

Any evaluation of Colorado's health care system involves two components: (1) how to assure appropriate access for all Coloradans to health care and (2) what foundational elements are essential in a quality, well-functioning health care system. This proposal will focus on the latter component: what issues must be considered and addressed in Colorado's health care system regardless of the final decision concerning method of payment and modalities of access.

### **General Comments**

The goals of increasing access and reducing cost will remain elusive until we as a society address *all* aspects of the health care system. CFMC and its partners and collaborators believe that a holistic approach to the problem will be more fruitful than the common approach: fix health care providers. This proposal examines the role of all constituents in the health care system to see how, by working together, we can improve the health care system.

1. **Personal responsibility for one's health** through diet, exercise, high blood pressure regulation, immunizations & screenings (breast, cancer), prenatal care and becoming knowledgeable of one's known illness, working to successfully manage one's diseases with direct and active health professional involvement. The focus is on disease prevention and management to assure the right care to best handle one's illnesses. Timely access to the right care is critical. Education and information are available from many sources: community based, religiously based or health system based. An inclusion of community supported end of life discussions from a legal, moral, religious and ethical perspective before a patient is in crisis is critical to knowing and following a patient's wishes in their last months of need.
2. **Active use of information technology** to let facilities and professionals manage health care, communicating through a common electronic medical record platform (one readable by all systems), that improves quality and safety reducing the need for redundant testing. Using data to drive performance and teaching quality improvement techniques to help providers integrate reliable systems and a culture of quality improvement and safety into their daily routines. CFMC and its partners bring strength to this activity through work with Colorado providers and

health professionals in nursing home, home health, hospital and physician office settings.

3. **A culture of patient safety and quality** that is *just* rather than blaming, that encourages the reporting and sharing of information about medical errors, and uses this information to drive system changes designed to eliminate errors. Transparency such as the early intervention programs supports the protected use of medical error data. Transparency to identify and address problems immediately, communicate and respond to them, drive change of respect both health care of providers and their patients by each other. The option of litigation still remains.
4. **Administrative efficiency.** Common billing process regardless of private or public payor. Common guidelines, measures and evidence based medicine used by all. Colorado has local strength in CCGC and national strength in the National Quality Forum. One set of system processes for billing and payment. One set of guidelines or Evidence Based Medicine (EBM) available with continual updates, one set of patient safety measures. Electronic insurance ID cards and common physician credentialing are additional items identified by MGMA. Use these simplifications to drive down cost, improve safety and enhance quality.

These four concepts mirror those of Dr. Ed Wagner as noted in the appendices:

- a. Data Sharing for Performance Measurement , b. Engaging Consumers,
- c. Improving Health Care Delivery , d. Aligning Benefits and Finances

Through this response to the 208 Commission RFP, the Colorado Foundation for Medical Care (CFMC) and its partners provide solutions that fulfill Governor Bill Ritter’s promise to “Promote regional health care quality collaborations to reduce costly medical errors and complications through better processes of care.” The following response is designed to present the systemic steps to address the overall system of health care reform.

## **Our Opening Thoughts**

Quality and safety are the cornerstones of cost-effective health care. Quality and safety permeate every aspect of health care reform and are keys to improving access and sustainability. The success of health care reform, therefore, begins with a discussion of how to increase quality and safety while simultaneously reducing costs.

In this spirit, CFMC collaborated with the Colorado Clinical Guideline Collaborative (CCGC), COPIC Insurance Company, the Colorado Patient Safety Coalition (CPSC), and numerous other professionals to identify solutions that would add value to all reform proposals. As Governor Ritter noted, “health care reform must be developed collaboratively.” The existing resources and expertise of organizations such as those represented here should be leveraged into any reforms the Commission chooses.

### **a. Comprehensiveness**

#### **1. What problem does this proposal address?**

The US spends more on health care than any other nation, yet a recent Rand study shows we only provide only about 55% of recommended care for prevention and chronic disease, and a recent Institute of Medicine report notes that 44,000 to 98,000 people die each year from medical errors. Coloradoans spent \$22.4 billion on health care in 2004 and costs are continuing to rise. Meanwhile, 770,000 Coloradoans are without insurance, which further increases costs as they use emergency departments for their primary care. The numerous initiatives to control costs have been ineffective because the current health care delivery system mainly focuses on disease treatment, not disease prevention, health management, not administrative efficiency. The current system will eventually collapse under its own economic weight. The changes proposed here are designed to align the numerous health care stakeholders towards a common mission; **to provide the right care, at the right time, every time.**

The Institute of Medicine defines quality as “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” Numerous organizations in Colorado

have been addressing quality and safety issues for decades. While these efforts have saved lives and dollars, the current health care delivery system's focus on disease cure is not designed to maximize quality and safety. Focusing the numerous health care stakeholders on the common goal of ongoing health management, existing quality and safety improvement resources can be leveraged to improve care, reduce waste, and add value to all reforms the Commission proposes.

## **2. What are the objectives of this proposal?**

The success of health care reform begins with a discussion of how to increase quality and safety while simultaneously reducing costs. A new system that rewards disease prevention and health management is central to the success of any health care reform.

### **b. General**

#### **1. Please describe your proposal in detail.**

Fundamental changes must be made to align the various elements of today's fragmented health care system towards the common goal of achieving and maintaining health. Some of these elements, such as who should have access to what level of care and how do we pay for it, are beyond the scope of this proposal. We will demonstrate that a focus on quality and safety can have a positive impact on all aspects of care: access, coverage, affordability, portability, benefits, efficiency, consumer choice, wellness, prevention and sustainability. Each aspect will be addressed in turn. Regardless of other reforms, high quality care, without harm, requires providers to:

- Provide care based on best available evidence; Implement systems and processes to assure that care is provided safely and effectively; Remove obstacles to timely, efficient, effective patient care

The physician's maxim to do what works best, do it consistently, and cause no harm sounds simple enough. In the complexity of today's health care delivery system this formula is anything but simple. Truly fundamental changes are required.

