



# Flashpoints and Fixes

An Asset and Gap Analysis of  
Barriers to Care for Coloradans  
with High Health Needs



**APRIL 6, 2015**

Prepared by the Colorado Health Institute  
for The Colorado Health Access Fund of The Denver Foundation



## Dear Colorado Community,

The Colorado Health Access Fund was created by a donor to The Denver Foundation with a commitment to Coloradans with high health care needs. This commitment led to the development of a Field of Interest Fund designed to invest statewide to increase access to health care for those with high health care needs by being responsive to the local climate and looking for long-term solutions.

Before launching the Colorado Health Access Fund at The Denver Foundation, we took the time to understand the unique health care needs within various regions throughout our state. We respect the good work already being done, and we are committed to having a meaningful impact. To design our funding model, we asked the Colorado Health Institute to collect data, building on existing community health assessments and filling in the gaps with additional data, both numbers and stories, to understand the climate of health in Colorado. This comprehensive approach gave us a full understanding of the needs right now. While the Colorado Health Access Fund advisory committee determined that it will focus on the issue of behavioral health care, we hope that this report will provide information that will help many in the community to identify gaps and opportunities in health care funding.

We know that the health care landscape will continue to change. We are also committed to maintaining the relevance of the fund. This will require ongoing evaluation of the health care climate and evaluation of grantees that are directly impacted through the Colorado Health Access Fund.

Currently, there is a substantial investment in health care across Colorado, and this fund is one of many sources committed to improving health and increasing access to care for Coloradans. We will work with funding partners to ensure that we are aware of and supporting one another's efforts. We are committed to continuing these conversations in the years to come. Together, we can explore how to collectively sustain the efforts of this work to ensure it has a long-lasting impact.

This report will help to inform the impressive work that is already occurring and the work yet to be completed. As we continue to invest in communities, we will report back on our acquired knowledge. We look forward to learning from the communities and our partners as well.

Sincerely,



**David Miller**  
President and CEO  
The Denver Foundation



**Monica Buhlig**  
Director, Basic Human Needs  
The Denver Foundation



**Michele Lueck**  
President and CEO  
Colorado Health Institute

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## **CHI staff members contributing to this report:**

- Jeff Bontrager, Principal Investigator
- Brian Clark
- Rebecca Crepin
- Amy Downs
- Joe Hanel
- Kathy Helm
- Deborah Goeken
- Tamara Keeney
- Michele Lueck
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- Anna Vigran
- Hannah Wear

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## **About the Colorado Health Institute**

The Colorado Health Institute is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. The Colorado Health Institute is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

# Flashpoints and Fixes

## An Asset and Gap Analysis of Barriers to Care for Coloradans with High Health Needs

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# Introduction

*Now is a time of rapid change for health and health care in Colorado, with many positive developments underway.*

*More than 300,000 people signed up for public or private insurance in Colorado during the initial open enrollment of the Affordable Care Act (ACA) in late 2013 and early 2014. Many more have enrolled since, with Medicaid clients topping 1 million for the first time in history.*

Health care experts and advocates across the state are working to ensure that the health system delivers care more effectively and efficiently. State government is leading efforts to change how some of our most vulnerable residents receive care.

But while these are important first steps, much work remains to be done. Many Coloradans still lack insurance and may for years to come. And even those with insurance, especially the newly insured and those covered by public insurance programs, are encountering obstacles when they attempt to use their insurance cards to get health care.

Opportunities abound for The Colorado Health Access Fund to make a difference in the lives of people across Colorado by improving their access to care. The Colorado Health Access fund is a Field of Interest Fund at The Denver Foundation. A Field of Interest fund is separate from The Denver Foundation's community grantmaking, and has specific criteria designed for the use of the funds based upon the original intent of the fund's creators. In this case, The Colorado Health Access Fund is committed to supporting programs and activities that generally promote access to health care and strive to improve health outcomes for populations in Colorado with high health care needs.

The Colorado Health Institute was engaged to study the state of health and health care in Colorado and identify opportunities to intervene in meaningful ways.

Our analysis addresses four essential questions:

- *What barriers do Coloradans with high health care needs face when accessing care?*
- *How do these barriers differ by region?*
- *What solutions or approaches hold promise for improving access?*
- *How can The Colorado Health Access Fund support improved access – and improved health – across the state?*

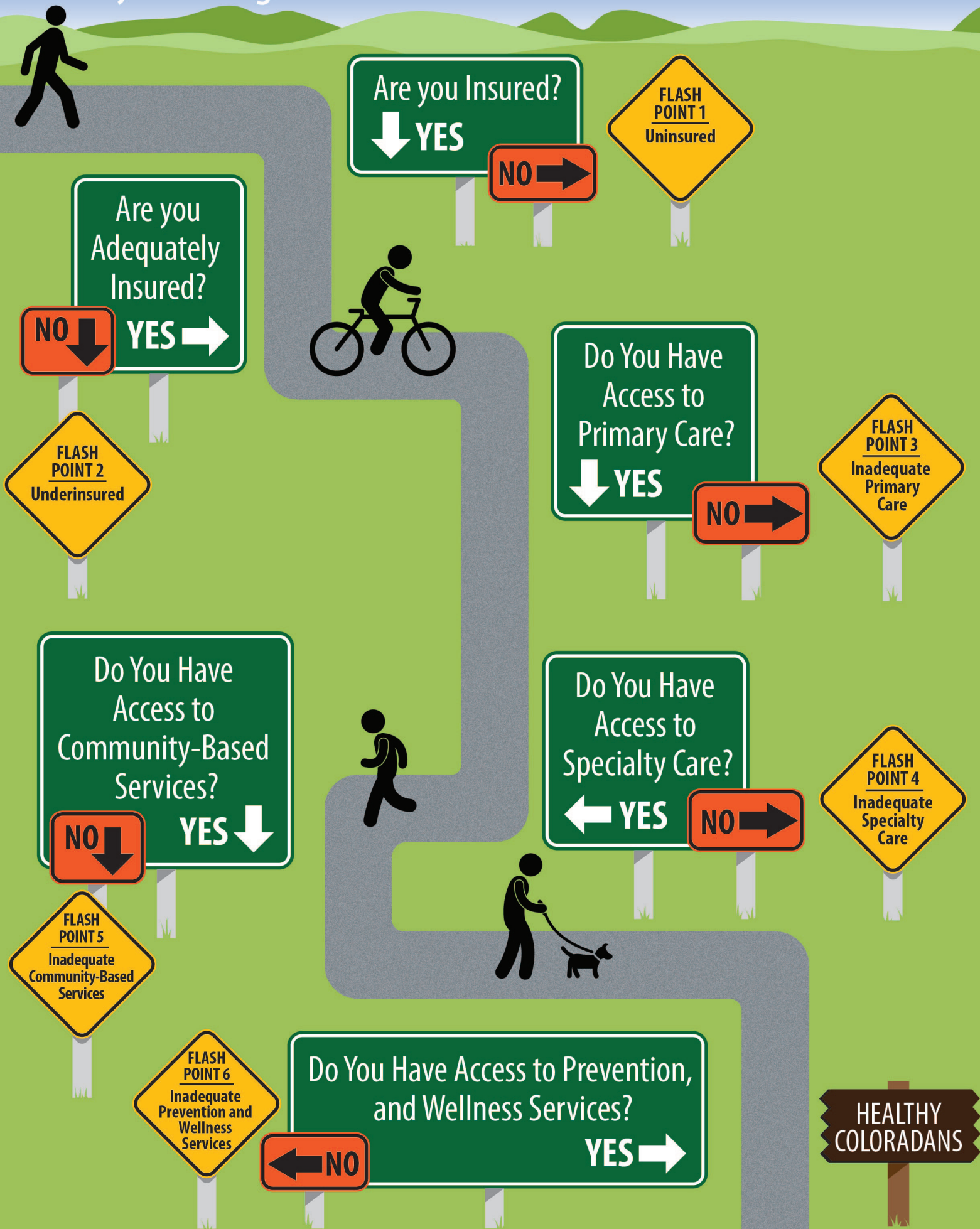
To prepare this report, the Colorado Health Institute analyzed quantitative data, relying especially on the Colorado Health Access Survey (CHAS)<sup>1</sup>, the most comprehensive look at Coloradans' health, and supplemented it with additional sources. We conducted a series of key informant interviews with health experts around the state. And we convened nine regional community dialogues to solicit insight on the greatest needs and the best opportunities for grantmaking at a local level.

We developed a theory of change model that identified six flashpoints where Coloradans seeking access to health care most often encounter barriers. The six flashpoints are: being uninsured or underinsured, or having inadequate primary care, specialty care, community-based services or preventive care support.

This theory of change model, titled "The Path to

Figure 1.

# Theory of Change: The Path to Better Health



Better Health,” is illustrated on the previous page in Figure 1. Building on this theory of change, the Colorado Health Institute constructed an overall grantmaking strategy, identified potential funding areas and offered specific funding strategies.

We believe that this report sets the stage for The Colorado Health Access Fund to invest over the next eight years to help make Colorado, its communities and its residents as healthy as possible.

## Key Findings and Recommendations

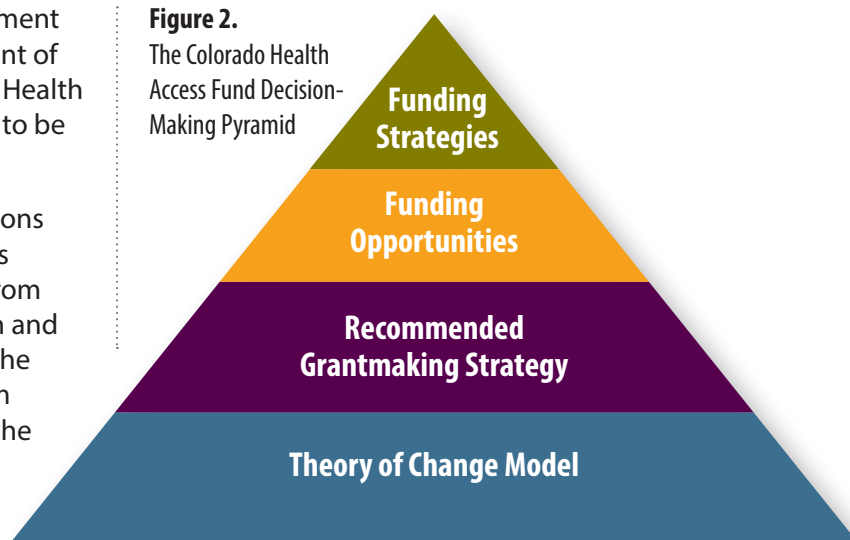
Moving from concept to reality – and from assessment to investment – is the most challenging component of creating a grantmaking strategy for The Colorado Health Access Fund. There is much work and much good to be done with these funds.

The key findings and grantmaking recommendations presented here are based on research and analysis that the Colorado Health Institute has compiled from the most current data resources, relevant research and analysis, interviews with key stakeholders across the state, robust community dialogues, learnings from Colorado’s health funders, and our experience in the health and health policy arena.

This section covers four components that the Colorado Health Institute has identified to provide a strong foundation moving forward, framed as The Colorado Health Access Fund Decision-Making Pyramid:

- **Theory of Change Model** addresses the rationale for the proposed Colorado Health Access Fund grantmaking approach. It identifies the six flashpoints of need, the levers that will effect change, and the outcomes we anticipate. This is the foundational thinking for a successful strategy and mindful grantmaking.
- **Recommended Grantmaking Strategy** identifies four leadership questions that we recommend be addressed in order to ensure the fund is successful and impactful.
- **Funding Opportunities** identifies the needs that were revealed by the asset and gap analysis and that align with the fund’s focus areas.

**Figure 2.**  
The Colorado Health Access Fund Decision-Making Pyramid



- **Funding Strategies** reveals recommendations based on an analysis and synthesis of the qualitative and quantitative research and framed around the six access to care flashpoints.

### Theory of Change Model

The Colorado Health Institute proposes a theory of change that focuses on six flashpoints where Coloradans with high health care needs may experience barriers when they attempt to access health care.

The central principle of the change theory is that as these flashpoints are improved – market by market, for both individuals and families – overall health and well-being will

#### Thoughts from the Field

*“In small communities, when you’re used to working with nothing, it’s amazing what we can do with something.”*

*Participant in Alamosa dialogue*



# The Flashpoints

*Our research suggests that there be a focus on these flashpoints as a decision factor when approving grants under The Colorado Health Access Fund.*

## Flashpoint 1: Uninsured

Insurance coverage is, in many cases, a necessary first step to accessing health care for most Coloradans. But even with significant improvement resulting from the Affordable Care Act and other health reforms, many Coloradans will remain uninsured, often for the long term.

## Flashpoint 2: Underinsured

Merely having insurance is often not enough. Having sufficient insurance that covers health needs and that is accepted by nearby providers helps to secure access. Many newly insured Coloradans are covered by Medicaid or have enrolled in the lowest-cost bronze level plans through the marketplace and may find themselves unexpectedly underinsured.

## Flashpoint 3: Inadequate Primary Care

Primary care, including behavioral health care, is often the first stop for many Coloradans attempting to access health care. And often it is not easy to find a primary care provider to accept their insurance or make an appointment.

## Flashpoint 4: Inadequate Specialty Care

Coloradans frequently encounter high obstacles when they need to see a specialist, especially patients who are uninsured, underinsured or covered by public insurance. The lack of necessary specialty care has long been a problem in Colorado, and it appears that it may become more acute heading forward.

## Flashpoint 5: Inadequate Community-Based Services

We found significant gaps in support for Coloradans who may be transitioning from care providers, including hospitals, into home- and community-based programs.

## Flashpoint 6: Inadequate Prevention and Wellness Services

Colorado has a number of areas that must improve in order to provide and support the prevention, wellness and self-care programs that we now know can make such a difference in health and quality of life.

improve. Investing in the right mix of flashpoints will accelerate improvement in specific markets and for specific populations of Coloradans.

The six access to care flashpoints provide a framework to assess how health care can be optimized for most Coloradans, particularly those with high needs. The ability to get efficient and effective health care when it is needed and where it is needed is fundamental to ensuring that Coloradans are as healthy as possible.

## Grantmaking Strategy

We recommend that the grantmaking strategy for The Colorado Health Access Fund focus on these four strategic areas:

- 1. Find the Focus.** Create a targeted grantmaking road map.
- 2. Support the Legacy.** Pay tribute to the original and intended use of these funds.
- 3. Partner Regionally.** Design a platform that encourages communities to collaborate in order to leverage the funding.
- 4. Maintain Momentum.** Build on innovations and investments already in place and develop strategies for sustainability.

### 1. Find the Focus

At first glance, the fund seems large. However, the investment the fund will make across the state over the next eight years must be considered within the context of great need. Money could be spent easily without making a significant impact. Investing wisely and strategically is essential in order for The Colorado Health Access Fund to make a true and lasting difference.

The Colorado Health Institute suggests several potential approaches for narrowing the focus:

- **Choose Specific Access to Care Flashpoints:** For example, an appropriate strategy may be to focus on increasing access to primary care or specialty care, or both, particularly because so many Coloradans have gained health insurance.
- **Select Specific Subpopulations:** The fund could decide to target Coloradans who will remain

vulnerable, either because they are not eligible for insurance coverage, even with all of the health reforms, or because they have obtained coverage that does not cover their medical costs and they are underinsured.

- **Spotlight Key Innovations:** This strategy would center on innovations that, based on current evidence, expand access to care, such as community health workers or specific applications of telehealth.

Regardless of the direction selected, it will be crucial to clearly focus the funding opportunity. While a number of stakeholders suggested the importance of this tactic, Colorado's health funding community expressed it most emphatically.

## 2. Support the Legacy

Honoring the original and intended use of these funds is an important consideration. In particular, understanding how people with high health needs access health care and then using this knowledge to reduce personal barriers are historically important aspects of these funds. The fund did not focus on systems or policy-level changes, opting to support individual areas of need.

The Colorado Health Institute recommends that The Colorado Health Access Fund grants be directed in a similar manner. Some ideas include:

- **Increasing Health Literacy** and health coverage literacy of Coloradans with high health needs.
- **Building Capacity** of patient navigators and community health workers so that more people get the care and education they need.
- **Addressing Transportation or Telehealth Infrastructure** to ensure patients gain access to care in rural and underserved areas.

## 3. Partner Regionally

Communities usually have an intimate understanding of the obstacles faced by their residents. They pride themselves on their collaboration and strong relationships. This collaborative spirit was addressed

in multiple ways across the state in the community dialogues. We recommend creating a grant strategy that recognizes this expertise by:

- **Encouraging** grant applicants to leverage existing local and regional partnerships in their proposals.
- **Building long-term relationships** with leadership of existing collaboratives to gain an understanding of real-time access issues over the next eight years.
- **Building on** assessments to understand the need. Existing analyses can be used, such as the public health priorities identified by local public health departments and nonprofit hospitals around Colorado. These assessments were developed by community experts based on an analysis of available data and identified health priority areas in local communities. In addition, all Area Agencies on Aging are completing community assessments as part of a four-year planning process which will serve as a valuable resource examining the needs of seniors and people with disabilities.
- **Securing an expert** on regional health partnerships on the Advisory Committee, such as the Colorado Coalition for the Medically Underserved's Colorado Network of Health Alliances.

Depending on how The Colorado Health Access Fund is focused, this may take shape in different ways. The funding strategy should be adaptable enough and flexible enough to address the "pain points" in a community. Depending on the focus of The Colorado Health Access Fund, communities can prioritize which topics require the most attention using the data in this report or other sources. Then they can apply for funding to address their greatest needs.

## 4. Maintain Momentum

The Colorado Health Access Fund can be used to build on existing infrastructure and programs, leveraging their impact. Communities may elect to

build on initiatives that are underway or partner with other local funders – such as community foundations – to build better facilities and programs.

Another strategy would be to partner with statewide health funders. Sustainability will be a key consideration. We have found that many communities are wary of

limited-term grant-funded programs because they create expectations from community members for services that may no longer be available once the grant funding runs out. Working in partnership is a key step toward sustainable strategies.

