

Health Elevations



A QUARTERLY
JOURNAL ON
HEALTH POLICY
IN COLORADO

SPRING 2014

Impatient: Making Health Make Sense

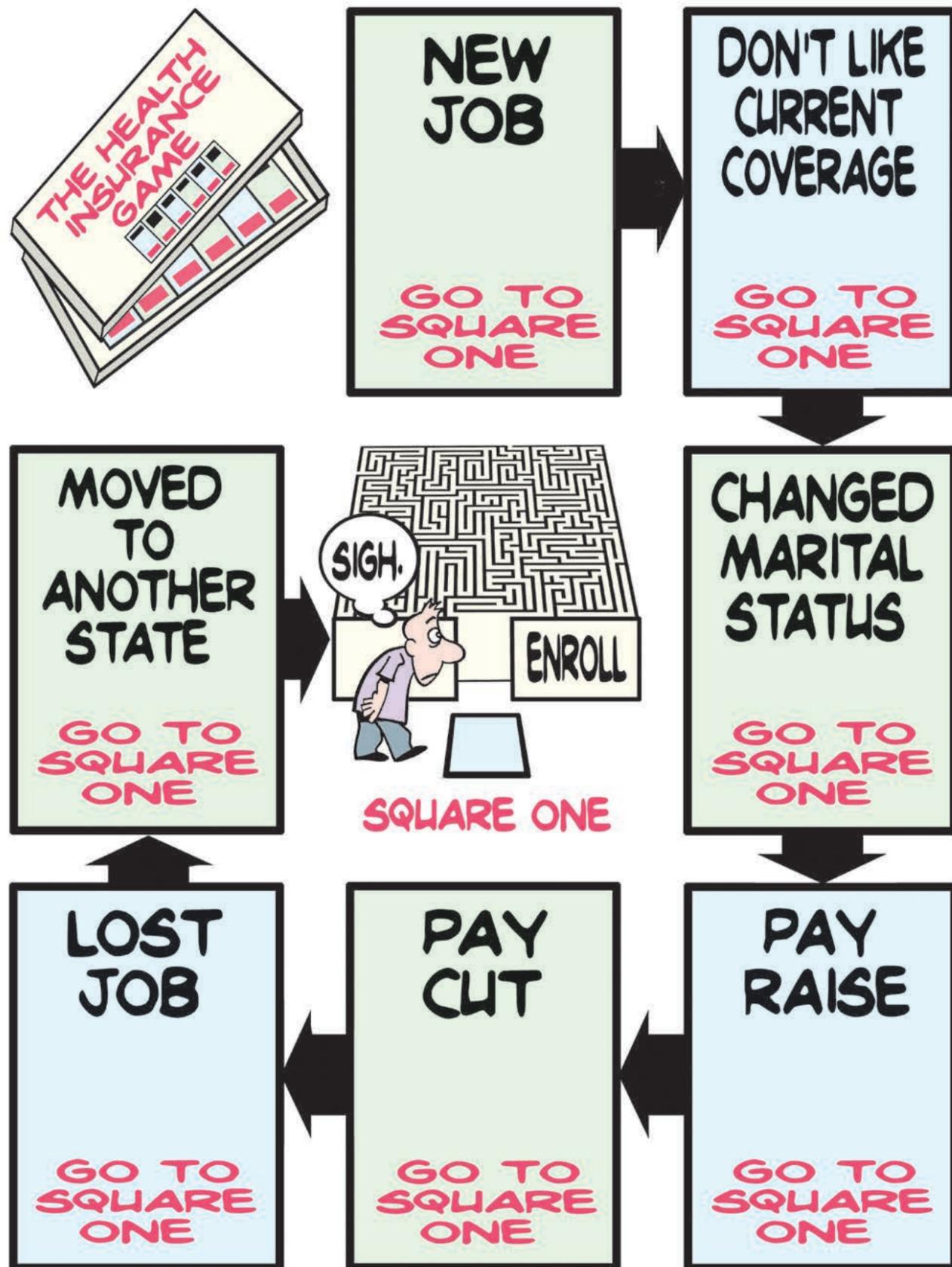
THE QUEST FOR 'CONSUMER FRIENDLY'

THE CHURN THAT BURNS

CALMING THE CONFUSING
INSURANCE WATERS

SYMBOLS OF A SIMPLER SYSTEM

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Health Elevations

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SEN. IRENE AGUILAR, MD, BRINGS PROVOKING HEALTH QUESTIONS TO THE LEGISLATURE.



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EXCLUSIVE ONLINE BONUS CONTENT

VISIT WWW.COLORADOHEALTH.ORG/JOURNAL FOR THESE STORIES:

- A mini-documentary on making health work for Grand County
- Deeper dives into the stories and people from *Health Elevations*
- Animation by Mike Keefe and other extras

For more commentary on improving the consumer experience in health care, we suggest you read Ezekiel Emanuel's "Progress, with Caveats," *The Wall Street Journal*, March 21, 2014; and "Why walk-in health care is a fast-growing profit center for retail center," *The Washington Post*, April 4, 2014.

ABOUT THE COLORADO HEALTH FOUNDATION

HEALTH ELEVATIONS SEEKS to further the goals of the Colorado Health Foundation by highlighting problems that can be solved, illuminating the people who are making progress in solving them and provoking a new way of looking at complex health issues. The journal will report on and synthesize a variety of sources to provide information that can further the work of policymakers, grantees, providers and the engaged public in advancing better health care, health coverage and healthier living. Useful information presented in a memorable way is indispensable to the complex field of health policy.

THE COLORADO HEALTH FOUNDATION works to make Colorado the healthiest state in the nation by ensuring that all Colorado kids are fit and healthy, and that all Coloradans achieve stable, affordable and adequate health coverage to improve their health with support from a network of primary health care and community services. To advance our mission, the Foundation engages the community through grantmaking, public policy, investing in evaluation, private sector initiatives and strategic communications. For more information, please visit www.ColoradoHealth.org.

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Creating a Consumer Health Culture

Most industries in America do everything they can to make the consumer experience better. Adapt or die is a business mantra that has served so much of consumer culture very well: Cell phones. Personal computers. Buying just about anything, anywhere, at any time.

And yet tell your employees they have to switch health insurance companies and a collective gasp of dread rises in the auditorium. Try to explain to ailing patients the difference between a copay, coinsurance and out-of-pocket maximum, and their stare turns from anxious to desperate. Offer someone good Medicaid coverage, but with no doctor who will accept the payment, and you are merely spinning society's wheels of change.



This issue of *Health Elevations* takes on the consumer experience of finding health insurance, and then finding health care – and asks what we can do better. Those of us who deal with it every day grow numb to the obvious: Health insurance and health care are hard to get and hard to use. What would Steve Jobs have done? What would Target do? How can government, policymakers and nonprofits do more to bring consumer health care into the 21st century of better service?

It's a culture change. Cities have launched 311 numbers and pothole lines because they have decided to operate with a principle that values the taxpayer. What's the equivalent in health care? It's government and policymakers saying there's value in the consumer experience, and whatever we do has to account for that. And it's also saying that we don't want to move backwards. If health reforms like the insurance exchange or Medicaid expansion don't work perfectly yet, let's fix them and move forward.

Consumers must play a role in this change, too. We have more tools than ever to take control: cost calculators, convenient nursing lines, office subsidies for exercise and fitness. We need to learn what's available to us to help make ourselves healthier. That will also help save resources for other people who need care even more. And we need to take the responsibility to say what's working and what's not working for us, and be outraged at what's not working.

Anne Warhover
ANNE WARHOVER, PRESIDENT AND CEO
THE COLORADO HEALTH FOUNDATION



Summer Preview: The Colorado Health Foundation's annual Symposium will dig deeper into questions of engaging the health insurance customer and health care patient. The annual conference, from July 23-25 this year, will bring together national experts on patient engagement and friendly system reforms. If you can't attend the Symposium, you can still participate by streaming the website and following us on Twitter, @COHealthFDN. Visit www.ColoradoHealth.org/healthsymposium for more information.

The Summer issue of *Health Elevations*, meanwhile, will take on the burgeoning "built environment" movement, sketching successes and diagramming the places where healthy living clashes with questions of "social engineering."

Health Care is Just Too Hard to Use

AND IT'S NOT YOUR FAULT.

BY MICHAEL BOOTH, HEALTH ELEVATIONS MANAGING EDITOR

PHOTOGRAPHY BY JAMES CHANCE

Walter Mossberg shook up the technology world by originating that phrasing in 1991. The computers he was talking about have gotten better – you could now run NASA from an iPhone – but health care has not.

Patients with little more than a sore throat or a panic attack show up at full-trauma emergency rooms because that's what “health care” has always meant to them. Or because their doctor's office was closed, and the nurse “help” line was a phone-tree thicket.

The young and the restless might rather pay a fine for bucking the new health insurance mandate because they have no time or patience for Byzantine insurance applications.

