (NCHA) in Greeley, could be the forum to address most of the other recommendations that follow in this report. Despite the hard work, history and past successes of the two existing community groups tackling

health care access in La Plata County, the work that needs to be done is beyond the scope of community volunteers. Only decision makers can speak for and obligate their organizations. This is the level of commitment that is needed for implementation and progress.

The Alliance should be created as a non-profit organization. Although legal assistance is not required, donated services from a supportive local attorney might be helpful in doing this. If the alliance was structured specifically as a 501(c)3 organization, it could accept tax-deductible donations. Just like the start of the NCHA, an alliance in La Plata County would not immediately require start-up funding. The work of identifying issues and problems, connecting resources and shepherding projects through implementation requires more in sweat equity than financial investment. The key is collaboration and involvement of high-level decision makers from key community organizations. Membership in the alliance should include representatives from both hospitals; the La Plata County Medical Society; La Plata County Dental Society; La Plata County and Durango, Bayfield and Ignacio; San Juan Basin Health Department; Southwest Colorado Mental Health Center; United Way of Southwest Colorado; 9R School District; Southwest Colorado Community College and Fort Lewis College; and insurers with an interest in the population health of the local health care market. A mutually rewarding relationship with an insurer can benefit patients, providers and the insurance company. Rocky Mountain Health Plans has expressed an interest in being involved in developments in La Plata County. Others may also want to be at the table.

There are many additional health care-oriented groups in the county. They may not need a seat at the table, but the alliance should communicate with them. The alliance should consider input from other population centers in the county, such as Hesperus. It should have a means of hearing from other interested groups such as the Women's Health Coalition, American Cancer Society, Promoviendo la Salud, the Collaboration of Caring Communities, and local business organizations to name just a few. These groups can be included in ad hoc work groups and they should have a way of identifying and bringing health care access concerns to the Alliance.

Leadership of the alliance will be important in making progress and implementing plans. If a leader does not emerge from local health care organizations, a consultant should be brought in to help the group get started. Dr. Mark Wallace of the Northern Colorado Health Alliance has generously offered to help the group coalesce and develop its leadership and cohesion as a community-wide group. There are a variety of options in how this could be done, ranging from seminars to having him join the group for a determined amount of time, to a combination of face-to-face meetings transitioning to telephone contacts. Rates for his services would be determined based on the services provided and would include compensation for his time plus travel expenses.

One of the first tasks of the Northern Colorado Health Alliance was to create a community health center and apply for status as a Federally Qualified Health Center (FQHC). A safety net clinic – whether it is a community health center, a free clinic or an FQHC - is the most traditional approach to meeting the needs of an underserved

population. La Plata County also needs an FQHC, although there are options for the sponsoring organization.

RECOMMENDATION 2: Plan and open a Federally Qualified Health Center.

The possibility of a Federally Qualified Health Center for La Plata County has been discussed and investigated for many years, most recently in 2007 by the consultants from JSI. At that time it was determined that the county would not meet qualifying criteria, particularly because of income levels and prior provider staffing ratios in the community.

There are a number of recent changes in circumstances which support this recommendation now, not the least of which is the current Administration's support of community health and access. Funding for community health has improved dramatically in the last year. To apply for status as a Federally Qualified Health Center requires a community to be either a designated Health Professional Shortage Area or be certified as a Medically Underserved Population. La Plata County has been designated as both. Neither of these was in place prior to 2007.

There are specific requirements for FQHC operations which include providing services to all patients regardless of insurance coverage or lack thereof. The center must provide a wide range of services including physical, behavioral, dental and vision health. It must offer a sliding fee scale. Its governing board must have a majority (at least 51%) of its members be patients of the clinic.

Application for a "start-up" FQHC can bring with it up to $650,000 in federal grant funding, guaranteed for the first three years of operation. The FQHC is also eligible for continued grants as the operation matures beyond three years. In addition to grant funding, an FQHC is eligible for reimbursement based on operating costs. The cap applied to this reimbursement is set higher than the cap for other reimbursement programs such as those for Rural Health Clinics. These two financial improvements, particularly the funding available for start-ups, improve the likelihood that an FQHC can operate at a break-even point.

An FQHC has a number of other financial advantages. It is eligible to participate in federal purchasing programs that allow it to purchase drugs at substantially reduced prices. Additionally the federal government provides professional liability insurance coverage for providers employed by the FQHC. This is a substantial cost savings when compared to the overhead costs of a non-FQHC operation.

