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NATIONAL HEALTH POLICY FORUM

Mission Possible? Maintaining the Safety Net in Urban and Rural Colorado

August 20-22, 2001
Colorado

The George Washington University
WASHINGTON DC

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SITE VISIT REPORT

Contents

SITE VISIT REPORT

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NHPF is a nonpartisan education and information exchange for federal health policymakers.

Acknowledgments

Mission Possible? Maintaining the Safety Net in Urban and Rural Colorado is a result of recommendations by NHPF's two core sponsors, the Robert Wood Johnson Foundation (RWJF) and the W. K. Kellogg Foundation (WKKF). Michael Rothman of RWJF, who had been a state official in Colorado prior to joining the foundation, pointed out various initiatives under way in the state to address gaps in the health care safety net. WKKF had held a successful site visit to Denver Health for its trustees and indicated that federal health policy staff might benefit from a similar review. The David and Lucile Packard Foundation showed interest as well, primarily because of its concern about health services for vulnerable children in the state.

With leads from the core sponsors and from Marcy Morrison, a former Colorado state legislator who had taken part in the WKKF event, NHPF Co-Director Karen Matherlee took on the task of organizing the site visit. Michele Black, NHPF's director of publications, and Dagny Wolf, the Forum's program coordinator, joined her to form a team that worked seamlessly.

Karen and Michele first developed the urban segment of the visit. They had extensive assistance from Patricia Gabow, M.D., chief executive officer (CEO) and medical director, and Patricia Marnette, executive assistant to the CEO, of Denver Health. They also received helpful suggestions on the community health portion of the segment from Denver Health's Richard Wright, M.D., director of community health services, and Elizabeth Whitley, Ph.D., R.N., director of Community Voices. Anita Wesley, program manager at the Colorado Medical Society, founder of the Colorado Coalition for the Medically Underserved, provided valuable support, convening a group of key persons from various organizations to advise the Forum and providing coalition materials for the briefing book.

The rural segment proved more challenging, given the size and terrain of the state. At the suggestion of Marguerite Salazar, president and CEO of Valley-Wide Health Services, Inc., Karen and Michele visited the system's Rocky Ford Clinic. They decided to include it in the visit because of its agricultural location and designation both as a federally qualified health center and migrant health services provider. At the recommendation of Denise Denton, executive director of the Colorado Rural Health Center, Karen went to the Limon-Hugo area of eastern Colorado. Her conversations with Brenda Higgins, director of the Plains Medical Center in Limon, and Herman Schreivogel, CEO of the Lincoln Community Hospital and Nursing Home in Hugo, indicated that the two organizations raised key rural/frontier issues that might be explored in the site visit. Both administrators provided thoughtful assistance and counsel, as did Larry Wall, president, and Peg O'Keefe, vice president, Colorado Health and Hospital Association, in developing the facility tours and concluding panel discussion.

As the agenda unfolded, the Colorado Trust and the Rose Community Foundation agreed to sponsor special site visit events. Both are very active and creative in the state's health arena. Jean Merrick of the Colorado Trust worked with Denver Health in organizing a luncheon that preceded a panel discussion at the medical center. The Rose Community Foundation, through the work of Annie Van Dusen, supported a reception/dinner at The Cliff House at Pike's Peak for federal and Colorado participants and others in the Colorado health community.

All of those Coloradans who provided briefings, took part in panel discussions, hosted tours, and provided information for the briefing book and this report contributed significantly to the success of the site visit. Many thanks to them and to Karen, Michele, and Dagny for their commitment and toil. Thanks, too, to all the federal participants who brought to the site visit and subsequent debriefing not only their concern for the safety net but also their expertise in various policy aspects of it. The questions they raised and the dialogue in which they engaged were alternatively illuminating and provocative.

Judith Miller Jones
Director

August 20–22, 2001/Colorado

Mission Possible? Maintaining the Safety Net in Urban and Rural Colorado

BACKGROUND

The National Health Policy Forum took 22 federal congressional and executive health staff to Colorado August 20-22, 2001, to examine the safety net in the Denver metropolitan area and in rural eastern Colorado. NHPF's core sponsors, the Robert Wood Johnson Foundation and the W. K. Kellogg Foundation, joined by the David and Lucile Packard Foundation, funded the site visit through program grants. In addition, two Colorado foundations sponsored special events during the visit. The Colorado Trust supported a luncheon at Denver Health for Colorado and federal participants, and the Rose Community Foundation funded a reception/dinner at The Cliff House at Pike's Peak for local and federal participants and others in the state's health community.

The overall purpose of the site visit was to provide federal health staff opportunities to visit health facilities and to engage in discussions on safety-net services, particularly those provided by an urban integrated health system and by several key organizations that operate in rural and frontier parts of eastern Colorado. The goal of the visit was to explore the following urban and rural safety-net organizations and the services they provide to vulnerable people and to look at the policy implications at the federal and state (and to some extent, local) levels.

- ***Denver Health—an integrated health system for vulnerable people.*** Founded in 1860, Denver Health addresses two major needs. The first consists of the special health needs of the entire population through such services as trauma and poison centers. The second involves the needs of special populations, such as those who are medically unserved, uninsured or underinsured, undocumented, homeless, victims of violence, chronically mentally ill, disabled, substance abusers, high-risk pregnant women and their babies, diagnosed with infectious diseases, or prisoners. Delivering services along a continuum of care, the system provides preventive, primary, and acute services, as well as emergency care, integrating all of them with public and community health services. In addition to ambulatory clinics on its main campus, the system includes 12 school-based clinics and 11 family health centers, one of which (Westside Family Health Center) federal participants visited.