Hospital bills are often incomprehensible and a disillusionment to patients even if they're not paying the bottom line.

Mental health care is now theoretically equal under the law to physical care, but patients struggle to connect with a provider.

And will the first person with a short, coherent explanation of “deductible-copay-coinsurance-out-of-pocket-maximum” please stand up?

The storm of criticism that descends on any major health system overhaul can be daunting and can discourage the best-intentioned from bold, public-oriented change. But the Colorado Health Foundation is encouraging health reformers – many mentioned in this issue – to step back and look at the system we are creating through clear eyes. Are we showing Colorado residents the simplest tools to guide their own health and wellness? If we agree on the goal of useful health insurance and accessible health care, have we made it clear how to find those? And are we offering Colorado the right care in the right places at the right time, so that good health is attainable and affordable to everyone?

What happens when Colorado consumers don't know how to acquire health insurance or how to use the health care system

once they've got it? Billions of dollars are wasted, and worse, Coloradans miss the chance to be as healthy as they could be.

The growing complexity of health coverage and health care – not yet solved by an Affordable Care Act that is itself multi-layered – is not by “grand design,” as Northwestern University's Kellogg School of Management professor Joel Shalowitz, MD, puts it. “It's by incremental stupidity.”

The private sector, nongovernmental organizations and government agencies work furiously to untangle the mess for consumers. “Right care, right place, right time” is one mantra at Colorado's Centura Health system, the largest hospital network in the region. “We spend a lot of money with people going to the wrong place for care,” said Pam Nicholson, senior vice president of strategic integration at Centura.

“THE HEALTH CARE ‘SYSTEM’ IS NOT A SYSTEM. IT'S A HODGEPODGE OF RANDOMLY OCCURRING ENTITIES.”

ELBERT HUANG, MD
CENTER FOR ADVANCED MEDICINE
UNIVERSITY OF CHICAGO

Yet hospital groups and other health institutions remain at the forefront of many complaints, from their billing practices to a recent “arms race” to build high-revenue emergency department space.

“The health care ‘system’ is not a system,” said Elbert Huang, MD, of the University of Chicago's Center for Advanced Medicine. “It's a hodgepodge of randomly occurring entities.” Huang likens the Affordable Care Act's extension of insurance to most Americans to handing a person the keys to a car stocked with outdated road maps.



This year's debate over the race to build emergency treatment space up and down the Front Range – a contest joined by nonprofits and for-profits alike – is a telling example of wider confusion over how to best use health insurance and health care.

The ER is the place that, when you have nowhere else to go, they have to take you in.

“People find emergency departments not only to be the safety net, but it's preferred because it's patient-centered,” said University of Colorado Hospital's vice chair of emergency medicine Jennifer Wiler, MD. Patients walk in at any time, get diagnosed relatively quickly, and leave with the answers and medicine they need. “Patients like it,” Wiler said.

A recent flurry of studies nudged researchers toward learning why emergency space is a first resort, rather than a last, for many consumers, and what the rest of the health care system could learn from the results.

A Colorado Health Institute exam of ER use in 2012 found a majority of ER patients could not get an appointment at a primary care site or could not use the regular doctor or clinic hours.

Both newly insured and newly uninsured consumers use emergency departments at much higher rates than those who have been stably insured or uninsured for a long time, according to a study by Wiler and others published in the Archives of Internal Medicine.

Patients visit emergency departments because of “lack of timely options elsewhere,” according to a recent RAND Corp. study. That review also found the entire health system relying more on ER doctors as triage for inpatient admissions and other options.

What new ideas will help consumers, their insurers and their providers answer the call to simplify, simplify?

Denver Health, swelling with both paying, exchange-driven members of its managed insurance plan and expanded Medicaid patients, “has a SWAT team on this trying to figure it out,” said LeAnn Donovan, CEO of the Denver Health Medical Plan.

“I would venture it's as high as 20 percent of people in the medical plan who go to the emergency department shouldn't be there, given what they've got,” Donovan said. The most common misdirected complaints include low-acuity situations like coughs and colds, the flu, pink eye, earaches and urinary tract infections.

“PEOPLE FIND EMERGENCY DEPARTMENTS NOT ONLY TO BE THE SAFETY NET, BUT IT'S PREFERRED BECAUSE IT'S PATIENT-CENTERED. PATIENTS LIKE IT.”

JENNIFER WILER, MD
VICE CHAIR OF EMERGENCY MEDICINE
UNIVERSITY OF COLORADO HOSPITAL

Many could be “caught” and helped by the existing nursing phone line, which translated nearly 200 different languages last year. But oddities arise that cry out for addressing: 60 percent of Denver Health's Medicaid population is Hispanic, yet they make up only 6 percent of the nursing calls.

Nurses can diagnose a urinary tract infection by common symptoms right over the phone, Donovan noted, and send a prescription to the consumer's nearest pharmacy. A taxi voucher is available to get those without cars to a pharmacy or clinic.

Another Denver Health goal is to establish more urgent care clinics within the year, by plotting ER usage from the consumer's home ZIP code. The city-based health network also contracted recently with Walgreens retail clinics, authorizing payment for convenient consumer care at the widespread drugstore locations.

Centura is also deepening its relationship with Walgreens, locations that have proven popular for everything from high school sports physicals to strep tests.

The parent of St. Anthony, Penrose-St. Francis and other hospitals tries to use visits at affiliated Walgreens clinics to make “warm transfers” of patients who don't yet have a primary care home. In a warm transfer, the Walgreens Take Care nurse practitioner puts the patient on the phone live with a virtual resource center run by Centura, as opposed to the “cold transfer” of just handing over a phone number and hoping the patient uses it later.

Patients who came through one of the Connect for Health Colorado exchange insurance plans using Centura as the exclusive medical provider are offered a free primary care visit, lab workup and risk assessment. They also get a loaded gift card to spend on future health care.

Centura signed an agreement with Walgreens to study the work flow between the retail clinic nurse practitioners and physician assistants, and the local primary care doctors. Even chronic-disease patients could use the convenient retail locations to manage their care. “An NP or a PA working to the full level of their license can do a lot,” Centura's Nicholson said.

Meanwhile, the primary physician practices Centura has absorbed or affiliated with will be required to extend after-hours access, with office hours and doctor-staffed call centers, within two years, officials said.

“Getting a doctor” after signing up for insurance is, among some Colorado groups, a cultural assumption that not everyone follows.

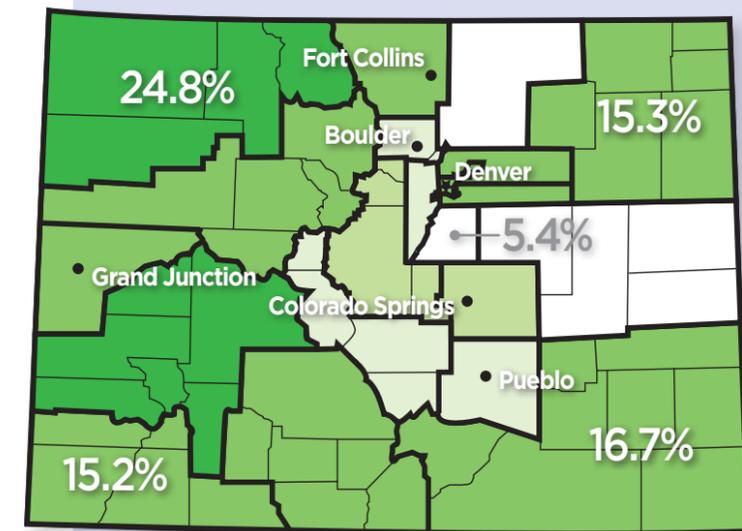
Servicios de La Raza in Denver has seen a heavy caseload of consumers who have heard about the Affordable Care Act and want to take the next step. Some see a Medicaid health coverage guide, others see a guide tapped into Connect for Health's private insurance offerings, as part of the “no wrong door” concept of health access. Often in the Latino community, the first step is integrating the very concept of health care for a family where “Mom was going to urgent care, Dad was going to Campesina clinics, and kids had access to Medicaid,” said Mirna Castro, CCARES program manager for Servicios.

Some learned they had access to private insurance through their employer, “and we'll say, ‘You need to go to your HR department,’” Castro said. “And they'll say, ‘No one speaks Spanish at my HR!’”

While focusing during the winter and spring on signing people in a health insurance plan of any kind, Servicios will be among the agencies changing focus over the summer to the “get a doctor” step. “We need to start talking about where is the right place to go for care,” Castro said.

Reaching Colorado's Uninsured

Picturing where Colorado has the highest concentration of uninsured residents can help health leaders concentrate their resources in the areas they can be most effective. Douglas County, south of metro Denver, has one of the lowest percentages of uninsured and the highest percentage of residents covered by private employers' insurance. Northwest and southwest Colorado may need concentrated surges of open enrollment publicity and Medicaid outreach to take a bigger bite out of their uninsured. A detailed map and more graphics visualizing the state's needs are at www.coloradohealthinstitute.org.