FQHCs have access to National Health Service Corps programs to recruit providers and help with their loan repayment. These programs also provide support for training of needed health workers, including stipends for living expenses. In addition, because an FQHC must serve patients with Medicaid and Medicare coverage AND uninsured patients, it becomes eligible for International Medical Graduate staffing. IMGs must serve a medically underserved population in exchange for having certain immigration requirements waived. This boosts the potential for provider recruitment success.

La Plata County is fortunate to have the 9 Health Fair which serves a large number of local residents with screening and preventive care. Many residents of La Plata County use these services in place of office-based primary care and are unable to follow-up with a provider if necessary. The additional providers in an FQHC could meet this need. A fully developed FQHC in La Plata County could eventually provide outreach services outside of the Durango area. The FQHC could have satellite operations in areas such as Bayfield, Ignacio, or Hesperus. At fully-staffed levels there is even the possibility of offering staffing to assist the Southern Ute Tribal Clinic. Any and all primary care providers recruited to staff an FQHC would be additional provider resources for the community.

It is important to note that a community can have only one Federally Qualified Health Center. The potential to create cooperative arrangements across the county strengthens the program and would be an asset in an application. There are several options as to who should apply for and put an FQHC into operation.

The Alliance recommended above could do this. The disadvantages are, however, that this group is yet to be formed and, beyond that, coalesced into a productive community-wide effort. Designing the service delivery system necessary for an FQHC could require lengthy planning. Applications must include detailed plans for operations. Time is of the essence in applying for 2010 and getting into the queue for available funding. And, once approval is given, the FQHC must be operational, open for business within 90 days. There would be huge financial commitments for the alliance to make, including a substantial application fee (approximately $10,000-$20,000).

Mercy Regional Medical Center could change its operations at the Health Services Clinic and apply for FQHC status. The disadvantage of this is that Mercy may or may not want to get into running a Federally Qualified Health Center and all of the operational and governance changes it would entail.

A third option, and the one I believe can give the community the most resources in the shortest amount of time, is the new business model being implemented by Southwest Colorado Mental Health Center. That group is transitioning to become Axis Health Systems, a provider of primary care integrated with behavioral health care. This model of care delivery brings together two critical pieces of the service model. This integrated model is already being implemented in other communities that Axis Health serves. It can move swiftly to add the necessary components and the organization is willing and able to commit the financial, personnel and other resources to submit the application and implement the plan.

Regardless of the sponsoring organization, an FQHC would bring additional primary care provider resources to the community and especially would meet the need for providers to care for the underserved population in La Plata County. In the best case scenarios of national health care reform, 5% of the population remains uninsured. At the time this paper is being written it is difficult to predict what might happen. In La Plata County

over 18% of the population (over 9,000 people) is uninsured. As of 2008, 11% of the population was Medicare-age – another 5,500 people who have difficulty finding primary care providers. Almost 34% of our county population lives below 200% of the federal poverty level – close to 17,000 people. These groups are not mutually exclusive, however the point is, there are thousands of people in La Plata County who would be served by a Federally Qualified Health Center.

Regardless of where people are cared for, there is an increasing awareness that communication plays an important part in the quality and the cost of the care that is delivered. No place has made this clearer than Grand Junction, Colorado. As communities grow they offer a variety of options to health care consumers. And as patients require services it is typical that records will need to be forwarded or images carried to specialists or facilities, often across different organizations. This is difficult enough in a local community, but referrals to larger, out of town medical complexes are even more challenging (and unsuccessful).

RECOMMENDATION 3: Create a Health Information Exchange platform so that all providers of health care and health-related services can have access to appropriate health care information for their patients.

Health Information Exchanges (HIE) are not electronic medical records. They are software platforms that allow for the exchange of information between offices. An HIE creates a way for medical providers to share information with each other electronically – eliminating the need for copying records and lengthy games of "phone tag." In the most contemporary version of HIE, offices that have their own electronic medical record systems can now share their information with offices that have completely different electronic medical record programs. Converting to an electronic medical record is attractive to offices that have not previously had an electronic record system because it brings efficiencies that save money and enhanced levels of service.