  Denver Health provides half of all uncompensated care in the Denver metropolitan area and nearly a third of unsponsored services in Colorado. The system's net revenues come from diverse sources. In 2000, 22 percent were from private insurance and 11 percent each were from disproportionate-share hospital (DSH) funds, Medicaid, and the system's own Medicaid health maintenance organization (HMO), the Denver Health Medical Plan. Medicare accounted for 10 percent, the city of Denver 8 percent, restricted grants and contracts 7 percent, other operating funds 5 percent, and unsponsored sources 4 percent. Federal/state grants, major teaching funds, and city-funded services each contributed 3 percent. Nonoperating funds were 2 percent of revenues. In a state in which HMOs have nearly 40 percent penetration (primarily urban and suburban), Denver Health participated in providing services in 2000 to subscribers of the Colorado Access Health Plan, a Medicaid HMO that has 63,700 members; to 10,400 members of Child Health Plan Plus, the state's Children's Health Insurance Program; to 55,000 members of Access Behavioral Care; and to 16,000 offenders in Access Correctional Care.

- ***Rocky Ford Clinic—part of Valley-Wide Health Services, Inc., a community health center (CHC)–based, primary-care provider serving a wide geographic area.*** Rocky Ford Clinic, located in an agricultural area in Otero County southeast of Denver, has two providers that offer preventive and primary health care services to 18 to 20 patients a day. Providers refer patients needing specialty care to a Valley-Wide health center in La Junta that holds orthopedic and other specialty clinics once or twice a month; they rely on personal relationships to arrange other referrals, in what they admit is a difficult and sporadic process. Relying on both public and private insurance as well as a sliding-fee scale, Rocky Ford Clinic provides migrant health services from June through October of each year. It has an outreach program that extends health-screening services to migrant camps and centers. Its caseload of migrants includes 450 to 500 persons a year.

Rocky Ford Health Clinic is one of 14 primary care clinics operated by Valley-Wide Health Services, Inc., a 25-year-old organization headquartered in Alamosa, Colorado, that also has two school-based clinics and three dental clinics. The system serves 10 counties in south-central Colorado, and also has a contract to provide services to migrants throughout the state. Focusing on the medically underserved, Valley-Wide is a federally qualified CHC/migrant health system with a total budget of approximately $14.5 million. While the bulk of its funding comes from federal grants and from Medicaid, Medicare, private insurance, and self-pay revenues for services, it also has some funds from WIC (Women, Infants, and Children), private grants and contracts, and foundation dollars.

- ***Plains Medical Center—a federally certified rural health clinic.*** Rebuilt in 1991 after a tornado destroyed its Limon facility, Plains Medical Center is one of 37 certified rural health clinics (RHCs) in Colorado. It also has a clinic in Hugo, located at Lincoln Community Hospital. Limon and Hugo are in frontier Lincoln County. Both the main and satellite clinics are staffed by family physicians (who also work at the hospital), as well as by registered and licensed practical nurses. Plains Medical Center relies upon Medicare, Medicaid, private insurance, and a self-pay sliding fee scale and maintains an open-door policy relative to indigent care.
- ***Lincoln Community Hospital and Nursing Home—a frontier provider of a continuum of services, recently designated a critical-access hospital (CAH).*** Lincoln Community Hospital and Nursing Home is one of 36 rural hospitals in Colorado, which has a total of 66 acute-care hospitals. Like other rural hospitals in the state, it is the only hospital in its community (in fact, in a wide geographic area). Close to a major interstate highway, it provides safety-net access to residents and travelers alike. Lincoln Community Hospital is also a critical-access hospital, one of 11 licensed in Colorado. In order to qualify for the program, which permits cost-based reimbursement for acute and outpatient services, the hospital had to be geographically isolated or certified by the state as a necessary provider, agree to provide 24-hour emergency care services, and maintain no more than 15 acute beds. In addition to the 15 beds, it has 10 swing beds that it uses interchangeably for acute or skilled-nursing care. Lincoln also operates a nursing home. Like other rural hospitals in the state, it serves a predominately rural population, with Medicare accounting for a significant portion of its inpatient and outpatient revenues. (Medicaid, on the other hand, is the major payer in the nursing home.)

Visits to these sites, combined with briefings and panel discussions, gave federal participants opportunities to explore public and private safety-net programs and initiatives; payer, provider, and consumer safety-net concerns; and urban and rural safety-net challenges.

At the end of the site visit, most of the federal participants completed detailed evaluation forms. They also took part in a debriefing meeting, which was held October 5, 2001. Drawing on the evaluation responses and the views expressed at the meeting, as well as oral comments made during and after the site visit, this report is a summary of impressions of the visit. It also reflects notes taken during the site visit. Some portions are reinforced by information provided in a briefing book given federal and Colorado participants prior to the site visit and supplementary materials handed out during and after the site visit.

While the report presents federal participants' impressions of site visit events and themes, it also reflects some initial perspectives on the safety net following the September 11, 2001, terrorist attacks on the World Trade Center in New York City and the Pentagon near Washington, D.C. At the debriefing meeting, participants expressed new insights into the definition and significance of the health care safety net and on the role of public health as a result of the September 11 attacks.

IMPRESSIONS

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Even those in the federal and state governments and in private organizations who work daily with the urban and rural/ frontier safety net have difficulty in defining and conceptualizing it.

