

Community Solutions for Healthcare Coverage

North Dakota's First 100% Access Health Care Summit

October 18-19, 2005
Doublewood Inn, Bismarck, ND

SUMMIT REPORT

Convened by the Governor's Health Insurance Advisory Committee and
the Dakota Communities Access Program

With support from:

HRSA State Planning Grant through the North Dakota Department of Health, HRSA Technical Assistance Grant through Dakota Communities Access Program, Blue Cross Blue Shield of North Dakota, Dakota Medical Foundation, and Northland Healthcare Alliance.



TABLE OF CONTENTS

Introduction	3
<i><u>Day 1 - Tuesday (October 18, 2005)</u></i>	
Welcome and opening comments	3
Opening exercise (“News Headlines”)	4
Measures – “The Gaps in Access, Health Status, and Quality”	6
Citizen Panel	7
“One Community’s Experience in Moving to 100% Access” - Vondie Woodbury	8
“What a Community’s Full Access Safety Net Will Look Like In ND” - Dr. Terry Dwelle	8
“ How a State Can Restructure Health Care Community by Community” Dinner conversation with Maggie Anderson, Medicaid Director	10
<i><u>Day 2 - Wednesday (October 19, 2005)</u></i>	
“Framework for Statewide Community Efforts for 100% Access and Disparities Elimination” – Karen Minyard and Governor’s Health Insurance Advisory Committee (GHIAC)	10
Collaborative Leadership and Setting Goals for North Dakota – John Scanlon	11
State Legislative Panel	15
Governor John Hoeven	15
Statewide Support	16
Wrap-up	16
State Map of Coalitions	17
Appendix	18

INTRODUCTION

“Community Solutions for Healthcare Coverage”, North Dakota’s First 100% Access Healthcare Summit was held in Bismarck, ND on October 18-19, 2005. This fast-paced, two-day statewide campaign brought together more than 120 healthcare professionals, elected officials, community champions and local community members. The participants looked at healthcare access issues confronting North Dakota and identified potential community-based solutions that could be built into a powerful portfolio of activities to achieve 100% healthcare access. The Summit was facilitated by “Communities Joined in Action”, a national organization dedicated to grass roots solutions for improving healthcare access and convened by the Healthcare Access Planning Committee led by Dr. John Baird.

The Summit was a highly interactive event with lots of work sessions and breakout sessions for the participants. The purpose of each of these sessions was to brainstorm ideas and solutions and to identify strategies to develop and implement these community-created ideas and solutions.

A HRSA State Planning Grant through the North Dakota Department of Health, a HRSA Technical Assistance Grant through Dakota Communities Access Program, Blue Cross Blue Shield of North Dakota, and Dakota Medical Foundation were the official sponsors for the Summit.

100% Healthcare Access Planning Committee

John Baird
Tim Cox
Gary Garland
Julie Haugen
Urmila Kamat
Alana Knudson
Karen Larson
Jon Rice
John Scanlon
Theresa Snyder

Day 1: Tuesday (October 18, 2005)

I. Welcome

Pat Traynor, Dakota Medical Foundation, opened the Summit with a welcome to all and an affirmation of the importance of the issue of access to healthcare for all North Dakotans. He offered acknowledgement of the great success in coverage solutions already underway in North Dakota. As examples of North Dakota successes, he referenced the work of **Covering Kids & Families**, which has been very effective in outreach and enrollment and in driving the simplification of the enrollment process. He also referenced the work of the **Healthy Community Access Program (HCAP)**, which has connected uninsured persons with coverage, in addition to providing dental access and pharmacy assistance.

Pat then made a very powerful leadership statement that **“Every North Dakotan should have a medical home where they are assured ready and affordable access to quality health care”**. He went on to describe the current trends in coverage, especially the decreasing prevalence of employer sponsored

coverage. In fact, 85% of the uninsured were found to be in working families with 62% full-time workers. He closed by encouraging participants in the Summit to speak with the Foundation about coverage solutions and how the Foundation may partner in the future.

Tim Cox, Northland Health Healthcare Alliance, next offered opening comments. First, he noted that this Summit was the vision of Dr. John Baird, who provided the leadership to convert it into reality. Tim suggested that North Dakota is in an excellent position to be the first state to achieve full coverage, since it already has 91.5% coverage at this point, among the best in the nation.

Tim then introduced **“Communities Joined in Action”** (www.cjaonline.net), the national membership organization of communities committed to 100% access to care and zero health disparities by creating local programs to achieve it. CJA in partnership with the Planning Committee for the Summit assisted in the

planning and preparation for the meeting as well as providing three speakers/facilitators: **Karen Minyard, Executive Director of Georgia Health Policy Center; John Scanlon, President of JSEA Consultants; and Eric T. Baumgartner, Policy and Program Director for the Louisiana Public Health Institute.**

John Scanlon then provided a leadership presentation picking up on the goal statement of Pat Traynor that all North Dakotans should have a medical home. John pointed out that this is the goal of 100% access to care.

John then asked the participants to identify which sector they each primarily represented. A quick assessment showed many persons from the health care sector, many from the state government and some from local government. In particular, there were members of the state legislature and from the Governor's Health Insurance Advisory Committee. In addition there were several uninsured persons or those representing the consumer. Also, there were

about a dozen Community Resource Coordinators from the HCAP program. John later set up the approach for the Summit by coaching the participants on working as "collaborative leaders," especially how to listen for the possibilities in what is said by all during the Summit. He encouraged each to suspend the critical/ analytical thinking that comes with serving as a manager or professional and participate by envisioning the preferred future and declare it to the others. In this way, people who share in that vision can work together to make it happen. He motivated the participants to think like "leaders", i.e. take risks, have a vision, be creative, think globally and set goals.

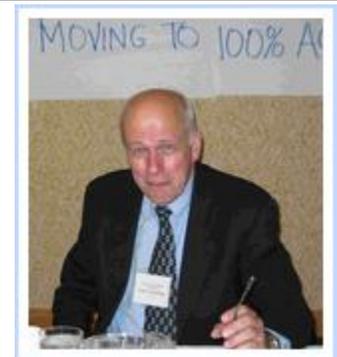
John suggested that participants run on two questions in active support of the mission.

- What action will I take to get 100% access in my community?
- As a state leadership voice, what action will I take to support communities in action for access?

II. Opening Exercise - Headlines

In this exercise, John asked the participants to envision bold but possible goals for improving access and health in North Dakota. He asked that these visions be captured in a couple of phrases, in the format of a possible news headline with a subtext. Participants quickly developed and shared their visionary headlines as represented by the following:

- **"North Dakota Rural Communities to have Affordable Insurance Coverage"**
Rural farmers have full access to health insurance.
- **"Northland Communities Develop Multiple Programs to Help People have Medical Homes"**
- **"North Dakota Cares"**
North Dakota has finally established a program called "ND Cares" to help pay for medical costs for people aged 22-65 years.
- **"Healthcare Access for American Indians"**
American Indians in North Dakota cities access health services at 100% level.
- **"Wellness as a Goal"**
100% access to health maintained.
- **"Healthcare Access Reaches 95% in North Dakota: Healthcare Coverage for ages 21-65 years attained"**
- **"Death is no longer Prolonged"**
80% of Medicare dollar is spent on the living, not the last 3 months of life.
- **"Access to Healthcare across North Dakota"**
Communities organize to provide health coverage to all North Dakotans.
- **"Health Enhancement Initiative Realizes Results"**
Improved health status spares treatment resources for severely ill.



- **“Dr. Everybody: State Citizens get Full Health Benefits”**
- **“Quality, Preventive Health Care Here to Stay”**
100% access for all North Dakotans
- **“No Person Left Behind”**
All citizens of North Dakota have health care access
- **“Chronic Disease Under Control”**
E. R. visits decline dramatically.
- **“Enough Flu Vaccine for Everyone!”**
- **“All North Dakotans are Covered”**
Ensuring a healthy future for all our citizens.
- **“North Dakota Universal Health Plan results in 0 Health Disparities”**
No group has poor health.
- **“Healthiest Health Insurance”**
Not a person in Griggs County without insurance.
- **“Rural Families Now Insured”**
Ashley, ND succeeds in developing a plan so farmers and their children have healthcare coverage.
- **“Nursing Home Becomes Home”**
St. Benedict’s makes nursing care more comfortable and home-like.
- **“State Ranks # 1 in Health Care Access”**
A statewide initiative drops the rates of uninsured to zero.
- **“Insurers Declare Primary and Preventive Care to be the Foundation of Medical Health and Pledge to Effectively Fund these Services”**
- **“ We’ve Got You Covered”**
North Dakota implements single payer coverage for physical, mental, dental and vision care for all residents – Lynn Gifford
- **“Diabetes Care Improves”**
90% of patients with diabetes in complete control
- **“All Children Covered”**
 - Expanded medical coverage programs for children
 - Communities working together to assure access
- **“Community Members have Health Care Homes”**
By 2010, 100% of community members will have access to healthcare
- **“ A Few People can make Decisions that Changes the World Indeed...”**
- **“Average North Dakotan Loses 25 Pounds”**
 - Wellness businesses flourish
 - Insurance premiums decline making health insurance affordable
- **“North Dakota was the Only State Prepared for the Avian Flu” OR “Bird Flu, Flew Over North Dakota”**
 - Public health and private sector worked together to prepare for the crisis
 - Loss of life limited in North Dakota
 - 100% access to healthcare was the key
- **“Everyone Free to Age with Dignity and Purpose”**
Alternative care options allow seniors to age in the place they choose.
- **“Caring for Children Enrollment Doubles”**
Stable funding results in benefits expansion.
- **“Small Employers have Big Plans”**
Employee access to health insurance has increased from 62% to 90%.
- **“Health Disparities Disappear”**
American Indians in North Dakota have positive health outcomes.
- **“Healthcare for All Online”**
 - All uninsured are online MR.
 - All may be seen for healthcare
 - Regional Open Access Clinics

- **“Medical Care for All is becoming a Reality”**
Neighbors taking care of neighbors.
 - **“Socialized medicine enthusiastically embraced in North Dakota”**
Finally, Healthcare for All
 - **“North Dakota Board of Higher Education mandates health insurance coverage for college students”**
....And will work with local and state insurers.
 - **“Southwest North Dakota first region to achieve 100% access to healthcare”**
 - **“Collaborative effort results in Healthy North Dakota”**
All players are on the field to solve Health Care Crisis....
.....Barriers eliminated, partnerships made, enrollment and pre-enrollment process simplified and central intake and information center formed.
 - **“Single entry point for access to health care in Richland County”**
 - 95% of North Dakota population covered with adequate healthcare.
 - Number of children not covered dropped from 11,000 to 2,000 in 3 years.
 - **“Seniors protected”**
Long Term Care insurance is a reality.
 - **“North Dakota creates safety net/ full coverage for all”**
Special health care needs for children – eligibility streamlined and simplified!
 - **“All (100%) North Dakotans have some kind of health care coverage and access”**
100% of North Dakotans have easy access to primary healthcare within 15 minutes of their homes and have the transportation to get there.
-

III. Measures

“Finishing North Dakota’s Health Care System: The Gaps in Access, Health Status and Quality” – a presentation prepared by Dr. Baird and presented by Alana Knudson, UND Center for Rural Health

Eric Baumgartner introduced the next presentation by describing to participants the importance of having data that relates to the access and disparity issues at hand. Running on data measures provides for important supports to the planning, implementation and evaluation of these initiatives. First, choosing measures supports selecting priority areas to be addressed. Secondly, for these priority measures, data can be gathered to establish the current status, or benchmark, of the health parameter or access issue. Thirdly, baseline data inform the process by which objectives for achievement can be forged. Finally, data helps track the progress over time towards changes in the baseline measure of priority issues to provide feedback on the effectiveness of the initiative.

The presentation aimed at providing an understanding of the gaps in healthcare access, the health status and the quality of North Dakota’s Health Care System. Alana provided results based on the research conducted by the Center for Rural Health at the UND School of Medicine and Health Sciences. According to their research, 8.2% (51,920) of North Dakotans and 31.7% of Native Americans were found to be uninsured. Those uninsured were mostly males, not married, young adults and children, those with lower income, and those employed with small firms. Poorer health status and lower quality care was also associated with uninsurance.