Quality Health Network (QHN) is the Health Information Exchange in Grand Junction. QHN has spent the last decade creating and perfecting the software necessary to connect providers across Mesa County. They have recently expanded to communities such as Montrose and Delta and have a strong interest in connecting with providers in La Plata County. President Obama's visit in the summer of 2009 highlighted that QHN has had an important role in the recognition Grand Junction has received for providing some of the nation's highest quality health care at some of the lowest costs. When physicians have access to patient information they can reduce duplication of diagnostic tests. They can get lab results sooner and begin treatments sooner. QHN has demonstrated that sending and managing patient information electronically can save practitioners hours of time. When an unconscious patient is brought to an emergency department, it can save lives. Imagine the possibilities of information-sharing between provider offices and public health, between nursing homes and providers, between a hospital here and a hospital in Denver. Communication can strengthen relationships between providers of traditional medicine and alternative therapies – enhancing care for their mutual patients. All of this can be

done in a manner compliant with privacy laws – minimizing the paper with patient information.

A unique advantage of Quality Health Network is its "lite" version of an electronic medical record system which may be attractive to practices worried about the cost and commitment necessary to purchase a full-blown digital system. This feature is available to members of QHN although it is not required for participation.

It is my specific recommendation that Quality Health Network be the Health Information Exchange program that La Plata County providers pursue.

The ability to develop a Health Information Exchange among providers of diverse affiliations will benefit patients first and foremost, improving the quality of the care they receive and reducing costs. Recognizing the important role that digital information can have for health care, the American Recovery and Reinvestment Act provided specific directives for implementation of health information technology in medical practices. The imminent need for medical practices to have "meaningful use" of an electronic medical record (EMR) is driving implementations in offices that have previously not had a digital record. The federal government is first offering financial incentives for implementation and then, after several years, will actually reduce reimbursement to practices which are not using an EMR.

Each state was directed to develop a program and a process for connecting its medical practices across the state. In Colorado the Colorado Regional Health Information Office is working with Quality Health Network to accomplish that goal. The state of Colorado received $20 million to accomplish the work. A portion of those funds have been set aside for southwest Colorado.

The Durango Network has sponsored several meetings between Quality Health Network and area providers and hospitals and can continue to play a leadership role in this effort. Interest in further discussions remains high and conversations continue. Initial estimates are that one-time implementation costs would be less than $1 million. Ongoing costs have been estimated to be, on average, between $200-400/month/provider. Monthly costs are based on use, but are more than covered by savings in the practices.

Having a Health Information Exchange might not seem to directly address access to care, but the ability to have the information available when care decisions are made eliminates unnecessary appointments and reduces delays in care.

As important as communication between and among providers is, communication with patients is just as critical in determining health status. Many states and communities across the country are challenged by keeping patients and their providers connected outside of the exam room. For the provider, the information the patient provides in the office is often incomplete. For the patients, instructions and education from their provider can be forgotten or misunderstood by the time they get home. Yet, the health status of a community depends on both having the complete picture.

RECOMMENDATION 4: Create a public health-private health partnership with Community Care Teams.

Community Care Teams take public health skills and use them to enhance private health practice and patient health status. The public health approach of preventing disease is much more economical than treating disease. Community Care Teams, in one form or another, are often seen in states which are implementing medical home models.

Many people in La Plata County may be familiar with the community-based model of public health nursing through case management. Community Care Teams, developed in Vermont as part of the Vermont Blueprint for Health, are a new twist on that approach. Each team is headed by a public health nurse. Additional members are included based on the community's needs (for example, if domestic abuse is a big problem, resources are added to the team who can help address it) and typically include a behavioral health team member and a social worker. The teams are responsible for meeting with patients in their homes and performing typical case management functions: assessing patient needs, identifying a plan, implementing, coordinating, monitoring and evaluating the plan. Community Care Teams can enhance the patient education offered in a provider office. They can assess compliance with medical treatment and connect the patient with psycho-social resources. By their very nature, Community Care Teams prevent fragmentation and provide an integration of services for an individual. Care Teams supplement the care provided in a medical office and have been shown to maximize scarce community resources and prevent duplication of services. Community Care Teams increase patient compliance, increase patients' quality of life and reduce health care utilization.

La Plata County has an exceptional resource in San Juan Basin Health Department. Programs within the health department are reaching and serving a number of underserved populations. There are currently several programs in La Plata County utilizing a community outreach nursing model:

The Integrated Child Health Coordination program, working with Pediatric Partners of the Southwest, helps families of young children obtain primary care, including dental and behavioral health. Developmental screenings and referrals to specialists are among the long list of services provided. It also helps families with insurance enrollment.

The La Plata County Senior Services Program, in collaboration with San Juan Basin Health Department, has two senior outreach nurses who visit the homes of vulnerable elderly in La Plata County. These nurses do health assessments and also provide a social connection to resources and other support services to allow for greater health and independence.