**I. Provide care based on best available evidence**

**A. Apply common definitions of quality and safety.** The definitions of what constitutes safe care, what care improves patient outcomes, and what health variables impact the progression of disease change as medical science advances. The result has been a large number of fragmented efforts to define measures and develop guidelines that actually work to hinder performance. Building on national guidelines and measures developed by authorities such as the National Quality Forum, US Preventive Services Task Force, Ambulatory Care Quality Alliance, Centers for Medicare & Medicaid Services and the Joint Commission, all stakeholders must work together to create a uniform set of definitions to align and strengthen the measurement, performance and reporting of safety and quality. Even when clear evidence is not currently available, incorporating care for certain conditions into coverage plans clearly makes sense. For example, evidence-based best practices have yet to clearly define guidelines to obesity counseling and treatment, but that does not mean we stop treating obesity until guidelines have been established. Even current actions can positively impact morbidity, mortality and costs.

**B. Shift health care focus to preventing disease.** Quality systems that promote wellness and prevention are key to efficient health care delivery. While good health is an obvious objective, focusing on prevention provides financial benefits as well. The current pay-for-procedure payment system rewards acute intervention while providing little or no incentive to prevent the conditions that create the need for acute intervention. Concentrating on prevention and evidence-based management of chronic disease that facilitates access to care before a patient is in distress, is showing reductions in overall costs by minimizing morbidity and mortality. The World Health Organization estimates that elimination of the major risk factors for chronic disease were eliminated, at least 80% of heart disease, stroke and type 2 diabetes and 40% of cancers would be prevented.

**C. Consumer approach to patient participation and responsibility.**

Coloradoans are ultimately responsible for their personal health. As consumers, they should be rewarded for their cost-effective behaviors. Because routine health maintenance and proactive chronic disease self-management is less expensive than acute disease treatment, consumers who actively participate in the self-management of their health should pay less for their health care. Second, providers should be compensated for discussing and educating about prevention, whether in the office or by email, phone or fax. Systems designed to engage patients and providers around proven models of chronic disease management are critical. These collaborative models leverage system-level best practices, strategies for proactive patient engagement, and provider accountability while empowering patients with self-help tools and education.

**D. Community discussion about the limits of care.** Providing safer health care, reducing the administrative costs of providing care, and helping Coloradoans self-manage their health will make health dollars go farther. However, we will always be challenged by the amount of resources put into the health care system. The current system places those decisions on limits of care on physicians and health plans rather than actively including patients/consumers prospectively in the conversation. Other states have openly addressed the issue of limited coverage using objective measures and definitions as a basis for proactive discussion of benefit limitations. If needed, Colorado should use a fair and objective process to address funding limits.

**II. Apply systems and processes to assure that care is provided effectively**

Efficient health care requires providers develop and implement reliable processes and systems to ensure safe, effective, timely, efficient and equitable patient-centered care. The infrastructure for these activities already exists, or is being developed in Colorado.

**A. Integrated health information technology and electronic medical records.**

1. Colorado Regional Health Information Organization (CORHIO), a central component of health care delivery reform is an integrated health information network. Such a system would permit every provider in Colorado with access to electronic medical records that capture patients' complete medical history including current medications, clinical and family history, and pharmacy contact information. Such a system can also access previous test results, immunization history, and screening and exam results. Expanding Colorado's central data exchange system developed by CORHIO will improve outcomes by facilitating the adoption of best practices while reducing costs through improved quality and safety and avoidance of unnecessary duplicative testing services. While these systems require upfront expenditures, they will ultimately reduce costs associated with the medical and legal costs of avoidable errors, as well as unnecessary procedures and tests through both evidence based decision support and disease prevention.

In order for COHRIO to be fully functional, both inpatient and outpatient facilities will need a mechanism to communicate with other providers using electronic medical records flowing through the CORHIO system. Small independent practices with no infrastructure and very small margins, (approximately 50% of independent physicians in Colorado practice in a group of 5 or less) will need assistance to purchase these systems and integrate them through practice redesign methods. This will help avoid putting an electronic system into a chaotic system (leading to "systematic chaos") and will help providers/staff use the EMR to enhance rather than detract from the physician-patient relationship during a patient encounter. In addition, a key component of health information technology is the disease registry, which must be included in any system. The disease registry can be used as a tracking and reminder system to ensure that all patients get recommended care, often without an office visit. A dynamic system increases reliability, reduces dependency on professional's

memory, increases efficiency, reduces workload, and ultimately reduces health care costs. Disease registries can also provide decision support tools proven to increase the efficiency of chronic disease management.

2. Electronic Medical Record (EMR), At the core of this proposal is a system to improve the flow of information through interoperable integration of health information technology (HIT). The most obvious HIT is the electronic medical record (EMR). Providing every provider in Colorado with access to and training on usage of EMRs, would facilitate good decision-making, improvement of care, and ensure the efficient coordination of care by incorporating practice redesign.

Increased access to information impacts clinical outcomes directly by providing caregiver decision support. Indirectly increased access to information improves coordination of care. The Institute of Medicine (IOM) report of July 2006 that showed medication errors were not only harmful to patients but also costly to treat. The report noted at least 1.5 million preventable adverse drug events occur in the United States annually. An estimated 400,000 of these events occur in hospitals at an estimated cost of \$3.5 billion. An integrated HIT system using computerized physician order entry (CPOE) and medication reconciliation systems combined with a culture of safety would prevent harmful errors and the associated costs from occurring.

Defensive medicine does increase the cost of care. The actual amount is difficult to determine, however research done by Price Waterhouse, 2006, indicated the cost may be as high as 10% across all specialties and territories. A study published in JAMA, June 2005, “Defensive Medicine Among High Risk Specialist Physicians in a Volatile Malpractice Environment (PA)” found that avoidance behavior increased costs specialty of OB/GYN (OB) 46%, Radiology (Mammography) 54%, Orthopedics (ER/Trauma) 26%, Neurosurgery (Cranial) 33% and General Surgery (Trauma) 21%. Through increased HIT, evidence

based medicine, and patient communication, the costs of defensive medicine may be reduced.

Health care costs are also reduced through the elimination of nonproductive, duplicative testing and the costs currently spent on data entry (Health Information Technology Leadership Panel, 2005). In an age when most industries rely heavily on computerized systems for successful business operations, only 10% of American physician practices are computerized (Conn, 2006). Groups such as (CORHIO) are working locally to develop an integrated system that would put Colorado at the leading edge of this cost saving, safety-enhancing technology.