Please refer to PowerPoint presentation in Appendix.

Eric commented that two particular measures in the presentation that struck him as particularly important: first that such a huge percentage of businesses do not offer coverage for their employees (even people working 2 or 3 jobs, do not have access to healthcare); and second, that over 30% of Native Americans were uninsured. After the presentation, Eric asked participants to generate their own

priority measures that they would like to see as one taken up by communities and the state in support of the 100% access and disparities elimination goals. Participants generated their own measures and then shared with the group as represented by the following suggested measures:

- ❑ Healthcare status by disease and treatment
- ❑ Priority of finances by age, sex and race
- ❑ Diabetes by demographics
- ❑ Homeless population
- ❑ Refugee/ Immigrant population
- ❑ Lesbian, gay, bisexual, transgender people
- ❑ People with pre-existing conditions
- ❑ Age 21-65 with medical needs
- ❑ Those who have access to health insurance coverage, but cannot afford it
- ❑ Uninsured Native American population (conflict of IHS & Medicaid)
- ❑ Insured by disease
- ❑ Inappropriate use of ER
- ❑ Rural health coverage
- ❑ Small business group coverage
- ❑ Lowest income people
- ❑ 18-65 year olds
- ❑ Geographic breakdown of uninsured American Indians/ all races
- ❑ Age breakdown of uninsured American Indians/ all races
- ❑ Number of uninsured defined as those who cannot afford deductibles
- ❑ Number of people working 2 or 3 jobs but still lack access to healthcare
- ❑ Actual number of uninsured
- ❑ Percent of Native Americans at the community level
- ❑ Infants born without health coverage
- ❑ Aging population
- ❑ Small business owners not offering insurance
- ❑ Uninsured children in urban areas – medium income families
- ❑ Uninsured children within families with fluctuating income
- ❑ 18-64 year old employed people who cannot afford health insurance
- ❑ Self-employed farmers who are underinsured
- ❑ People who have to change jobs or their lifestyle in order to keep health insurance for a special needs child
- ❑ Farmers, ranchers and single people in agricultural environments (farm families)
- ❑ Number of people who indicate that they do not want to pay for health care insurance i.e. wish to be “self-insured”
- ❑ Combined charity/ unreimbursed care given away in North Dakota
- ❑ Number of healthy births
- ❑ Number of people with primary care providers
- ❑ Age groups of uninsured
- ❑ Health coverage by employee size
- ❑ Number of “ER visits” and “preventative visits” for the uninsured
- ❑ Distance to nearest healthcare providers
- ❑ Medical bankruptcy numbers
- ❑ Personal medical debt
- ❑ Combined give away care

As a result of this exercise on priority measures for health access and disparities elimination, several participants offered comments on goals that came to mind when reflecting on the measures:

- ❑ Making insurance affordable through small employers
- ❑ Providing education on the opportunities available
- ❑ Oral health and behavioral health as part of primary care
- ❑ Long term care insurance access
- ❑ Mental health care parity

IV. Citizen Panel – Tim Cox

Tim introduced this part of the Summit by reminding us that the access initiative is to always be grounded in the real needs of North Dakotans. To assure such grounding in this

Summit, four residents presented real-life stories relating to uninsurance, underinsurance or other challenges to access and health.

The clear message from these persons were that access to care can be severely compromised for the uninsured/underinsured and that, even with significant individual effort and personal responsibility, it is simply not possible to receive all



necessary services, meds and supplies in a timely, consistent and affordable way. One person described having to choose between child support payments and his own life-saving care. Another person described a balance bill for services at \$70,000 and the real possibility of losing his home. The common theme from these real-world accounts is that lack of adequate and affordable health care leaves

persons, otherwise thriving, employed and essentially healthy, foregoing needed care. This results in outcomes of ill health, disability and dependency on social and safety net programs. Tim closed this discussion by stating that, across North Dakota, there are thousands of persons much like those who have shared their story. He suggested that this is why the leaders in the room and in communities across the state must work together to achieve 100% access to affordable healthcare.

Some of the emotional comments or reactions from the audience included:

- ❑ Despair
- ❑ Recognition of the need to create universal coverage in North Dakota
- ❑ Comment: "Healthcare should be a right and not a commodity"
- ❑ Realization: Importance of having access to quality healthcare

V. "One Community's Experience in Moving to 100% Access" – Vondie Woodbury, Project Director of Muskegon Community Health Project, Muskegon, MI

Vondie Woodbury represents a true collaborative leader who has been in the lead for a host of significant community access and health achievements in her hometown in Michigan.

She presented an overview of a program that provides for a locally driven health care coverage plan that is outside of health insurance. It runs on monthly contributions from small employers, their uninsured employees and from local community funds matched by federal funds and offers services from almost every provider in the county. This innovative "3-Share" approach has worked for

years in Michigan and is being replicated by a growing number of communities across the nation.

The participants reacted to the Muskegon Project with the following comments:

- ❑ Collaborative is powerful
- ❑ Amazement that 100% access is truly possible
- ❑ Excitement about community conducting planning
- ❑ Opened venue to the possibility of small businesses getting involved to offer healthcare coverage

Please refer to PowerPoint presentation in Appendix.

VI. What a Community's Full Access Safety Net Will Look Like in North Dakota" – Terry Dwelle

This session involved framing of the key attributes of community systems for care and an illustration of the current programs and strengths already in play in North Dakota. Dr. Dwelle offered that the four key elements of an effective community integrated system include:

- 1) communication,
- 2) real-time data access,

- 3) seamless transition across services, and
- 4) flexibility to continuously improve the responsiveness to community needs.

With that, he introduced in series, representatives from 12 representative organizations that demonstrate the existing resources, programs and leadership in place that can be drawn upon to further develop effective community and state approaches to access and disparities elimination. Each leader briefly described their mission, their core service and the biggest value to community.

- ❑ **Healthy North Dakota:** Healthy North Dakota is a dynamic, statewide partnership supporting North Dakotans in their efforts to make healthy choices by focusing on wellness and prevention. It is comprised of different health programs lead by community developers and professionally trained facilitators. **“Healthy North Dakota: Healthy people, healthy communities”** is their vision.
- ❑ **Hedahls Wellness Earnback Plan:** Dick Hedahl, President of Hedahls Parts Plus talked about the **Hedahls Wellness Earnback Plan** through which his company provides financial incentives to his employees and their spouses for healthy behaviors i.e. monthly \$25 each for not smoking, not drinking, keeping weight in control, and annually for screening tests – cancer, cholesterol, blood pressure and blood sugar.
- ❑ **Dakota Cares (Three Share Program):** The Three Share Program is a community based health coverage program (**not insurance**) primarily based on health care provided by a managed care network and does not cover services used outside of the network.
- ❑ **Good Neighbor Program:** The Good Neighbor Project is a grassroots campaign committed to ensuring access to high-quality health care for the people of the West River area of North and South Dakota. It aims at providing medical cost assistance (co-pays and deductibles), core preventive services and mental peace to the West River area residents.
- ❑ **Pharmacy Programs:** Provide pharmacy access in an affordable way, e.g. the discounted 340B pharmacy program, community pharmacy programs and the no cost pharmacy assistance program.
- ❑ **Bridging the Gap (Dental Health Service):** Provides dental services to low-income patients.
- ❑ **Indian Health Service:** Provides primary, specialty and hospital care for Native Americans on reservations.
- ❑ **Children’s Special Health Services:** Consists of 8 programs that provide services for children with special health care needs and their families and promote family-centered, community-based, coordinated services and systems of health care.
- ❑ **Covering Kids and Families:** This program focuses on statewide strategies designed to conduct outreach; simplify and coordinate coverage; and ensure access to available low-income health coverage programs for children. The program aims at building a sustainable, model health coverage system for all eligible North Dakota children, the target populations being low-income families and Native Americans.
- ❑ **The Caring Program for Children:** This is a specially designed physical, mental and dental health benefit program for eligible children, at no cost to the children or their families.
- ❑ **HCAP:** The Healthy Community Access program is a statewide network of Community Resource Coordinators who work one-on-one with people to assist them in applying for health coverage and other programs that can help. To date, CRCs have helped over 1,800 people successfully enroll in health coverage programs. CRCs also connect people with other programs, and

work with their communities to identify and address health access issues.

- ❑ **Community Health Center:** These are health centers that are located in medically

underserved areas and provide comprehensive primary care services as well as supportive services such as translation and transportation services that promote access to health care.

Vondie Woodbury reacted to the brief presentations of these existing strengths from across the state and affirmed that these resources are just what it takes to build effective access solutions for communities. Terry closed by adding that the Healthy North Dakota initiative has expert community facilitators already working to make that happen.

VII. Dinner conversation “How a State Can Restructure Health Care Community by Community” – Maggie Anderson, Medicaid Director, ND Department of Human Services.



Karen Minyard introduced the dinner presentation by Maggie Anderson by describing the work that communities must do to be successful in achieving anywhere near 100% access as playing “Three Level Chess.” By that, Karen explains, it is meant that the work really runs on three levels – the local public and private activities, those at the state level and those at the national level. Communities should try to work on all three levels to maximize their opportunities for access. By having the Medicaid Director, members of the legislature, the Governor, the state public health leadership and community leaders all participating, Karen affirms that the participants are already playing effectively at two levels – local and state.

Please refer to PowerPoint presentation in Appendix.

DAY 2: Wednesday (October 19, 2005)

VIII. “Framework for Statewide Community Efforts for 100% Access and Disparities Elimination” – Karen Minyard and Governor’s Health Insurance Advisory Committee (GHIAC)

Karen started the second day of the Summit with a framing of the key functions, relationships and resources that could make for a successful initiative in North Dakota.

Karen talked about the framework necessary to build successful community coalitions. The important components of this framework being convening new organizational structures within the communities with statewide support; information gathering and sharing; technical assistance; funding; and tribal coalitions. Local collaborative members (Hospitals, physicians, Health & Human Services, public health, local government, Chamber, faith, schools, philanthropy, payers, etc) with community support can build the successful framework for “Statewide Community Efforts for 100% Access and Zero Disparities”.

There were affirming comments from members of the GHIAC in response to Karen’s framework. Dr. John Baird referenced relevant processes and resources already in play such as the ‘**Healthy North Dakota initiative**’. He also referenced the current processes underway to focus on the Native American health and access issues. Gary Garland commented, “We have the people who can make a difference in this room...communities haven’t been involved in a substantial way before”

IX. Collaborative Leadership and Setting Goals for North Dakota – John Scanlon

John provided further coaching on 'collaborative leadership' by describing the process through which leaders succeed. At its essence, leaders invent the future. He described how leaders suggest what is possible (preferred future), followed by looking for opportunities to achieve the possible (potential solutions), followed by commitments to seize the opportunities (assets) to be consummated by action.

John suggested that there are four major steps by which this is accomplished. First, leaders declare what the preferred future is. Leaders simply state what will be achieved as a leadership vision to which others can find their own personal connection. Secondly, leaders make assertions of its doability by holding out models and other evidence, ex. 3-Share model from Muskegon. Thirdly, leaders convene people for purposes of organizing around the vision. And, finally, seeking commitments for action and resources through a process of requests and offers among potential partners.

With this framework in mind, John then offered a potential leadership story for the communities in the room and the state of North Dakota, as follows.

In 2008, 52,000 uninsured North Dakotans have a medical home (the Summit opening vision by Pat Traynor)

- This is the leadership declaration

In achieving the above vision, in 2007-2008, 28 regional integrated systems were operating and growing to meet the need in providing medical homes to those in need.

To achieve the above milestone, at the close of 2006, 28 developing regional health access coalitions each secured the 12 or so necessary respective "deals" needed to support a regional integrated health care system (see the "Return on Community Investment" workbook in the registration packet).