San Juan Basin Health Department also has a nursing outreach program for prenatal care for low income women.

Any of these programs could be the starting point for a Community Care Team. It would be impossible to start out attempting to outreach to the entire county, so the challenge is to identify a starting point with a specific population and expand as the program is successful. To develop a successful team, leadership at San Jan Basin Health Department will need to continue to engage local health care professionals.

Funding for this program could come from a number of sources. In many of the models volunteers are used as community health aides. As part of a community care team they can make phone calls, provide transportation to grocery stores or pharmacies. Sometimes they just go on walks with the patients and take an interest in their lives. Collaboration among the team members' organizations in the form of in-kind donations of staff time is an effective investment as this model serves patients of many agencies. Insurance partners have seen the advantages of community-based support. In a number of states, pilot programs have seen investments by major insurers in the costs of care teams. In Vermont the five major insurers (including the state's Medicaid and Medicare plans) covered the $350,000 cost of each of the pilot teams, recognizing that their individual $70,000 per team investment could be easily recovered by preventing just a few hospitalizations.

Currently in Colorado there is a medical home pilot project with 17 clinics, the Colorado Clinical Guidelines Collaborative and 5 major health insurance companies (Anthem, United, Humana, Aetna, and Cigna) as well as Colorado Medicaid and Colorado Access. This two year project, funded by the Colorado Trust and the Commonwealth Fund, began in the spring of 2009 and will track the care of over 30,000 patients with the potential for increased reimbursement to practices. The project is designed to study the impact of the medical home model. A study of Community Care Teams and their further impact as an approach within the medical home model is an opportunity for partnerships with health insurers as well as foundations and other interested parties.

Existing programs within the community could also be expanded dependent on budget opportunities within La Plata County or the San Juan Basin Health Department. Expansion would not have to be full-scale, but gradual. Consolidation of programs and savings or reallocations could fund part of the costs.

Leadership for this program can come from San Juan Basin Health Department, La Plata County and local medical practices.

Health care and connections in the community can also be accomplished through employers. Across the county employers are very concerned about their inability to be able to afford to offer health insurance to many of their employees. Any time there is a high rate of uninsurance coupled with a relatively low rate of unemployment it indicates that employer-sponsored insurance may not be available or accepted. Some relief may come from national health care reforms, but that has yet to be finalized. And if reform dictates that employers provide coverage, the cost of that mandate will be a concern if affordability is not addressed.

RECOMMENDATION 5: Create a Health Access La Plata multi-share employee health benefits package for small employers and their employees.

In Pueblo and in Alamosa, employers, employees and the communities have joined together to create Health Access systems. La Plata County could do this, too. In the Options Paper, written in 2008 by the Colorado Health Institute, it was noted that there was "no reason why [this model] would not work" in La Plata County. These programs are "multi-share," meaning the multiple different parties (employer, employee and a third entity) each pay a share of the cost of the package. The third share can be paid by a foundation, a local community or a government entity. The program is NOT health insurance. It is the creation of a specific set of health benefits which the program, administered through a third-party, will pay for. These programs are designed for small employers and entry-level wage earners. There are specific criteria defining the benefits offered and the employers and employees who are eligible to participate but the most important aspect to these plans is that they require State legislative approval granting statutory authority as a pilot site before they can be offered. Although these plans offer health benefits, they are not considered to be, nor are they regulated as, health insurance.

Planning, particularly actuarial projections, is an important part of developing this type of program, as is establishing a relationship with an entity to administer the program.

Benefits included in the program are established by a committee of local interested parties, including local health care providers, employers and the employees who could potentially be covered by the program. Criteria for employer and employee eligibility must also be determined.

This model is garnering interest at the state and national levels which is increasing funding opportunities for the third share of the cost. Foundations and local communities or counties typically have paid the third share and this could be a possibility in La Plata County. A more likely possibility is funding from the state. Colorado has been awarded a five-year federal grant so support health care expansion. A part of the proposal from the Colorado Comprehensive Health Access Modernization Program, (Co-CHAMP) included support of three-share community projects. Colorado has been awarded $9.96 million for the first year and part of the 2010 funds have been allocated to the Pueblo and San Luis Valley Health Access programs. There is opportunity for La Plata County in any of the next 4 years. This timing would allow La Plata County to obtain the necessary legislative action and designation as a pilot site.

Leaders for this effort could come from the many business groups in La Plata County communities including La Plata Economic Action Partnership, Region 9 Economic Development and other local business groups.