Ultimately, however, individuals should take responsibility for their health and the health of their loved ones. An electronic version of a personal health record (EHR) would allow Coloradoans to track their health status and engage them in the self-management of their health. A transparent system would allow Coloradoans to more effectively participate in the decision-making process and judge the impact of their decisions, both clinically and financially. Clearly, the current privacy protectors and requirements of HIPAA would remain in place.

**B. Using data to drive performance.** Technology offers an efficient process to track and measure performance. Consistently applying data collection and analytic techniques will allow providers in all settings to continuously monitor their performance, make specific improvements, and better meet the needs of their patients.

Data on quality and efficiency measures should be initially collected and independently audited, available to combine data from multiple sources into a central data repository (CMS already provides this service for Medicare patients). This system needs to provide reports to the various stakeholders while ensuring appropriate privacy protection. A common method of data collection should be used in order to reduce the burden on individual providers until a universal

electronic system is available to all providers. The data collection process and reporting methods should be made transparent and reviewed by CFMC and others to ensure its accuracy and fairness, to identify areas of improvement with timely resolution of those deficiencies.

Transparency of the data enables it to be used to demonstrate provider performance as a way to educate patients, improve health care providers' performance, inform payers and employers, and encourage selection of providers that meet appropriate standards. However, transparency alone will not change behavior. Use of the data and information to measure progress towards improving patient outcomes is needed, combined with a culture of quality improvement and safety.

**C. Reward excellent and improving performance.** Incentives must be utilized to reward both consumers and providers for their cost-effective behaviors. Rewarding preventive care and effective self-management will increase the efficiency of the entire health care delivery system. Health care facilities and providers, who participate in quality improvement and patient safety activities and who take the time to educate their patients about self-management, should be compensated for these efforts, whether done face to face, by phone, fax or email. Providers who consistently score high on risk adjusted performance measures or show an ongoing trend of improvement should be rewarded with higher payments, tax benefits, or other incentives.

**D. Promote proven delivery models.** Increased workloads and administrative burdens, competing demands, and decreasing reimbursements are combining to create a crisis in primary care. The effective, efficient delivery of primary care is a key to increased access and reduced expenditures. Regardless of what health care reform program is selected, strengthening of our primary care system is crucial using concepts such as the Medical Home to improve access, quality, efficiency and coordination of care. As part of this, physician practices

will need assistance in redesigning the way they deliver care using tested methods such as the Planned Care Model to improve efficiency, quality, and satisfaction for both patients and the health care team. Reform proposals should include these models and compensate providers for a variety of more efficient and cost effective patient contacts including group, email and phone visits in addition to face to face visits.

### **III. Remove obstacles to timely, efficient, effective care**

**A. Align incentives towards a common goal.** Fragmentation is one of the most destructive forces in our health care system today causing inefficiencies, increased costs, and leaving patients vulnerable to safety errors. All major health care stakeholders, including providers, professional liability insurers, funding foundations, payers, purchasers, government agencies, delivery organizations, consumers, and the various organizations representing each group, should work together to develop a coordinated strategy to leverage limited resources, facilitate information exchange, and focus targeted education messages. This alliance, backed by the full force of the 208 Commission and the Governor's office, should build on the common goal of safe, effective health care with a focus on good quality at a reasonable cost.

**B. Simplified financial systems.** The health care delivery system must address overhead expenses caused by the multitude of medical billing and payment systems. Resources that providers and facilities currently spend navigating multiple, ever changing payment and billing systems would be better utilized providing patient services. The costs of multiple systems are ultimately passed back to the consumer through higher premiums and copays. Representatives of all stakeholders should be brought together to create a viable single-process billing and payment system. Suggestions have already been provided to the Commission by MGMA in this regard.

**C. Fair and balanced legal system.** The current fault-based tort system promotes deniability and impedes development of a culture of safety. Failure to acknowledge mistakes, learn from them, and implement better care processes to eliminate future occurrences creates several unnecessary costs: the cost treating any harm caused by the error and the cost of subsequent legal action. When an unanticipated medical result occurs, patients should be offered a sincere apology, including an investigation into the event, and be assured that processes of care improvement will occur. Programs using systems to assure open communication ([www.sorryworks.net](http://www.sorryworks.net)) have been shown to improve the clinician-patient relationship and ensure equitable and appropriate compensation without limiting the patient's right to take subsequent legal action.

**D. Promote consumer participation.** We must work in partnership with the entire community to activate Coloradoans as responsible consumers and to empower them to become proactive participants in health care reform. Better patient outcomes are achieved through the use of evidence-based techniques that emphasize patient participation/empowerment, collaborative goal setting, and patient-centered problem-solving. Consumers should have access to useful information about their health and receive help from providers, family, friends, and the community as they develop self-management skills. Decisions about care, including end of life and palliative care issues, should be part of ongoing advanced discussions occurring when individuals are more likely to make unpressured decisions, be satisfied with their decision, and avoid having decisions forced upon them in a time of crisis.

**E. Facilitate communication.** Each of the initiatives identified in this proposal can be supported through improved communication (improved communication between family and patients, patients and clinicians, clinicians and other clinicians, acute care facilities and long term facilities). Open communication facilitates the development and sharing of best practices. Above all, improvement of communication among all of the stakeholders, including

providers, professional liability insurers, funding foundations, payers, employers and other purchasers, government agencies, delivery organizations, consumers, and the various organizations representing each group.

## **2. Who will benefit from this proposal?**

As consumers of health care services, the actions proposed will benefit all Coloradans and health care givers. The benefits for patients would be better health status through education, wellness, prevention, better quality and patient safety as well as better communication and understanding of one's health care.

For health caregivers, greater satisfaction from more accurate and informed decision making, an ability to effectively focus on prevention than cure, and the joy from working in a functioning system of health care.

### **Who will be negatively affected by this proposal?**

Switching from a pay-for-procedure health delivery system to a pay-for-performance system is likely to cause some growing pains as diseases and complications that require curative measures are reduced. The evaluation firm can address the short-term implications of this fundamental shift. The long term cost savings, however, may greatly outweigh any short-term inconvenience as the market shifts from an emphasis on curative services to preventive services. These cost savings can be used to broaden access to care and/or be shared with the consumer, employer, and/or provider.

Additional negative effects will come to those working in the current fragmented administrative system. We will have a huge job placement/retraining need.