To achieve the above milestone, in latter 2006, most or all 28 developing regional access coalitions received seed funding (~\$10,000) to support their development. Each coalition had an effective Network Director in place and the coalition partners, through their collaborative efforts, had effectively driven the community to the tipping point for assuring medical homes to all residents.

To achieve the above milestone, by May 2006, access coalitions from across the state came together for the 2nd summit (after this first one). They were receiving ongoing technical assistance from in-state and national experts and peer leaders. The coalitions had brought to the fore hundreds of "on-fire" leaders from communities across the state.

With this compelling leadership story as impetus, John asked that participants divide into groups by their own sense of regions of the state that made sense for purposes of health access coalition organizing. The participants divided into 6 regions, one statewide group and one Native American access and disparities group. Each group did actual planning for impact goals for access and disparities and suggested formative next steps for developing/supporting effective regional coalition work.

Each group then reported out their leadership plans as follows:

1. SOUTHWEST ND

Statistics:

- Population: 40,000
- # Uninsured: 4,500
- # Uninsured with access to high quality medical home: 1,500

Coalition name: Healthy Corner Coalition (HCC)



Motto: "Healthcare for all."

Leaders: Karen Hilfer (Dickinson) & Denise Andress (Hettinger)

Participants: Kim Schalesky (Hettinger), Larry Bernhardt (Dickinson), Donald Binstock (Dickinson)

Members: Hospitals, clinics, physicians, dentists, pharmacy, clergy, chamber, universities, city and county government, community members, health department, social services, providers, media, philanthropy.

May 2006 headline: "Coalition formed to address healthcare access in southwest North Dakota."

October 2008 headline: "All employees have health coverage."

Pacing event:

- 7:00 PM on March 17, 2006 at New England Community Center
- Key points:
 - ✓ Form the coalition
 - ✓ Set coalition agenda (Coalition sets own agenda)
 - Define the issue
 - Create vision

3. NORTH CENTRAL ND

Statistics:

- Population: 50,000
- # Uninsured: 5,500
- # Uninsured with access to high quality medical home: 20% (1,100)

Coalition name: North Central Rural Health Coalition

Motto: "Healthcare solutions for our communities"

Leader: Ronald Volk (Harvey)

Participants: Carrie Cote (Bottineau), Brenda Bergsrud (Rolla), Beth Huseth (Harvey), Sr. Margaret Rose Pfeifer (Fargo)

May 2006 headline: "North Central begins providing wellness!"

October 2008 headline: "North Central provides wellness to all in area!"

Pacing event:

- North Central Geographical Rural Health Meeting.
- March 4, 2006 in Rugby
- Models:
 - ✓ Rural Nursing Coalition
 - ✓ Rural Mental Health Consortium



4. NORTHWEST ND

Statistics:

- Population: 90,000
- # Uninsured: 8,500
- # Uninsured with access to high quality medical home: 2,500

Coalition name:

Motto:

Leaders: Gerald Lumley (Minot) & Annette Funk (Minot)

May 2006 headline: "Urban and Frontier Leaders convene to provide 100% Access to Primary Care"

October 2008 headline: "Frontier population finds a medical home"

Pacing event:

5. BURLEIGH-MORTON COUNTIES

Statistics:

- Population: 150,000

- # Uninsured: 20,000
- # Uninsured with access to high quality medical home: 13,000 (25% of ND)

Coalition name: Capital Area Healthcare Coalition [C.A.R.E.?)

Motto: "Accessible healthcare for all"

Leader: Rodger Wetzel (Bismarck)

Participants: Keith Johnson (Mandan), Paula Flanders (Bismarck), Gary Garland (Bismarck), Darleen Bartz (Bismarck), Dick Dever (Bismarck), Arvy Smith (Bismarck), Janelle Johnson (Bismarck), Chadwick Kramer (Bismarck), Peggy Vaagen (Mandan), Deborah Larson (Bismarck)

May 2006 headline: "Citizens spearhead region-wide 100% access to healthcare initiative" – Local coalition leads effort!

October 2008 headline: "100% access to healthcare achieved for all area persons, including the homeless and the uninsured"

Pacing event:

- Model: Regional summit (supper, 9 PM) – "All of our people deserve healthcare"
- Important event

2. EAST CENTRAL ND (RURAL)



Statistics:

- Population: 50,000
- # Uninsured: 8% (4,000)
- # Underinsured: 12,000
- # Uninsured with access to high quality medical home: 0%

Coalition name: East Central (Rural) Access Coalition

Motto: "Unified to find medical homes."

Leader: Sheryl Rude (McVille)

Participants: Julie Ludwig (Northwood), Rita Raffety (Larimore), Pam Ressler (Cooperstown), David Carda (Park River), Theresa Will (Valley City), Evelyn Quigley (Fargo), Sharon Ericson (Northwood), Rockford (Rocky) Zastoupil (Jamestown),

May 2006 headline: "Assessed our access to healthcare."

2008 headline: "Provided a medical home for 50% of our uninsured and medically underinsured."

Pacing event:

- Valley Rural Health Cooperative Meeting
- April 2006 in Northwood
- Model: Ability to innovate and be creative as we go

6. CASS COUNTY

Statistics:

- Population: 150,000
- # Uninsured: 16,000
- # Uninsured with access to high quality medical home: 8,000

Coalition name: South Valley Healthcare Access Coalition

Motto: "Access 100: We've got you covered"

Leader: Mary Kay Hermann (Fargo)

Participants: Steven Boehning (Fargo), Tom Fischer (Fargo), Lynn Gifford (Fargo), Ruth Hanson (Fargo), Muriel Hedrick (Wahpeton), Shannon Heick (Fargo), Sherry Jensen (Fargo), Tim Mathern (Fargo), Susan Nelson (Fargo), Rod St. Aubyn (Fargo), Darrell Vanyo (Fargo).

Members: Public health, CRCs, providers, employers, pharmacies, churches, faith communities, uninsured consumers, dentists, social service agencies, schools (secondary/ higher education), insurers/ payers, local and state government, philanthropy, advocacy, rapid care centers, professional associations, chamber, United Way, service clubs, physicians, shelters, YWCA, YMCA, rodeo, mental health, senior services, voluntary groups, Healthy ND, CJA, Center for Rural Health, and Center for New Americans.

May 2006 headline: "Southeast Regional Coalition formed to map out healthcare coverage goals and strategies."

October 2008 headline: "Southeast North Dakota achieves 100% access to healthcare coverage."

Pacing event:

- Mid May 2006 at the Fargo Dome.

7. TRIBAL REGION

Statistics:

- Population: 63,000
- # Uninsured: 7,000
- # Uninsured with access to high quality medical home: 10% (700)

Coalition name: Northeast Communities Cares

Motto: "Putting the care back into healthcare."

Leaders: Margaret Mowery (Fargo)

Participants: Shary Johnson (Devil's Lake), Antonette Young (Fort Totten), Donna Langton (Devils Lake), Kyle Muus (Grand Forks), Theresa Snyder (Bismarck), Chad Gerloff (Grand Forks).

May 2006 headline: "Health access coalition formed for Northeast North Dakota."

October 2008 headline: "Northeast Communities Cares attains 100% healthcare access."

Pacing event:

8. STATEWIDE

Statistics:

- Population: 641,000
- # Uninsured: 52,000
- # Uninsured with access to high quality medical home: 52,000

Coalition name: State Coalition for 100% healthcare access.

Motto:

Leaders: Julie Haugen (Fargo)

Participants: David Peske (Bismarck), Patricia Hill (Bismarck), Susan Bosak (Fargo), Karen Tescher (Bismarck), Linda Wurtz (Bismarck), Jeana Peinovich (Fargo), Kathryn Grafsgaard (Bismarck), Margaret Sitte (Bismarck).

May 2006 headline: "New community health plans expand options that provide a continuum of care."

October 2008 headline: "All 641,000 North Dakotans offered 100% access to healthcare."

Pacing event:

- Meeting in March 2006 in Bismarck with Karen Tescher @ Medicaid organizing it.

9. SOUTHEAST & SOUTH CENTRAL ND

Statistics:

- Population: 35,000
- # Uninsured: 1,400
- 4% self payer, uninsured
- # Uninsured with access to high quality medical home: 0

Coalition name: Region Six 'CARES'

Motto: "Community Access for Rural Effective Healthcare Services."

Leader: Diane Weispenning (Oakes) & Derrick Jones (Wishek)

Participants: Dixie Robinholt (Ashley), Nancy Skjefte (Oakes), Karen Jones (Wishek),

May 2006 headline: "Southeast and South Central North Dakota Collaborative meets to discuss healthcare coverage."

October 2008 headline: "21 communities provide healthcare coverage to all citizens by joining forces."

Pacing event:

- Identify healthcare players.
- Assign "contact" players for next pre-event meeting of all representatives.

CROSS CUTTING ISSUES: The following crosscutting issues were brought to notice by participants.

1. Rodger Wetzel:
 - Healthcare of urban Indian people e.g. Burleigh County
 - Long distance to IHS services
 - Who speaks or advocates for Indian people?
 - Who provides primary care?
2. Karen Tescher:
 - Need to assure health care cost containment in areas of prevention, medications, labs, procedures, etc. while giving high quality care.
 - Be cognizant of actual needs and delivering them in the most efficient manner.
3. Native American population in North Central America.
4. College health (18-24 years or older).
5. How to address the border areas – Fargo/ Moorhead & Wahpeton/ Breckenridge.
6. Military bases, Tricare and Reserve issues.
7. Deployment issues of the temporarily insured – National Guard 3 months prior to deployment and 3 months after.



Please refer to a state map showing approximate areas of coalitions on page 17.

X. State Legislative Panel

Members of the Legislature provided their own leadership comments and offers. Among them, these leaders offered concurrence that access to affordable health care is an important issue for them and the state. Health access is linked to rural issues, such as transportation and out-migration of

rural settings. Members stated that there need to be sound solutions that have appropriate, shared responsibilities across government, individuals, providers and payers, including employers. One key comment emphasized that planning to improve access through a budget-neutral approach, will also make for better plans and rationales for any approach that, in the end, may require additional funding. Finally, the leadership comment was made that “We are all one community in North Dakota.”

Legislative Panel
Senator Dick Dever (R) Bismarck – District 32
Senator Tom Fischer (R) Fargo – District 46
Senator Tim Mathern (D) Fargo – District 11
Representative Jim Kerzman (D) Mott – District 31
Representative Margaret Sitte (R) Bismarck – District 35

XI. Governor John Hoeven

The Governor presented rousing comments reaffirming the great strengths of North Dakota, including and especially as related to health and health care. He referenced the great quality of life indicators for residents of the state. Regarding health care, he acknowledged that North Dakota health care is rated number one in the nation. With regard to insurance, he reminded the participants that the state enjoys one of the very best insurance rates in the nation. He did highlight, however, that the disparities in health and access for the Native American residents of the state were clearly not so favorable and in need for more deliberate attention. The Governor closed his remarks by emphatically declaring that, in fully addressing health and health access issues, state government must work in partnership with communities.

XII. Statewide Support



Eric picked up on the leadership conversation of the morning by asking the participants to recall the framework for successful community coalitions presented by Karen Minyard and to keep in mind the leadership plans they made as regional and statewide groups in pursuit of their own leadership stories. Where those plans represent the community level of the “3-level Chess,” the group focused on those activities at the state level which, if aligned, would further support the community efforts.

With the members of the GHIAC back at the front table, Eric framed with the participants those elements of state activity that will be sought.

First was the role of state “home” (convener) of community coalitions and the statewide and other partners. Dr. Baird offered the establishment of a Community Initiatives subcommittee of the GHIAC to serve as such convener.

Information sharing (statistics, programs and services) was a necessary element described earlier by Karen for which Dr. Baird offered to have the sub-committee serve as broker and clearinghouse. Information would include data on health status, insurance status, programs and resources as well as that relating to models in state and beyond.

Technical assistance was the next factor for which there was commitment by Dr. Baird to work to identify and secure commitments from in-state and other sources of technical assistance and peer community mentoring.