Just as leaders from the business community can impact access to care, so can leaders within our medical provider community. In communities across the country, local medical societies are developing Donated Care models. Based on the Project Access model developed in North Carolina, physicians donate their services for care to patients

meeting specific criteria (in North Carolina it was uninsured patients below 200% of the federal poverty level). Variations on the program exist in dozens of communities across the country. Some physicians offer the donated care in their own offices. Some donate care at their local community health center.

RECOMMENDATION 6: Formalize a Donated Medical Care Program.

In La Plata County there are many providers who see indigent patients and offer a variety of programs of reduced fees, up to and including donated care. Mercy Health Foundation facilitates referrals to medical and surgical specialists who can choose to receive tax credit for their donated care. The difficulty of the current situation is the variety of approaches results in the inability to quantify and review the work that is being done. With a specific program medical practices could set explicit criteria for eligibility, and the patients could be distributed through practices enrolled in the program. Practices could benefit from tax credits and medically underserved patients could have a point of contact to learn which providers are in the program.

Providers might also choose to donate their services at the newly established FQHC. An FQHC can offer "employed" physicians coverage through the FQHC's federally provided professional liability coverage. A minimal annual salary paid to the physician could entice retired physicians to donate their time to help staff the center. Currently employed physicians, covered by their own liability plan, could donate time to see their eligible patients at the FQHC rather than their office, freeing up the in-office appointment times for patients with commercial insurance coverage.

There are minimal costs to establishing a donated care model. In some models an organized administrative office is set up to determine eligibility, make appointments and reminder calls and to track program enrollment. To minimize these expenses, the program could be accomplished through La Plata County Medical Society membership renewal processes. Physicians expressing an interest in involvement could indicate it. The name of these volunteers could be forwarded to the Foundation at Mercy which could keep the data base of participating physicians and arrange for tax credits per the current procedure. Patient eligibility could be established as part of Recommendation 8 (see below). The largest "cost" of this program is the effort to recruit enough participants to serve the population of patients. The most successful of the donated care models have buy-in and agreement among medical staff that the goal of a healthy community is EVERYONE's responsibility.

Leadership for this project could come from the La Plata County Medical Society and its membership, in particular Dr. Greg Schackel. Dr. Schackel was instrumental in developing the Project Access donated care program in Santa Fe, NM before he moved to Durango. Leadership from within the Mercy Health Foundation could be helpful. If local medical leaders could not devote time to developing the project, assistance can be obtained from consultants such as the Physician's Innovation Network (PIN). PIN is a national consulting firm specializing in Project Access program development. Eventually, leadership from the FQHC will have an important role in contacting retired health professionals in the area to determine their interest in helping staff the health center.

Of all of the people in the county who are uninsured, there is one population that is often overlooked. Eleven percent of the population of La Plata County is Latino yet their needs are often neglected in health care interactions. Eligibility determination and forms are not bilingual. Some offices offer Spanish-speaking health care workers, but not all. Very few could be described as culturally sensitive.

Among this group there is another subpopulation in the county that many people do not acknowledge. These are the undocumented residents of La Plata County. Many of them are Latino. These people are not here because of the low cost of living. They are here because they are working here. They are doing the work that needs to be done, work that local residents will not do. They come with spouses and families. Even if they were "legal" it is highly unlikely that these people would be in jobs that have health insurance benefits. The fact that they are undocumented complicates their access to programs their low-income resident neighbors can take advantage of. Despite their relatively poor standard of living (compared to what many would accept), these people believe they are making a better life for their families here in La Plata County. Yet, many of them do not access health care for fear of reprisal. Children go without well-child exams, adults do not get screenings and preventive care. They end up in local emergency departments when things have progressed to life-threatening circumstances.

RECOMMENDATION 7: Create a non-profit organization which will accept private donations and implement a voucher program to obtain care for eligible undocumented residents in La Plata County.

There are many restrictions on the use of federal or state funds for health care. One of the restrictions is that the funds cannot be used to provide health care to non-residents. For that reason a non-profit would have to depend on private donations to support this program. Being up front about the purpose of the program will give people who have emotional or political reasons for not supporting the program the opportunity to choose not to get involved. La Plata County residents have a history of strong financial support for health care programs through the foundation at Mercy. Mercy, and other local groups like the American Cancer Society currently have programs to fund screening tests like mammograms for low income county residents. The recommended voucher program could work with these established efforts and expand them.