Although the briefing book presented and several speakers addressed descriptions and definitions of "urban," "rural," "frontier," and "safety net," federal participants noted a fair amount of ambiguity, which carries over to the administration of programs by federal and state agencies. According to the Colorado Rural Health Center, an "urban" area is defined as a place of 2,500 or more people by the U.S. Census Bureau, which also uses the term "urbanized area," usually a designation of at least 50,000 inhabitants. The U.S. Office of Management and Budget (OMB), on the other hand, uses the term, "metropolitan area," which it defines as a city with 50,000 or more inhabitants or an urbanized area (as defined by the Census Bureau) plus a total metropolitan population of at least 100,000. OMB considers its designation to be countywide. "Rural" then is defined as a geographic area or population

that is not urban or metropolitan. "Frontier," on the other hand, is defined as "a county with six or more people per square mile." While the term "safety net" may be used broadly to cover the "system" of care for people who lack health insurance or funds to pay for health services, it generally has a more specific definition. It is a fragmented system of health care, available at no or low cost to people who cannot afford to pay, made up of organizations or programs that are legally obligated to provide the services.

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The "great person" or "charismatic leader" is a significant feature of the safety net in Denver and eastern Colorado.

Asked on the site visit evaluation forms to identify a site visit briefer or panelist who stood out as being particularly knowledgeable, articulate, and/or dedicated to services for vulnerable persons, several federal participants mentioned the "across-the-board" quality and commitment of the Coloradans they had met. In singling out one person, half of the participants who completed the forms mentioned Patricia Gabow, M.D., CEO and medical director of Denver Health. Nearly as many mentioned Marguerite Salazar, president and CEO of Valley-Wide Health Services, Inc. Both have headed their organizations for extensive periods of time, have shaped the organizations' mission and growth, and are credited in large part for the organizations' success. At the debriefing, several brought up the role played by the "great person in history" or the "charismatic leader" in successful organizations and the difficulty of finding or developing such a leader or replicating such a model in other places.

■

Major challenges facing Denver Health seem typical of those facing safety-net providers across the country. They include the concentration of services for vulnerable populations to a few providers, rising costs of providing services (in large part due to developing technology and increasing pharmaceutical expenses), limited revenue streams, difficulty in accessing capital financing, workforce scarcities, and federal and state regulatory requirements.

■

Although the need to develop organized systems of care receives a great deal of lip service, there seem to be few incentives and rewards for providers to address the need.

Participants repeatedly noted the degree of dedication and commitment—and the lack of financial and regulatory support—needed to put together a system of care, particularly one designed for vulnerable populations. The difficulties of coping with public and private insurance systems that are oriented to acute care, fragmentation of coverage between entitlement and categorical programs, compartmentalization of targeted grants for specialized populations, and difficulty in coordinating public and private gave rise to a recurring question: "Why should anyone want to do this?" This was true both in Denver, where Denver Health had exerted strenuous efforts to bring together a complex patchwork of support to build its system, and in rural eastern Colorado. Both the incentives and the rewards for serving vulnerable people in a systematic way seemed biased against, rather than oriented toward, service and efficiency.

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In a state in which the Medicaid program is fairly limited, compared with the programs of other states, the importance of federal Medicaid disproportionate-share hospital (DSH) funding is crucial to maintaining the safety net. The role of Medicaid and even Medicare DSH funding at Denver Health cannot be overstated, whether in the provision of services to vulnerable people, development of an integrated continuum of services, or engagement in certain initiatives (such as streamlining of information systems).

Colorado's Medicaid program is fairly lean, primarily restricted to federally mandated services (thereby largely bypassing optional services). The state investment in public health services is also lean and, given the emerging budget crisis in all states, is likely to remain so. The leanness of these programs gives greater importance to federal DSH payments under the federal-state Medicaid program. In recognition of its provision of care to a disproportionate number—compared to some other hospitals—of Medicaid or low-income patients, Denver Health received nearly $37 million in Medicaid DSH funding in 2000. (The Colorado Indigent Care Program [CICP], a statewide program to help providers recoup part of the costs they incur as a result of treating indigents, is financed under Medicaid DSH. CICP boosted Denver Health's share of Medicaid DSH funding because the

system provides about a third of the state's CICP services.) In recognition of its provision of care to a disproportionate number of Medicare or low-income patients, Denver Health also receives Medicare DSH payments. While Medicare DSH is not separated out in Denver Health's revenue statement, it obviously plays a smaller role than Medicaid DSH. Medicare *in toto* accounted for a little over $33 million in revenues in 2000. In large part because of its DSH funding for uncompensated care, Denver Health has been able to build up a reserve fund, giving it some flexibility in providing services and in developing new initiatives to serve its special populations. As the University of Colorado leaves its downtown campus, a question arises as to whether Denver Health should get a larger share of the state's Medicaid DSH dollar.

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Because Colorado law limits increases in state revenues that can be spent on health care, safety-net providers are increasingly concerned about their ability to meet rising health care costs, especially in an economy that has leveled off and seems on the downturn.

A Taxpayers' Bill of Rights (TABOR), the result of a citizen-initiated referendum, passed in 1992, making an earlier 6 percent limit on state spending increases part of Colorado's constitution. Because Medicaid tends to be the state's fastest growing program, increases in Medicaid spending tend to hamper spending on other state activities. Federally provided and state-allocated Medicaid DSH, as already noted, has made up much of the difference. Although, at the time of the site visit, the state had been experiencing an economic boom, there were signs that economic growth was leveling off and maybe was on a downturn. This caused considerable concern among public and private Colorado participants alike, because of the likely reduction in state revenues and the likely growth in health service needs. With the cost of health care increasing significantly, a major question, for public and private payers alike, was "how do we sustain what's really important?"

■

As has been shown in other site visits, there is concern about the lack—or unevenness—of health care data, especially longitudinal data on patient symptoms, episodes of illness, and services in the continuum of care. However, Denver Health appears to be progressive in tracking the vulnerable populations that the system serves.