**Table 1.** Colorado Health Access Fund Focus Areas and Key Findings.

| Educating Those with High Health Needs as Well as Families and Caregivers  |   |
|--|---|
| Challenges   | Solutions   |
| Low health literacy – and low health insurance literacy specifically – prevents many vulnerable and newly insured Coloradans from effectively navigating the health care system and using their benefits.            | Promising approaches include high school and community college financial management curricula that include a coverage focus and leveraging opportunities to use or train patient navigators, community health workers and Connect for Health Colorado’s coverage guides to educate patients in culturally appropriate ways. |
| Transitions in Care  |   |
| Challenges   | Solutions   |
| Transitions between the home and the health care system are flashpoints when patients are particularly vulnerable.   | Community health workers and patient navigators link patients to the health care system and assist them once they are in.   |
| Innovations in Care Delivery   |   |
| Challenges   | Solutions   |
| Access to specialty care in rural and other underserved areas is a challenge across Colorado, particularly for psychiatry, pain management, neurology, dermatology and endocrinology.                                | Telehealth holds great promise in this area.  |
| Improved Access to Care, Particularly in Rural Communities   |   |
| Challenges   | Solutions   |
| <b>Behavioral Health:</b> Major barriers include stigma in seeking mental health services, especially in rural areas, and lack of psychiatrists, children’s behavioral health services and inpatient rehabilitation. | Opportunities exist to support models of care that integrate behavioral and physical health as well as development of behavioral health workforce and infrastructure. Stigma may best be addressed in rural areas through integration and stigma programming in schools and other settings.                                 |
| <b>Transportation:</b> Seniors, people with disabilities, those with low incomes, and rural residents face significant challenges in finding transportation to needed care.  | Non-profit and provider-based transportation service programs around the state. Physical consolidation of services in one location to minimize transportation needs.  |
| <b>Affordability:</b> High premiums and high cost-sharing deter many people from getting insurance or using it effectively once they have it.  | Few solutions were proposed. Related approaches include support for safety net programs for the uninsured and underinsured, patient navigators to educate about preventive services that have no cost-sharing, and health insurance literacy programs to better understand benefits.  |

## Funding Opportunities

The Colorado Health Institute's asset and gap analysis found that the key barriers to accessing affordable and effective health care – and the promising strategies to address those barriers – strongly align with the four focus areas identified by The Colorado Health Access Fund (See Table 1). The key findings summarized here represent the needs most frequently cited in the community dialogues and the one-on-one interviews and are supported by our analysis. We are also presenting the challenges and potential solutions within these focus areas. They suggest specific funding opportunities for The Colorado Health Access Fund.

## Suggested Funding Strategies

Based on an analysis and synthesis of the qualitative and quantitative research conducted by the Colorado Health Institute, we offer these suggested funding strategies framed around the six access to care flashpoints.

These are cross-cutting strategies that will reach thousands of Coloradans, including those with high health care needs, and that incorporate the four focus areas of interest identified by The Colorado Health Access Fund: health education, care transitions, delivery innovations and improved access to care.

### Flashpoint 1: Uninsured

Address the high barriers to coverage faced by the uninsured. Support efforts that: increase awareness of low-cost health insurance options; mitigate the effects of churning on and off of insurance; and increase the quantity and quality of safety net care.

### Flashpoint 2: Underinsured

Address the health and financial consequences faced by the underinsured. Support efforts that: increase awareness of the pros and cons of enrolling in specific “metal levels;” build health literacy about plan benefits, cost-sharing, and how to best use coverage to access needed medical care.

### Flashpoint 3: Inadequate Primary Care

Increase the availability and accessibility of primary care. Support efforts that: integrate primary care and behavioral health care; improve the cultural competence of primary care providers; promote innovative approaches that expand the primary care workforce; and reduce the stigma surrounding behavioral health care.

### Flashpoint 4: Inadequate Specialty Care

Increase the availability and accessibility of specialty care. Support efforts that: further the use of telehealth and other innovative technologies that connect

people in remote areas to specialists; provide needed transportation; and build self-care education tools for patients in remote areas.

### Flashpoint 5: Inadequate Community-Based Services

Increase the availability and effectiveness of community-based services. Support efforts that: empower Coloradans who are transitioning from hospitals or care facilities to their homes or communities with knowledge and supportive services; increase the community, home and transportation infrastructures; focus on non-health areas such as housing and transportation.

### Flashpoint 6: Inadequate Prevention and Wellness Services

Increase the availability and effectiveness of prevention and wellness initiatives. Support efforts that: work upstream to keep Coloradans healthy; promote partnerships with community organizations such as churches and local health departments; increase knowledge of chronic disease self-management; implement curricula to recognize signs of behavioral health issues.

#### Thoughts from the Field

*“I believe innovation exists and we have not had the dollars and the bandwidth to document it and share it.”*

*Participant in Denver metro dialogue*

# The State of Health and Health Care Access in Colorado

An estimated 14.3 percent of Coloradans – about 741,000 people – lacked health insurance in 2013.

The year 2014 saw the beginning of many coverage expansions under the Affordable Care Act (ACA). About 150,000 people had enrolled in private insurance through the state's new marketplace, Connect for Health Colorado. Enrollment in Medicaid surpassed 1 million people for the first time in the wake of the legislature's decision to expand eligibility.

With these developments, the conversation in Colorado's health and health care community is shifting from getting more people insured to making sure that they have access to good quality and affordable health care that addresses the Triple Aim goals of improving health, improving quality and lowering costs.

Colorado is a prime testing ground for health care innovation that tackles these goals. The state has invested in a major initiative – the Accountable Care Collaborative – that connects Medicaid enrollees with coordinated care and medical homes. Recently, this program was expanded to Coloradans dually enrolled in Medicaid and Medicare.

The state has also continued its focus on integrating behavioral and physical health care with the award of a \$65 million federal State Innovation Model (SIM) grant. Finally, new initiatives focused on “big data” and technology – such as telehealth, the All-Payer Claims Database and interoperability between electronic health records – hold promise for new ways of delivering health care.



BRIAN CLARK/CHI

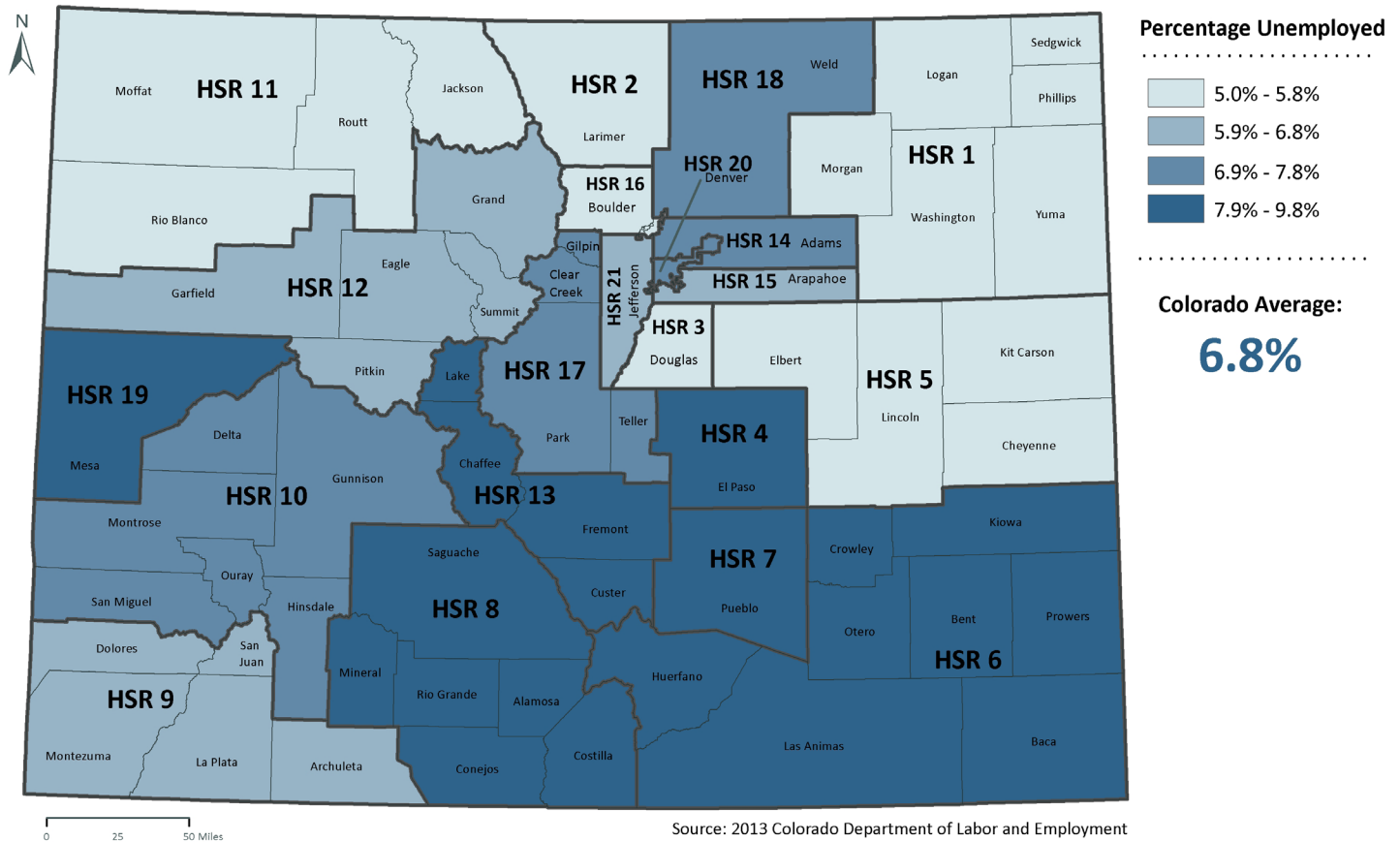
## What it Means

The Colorado Health Institute used a broad definition of “high health care needs” to conduct this study. Our definition includes people who: have multiple chronic or acute health conditions, lack insurance coverage, earn a low household income, live in a rural area, are homeless, lack legal documentation, have a disability, come from a culture different from the mainstream, or don't speak English well. Any of these factors can make it difficult to access care. Many people have more than one high health care need.

It is becoming clear that increasing enrollment in health insurance does not necessarily guarantee better access to care. For example, 13 percent of Coloradans with public insurance such as Medicaid or Medicare were

## Map 1. Unemployment

Percentage of Coloradans Who are Unemployed, by Health Statistics Region, 2013



turned away by physicians who did not accept their type of coverage, more than twice the rate of those with private insurance, according to the CHAS. Shortages of primary care providers have been documented in some regions.

The economy plays a crucial role in access to care. Colorado continues to recover from its worst economic slowdown since the Great Depression. Colorado's unemployment rate stood at 4.8 percent in 2008. It rose to 8.9 percent in 2010 before dropping to 6.8 percent in 2013.

When jobs disappeared, so did health insurance for many Coloradans. Uninsured rates peaked in 2011 at 15.8 percent and then fell to 14.3 percent in 2013, but did not reach the pre-recession level of 13.5 percent, according to the CHAS.

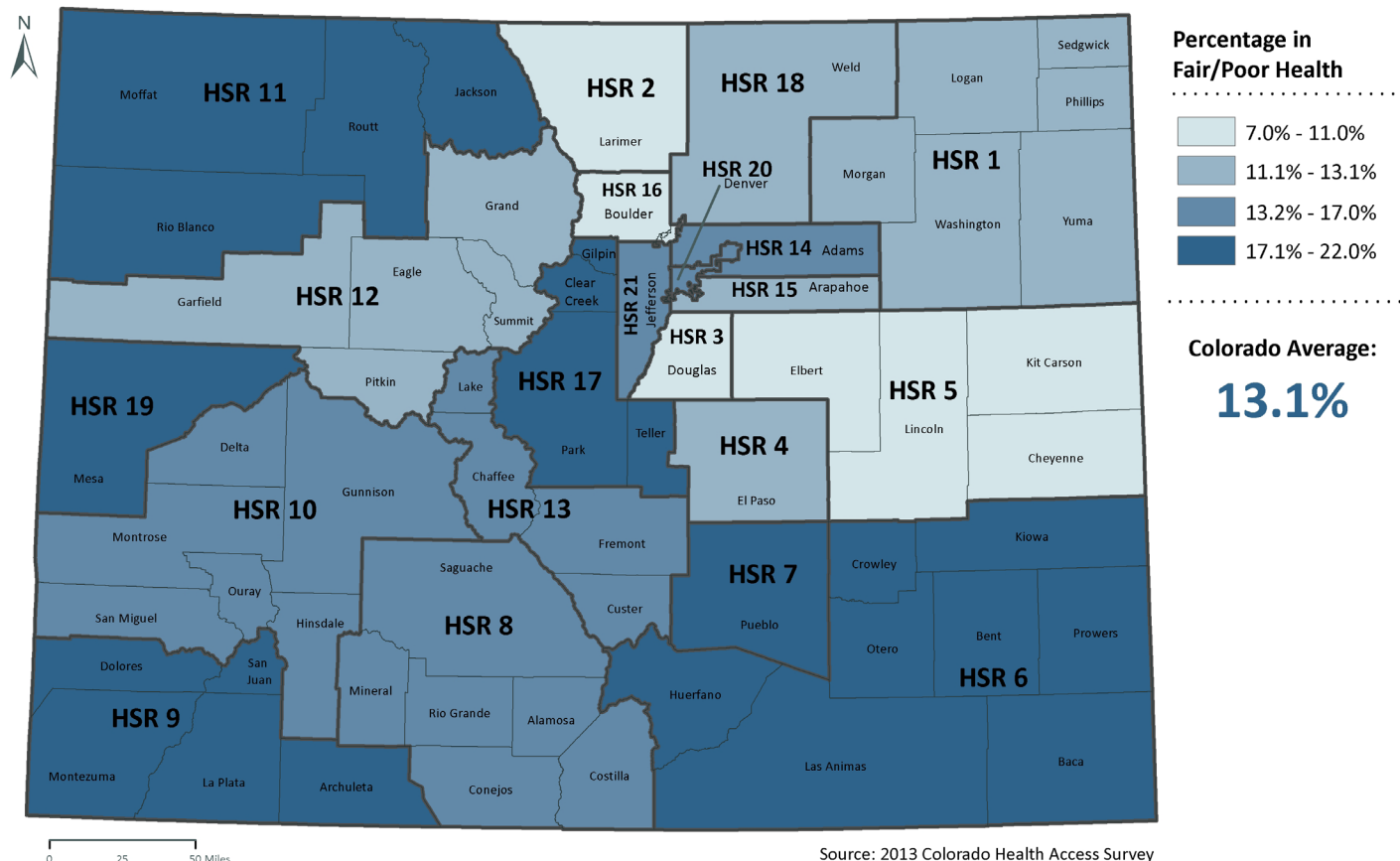
The recovery in Colorado has not played out equally

across the state. Unemployment remains high in southeastern Colorado, Pueblo County and the San Luis Valley. (See Map 1.) About one of three residents of the southeastern plains and the San Luis Valley live below the federal poverty level of \$11,670, or \$23,850 for a family of four. Drought and the recession led one Pueblo commentator to label the southeastern corner of the state as "Colorado's Detroit." When the local economy struggles, it places greater stress on local health systems, many of which are already financially fragile.

Finally, access to care is even more complicated for Coloradans with high health needs. Many economically depressed areas also have a relatively high percentage of residents reporting poor health such as the southeastern plains, Pueblo County and Mesa County (See Map 2.) Although Colorado ranks as one of the fittest states in the country, it still has rising rates of chronic diseases such as diabetes, high blood pressure and obesity.

**Map 2. Poor Health**

Percentage of Coloradans Who Report That Their General Health is Fair or Poor, by Health Statistics Region, 2013



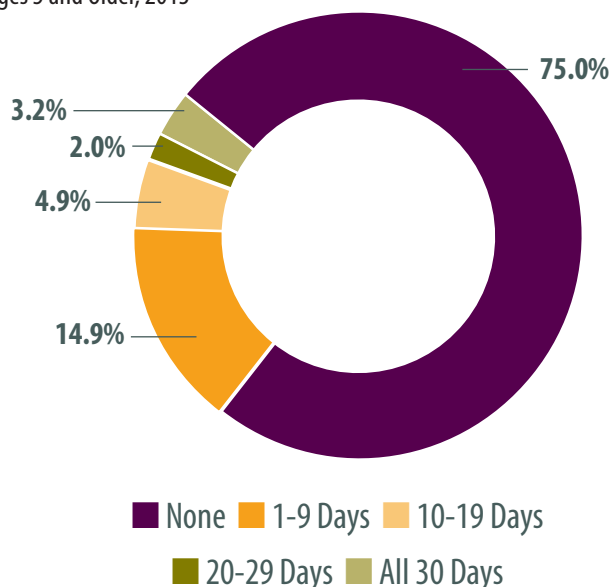
Mental health is another unmet need for many Coloradans, and health care experts are coming to appreciate the links between mental and physical health. People in poor mental health are more likely to report poor physical health as well, according to the 2013 CHAS (See Figure 3).

The aging of the Baby Boomers is creating what many are labeling the “senior tsunami.” The population of Coloradans ages 65 and older is projected to increase by 32 percent by 2020, faster than any other age group.

**Conclusion**

An aging population, the growing number of insured Coloradans and a health care workforce that isn't keeping up – especially in underserved and economically fragile areas – are coalescing to create new demands on the state's health care system.

**Figure 3. Number of Poor Mental Health Days During the Past 30 Days, Ages 5 and Older, 2013**



Source: 2013 Colorado Health Access Survey



## CHI's Analysis:

# A Description of the Methodology

The Colorado Health Institute used both quantitative and qualitative data to prepare this asset and gap analysis of access to care across Colorado. Together, these two approaches provided a comprehensive picture of this complex topic.

Our analysis addressed four essential questions:

- What barriers do Coloradans with high health care needs face when accessing care?
- How do these barriers differ by region?
- What solutions or approaches hold promise for improving access?
- How can The Colorado Health Access Fund support improved access – and improved health – across the state?

To answer the questions, we used survey data to give consistent measures of health and access, both at statewide and regional levels, while subject matter experts and community stakeholders identified promising solutions, as well as nuances that may not be reflected in survey data.

## Quantitative Data

Our review of quantitative data began with several data sources measuring health needs and barriers to accessing health care. These included the Colorado Health Access Survey (CHAS), the Behavioral Health Risk Factor Surveillance Survey, labor and employment data, and demographic data from the American Community Survey.

We selected measures to include based on their relevance to the identified access to care flashpoints, availability of the data both at state and sub-state levels to show regional variation, and inclusion of Coloradans regardless of their health insurance status. We also sought out measures that indicate high health needs, including obesity, aging, self-reported health status and

socioeconomic indicators associated with unmet health care needs, including poverty and unemployment.

We then analyzed these data for geographic variation. The first step was identifying which regions were above or below state average. Next, we used ArcGIS mapping software to identify natural breaks in the data to better show which regions were further from the state average – either above or below.

This analysis identified natural groupings in the data, showing which regions are most similar. The results of this analysis group regions of Colorado in one of four categories: those most above the state average, those closer to the state average but still higher, those a bit below the state average, and those furthest below the state average. These maps are included throughout this report.

Table 2 on page 18 illustrates the regional variation revealed by the data. Regions with the greatest need, those most above the state average, are in red. Regions with the lowest level of need, those furthest below the state average, are in green. The two middle categories – those regions closest to the state average – are shown in yellow.

It is important to note that in a few cases the qualitative data collected from local stakeholders contradict findings from the quantitative data.

## Qualitative Data

The first step in collecting qualitative data for this project began with key informant interviews. We conducted 14 hour-long interviews, with subjects who have statewide expertise on access to care, innovations in care delivery, transitions in care and educational approaches to improve health and the effective use of the health care system.

We made sure to include key informants with extensive experience working with populations that have high health needs or face particularly high barriers to care,





**Rifle was the site** of one of nine community dialogues.

such as people with disabilities or those who do not speak English well. We also selected experts on certain kinds of care such as mental health. These conversations explored how access to care in Colorado has changed in the past few years in the wake of state and federal health care reforms as well as barriers to care and ongoing efforts to improve access.