A non-profit organization voucher program accepts donations and then negotiates for care at local medical offices, typically offering something near Medicaid rates. Criteria need to be established to determine eligible participants. The ECHO Kids program in Taos, New Mexico focuses on care for children and pregnant women in families whose income level was under 235% of Federal Poverty Level. Decisions on program specifics would need to be made based on careful projections of available funding and would need to include some administrative costs. Starting with one specific group, like children, and expanding to care for adults when funding levels permit is one way to approach developing the program. In the first year of the Taos program, $48,000 in donations covered 175 vouchers for $150,000 worth of care.

There are several community partners who could work on this project. There is a role here for interested business leaders. Local foundations such as the Mercy Health Foundation could provide guidance.

RECOMMENDATION 8: Develop a single source of eligibility determination that would provide documentation of compliance with agreed-upon criteria.

Many of the recommended programs above reference criteria to determine eligibility for the program or its benefits. This can be a process which is embarrassing to applicants and burdensome for organizations. In La Plata County, in order to determine whether they are eligible for discounted fees or other programs, an individual or family must go through this process at each location, telling their circumstances over and over. It is not an experience that many of us would like to endure. It is humiliating. Any health care organization that wants to offer discounts needs to have a process for determining who is eligible. Those who sought to simplify things and offer discounts without documentation have been taken advantage of. Their response is to have staff dedicated to reviewing financial documents and expense reports.

Many health care businesses in La Plata County offer discount programs for eligible patients. Yet, this creates a double burden. In order to be socially responsible, the business bears additional overhead to determine who is qualified in addition to the discount extended. Having a single organization or process that could determine eligibility would minimize the overhead and therefore the financial burden the business needs to assume. The costs of the current process are duplicated over and over as the individual or family goes through the process again at every location and results in costs in the community that are much higher than they need to be.

A first step in developing this type of a program is getting consensus on the criteria for eligibility. In a similar model which has been implemented in Northwestern Colorado: the local health care organizations met and agreed on the criteria which will be used to determine eligibility for different levels of reduced fees.

San Juan Basin Health Department has a current process for determining eligibility for government assistance programs. This eligibility program could become part of the current procedure. It has the added benefit of also getting people enrolled in state and federal programs for which they are eligible. Only 2/3 of La Plata County's children who are eligible for Medicaid or CHP+ are enrolled.

Since the program would be addressing only the number of individuals or families needing to go through the process and not a total of the number of applications for all the different health care offices combined, the number of staff needed is considerably less than the total number of staff previously engaged in doing eligibility work across all the organizations. Savings within organizations involved in the effort could permit a contribution to the program towards the cost of the necessary staff – a substantially smaller cost than their current overhead – essentially outsourcing this part of their operations for a considerably lower cost.

There is a current community effort consisting of community volunteers, and representatives of local medical practices and the health department that is investigating development of this type of a program. Their leadership can be used to accomplish this recommendation.

The above are the recommendations of this project for new efforts to improve access to care in La Plata County. There are additional, existing programs that need the sustained support of the community. The school-based health center at Durango High School has received much recognition for its success. The leadership of those efforts from both the 9-R school district as well as the health center is working to expand services to Florida Mesa Elementary School. This would provide a family-oriented opportunity to expand coverage to additional students and ultimately their families.

The school-based health center and other ideas could provide additional, potential projects for the local Health Alliance. These include expansion of the current pharmacy discount program, further development of hospice and palliative care services, working with other community groups to develop programs for aging adults, community-sponsored health insurance cooperatives or additional healthy lifestyle projects.

As this project was being proposed there was much discussion regarding recruitment and retention of physicians. When I started interviews many people believed that there was a single solution to La Plata County's health access problems, "we just need more doctors." The JSI report in 2007 recommended the community recruit and retain more physicians however it did not provide any specific guidelines on how to accomplish that. The majority of communities across the country are struggling with the same issue. Any area attracting baby-boomer retirees faces an even bigger challenge as large numbers of people reach Medicare age.

La Plata County is an amazing place to live and many people I spoke with remarked that we will never have trouble finding physicians because "people want to be here." I caution the community not to get too overconfident. There are many beautiful places in nation, even though many of us think Colorado is THE most beautiful state. And, there are many beautiful places to live and practice within Colorado.

Do we need more doctors? In fact, La Plata County has plenty of primary care providers, if you look at the population numbers overall. As of 2009, according to the state Licensing Board, 38 physicians practice primary care in La Plata County. However the 38 physicians don't all work what would be considered "full-time" in a typical practice. La Plata County has the equivalent of 28.7 full-time practices (Another way of saying this is the average physician in La Plata County works in his/her office about ¾ time.)