Although federal participants saw a lot of data, they tended to view it as "tracking those who show up at the door." The data, for instance, indicated those who *were* receiving services, at least on an encounter basis, but not those who *were not*. Some participants questioned the relevancy of certain health data elements, such as those required of CHCs by the Health Resources and Services Administration, U.S. Department of Health and Human Services. Participants saw the need for tracking of patients, standardization of data, and portability of individual information. Some praised Denver Health's attempts to do this, in the expenditure since 1996 of $103 million for an information system geared to the system's special populations. One participant concluded, "Rather than universal health insurance, we need a more universal information system."

■

The recruitment and retention of health professionals, especially nurses and physicians, are ongoing concerns both at Denver Health, which has a stable workforce but faces competitive pressures from other providers, and at the rural facilities that depend upon federal recruitment programs.

Workforce needs was a recurrent theme during the site visit, whether at the rural sites or at Denver Health, which faces competition from other public as well as private providers, especially for nurses and allied health personnel. In rural and frontier eastern Colorado, the discussion centered on recruitment and retention of practitioners to isolated areas, where lifestyle or quality of life might be a factor. Federal assistance—through National Health Service Corps loan repayment, granting of J-1 visas to international medical graduates, and other initiatives—seemed to play a large role in rural parts of the state.

■

Although city and county public health functions are housed on Denver Health's campus, the relationship between service delivery and public health in rural and frontier eastern Colorado was not clear, raising questions about tie-ins and coordination.

During the Denver portion of the visit, federal participants had an opportunity to visit health department clinics that were located on the Denver Health campus. Immunization

clinics, as well as facilities for the diagnosis and treatment of HIV/AIDS, tuberculosis, sexually transmitted diseases, and other health problems were in the public health department building. The presence of public health was less obvious in the rural and frontier areas, although providers indicated that cooperative arrangements existed. A public health nurse from far eastern Colorado indicated that public health nursing had evolved from a direct-care model to a broader mission of health promotion and disease prevention—for example, home visits aimed at risk reduction and the targeting of special populations for needed services.

■

The importance of preparedness—the need for multiple capacities in multiple places—was highlighted by the events of September 11, emphasizing the need to integrate public health's role of surveillance with providers' responsibility for diagnosis and service delivery.

Given federal participants' perception that service providers and public health departments are taking divergent paths, there was concern shown at the debriefing over the demands upon both after the events of September 11. Given a lack of definition and coordination of various functions, planning and preparedness for public health emergencies and national disasters are difficult. For example, given the need for emergency preparedness, the idea of excess capacity—particularly in acute-care hospitals—may take on a different meaning. Even the concept of the safety net may take on greater significance, perhaps in a bifurcated system of the traditional safety net and an emergency-response safety net. While federal participants debated such concepts as local versus regional or national responses, the nature of communications linkages, and infrastructure integration, all seemed to have a heightened awareness of "safety-net" demands as a result of a national crisis.

■

Federal and state policies, intended to be supports, may have the effect of causing safety-net providers to scramble in putting care systems together.

Colorado participants pointed out, and federal participants recognized, that certain federal and state legislative and regulatory requirements might serve as barriers to the provision of care. In both urban and rural Colorado, there seemed to be concern about Emergency Medical Treatment and Active Labor Act (EMTALA) provisions governing patients' access to care and their transfer from one health care facility to another. In rural eastern Colorado, a provider mentioned as a barrier Davis-Bacon Act requirements for union contracts in the construction of facilities that receive federal funding, indicating that its provisions are more suited to larger eastern and urban areas. Another provider singled out physician self-referral provisions. Such provisions prohibit a physician from referring a patient for a designated health service if the physician or a family member has a financial relationship with the organization that provides the service and if Medicare or Medicaid pays for the service. Another rural participant mentioned the difficulty of meeting electronics standards provisions in the Health Insurance Portability and Accountability Act, although certain rural providers have additional time in which to comply. While all agreed that conflicts with certain Medicare, Medicaid, and other federal rules at times cause difficulty, they did not concur on which rules are most onerous and perhaps should be scrapped.

■

The rural/frontier safety net seems to depend upon communities' ingenuity in pulling together a health system that works.

Comparing one-size-fits-all federal programs with assembly-line automobiles, a federal participant commented that the way rural/frontier communities manage is to take the standard-issue cars the federal government provides, disassemble them for parts, and put the parts together to make a vehicle that works for them. "How do such communities relate to federal and state policies?" was a key question. A pieced-together or pulled-together rural system or network was the prevailing perception of the federal participants, who saw it as a major challenge to policymakers.

■

The critical-access hospital initiative seems to be improving the bottom line for Lincoln Community Hospital and Nursing Home, illustrating the need for special treatment in a geographic area in which economy-of-scale considerations may not justify a full-service hospital.

While Lincoln Community Hospital seemed to have difficulties in interacting with its fiscal intermediary, it seemed to be benefiting from its designation as one of Colorado's 11 CAHs. Under the program's cost-based reimbursement provision, the hospital's bottom line had improved and its configuration of acute and swing-beds (plus long-term-care beds in its nursing home) seemed to

be working. Given the choice of inclusion in the Medicare prospective payment system (PPS), a sole community provider exemption from Medicare PPS, high-Medicare caseload allowance, or CAH designation, Lincoln Community Hospital seemed to prefer CAH. Federal participants had numerous questions about the progress of the program: How does a hospital qualify? How does the reimbursement system work? Is CAH a safety valve against closure? How burdensome are the regulations? Lincoln's major concern had to do with cash flow, because of the fiscal intermediary's seeming lack of understanding of the program and the inability of CAHs to receive interim payments.

■

Difficulty in gaining access to specialty care—especially for low-income or uninsured patients—is a big problem in rural/frontier eastern Colorado.