We sought input from the philanthropic community. A breakfast meeting at the Colorado Health Institute brought together representatives from the Colorado Health Foundation, The Colorado Trust, Rose Community Foundation, Caring for Colorado Foundation, Community First Foundation and The Denver Foundation. Our objectives included gathering advice about successful health care grantmaking strategies, understanding the latest thinking among Colorado's leading funders, avoiding duplicative efforts, and setting the stage for potential collaborations.

The Colorado Health Institute also administered an online survey of community foundations across the state to learn about their funding priorities to avoid duplication and to discern potential opportunities to leverage The Colorado Health Access Fund's grantmaking work.

Next, we conducted a series of nine community dialogues to explore barriers to care and promising solutions. We were particularly interested in how answers vary by region. We identified seven regions and convened meetings in Alamosa, Denver, Durango, Fountain, Greeley, La Junta and Rifle. These regions and cities were identified

collaboratively with The Colorado Health Access Fund to include both rural and urban representation, geographic accessibility and opportunities to build on existing relationships.

In total, 92 participants attended these regional meetings. The Colorado Health Institute invited key leaders knowledgeable about access-to-care issues in their communities. We also targeted a few specific groups of experts, including the leadership of health care safety net clinics, local public health departments, area agencies on aging and regional health alliances. We asked invitees to share the invitation with others in their community who they thought should be part of this discussion. This ensured that the discussion was not limited to our existing connections in those communities. In addition to this outreach, Colorado's community foundations were invited to participate in these dialogues and extend the invitation to colleagues.

Two more community dialogues included groups with specific expertise. One was with the Colorado Health Institute's Safety Net Advisory Committee, which meets regularly to discuss access to care challenges and solutions. Thirty-nine attendees participated.

We developed a set of standard focus group questions that each facilitator followed. The facilitators recorded barriers and solutions on flipchart sheets for each of the flashpoints. At the end of each session, participants were asked to "vote" on three solutions in which they would invest. The areas that garnered the most votes are identified as takeaways in the community dialogue summaries in Appendix A.

The questions were also discussed during a meeting in Vail with the directors of Colorado's six Area Health Education Centers. Since that was a smaller group, we used a conversational format without flipcharts or priority "voting."

Finally, seven key informant interviews were conducted after the community dialogues to gather more information on topics that had emerged as priorities. For example, community health workers came up as a popular approach to increasing health literacy and access to care, so we interviewed Andrea Dwyer, a researcher at the University of Colorado Denver, who is helping lead the Colorado Patient Navigator and Community Health Worker Collaborative to gain a better understanding of ongoing work on this topic.

We also conducted second-round key informant interviews with experts on telehealth services, mental health and community-based care for older adults to add to our understanding.

Summaries of all key informant interviews and community dialogues are included in Appendix B.

## Review of other assessments

Several other organizations have conducted assessments that explore access to care issues. Many of those informed this assessment, including the public health priorities identified by local public health departments, recommendations from the statewide Community Living Advisory Group and past research by the Colorado Health Institute and The Colorado Trust.

## Analysis

Taken together, these three approaches provided a multi-dimensional understanding of access to care in Colorado and how it varies by region.

The quantitative data identified which regions are doing better or worse than the state as a whole on several indicators of need for health care and ease of use. While

the quantitative data provide the “what,” the qualitative data from statewide experts and community stakeholders provided the “why” behind the numbers.

In some cases, this further supported the topics prioritized in the quantitative data and provided promising interventions to improve health and access to care. Sometimes the qualitative data showed a different story than the quantitative data, illustrating community-level nuances that aren’t captured in survey data.

We reviewed the priorities of local public health agencies and state level recommendations from groups such as the Community Living Advisory Group. These assessments point to options for collaboration with ongoing work, much of which is focused on the topics that emerged as priorities in both the quantitative and qualitative data.

Through analysis of these data, we have identified which needs are most pressing for each of the six flashpoints for access to care as well as promising approaches to improve both access and health. Many of these themes emerged consistently across the state. Regions where particular needs are more pronounced are identified in the discussion of each flashpoint.

## How to Use This Report

This report is designed to support and accelerate the formation of the final grantmaking strategy and process.

- The six flashpoints for access allow the advisory committee, potential grantees and the funder to identify where proposed programs and services will make an impact on access. This shared framework illustrates where needs are greatest and where investment activity may be targeted.
- Maps throughout the report reveal regional variations that will be helpful to consider.
- The Health Hotspots matrix compares access to care variables related to the six flashpoints by the state’s 21 Health Statistics Regions. This allows stakeholders to understand the relative need for investment in a market compared with the state.

- The Options and Opportunities section included in each flashpoint chapter identifies promising strategies, existing programs or solutions identified through qualitative analysis.

## Interpreting Health Hotspots

The Health Hotspots matrix synthesizes and summarizes the regional variations across Colorado related to health care needs and access to care barriers. The table also shows the priorities identified in the state’s health needs assessments.

The data indicators compiled by the Colorado Health Institute from a variety of sources are designed to help illuminate the flashpoints framework.

The core of the matrix is seven measures from the 2013

Colorado Health Access Survey that focus on access to care barriers. They are the percentage of the population that was:

- Uninsured;
- Underinsured (spending at least 10 percent of annual income on out-of-pocket medical expenses or five percent for families below 200 percent of the federal poverty level);
- Unable to get an appointment to see a doctor;
- Unable to get needed medical care because the cost was too high;
- Unable to see a specialist because the cost was too high;
- Unable to get needed care because they didn't have transportation;
- Unable to get needed mental health care.



BRIAN CLARK/CHI

In addition, Health Hotspots features three indicators to provide context on populations that may experience high health care needs. They are:

- Percentage of adults who are obese, with a body mass index (BMI) of 30 or more.<sup>2</sup>
- Percentage of Coloradans who describe their health as "fair" or "poor," the two lowest options.<sup>3</sup>
- Projected percentage increase in the number of Coloradans ages 65 and older by 2020.<sup>4</sup>

Because access to care is so closely linked with economic conditions, we include two socioeconomic indicators:

- 2013 unemployment rates.<sup>5</sup>
- Poverty, measured by the percentage of the population below the federal poverty level.<sup>6</sup>

### Interpreting the Table

The color-coding is tied to the maps throughout the report and in Appendix D. Red represents the regions that are worse compared with the state average (the darkest blue on the maps), and green represents regions with the best numbers (the lightest blue on the maps). The yellow shading includes the two categories just above and just below the state average.

The table may be read across rows by region or down the columns by topics. For example, the affluent counties of Douglas County (Region 3) and Boulder and Broomfield (Region 16) have fewer residents with access to care problems, as suggested by the green shading. Specialty care tends to be an issue in many rural and urban underserved areas, including Adams and Arapahoe counties and the Eastern Plains, shown by the red shading.

Finally, the table includes a summary of regional health needs identified by Colorado's local public health agencies. Throughout 2012 and 2013, the local public health agencies prioritized health needs as part of Colorado's Public Health Improvement Plan. Each agency undertook an extensive analysis to identify and prioritize the most pressing health needs in their communities.

This table is intended to complement findings from the Colorado Health Institute's qualitative analysis. Occasionally, the quantitative data do not support what we heard in our qualitative research. However, we believe that it can be used as a tool to evaluate at a glance the most pressing needs within a region.

Table 2. Health Hotspots

■ Better than state average ■ At or around state average ■ Worse than state average

| Region<br>Colorado Health Statistics Regions                              | FLASHPOINT 1 | FLASHPOINT 2  | FLASHPOINT 3                   | FLASHPOINT 3                     | FLASHPOINT 3                   | FLASHPOINT 4                         | FLASHPOINT 4                      | FLASHPOINT 5                      |
|---|--------------|---------------|--------------------------------|----------------------------------|--------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|
|   | Uninsured    | Under-insured | Could not get in to see doctor | Did not see a doctor due to cost | Did not get mental health care | Did not see a specialist due to cost | Did not get care due to transport | Aging (Growth in 65+ pop by 2020) |
| <b>1</b> Logan, Sedgwick, Phillips, Morgan, Washington, Yuma              | 15.3%        | 22.7%         | 13.9%                          | 13.4%                            | 8.0%                           | 14.5%                                | 6.1%                              | 12.2%                             |
| <b>2</b> Larimer  | 15.1%        | 12.9%         | 14.0%                          | 7.6%                             | 7.4%                           | 8.8%                                 | 3.2%                              | 32.6%                             |
| <b>3</b> Douglas  | 5.4%         | 14.7%         | 10.5%                          | 5.2%                             | 4.7%                           | 5.1%                                 | 1.0%                              | 49.3%                             |
| <b>4</b> El Paso  | 13.1%        | 12.0%         | 14.8%                          | 9.8%                             | 7.8%                           | 11.3%                                | 5.9%                              | 31.4%                             |
| <b>5</b> Elbert, Lincoln, Kit Carson, Cheyenne                            | 9.3%         | 20.8%         | 11.2%                          | 6.9%                             | 9.0%                           | 10.1%                                | 2.7%                              | 37.1%                             |
| <b>6</b> Crowley, Kiowa, Otero, Bent, Baca, Prowers, Huerfano, Las Animas | 16.7%        | 20.4%         | 14.1%                          | 10.9%                            | 7.2%                           | 11.7%                                | 4.7%                              | 16.0%                             |
| <b>7</b> Pueblo   | 10.9%        | 13.1%         | 16.7%                          | 15.3%                            | 7.0%                           | 14.4%                                | 3.3%                              | 26.5%                             |
| <b>8</b> Saguache, Mineral, Rio Grande, Alamosa, Conejos, Costilla        | 16.8%        | 14.7%         | 19.3%                          | 9.4%                             | 3.9%                           | 7.9%                                 | 6.2%                              | 22.3%                             |
| <b>9</b> Dolores, San Juan, La Plata, Montezuma, Archuleta                | 15.2%        | 20.9%         | 15.2%                          | 11.7%                            | 6.3%                           | 12.6%                                | 4.8%                              | 36.3%                             |
| <b>10</b> Delta, Gunnison, Montrose, San Miguel, Ouray, Hinsdale          | 22.7%        | 10.7%         | 15.5%                          | 15.6%                            | 7.9%                           | 11.5%                                | 5.2%                              | 21.7%                             |
| <b>11</b> Moffat, Routt, Jackson, Rio Blanco                              | 24.8%        | 12.5%         | 16.1%                          | 14.8%                            | 5.4%                           | 9.3%                                 | 2.4%                              | 33.9%                             |
| <b>12</b> Garfield, Eagle, Grand, Summit, Pitkin                          | 19.4%        | 13.0%         | 15.6%                          | 9.2%                             | 5.6%                           | 14.8%                                | 3.7%                              | 51.1%                             |
| <b>13</b> Lake, Chaffee, Fremont, Custer                                  | 12.8%        | 15.5%         | 18.0%                          | 12.8%                            | 8.4%                           | 14.9%                                | 5.4%                              | 21.9%                             |
| <b>14</b> Adams   | 15.3%        | 16.3%         | 13.4%                          | 16.3%                            | 12.4%                          | 14.5%                                | 5.4%                              | 34.9%                             |
| <b>15</b> Arapahoe  | 16.9%        | 12.3%         | 18.4%                          | 13.3%                            | 7.2%                           | 13.7%                                | 4.5%                              | 35.5%                             |
| <b>16</b> Boulder, Broomfield   | 11.8%        | 12.3%         | 12.5%                          | 12.9%                            | 7.7%                           | 9.1%                                 | 1.2%                              | 37.3%                             |
| <b>17</b> Gilpin, Clear Creek, Park, Teller                               | 13.8%        | 16.8%         | 15.9%                          | 13.5%                            | 16.9%                          | 14.3%                                | 9.2%                              | 40.7%                             |
| <b>18</b> Weld  | 9.3%         | 13.1%         | 22.0%                          | 16.6%                            | 1.2%                           | 11.4%                                | 4.2%                              | 38.0%                             |
| <b>19</b> Mesa  | 18.5%        | 15.6%         | 10.3%                          | 13.7%                            | 7.5%                           | 11.3%                                | 2.9%                              | 29.9%                             |
| <b>20</b> Denver  | 18.4%        | 11.1%         | 16.0%                          | 14.1%                            | 8.9%                           | 13.4%                                | 7.6%                              | 24.4%                             |
| <b>21</b> Jefferson   | 11.6%        | 17.2%         | 12.9%                          | 12.5%                            | 9.6%                           | 12.5%                                | 2.2%                              | 32.1%                             |
| <b>Colorado average</b>   | <b>14.3%</b> | <b>13.9%</b>  | <b>15.0%</b>                   | <b>12.3%</b>                     | <b>7.8%</b>                    | <b>11.9%</b>                         | <b>4.4%</b>                       | <b>32.3%</b>                      |

Table 2 (continued). Health Hotspots

■ Better than state average ■ At or around state average ■ Worse than state average

| Region<br>Colorado Health Statistics Regions                              | FLASHPOINT 6<br>SOCIAL DETERMINANTS OF HEALTH |                         |                        |                      | Local Public Health Priorities  |
|---|---|-------------------------|------------------------|----------------------|---|
|   | Obesity                                       | Fair-poor health status | Percent jobless (2013) | At or below 100% FPL |   |
| <b>1</b> Logan, Sedgwick, Phillips, Morgan, Washington, Yuma              | 27.3%   | 12.9%                   | 5.4%                   | 25.8%                | Physical Activity, Nutrition, Healthy Weight  |
| <b>2</b> Larimer  | 17.5%   | 10.7%                   | 5.4%                   | 26.3%                | Mental Health, Raising Healthy Kids   |
| <b>3</b> Douglas  | 17.2%   | 7.9%                    | 5.4%                   | 17.4%                | Mental Health   |
| <b>4</b> El Paso  | 23.6%   | 11.3%                   | 8.0%                   | 22.9%                | Obesity   |
| <b>5</b> Elbert, Lincoln, Kit Carson, Cheyenne                            | 24.9%   | 10.0%                   | 5.2%                   | 21.6%                | Substance Use, Obesity, Oral Health, Unintended Pregnancy, Teen Sexual Health, Chronic or Heart disease, Mental Health, Tobacco           |
| <b>6</b> Crowley, Kiowa, Otero, Bent, Baca, Prowers, Huerfano, Las Animas | 28.9%   | 18.7%                   | 8.2%                   | 32.1%                | Obesity, Chronic or Heart Disease, Unintended Pregnancy, Access to Care, Substance Use  |
| <b>7</b> Pueblo   | 29.7%   | 21.4%                   | 9.6%                   | 25.4%                | Obesity, Unintended Pregnancy   |
| <b>8</b> Saguache, Mineral, Rio Grande, Alamosa, Conejos, Costilla        | 24.3%   | 15.3%                   | 9.1%                   | 35.3%                | Clean Air & Water, Mental Health, Substance Use, Obesity, Safe Food, Capacity Building, Access to Care, Chronic or Heart Disease, Tobacco |
| <b>9</b> Dolores, San Juan, La Plata, Montezuma, Archuleta                | 16.9%   | 18.0%                   | 6.4%                   | 25.2%                | Obesity, Access to Care   |
| <b>10</b> Delta, Gunnison, Montrose, San Miguel, Ouray, Hinsdale          | 18.4%   | 16.0%                   | 7.6%                   | 23.0%                | Clean Water, Obesity, Mental Health, Substance Use, Safe Food   |
| <b>11</b> Moffat, Routt, Jackson, Rio Blanco                              | 18.5%   | 17.1%                   | 5.8%                   | 24.0%                | Oral Health, Injury Prevention, Mental Health, Clean Air, Clean Water, Substance Use, Unintended Pregnancy                                |
| <b>12</b> Garfield, Eagle, Grand, Summit, Pitkin                          | 10.8%   | 12.4%                   | 6.5%                   | 20.5%                | Mental Health, Substance Use, Obesity, Access to Care, Chronic or Heart Disease, Older Adults, Clean Air, Maternal/Child Health           |
| <b>13</b> Lake, Chaffee, Fremont, Custer                                  | 24.5%   | 15.1%                   | 8.1%                   | 24.8%                | Obesity, Oral Health, Mental Health, Substance Use, Unintended Pregnancy, Clean Air, Clean Water, Safe Food, Access to Care               |
| <b>14</b> Adams   | 27.0%   | 16.6%                   | 7.5%                   | 24.8%                | Mental Health   |
| <b>15</b> Arapahoe  | 22.4%   | 12.9%                   | 6.5%                   | 25.8%                | Mental Health   |
| <b>16</b> Boulder, Broomfield   | 13.9%   | 8.0%                    | 5.4%                   | 21.3%                | Mental Health, Substance Use, Obesity   |
| <b>17</b> Gilpin, Clear Creek, Park, Teller                               | 19.4%   | 18.7%                   | 6.9%                   | 15.9%                | Disease Prevention, Injury Prevention, Mental Health, Substance Use, Obesity, Access to Care, Chronic or Heart Disease, Transportation    |
| <b>18</b> Weld  | 31.2%   | 12.4%                   | 7.1%                   | 23.7%                | Mental Health, Substance Use, Obesity   |
| <b>19</b> Mesa  | 24.3%   | 17.5%                   | 8.1%                   | 22.8%                | Mental Health, Obesity, Unintended Pregnancy  |
| <b>20</b> Denver  | 19.8%   | 13.1%                   | 7.0%                   | 29.6%                | Mental Health, Obesity, Access to Care, Healthy Living  |
| <b>21</b> Jefferson   | 17.5%   | 13.8%                   | 6.3%                   | 20.2%                | Obesity   |
| <b>Colorado Average</b>   | <b>21.3%</b>                                  | <b>13.1%</b>            | <b>6.8%</b>            | <b>24.0%</b>         |   |

## Comparing the Qualitative and Quantitative Findings

Most of the findings displayed in Table 2 align with themes from our qualitative research. Occasionally, however, the quantitative data do not support what we heard in the community dialogues and key informant interviews.

### Transportation

Lacking transportation to obtain needed care is one area where the quantitative data and the qualitative data tell different stories. It was not identified as a major barrier to care by the Colorado Health Access Survey (CHAS), with just over four percent of Coloradans indicating they couldn't obtain health care due to transportation challenges.

The CHAS data do not report if care was delayed due to lack of transportation. This barrier was raised repeatedly in community discussions across the state, especially in rural areas. In Denver County (HSR 20), 7.6 percent of residents indicated insufficient transportation in the CHAS – higher than the state average – and a key informant identified it as a major barrier for seniors in Denver. Transportation did not, however, emerge as a theme in the Denver focus group.

### Mental Health

Access to mental health care is another topic where community discussions often did not reflect the survey data. For example, CHAS data suggest that fewer people in the San Luis Valley (HSR 8) do not get the mental health services they need compared with the state average.

Participants in the Alamosa discussion indicated that this did not match their experience. They suggested that many people in their community might not realize they need mental health services or do not want to

admit this need. They interpreted the data to mean that the community needed to increase education about mental health and reduce stigma, as well as increase the capacity to provide services.