There are 17 nurse practitioners and physician assistants in primary care practices in La Plata County. Again, not all these people work full-time. Factoring in the same ¾ time average equals 12.75 full-time equivalent practices

All of the above equals a total of 41.45 full-time equivalent practices.

A national standard for patient caseloads for primary care is approximately 2000 patients/provider. At that rate, with 41.45 providers, local care providers would be able to care for 82,900 people. Even if we allow for a slightly slower pace in the practices here, say 1500 patients/provider caseload because we know people like to balance work and personal endeavors, there is an ability to provide primary care for 62,175 people. Projections for La Plata County's 2010 population are approximately 54,800 residents. Dividing that up among the 41.45 providers is just over 1300 patients/provider.

So, a revised version of the comment heard in the interviews could be "we need more physicians who see Medicare, Medicaid and uninsured patients." Yes, we do. The abysmal reimbursement that practices receive from the federal and state programs force very difficult business decisions. It is easy to overlook the fact that medical practices are the livelihoods of our friends and neighbors. Complicated and often unpleasant business decisions have been made which limit the number of un- and under-insured patients who can be seen in medical practices. La Plata County needs other options to serve this population of patients. The recommendations above will address that, but they still depend on successful recruitment of providers.

As positive as our current overall provider/patient ratio is, forty-four of our 162 actively practicing physicians (in all specialties) are age 55 or older. It is reasonable to assume that replacing these physicians will be very important over the next 5-10 years, especially those in primary care. In 2009 only 2% of students graduating from medical school chose residencies in primary care. Right now the U.S. has approximately 100,000 family physicians. The American Academy of Family Practice estimates that by 2020 the country will need 139,500+. All across the country communities will need to replace their retiring family physicians. Although Durango is a very attractive location, there will be precious few physicians to recruit.

Nurse Practitioners and Physician Assistants can and will fill this need. In spite of the fact that the American College of Physicians supports workforce efforts to ensure adequate supplies of primary care physicians, the American Academy of Family Practice is predicting a shortage of 40,000 family physicians within the next 10 years. The State of Colorado has restrictions on the practices of primary care nurse practitioners that do not exist in our bordering states. It is important that the residents of La Plata County realize what this means. There is an impending shortage of primary care physicians and a practice environment in Colorado that is not conducive to recruitment of allied health professional providers in La Plata County. Advocacy with our state elected officials will help them understand the impact this could have on health care access in the state.

Another important recruitment tool is working with training programs and becoming a rotation site. "Rural rotations" are often part of urban training programs and allow practitioners a chance to see what practice is like in a smaller community. There are requirements for participation in programs like this: contractual relationships with training institutions and identification of willing supervising providers.

Physician or nurse practitioner, the key will be successful recruitment. Our friends and neighbors depend on it, as do physician colleagues. Medical practices depend on each other. Without primary care referrals, subspecialty and surgical practices flounder. Without enough primary care some medical specialties are burdened providing basic care instead of doing their specialty work. Primary care needs the support and expertise of the medical consultants. As a county with just over 50,000 people, we are fortunate to have a medical community with such a depth and breadth of specialties. To keep it, La Plata County needs to approach recruitment together, as a community effort. Many providers come with partners or spouses and families. These people are a critical part of successful recruitment. Identifying their interests and connecting them with people outside of the medical recruitment process is significant. For many candidates the decision is not just an individual decision. A true community effort means candidates are recognized for their skills but recruited to the community. It becomes more than an employment opportunity, it becomes a life opportunity. Retention happens in the beginning of the process, not as an afterthought.

The Alliance recommended above can provide the leadership to bring the community together for this effort, promoting collaboration for the overall good of the community.

A final thought on recruitment: having some medical services in Durango doesn't necessarily mean having the physician in Durango. Telemedicine allows local residents to have access to specialists via high-tech audio and visual connections. Patients across the country are now able to have initial contacts or consultations via secure networks that use the Internet. The advantage of this type of service is that communities can access medical specialties that are not available locally, either because recruitment has not been successful or because the number of patients who would need the specialty could not support a full-time practice. Contractual arrangements are made with specialists in large cities. Telemedicine is also very cost-effective for physicians – saving the travel time normally associated with an outreach practice, and allowing that time to be spent in patient contact instead. Beyond connections to distant specialists, telemedicine could also be used to provide primary care services to remote corners of the county. It is even being used in some programs for elderly or homebound patients, allowing them to have a different kind of "face-to-face" contact with their medical providers

A telemedicine program does require some dedicated equipment, but it is not expensive or complicated. The most important aspect of a telemedicine program is a reliable high-speed internet connection. A proposal for a project to enhance the high-speed infrastructure in Southwest Colorado has been submitted for funding from the American Recovery and Reinvestment Act (stimulus funds) by a group of local business people led by the Region 9 Economic Development Office. Members included representation from

Mercy Regional Medical Center, local communities and La Plata County. All indications for progress are positive.