## **3. How will your proposal impact distinct populations?**

The Healthy People 2010 campaign has set a national goal to eliminate health disparities among different segments of the population. A study completed by the Colorado Department of Health Care Policy & Financing in 2002 demonstrated under-utilization of preventative services within the Medicaid disabled population. This data is consistent with national trends where cancer screening rates are low within similar populations

(NRHArural.org, National Rural Health Association). Focusing on disease prevention and self-management, this proposal stresses the importance of timely health care for all Coloradoans regardless of geographic location, income, or health status. Short-term costs incurred by providing preventive care are more than offset in the long term by cost savings gained by avoiding the need for more expensive treatments. For example, effectively managing diabetes in the home setting/physician office is less expensive than treating kidney failure. Individuals, families, and communities should be engaged in partnership with their health care givers to make decisions locally, based on education and information.

**4. Please attach evidence regarding the success or failure of your approach.**

Please reference the appendices for supporting evidence and the cover page of the appendices for a summary of evidence.

**5. How will the programs be governed and administered?**

No single organization has the knowledge, experience, or resources to provide every aspect of this proposal. Fortunately, a supportive network of organizations is already at work on many of the proposed activities. Substantial efficiencies lie in the coordination of these activities. CFMC partnered with the Colorado Clinical Guideline Collaborative (CCGC), COPIC Insurance Company and the Colorado Patient Safety Coalition (CPSC) to develop this proposal. Together we represent a hundred other organizations and thousands of clinicians. Working in cooperation, each organization can participate in efforts in its area of expertise in concert with those organizations proposing access reform. For example: CFMC offers the provision of quality improvement training and support; CCGC offers the development and promotion of clinical guidelines; COPIC offers efforts to engrain a non-fault-based culture of reporting and disclosure; and CPSC offers invigorating patient safety efforts. All four organizations have overlapping strengths for these competencies.

**6. Will any federal or state laws or regulations need to be changed?**

Unknown. While ACCESS proposals will best respond to these questions, improvement in quality and safety, consumer participation and HIT are all currently permissible. Regulatory and market driven accomplishments to improve care should be considered.

**7. How will your program be implemented? How will your proposal transition from the current system to the proposal program? Over what time period?**

The diverse cultural and geographical features of Colorado complicate the implementation process. No two consumers, payers or providers operate in the same exact way. Throughout this proposal are examples of some of the major differences and proposals for how they should be addressed.

**The first step** is to increase spending to complete the communication infrastructure. Basic patient safety, clinical quality improvement, and health information technology is already in place at many hospitals. The CORHIO is developing a uniform foundation IT interoperability for Colorado. CFMC should continue its work with acute care facilities as these providers develop their infrastructures through the Colorado Trust Institute for Health Care Improvement 5 Million Lives Campaign along with Medicare sponsored Quality Improvement Organization efforts in physician office, home health agency and long term care activities. CCGC's Improving Performance In Practice is assisting outpatient providers in redesigning their practices to incorporate registries into their office practice, while COPIC Insurance Company's Practice Quality program monitors systems that are in place and supports early intervention programs. All groups encourage the adoption of appropriate interoperative electronic medical records. Providers would then be able to expand reporting outcome data, creating gains toward better quality of care. All hospitals are already collecting and reporting health care improvement information.

The first step would also begin aligning consumer incentives with desired behaviors. For example, consumers could receive reduced or nonexistent co-pays for preventive

services. Consumers would not receive premium reductions for smoking, excess alcohol consumption, and drug use. Numerous consumer groups are available to assist Coloradoans adapt to reforms. To promote efficiency, a coordinating organization should be identified to facilitate educational information distribution to existing patient advocates groups, health insurance brokers, human resources departments, schools, churches, Chambers, and other social organizations. Efforts such as the *9 Health Fairs* need to be strengthened and coordinated with health care providers.

**The second step** would focus on aligning provider payments with the desired patient care and outcomes. Initial incentives would support information technology. Also needed is support for chronic care management activities, coordination of care, and the active involvement of informed patients. Finally, a true pay-for-performance compensation for prevention efforts system could be implemented to complement the current disease treatment payment system.

These efforts should occur as simultaneously as possible. Strong educational support will be essential to provide training and the learning needed to make this transition successful. Such educational efforts need to be embedded in our efforts both in secondary, college, professional schools and available through the web.

Health care professionals should also be rewarded for use of health information systems that promote improved quality and allow outcomes to be measured and trended. These systems, integrated to include an electronic medical record (EMR), facilitate the adoption of best practices such as the use of patient safety practices and evidence-based medicine. A dynamic system should support the ever-changing landscape of health care, increase reliability, reduce the opportunity for medical error (safeguards), reduce dependency on memory, increase efficiency, reduce workload, and ultimately reduce health care costs. Providers who consistently score high on risk adjusted performance measures should be rewarded with higher payments, tax benefits, and other incentives.

EMRs should be combined with incentives to support a proactive discussion of end of life care issues. The National Quality Forum is developing measures that assess the congruence between patient preferences and the care that is delivered. Providers should be rewarded for addressing these issues with their patients and for complying with their wishes. Colorado has also addressed this planning for end of life in an organized and appropriate way. The appendices include three references to existing efforts underway in Colorado that should be supported.

### **c. Access**

#### **1. Does this proposal expand access?**

While this proposal does not directly address the question of access, the foundational elements have major access implications. A consumer focused system that uses integrated health information technology (HIT) to address quality and safety is going to help Coloradoans improve their health status through an understanding of prevention and self-management. Such a system will also slow the progression of chronic disease and ultimately reduce individual cost of care. Resources freed as a result of this increased efficiency could be used to provide access to additional Coloradoans, while also rewarding providers, payors and Coloradoans for changed behaviors.

Urban versus rural differences illustrate the effect quality HIT can have on the system. Currently, nearly 24% of rural children live in poverty. Abuse of alcohol and tobacco are significant problems among rural youth. With 40% of rural high school seniors reporting that they use alcohol while driving, compared to 25% in urban areas, it is not surprising that the rate of DUI arrests is significantly greater in rural counties. Rural eighth graders are also twice as likely to smoke cigarettes. One-fifth of non-metro counties lack basic mental health services (NRHArural.org).

Rural areas represent a tremendous opportunity for improvement. The Institute of Medicine (IOM) cites the investment in HIT is a key component to the future of rural health care. A statewide HIT network with personal electronic medical records (EMRs)

would permit rural providers to better monitor chronic diseases, such as alcoholism and tobacco use, while improving access to health care.