Funding (including community grants) for statewide activities and seed funding for regional coalitions was also addressed. The discussion suggested that the coalitions could look to reallocation of existing government funding for related goals; state, national and local philanthropic funding; in-kind contributions; and corporate giving all as areas for resourcing. Examples: Blue Cross Blue Shield grants, Bremer grant, United Way sponsorships and North Dakota Public Health Funds.

Tribal Indian health would require concerted focus and action. Dr. Baird reaffirmed the role of existing bodies to assure such process.

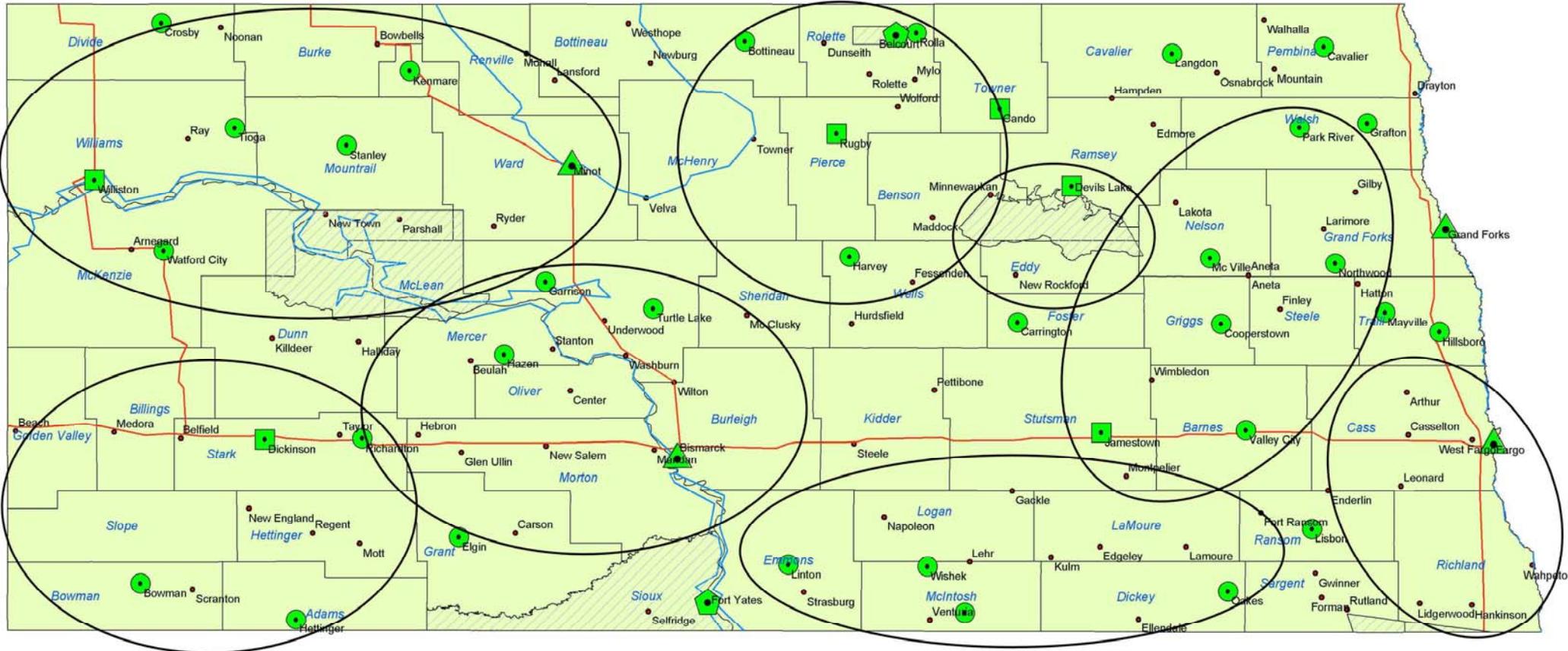
Convening was the other element of Karen’s framework. It was the group’s intent to reconvene in the spring of 2006.

XIII. Wrap-up

Upon conclusion of the state level support of community coalitions and with the portfolio of commitments at the local and state level by participants throughout the Summit, John and Dr. Baird acknowledged the great work of the group, the powerful vision shared by all and the great anticipation of making **the leadership story for North Dakota a reality – the first state in the nation with 100% access to care.**

This report was compiled by Urmila Kamat (Fargo Cass Public Health) with support from Dr. Eric Baumgartner (Louisiana Public Health Institute) and Julie Haugen (Dakota Medical Foundation). We would also like to acknowledge the report editing team: Tim Cox, Lynn Gifford, Muriel Hedrick and Margaret Mowery.

Community Solutions for Healthcare Coverage



- Legend**
- ▬ Indian Health Service Hospital
 - Critical Access Rural Hospital
 - Regional Coalitions
 - ▲ Tertiary Hospital CAH Network
 - Rural Hospital
 - Invited Cities
 - Tribal Reservation Boundaries

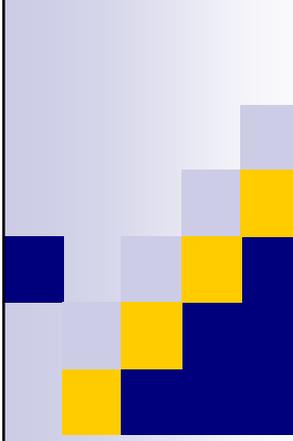


Prepared by: Garth J. Kruger, MA

Appendix

PowerPoint Presentations

“Finishing North Dakota’s Health Care System: The Gaps in Access, Health Status and Quality” – a presentation prepared by Dr. Baird and presented by Alana Knudson, UND Center for Rural Health	1 – 15
“One Community’s Journey Reaching 100% Access in Muskegon County Michigan” – Vondie Woodbury, Project Director of Muskegon Community Health Project, Muskegon, MI	16 – 30
“North Dakota Medicaid” – Maggie Anderson, Medicaid Director, ND Department of Human Services.	31 – 32



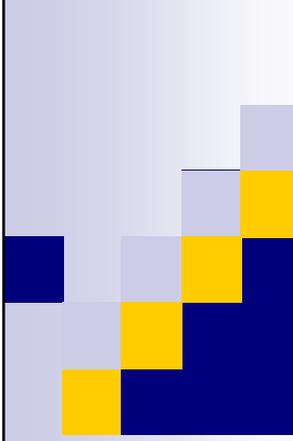
Finishing North Dakota's Health Care System: The Gaps in Access, Health Status & Quality

**John R. Baird, M.D.
State Medical Officer**

October 18, 2005



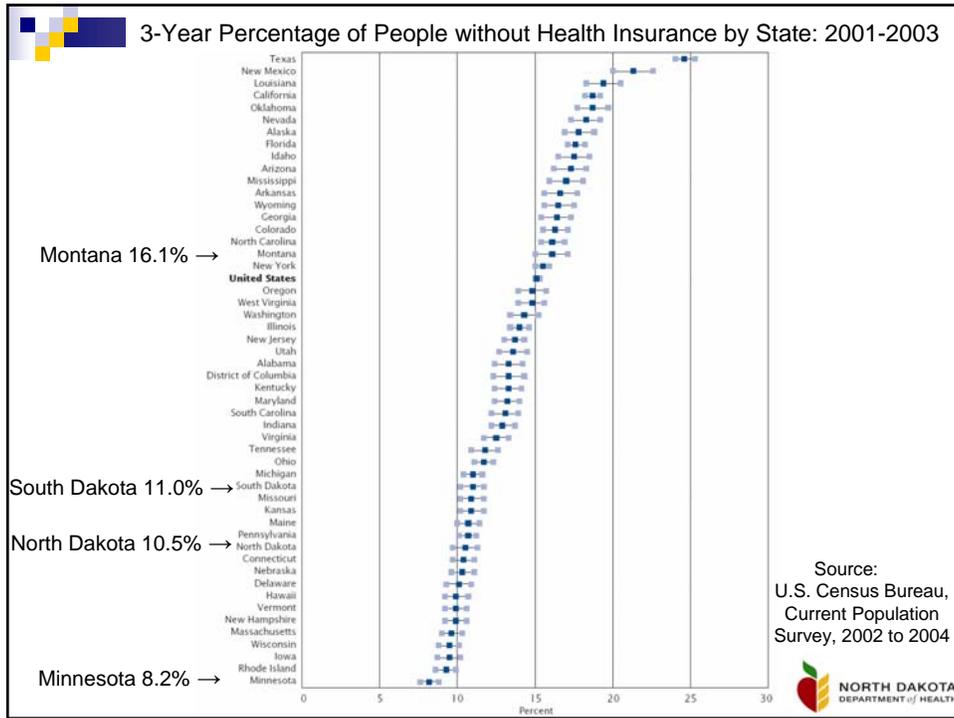
**NORTH DAKOTA
DEPARTMENT of HEALTH**



Access



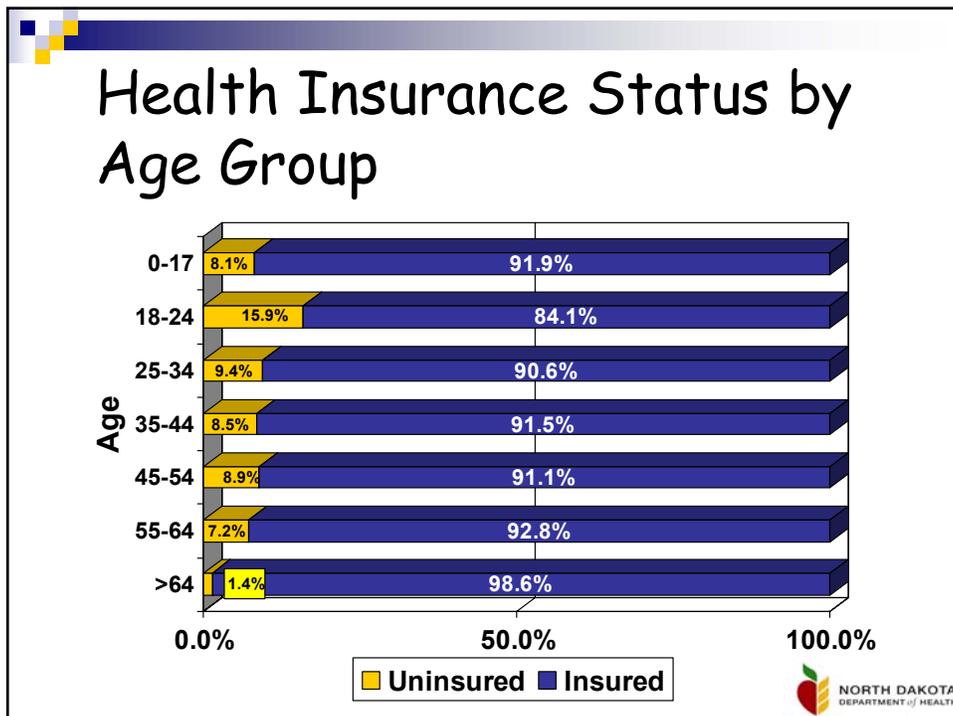
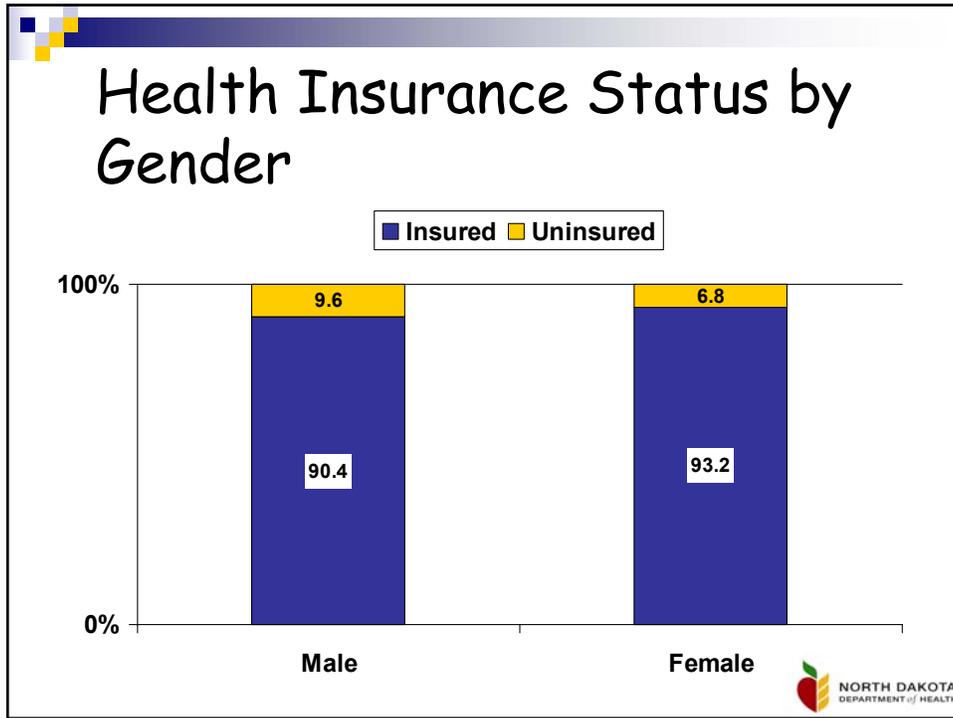
**NORTH DAKOTA
DEPARTMENT of HEALTH**