Communities from other areas of the state that showed better than average access to mental health services, including parts of northwest Colorado (HSRs 11 and 12) and Weld County (HSR 18), also voiced concern about access to mental health services as well as access to substance use disorder treatment.

### Specialty Care

Access to specialty care was also an area where the survey data and the community discussion diverged. This was particularly true in the San Luis Valley (HSR 8). While the CHAS data show this region doing better than the state average, with a smaller percentage of the population reporting they did not forgo needed specialty care due to cost, community members said this did not match their experience.

### Aging

Finally, the aging of the population requires additional discussion. Many regions that are projected to see the slowest growth in the population age 65 and older by 2020 already have a high proportion of seniors. Therefore, even areas where projected growth in the aging population is lower than average, the overall senior population is already high – with the notable exception of Denver.

### Conclusion

The Colorado Health Institute's qualitative and quantitative analysis are intended to be complementary. Despite occasional discrepancies between these two sets of findings, we are confident that Table 2 can be used as a tool to evaluate at a glance the most pressing needs within a region.

# Flashpoint 1: Uninsured

## The Problem

Being uninsured is hazardous to people's health – and their financial future. Health insurance can open the door to better health and more stable finances, while lacking insurance often prevents people from getting the care that can head off expensive medical problems down the road.<sup>7</sup>

About 741,000 Coloradans, or one of seven residents, did not have health insurance in 2013, according to the Colorado Health Access Survey (CHAS). Many Coloradans have gained insurance in 2014 with the expansion of Medicaid eligibility and the launch of Connect for Health Colorado, both part of the Affordable Care Act (ACA).

Despite this progress, however, hundreds of thousands of Coloradans still do not have health insurance.

Looking ahead, the Colorado Health Institute projects that a number of populations will remain among the long-term uninsured, including those without legal documentation, mixed documentation families, people who can't afford coverage, and those who may be eligible for public insurance but don't know how to go about enrolling.

## The Data

Estimating the number of Coloradans who are becoming insured – as well as those who aren't enrolling in health insurance – is a moving target, particularly because Connect for Health Colorado is not asking enrollees whether they already had insurance. A reliable estimate will be available after the CHAS is fielded in February 2015 following the end of the second open enrollment period.

A Gallup survey released in August estimated the state's uninsured rate among adults had fallen to 11 percent, down from Gallup's estimate of 17 percent uninsured

rate in 2013. (Note that this estimate differs from the CHAS 2013 uninsured estimate of 14.3 percent.)

Being without health insurance on a long-term basis is more common than short gaps in coverage in Colorado. It is also a more difficult problem to solve. Four of five uninsured Coloradans have been without coverage for at least a year. Among uninsured Coloradans, 10 percent report never having coverage.

The high cost of health insurance ranks as the top reason for being uninsured. But nearly one of five uninsured Coloradans (17.2 percent) does not know how to get health insurance.

### Thoughts from the Field

*"Insurance is about taking thoughtful preparation for some risk in the future. That's impossible for people to understand who are living in extreme poverty and living day to day. Their frame of mind is living in the now, not planning for the future."*

*Participant in Greeley dialogue*

More than one of four young adults between 19 and 26 (27.1 percent) do not have health insurance, meaning that this group, often called the "young invincibles," has the highest rate of uninsurance of any age group in Colorado.

And Hispanic Coloradans are disproportionately uninsured. Approximately 26 percent of the population identifies as Hispanic, but Hispanics represent 38.6 percent of the uninsured.

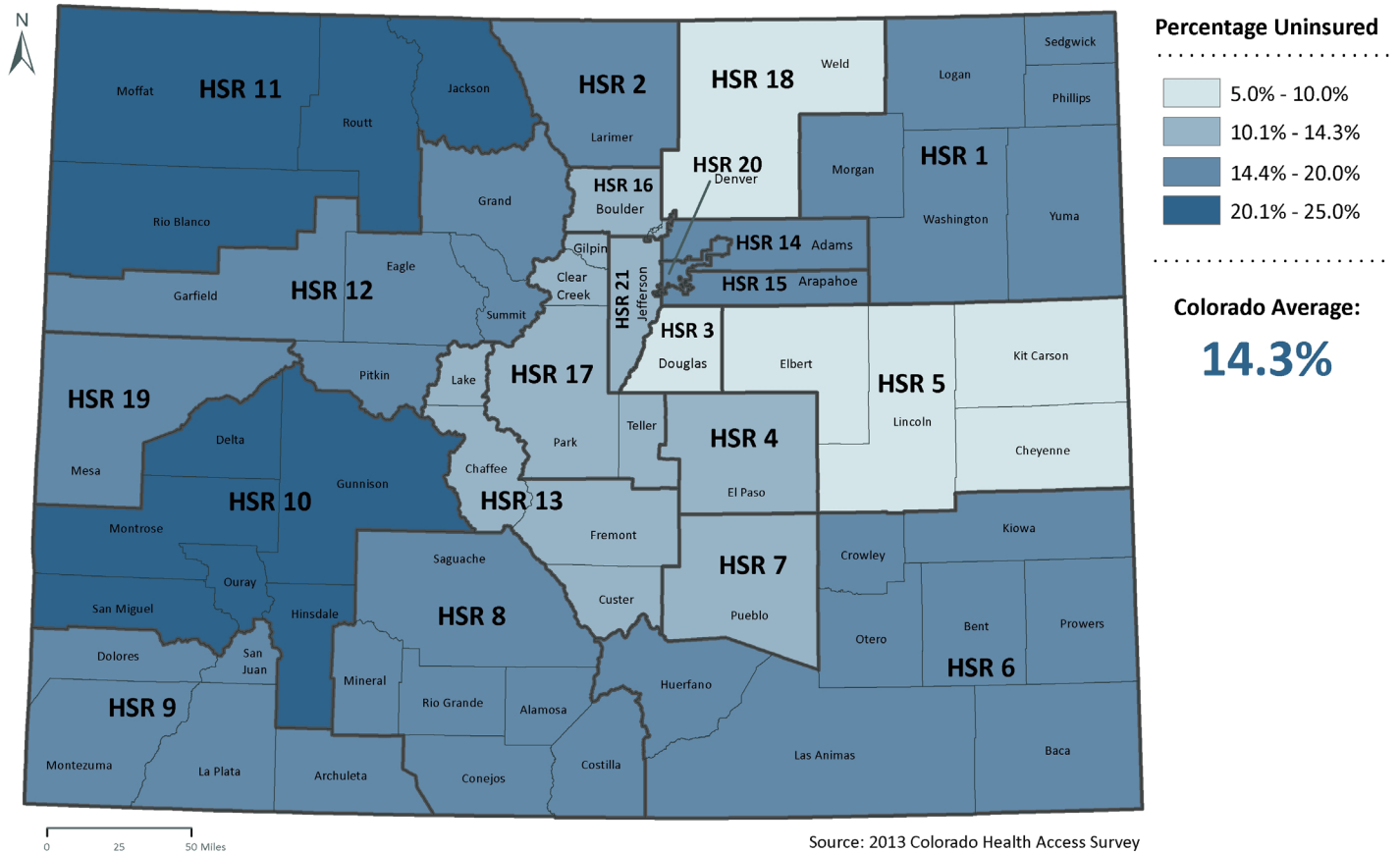
Regional variation in insurance coverage is significant. In northwest Colorado, one of four people were uninsured, the highest rate in the state. By sheer numbers, nearly a third of the state's uninsured live in Denver and Arapahoe counties. (See Map 3.)

Affluent counties like Douglas, Boulder and Broomfield have higher than average proportions of their populations covered by private insurance. Less well-to-do regions, like Pueblo County, also have a lower rate of uninsured people, but that is because of high enrollment in public insurance programs, Medicaid, Child Health Plan *Plus* (CHP+) and Medicare.

Although lacking insurance creates a significant barrier to seeking services, it does not mean that care

Map 3. Uninsured

Percentage of Coloradans Who Are Uninsured by Health Statistics Region, 2013



is unavailable. The health care safety net serves low-income Coloradans and other vulnerable Coloradans, including the uninsured, underinsured and those on Medicaid.

Community health centers, rural health clinics, school-based health centers, community mental health centers, faith-based clinics and other community safety net clinics create a patchwork of care across Colorado. Colorado's community health centers served 498,828 people,<sup>8</sup> 37 percent of them uninsured, in 2013. Community safety net clinics – including faith-based clinics, those staffed by volunteer clinicians and family practice residency clinics – served another 152,000 people.<sup>9</sup>

Since 2011, 11 new community health center locations have opened as a result of ACA New Access Point Grants. Despite this investment, however, many safety net providers are experiencing increased demand as more Coloradans are enrolled in Medicaid and the state's population grows.

## Regional Expertise

The Colorado Health Institute conducted interviews with experts around the state as well as nine community dialogues. Access to care for people who remain uninsured came up in three of the community dialogues. Specifically, undocumented immigrants



are not eligible to enroll in Medicaid or to buy private policies sold on the insurance marketplace. Cultural factors and a fear of deportation compound problems with access to care for this population.

The majority of uninsured Coloradans (82.0 percent) reported the cost of insurance as a reason they were uninsured. Our research found that affordability is still very much an issue across Colorado and not only for Coloradans with low incomes. Middle income Coloradans – those who make too much to qualify for public coverage or financial assistance – are still finding health insurance unaffordable and don't enroll. Other Coloradans have not enrolled in coverage because they decided they don't need it or they might not realize they are eligible for coverage and possibly tax credits for premium assistance.

Another vulnerable group is people who have “churned” between being insured and uninsured, or between different types of insurance, such as Medicaid and private coverage, because of changes in their income. Churn is a critical issue because people may go without insurance for months or may find that they must change providers when they change insurance.

Our informants cited several other barriers to becoming insured. Information about insurance may not be presented in culturally appropriate ways, people may not understand how insurance works, or they may balk at the high cost of private insurance. Others might not sign up for Medicaid or other programs because no nearby care providers accept that insurance.

## Options and Opportunities

Many uninsured people are still able to access health care through safety net clinics, which accept patients even if they don't have insurance. For example, community health centers and school-based health centers are safety net clinics. A full list of the kinds of

## Regional Finding

Participants in the La Junta community dialogue said that many uninsured residents who are eligible for Medicaid do not enroll due to anti-government sentiment.

clinics that are part of the safety net, as well as where they are located across Colorado, are included in Map 14. General operating support for these clinics is one way to improve access to care for the uninsured.

Churn could be reduced through better data sharing among Medicaid and Connect for Health Colorado, the insurance marketplace. If clients could be identified before they lose coverage, case workers could help them either update the paperwork to renew their coverage or transition into private coverage.

We found it notable in our community dialogues that only one person said the first priority should be getting more people enrolled in coverage. Instead, the focus was

on improving health insurance literacy so people know how to use their coverage.

## Takeaways

- Even with the expansion of public and private coverage under the ACA, a lack of insurance remains the first barrier to accessing health care for hundreds of thousands of Coloradans.
- Barriers to getting insured include churning on and off of eligibility, refusing to enroll, not having legal documentation, not knowing how health insurance works, and not being able to find a nearby provider.
- Funding for the health care safety net – which serves everyone regardless of their insurance – is an opportunity to address the needs of the remaining uninsured.

## Suggested Funding Strategies

Address the high barriers to coverage faced by the uninsured. Support efforts that: increase awareness of low-cost health insurance options; mitigate the effects of churning on and off of insurance; and increase the quantity and quality of safety net care.

## Flashpoint 2: Underinsured

### The Problem

Underinsurance, while often less understood and less discussed than uninsurance, ranks as a significant barrier to getting health care for many Coloradans. And it stands to become a bigger problem because tens of thousands of Coloradans chose to buy the least expensive Bronze-level plans through the insurance marketplace.

A policyholder is underinsured if his or her plan doesn't cover necessary medical expenses, resulting in out-of-pocket expenses that eat up 10 percent of annual incomes – five percent for those with annual incomes below 200 percent of the federal poverty level.

It's possible that many people think their coverage is adequate until they get a big doctor's bill in the mail. Others may decide that the expected out-of-pocket costs make it too expensive to even schedule an appointment in the first place.

Underinsurance is on the minds of many health care leaders and advocates in Colorado in the wake of the first round of open enrollment under the Affordable Care Act. Coloradans selected Bronze plans, which have lower premiums but the highest levels of cost-sharing, at nearly double the national rate.

Hawaii (41 percent) and Colorado (40 percent) had the highest proportion of marketplace enrollees selecting a Bronze plan in the nation.<sup>10</sup> The U.S. average was 20 percent.

The most common barrier to health care for the underinsured is affordability. However, the Colorado Health Institute identified two more common problems faced by the underinsured: Difficulty understanding their insurance benefits as well as how to access health care and not having a nearby provider who accepts their plan.

#### Thoughts from the Field

*"Health care is least affordable for people who have coverage because they can't afford high deductibles."*

*Participant in Durango dialogue*

### The Data

About 720,000 Coloradans were underinsured in 2013, roughly the same number as the uninsured. (See Map 4.) This means that more than one of four Coloradans (28.2 percent) were either uninsured or underinsured.

The age group between 50 and 64 had the highest underinsured rate at 17.2 percent, followed by the 19- to 29-year-olds at 12.9 percent. When looking at race/ethnicity, blacks had the highest underinsured rate at 15.8 percent. Those below the poverty level had an underinsured rate of 27.7 percent compared with a 2.1 percent rate for people at four times the poverty level.

Finally, the underinsured reported their health as fair or poor, the two lowest levels, at nearly twice the rate as the adequately insured.

Again, there are important regional variations in underinsurance. The Eastern Plains and southwest Colorado had underinsurance rates of more than 20 percent, highest in the state. An aging population on the Eastern Plains might explain the high rates of underinsurance there. Many retired people live off their assets, which drives up the ratio of their medical spending to their incomes.

Jefferson County had the highest rate of the urban counties at 17.2 percent.

### Regional Expertise

Many private insurance policies have deductibles that can reach several thousand dollars a year, which is unaffordable for many families. Participants in the community dialogues indicated that high deductibles are a serious problem.

## Regional Findings

The median income in southeast Colorado is \$28,078 compared with the state median of \$35,990. Only the San Luis Valley has a lower median income, at \$24,859. Residents there are very sensitive to the cost of insurance. On the opposite end of the spectrum, the high cost of living in resort areas such as Durango means that families with higher incomes cannot afford health insurance either. These middle-income earners make too much to qualify for Medicaid or financial assistance through the state health insurance marketplace, but they are not wealthy enough to afford the premiums and cost-sharing.

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In Greeley, with its large Latino and immigrant population, participants in the community dialogue stressed the need to provide not just Spanish-language education, but culturally appropriate education. For example, many Latinos do not purchase goods and services over the Internet, yet much of the marketing surrounding the Affordable Care Act has been geared toward the online marketplace.

Health insurance literacy came up as an issue at every community dialogue and in many key informant interviews. People could benefit from health insurance literacy education at several points:

- **Enrolling:** Merely signing up for insurance is confusing. Those attempting to purchase private insurance through Connect for Health Colorado encountered a number of problems during the first open enrollment, including having to be deemed ineligible for Medicaid before applying for financial assistance. They also had to figure out whether their doctor was included in a plan's network.
- **Upon becoming insured:** Half of uninsured Coloradans have lacked insurance for at least three years and 10 percent have never had insurance, according to the CHAS. The newly insured may not understand concepts like co-pays and deductibles.

- **Upon seeking services:** People may not know where to go to seek care and how to interact with the health care system. Many do not know that there is no co-pay for most preventive services, an Affordable Care Act provision that went into effect in late 2010.
- **After receiving services:** The newly insured may not be expecting a bill and might need help interpreting an explanation of benefits form.

Our informants stressed that coverage does not guarantee access to health care. Even though people might have an insurance card, they sometimes can't find a provider who accepts their type of coverage. A lack of Medicaid providers is the biggest problem, stemming from poor reimbursement rates. Fewer providers are accepting Medicare as well. Some providers, like psychiatrists, are in such high demand that they will not even take private insurance and accept only cash-paying clients.

## Options and Opportunities

People interviewed by the Colorado Health Institute had few ideas for addressing the high cost of health insurance and reimbursement costs. Health literacy initiatives could be promising.

### Education

Participants in our Durango dialogue suggested adding health literacy to community college curricula.

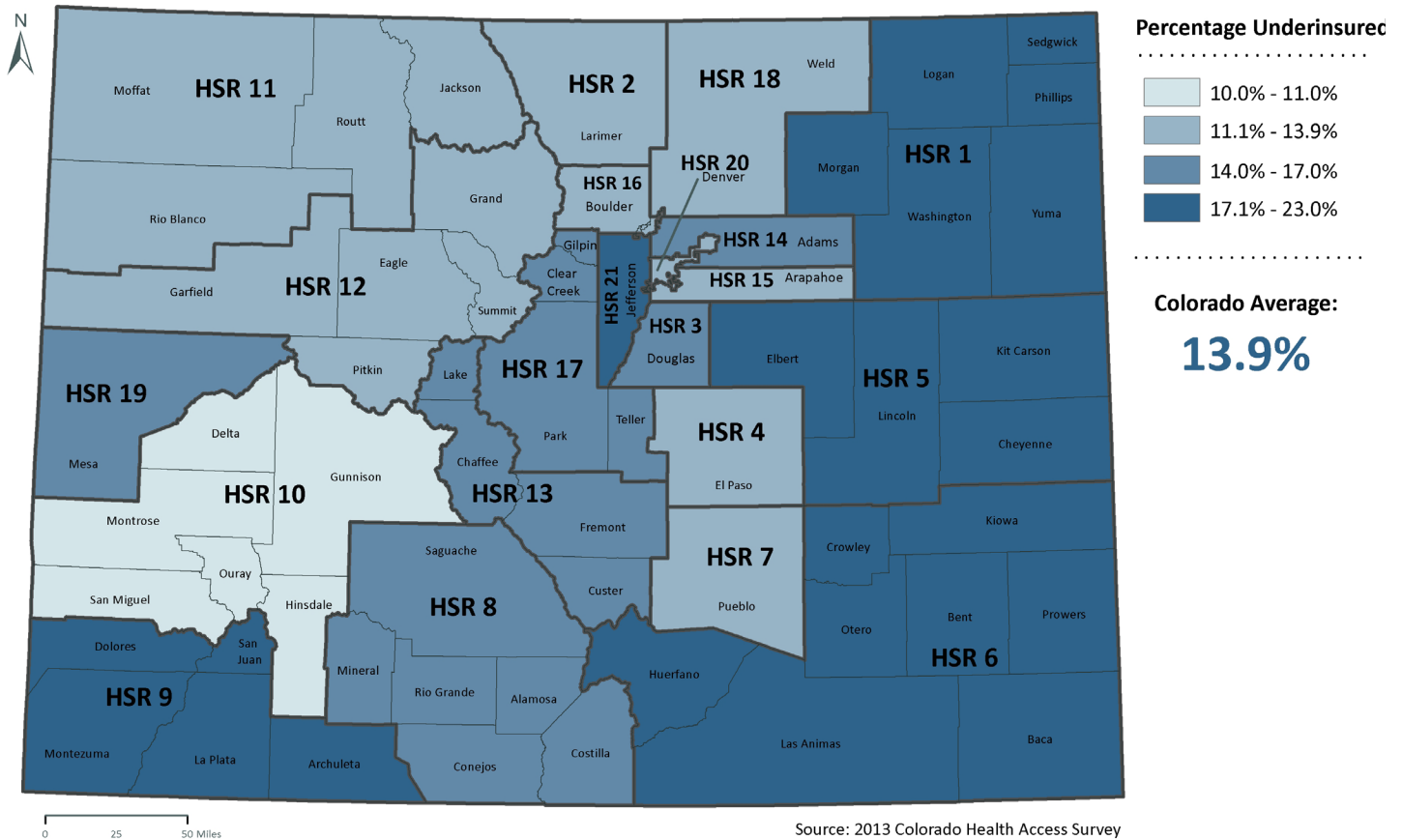
The advocacy group Covering Kids and Families plans to pilot-test a new curriculum of health insurance literacy with Denver Health's school-based health center program. The curriculum – called Peer Health Insurance Rights Education (PHIRE) – aims to educate students and encourage them to share what they learn with their parents and family members, some of whom are not native English speakers.