Rural areas have been slow to adopt new technology. The lack of Internet access and the cost of hardware have been barriers in some areas. Unfortunately, a common barrier has been reluctance to use technology. Only 51% of rural physicians use clinical pathways and guidelines. Organizations such as CFMC, CCGC, COPIC and CPSC have been working to educate providers across Colorado in the adoption of this technology. HIT provides the disease registries and decision support tools proven to increase the efficiency of chronic disease management. This technology also facilitates the use of telehealth, connecting rural facilities with specialized resources and training only available in large urban areas.

According to the American Hospital Association, 80% of Colorado's critical access hospitals (CAHs) are using teleradiology and 24% are using telepharmacy to improve the quality and safety of care. Approximately 30% of CAHs are interconnected with local physician offices and nursing homes to ensure an integrated continuum of care. While 48% of CAHs track patient allergies and pharmacy interaction information electronically, only 21% have a complete EMR system.

Grant making foundations have helped offset the cost of building a health information network by providing resources to rural hospitals, physician offices, and nursing homes. The impact of these efforts can be leveraged to maximum impact if the entire community is engaged in collaboration. Community benefits include increased health literacy, better clinical outcomes, reduced medical errors, and the elimination of duplicative efforts. The cost savings and improved patient safety from the increased efficiency would be significant.

Currently the two biggest barriers to access include lack of coverage (physicians refuse to see patients without insurance) and lack of appointments (long wait times for patients to get in to see their physicians). One method to increasing access is to expand uninsured

coverage for all Coloradoans. Another way is to open additional office visits for patients who need care. Currently it is estimated that up to 40% of office visits could be done through email, phone or fax communications (“alternative visits”) - (KILO article). If the new finance system going forward covers alternative visits, it will open several new appointment slots for patients who currently use Emergency Departments for Primary Care and those with chronic disease who, through registry tracking, are reminded that they need to come in for regular care.

## **2. How will the program affect safety net providers?**

The current payment system of limited access focuses providing care at a late point in one’s health needs, at an acute level. While the care is appropriate, it is often only accessed after the condition has progressed to a critical point. By creating a system that provides earlier access and focuses on ongoing preventive care, many conditions can be treated earlier and prevent or limit progression of the condition, eliminating or minimizing the need for more expensive acute intervention. While acute level services will always be needed to address emergencies, changes in system incentives, followed by billing efficiencies and timely payment, with a strong community emphasis on prevention and disease management, will allow more providers the means to better care for the patient. These system changes will reduce the current increased stress on safety net providers today’s system causes.

### **d. Coverage**

## **2. Does your proposal “expand health care coverage?”**

As with the issue of access, this proposal does not directly address the question of coverage, but the foundational elements have major implications for the issue of coverage. Providing safer health care, reducing the excessive administrative costs of providing care, and helping Coloradoans self-manage their health will facilitate health care dollars to go farther. These efforts will reduce the need for hospital admissions, reduce readmissions, permit better care of chronic disease such as diabetes, congestive heart failure and improve the delivery of healthier babies. Preventive care will permit greater access and better health outcomes, using our dollars more wisely.

The possibility of limiting coverage to expand access also needs to be discussed within the community. The current system fails to provide Coloradoans sufficient knowledge about their health and the costs and benefits of the various health care options and leaves coverage decisions to outsiders. Other countries and states have openly addressed the issue of limiting coverage and have established objective measures and definitions. Frequently divisions are made based on age and disease status. For example, patients over a certain age may not be eligible for organ transplants or must meet specific objective criteria before a pacemaker is allowed. Others have enforced spending limits based on set budgets. As we budget our household spending, access to lower priority services is limited if insufficient funds are available.

Whether limits on coverage are imposed or how those limits are determined will not be answered by this proposal. This discussion concerning thoughtful and appropriate limitation of care needs to occur, however, before the situation necessitates decisions. The state of Oregon has sought to have a full and open discussion on the issues identified here. Colorado needs to determine its need for a viable approach to solve this challenge of limited resources in a humane way.

The current health care system spends a substantial amount of one's total lifetime health dollars in the last 6 months of life. Considering these issues before a critical need is important. Individuals who make decisions about end of life issues in advance are more likely to make reasonable decisions, be satisfied with their decision, and avoid having decisions forced upon them in a time of crisis.

**3. How will outreach and enrollment be conducted?** Not Applicable

**4. If applicable, how does your proposal define "resident?"**

For this proposal, a resident is defined as anyone accessing care in Colorado, including Colorado citizens, non-residents visiting the state, and individuals here illegally. Under the current system, anyone can access acute care through a hospital's emergency department. The cost of providing care to those who cannot pay is "shifted" to those who

can pay. Ultimately, all Coloradoans pay the price through higher taxes and/or higher insurance premiums. Therefore, attending to the financial interest of all Coloradoans dictates that care for all individuals is addressed in any access proposal and all individuals be provided for in the most cost effective manner possible.

**e. Affordability**

**2. If applicable, what will enrollee and/or employer premium-sharing requirements be?**

Incentives need to be created within the health care system to secure an environment that rewards organized efforts to improve care and reduce costs. Employers promoting preventive care services are already demonstrating both health care outcome benefits and reduced costs (Wall Street Journal, 2006). Research has shown that early detection and intervention for chronic diseases such as heart disease, diabetes, and asthma are cost-effective. Patients, employers and families that actively participate in prevention and disease management to coordinate and improve care should see cost reductions in their premiums, copays and/or deductibles.

**3. How will co-payments and other cost-sharing be structured?**

All major health care stakeholders, including providers, professional liability insurers, funding foundations, payers, employers and other purchasers, government agencies, delivery organizations, consumers, and the various organizations representing each group, should work together to develop a coordinated strategy to leverage limited resources, facilitate information exchange, and focus targeted education messages. This alliance should build on the common goal of safe, effective health care to implement a health care system based on prevention and disease management.

For example, consumers who actively participate in the self-management of their health should pay less for their health care. To provide an incentive for self-management, co-pays and deductibles for low cost/high benefit activities, particularly for preventive care, should be reduced or eliminated. Routine health maintenance and proactive chronic disease self-management is often less expensive than acute disease treatment. Savings

generated by these activities should be passed back to the consumer, the payer and the provider. Other states have shown that free or low cost community-based health management and screening programs effectively promote self-management.