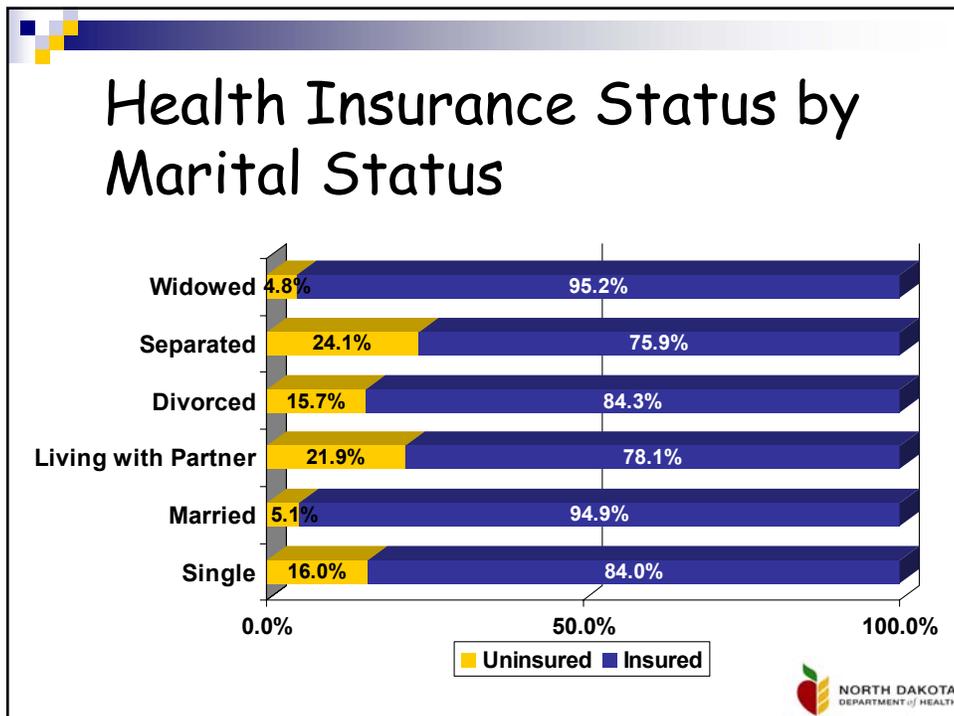
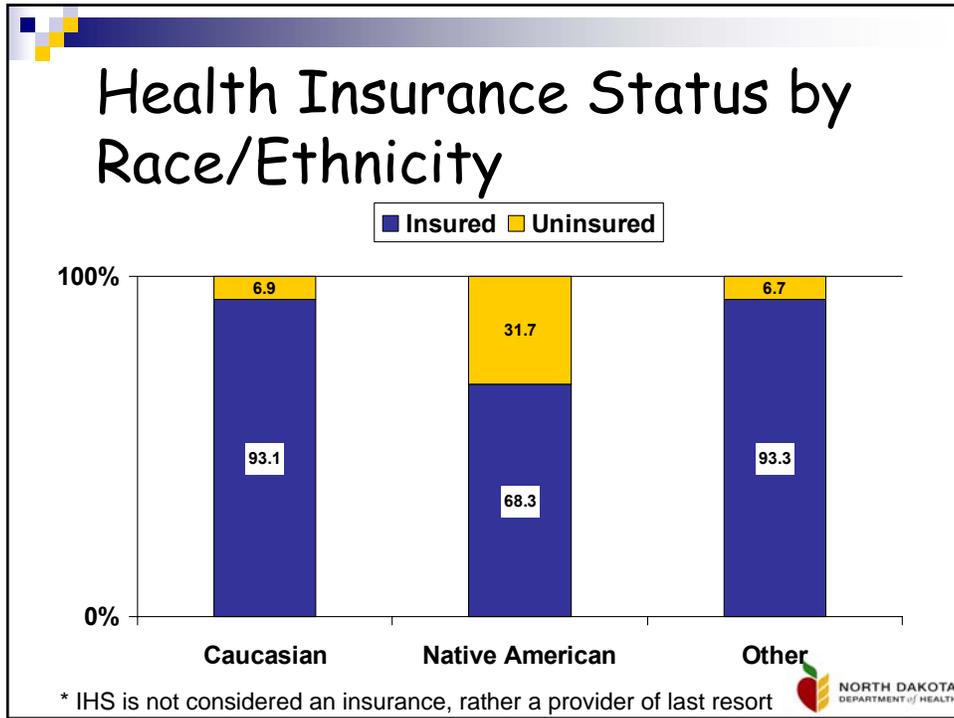


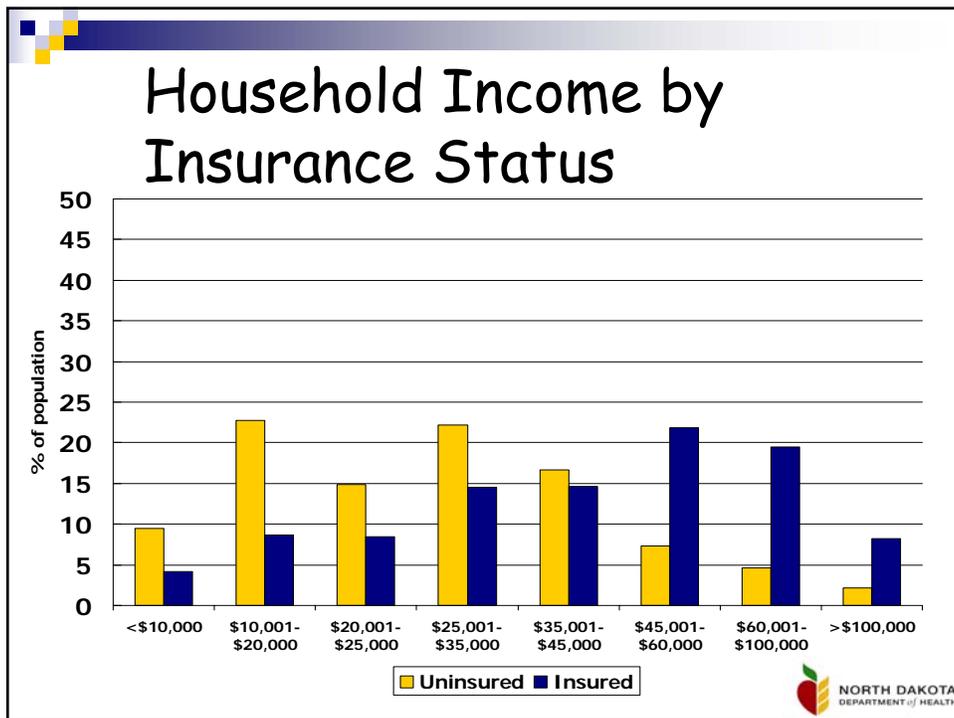
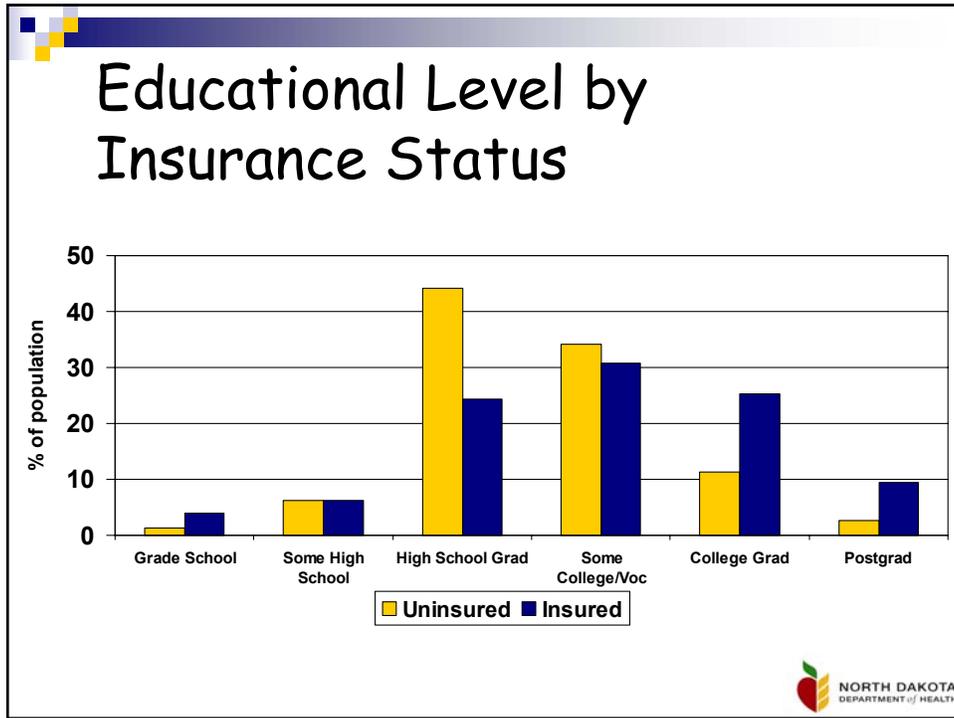
Percentage and number of the uninsured in North Dakota