Both at the Rocky Ford Clinic and during the concluding panel discussion in Hugo, referral of patients for specialty care, either in their own communities or in urban centers, was raised as a severe problem. The reasons for the problem included lack of incentives for specialists to practice in isolated areas, limited ability of patients to pay, long distances for patients to travel to receive services, and the absence of a coordinated referral system. While Valley-Wide Health Services, Inc., and Plains Medical Center/Lincoln Community Hospital and Nursing Home arranged for visiting specialists at certain intervals, such arrangements were insufficient. Gaining referrals, particularly for patients with limited ability to pay, depended almost solely upon provider relationships.

■

While concern about capital financing to upgrade and replace aging facilities is acute in rural/frontier Colorado, it also is an issue at Denver Health, which, as a public authority, is preparing a new bond issue.

Given the trend toward for-profit health care, in part because of the advantages for-profit status offers in raising capital, the not-for-profit organizations featured in the site visit invariably complained about capital financing. Whether for upgrading or adding facilities, they addressed the difficulties of raising capital, either through the private market or through tax-exempt bonds. The capital problems of CHC systems like Valley-Wide Health System, Inc., are well-known, although Rocky Ford Clinic seemed to have an adequate facility. Plains Medical Center had rebuilt due to tornado damage but rapidly seemed to be running out of space. Both Denver Health and Lincoln Community Hospital were in outmoded facilities, although both had taken steps to update their physical plants. "We need support to replace aging facilities" was a refrain that federal participants took away, at a time when competing demands for assistance are multiplying.

Agenda

Monday, August 20, 2001

3:00 pm Check-in at headquarters hotel, Denver *[Hyatt Regency Denver Downtown]*

3:30 pm SETTING THE STAGE: URBAN AND RURAL SAFETY-NET CHALLENGES
[Mt. Evans A and B, Conference Center, Hyatt Regency Denver Downtown]

William N. Lindsay III, *President,* Benefit Management and Design, Inc.

Karen Reinertson, *Executive Director,* Department of Health Care Policy and Financing, State of Colorado

Larry H. Wall, *President,* Colorado Health and Hospital Association

5:30 pm Adjournment

6:00 pm Dinner with briefing participants *[Maggiano's]*

Tuesday, August 21, 2001

7:30 am Breakfast briefing *[Mt. Evans A and B, Conference Center, Hyatt Regency Denver Downtown]*

DENVER HEALTH: A HEALTH SYSTEM INTEGRATING SAFETY-NET SERVICES

Patricia A. Gabow, M.D., *Chief Executive Officer and Medical Director,* Denver Health

Frank Barrett, *Chief Financial Officer,* Denver Health

Stephanie Thomas, *Chief Operating Officer,* Denver Health

Richard A. Wright, M.D., *Director,* Department of Community Health Services, Denver Health

Elizabeth M. Whitley, R.N., Ph.D., *Director,* Community Voices, Denver Health

9:30 am Bus departure for Denver Health's Westside Family Health Center (commentary during bus trip)

Richard A. Wright, M.D. (see title above)

Elizabeth M. Whitley, R.N., Ph.D. (see title above)

9:45 am Tour of Westside Family Health Center and question and answer period

Richard A. Wright, M.D. (see title above)

10:45 am Bus departure for Denver Health's main campus (commentary during bus trip)

Richard A. Wright, M.D. (see title above)

Elizabeth M. Whitley, R.N., Ph.D. (see title above)

11:00 am Tour of Denver Health facilities and question-and-answer period

Patricia A. Gabow, M.D. (see title above)

Stephanie Thomas (see title above)

12:30 pm Break

12:45 pm Lunch, followed by panel discussion *[Classroom A, Denver Health Medical Center]*

DELIVERING AND FINANCING SAFETY-NET SERVICES:
PAYER, PROVIDER, AND CONSUMER ISSUES

Patricia A. Gabow, M.D. (see title above)

Douglas L. Clinkscales, *Executive Director,* Denver Health Medical Plan, Inc.

Dennis C. Brimhall, *President and Chief Executive Officer,* University of Colorado Hospital

Heidi Frey, J.D., *President,* Patient Advocacy Coalition, Inc.

Donald Hall, M.P.H, *President and Chief Executive Officer,* Colorado Access

Victor Lazzaro, Jr., *President and Chief Executive Officer,* UnitedHealthcare of Colorado, Inc.

Donna Marshall, *Executive Director,* Colorado Business Group on Health

Richard Allen, *Director,* Office of Medical Assistance, Department of Health Care Policy and Financing, State of Colorado

Gary D. VanderArk, M.D., *Chair,* Colorado Coalition for the Medically Underserved

3:45 pm Bus departure for Manitou Springs
Hotel check-in *[The Cliff House at Pike's Peak]*

7:00 pm Reception/buffet dinner with Colorado participants *[J. S. Morley Ballroom, The Cliff House at Pike's Peak]*

Wednesday, August 22, 2001

7:30 am Breakfast briefing *[J. S. Morley Ballroom, The Cliff House at Pike's Peak]*

FACILITIES ON THE FRONTIER:
RURAL SAFETY-NET SERVICES IN EASTERN COLORADO

Denise Denton, *Executive Director,* Colorado Rural Health Center

Elena Thomas, *Community Development Director,* Colorado Community Health Network

Marguerite Salazar, *President and Chief Executive Officer,* Valley-Wide Health Services, Inc.