Likewise, health care facilities and providers that participate and document best or better outcomes in quality improvement and patient safety activities and who take the time to educate their patients about self-management and prevention efforts should be compensated for these efforts. Because organizations that use disease registries and maintain high performance levels or are trending in this manner are more efficient, they should be rewarded for their performance. The current health care delivery system is structured to reward doing more, not doing better, includes curative measures and procedures for acute events, and promotes payment for hospitalization. For example, telephone follow-up to patients by physician offices has been shown to reduce acute care readmissions and should be rewarded. This shift from a focus on a procedure-based payment system is critical to the success of long term reform.

**f. Portability**

**2. Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances (e.g., employment, public program eligibility) and health status change.**

Every Coloradoan should create their own electronic version of their personal health record that provides a complete medical history including, current medications (i.e., prescriptions, over the counter medications, supplements and herbal medication), clinical and family history, pharmacy contact information, and basic screening results. A living will and durable power of attorney should also be available consistent with the individual's preferences. The internet currently offers a variety of these tools through Web MD or other web sites. These individual electronic health records should be compatible with the electronic medical records (EMRs) available to providers. EMRs would include test results and other information collected by providers. This strategy would eliminate the redundant production of new records and the need for repeating costly tests every time an individual's life circumstances change. Individuals, regardless

of circumstances, will then have continuous access to their personal health record and self-management materials, making them better able to access the health care they need.

**g. Benefits:** Not applicable

**2. Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.**

Not applicable.

**3. Please identify an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g. Small Group Standard Plan, Medicaid, etc) and describe any differences between the existing benefit package and your benefit package.**

Not applicable.

**h. Quality**

**2. How will quality be defined, measured, and improved?**

The definitions of what constitutes safe care, care that improves patient outcomes, and the personal health status variables that impact the progression of disease change as medical science advances. Building on national measures developed by authorities such as the National Quality Forum, Centers for Medicare & Medicaid Services and the Joint Commission, the organizations represented by this proposal propose to work with Colorado hospitals, physician offices, nursing homes, and home health agencies to *create* a uniform set of definitions to align and strengthen the measurement, performance and reporting of safety and quality.

Work addressing health information system interoperability is currently underway and will provide a mechanism for consistently measuring performance. The HIT system will need the capacity to adapt to advances in medical knowledge and best practices. This capability has been shown to improve patient outcomes and enable better care coordination between and among care settings.

### **3. How will quality of care be improved?**

All Coloradoans have a direct interest in health care quality and safety. Medical errors are the eighth leading cause of death in this country (State of Science on Safe Medication Administration, symposium). Nearly 98,000 hospitalized Americans die each year, 268 per day, not as a result of their illness or disease, but as a result of errors in their care. These figures can only be reduced in a culture that promotes deficiency identification, root cause analyses, and provides education to improve quality and patient safety practices.

The infrastructure for quality and safety improvement already exists in Colorado. This proposal attempts to speak for over one hundred different organizations committed to improving the care delivered in Colorado. By focusing these stakeholders on the common goal of ongoing health care improvement, supplemented by strong educational efforts, existing quality and safety improvement resources can be leveraged to improve care, reduce waste, and add value to whatever other reforms the Commission endorses.

Current activities to foster a culture of continual quality improvement must continue. The resultant system improvements reliably produce better outcomes, increased patient and health provider satisfaction, and reduced costs. The appendix contains literature demonstrating the link between cost savings and quality improvement in the areas of medical errors, patient safety, quality outcomes, end of life planning, health information technology, electronic medical records, self-management, and legal system improvements.

From this literature we can identify numerous cost saving opportunities. For example, electronic medical records would ensure caregivers have the necessary information to make good decisions, facilitate transitions between care settings for patients, and prevent errors. They also provide a system to measure and subsequently improve quality. This approach is especially important given the dynamic nature of health care best practices.

By also including fiscal incentives as well as quality recognition awards combined with regulatory and tax policy changes, we believe Colorado can appropriately stimulate both personal and provider behavior change and sustain such changes to become a more efficient health system. The following is a partial list of current and future activities our partnership and the Colorado health community are working on to improve the quality of Colorado's health care system and should be continued:

#### Leadership initiatives

- Leadership training including the Institute for Health care Improvement "Get Boards on Board" campaign and Centers for Medicare and Medicaid Services' Leadership program
- Recruiting, training, and sustaining a workforce are critical (Turnover rates are directly associated with higher average cost per discharge and lower profitability as a result of increased length of stay).
- Human Factor training such as safety briefings, critical conversations, communications training.
- Teamwork training to strengthen quality improvement activities.
- Training for health profession students and professionals on evidence based practice, quality improvement processes and systems, and risk management techniques.
- Retention efforts
- Lean Methodology
- 6-Sigma and Baldrige certification opportunities

#### Detection and tracking systems

- Chart audit (e.g., root cause analysis, Plan, Do, Study, Act(PDSA))
- Institute for Health Care Improvement Global trigger tool (measuring Adverse Drug Events)
- Utilization of data for systems improvement/change
- Agency for Health Research & Quality Safety Survey

- Doctors Office Quality – Information Technology (DOQ-IT) to assist physician practices in selecting and integrating EMRs into their offices
- The Collaborative Care Network to improve communication and coordination of care (i.e., between physicians and patients, primary care and specialists) and ensure patients get the recommended care they need.

#### Organization structure

- Critical conversations
- Just Culture and transition to safety accountability
- Workflow analysis
- Improving Performance In Practice (IPIP) to assist physicians in redesigning their practices to improve patient care, efficiency and satisfaction for both patients and the healthcare team
- Develop business case for patient safety
- Provide Agency for Health Research & Quality tools for training

#### Safety Features within and among community

- Promote Healthy Handoffs
- Facilitate practice redesign

#### Core Theory

- Workload
- Ethics and quality improvement initiatives

#### Role of Technology

- Decision support systems
- Robust use of computerized records and education

#### Role of National and State Policy

- Leadership through the development of a Patient Safety Organization
- Incentives for providing the right care, at the right time, every time
- Measuring performance and improving safety, while rewarding high performance
- IHI *5 Million Lives Campaign*
- American Heart Association's *Get With The Guidelines* program

- The Joint Commission
- Centers for Medicare and Medicaid Services
- Value Exchanges

Efforts to educate consumers and providers about self-management and the timely discussion of health planning issues must continue to be made. Focusing the contributions of all public and private stakeholders and promoting the interconnectivity of local health care providers are essential to the successful completion of these programs.