Source: Colorado Health Institute, 2013 Colorado Health Access Survey

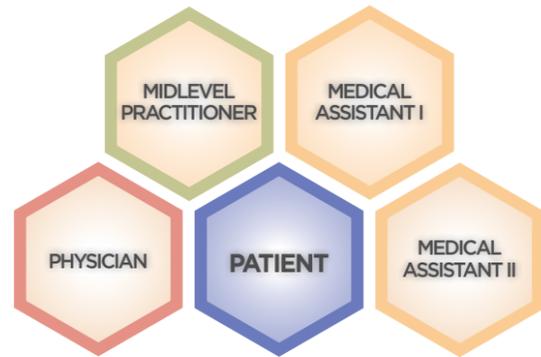


The sprawling New West Physicians group, based in Golden, is redoubling efforts to get its patients out of the ER and to better, more responsible care.

New West, with 80 providers, 16 locations and 160,000 patients, launched its own urgent care office with extended hours two years ago. It is watching demand carefully, and plans another urgent care location.

A nurse practitioner reviews a daily report on all New West patients who went to an ER the day before, then follows up on their symptoms. If they went in for a migraine, for example, then an office visit and better medication could prevent the next “frequent flier” ER trip.

The practice is also redesigning itself around a “hive” model of primary care, matching patients to a team including a physician, a midlevel practitioner and two medical assistants. The doctors concentrate on the complex cases, while other team members treat lesser complaints. “We’re hopeful that will improve waiting times and other frustrating aspects,” said Ken Cohen, MD, chief medical officer of New West.



PRIMARY CARE “HIVE” MODEL MATCHES PATIENTS TO A TEAM INCLUDING A PHYSICIAN, A MIDLEVEL PRACTITIONER AND TWO MEDICAL ASSISTANTS.

Cohen is among those making the argument that government systems could influence ER use by charging copays for Medicaid users, or creating other incentives or small penalties. “A \$10 copay makes big changes,” he said. “I firmly believe some financial responsibility results in a huge behavior shift.”

Physician and state Sen. Irene Aguilar, a Denver Democrat, agrees insurers and government planners might need to consider more sticks as well as carrots. The first proposals will be attacked, but inappropriate use costs the whole system, Aguilar said. A combination of patient education and firm redirection to different care could make such changes “socially acceptable,” she said.

“A \$10 COPAY MAKES BIG CHANGES. I FIRMLY BELIEVE SOME FINANCIAL RESPONSIBILITY RESULTS IN A HUGE BEHAVIOR SHIFT.”

KEN COHEN, MD
CHIEF MEDICAL OFFICER
NEW WEST PHYSICIANS

Salud Family Health Centers, with nine clinics stretching from the northeast Denver suburbs toward the Nebraska border, is using a “patient portal project” with state Medicaid to give worried patients more options.

Salud is working to link every patient with an online sign-in, providing direct emailing to doctors and nurses, and access to labs and medical records, appointment calendars and prescription refill requests. If an online depression-screening questionnaire adds up to a cry for help, a mental health provider reaches out to the patient.

A patient with an earache recently used the portal to explain symptoms to her doctor. The provider advised to keep using an antibiotic for 24 hours before going to the ER, and the symptoms resolved.

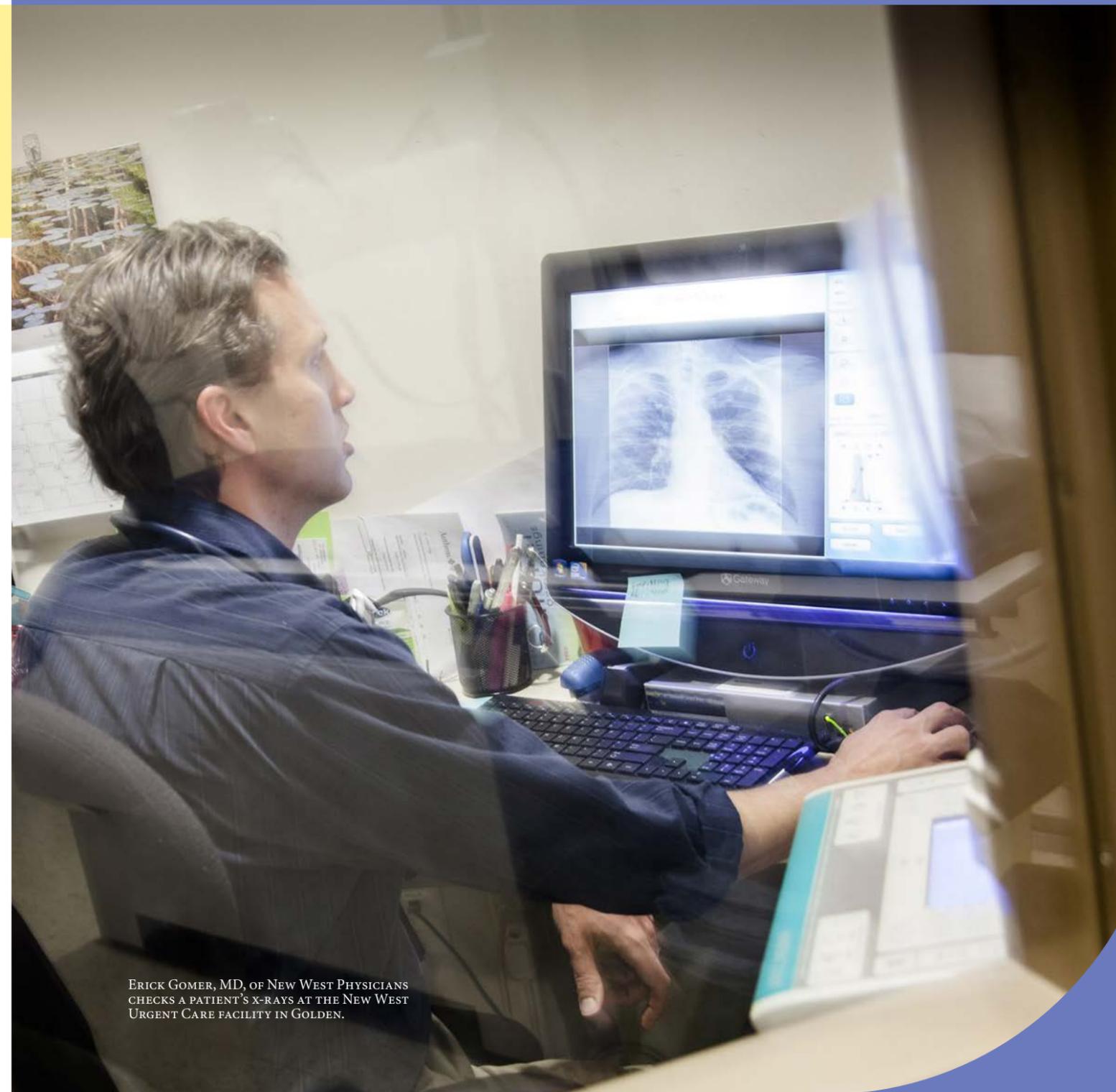
Salud has about 13,000 of its 73,000 patients connected to the portal and plans to reach half in 2014, officials said.

University’s Wiler has worked with the Aurora-based hotspotting program, Bridges to Care, on a set of frequent ER patients separate from those discovered by the Triage program. Patients with four or more ER visits in six months can get a mental health consult and home visits from a nurse practitioner to sort out underlying problems.

The coordinated care has cut emergency use by 50 percent in the group, successful enough that Wiler would like to see the threshold reduced to three ER visits in six months. “Our early results are very promising,” she said.

But a key attitude, she added, is to not just look around a busy ER and sound like a scold.

“It’s unfair to blame patients for their choice of site of service,” Wiler said. “It’s the responsibility of the health community to educate people and cross that disconnect, to remove the barriers so patients want to go where it’s best for them.”



ERICK GOMER, MD, OF NEW WEST PHYSICIANS CHECKS A PATIENT’S X-RAYS AT THE NEW WEST URGENT CARE FACILITY IN GOLDEN.

Medicaid

THE CHURN THAT BURNS

BY MICHAEL BOOTH

If you thought a dozen-plus pages of Medicaid applications were mind-numbing, try going through the tortuous public health insurance process three times in a year.

“Churning” on and off various forms of insurance, some subsidized, some not – and occasionally churning to no insurance at all – will be a bewildering fact of life for tens of thousands of Colorado health consumers in 2014.

Too abstract to ponder?

Let’s say a grocery stocker earning income for a family of three earns at the rate of \$23,000 a year in January, qualifying the family for expanded Medicaid at about 120 percent of the federal poverty level. And let’s say the ambitious stocker moves up to the higher-paying role of cashier – might be less than a \$2 an hour bump, but it would put the family over the income level qualifying for Medicaid. The family might seek subsidized private insurance on Connect for Health Colorado (first having to prove all family members have now been denied Medicaid, of course). But the young daughter might still qualify for Child Health Plan Plus. And if the grocery business slows by November, and the cashier goes back to stocking inventory, the family might be right back at its local Medicaid office, seeking records and clear answers.