9:00 am Bus departure for Valley-Wide Health Services Clinic, Rocky Ford (commentary during bus trip)

Marguerite Salazar (see title above)

11:15 am Tour of Valley-Wide Health Services Clinic, Rocky Ford

Victoria Valdez, *Manager,* Rocky Ford Clinic, Valley-Wide Health Services

Noon Bus departure for Plains Medical Center, Limon (box lunch on bus)

Marguerite Salazar (see title above)

2:15 pm Tour of Plains Medical Center, followed by question-and-answer period

Brenda Higgins, *Executive Director*, Plains Medical Center

2:45 pm Bus departure for Lincoln Community Hospital and Nursing Home, Hugo

3:00 pm Tour of Lincoln Community Hospital and Nursing Home, followed by question-and-answer period

Herman Schreivogel, N.H.A., *Chief Executive Officer,* Lincoln Community Hospital and Nursing Home

Linda Grauberger, R.N., *Director of Nursing,* Lincoln Community Hospital and Nursing Home

3:30 pm Departure for Lincoln County Courthouse, Hugo

3:45 pm Panel discussion

RURAL HEALTH POLICY CONCERNS AND CHALLENGES
[Jury Assembly Room, Lincoln County Courthouse]

Brenda Higgins (see title above)

Herman Schreivogel, N.H.A. (see title above)

Michael Bass, *President and Chief Executive Officer,* First National Bank of Hugo

Jacqueline Brown, R.N., M.S.N., *Director,* Prowers County Public Health Nursing Service

John E. Fox, M.D., *Chief of Staff,* Lincoln Community Hospital and Nursing Home

Lindy Nelson, M.P.H., *Associate Director, Health Programs*, Boulder County Health Department*

Marguerite Salazar (see title above)

5:45 pm Bus departure for Manitou Springs

7:45 pm Informal dinner for federal participants *[Stagecoach Inn, Manitou Springs]*

* Former Director of Rural and Primary Health, responsible for the critical access hospital program, Colorado Department of Public Health and Environment

Federal Participants

Alexis Ahlstrom
Analyst
Health Cost Estimates Unit
Congressional Budget Office
U.S. Congress

Sylvia C. Brown
Legislative Assistant
Office of Rep. Mike Ross
U.S. House of Representatives

Alison Buist
Legislative Assistant
Office of Sen. Gordon Smith
U.S. Senate

Aaron K. Cohen
Legislative Assistant
Office of Sen. John Ensign
U.S. Senate

Mary Lou De Zeeuw
Colorado-Wyoming State Team Lead
Denver Field Office
Health Resources and Services Administration
U.S. Department of Health and Human Services

Blanca Fuertes
Congressional Fellow
Office of Sen. Jack Reed
U.S. Senate

George D. Greenberg, Ph.D.
Executive Advisor
Office of Health Policy
Office of the Assistant Secretary for
Planning and Evaluation
U.S. Department of Health and Human Services

Thomas A. Gustafson
Director
Purchasing Policy Group
Center for Medicare Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services

Jan Heinrich, Dr.P.H., R.N.
Director
Health Care Group
General Accounting Office
U.S. Congress

Jennifer Jenson
Special Assistant to the Executive Director
Medicare Payment Advisory Commission
U.S. Congress

Lisa N. Kidder
Senior Health Policy Advisor
Office of Sen. Larry Craig
U.S. Senate

Kate Kirchgraber
Professional Staff Member
Committee on Finance
U.S. Senate

Stephanie Monroe
Chief Counsel, Minority
Committee on Health, Education, Labor and Pensions
U.S. Senate

Jennifer O'Sullivan
Specialist in Social Legislation
Domestic Social Policy Division
Congressional Research Service
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Biographical Sketches—Speakers and Panelists

Frank Barrett has been chief financial officer (CFO) of Denver Health and Hospital Authority (Denver Health), Denver's public health care system, since August 1995. Earlier, Barrett held several positions in California. From 1987 to 1995, he served as CFO of Santa Clara Valley Health and Hospital System; for the preceding five years, he was CFO at Kern Medical Center in Bakersfield. Prior to that, he spent three years as corporate accounting manager at Advanced Health Systems in Irvine.

Michael Bass has been president and chief executive officer (CEO), First National Bank of Hugo, for six years. He previously served as senior vice president of the bank from 1984 to 1990 and then executive vice president from 1990 to 1995. He is also a member of the board of the Independent Bankers of Colorado.

Dennis C. Brimhall has been president and CEO of the University of Colorado Hospital since 1988. He also serves as associate vice chancellor for the Fitzsimons campus at the University of Colorado Health Sciences Center.

Jacqueline M. Brown, R.N., M.S.N., has been director, Prowers County Public Health Nursing Service, since 1995, having previously held that position from 1988 to 1993. Her other experience in Colorado includes six years as director of the Baca County Public Health Nursing Service. She has been president of the Public Health Nurses Association of Colorado since 1999.

Douglas L. Clinkscales is executive director of Denver Health Medical Plan, Inc., and director of managed care, Denver Health. Before opening the Managed Care Division, he was the authority's deputy manager for community health services for five years. Clinkscales has served as president of both the Colorado Community Health Network and the Community Health Association of Mountain/Plains States.

Denise Denton has been executive director of the Colorado Rural Health Center, Colorado's Office of Rural Health, since the center's creation in 1992. Involved in rural health care for almost 20 years, she previously held positions with the offices of rural health in Arizona and Utah. For eight years she served on the board of the National Rural Health Association and was the association's president in 1994.

John E. Fox, M.D., is a professional staff member at the Plains Medical Center in Limon and chief of staff at Lincoln Community Hospital and Nursing Home in Hugo. His other positions include member of the board of the Colorado Rural Health Center from 1991 to 1994 (president from 1992 to 1994), Eastern Colorado Medical Society delegate to the Colorado Medical Society since 1993, and member of the board of the Colorado Academy of Family Physicians.

Heidi Frey, J.D., is president of Patient Advocacy Coalition, Inc., in Denver. Before founding the coalition in 1966, she was a partner with the law firm of Hopkins and Sutter. Frey also serves as a member of the Advisory Board of PorterCare Hospital.