Finally, many of you who have lived in La Plata County for five years or more will likely note the absence of a recommendation regarding a Health Services Tax District. While this is an approach that has been successful in several Colorado communities, they are the result of efforts in past years. 2010 brings with it some particularly challenging financial circumstances. Taxes and the support of community programs are challenged by a number of realities: decreased property values and changing revenues from the gas and oil industry. Difficult discussions are on the horizon as our government officials strive to find solutions to fewer dollars and increased need. As difficult as the effort was in the past, I believe the timing now would be even worse and doom any attempt to failure from the start. People are concerned about the ever-growing burden of taxes. A Health Services Tax District is not a bad idea, just a good idea whose time has not yet come.

SUMMARY:

Health care is local. Each community is unique. What works in Chicago or Los Angeles won't necessarily work in Denver. What works in Denver might not work in Durango. Having said that, though, there is an opportunity to look to our neighbors across the state and across the country, see what they are doing and consider local adaptations. Research has demonstrated that local initiatives have made positive changes in their communities and significant improvements in community health and access have been documented as a result of their locally-focused efforts. The recommendations above are intended to do that. The Robert Wood Johnson Foundation advises that good health requires personal responsibility and a societal commitment to remove obstacles preventing people from leading healthy lives. This project has focused on the people of La Plata County and the ways they live their lives, in particular how they seek health care.

National health care reform eventually may help us in some ways, but it is not going to address the true underlying reasons why people are unhealthy. Health "care" is only a small part of what determines people's health. Only 10% of people's health status is affected by organized medicine. Our physical environment, socio-economic factors (like education and income) and our personal behaviors (tobacco use, alcohol use, high risk sexual behaviors or violence) are the real determinants. The importance of personal responsibility cannot be overstated. Non-communicable diseases have now replaced communicable diseases as global health issues. The world is burdened with heart disease, respiratory disease and certain cancers – all of which we know how to prevent. Being healthy means healthy lifestyles and accessible medical support when it is needed. Healthy communities mean successful approaches to community health at the personal and community level, interdisciplinary and collaborative approaches that cross the traditional boundaries.

La Plata County and the communities within its borders give residents many opportunities to be healthy – from locally grown healthy food, endless recreational

opportunities and alternatives to automobile transportation. There are a wide range of practitioners supporting good health.

Health insurance alone does not produce a healthy population. Every community needs a combination of access to private health care and a well developed public health system: a cooperation of public and private health – and residents need the means to take advantage of local resources.

Attempting to address the entire under-served population with just one approach would be overwhelming and have a high risk of failure. Research shows that success in local efforts comes from projects with smaller scopes and small, specific target populations. The recommendations above approach the access issue from a number of different perspectives and allow different projects to take advantage of multiple funding sources. The recommendations also increase available resources to community members and spread the financial and failure risks throughout the community. The advantage of this approach is evident in reflection on the crisis that occurred in 2007 when one piece of the local health care picture (the Valley-Wide Health System primary care clinic) was discontinued.

That is not to say that any of this is easy. Health care is a challenging business. Provider shortages appear to be certain. Recruitment will become increasingly competitive. But – there is good news. The fierce independence that describes the personality of southwest Coloradans will drive solutions. Community members throughout the county are known for their involvement in important causes. Many community organizations are ready to get involved and invest their resources in the projects recommended above. La Plata County has an abundance of excellent health care organizations. We are not starting from scratch.

There are features common to successful local efforts. These have been proven over time to be present in successful programs. They include committed leadership, effective collaboration, strategies to meet the needs of different populations, and effective methods to evaluate program success. In return for their support, funding sources will expect these characteristics to be part of local efforts

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We don't need to do everything right away. We can be realistic about what we take on. Things can be done in stages. Different groups can own and implement different projects. Chris Adams, a Colorado health care consultant advises, "Don't worry about perfection. Just put things together and do it."

It is time to move ahead, to make plans and measure success.