“We anticipate a lot of stress as people enter new insurance plans,” said Ken Cohen, MD, chief medical officer of the large New West Physicians group based in Golden.

The more specialized the population, the greater challenge facing anybody trying to help sort the confusion for consumers in coming months. Servicios de La Raza works to navigate people through either Medicaid or the private insurance exchange, but there’s always that daunting first step of the “Medicaid denial,” said CCARES program manager Mirna Castro. While the application has been whittled somewhat from the 21-page mess of last fall, it’s still overwhelming to many would-be consumers. And many of Servicios’ clients have been on some form of assistance in the past, including food stamps – meaning some of their information already exists in the notorious Colorado Benefits Management System tangle. That means Servicios aides can’t use the simpler PEAK sign-up system to get them the Medicaid step.

As for Servicios clients who are “other than legal” residents, more layers: They can’t qualify for Medicaid, meaning they don’t get the formal Medicaid denial needed to shop for private insurance and subsidies on the exchange, forcing Servicios into a longer process for matching clients with affordable coverage. “These workarounds can take a month,” Castro said.

A national study by the Medicaid and CHP Payment and Access Commission (MACPAC) estimated as many as 35 percent of childless adults will “churn” above the Medicaid-qualifying poverty level over a 12-month period.

Colorado consumers were “churning” long before Medicaid expanded with the Affordable Care Act, said Antoinette Taranto, director of client services, eligibility and enrollment divisions for Colorado’s Medicaid program. It’s just that the raw numbers affected get bigger and bigger as the state Medicaid population expands past 800,000 residents. At past rates, Colorado can expect 24,000 or more residents to churn in a given year, she said.

One overarching solution is simple on the surface: 12-month continuous eligibility, meaning an adult who qualifies for Medicaid at some point in the year can stay on it for a full year, no matter what happens with a job or family situation. That boon already existed in the Child Health plans, and Colorado has added it in March for “regular” Medicaid children.

Now the push will be on to get the same sensible, stable coverage to all Medicaid adults.

States can apply for a Medicaid waiver to allow continuous adult eligibility, and work out who will pay for what between federal and state governments; so far only one state has done so, officials said. The Colorado Legislature would have to authorize state officials seeking a waiver, and the state would have to calculate for the Legislature how much the smoothed-out coverage would cost the general fund. Federal officials are supportive, but talks have not reached the touchy questions of who pays – Medicaid’s expansion is 100 percent federally funded in the first years. What would be the match for continuous eligibility?

“All states have asked the question, but historically it hasn’t been an option,” Taranto said. “Once the federal government says the states can pursue it, then our state Legislature would have to look at the viability of it and see if it’s something we can financially sustain.”

In the meantime, the Connect for Health Colorado exchange is trying to look at Medicaid churn customers as a success of the system and a marketing opportunity. After all, someone making enough money to leave Medicaid is exactly the goal of a progressive social welfare system – and those suddenly unmoored customers could buy a private policy on the exchange.

“ [MEDICAID CHURN CUSTOMERS] ARE PEOPLE WE WILL REACH OUT TO. IT WILL BE A VERY DRAMATIC WAY FOR US TO CONTINUE TO SEE ENROLLMENT.”

PATTY FONTNEAU
EXECUTIVE DIRECTOR AND CEO
CONNECT FOR HEALTH COLORADO

“Those are people we will reach out to,” said exchange executive director and CEO Patty Fontneau. “It will be a very dramatic way for us to continue to see enrollment.”

Unbroken eligibility has been a goal of many advocates for years, said Gretchen Hammer, executive director of the Colorado Coalition for the Medically Underserved. Now that Colorado has just expanded that umbrella to all children, advocates and state officials may need to study the results before they push for another step.

“In my humble experience with policy, it’s best to be abundantly clear about what the problem is that the policy change could tackle, and have it be very focused on that narrow solution,” Hammer said.

35% 
Percentage of childless adults eligible for Medicaid who will earn enough money to “churn” above 138 percent of the federal poverty level within a year, and thus need a new insurance arrangement.

A Grand Effort to Reach Patients

County's Rural Health Network and a Father-Daughter Doctor Team Strive to Simplify

By MICHAEL BOOTH

PHOTOGRAPHY BY JAMES CHANCE

It's a simple question: "I know what all my prescriptions do." Agree? Disagree? Unsure?

And yet the simple question is one key catalyst in cementing consumer health connections to insurance and care in remote Grand County, where people love the lifestyle but too often don't live in a style that will prolong their life.

The Grand County Rural Health Network employs the questionnaire – packed with about a dozen queries – for patients who use the network's navigators to find care. The navigators, funded in part by the Colorado Health Foundation, can help out with something as basic as making a doctor's appointment or as complicated as researching a disease and consulting specialists.

The questionnaire sets a baseline in "patient activation measures," the current buzzwords for making sure consumers understand their role in landing appropriate health insurance and medical care. The patients get a score on a 100-point scale developed by Insignia.

When caseworkers go back later to ask the same questions, they've been told to hope for just a three- or four-point improvement in "activation." Instead, said network director Jen Fanning, Grand County scores were jumping by seven points. Better yet, the activation scores are translating to better health outcomes in those patients – weight loss, lowered blood pressure, improved blood sugar results.

Grand County has also created successes with the Affordable Care Act, linking more residents to reliable health insurance, and then finishing the handoff to a provider who will get them care. In early winter, the county of about 14,000 people had put 255 residents into expanded Medicaid and 150 people into Connect for Health Colorado exchange policies.

Landing the insurance doesn't help much if providers aren't interested in taking it. Fanning sees one of the network's jobs as rallying local doctors, clinics and other providers around the intent of the Affordable Care Act, especially in Medicaid. The network has helped bring at least two smaller clinics into accepting Medicaid payments for their patients, a major coup in a thinly populated area.

It helps that one of those newly signed providers, Jim Kennedy, MD, of Byers Peak Family Practice, chairs the network's board. "We knew a lot of our patients, many we'd taken care of for nine or 10 years, would get bumped into Medicaid," so it was important to continue caring for

“ [MEDICAID IS] THE TYPICAL PAIN IN THE NECK FOR MINIMAL REIMBURSEMENT. BUT WE'RE GOING TO GIVE IT A TRY. ”

JIM KENNEDY, MD
BYERS PEAK FAMILY PRACTICE

them, Kennedy said. He also was willing to retry the program, after giving it up years ago in frustration, because the new rates more closely match Medicare rates that can sustain a practice.

That doesn't mean Kennedy is suddenly enamored of Medicaid. The state lost his first application to resume his Medicaid provider number. Then it lost the second application of his partner – who happens to be his daughter, Kelley Glancey, MD. So they are on their third go-round.

"It's the typical pain in the neck for minimal reimbursement," Kennedy said. "But we're going to give it a try."

Kennedy can't foist the work onto his back office. He and his daughter are the back office. They run a "micro-practice," with no employees, and submit their own insurance billing through enhanced electronic medical records. It keeps the Byers Peak overhead to 20 percent of revenue instead of the typical 60 percent at a small practice. And Kennedy can schedule a leisurely dozen patients in a day instead of 25 to 30 needed to pay the bills.

County leaders have now identified their next big consumer health problem – finding mental health care for all who need it. Mental and physical care are now theoretically equal under the ACA, but that doesn't mean Grand County patients can get to a psychiatrist or psychologist they like.

Kennedy hopes for quick adoption of telehealth for those needing care. "You can Skype on your cell phone – I'd love to see more of that in mental health here," he said. "We're working very hard on that."

Grand County Rural Health Network, Inc.
Patient Navigator Program
Patient Survey
Mail-In, Phone or Direct Interview

Name of Patient _____ Date _____

1. Did the patient navigator help you get the resources you needed so you could get the care you needed? (example: medications, transportation, financial.)
 Yes No

2. What was the most important resource the navigator helped connect you with?
Why? _____

3. Did you have a primary care provider (e.g. family doctor) when you started with the patient navigator?
 Yes No

4. Do you have a primary care provider now who you visit regularly?
 Yes No

5. Do you understand your chronic disease(s) better as a result of your experience with the patient navigator?
1 Not at all 2 3 Neutral 4 5

6. Do you feel better equipped to manage your chronic disease(s) as a result of your experience with the patient navigator?



JIM KENNEDY, MD
BYERS PEAK FAMILY PRACTICE

JIM KENNEDY, MD, AND DAUGHTER
KELLEY GLANCEY, MD
BYERS PEAK FAMILY PRACTICE

When 9-1-1 is the Wrong Number

Aurora's Triage Program Sorts Out Best Help for the Most Frequent 'Fliers'

By MICHAEL BOOTH

PHOTOGRAPHY BY JAMES CHANCE

The homeless veteran knew how to access the consumer health system in Aurora.

But he only knew how to use it in the most expensive and least healthy way.