### Health Coverage Guides, Navigators and Community Health Workers

Many people said the health coverage guides sponsored by Connect for Health Colorado have shown promise in educating new enrollees. Others, however, said that guides often provide little help after getting people signed up for Medicaid. There is work to be

**Map 4. Underinsurance**

Percentage of Coloradans Who Are Underinsured, by Health Statistics Region, 2013



done in post-enrollment education for Medicaid clients. Health navigators already help people figure out how to get care. They could take on additional tasks in increasing health literacy in general.

**Takeaways**

- Underinsurance in Colorado touches nearly as many people as a complete lack of insurance.
- Health insurance literacy is a major barrier across the state to efficient use of the health care system.
- Educational curricula, insurance assistance sites and patient navigators or community health workers are seen as promising opportunities to increasing health insurance literacy.

**Suggested Funding Strategies**

Address the health and financial consequences faced by the underinsured. Support efforts that: increase awareness of the pros and cons of enrolling in specific “metal levels;” build health literacy about plan benefits, cost-sharing, and how to best use coverage to improve access to needed medical care.

# Flashpoint 3: Inadequate Primary Care

## The Problem

A primary care provider is often the first stop for people who need health care, a place where prevention is emphasized and medical problems can be treated before they require expensive specialists or hospitalization. But in Colorado, a number of factors have converged to make it difficult for many residents to obtain this basic building block of health care.

One of the most pressing hurdles is the shortage of primary care providers in many areas of the state. A Colorado Health Institute analysis published in 2014 found that while the state as a whole has enough primary care physicians, there are wide regional variations in workforce capacity.<sup>11</sup>

Nine of Colorado's 21 Health Statistics Regions (HSRs), covering large rural, mountain and underserved urban areas, struggle to attract and retain enough primary care physicians. And for Coloradans covered by Medicaid, the study found a number of areas without enough primary care providers who accept their insurance, shortages that are likely to become even more pronounced in the wake of eligibility expansions that have pushed Medicaid enrollments to historic highs in Colorado.

High costs, a lack of transportation and cultural or linguistic issues also present barriers to obtaining primary care.

Meanwhile, behavioral health services – including mental health care, substance use disorder treatment and support for lifestyle changes such as diet and exercise – are increasingly considered part of primary care. But, again, many Coloradans face barriers in obtaining this crucial care.

Nearly eight percent of Coloradans surveyed by the 2013 CHAS said they needed mental health services or counseling services in the 12 months before the

survey, but did not get them, mostly because they were uninsured or worried about the cost. A third felt uncomfortable talking about personal problems with a health care provider, indicating an ongoing stigma surrounding mental health care.

## The Data

High cost as a barrier to primary care was cited by about one of eight Coloradans who said they could not afford to get the primary care they needed, according to the CHAS. Weld County had the highest rate of residents who cited cost as a barrier to primary care at 16.6 percent. But higher-than-average rates were seen in Denver, Adams, and Pueblo counties as well as portions of the Western Slope. (See Map 5.)

When it comes to the primary care workforce, we identified five of the nine Health Statistics Regions with

shortages of primary care physicians as “hot spots” because they need to boost their physician workforce by at least 10 percent and they need to augment their capacity to serve Medicaid enrollees. The five HSRs are:

- El Paso County
- Cheyenne, Elbert, Kit Carson and Lincoln counties
- Eagle, Garfield, Grand, Pitkin and Summit counties
- Chaffee, Custer, Fremont and Lake counties
- Clear Creek, Gilpin, Park and Teller counties

We found regional variations in access to mental health care that were somewhat surprising. (See Map 6.) The best-performing regions were a mix of rural areas and wealthy suburbs, including the San Luis Valley, Douglas County, northwest Colorado and Weld County. Regions where residents have the most difficulty obtaining mental health care were Adams County and the mountain counties of Gilpin, Clear Creek, Park and Teller.

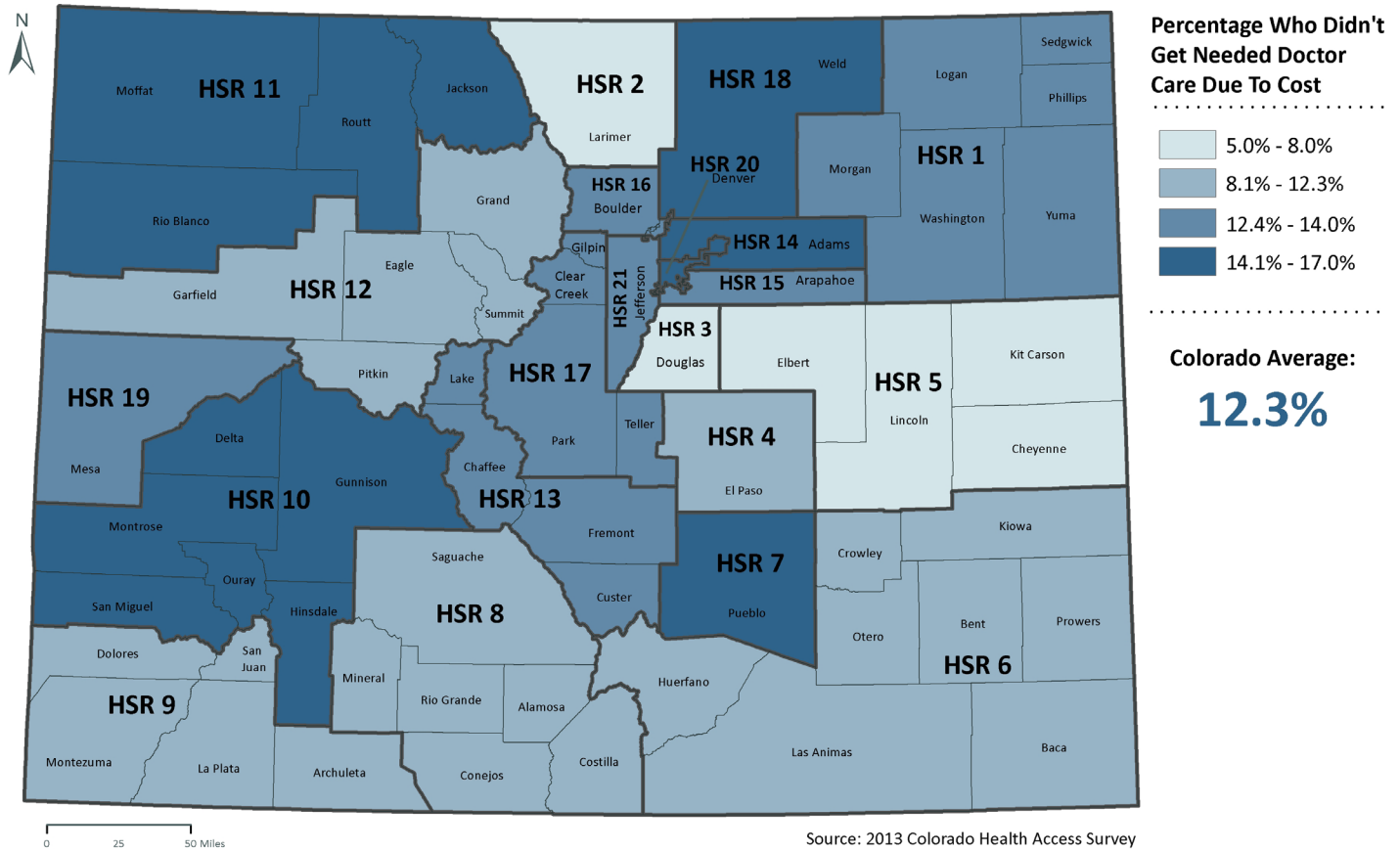
### Thoughts from the Field

*“If you don't have providers, if you don't retain them, and there's a shortage, there is no game to be had. Support workforce so clinics can be staffed well.”*

*Participant in Rifle dialogue*

**Map 5. Access to Affordable Primary Care**

Percentage of Coloradans Who Did Not Get Needed Doctor Care Due to Cost, by Health Statistics Region, 2013



## Regional Expertise

A lack of health literacy came up frequently during the community dialogues and key informant interviews. Many residents do not know how the systems works or where to go for care. They also don't know what is covered by insurance and what is not.

While health navigators are helping people get signed up for insurance, they can't assist newly insured people in scheduling a doctor's appointment. The Medicaid system is especially challenging for clients to navigate, and many do not understand their benefits.

The experts who spoke to the Colorado Health Institute agreed with the data on the lack of primary care providers in certain regions. Hiring providers of all types is especially

difficult in rural communities. (See the next section on specialty care for more discussion of this problem.) Local public health priorities identified increasing access to care and building capacity as a public health priority in the southern part of the state, the central mountains into the Western Slope and Denver.

Experts in most communities identified care gaps resulting from providers not accepting certain types of insurance, especially Medicaid. Increasingly, Medicare providers are also in short supply. Other providers accept only certain types of private insurance because of insurers' reimbursement rates or because they are not in an insurer's network. Providers report that many insurers are not expanding their networks, even if more providers would like to join.

## Regional Findings

Access to women's health and family planning services are problems in southwest Colorado, where the major provider does not offer some of these services. Unintended pregnancy was identified as a public health priority by local public health agencies in much of the Eastern Plains, the central mountains, the northwestern corner of the state and Mesa County.

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A shortage of bilingual providers was noted at CHI's community dialogue in Rifle. Concerns about caring for undocumented families were especially pronounced at our meetings on the Western Slope and in southern Colorado.

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People in southwest Colorado and the San Luis Valley cited the need for community education about mental health and substance use disorders.

Even if communities have enough primary care providers, they may lack providers trained in caring for people from different cultures and people who don't speak English well. Some communities do not have enough providers who care for people with disabilities.

Mental health care access problems may be more widespread than the survey data suggest, according to experts we interviewed. Places like the San Luis Valley may show adequate levels of mental health care because residents don't want to admit needing such care, reflecting continuing stigma. Also, people might need more education about mental health care before they can realize that they need it. Providers in these communities say the numbers point to the need for anti-stigma education.

Addressing mental health needs and substance use disorders were identified as priorities by local public health agencies across the state. Fifteen of the 21 Health Statistics Regions have these as local health priorities.

They emerged as an important topic in community dialogues even where they had not been selected as an official public health priority, such as southwest Colorado.

Oral health was identified as a critical need in communities across the state, particularly with the recent addition of a dental benefit for all adult Medicaid clients. Local public health agencies listed oral health as a priority in northwest Colorado, the central mountain region and the central Eastern Plains.

Logistical barriers also block people from obtaining all types of care. A lack of transportation is a problem in both rural and urban communities. Limited clinic hours are a barrier, too. Keeping clinics open after 5 p.m. and on weekends would increase access.

Finally, a lack of funding hinders access in three ways. Many communities need more funding to maintain and strengthen safety net clinics. Providers need higher reimbursement rates, especially for behavioral health care. And many people simply need more money to pay their out-of-pocket costs.

## Options and Opportunities

### Behavioral Health Integration

Integrating behavioral health with primary care can improve health outcomes, particularly for patients with both medical and behavioral health needs. Colorado secured federal funding under the State Innovation Model (SIM) program to launch a major statewide integration effort. A number of clinics and systems have already begun their own integration.

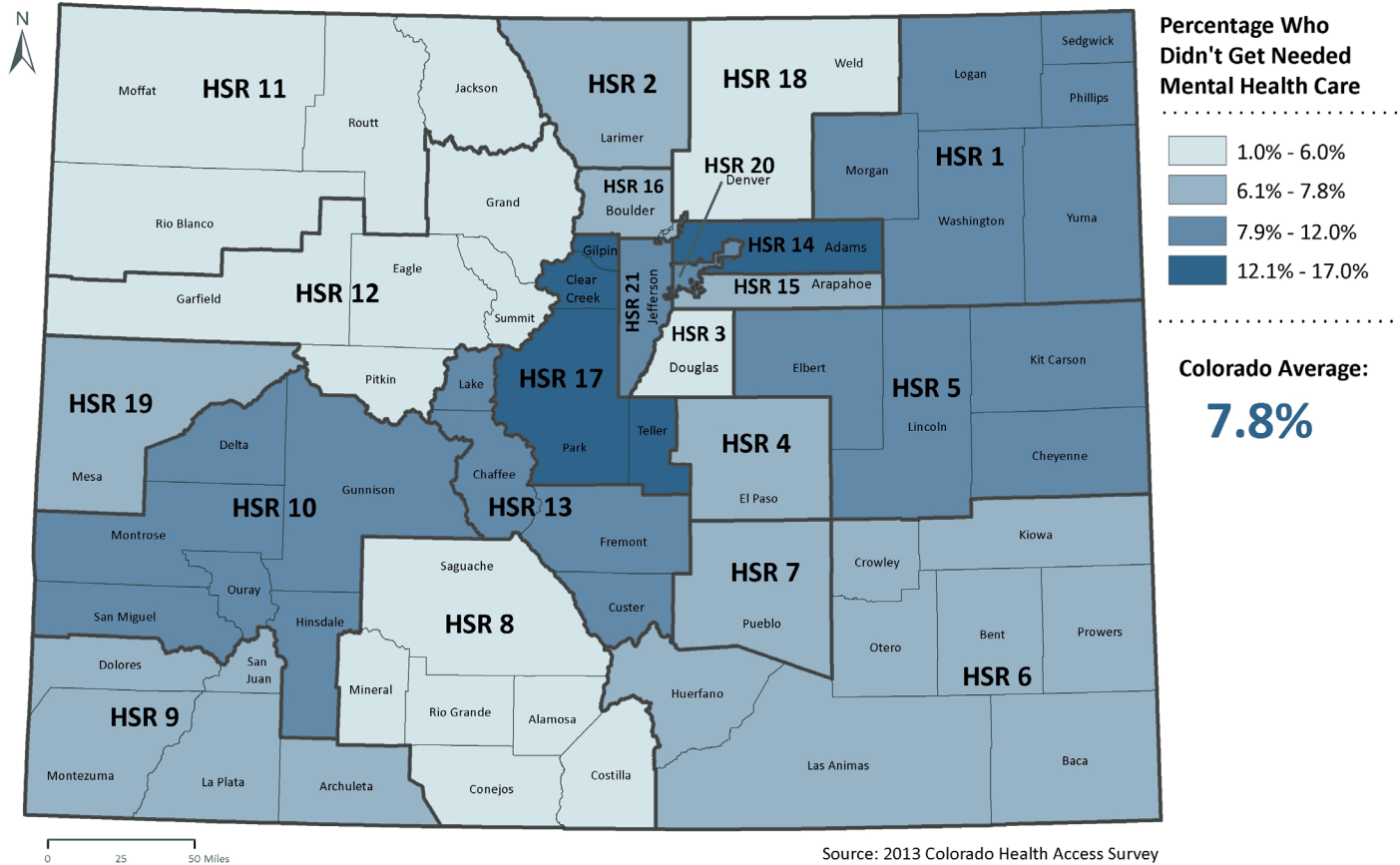
Aligning The Colorado Health Access Fund with the SIM project, which has broad stakeholder engagement and support, is an opportunity to strengthen primary care services.

There are, however, challenges to integrating primary and behavioral health in Colorado, including:

- Paying for behavioral health in the primary care setting.

## Map 6. Access to Mental Health Care

Percentage of Coloradans Who Didn't Get Needed Mental Health Care, by Health Statistics Region, 2013



- Training providers for this new team-based model of care.
- Evaluating pilot projects to learn how they can be scaled up.

### Health Care Guides

The workers who help people navigate one aspect or another of the health system have a variety of titles: community health worker, care coordinator, navigator promotora. There is broad support around Colorado for the idea of a cross-cutting position, someone who can assist people with the range of activities involved in getting care, from enrolling in a health insurance plan to finding a provider to connecting with community

resources such as housing, food assistance and transportation.

### Other Promising Approaches

School-based health centers are a proven way to provide primary care to children and their families.

Training community paramedics to visit people in their homes is an example of an innovative method to expand primary care access.

Existing programs could be partners in an education campaign to reduce the stigma of seeking mental health care. For example, Meals on Wheels, which delivers food to seniors, could also deliver messages about the importance of mental health care.



## Takeaways

- Access to primary care is challenging in communities across Colorado. Numerous barriers are present not only for vulnerable populations but for middle-income people as well.
- Many Coloradans do not understand how to use health care. Having coordinators or community health workers help people navigate the system is a promising solution that is increasingly popular but lacks sustainable funding. In community dialogues, this solution was the highest priority.
- Across all the community dialogues, primary care and behavioral health workforce shortages were identified as the second-highest priority.
- Integrating behavioral health and medical services in the primary care setting can improve patients' access to care and is increasingly considered as a best practice. Numerous ongoing projects seek to address the challenges of integrating care and offer opportunities for partnerships to accelerate innovation. This also was a priority for community leaders.

### Policy Note

Many policy issues came up related to access to primary care. Better reimbursement rates would encourage primary care providers to serve the 1.1 million clients in the Medicaid program. Additional Medicaid funding for care coordination could help clients make better use of their coverage.

Broader conversations about how care is paid for included integration of behavioral health and primary care. The traditional fee-for-service payment structure is a major challenge to the model of integrated care.



BRIAN CLARK/CHI

## Suggested Funding Strategies

Increase the availability and accessibility of primary care. Support efforts that: integrate primary care and behavioral health care; improve the cultural competence of primary care providers; promote innovative approaches to expanding the primary care workforce; and reduce the stigma surrounding behavioral health care.

## Flashpoint 4: Inadequate Specialty Care

### The Problem

Access to specialty care such as psychiatry and pain management continues to be a problem for many Coloradans. Not surprisingly, the most vulnerable – the uninsured and underinsured, rural residents, the poor, Medicaid clients, non-English speakers and people with disabilities – have the most pressing access problems.