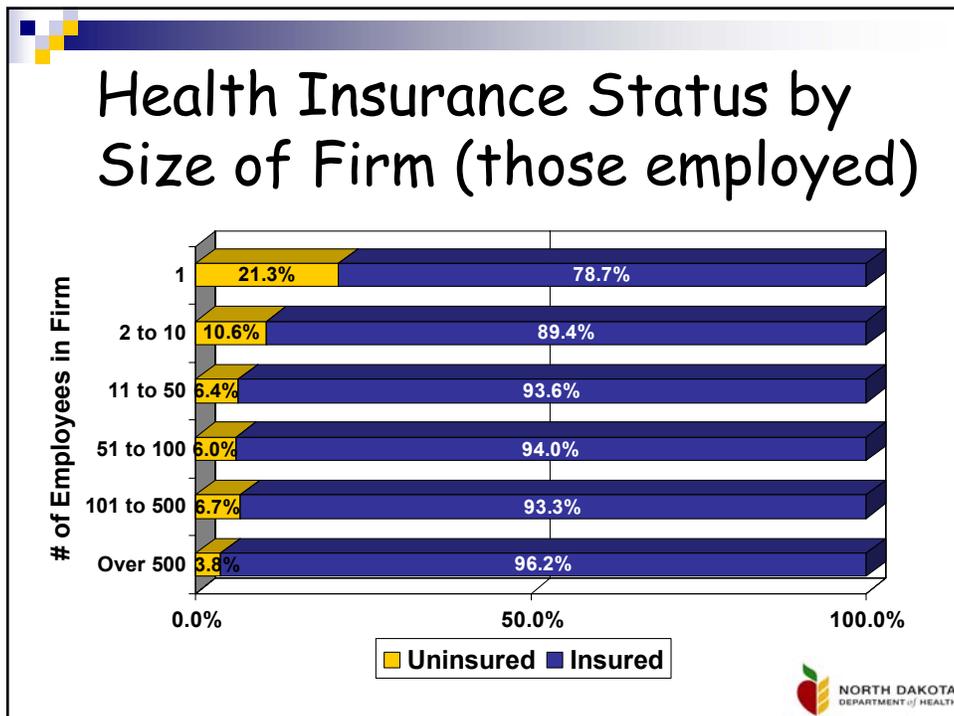
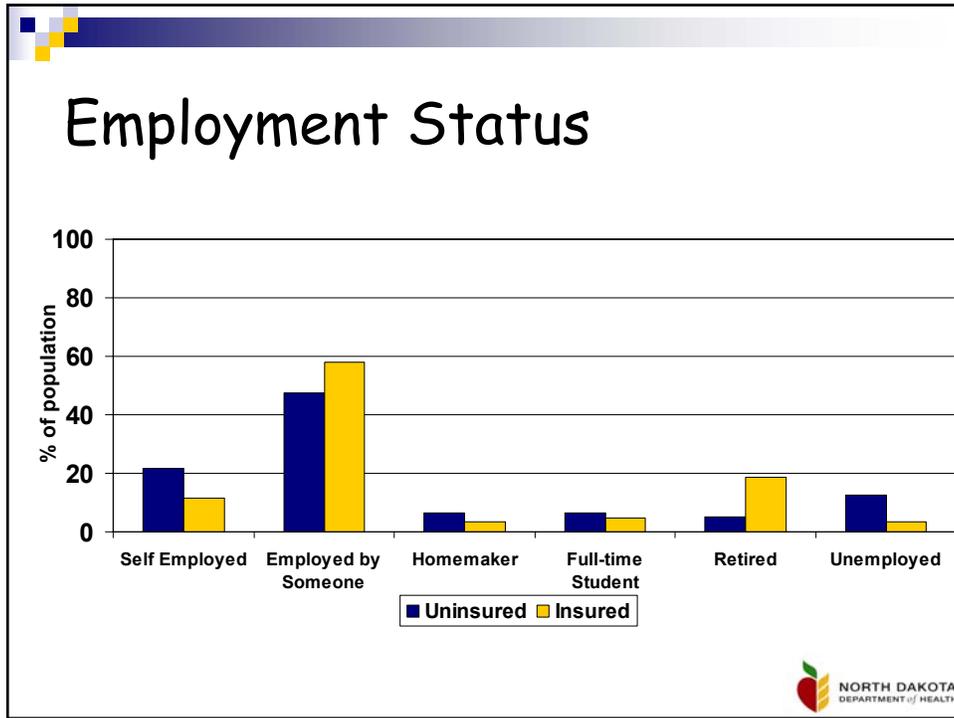
- 8.2% of North Dakotans are uninsured
- 51,920 people
 - Similar to the population of Bismarck

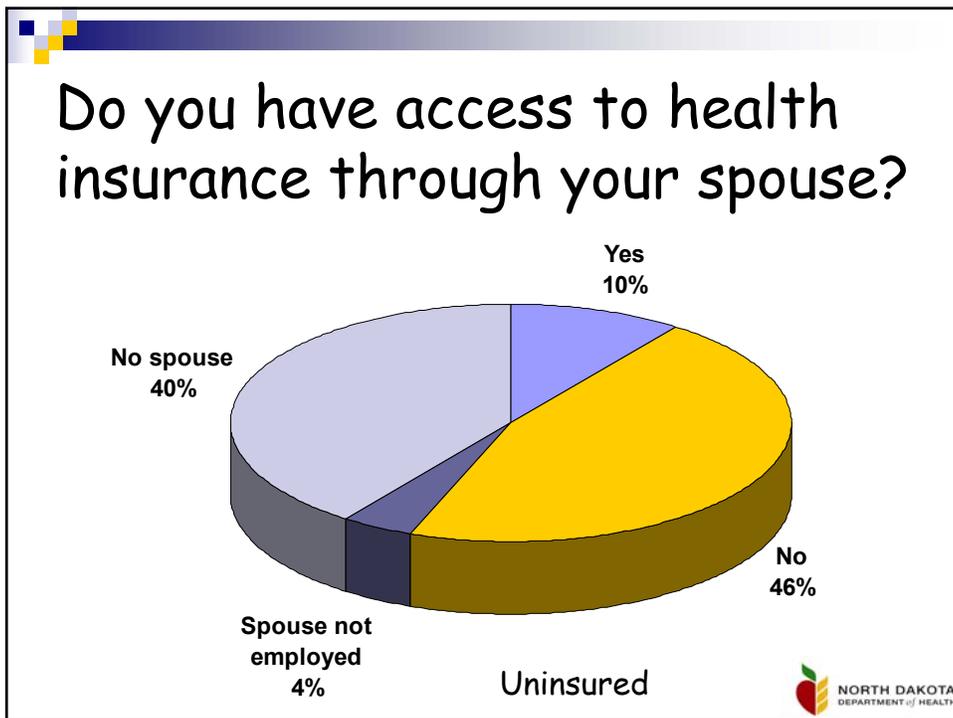
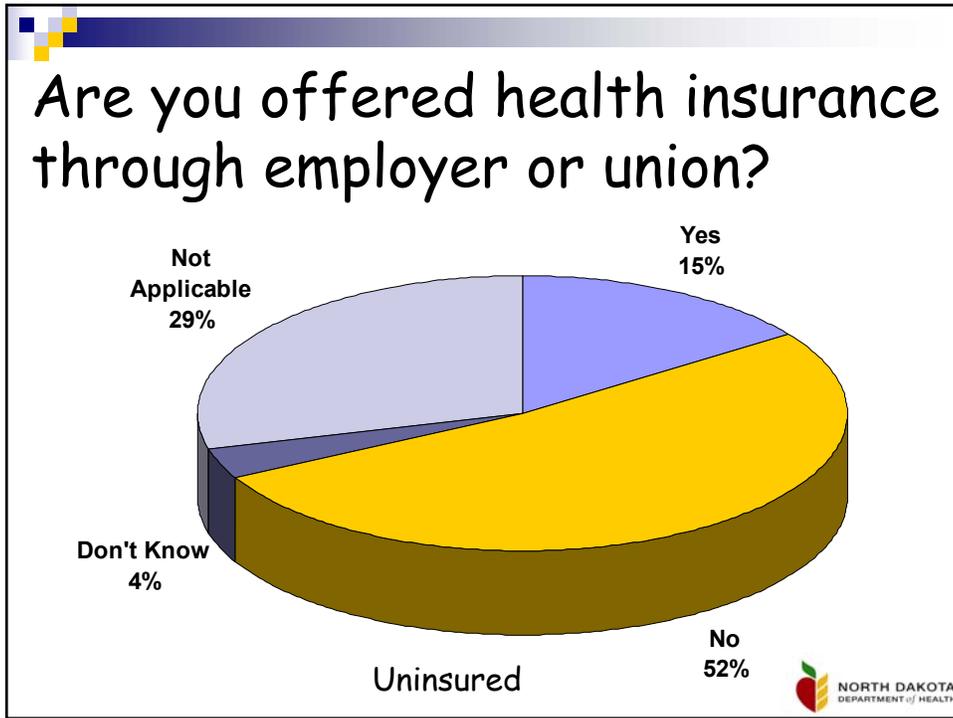
North Dakota Household Survey – Feb-Mar 2004
 By UND Center for Rural Health funded by HRSA State Planning Grant









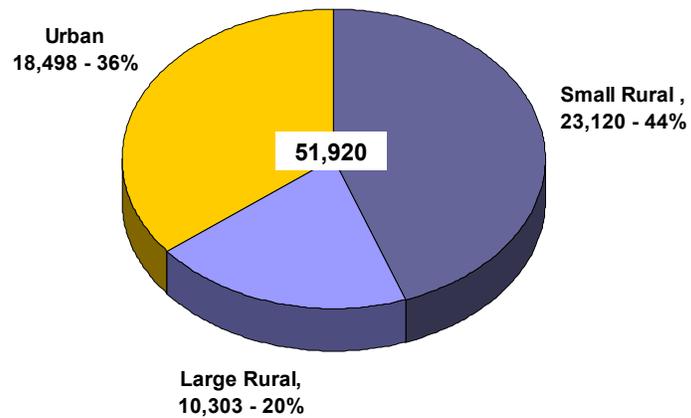


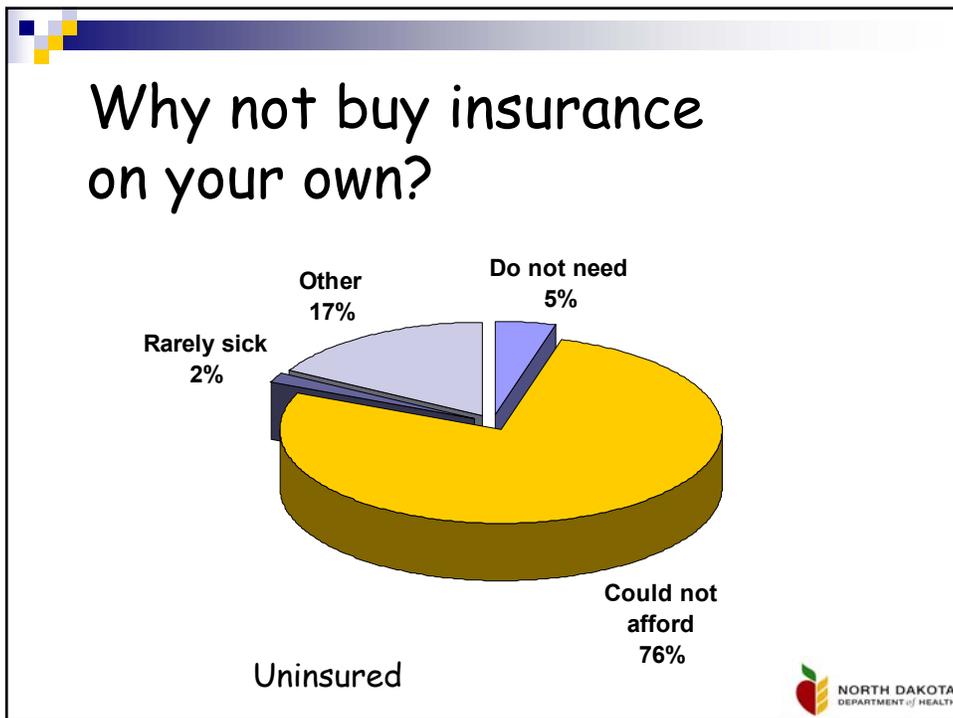
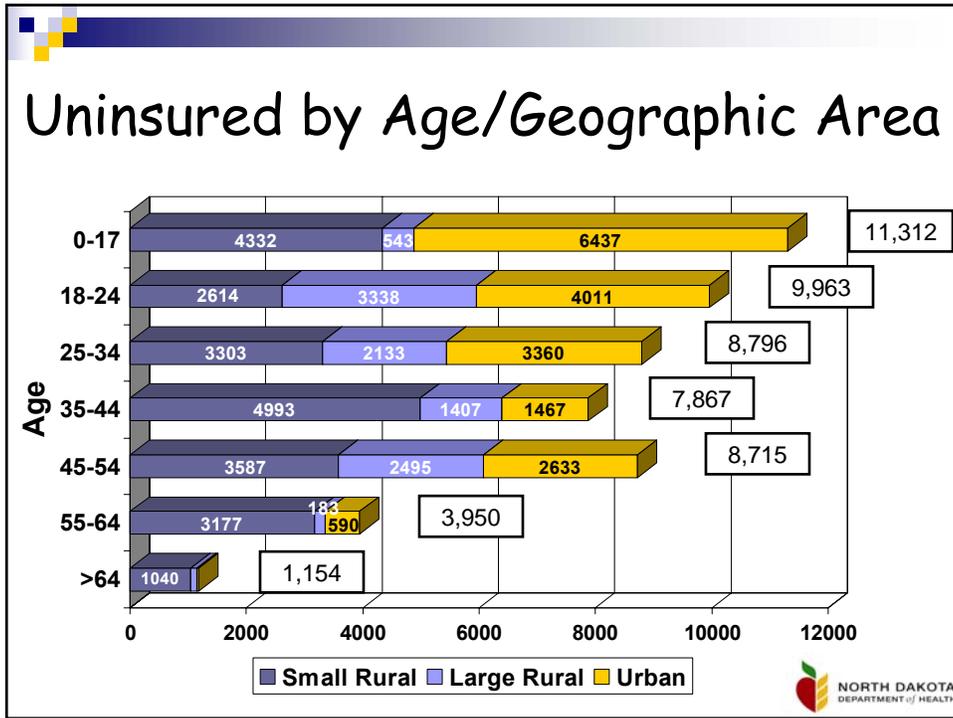
3 Geographic population groups