Fifty-seven times in 10 months, well more than once a week, the man would call 9-1-1, because he was panicked, or drunk, or in severe pain or all those things at once.

He would be picked up by Aurora police or fire units, or paramedics with an ambulance, and inevitably taken to an emergency room at a local hospital. He didn't need the ER – he needed substance abuse treatment, a conversation with a housing and job counselor, a navigator who could help him find his VA benefits or a short-term prescription for pain pills. But the ER was what he knew, and what the police and fire departments knew would be open, and so in he'd go, for a huge and largely pointless cost to the system each time.

"You're talking thousands and thousands of dollars already, even if they don't get admitted to the hospital," said Leslie Winter, MD, a psychiatrist and medical director with Aurora Mental Health Center.

“YOU'RE TALKING THOUSANDS AND THOUSANDS OF DOLLARS ALREADY, EVEN IF THEY DON'T GET ADMITTED TO THE HOSPITAL.”

LESLIE WINTER, MD
MEDICAL DIRECTOR
AURORA MENTAL HEALTH CENTER

Winter and other Aurora leaders created the Triage program, funded primarily by city government, to zero in on a few dozen cases where patient care was as expensive as it was misdirected. Police, fire, mental health and physical health teams compiled a list of 67 "high utilizers" of 9-1-1 services. The top five each had more than 50 uses in a year. More than two-thirds of the high utilizers were homeless at the beginning of the program.

Teams would get a call when one of the high-use patients was checked into an ER. They quickly learned that "time of crisis" was not the best point to intervene, but they would make contact, and give phone numbers and get addresses for later. Sometimes caseworkers go with police and fire personnel who know where the frequent patients live – often on the street. "They can decide not to speak with us, but they do speak with us, because they have a problem, and something's not working for them," Winter said.

The team included substance abuse specialists from Arapahoe House, one of the Colorado leaders for inpatient and outpatient treatment and counseling. Quick access to substance experts is a key to success in Triage.

The homeless veteran, it turned out, had access to VA treatment and services, but would often miss appointments for lack of transportation, or from binges. "So what we'd start to do is check him into Arapahoe House the day before an appointment so that he'd get sober, then take him to the appointment as a sober person," Winter said.

One night the client was in jail because of a typical incident, and his caseworkers knew he had an important appointment the next morning. "He was released from jail at 5 in the morning, and one of our people went to the jail at 5 a.m. and picked him up, stayed with him and got him to the appointment," Winter said.

Triage must be as quick-thinking as the label implies. A woman who'd had gastric bypass surgery needed a drug cocktail every week to soothe her stomach. She went to the ER to get the prescriptions because she lacked a regular provider. Triage arranged for prescriptions to be sent to the local Arapahoe House offices, a place the woman could manage to reach.

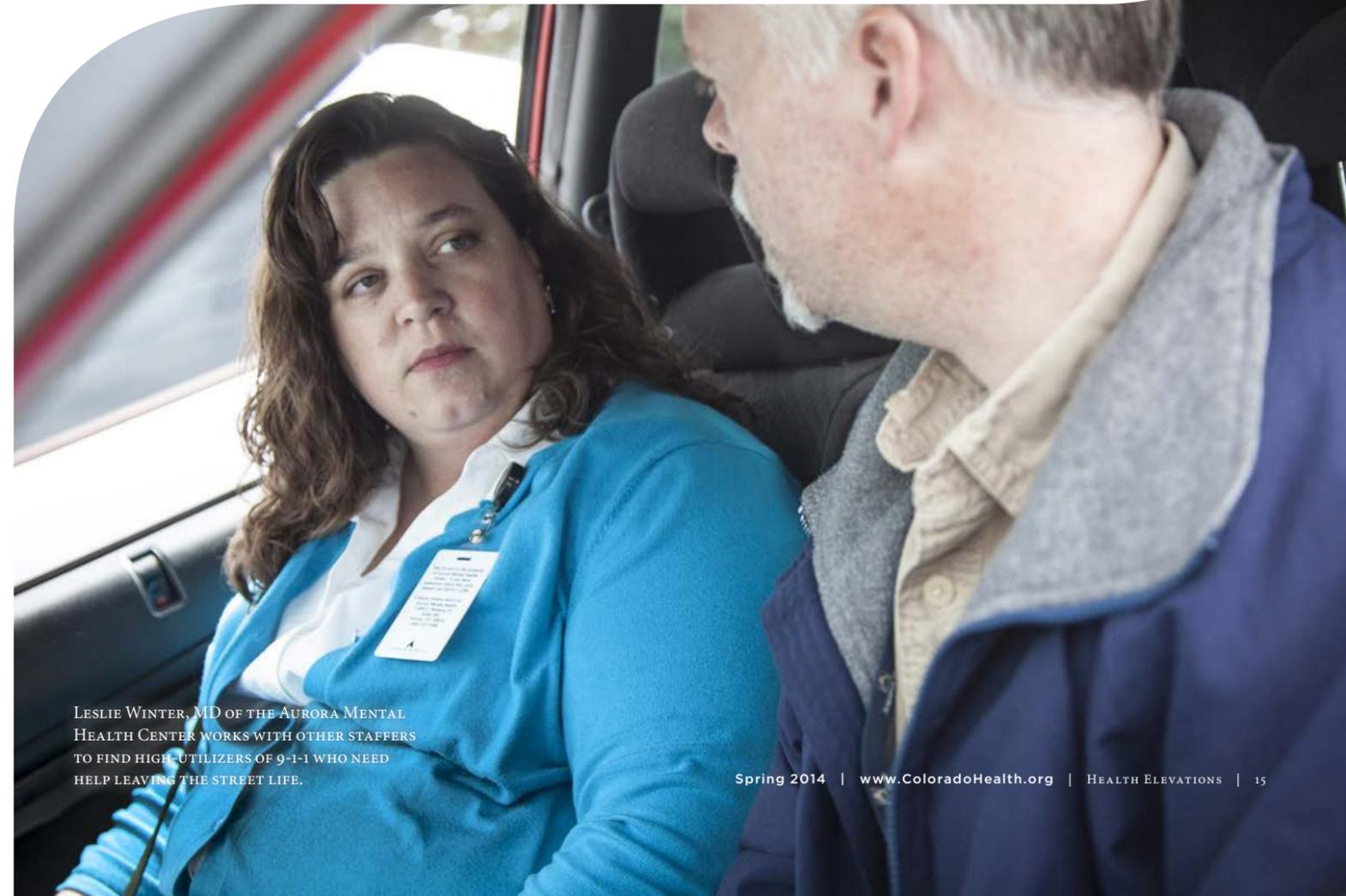
"She had physical issues, but she was also a social person, and at the ER there's lots of people. So we hooked her up with a day program for people with mental illness, and she got into a group

home for more contact with people," Winter said. The woman's use of 9-1-1 dropped from 40 in a year to three.

"Triage" does not mean passing on problems to another level. The work is difficult and success comes over years, not weeks. The homeless veteran has taken three years to stabilize, and he still calls 9-1-1 occasionally. "Free will is annoying, because people still have it," Winter laughed.

But there is measurable success. The top 10 utilizers had 360 emergency calls among them in 2012. The same group, after a year of Triage work, had 146 calls in 2013.

The next step, Winter said, is to take the results to the hospitals that bear the burden of the high utilizers, often unreimbursed. The savings could help pay for continuation or expansion of Triage. "It takes a lot of manpower on the prevention end," Winter said. "It's a persistence thing." ❄️



LESLIE WINTER, MD OF THE AURORA MENTAL HEALTH CENTER WORKS WITH OTHER STAFFERS TO FIND HIGH-UTILIZERS OF 9-1-1 WHO NEED HELP LEAVING THE STREET LIFE.

Patty Fontneau

Solving Hang-Ups at Connect for Health Colorado

Exchange Will Refine and Refresh Consumer Experience

By MICHAEL BOOTH

PHOTOGRAPHY BY JAMES CHANCE



PATTY FONTNEAU, EXECUTIVE DIRECTOR AND CEO, CONNECT FOR HEALTH COLORADO

EDITOR'S NOTE As executive director and CEO of the Connect for Health Colorado private insurance exchange, where federal tax subsidies are channeled to the public, Patty Fontneau has been at the front lines of trying to connect consumers to insurance and care. The state exchanges are political targets, but also crucibles of adapting technology and bureaucracy to serve the public. We talked with Fontneau about lessons learned in the first operating season of the exchange.

Is it easy enough yet to sign up for health insurance in Colorado?

It depends on who you are. It depends on your level of knowledge about the resources available to you. It depends on whether or not you are computer-proficient. I think it's easy for many people. I think it's very difficult for pockets of people who don't have access to the system. Health insurance isn't easy. There's an educational piece to this. There are people coming at it who don't know how it works, and we've tried to accommodate that. And there are things we can do to help, but that's going to be a function of time and education and improvements to the system.

How can it be simpler in terms of what you can control here at the exchange?