Rural areas report the most trouble getting access to specialty care, but problems show up in urban areas as well. An aging population will make the need for specialists even more acute.

All sorts of specialists are in short supply in rural areas, according to our community dialogues. An informal study by the Department of Health Care Policy and Financing (HCPF) identified four especially problematic specialties for its clients: pain management, neurology, psychiatry and dermatology. These specialists either do not accept Medicaid or have long wait times.

Our community dialogues identified high needs for those same specialties, as well as endocrinology, orthopedics, pediatric specialists and developmental disability specialists.

People in almost every region report a critical shortage of psychiatrists, particularly pediatric psychiatrists. Some psychiatrists accept only self-pay patients and do not take public or private insurance.

The Colorado Health Institute studied the ability of safety net clinics to refer clients to specialty services in a 2010 study for Kaiser Permanente Colorado.<sup>12</sup> Providers had the most trouble getting referrals for Medicaid and uninsured patients. Some clinics also had referral difficulties for patients covered by Medicare or private insurance. Pain management, endocrinology and elective surgery were the most problematic specialties, although every specialty was difficult.

### The Data

About one of eight Coloradans reported not getting specialty care because it cost too much, according to the CHAS. In Lake, Fremont, Chaffee and Custer counties, nearly 15 percent of residents said they couldn't afford to see a specialist. (See Map 7).

Other regions where a high rate of residents said they couldn't afford specialty care are an interesting mix of the metro counties of Denver, Adams and Arapahoe, the central mountains and the Interstate 70 resort communities.

The Colorado Health Institute analyzed a comprehensive database of doctors and other health care providers around the state compiled by the Peregrine Management Corp. We examined

five specialties identified as being in short supply in our qualitative research: dermatology, endocrinology, neurology, pain management and psychiatry.

No specialists in these disciplines have their primary practice location in the Eastern Plains regions from Logan and Sedgwick counties in the north to Las Animas and Baca counties in the south, with the exception of two psychiatrists. In addition, eight central mountain counties – Gilpin, Clear Creek, Park, Teller, Lake, Chaffee, Fremont and Custer – have one dermatologist, two psychiatrists and none in the other disciplines.

Physicians in these specialties predominantly practice along Colorado's Front Range stretching from Pueblo to Larimer County. Just a fraction of these specialists have their primary practice in regions other than the Front Range:

- **Dermatology:** 13 percent
- **Endocrinology:** 5 percent
- **Neurology:** 9 percent
- **Pain Management:** 9 percent
- **Psychiatry:** 8 percent

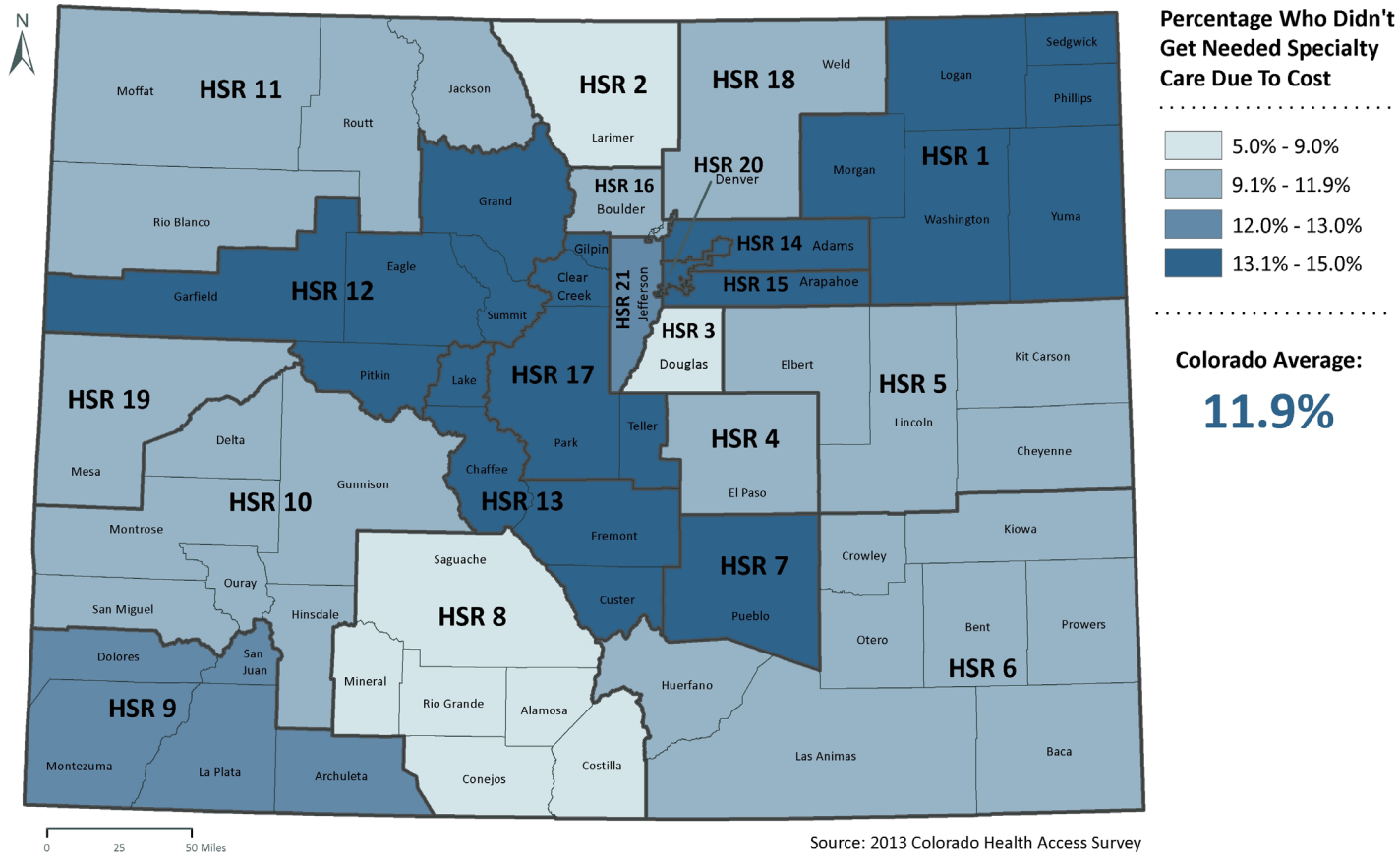
#### Thoughts from the Field

*"Each client needs a team, and every client needs a different team."*

*Participant in Fountain dialogue*

**Map 7. Access to Affordable Specialty Care**

Percentage of Coloradans Who Did Not Get Needed Specialist Care Due to Cost, by Health Statistics Region, 2013



While most of Colorado’s population is also located along the Front Range, and many specialists practice in locations other than their primary location, the data suggest a significant lack of these specialties in rural areas of the state.

### Regional Expertise

Broadly, the three biggest barriers to specialty care are workforce, money and transportation, according to our community dialogues.

#### Workforce

Rural areas face the same set of challenges in attracting and retaining specialists as they do with primary care providers. Reimbursement rates can be lower, and there

## Regional Findings

Economically depressed areas of the state – such as southeast Colorado – have an especially hard time attracting specialists.

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In Greeley, patients wait up to three months to get specialty care, so they often end up in the emergency department. Patients who miss an appointment may get “blacklisted” by a provider, unable to make future appointments, even if the missed appointments are for legitimate reasons like transportation problems.

are fewer professional and social opportunities for providers and their spouses. Loan repayment programs have had mixed results. While they get a provider into the community, the doctors frequently move away as soon as their loans are repaid. Some rural areas may not have the population density to generate enough business to support a specialty clinician.

### Payment and Contracting

Many Coloradans have difficulty accessing specialty care because of the payment policies of providers and insurers. Some specialty providers do not accept Medicaid or Medicare, uninsured patients, undocumented residents or even some privately insured patients, citing low reimbursement rates or full patient panels.

An increasing trend in Colorado and across the nation is the narrowing of provider networks by insurers in order to keep down costs. Community dialogue participants said the narrow networks that are increasingly a feature of insurance plans limit the availability of providers in their communities. People in Denver and Alamosa counties identified this as a major barrier, particularly for behavioral health services. Others said that it may appear there is a provider shortage in a region when, in fact, the providers are just not available through certain insurance plans.

Money is also a problem in recruiting specialists to some regions. Rural communities often do not have the volume of patients to generate salaries that match those in more urban areas. Low reimbursement rates from Medicaid discourage some specialty providers from accepting Medicaid clients. According to key informants, specialty providers are increasingly staying away from Medicare patients as well.

### Transportation

A lack of transportation affects many access to care issues, including specialty care. Many rural communities do not have public transportation systems. Vulnerable people, like seniors and those with low incomes, may lack a car or enough gas money to travel to a referral on the Front Range.

#### Thoughts from the Field

*“Transportation is a big issue. It sounds kind of odd that people can’t drive 30 miles, but we’re the poorest county in the state and a fair amount of people don’t have cars.”*

*Participant in La Junta dialogue*

## Regional Findings

The high cost of living in the mountain resort towns is yet another barrier in attracting professionals to those communities.

Southwest Colorado stands out for its transportation challenges. It is hemmed in by mountain passes that often close in the winter. Durango residents would have a shorter drive to see a specialist in New Mexico, but crossing state lines complicates coverage by Medicaid and other programs.

## Options and Opportunities

### Telehealth

Telehealth holds great promise to increase access to specialty care, although it is not a panacea because of costs, insufficient broadband connections and a preference among some patients and providers for face-to-face interactions.

A 2014 Colorado Health Institute report shows that telehealth can increase access, especially in rural areas.<sup>13</sup>

The University of New Mexico’s Project ECHO has shown that primary care providers in rural areas can co-manage patients with specialists in cities for chronic conditions such as diabetes, hepatitis C and lupus. Project ECHO patients had health outcomes similar to those of patients treated in the university hospital.

Kaiser’s eConsult program lets clinicians at three community health

centers consult via e-mail with specialists at Kaiser Permanente. Evaluations of the eConsult program show that patients and providers are satisfied in general, even though some providers don’t trust the technology and patients are sometimes frustrated that they have to wait for a response.

## Referral Networks

Doctors Care, a safety net clinic in Englewood, has extensively documented its referral network model.<sup>14</sup>

The model involves both volunteer physicians and practices that offer services to Doctors Care patients at reduced rates. Other referral networks include Mile High Health Alliance in Denver, which is in development, and Community Access to Coordinated Healthcare (CATCH) in Colorado Springs. Developing referral models may work best in urban areas, where there are enough specialists. Some physicians who participate in the network are compensated for their time by their employers, making the model more sustainable than a purely volunteer network.

## Developing Relationships

Participants in the community dialogues in southwest Colorado, southeast Colorado and the San Luis Valley talked about forming relationships with hospitals and medical schools. Durango uses traveling specialists who visit the area four times a year. Some stakeholders are interested in developing remote training programs so providers in rural areas don't have to travel to the Front Range. Others brought up forming preceptorships with medical schools or starting residency programs as ways to increase the specialist workforce.

## Education

Educating patients to improve their health and health insurance literacy holds promise to reduce no-show rates. For example, Doctors Care in Englewood provides patients with guidelines upon intake about the patient's responsibility for payment, how to use the emergency department appropriately and how to renew their coverage.

## Takeaways

- Rural regions – and some urban underserved areas – face recruitment and retention issues in attracting specialists. Psychiatry, pain management, neurology



and endocrinology are among the more challenging specialties to find.

- Reimbursement of specialists from Medicaid and Medicare seems to be an especially challenging barrier.
- Opportunities include investing in telehealth technology, encouraging collaboration through volunteer specialist networks and investing in patient education strategies.

## Suggested Funding Strategies

Increase the availability and accessibility of specialty care. Support efforts that: further the use of telehealth and other innovative technologies that connect people in remote areas to specialists and provide needed transportation and self-care education for patients in remote areas.

### Policy Note

Several policy issues came up related to specialty care access:

- Promoting payment reform to encourage specialists to take Medicare and Medicaid.
- Ironing out payment structures for providers on both sides of telehealth.
- Resolving licensing problems for telehealth.

## Flashpoint 5: Inadequate Community-Based Services

### The Problem

Many Coloradans are falling through the health care cracks. They are being discharged from hospitals without a plan for follow-up care in their home or community. Arrangements haven't been made for driving them to their care appointments or delivering meals to them.

Smooth transitions between different settings and providers may help to ensure that people get the care they need, which often includes community-based services like home health, adult day programs, transportation services and meal delivery.

Seniors, who often have more chronic health needs, tend to experience more care transitions and often have a greater need for community-based services. Good coordination between primary care and behavioral health providers is often lacking as well.

### The Data

The number of Coloradans who are at least 65 will increase significantly in the next several years, up more than 32 percent from 2014 to 2020, according to projections from the State Demography Office. It is important to address aging now, because it takes time to develop community-based services.

Map 8 shows how the population of Colorado seniors will increase regionally by 2020. Eleven of the state's 21 Health Statistics Regions will see their 65-and-up population increase by roughly a third or more by 2020. The increases are even more dramatic by the middle of the 2020s.

The increase is less pronounced in many southern and

eastern regions where the populations are already older, with 15 percent to 30 percent of their residents age 65 or more.

Currently, about a third of Coloradans who are 65 or older have at least one disability. Of those 75 and older, about a third live alone. Living alone and having a disability both increase the likelihood of needing community-based services. As people age, they are increasingly likely to need long-term care and community-based services. Over the next 20 years, the number of people over the age of 85 is expected to grow more dramatically than those between the ages of 65 and 74, or 75 to 84.

#### Thoughts from the Field

*"People tend to think if you take the highest needs population and educate them a little, they'll be fine alone. That's not true. Those with the highest needs have behavioral health issues and really intense needs that require continual work with care management."*

*Participant in Greeley dialogue*

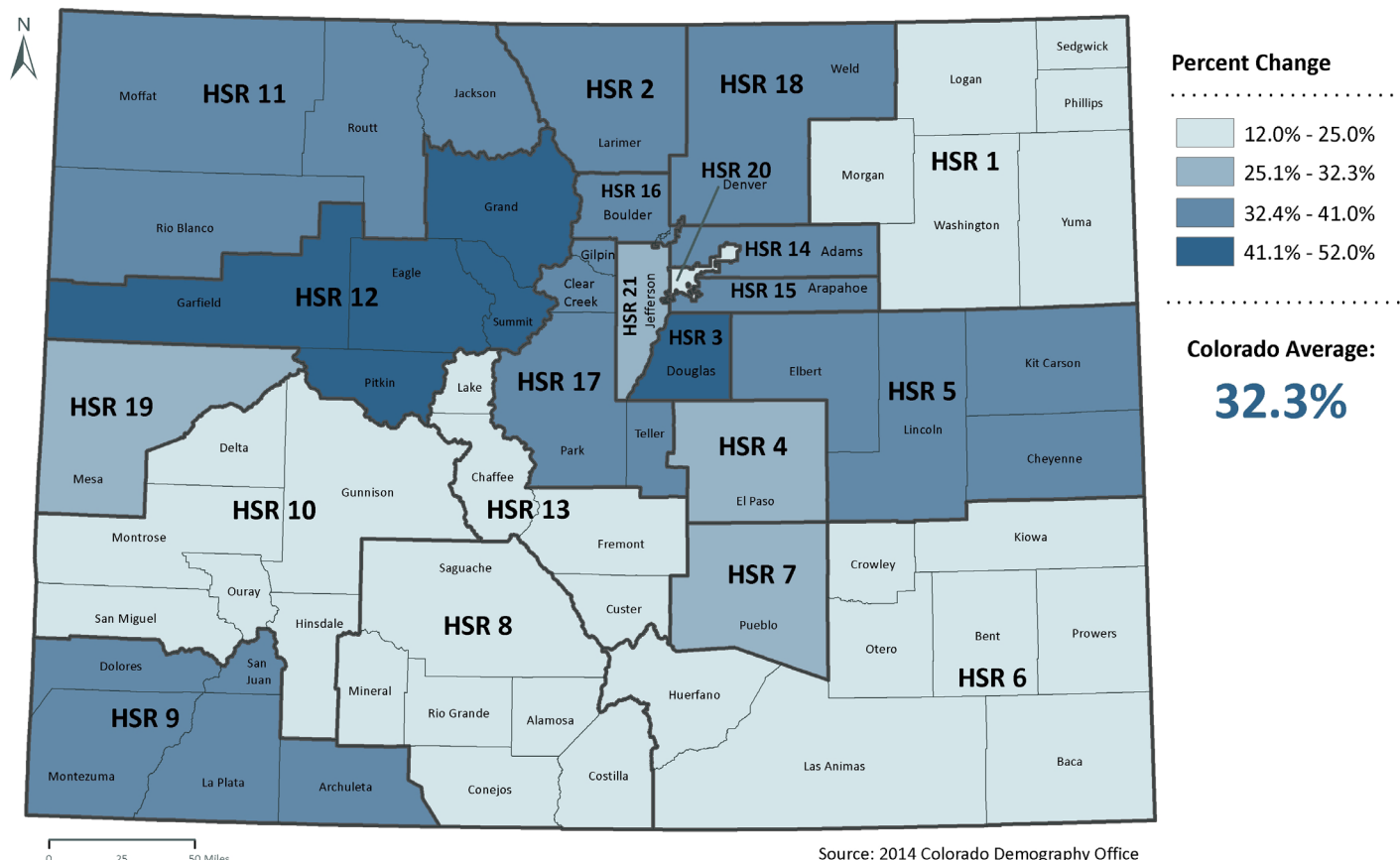
Who will provide community-based services and other kinds of long-term care? The Bureau of Labor Statistics projects that, nationwide, the number of home and personal care aides will increase by 70 percent between 2010 and 2020 – the greatest increase in any health care profession. Nationally, in 1990 there were five working-age adults for each person over age 65. By 2040,

there are projected to be just 2.8 working-age adults for each person over age 65. This not only raises economic questions, but also concerns about the availability of a sufficient number of care providers.

Colorado's Community Living Advisory Group recommends growth and strengthening of the workforce that provides long-term services and supports – including both people paid to provide these services and the unpaid workforce, typically family members. The group recommends training, recruitment and retention of care providers, increased pay and promotion of career opportunities for the professional workforce, and short-term services to provide unpaid care givers time to rest.

Map 8. Aging Population

Percent Change in the 65+ Population, by Health Statistics Region, 2014 to 2020



## Regional Expertise

Several challenges and potential solutions emerged from our interviews and community dialogues.

### Health Literacy

Patients and sometimes even providers are not familiar with the full range of services people need. This problem came up repeatedly in our conversations across the state. This is a multifaceted problem, because needs and resources vary by patient and community. But many agreed that addressing this problem would be beneficial in improving the access to community-based services.

Health navigators are a widely supported model. These workers can guide patients through the health care system and connect them with community-based services. Some focus on coverage, while others

focus on accessing and coordinating clinical services, community-based services, or a combination of all three kinds of resources. Their services may be tied to certain kinds of transitions in care, such as being discharged from the hospital, or certain a diagnosis like diabetes. Others can help address a specific issue like frequent use of the emergency department for nonemergency conditions.