Patricia A. Gabow, M.D., has been medical director of Denver Health since 1989 and its CEO since 1992. She joined the staff there in 1973 as chief of the Renal Division, becoming director of the medical service in 1981. She is also a professor of medicine in the Division of Renal Disease at the University of Colorado School of Medicine. A member of several professional societies, she has received numerous awards and professional distinctions.

Linda Grauberger, B.S.N., R.N., is director of acute care nursing at Lincoln Community Hospital and Nursing Home. Grauberger, who has over 25 years' experience as a registered nurse, started at Lincoln in 1989 as a traveling nurse. Subsequently, she worked as a staff nurse for six years and then held the post of assistant director of nursing before being named to her current position two years ago.

Donald Hall, M.P.H., is president and CEO of Colorado Access. He joined the organization in 1999, after working for Blue Cross and Blue Shield of Texas, Inc., where he last served as its vice president of strategic business development. His previous health care experience includes positions with EQUICOR, Hospital Corporation of America; HCA Partners in Health, HCA Regional Office; and Behavioral and Occupational Services, HCA Presbyterian Hospital.

Brenda Higgins is executive director of Plains Medical Center. She became executive director in March 2000 after being a member of the Limon Doctors Committee, the medical center's board, as well as its treasurer since 1988. She also served for two years as treasurer of the Limon Chamber of Commerce.

Victor Lazzaro, Jr., has been president and CEO of UnitedHealthcare of Colorado, Inc. since early 2000. He oversees operations in Colorado, New Mexico, Wyoming, Montana, and North and South Dakota. Previously, he served Prudential Insurance Company of America for more than 10 years, most recently as vice president of Health Plan Operations, Gulf South, in its Central Division in Houston. Earlier, he had executive positions with CIGNA in Louisiana and FHP, Inc. in California.

William N. Lindsay III has been president of Benefit Management and Design, Inc., since the company was founded in 1985. Previously, he held several positions with Aetna Life Insurance Company. He is chair of the Colorado Children's Basic Health Policy Board, chair of the Health Care Committee of National Small Business United, and a member of the boards of St. Joseph's Hospital and the Colorado Small Employers Reinsurance Program.

Donna Marshall has served as executive director of the Colorado Business Group on Health (CBGH) since its inception in 1996. From 1990 to 1995, Marshall was the manager of the Managed Care Section for the Colorado Medicaid program. She also served as the Region VIII representative to the Health Care Financing Administration on the Quality Technical Assistance Group. Earlier, she worked in the Systems Management Section as the lead analyst for the Medicaid claims payment system.

Lindy Nelson, M.P.H., was recently named associate director, health programs, Boulder County Health Department. Her previous position, which she held from 1987 to 2001, was director of rural and primary health (responsible for the critical access hospital program, among other initiatives), Colorado Department of Public Health and the Environment. She also served as vice president for outreach services for Columbia HealthONE from 1997 to 1999.

Karen Reinertson is executive director, Colorado Department of Health Care Policy and Financing. Since 1975, she has worked in both the private and public sectors as a lobbyist, a consultant, and a senior government official. From 1990 through 1994, Reinertson served as director of the Colorado Office of State Planning and Budgeting; she has also served as director of the state's Office of Energy Conservation.

Marguerite Salazar is president and CEO, Valley-Wide Health Services, Inc. She joined Valley-Wide in 1985 as associate director and assumed her current position in 1989. Previously, she directed a firm that contracted with local public health departments, hospitals, and nursing homes to provide social work services. She is a member of the board of Colorado Access and serves on the Child Health Plan Plus policy board as well as on the boards of numerous other organizations in the state.

Herman Schreivogel, N.H.A., is CEO of Lincoln Community Hospital and Nursing Home. Before moving to that position in 1998, he served as the facility's CFO. Previous experience includes six years as chief financial officer of Keefe Memorial Hospital in Cheyenne Wells, Colorado.

Elena Thomas, M.A., has been director of community development, Colorado Community Health Network, since 1998. She has worked as an advocate on health issues, including migrant farm worker issues, HIV/AIDS, and health disparities since 1992.

Stephanie Thomas has been chief operating officer, Denver Health, since 1997. Her previous positions at Denver Health include associate hospital administrator (1991 to 1993) and hospital administrator (1993 to 1997).

Victoria Valdez has been director of operations, Arkansas Valley Division, Valley-Wide Health Services, Inc., since March 2001. After joining Valley-Wide as a receptionist, Valdez moved up to become an administrative assistant and then, in 1997, became support staff coordinator.

Gary D. VanderArk, M.D., is chair of the Colorado Coalition for the Medically Underserved, a post he has held since 1997. Since 1988, he has also been president of the Colorado Neurological Institute.

Larry H. Wall has been president of the Colorado Health and Hospital Association since 1984. Prior to that, he was vice president for rural hospitals and operations for the association, which he joined in 1974. Earlier, he was administrator of Craig Hospital and assistant administrator of Swedish Medical Center, both located in Englewood. A pharmacist by training, he has served on numerous American Hospital Association councils and committees at the national level and on dozens of professional and civic committees at the state level.

Elizabeth M. Whitley, R.N., Ph.D., is director, Community Voices, Denver Health, a post she has held since 1999. For the previous seven years, she was senior consultant, Rocky Mountain Center for Healthcare Ethics. From 1980 to 1993 she was with Lutheran Medical Center in Denver, serving first as neonatal clinical specialist/head nurse, then as assistant director of nursing, and finally as director of Women's and Children's Services.