#### **i. Efficiency**

##### **2. Does your proposal decrease or contain health care costs? How?**

Quality and safety are the cornerstones of cost-effective health care. Providing incentives for preventive care and self-management will increase the efficiency of the health care delivery system.

An integrated system of electronic medical records will dramatically reduce cost and increase efficiencies. In addition to increased timeliness of information and reduced duplication, this system would provide opportunities for the type of analyses that lead to new best practices. One such outcome has been the ability to better monitor and manage preventative services. The Partnership for Prevention recently ranked 25 most cost effectiveness preventive services and published the results in the July, 2006 issue of the *American Journal of Preventive Medicine*. They found that some of the least expensive services were also the most under utilized, including:

- Daily aspirin therapy, Childhood immunization, Tobacco use screening and brief intervention, Hypertension screening, Influenza and pneumococcal immunizations.

While Colorado performs better than most states in some of these areas, significant room for improvement still exists.

The potential for efficiency improvements extend deep into the health care delivery system. For example, the costs of continuously recruiting and training personnel are staggering. It is an expensive process for a hospital to fill a single nursing position. The costs are even higher in rural and underserved locations. Turnover rates have been directly linked with higher average costs per discharge and reduced profitability as a result of increased lengths of stay. Meaningful, sustainable change requires commitment to all foundational strategies highlighted by this proposal. This requires visionary leadership such as that promoted by the Institute of Health Care Improvement's "Get the Boards on Board" campaign and the Centers for Medicare & Medicaid Services' Leadership Program.

While some interventions such as PDA-based prescription ordering require an upfront investment in technology, other activities can be initiated immediately with no cost. For example, a free web-based health survey tool is available to help consumers and providers communicate more effectively. Promotion of tools such as the health survey or one's individual electronic health record clearly need to be included into ongoing consumer outreach programs.

**3. To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain.**

Better patient outcomes are achieved through the use of electronic measurement of evidence-based techniques that emphasize patient participation/empowerment, collaborative goal setting, and patient-centered problem-solving. Programs should offer incentives for both consumers and providers to comply with electronic measurement data over time and use of evidence-based techniques. Systems designed to engage patients and providers around proven models of chronic disease management are critical. These collaborative models leverage system-level best practices, strategies for proactive patient participation, and provider accountability while empowering patients with self-help tools and education.

Consumers, payers, and providers should all be rewarded for use of cost-effective behaviors. Consumers with chronic conditions should be rewarded for compliance with self-management activities. For some groups, rewards need not be significant to be effective; the incentives just need to be meaningful. The proverbial gold star from the diabetes support group for perfect attendance works when presented with sincerity. For hospitals, 1% of DRG payments are clear incentive. For physicians, a 15-20% reimbursement change may be required. (Robert Berenson, Urban Institute)

The key to effective use of incentives is application fairly and consistently across all stakeholders. Medication management follow-up visits with a case manager or nurse cost less to provide per patient than a single hospitalization for an adverse drug event. Providers should be rewarded for better patient outcomes, safer care and for saving the system money through attention to follow-up. Consumers should benefit from these savings as well, perhaps through the waiver of co-pays or deductibles.

#### **4. Does this proposal address transparency of costs and quality?**

Transparency is a fundamental shift from a culture of blame to a culture of accountability. Fear of blame can cause mistakes to be covered up and not addressed. By not learning from past mistakes, people are assured of repeating them in the future. This creates unnecessary costs:

- The cost of treating any harm caused by the error
- The cost of subsequent legal action.

When an unexpected medical result occurs, the patient safety literature says patients want three reasonable steps to be taken:

- A sincere apology
- An investigation into the event,
- Assurance that preemptive measures will be taken to prevent this from happening to someone else.

Failure to acknowledge mistakes causes patients to feel angry, betrayed and disconnected from their provider. Frustrated by the lack of accountability, they are 50% more likely to hire an attorney than if they were able to obtain information directly from the provider through full disclosure and personal communication.

Acknowledging mistakes, showing empathy and apologizing benefit all parties. For example, the costs of malpractice litigation are dramatically reduced. The University of Michigan Health System (reference) found that apologies caused the number of malpractice claims and lawsuits to drop almost 50% and the average legal expense per case was reduced by 50%. This strategy resulted in the university's legal defense budget being reduced from \$3 million to \$1 million in 18 months. Non-monetary benefits include greater provider satisfaction, increased trust within the facility, and the opportunity to learn and improve from past mistakes. The emotional well being of the patient is significant as well. Consistent with theories of restorative justice, apologies restore a person's dignity and respect, reduce anger, promote open communication, and facilitate reconciliation. Each of these elements can be linked to improved clinical outcomes.

Many of these issues stem from poor communication by health care providers once a problem has occurred. Programs using systems to assure open communication have been shown to improve the clinician-patient relationship, ensuring equitable and appropriate compensation without limiting the patient's right to take subsequent legal action. Additional efforts to foster a non-fault-based culture of quality include training students of the health professions and retraining current health professionals in evidence based practice, quality improvement processes, and risk management.

Transparency is also required if consumers are to know the positive and negative impact of their decisions. Research indicates that consumers are more likely to choose cost effective care alternatives when given information to make an educated decision. This need for information applies to every aspect of care, from choosing generic over brand-name medications to palliative care and end of life care.

## **5. How would your proposal impact administrative costs?**

When Coloradoans have access to an electronic version of the health records that are trusted by health professionals, the redundancy of recreating records would ease, causing unneeded administrative costs to decline. The increased accuracy of electronic records would also reduce administrative costs. Finally, a rationalized billing and payment structure including electronic insurance ID cards would eliminate the countless hours that health care employees and patients waste navigating the impossibly complex billing and payment systems. The administrative cost for the multitude of plans, each with different billing rates, is very high.

## **j. Consumer choice and empowerment**

### **2. Does your proposal address consumer choice? If so, how?**

This proposal will increase consumer choice across all populations. Consumers would have access to their complete medical history through their electronic personal health record. With a listing of current medications (i.e., prescriptions, over the counter medications, supplements and herbal medication), clinical and family history, and access to screening results, consumers will have the information necessary to make better informed decisions about their health. Provider contact information will make it easy for consumers to receive timely answers to their questions by calling, emailing, or faxing the appropriate provider (e.g., a pharmacist for medication questions) rather than waiting to make an unnecessary appointment with a physician.