People who provide these kinds of services have different titles, including community health worker, patient navigator, coverage navigator, promotora, care coordinator and case manager. Whatever they are called, they stood out in all the community dialogues as the most frequently prioritized approach to increase access to care. At the same time, several people said too many people are performing this function, leading to the need to “coordinate the coordinators.”

### Information Gaps

Providers don't always adequately share information about their patients, our informants said. Health information exchange systems were identified as a possible solution. Strong working relationships among providers is also key. Providers need more training in what kind of information can be shared. Confusion about confidentiality rules – particularly around mental health and substance use issues – can hinder the sharing of information.

### Home-Based Care

Home health services are not sufficiently available. This includes medical services delivered in the home and home health workers who support patients and families. Home health services can reduce the challenges of transportation and they can help providers get a better idea of their patients' daily needs and connect them with community-based services.

Many community dialogue participants were interested in increasing the frequency of home visits from primary care providers. Additionally, innovative approaches to increase home health services include sending paramedics to make home visits not only for acute needs but also for regular checks-ins. This model was launched in Colorado in 2010, when Eagle County Public Health partnered with Western Eagle County Ambulance District for a five-year pilot project that allows primary care physicians to refer patients to paramedics for ongoing home care.<sup>15</sup> This could align with community health worker programs.

### Basic Needs

Home health care is only possible if someone has a place to call home. Many Coloradans have unmet basic needs that, although they are not medical needs, harm their health:

- Housing, either in the community or in a care facility that provides the appropriate level of care. Populations that face particular challenges in finding affordable housing include seniors, low-income workers, people coming out of residential treatment facilities, and those returning to the community after incarceration.
- Healthy food. Many areas of Colorado are designated as food deserts – places without adequate and affordable fruits and vegetables.

## Regional Findings

In the San Luis Valley, there is a need for more home health workers as well as a need to train them to meet a greater range of patients' needs. (This need showed up in other regions as well.)

Affordable housing needs are reported by stakeholders to be most acute in Denver, Pueblo and La Plata counties.

Southwest Colorado lacks adequate in-patient treatment for substance use disorders.

- Respite care, including an array of services to provide relief and rest for primary caregivers, can help make it possible for people with significant health needs to continue living at home.

### Transportation

A lack of reliable transportation is a barrier that blocks people at several different flashpoints in the health system. A lack of adequate transportation was noted in communities across the state, including El Paso County, Pueblo County, southeast Colorado and the Western Slope. Problems include a lack of public transportation, as well as a dearth of companies or community groups that provide shuttle services for medical care.

A related concern is that while insurance will pay for ambulance transportation to a hospital, it will not pay for a ride back home. It can be time consuming and difficult to get a patient from a Pueblo hospital back home to Alamosa, for example.

### Behavioral Health

Transitions in care also apply to behavioral health. Although efforts are underway to integrate primary and behavioral care, transitions between providers are often not smooth.

Gaps exist in access to both pre- and post-treatment care, said Don Mares, former CEO of Mental Health America of Colorado. Communities often lack resources to address individual behavioral health needs until the needs are severe. After residential treatment, there is often little support or follow-up in a community setting.



## Options and Opportunities

Research shows that community health workers and patient navigators can help increase health screenings and early detection of health problems, leading to better health. But more study is needed on which models of care navigation are most helpful and will provide a positive return on investment.

Further evaluation of community health worker models would help to build the evidence for what would help make them financially sustainable. It could also demonstrate return on investment to payers, who for the most part don't pay for these services now.

Several people mentioned that good work is already happening to improve transitions in care, but there is a need to better connect the innovations that are underway.

Three ongoing efforts are worthy of mention:

- The Colorado Patient Navigator/Community Health Collaborative held a summit in September 2014 to launch an ongoing dialogue. Recommendations from the meeting included developing a multisector advisory board; evaluating the return on investment, including health outcomes and cost savings; being sure to include the patient's perspective in these discussions; and securing funding beyond grant and foundation money.<sup>16</sup>
- Healthy Transitions Colorado is a collaboration between patients, providers and communities around the state that focuses on avoiding hospital readmissions.<sup>17</sup>
- Colorado's Community Living Advisory Group (CLAG) has worked closely with the Colorado Commission on Aging and other planning groups to craft recommendations to improve delivery of long-term services and supports (LTSS). Recommendations include improving the quality and coordination of care, simplifying regulations and structures for accessing care, growing and strengthening the LTSS workforce, promoting affordable and accessible housing, and promoting employment opportunities for all. Work to implement these recommendations is ongoing.<sup>18</sup>

Finally, the need for expanded transportation services stands out. Many rural communities run

bus services, and some communities also have non-profit organizations that provide nonemergency medical transportation so patients can get to their appointments. But the capacity of these services is lacking, and expansion would help address a problem that affects several flashpoints.

## Takeaways

- Colorado has a significant need to improve transitions and access to community-based services, and the need will grow quickly as Colorado's population ages.
- There is strong interest across the state in using community health workers/patient navigators to improve transitions in care and access to community-based services.
- Communities across the state also recognize the need for greater availability of community-based resources such as affordable housing, home health services and nonemergency transportation.

## Suggested Funding Strategies

Increase the availability and effectiveness of community-based services. Support efforts that: empower Coloradans who are transitioning from hospitals or care facilities to their homes or communities with knowledge and supportive services; increase the community, home and transportation infrastructures; focus on non-health areas such as housing and transportation.

### Policy Note

- Payment reform is important for supporting care coordination and community health workers, because these services generally aren't paid for in a traditional fee-for-service payment model.
- Certification or credentialing of community health workers would bring formal recognition and standardization to these services. But it could create barriers to providing this care, particularly for community health workers who have community experience but little formal training.
- The CLAG recommendations describe several policy proposals to strengthen long-term services and supports.

## Flashpoint 6: Inadequate Prevention and Wellness Services

### The Problem

Prevention and wellness services are chronically underfunded in Colorado and elsewhere. While the research community knows that money spent on prevention and wellness is a sound investment with a good return, there is often little left over after funding acute medical care.

Prevention and wellness services can help people stay healthy and avoid the need for expensive medical care down the road. Wellness services can also help those with chronic illnesses better manage their conditions, improving their quality of life and reducing the need for more intensive medical care.

While most people can benefit from prevention and wellness programs, the greatest benefit tends to be for those with chronic health problems and significant barriers to care.

But in a society that often has a short attention span, when the return on investment for prevention and wellness will be most visible in 10 or 20 years, it's often difficult to make the immediate case for the dollars.

### The Data

Obesity is an area of particular focus for many prevention and wellness experts because it is associated with a wide range of health problems, including diabetes, cardiovascular disease, depression and some forms of cancer. High levels of obesity indicate likely future health care needs.

While Colorado has the nation's lowest obesity rate, we've been heading higher in recent years. Today, more than one of five Coloradans are obese. Residents of eastern Colorado and the San Luis Valley have higher obesity rates than the state average. This is shown in Map 9. The obesity rate is below the state average in the

western half of the state, with the notable exception of Mesa County.

The public health priorities by local public health agencies reveal the need for prevention and wellness activities outside the medical setting. Some of the priorities are related to the physical environment such as availability of nutritious food and clean water and the opportunity to be physically active. Obesity was the most commonly cited local public health priority, showing up in 17 of Colorado's 21 Health Statistics Regions.

### Regional Expertise

The need for preventive care and wellness services was identified by many experts in our interviews as well as in some community dialogues. There is broad interest in helping people stay healthier.

Besides reducing obesity, reducing the incidence of chronic disease, such as heart disease, and improving management of these conditions when they do occur were identified as public health priorities in five regions – in the San Luis Valley, the southeast corner of the state through the central plains, and the central mountains to parts of the Western Slope. Other local health priorities focus on prevention and wellness services such as smoking cessation and injury prevention.

#### Thoughts from the Field

*"We have lost the art of self-care. Who is teaching the patient about their disease and how they can self-manage?"*

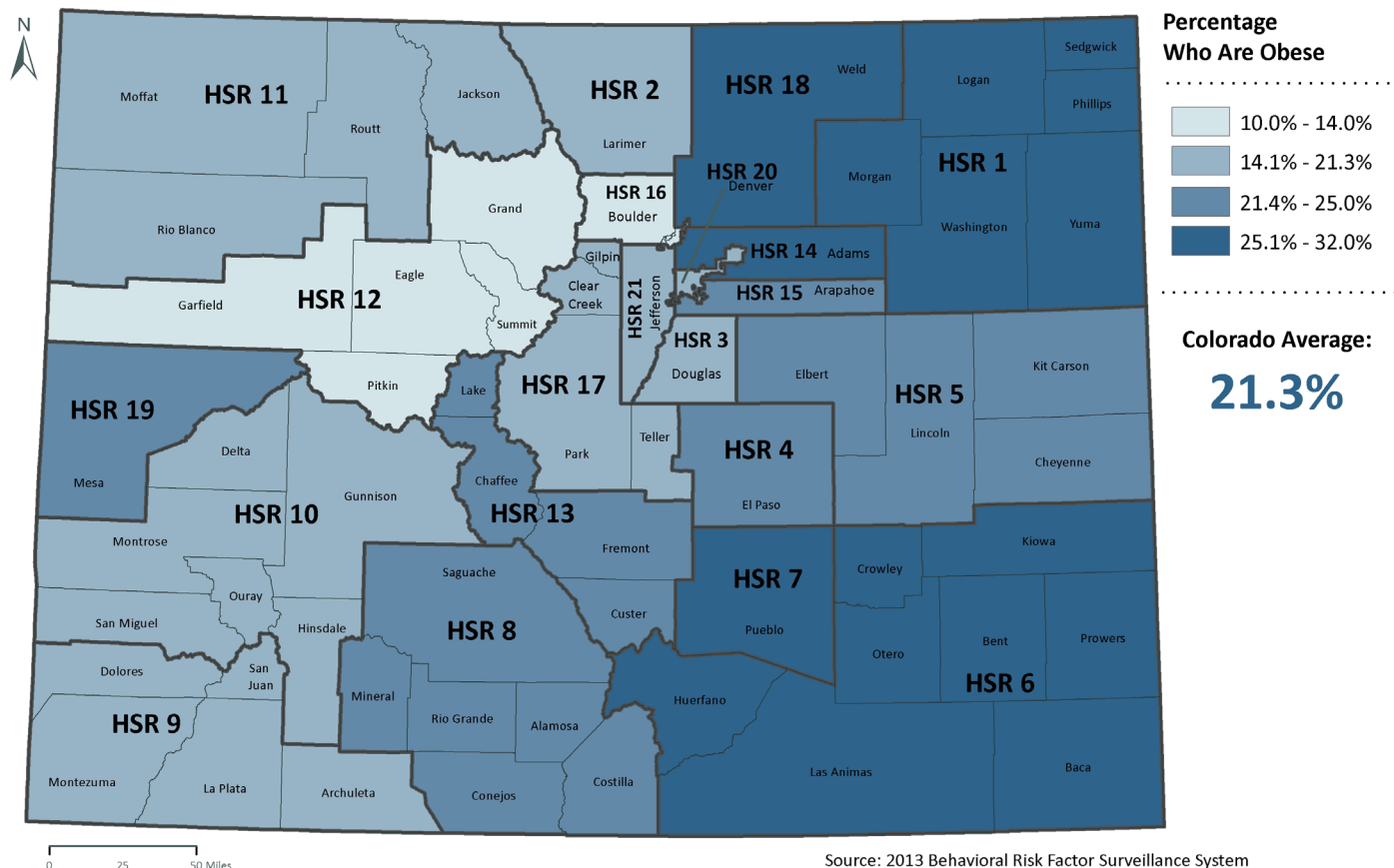
*Participant in Alamosa dialogue*

Patient education is an important component, as it is with most of the access to care flashpoints we identified. As one community member put it, "Self-care is access to care." Patients are much more likely to successfully deal with their chronic conditions, like diabetes, when they understand and manage their own health needs.

Patient education can be done through partnerships with community organizations, such as churches, that already have strong relationships with patients and

Map 9. Obesity

Percentage of Colorado Adults Who Are Obese, by Health Statistics Region, 2013



can meet their cultural needs. Evidence-based interventions for chronic disease management, prevention and overall wellness can be delivered through partnerships with these organizations. Public health departments are another resource that can provide prevention and wellness services.

Prevention and wellness play an important role in behavioral health. Early identification and treatment of behavioral health issues are important for maintaining overall health. But teaching techniques to maintain

**Regional Finding**

The need for more and stronger prevention and wellness services was expressed most clearly in southwest Colorado and the San Luis Valley.

mental and emotional wellness can help even earlier.

Participants in our dialogues talked about the importance of addressing the social determinants of health – the nonmedical factors that can play an even larger role in health than anything that happens in the clinic. Social factors include:

- Housing.
- Poverty and all the stresses that come with it.
- Access to social services.
- Transportation to all sorts of services, not just medical care.

A further challenge is that insurance companies do not cover most prevention and wellness services.

## Options and Opportunities

There are evidence-based best practices for prevention and wellness, addressing both physical and behavioral health. For example, the Stanford Chronic Disease Self-Management Program is a six-week curriculum that teaches techniques for managing chronic illness, including how to deal with frustration, fatigue and pain; appropriate physical exercise; medication management; communication with family, friends and care providers; good nutrition; decision making skills; and how to evaluate new treatments.

Mental Health First Aid is a curriculum that teaches how to recognize signs of addiction and mental illness, the impact of these disorders, steps to assess a situation, and local resources.

Both of these tools are widely used in Colorado and elsewhere, often provided through a partnership with local groups that have strong relationships in the community.

The Center for African American Health in Denver provides one example of an organization partnering with community groups to deliver evidence-based wellness interventions. Executive Director Grant Jones said that access to care is not just about having coverage. It's also about addressing cultural barriers and offering people a comfortable place for care.

Working from the ground up to determine community-level fixes is the only way to know what health issues exist, and what will solve those issues. Evidence-based community health programs are a necessary supplement to traditional health care. In the experience of the Center for African American Health, increased funding relied on whether programs were evidence-based, since funders wanted to know that community services were effective.

Mental Health America Colorado is working with community groups to provide prevention and wellness services. Check Your Head teaches sixth- to ninth-graders about how to talk about mental health and



BRIAN CLARK/CHI

how to be mentally well. This six-week program is undergoing evaluation to understand how successful it will be at changing knowledge, behavior and attitudes about mental wellness. B4Stage4 is an awareness campaign with the goal of increasing prevention and early treatment for mental health needs, and not waiting until the need is severe before addressing it.

## Takeaways

- Prevention and wellness services are an important and effective way to improve health and reduce the need for more intensive care.
- Community-based organizations and public health departments can be effective partners for delivering evidence-based interventions for both physical and mental health.
- Health is also closely linked with social factors such as poverty, transportation and connection to community resources. Supporting those factors should not be overlooked in efforts to improve health.

## Suggested Funding Strategies

Increase the availability and effectiveness of prevention and wellness initiatives. Support efforts that: work upstream to keep Coloradans healthy; promote partnerships with community organizations such as churches and local health departments; increase knowledge of chronic disease self-management; implement curricula to recognize signs of behavioral health issues.



# Work Underway: The Landscape of Health Innovation in Colorado

Colorado has a large and well-functioning infrastructure of health philanthropies. Still, The Colorado Health Access Fund is launching at a time of major change in the state's philanthropic world. These changes provide an opportunity to explore partnerships with Colorado's established health funders.

First, an overview of some of the most significant efforts that are underway statewide:

- Colorado received a State Innovation Model (SIM) grant from the federal Center for Medicare & Medicaid Innovation totaling \$65 million over four years. The goal is to increase access to integrated primary care and behavioral health care for most Coloradans. The state has expressed a commitment to promoting models of integration, reducing fragmented care and moving away from fee-for-service payment models.
- The Accountable Care Collaborative (ACC), Colorado's signature effort to deliver better care to Medicaid clients and lower costs of the program, was launched in mid-2012. The ACC is connecting clients with a medical home and coordinating their care through seven Regional Care Collaborative Organizations. The program was expanded in September to include more than 32,000 Coloradans dually enrolled in Medicare and Medicaid. Nearly 725,000 of the 1.1 million Medicaid clients were enrolled in the ACC as of October.
- The Community Living Advisory Group (CLAG) delivered recommendations in September to reform the state's long-term services and supports (LTSS) system. The recommendations included strengthening access to LTSS services, simplifying regulations, improving the coordination of care and promoting affordable housing, among others.
- The Center for Improving Value in Health Care (CIVHC) has developed the All-Payer Claims Database, which aims to improve transparency around health care payments.

- The Colorado Telehealth Network is working to develop health care broadband infrastructure in the state's rural and underserved areas.
- And organizations such as the Colorado Regional Health Information Exchange and the Quality Health Network are working towards greater efficiency of interoperability of electronic health records.

Meanwhile, the community dialogues illustrated that much innovation in health and health care is happening at the regional and local levels.

## The Landscape of Health Philanthropy in Colorado

Colorado benefits from a mix of large statewide philanthropies and smaller community foundations.

Statewide foundations include Caring for Colorado, the Colorado Health Foundation and The Colorado Trust. Examples of community foundations include The Community Foundation Serving Greeley and Weld County, the Rose Community Foundation, the Community Foundation of Boulder County and Southern Colorado Community Foundation.

A number of the community foundations include health as part of a broader portfolio that may include aging, education, environment and the arts.

Members of the health philanthropy community in Colorado work well together. Staff from the Denver-based foundations stay in close contact and meet regularly. Many programs or organizations – including the Colorado Health Institute – are cosponsored by multiple foundations.

During this time of change in the health care world, the state's health philanthropies are shifting their focus to supporting innovative ideas while placing greater emphasis on evaluating programs to ensure that their investments are achieving their stated goals.