Can we tweak our system and make it more usable? Always and forever, we should do that. Are there big hurdles? No, there are not. If you are looking for the advance tax credits, we are in the midst of a rebuild of the application and having a shared eligibility service with Medicaid that will allow people to put in a minimal amount of information and get a determination on where they should go.

What are some examples of what you've changed already to make things run more smoothly?

During peak times we expanded peak hours, but we'd always planned to do that. Opening on Sundays during December, it certainly became quickly apparent to do that. Having your doctor in your network was really, really important – outside of how much you pay, whether you could go to your doctor is an enormous point. So the addition of the provider directory was a big piece.

What else were you surprised about, that took longer to explain over the phone?

We were very surprised that very few people bought in October. It's the pattern of human nature. We overestimated the purchasing in October and early November, and we underestimated the last-minute push. Fifty percent of our enrollments in 2013 came in the last two weeks of December.

How have we done compared to other states?

I don't find it helpful to compare ourselves to other states. For ourselves, we made early estimates. Our conservative estimates were 75,000 people for coverage year 2014; our midpoint was 136,000. We hit 75,000 in early February. We have six or seven weeks to go [at the time of this interview; enrollment eventually reached 118,000], and we will blow by our conservative estimates. So the fact we're hitting these marks will allow us to keep our fees low; we will be able to keep them significantly lower than the federal marketplace does.

Demographically, it appears that young people are coming to the table a little late, but they are coming.

With high-deductible plans and more people moving to that kind of plan, is the exchange worried what the reactions will be as people start using insurance now and realize that a \$5,000 or \$7,000 deductible leaves them with a hefty bill?

I believe there will be a reaction to that. And these are the kinds of reactions we are going to have to deal with and adjust to. See Answer A – if you don't understand how health insurance works and you have a deductible and a copay, it is surprising and can be shocking.

Is it your problem?

As a part of the system as a whole, yes. I can't fix that, but we can be part of an education process beforehand. We don't have a lot of control over the insurers or what they offer, so we can't influence product design. But we can certainly influence education and how to use health insurance as well. And that will be one of our initiatives going forward – now that you have health insurance, how do you use it? You're taking advantage of the preventative, you're taking care of things sooner so they don't become a bigger, expensive problem.

Will there be difficulties as people change jobs and income levels and churn in and out of Medicaid and exchange subsidies and employer insurance?

We're working very closely with the Colorado Department of Health Care Policy and Financing on this; it's going to be one of the first topics we deal with in our advisory groups. People who are bumped out of Medicaid for whatever reason, those are people we will reach out to. It will be a very dramatic way for us to continue to see enrollment, to focus on people who are removed from Medicaid.

In April 2015, consumers who got subsidies will be doing their taxes and finding out if their estimates of their income were accurate. Is there a "great reconciliation" we are headed for next April, when people might be surprised that they didn't deserve all of their subsidy or deserved more?

We wanted to start maybe in March, to notify all of our customers who had tax credits – if your income changes, let us know. Personally I'd like to send that message to them every month, with a very clear indicator if you end up differently than you'd thought at the back end, there are clear IRS guidelines on who would owe what. If you fall into this category, there would be some payback. Yes, there is going to be a reconciliation. This is a tax credit based on your income bracket, and we just need to make sure we are constantly communicating with our customers that if there's a change in your income, you need to let us know. It's a function of education. ✨



CONNECT for HEALTH COLORADO™

How They Connected

1,285,098 unique website visitors

334,507 calls & chats served

59% of enrollees received tax credit

29 languages translated

Source: Connect for Health Colorado, October 2013 through March 2014

Sen. Irene Aguilar, MD

Consumers Need to Meet Reform Halfway

Balancing State Control with Consumer Empowerment

BY MICHAEL BOOTH

PHOTOGRAPHY BY JAMES CHANCE

EDITOR'S NOTE *One of the consistent voices in state politics for the average person's health experience is Sen. Irene Aguilar, a Denver Democrat and physician who has long championed easier access and a better health care experience for all patients. Aguilar, who has worked at Denver Health and seen where the patient "rubber" meets the rough "road" of health bureaucracy, often pushes the biggest health changes at the state level. We talked at her state Capitol office between meetings on health bills.*

Have we made it simple enough to find health insurance, and then health care itself, in Colorado?

I have had the chance to go on the Connect for Health Colorado website because I have some care providers for my daughter who do not have insurance. I think that for people who are comfortable with technology, the manual part of it is accessible. I was surprised because the women I work with qualified for some premium tax credits, and perhaps because we waited until later in November and December, the Medicaid application was not nearly as complex as I remembered. Even for me, it was very hard to tell what coinsurance was vs. copays. I know that before my children were born, because my employer paid so much of my plan, I just picked the highest price plan and had no idea what the details of it were. Once I had a daughter who was disabled, and I started looking at the details, I realized how complex the plans were. You pick based on what you have right now, and what you think might happen, and then life pitches a curveball.

Can the private sector do a better job connecting people with insurance? What role can it play?

It would be great for small businesses in particular. There are people at Connect for Health who will talk just with them. My husband is actually part of a small business, and they had just Humana for a long time, and I encouraged his business manager to talk to Connect for Health because they had employees with different needs. Year 1, a lot of people just wanted to stay with what they had and knew; I would hope that in Year 2 more businesses would make the connections to Connect for Health and find out what more is offered to the small employer.

The consumer plays a role. What would you encourage consumers to learn to achieve better health care for themselves?

I don't know that it's intuitive to people. There are people who have learned that getting care means you are sick, so you go in. I think most people might think preventive care is something for children. Probably all of us need to do a better job educating consumers to go in at least one time and become familiar with a general care provider, and make sure you don't have any silent diseases, and what you should do to stay healthy.

Are there problems with the roles of emergency rooms at the moment, and the ways people use them?

I don't mean to be mean to primary care, but I think the problem with emergency rooms is really the problem with primary care. Primary care tends to be open 8 to 5, and they tend to have a wait. Those become barriers to people accessing the right care at the right place. Realistically, if you're healthy, getting care doesn't have to be right now. But most of us are like, "I finally have this, I have an hour, I'll get it done!" So I think the easy availability of emergency rooms gives some people the misperception that even though my life is not in danger, I can go here and at least get seen. I don't think people realize emergency rooms cost 10 to 100 times more than a

regular visit to the doctor, and even though your copay may only be two or three times more, it's going to cost the system 100 times more money; and that will be reflected when your rates come up for next year. It's because you didn't seek the most cost-effective care.

Are there things Medicaid should do to make sure patients are getting the right care?

I wouldn't target just Medicaid. It's something all of us as a society need to think about doing this together. I think what we can tell people is that at least when they come to the ER, they're going to get a screening no matter what. And that screening will rate how sick you are, with 1 being very sick and 5 not being very sick at all. And I think most providers would agree that if you are not a 1, 2 or 3, you don't need to be seen at an ER. It's OK to find out that you're a 4 or 5, and we're not going to see you here, and we're going to help you find a provider who will see you.

You've been involved in legislation that looks at the growth in emergency beds in Colorado and suggests there's a lot of growth in the areas with the most expensive care. What role does the private sector have in making more sense of the system?

I had someone come in the other day and wanted to talk about their new idea for four new micro-hospitals. They came in unfortunately on a day when I was thinking about how to contain costs, so I went on a rant about why we don't need more hospitals. At the end the business manager said, "But that's what we're paid to do. That's what you're incentivizing us to do right now." I said, "You're absolutely right. How do I change the incentive to make sure the primary clinics are open from 6 in the morning to 11 at night?" What can society do to make that happen? If most people get access when they need it by the right provider, they wouldn't care if it was labeled emergency or not. That would be my request to the medical system. People want care when they don't feel well, and if you're not available to them, they're going to go where they can get care.

One reason people may seek emergency rooms is the lack of a doctor taking Medicaid, for example. Have you come across incentives that will draw providers to places that are underserved?

Medical schools have expanded capacity, but Medicare put a freeze on graduate medical education. So in 2013, there were 500 doctor (MD) graduates and 600 Doctor of Osteopathic Medicine (DO) graduates who could not find a training program. Period. Eleven hundred people who went through all that cost and brain damage of graduating medical school and had to go find something else to do for a year while they waited to get licensed. Colorado has huge numbers of applicants for a program that gives them a year in rural residency; research shows 70 to 76 percent of doctors who train in a rural residence end up practicing in a rural setting. Part of the problem with training in family practice is the billing loses money. So we're going to ask the programs what they bill, and see if we can help make up the difference. We'll provide the safety net to make sure these training programs remain fiscally sustainable in rural areas.

“I DON'T KNOW THAT [HEALTH CARE IS] INTUITIVE TO PEOPLE. THERE ARE PEOPLE WHO HAVE LEARNED THAT GETTING CARE MEANS YOU ARE SICK, SO YOU GO IN.”