Electronic health records would also encourage Coloradoans to discuss end of life decisions and establish a processes to ensure their wishes are followed. Once incorporated into an individual's electronic health record, caregivers, regardless of location, will know and be able to comply with these advance directives. Researchers cite the lack of access to this information as the root cause of a significant amount of patient undesired, invasive, and expensive treatments.

**3. How will your proposal help consumers to be more informed about and better equipped to engage in health care decisions?**

Patients with chronic illness need support, as well as information, to become effective managers of their own health. This proposal promotes providing consumers with information about their health and assistance building self-management skills while promoting ongoing support from health provider team members, family, friends, and the community. The health provider team can use existing assessment tools to identify patient self-management needs by asking questions about self-management knowledge, skills, confidence, supports and barriers. These tools provide the information and resources to enhance the health provider's ability to provide valuable support to consumers.

**k. Wellness and prevention**

**2. How does your proposal address wellness and prevention?**

We propose both health providers and their patients and their families engage in wellness activities and appropriate prevention efforts including: regular exercise, eating a healthy diet, using seat belts and helmets, discontinuing tobacco use, minimizing alcohol use, addressing mental health issues early and effectively, and supporting and using school based wellness programs including vaccinations, dental exams, prenatal care, and well-baby care.

Most importantly, concentrate on preventing disease in order to avoid costly treatments later. The Partnership for Prevention found that over 50% of Americans do not get the valuable preventive services they should so they ranked the health impact and cost effectiveness of 25 preventive services recommended by the U.S. Preventive Services Task Force and Advisory Committee on Immunization Practices. The results appeared in the July 2006 issue of the *American Journal of Preventive Medicine*. The top 15 underutilized preventive services that would provide the most gains, in order of magnitude, are:

- Aspirin Chemoprophylaxis, Childhood Immunization Series, Tobacco Use Screening and Brief Intervention, Colorectal Cancer Screening, Hypertension

Screening, Influenza Immunization, Pneumococcal Immunization, Problem Drinking Screening and Brief Counseling, Vision Screening-Adults, Cervical Cancer Screening, Cholesterol Screening, Breast Cancer Screening, Chlamydia Screening, Calcium Chemoprophylaxis, Vision Screening-Children

The CDC recommends screening patients to determine if they smoke or use other tobacco products, providing brief smoking cessation counseling, and offering patients therapies and referrals to help them quit. This service is one of the three most important and cost-effective preventive services that can be offered in medical practice, yet 65% of adults have not received this service as it is recommended. If offered to all smokers, even assuming only a modest success rates, the CDC estimates that \$3 billion in medical costs could be avoided annually.

Quality systems that promote wellness and prevention are key to efficient health care delivery. While good health is an obvious objective, there are financial benefits as well. Evidence-based management of chronic disease has been shown to reduce overall costs by minimizing avoidable morbidity and mortality.

All Coloradoans have ultimate responsibility for their health status and can learn to be proactive both in their participation in the health care process and the maintenance of their health and well-being. This responsibility needs to go beyond a declaration of responsibility. Coloradoans should be rewarded for engaging in wellness activities and prevention efforts that include regular exercise, eating a healthy diet, using seat belts and helmets, smoking cessation, addressing mental health issues early and effectively, minimizing alcohol use, supporting and using school based wellness programs including vaccination, dental exams, prenatal care, and well-baby care.

We must work in partnership with the entire community to activate Coloradoans as responsible consumers and to empower them to become proactive participants in health care reform. Providers and the community need to work together to provide the right mix of tools, education, and resources to manage and document care history and assess

developing needs. Regardless of the payer model, a common set of standards and tools can be used to accomplish this goal.

## **I. Sustainability**

### **2. How is your proposal sustainable over the long term?**

The current system is not sustainable. This proposal outlines an investment in systems and education that can effectively and efficiently address the health care challenges of the future. While much of the infrastructure and experience are in place, there is no hiding the fact that reforms will cost money initially. Up front costs include the cost of making system changes, promoting collaboration, and establishing an integrated information network that supports a transparent, non-punitive culture of safety and quality. The proposal evaluation firm can calculate the cost of these investments. The attached appendices illustrate the magnitude of the expected returns. Once implemented, a system of safety and quality, supported by HIT, personal wellness and prevention, and administrative simplification, will continue to sustain itself until all waste is removed from the system.

### **3. How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.**

Coloradoans spent \$22.4 billion on health care in 2004. Obviously, even a small percentage reduction in costs would amount to millions of dollars. Evidence suggests that one of the most effective ways to reduce total costs is to direct more resources to preventive health services. Better management of congestive heart failure, for example, could save Coloradoans over \$40 million a year. Nationally, the Center for Information Technology Leadership estimates that the improved efficiencies and reduced errors offered by electronic medical records could save at least \$94 billion per year. Even with Colorado responsible for only 1.43% of national medical spending, this effort would represent a potential annual savings of \$1.35 million.

### **4. Who will pay for any new costs under your proposal? Not Applicable**

- 5. How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please explain.**

This proposal presents a means by which to align the goals of all health care stakeholders in a manner that will allow waste to be eliminated, efficiencies maximized, and outcomes improved. The net result would be a healthier more cost-effective system.

- 6. Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.** Not applicable

- 7. (Optional) How will your proposal impact cost-shifting? Please explain.**

Not applicable.

- 8. Are new public funds required for your proposal?** Not applicable.

- 9. (Optional) If your proposal requires new public funds, what will be the source of these new funds?** Not applicable.

**m. A single page describing how your proposal is either comprehensive or would fit into a comprehensive proposal.** Already included, will fit into comprehensive proposals and are essential cost reduction components of any comprehensive proposal.

**n. (Optional) A single page describing how your proposal was developed.**

CFMC began by attending Commission hearings and sharing thoughts with our existing partners. Through ongoing discussions, we sought to distinguish the important concepts and identify the areas where we could provide the greatest value. After attending the RFP meetings, we worked collaboratively with our partners and individual contributors to develop this response, and have proactively shared the concepts in this proposal with multiple organizations.