Richard A. Wright, M.D., is director, Department of Community Health Services, Denver Health. He is also a professor in the Departments of Medicine and Preventive Medicine and Biometrics at the University of Colorado Health Sciences Center. Wright also serves on numerous local and national boards and committees related to health care reform and community health services.

Biographical Sketches—Federal Participants

Alexis Ahlstrom, M.P.H., is an analyst with the Health Cost Estimates Unit, Congressional Budget Office (CBO).

Sylvia C. Brown is a legislative assistant in the Office of Rep. Mike Ross (D-Ark.). Before moving to that position in January 2001, she was a legislative aide to Sen. Blanche Lincoln (D-Ark.).

Alison Buist, Ph.D., is a legislative assistant to Sen. Gordon Smith (R-Ore.). She is also an adjunct assistant professor of health policy and the health care system at the George Washington University School of Medicine and Health Sciences.

Aaron K. Cohen is a legislative assistant in the Office of Sen. John Ensign (R-Nev.). Before joining Senator Ensign's staff in January 2001, he was first legislative aide and then legislative correspondent in the Office of Sen. Richard Bryan (D-Nev.).

Mary Lou De Zeeuw is Colorado-Wyoming team leader in the Health Resources and Services Administration's (HRSA's) Denver Field Office, Department of Health and Human Services.

Blanca Fuertes, M.P.A., is a congressional fellow in the Office of Sen. Jack Reed (D-R.I.). Since 1999 she has been a policy analyst and public affairs coordinator in the Office of Rural Health Policy, HRSA. Previously, she was a health care specialist in the Office of Legislation at the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services or CMS) and executive director of the D.C.-based Spanish Senior Center.

George D. Greenberg, Ph.D., is executive advisor in the Office of Health Policy, Assistant Secretary for Planning and Evaluation (ASPE), DHHS. He has been with ASPE since 1976.

Thomas A. Gustafson, Ph.D., is director, Purchasing Policy Group, Center for Medicare Management, CMS, DHHS. Previous positions at CMS, which he joined in 1985, include deputy director, Office of Strategic Planning; deputy director, Office of Research and Demonstrations; deputy director, Office of Legislation; and director, Division of Medicaid and Long-Term Care Policy.

Jan Heinrich, Dr.P.H., R.N., is director for the Health Care Group in the U.S. General Accounting Office (GAO), overseeing all issues dealing with public health. She was director of the American Academy of Nursing for seven years and before that served as the director of extramural programs for the National Institute of Nursing Research at the National Institutes of Health.

Jennifer Jenson, M.P.H., M.P.P., has been special assistant to the executive director of the Medicare Payment and Advisory Commission since 1998. She was previously a budget analyst at CBO.

Lisa N. Kidder is senior health policy advisor, Office of Sen. Larry Craig (R-Idaho). She joined Senator Craig's office as a legislative assistant in 1998.

Kate Kirchgraber is a professional staff member, majority, Senate Finance Committee. Previously with the Office of Management and Budget, she has also worked as a health and education analyst for the New York State Assembly Ways and Means Committee and as a budget analyst for the City of New York.

Stephanie Monroe is chief counsel, minority, for the Senate Committee on Health, Education, Labor and Pensions. She previously served as the majority staff director for the committee's Subcommittee on Children and Families.

Jennifer O'Sullivan has been a specialist in social legislation, Congressional Research Service, Library of Congress, for the past 20 years. She was previously a legislative analyst and program analyst at DHHS.

Amanda Pezalla is legislative assistant, Office of Rep. Bill Luther (D-Minn.). Before coming to Capitol Hill in 1999, she served for one year as a Mickey Leland Hunger Fellow, which involved stints with a food bank in Lubbock, Texas, and the Urban Institute's Assessing the New Federalism project.

Stephen M. Phillips is deputy director of the Division of Acute Care, Purchasing Policy Group, Center for Medicare Management, CMS, DHHS. Prior to accepting this position one and a half years ago, he served for four years as a technical advisor to the agency.

Colin Roskey serves as health policy advisor to the Senate Finance Committee. His primary area of responsibility is the Medicare program. He also is involved with insurance, Medicare supplemental insurance, and competition issues. From 1997 to 2001, Roskey practiced health care law with

Mintz, Levin, Cohn, Ferris, Glovsky and Popeo and with O'Connor and Hannan, both in Washington, D.C.

William J. Scanlon, Ph.D., is the director of the Health Financing and Public Health Issue Area at GAO. He has been engaged in health services research since 1975. Before joining GAO in 1993, he was the co-director of the Center for Health Policy Studies and an associate professor in the Department of Family Medicine at Georgetown University. He has also been a principal research associate in health policy at the Urban Institute.

Yvette Shenouda, M.P.P. is senior legislative assistant for health policy, Office of Sen. John Rockefeller IV (D-W.Va.). She was previously a program examiner in the Office of Management and Budget.

Jessica Townsend is a senior staff fellow in the Office of Planning Evaluation, and Legislation, HRSA, DHHS. Before joining the agency in 1992, she was for ten years a study director with the Institute of Medicine. She has also worked at Codman Research and was assistant economics editor at *Business Week.*

Jason B. VanPelt is legislative director for Rep. Ed Whitfield (R-Ky.). He was previously senior legislative assistant to the congressman, whose office he joined in 1996. He was a law clerk for the Newport News Circuit Court from 1995 to 1996.

Thomas J. Walsh, J.D., M.P.H., serves as health policy advisor to the Senate Committee on Finance. His areas of responsibility include Medicare and rural health issues within the jurisdiction of the committee. During the 105th and 106th Congresses (1997-2001), he served under Sen. Charles Grassley (R-Iowa) as counsel on the Senate Special Committee on Aging. Previously, Walsh practiced health care law with McDermott, Will & Emery, in Washington, D.C.

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