SEN. IRENE AGUILAR, MD

SEN. IRENE AGUILAR, MD

You've fought hard in the Legislature for transparency, especially billing transparency and fairness. Is there more to do on that when we may be headed for deductible shock and other issues?

There's a lot more to be done on that. One way to do that is to create a commission around health care costs. Come to agreement and bring forward legislation together; otherwise it's too easy for one side to take the other side out. Everybody wants to know how you control costs, but nobody wants to do what it takes to control costs. If we really want to control costs, there are going to be winners and losers.

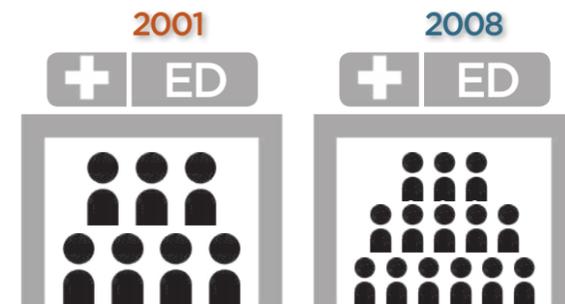


You've also been interested in some form of a universal or single-payer system in Colorado and nationally. Do you feel as consumers realize more about high-deductible plans and other issues that haven't been solved, it will push more people toward some form of a single-payer system?

I would hope so. What people don't realize is what having a single-risk pool does for prices for everybody. The classic example is what's happening in our mountain communities with prices. People ask, "Can't you just rate the state as a whole?" If we do that, the mountain communities' prices would go down dramatically, but everybody else's would go up. There's enough money in the system. I don't think people realize that with the premium tax credits, we're subsidizing money from here to there. We're just doing it in a different way. It's not as transparent. We're helping people to pay for the same thing you get. They're just not paying the full price. ✨

2X

Between 2001 and 2008, emergency department use rose at twice the rate of population growth.



Source: The RAND Corp.



Making Health Insurance ... Sexy?

Colorado HealthOP Takes an Edgier Approach to Reach Young Adults

BY MICHAEL BOOTH

PHOTOGRAPHY BY ERIK KEITH

Convincing busy, confused consumers to try a whole new model of health insurance calls for trying everything in the playbook, new and old.

Colorado HealthOP, the only consumer-owned cooperative health insurance plan in the state, had a brief window to sign customers and justify its massive federal startup grant. That meant making a big splash early with a lot of old-school eye candy. The later, more complicated piece involved testing a whole new argument: Consumers should take care of themselves to save money for their ideological brothers and sisters in their same risk pool. We stay healthier together, we save money together, and we make our own decisions.

The eye candy was based on the oldest of consumer-focused publicity: Beautiful people make good messengers. The HealthOP hired well-sculpted male and female models with minimal clothing,

“HEALTH INSURANCE IS NOT A SEXY ISSUE. IT’S SOMETHING PEOPLE HATE TO BUY. SO WE WANTED TO GO OUT AND CELEBRATE IT.”

JULIA HUTCHINS
CEO
COLORADO HEALTHOP

then asked them to parade the 16th Street Mall and other high-profile locations with “Ask me” signs advertising the cooperative. Photos of the sleekly healthy cast greeting enthusiastic shoppers won widespread free placement in newspapers, on websites, and on Twitter and Facebook.

“Health insurance is not a sexy issue. It’s something people hate to buy,” said HealthOP CEO Julia Hutchins. “So we wanted to go out and celebrate it.” Just as important, the high profile was a big motivator for the co-op’s staff and early adopters: “We keep seeing it pop up everywhere,” Hutchins said. “And it gave us so much energy internally.”

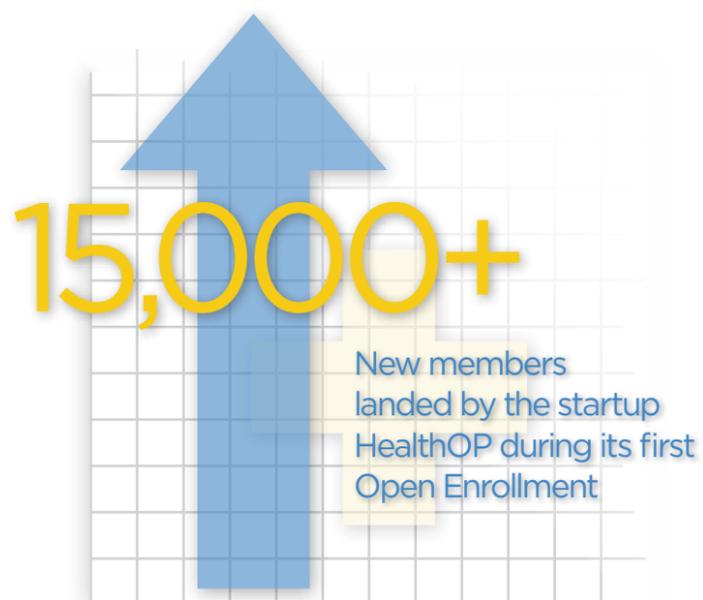
Once they had people’s attention, the more serious conversations began. The co-op suspended pharmacy formularies for new members if they were accustomed to another medication not on the list. “The last thing we wanted was someone stuck in line at a pharmacy, not able to get the medication they’ve been using for years,” said Chief Operating Officer Dana Held.

The co-op sends out mailings to remind members to get their wellness checks and “take their first health action,” such as a health survey and biometrics kit. Any three “actions” they take can cut their premiums, and they receive a health spending card loaded with \$150.

And there’s a long-term reminder: “At the end of the day, if we have extra revenue, the members decide what to do with it,” Hutchins said. The results have been more than 15,000 members to a startup health plan, in a few months.

The staff constantly tries to keep the consumer-members in mind. “A big value of ours is making things simple,” Hutchins said. At internal workshops, the staff will “call each other out on our health-care jargon,” from “out-of-pocket” to “formulary.”

Putting the lingo up on a chalkboard was meant to help brainstorm, “but it ended up like a parody instead of a simplification,” Hutchins laughed. “We still have a long way to go.”



COLORADO HEALTHOP MODELS TALK UP HEALTH INSURANCE ADVANTAGES IN BUSY SPACES.



A Personal Safety Net

Affordable Insurance Allows for Change

By MICHAEL BOOTH

PHOTOGRAPHY BY STEVAN MAXWELL

“Pretty easy, not perfect,” is young invincible Craig Smith’s take on buying health insurance for the first time through the new tools of the Affordable Care Act.

Smith is deeply embedded in the cohort health reformers so desperately want: a young, working man who – faced with too much bureaucracy or too high a price – might simply go without insurance and take the consequences.

Unless he’s convinced otherwise. And Smith found the Connect for Health Colorado and Medicaid applications runaround just tolerable enough to stick with it. Then, more importantly, he found the price he needed to get insured and be able to keep working, while also finding more time to take college courses to further his career.

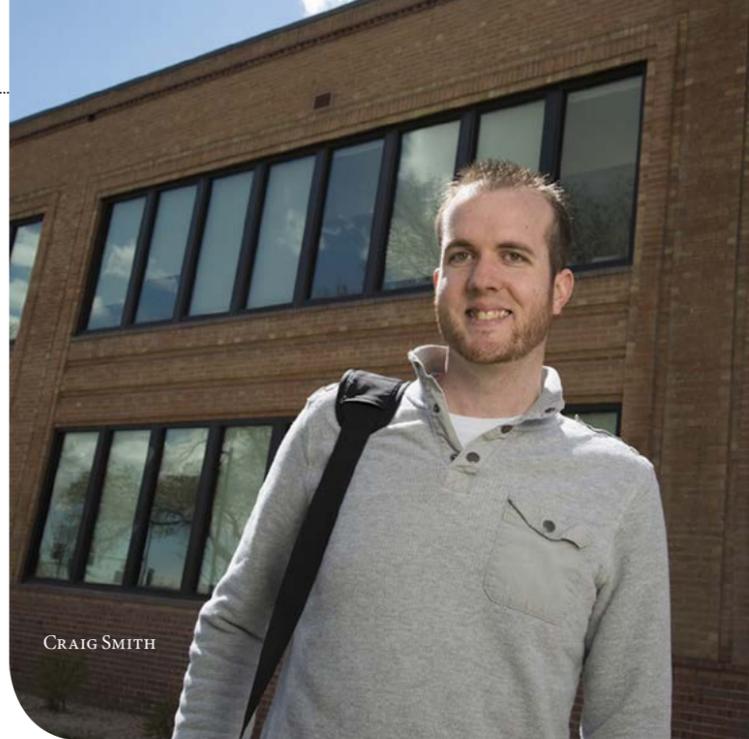
“My manager had cancer at age 29. It was a big financial battle for surgery and chemotherapy, and he had insurance,” said Smith, a restaurant server and student in Grand Junction. “If something like that happened to me, I’d be bankrupt, or dead.”

Smith was on his father’s insurance plan through July of 2013, an earlier benefit of the Affordable Care Act and one of the first health reforms adopted in widespread fashion by the “young invincibles” – the 18- to 29-year-olds that reformers fear won’t sign up for insurance because they rarely get sick. But when Smith turned 26 last summer, he had to find his own way.