- Urban (greater than 16,718)
 - Bismarck, Fargo, Grand Forks & Minot
- Large Rural (5,000 to 16,717)
 - Devils Lake, Dickinson, Jamestown, Minot AFB, Valley City, Wahpeton, & Williston
- Small Rural (under 5,000)
 - Remainder of the state

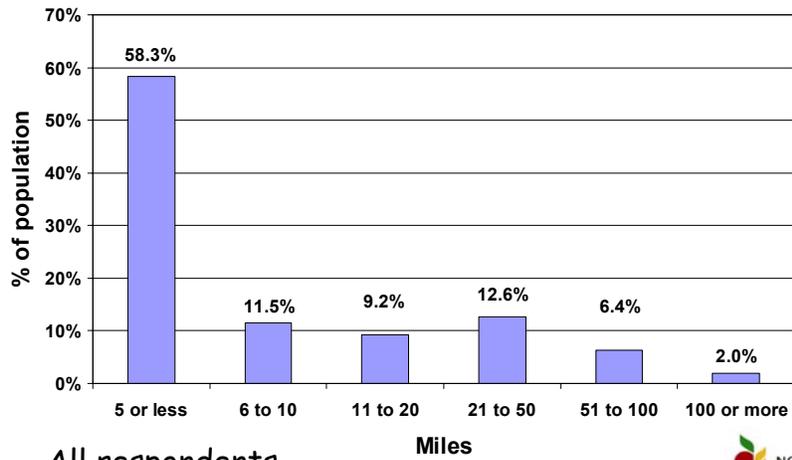


Where do the uninsured reside?





How many miles do you travel to receive health care services?



All respondents



A graphic featuring the text "Health Status" in white on a dark blue background. To the left of the text is a decorative staircase pattern made of yellow and light blue squares. The North Dakota Department of Health logo is in the bottom right corner.

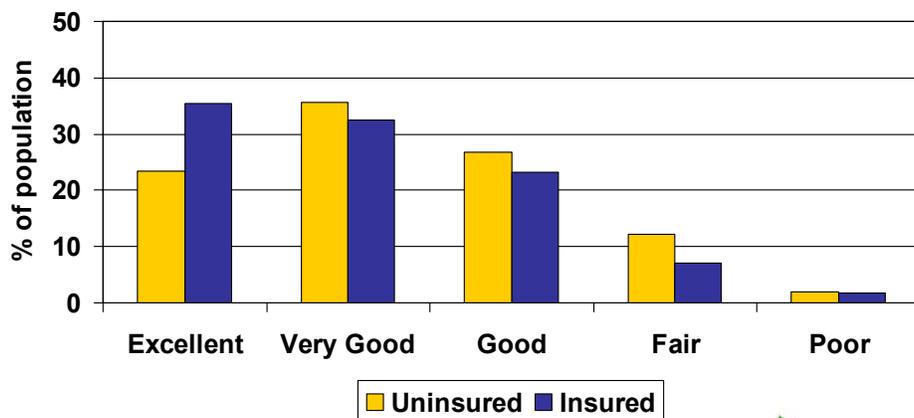
Health Status Consequences - Uninsured

- Worse clinical outcomes for chronic diseases
Diabetes, CV disease, Mental illness
- Decreased life expectancy

Source: *Insuring Americas Health, Principles and Recommendations*, IOM 2004



Perceived Health by Insurance Status





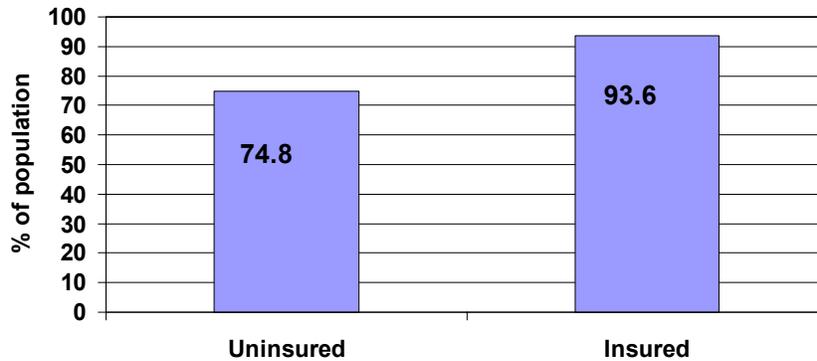
Consequences - Uninsured

- Receive fewer services or no care at all
- Less likely to receive preventive services
- Medical bills - a factor in half of bankruptcies
- Uncompensated care – \$35 billion annually

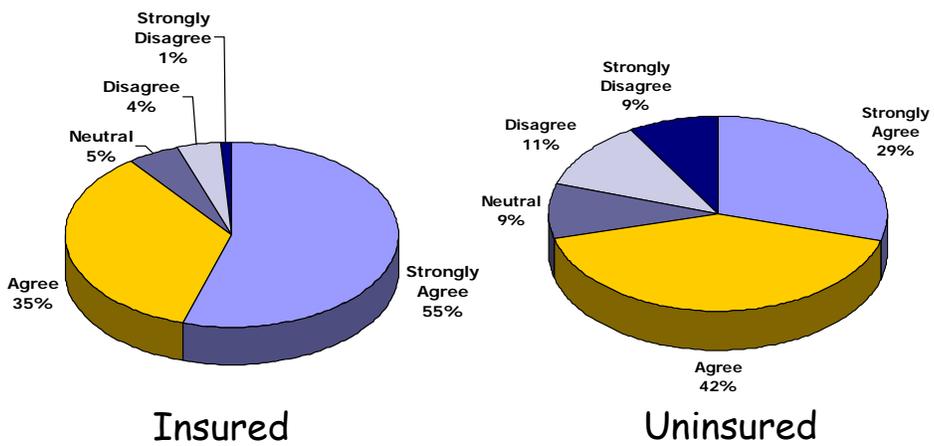
Source: *Insuring Americas Health, Principles and Recommendations*, IOM 2004

NORTH DAKOTA
DEPARTMENT OF HEALTH

North Dakotans Indicating a Regular Place for Health Care



Are you confident that you can get health care when you need it?

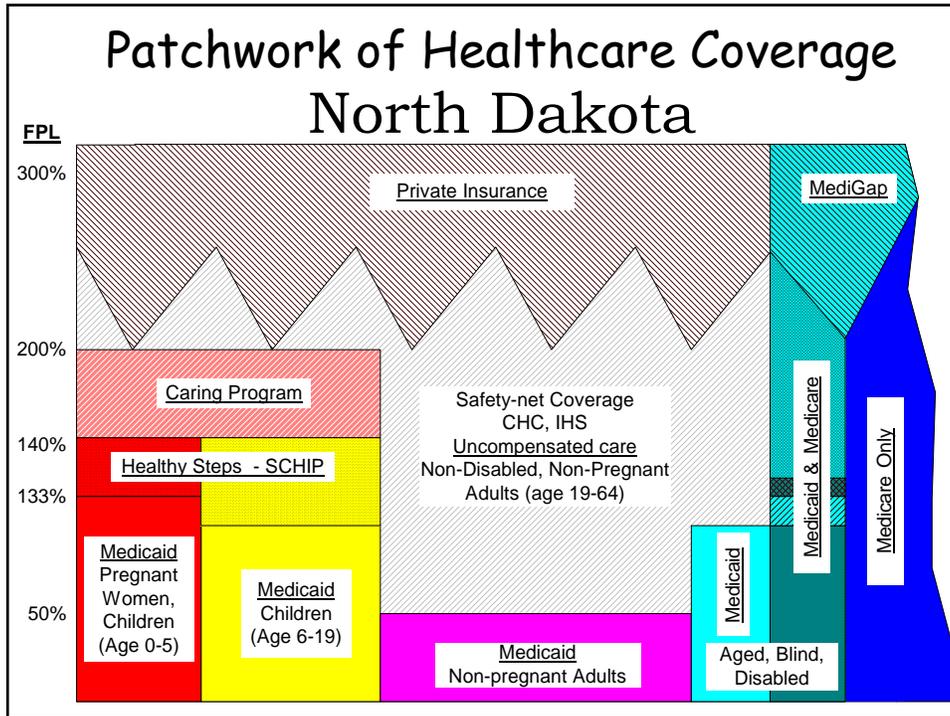




Uninsured

- 8.2% - 51,920
- 31.7% of Native Americans
- Male, not married
- Young adults & children
- Lower income
- Employed (71.7% of uninsured)
 - small firms
- Poorer health status
- Lower quality care

NORTH DAKOTA
DEPARTMENT OF HEALTH



Comments are welcome. Contact:

John R. Baird, M.D.
State Medical Officer
North Dakota Department of Health
Bismarck, ND 58505-0200

701-328-2372

E-mail to State Planning Grant program:
jbaird@state.nd.us

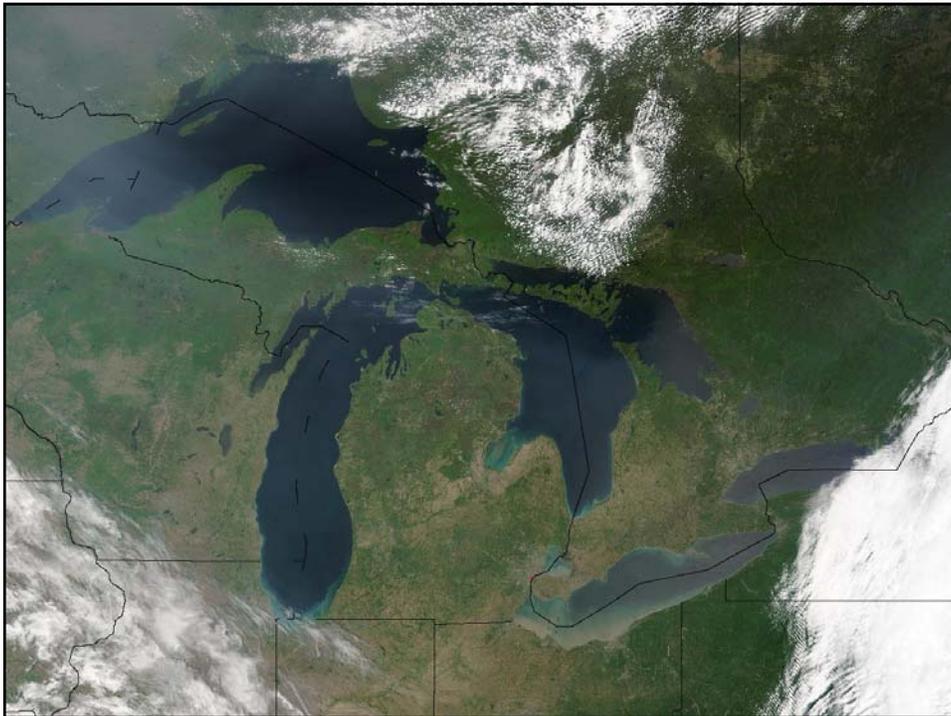


For research information contact:
Center for Rural Health
UND School of Medicine and Health Sciences
Grand Forks, ND 58202-9037
701-777-3848
<http://medicine.nodak.edu/crh>




Muskegon Community
HEALTH PROJECT

**One Community's Journey
Reaching 100% Access
In
Muskegon County, Michigan**



Muskegon Community HEALTH PROJECT

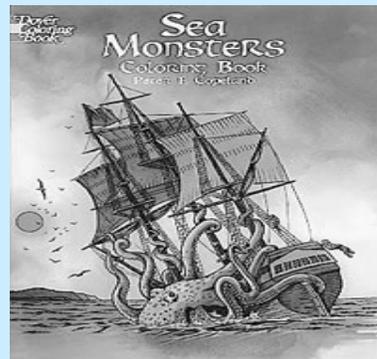
COMPREHENSIVE COMMUNITY HEALTH MODELS OF MICHIGAN - 1993

- Funded by W.K.Kellogg Foundation
- Address access, disparities, technology, coverage
- Seven years of funding @ \$3.6 million

Muskegon Community HEALTH PROJECT

The good news....