The cost at the time on the private insurance market was \$250 a month, and he couldn’t afford both that and the college courses he wanted. In the fall, Smith started shopping on the Connect for Health Colorado exchange after following its development and health reform politics in the news. “I wanted to see it for myself,” he said.

His consumer irritations with the process were mundane but universal in early-adopter anecdotes: The step required to be denied for Medicaid even when he wasn’t asking for it was understandable, but an overly lengthy application. There and back at the Connect for Health Colorado site, he felt he was entering the same personal information over and over again, for no obvious purpose. The instructions for uploading his Social Security card copies and driver’s license were confusing and didn’t work as described, he said.

But the price comparisons for private insurance plans, once he got there, were clear and attractive, Smith said. He had planned on buying only a catastrophic plan, a cheaper option allowed for younger, healthier users. With a tax credit subsidy of about \$169 a month at his income level, his cost would only have been \$30.

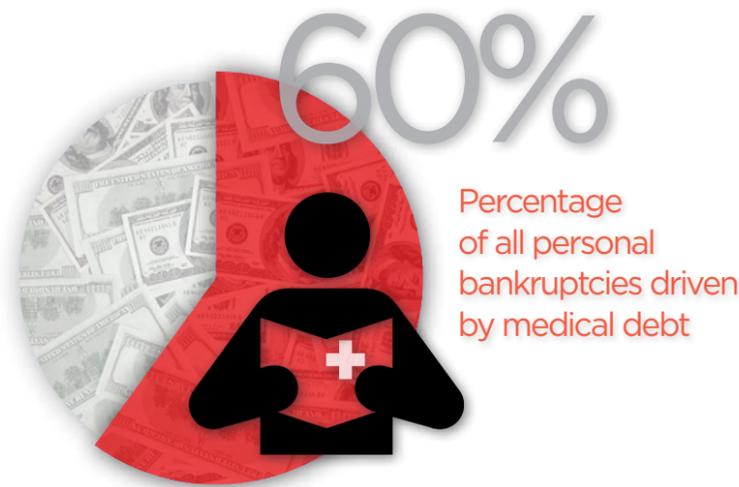


CRAIG SMITH

But he kept shopping, with friends’ experiences in mind, and chose a more robust “silver” plan, which cost him about \$59 a month after his subsidy. The day we spoke with Smith, he had just been to the doctor, and instead of his usual \$90 charge as uninsured, he made a \$40 copay and received a reduced-price prescription.

Smith’s solution is one illustration of the controversial Congressional Budget Office report on “Obamacare” impacts in the winter: Yes, Americans may end up with reduced hours of work overall as a result of more affordable health insurance. But that’s not because millions would be laid off as a result of higher business costs, as opponents portrayed the study. Instead, a deeper read of the study showed reforms were having many of their desired effects: People with a stronger health safety net had more choices in making a bold switch to a new job, or deepening their education to advance a career, or making the entrepreneurial leap Americans say they value.

“You never know,” Smith said. “I tend to think I won’t get sick. But it happens.”



Symbolic Change

By MICHAEL BOOTH

If a picture is worth a thousand words, when it comes to health care, one pure symbol can stand in for a thousand frustrating acronyms: HMO, PPO, EKG, OOP, ER, CHP+, etc.

The Noun Project, based in Los Angeles, is both an immediate product health reformers can use to simplify their offerings, and a thinking exercise organizations can go through to make everything they do more consumer friendly. The project collects the work of artists who upload symbols that represent ideas in fields ranging from health to hardware to parks and recreation to engineering to global warming. Any person or company can then use those symbols, for the public good or for profit, or both. Some artists want credit by name; others put them in the public domain.

The Noun Project also holds “Iconathons” around the nation for organizations that have requested help in rethinking their public faces. Health leaders in Colorado sought an “Iconathan” to walk through the consumer experience in seeking health insurance and health care, and then came up with their own ideas for symbols.

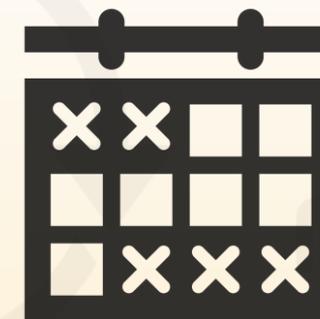
“Symbols communicate information faster than words. They are incredibly powerful communication tools,” said Edward Boatman, a designer who co-founded The Noun Project.

One of his favorite exercises in the Colorado design marathon, Boatman said, involved trying to explain the complex differences between “uninsured,” “underinsured” and “insured.” The best idea seems obvious only in hindsight: An umbrella completely protecting the user for “insured,” a too-small umbrella for “underinsured,” and a lonely, rained-on figure for “uninsured.”

Try to guess some of the other health symbols offered on this page. Look for more at www.thenounproject.com.



How to show one bad cell can ruin a whole bunch? One answer was this oncology symbol.



Some days you can, some days you can't. Here's one idea for illustrating open enrollment.



Navigating departments in a hospital setting can be daunting, thus the easy symbol for physical therapy.



What does a health coverage guide do exactly? One good symbol can say it all.



THE COLORADO HEALTH FOUNDATION
501 South Cherry Street, Suite 1100
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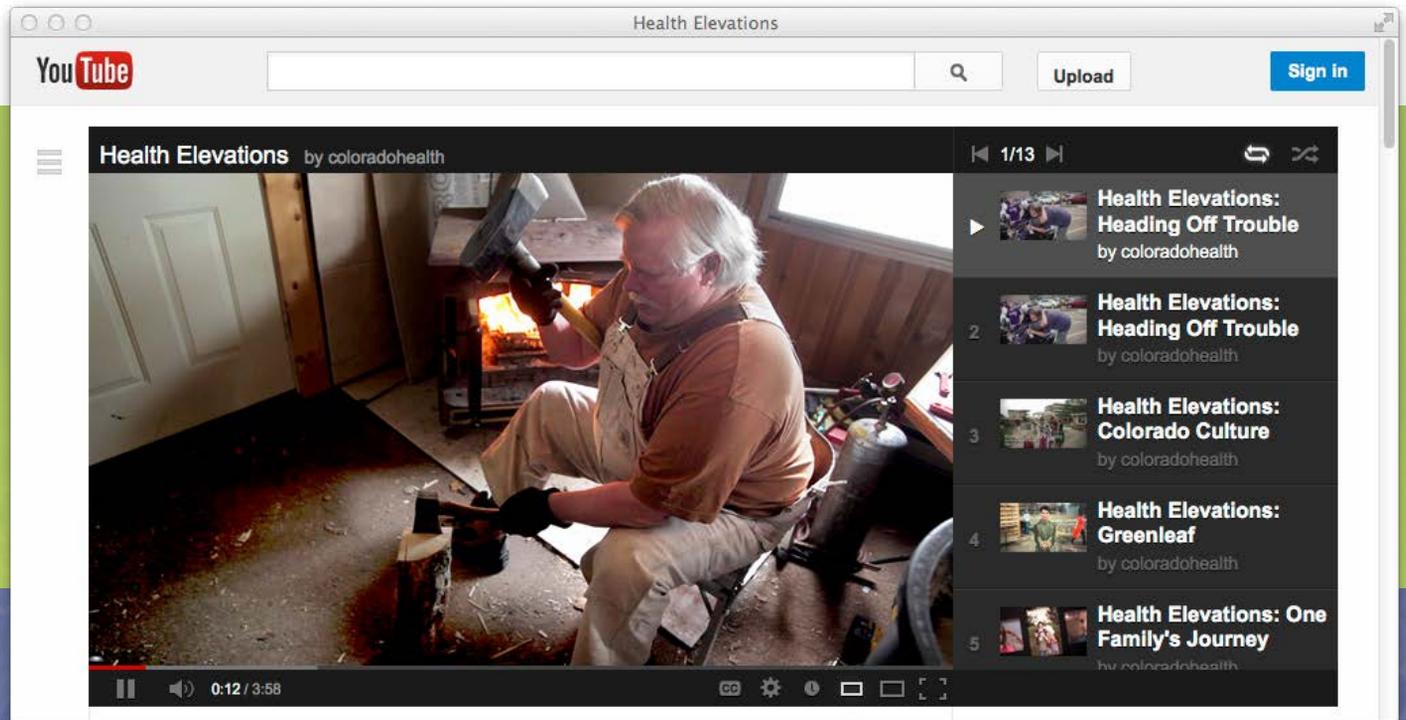
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RETURN SERVICE REQUESTED

Consumer Friendly

Many navigators and reformers who are 'impatient' with glitches in the health care system are working to help people like Monty, shown in the video below. Watch his story and the work of a Grand County support team at www.ColoradoHealth.org/journal.

EXCLUSIVE ONLINE VIDEO CONTENT



Read related story on page 12 in this edition of Health Elevations.