***The world is not flat;
There are no sea monsters;
It is still possible.....
to be a pioneer***



Muskegon Community HEALTH PROJECT

COLLABORATIVE DECISION MAKING

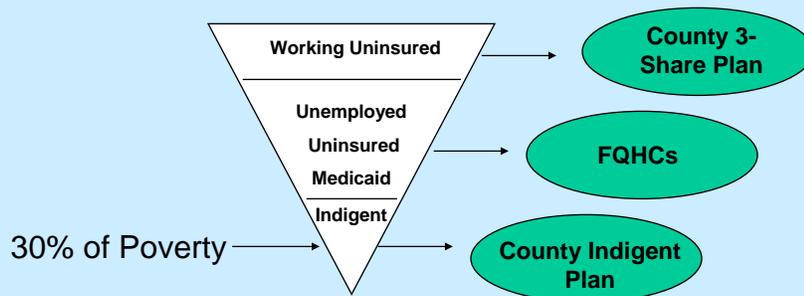


- Over 800 volunteers since inception
- Groups come and go
- Manage up to 14 planning groups in a year
- Community identifies the issue - not top down!
- Board of Directors maintains governance
- Endorsing Organization: 100% Access/0 Disparity

Muskegon Community HEALTH PROJECT

Muskegon's Medical Homes

100% access for low income populations



Muskegon Community HEALTH PROJECT

Discovery 1997:

Health Care as a Problem ranked: 4th
Local Health on Par with Surrounding Counties: 64%

It is difficult, if not impossible to persuade and motivate people to solve a problem if they do not know they are unhealthy or how poorly their health compares to all state residents...EPIC/MRA REPORT '96

Muskegon Community HEALTH PROJECT

THE ENVIRONMENT WE FOUND

- Hospital merger creates two camps of competition
- Weak medical societies
- Two hospital affiliated clinics
- No marketing for decision making
- Opposition from stakeholders



Muskegon Community HEALTH PROJECT

What We Learned in 1997

- Muskegon Values Coverage

Determine strength of political will

97% All children should have access to care

92% All people should have insurance or coverage

81% Any reform effort should include health coverage



Muskegon Community HEALTH PROJECT

Identify Economic Self Interest

76% If affordable health coverage is available, more businesses will locate here.

69% If health care costs too much, businesses won't locate here.

67% Businesses are less likely to come here if we have a higher sickness or disease rate.



Muskegon Community HEALTH PROJECT

Four Strategies for Change

- Enrollment Maximization
- Capacity Expansion
- New Programs
- Health Improvement



Muskegon Community HEALTH PROJECT

Staff and volunteers maintain community visibility through outreach and event participation -

- Healthy People 2010



Muskegon Community HEALTH PROJECT

Enrollment and Access to Care

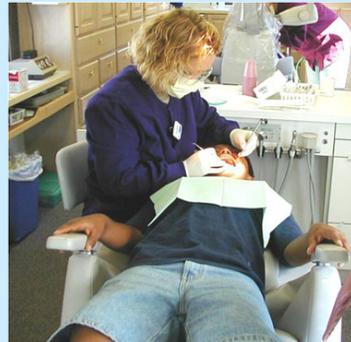
Single Door Enrollment Assistance

- Medicaid enrollment
- MIChild/Healthy Kids - Ranked Fourth
- Maternity Outpatient Medical Services Program
- Food Stamp Assistance Program – 3 counties
- Diabetes Retinopathy Program
- Renew Student Vision Program
- Translation Support

Muskegon Community HEALTH PROJECT

Capacity Expansion

- 2 – FQHC’s – 30,000 visits
 - Primary Care
- Oral Health Clinics –
 - 20 operatories
 - 100 people a day



Muskegon Community HEALTH PROJECT

Dental Coalition outcomes:

- Triple dental capacity
- U-M Partnership
- Head Start compliance
- County Coordinator
- Miles of Smiles
- Regional Expansion
- New focus populations



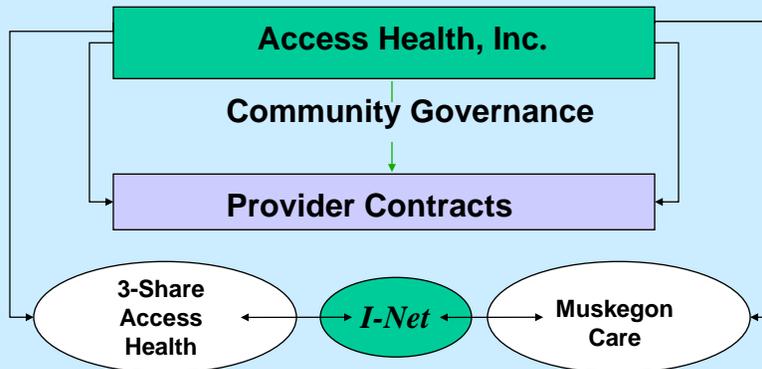
Muskegon Community HEALTH PROJECT

Access Health Business Coverage & Muskegon Care



Muskegon Community HEALTH PROJECT

Muskegon's Community Plans



Muskegon Community HEALTH PROJECT

Access Health Market

- 500 local businesses
 - Full and part-time employees
 - Children ages 19 – 23
 - Identify government coverage
 - Medicaid (Healthy Kids)
 - SCHIP (MIChild)
- 3-5 applications per week*



Muskegon Community HEALTH PROJECT

Eligible Businesses



- Located in Muskegon county
- No health insurance for 12 months
- Median wage of \$11.50 per hour

Muskegon Community HEALTH PROJECT

Access Health Accomplishments

- 1,500 people served in '04 – over 430 businesses
- 97% of all local physicians participate
- 38% of market penetration (eligible businesses)
- \$2.3 million generated annually for health providers
- Hundreds of children identified and enrolled in SCHIP/Medicaid

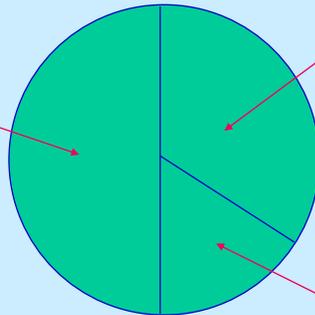


Muskegon Community
HEALTH PROJECT

Muskegon Care

Low Utilization

50% of members are typically short-termed unemployed



Moderate Utilization

30% are generally longer termed unemployed

High Utilization

20% are chronically diseased and unemployable

Muskegon Community
HEALTH PROJECT

Muskegon Care

PLAN DEMOGRAPHICS

- Annual plan enrollment of about 2200
- 20% are chronically ill members
- 50% of costs are for pharmaceuticals
- 10% of patients costs 67% of all drug expenses



Muskegon Community HEALTH PROJECT

Going Beyond the HMO Finance Model

Community Ownership Benefits

Financial Benefits

- Control of eligibility
- Medical utilization control
- Drug utilization control
- Lower-cost community health service partnerships
- Reduced admin cost
- Lower claims payment costs

Health Benefits

- Intensive case management of chronically ill patients
- Identification of disabled for Federal Medicaid enrollment
- Improved diagnostic tools
- Quality of Life monitoring



Muskegon Community HEALTH PROJECT

Muskegon *i-Net* Software



- Internet-based case management
- Local claims payment service
- Community-based treatment
- Tracks utilization and costs
- Health improvement evaluation

Muskegon Community HEALTH PROJECT

Health Improvement – Education and Screening

- Stanford Chronic Disease Self Management Program
- Oral Health Screening
- School and Community Tobacco Health Education
- Pulmonary Screening
- School and Community Asthma Screening
- Diabetes Screening and Supplies
- African American Prostate Screening
- Stay Active Muskegon – pedometer program

Muskegon Community HEALTH PROJECT



Diabetes Network outcomes:

- 12,000 screened in community
- Common protocols developed
- Community education
- African American intervention
- Pharmacy partnership
- Annual Walk for Diabetes
- Annual African American Conference

Muskegon Community HEALTH PROJECT

a lifeline drug...

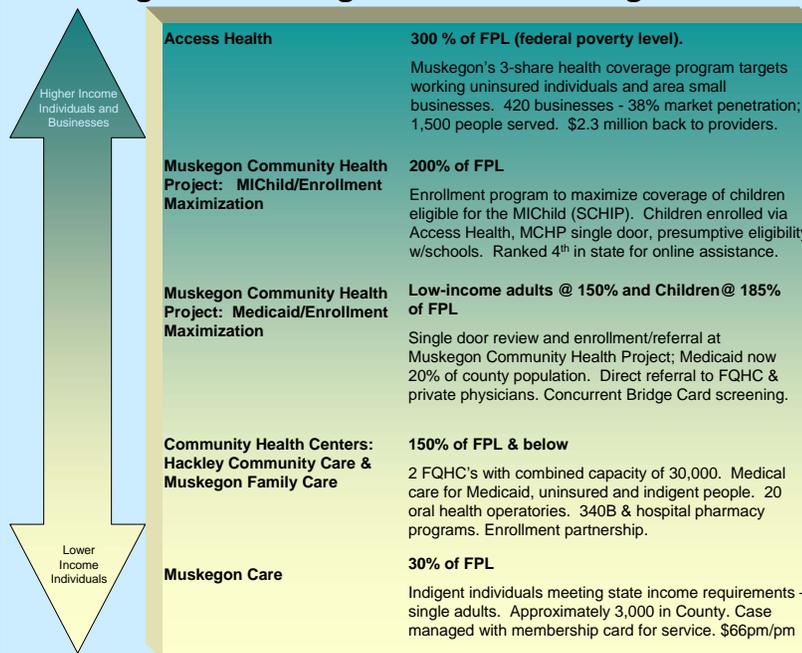
ANTIBIOTICS

Just Bad Medicine For Colds and Flu

Sponsored by




Muskegon's Building Blocks to Coverage



Muskegon Community HEALTH PROJECT

Collaboration – What Worked for Us

- Measure “political will” – qualitative & quantitative
- Understand the importance of an “early win”
- Be willing to allow conflict
- Find ways to expand participation – on/off the table
- Don’t disband the group
- Don’t let money define the debate
- Trust builds commitment
- Good public policy should not be partisan

Muskegon Community HEALTH PROJECT

Vondie Woodbury, Exec. Director



Muskegon Community Health
Project
565 W. Western Avenue
Muskegon, Michigan 49441

Phone: 231 728-3201
Email: vwoodbury@mchp.org

North Dakota Medicaid

Maggie Anderson
Medical Services
Department of
Human Services

Celebrating Medicaid

- 40th Anniversary of Medicaid
- Excellent coverage of optional services
- 53,000 North Dakota recipients
- 2992 children covered through SCHIP
- 1371 children receive services through CSHS

Medical Services – Continuing to Evolve.....

- Medicaid Waiver Applications
- PACE (Program of All Inclusive Care for the Elderly)
- Changes in SCHIP
- Personal Care – now in State Plan
- Attending State Coverage Initiative meeting
- Collaboration within DHS regarding coverage for kids
- Expanding Managed Care
- Partnership Programs for Long Term Care

Areas of Interest and Effort

- Dental Access
- Pharmacy Reimbursement Changes
- Medicare Part D Implementation
- PACE
- Pay for Performance
- 3-share programs