**Table 3.** Overview of Health Grantmaking Among Selected Philanthropies

| <b>Caring for Colorado • Statewide Focus</b>  |  |   |
|---|--|---|
| <b>Mission and Funding Priorities</b>   | <b>Key Elements of Funding Strategy</b>  | <b>Specific Types of Health Grants</b>  |
| <p><b>Mission:</b> To promote health and improve health care for the people of Colorado.</p> <p><b>Funding focus areas:</b></p> <ul style="list-style-type: none"> <li>• Community Health</li> <li>• Health Care Workforce</li> <li>• Healthy Children and Youth</li> <li>• Mental Health</li> <li>• Oral Health</li> </ul>                     | <p>Priorities:</p> <ul style="list-style-type: none"> <li>• Underserved populations including low-income, under-represented and geographically isolated communities</li> <li>• Prevention and health promotion activities targeted to children and youth</li> <li>• Health-system improvement at local and state levels</li> </ul> <p>Types of Grants:</p> <ul style="list-style-type: none"> <li>• Program support</li> <li>• Capital/equipment</li> <li>• Special initiatives</li> <li>• Single and multi-year grants; must demonstrate health outcomes/improvements.</li> </ul> | <ul style="list-style-type: none"> <li>• Operating support/technical assistance for community-based safety net clinics</li> <li>• Integration of behavioral health into physical health in safety net clinics</li> <li>• Systems and services to promote healthy social and emotional growth in children under 5 years of age</li> <li>• Innovative delivery models to improve access to oral health</li> <li>• Efforts to increase the diversity of the health care workforce</li> <li>• Capital improvements for rural hospitals, EMS services and clinics</li> <li>• Supports to help access care (transportation, translation, navigation)</li> </ul> |
| <b>Rose Community Foundation • Metro Denver (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson)</b>  |  |   |
| <b>Mission and Funding Priorities</b>   | <b>Key Elements of Funding Strategy</b>  | <b>Health Funding Priorities and Focus</b>  |
| <p><b>Mission:</b> To enhance the quality of life of the Greater Denver community through its leadership, resources, traditions and values.</p> <p><b>Funding Programs:</b></p> <ul style="list-style-type: none"> <li>• Aging</li> <li>• Child and Family Development</li> <li>• Education</li> <li>• Jewish Life</li> <li>• Health</li> </ul> | <ul style="list-style-type: none"> <li>• Grants awarded to organizations, projects, and initiatives that support the five programs' funding priorities.</li> <li>• Beyond program area grants, RCF also awards special grants through donor-advised funds and foundation initiatives.</li> </ul>   | <ul style="list-style-type: none"> <li>• Access to care</li> <li>• Improvements to the cost effectiveness of health care system</li> <li>• Health policy and public health leadership</li> <li>• Primary prevention</li> <li>• Innovative approaches to systems level issues</li> </ul>   |
| <b>The Colorado Trust • Statewide Focus</b>   |  |   |
| <b>Mission and Funding Priorities</b>   | <b>Key Elements of Funding Strategy</b>  | <b>Specific Types of Health Grants</b>  |
| <p><b>Mission:</b> Advancing the health and well-being of the people of Colorado.</p> <p><b>Funding focus areas:</b> Health equity and social determinants of health.</p>   | <ul style="list-style-type: none"> <li>• Policies and information related to advancing health equity</li> <li>• Projects that address health equity in partnership with Colorado communities</li> <li>• Focus on community- and resident-driven solutions</li> </ul>   | <ul style="list-style-type: none"> <li>• Policy and advocacy: Field-building strategy to advance advocacy and policy change for health equity</li> <li>• Data and information: Colorado Health Access Survey, All Payer Claims Database, Colorado Health Institute</li> <li>• Community partnerships: Community and place-based grantmaking driven by residents to advance health equity for all</li> </ul>   |

**Table 3 (continued).** Overview of Health Grantmaking among Selected Philanthropies

| <b>Community First Foundation</b> • <i>Metro Denver area, with focus in Jefferson County</i>   |  |   |
|--|--|---|
| <b>Mission and Funding Priorities</b>  | <b>Key Elements of Funding Strategy</b>  | <b>Specific Types of Health Grants</b>  |
| <p><b>Mission:</b> To inspire philanthropy and build strong community.</p> <p><b>Funding focus areas:</b></p> <ul style="list-style-type: none"> <li>• Promoting Mental Wellness</li> <li>• Health and Well-Being of Jefferson County (Lutheran Legacy Fund)</li> </ul>  | <p>Denver Metro Area:</p> <ul style="list-style-type: none"> <li>• Promote early childhood mental wellness and resilience.</li> <li>• Improve the systems supporting mental wellness.</li> <li>• Change the public perception of mental health and mental illness.</li> <li>• Population-based approaches to cultivate resilience and prevent the onset of mental health problems.</li> </ul> <p>Jefferson County:</p> <ul style="list-style-type: none"> <li>• Mental Health</li> </ul> | <p>Denver Metro Area:</p> <ul style="list-style-type: none"> <li>• Mental Health Screening (0-3/ Caregivers)</li> <li>• Home Visitation / Parent Education</li> <li>• Improve mental health system</li> <li>• Community education around mental health perception</li> <li>• Evidence-based practices</li> </ul> <p>Jefferson County:</p> <ul style="list-style-type: none"> <li>• Mental Health First Aid / Training Gatekeepers</li> <li>• Reducing Stigma</li> </ul>                   |
| <b>The Colorado Health Foundation</b> • <i>Statewide focus</i>   |  |   |
| <b>Mission and Funding Priorities</b>  | <b>Key Elements of Funding Strategy</b>  | <b>Specific Types of Health Grants</b>  |
| <p><b>Mission:</b> To improve the health and health care of Coloradans by increasing access to quality health care and encouraging healthy lifestyle choices.</p> <p><b>Funding focus areas:</b></p> <ul style="list-style-type: none"> <li>• Healthy Living</li> <li>• Health Coverage</li> <li>• Health Care</li> </ul>      | <p>Core tools of funding:</p> <ul style="list-style-type: none"> <li>• Grantmaking: projects; general operating support; capacity building; capital</li> <li>• Evaluation</li> <li>• Public policy</li> <li>• Private sector initiatives</li> <li>• Communications</li> </ul>  | <ul style="list-style-type: none"> <li>• Healthy living – children’s access to physical activity and affordable, healthy food/beverage availability</li> <li>• Health coverage – community outreach/enrollment; consumer advocacy; long-term services and supports initiatives</li> <li>• Health care – team-based care, preventive health services, and health engagement through technology, such as patient portal use.</li> </ul>   |
| <b>El Pomar Foundation</b> • <i>Statewide Focus</i>  |  |   |
| <b>Mission and Funding Priorities</b>  | <b>Key Elements of Funding Strategy</b>  | <b>Specific Types of Health Grants</b>  |
| <p><b>Mission:</b> To enhance, encourage, and promote the current and future well-being of the people of Colorado.</p> <p><b>Funding focus areas:</b></p> <ul style="list-style-type: none"> <li>• Arts and culture</li> <li>• Civic and community</li> <li>• Education</li> <li>• Health</li> <li>• Human services</li> </ul> | <p>• Responsive grantmaking approach</p> <ul style="list-style-type: none"> <li>• Grants</li> <li>• Programs</li> <li>• Legacy properties</li> </ul> <p>• 11 Regional Councils that cover entire state, represent distinct regional communities and provide direct grant recommendations to foundation’s trustees.</p>   | <p>Direct services, general operating support and/or specific equipment to various recipients:</p> <ul style="list-style-type: none"> <li>• Community/mental health centers (general operating support and capital support)</li> <li>• Health foundations (general operating support; expansion/renovation capital support; capital campaigns; events)</li> <li>• Hospitals and clinics (general operating support; specific equipment and machines; specific clinic programs)</li> </ul> |

Foundations are also becoming more cognizant of the need to fund projects that will be sustainable rather than relying on grant funding.

Two of the largest philanthropies undertook major strategic planning initiatives in 2014. The Colorado Trust shifted its strategy to focus on health equity and now plans to pursue its goals through community participatory grantmaking. The Colorado Health Foundation announced a 10-year “collective impact” strategy to foster greater collaboration among its grantees so that they are working together toward achieving the Triple Aim goals of better care for individuals, improved population health and lower costs.

A summary of grantmaking focus areas of the largest health philanthropies in Colorado is included in Table 3.

## Research and Findings

### Health Philanthropy Breakfast

The Colorado Health Access Fund is committed to ensuring it complements – rather than duplicates – efforts that are underway to improve access across the state. With that goal in mind, the Colorado Health Institute hosted a health philanthropy breakfast on October 14, 2014, inviting a group of representatives from foundations immersed in supporting health care efforts to share their experiences in addressing access to care challenges across Colorado. Attendees of the breakfast are listed on this page.

Five themes emerged from the discussion.

- **Behavioral health:** Access to mental health and substance use disorder services are pressing issues. Barriers to access come from stigma about mental health care, a shortage of psychiatrists and a lack of children’s mental health services.
- **Rural mental health:** Gaps in mental health care are an even greater problem in rural areas. Anti-stigma campaigns have not been effective. Instead, there is greater promise in integrating behavioral health care into other settings, such as primary care and school-based health clinics.
- **Health literacy:** Although hundreds of thousands of Coloradans recently gained health insurance, many of them do not know what to do with their coverage.

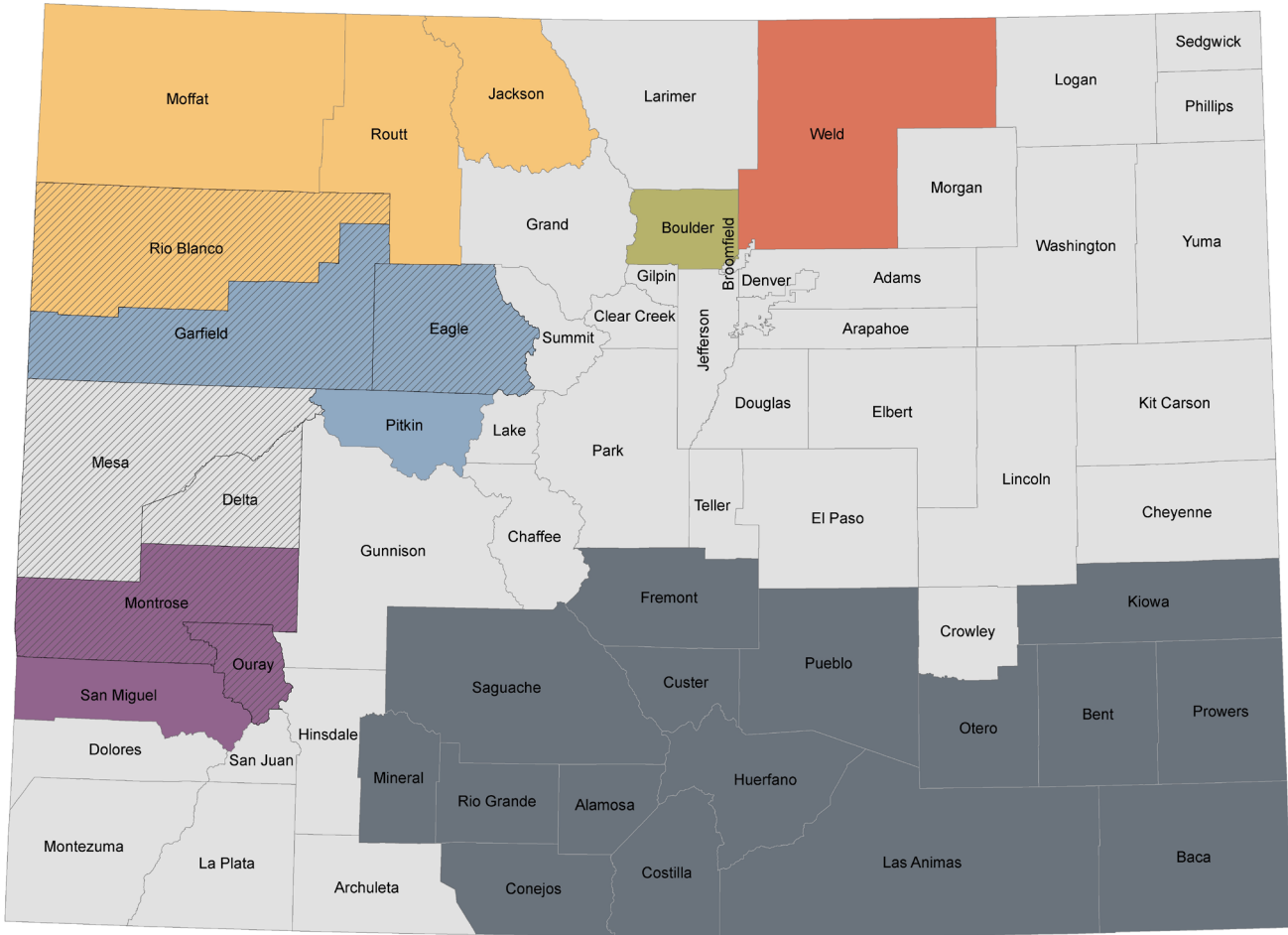
## Attendees at the October 14, 2014 Health Philanthropy Breakfast

- **Gwyn Barley**, Director of Community Partnerships and Grants, The Colorado Trust
- **Colleen Church**, Senior Program Officer, Caring for Colorado
- **Whitney Connor**, Senior Health Program Officer, Rose Community Foundation
- **Cheryl Haggstrom**, Executive Vice President, Community First Foundation
- **Sara Overby**, Associate Program Officer – Health Care, The Colorado Health Foundation
- **Linda Reiner**, Vice President of Strategy and Communication, Caring for Colorado
- **Annie Taylor**, Fellow, Caring for Colorado
- **Chris Wiant**, President and Chief Executive Officer, Caring for Colorado

- 
- **Focused and strategic funding:** Given the eight-year span of funding, The Colorado Health Access Fund should consider choosing one or two specific areas of focus. Setting specific, achievable goals and developing evaluation plans in partnership with its grantees also will be important. At the same time, there should be realistic expectations about what evaluations can and can’t show.
  - **Broken system:** Participants strongly advised against funding direct services within a “broken system” – for example, direct payments to help people afford medications. A better approach is to fund a limited number of innovative and evidence-based ideas that could be scaled up and achieve real and lasting improvements.



**Map 10. Colorado Community Foundation Survey Respondents, 2014**



- Western Colorado Community Foundation
- Aspen Community Foundation
- Pioneers Healthcare Foundation
- Telluride Foundation/Tri-County Health Network
- The Community Foundation Serving Boulder County
- Southern Colorado Community Foundation
- Community Foundation Serving Greeley and Weld County

## Foundation Survey

The Colorado Health Institute administered an online survey of Colorado's regional community foundations to understand their health grantmaking strategies. Seven community foundations responded. The counties they serve are displayed on Map 10.

Six of the seven respondents had plans to fund health-related projects. The exception was the Community Foundation Serving Greeley and Weld County.

Four foundations currently funding health-related initiatives are the Aspen Community Foundation, the Community Foundation of Boulder County, Pioneers Healthcare Foundation and the Telluride Foundation. Of particular interest to The Colorado Health Access Fund:

- All four said that they fund in the area of access to care.
- Three of them fund behavioral health. Pioneers does not.
- Three fund education on how to manage chronic conditions. Boulder does not.

Three are located on the Western Slope. Depending on the focus areas of The Colorado Health Access Fund, it will be particularly useful to discuss partnership opportunities and potential duplication of effort with these foundations throughout the eight years of the fund.

Two foundations had no current health projects but do have plans for future health funding. The Southern Colorado Community Foundation has plans to fund access, behavioral health services, education on managing chronic conditions, long-term services and supports, oral health, healthy eating, physical activity and school health. The Western Colorado Community Foundation plans to fund improved access to health care in rural areas.

Although the seven respondents may not be representative of all community foundations, the data suggest that there is – or will be – a substantial amount of local investment in health-related activities across Colorado's regions. Access to care was indicated in every response except one.

In addition to the survey, the Colorado Health Institute also conducted interviews with two community foundations – The Community Foundation of Boulder County and the Aspen Community Foundation – when they expressed an interest in The Colorado Health Access Fund. These two foundations also completed the survey.

Both the Community Foundation of Boulder County and the Aspen Community Foundation said they welcome the idea of partnering with The Colorado Health Access Fund. Each indicated that the type of partnership may vary by how they approach their work. Both reiterated that the size of a community foundation's endowment and how the foundation is organized may also influence its ability to be a partner. The Boulder foundation, for example, has few unrestricted dollars for new projects, so a partnership may be limited to existing grantees.

The survey was administered between October 15 and November 2. The Denver Foundation sent the invitation to a distribution list provided by the Colorado Association of Funders. The survey is printed in Appendix C, and answers are summarized in Table 4.

The Colorado Health Access Fund is being launched at an exciting time. Colorado's health and community funders have diverse portfolios of health grantmaking. Many of them support – or are planning to support – areas identified in this report, such as mental health and technology. Communication with other funders is key to ensure that efforts are not duplicated once the focus of The Colorado Health Access Fund is established.

The Colorado Health Access Fund can expect to find able and willing partners among Colorado's health and community foundations and opportunities to leverage existing work. At the very least, The Colorado Health Access Fund will be able to draw upon the collective experience of Colorado's foundation community.

**Table 4.** Summary of Community Foundation Online Survey Results: Health Grantmaking

| <b>Aspen Community Foundation</b>   |  |  |   |
|---|--|--|---|
| <b>Funding Priorities</b>   | <b>Methods of Funding</b>  | <b>Areas of Health Grants</b>  | <b>Additional Details on Grantmaking</b>  |
| <ul style="list-style-type: none"> <li>• Children</li> <li>• Education</li> <li>• Families</li> <li>• Health (accounts for 50% of grants)</li> </ul>                      | <p><b>Type of grants:</b> direct services</p> <p><b>Populations of focus:</b></p> <ul style="list-style-type: none"> <li>• Children/youth</li> <li>• Immigrants/refugees</li> <li>• Low-income</li> <li>• People with high health care needs</li> <li>• Seniors</li> <li>• All residents within certain geography</li> </ul> | <ul style="list-style-type: none"> <li>• Access to health care</li> <li>• Behavioral health services</li> <li>• Oral health</li> <li>• Healthy eating</li> <li>• School health</li> </ul>  | <ul style="list-style-type: none"> <li>• <b>Access:</b> general grantmaking – basic human needs, direct assistance</li> <li>• <b>Behavioral health:</b> Mental Health Fund</li> <li>• <b>Oral health:</b> general grantmaking – basic human needs, direct assistance</li> <li>• <b>School health:</b> general grantmaking – basic human needs, direct assistance, community partnerships</li> <li>• <b>Healthy eating:</b> general grantmaking; donor advised fund</li> </ul> |
| <b>Community Foundation Serving Greeley and Weld County</b>   |  |  |   |
| <b>Funding Priorities</b>   | <b>Methods of Funding</b>  | <b>Areas of Health Grants</b>  | <b>Additional Details on Grantmaking</b>  |
| <ul style="list-style-type: none"> <li>• Arts</li> <li>• Children</li> <li>• Education</li> <li>• Women/girls</li> <li>• No current or future plans for health</li> </ul> | N/A  | N/A  | N/A   |
| <b>Pioneers Healthcare Foundation</b>   |  |  |   |
| <b>Funding Priorities</b>   | <b>Methods of Funding</b>  | <b>Areas of Health Grants</b>  | <b>Additional Details on Grantmaking</b>  |
| Health (accounts for 100% of grants)  | <p><b>Types of grants:</b> capital; direct services</p> <p><b>Populations of focus:</b></p> <ul style="list-style-type: none"> <li>• Low-income</li> <li>• People with disabilities</li> <li>• Seniors</li> </ul>  | <ul style="list-style-type: none"> <li>• Access to health care</li> <li>• Education on how to manage chronic conditions</li> <li>• Long-term care</li> <li>• Healthy eating</li> <li>• Increased physical activity</li> <li>• Other</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Access:</b> regional partnerships to increase access to various health care needs</li> <li>• <b>Other:</b> preventative care; cancer screening; health care workforce development</li> </ul>  |

| Southern Colorado Community Foundation (SCCF)   |  |  |   |
|---|--|--|---|
| Funding Priorities  | Methods of Funding   | Areas of Health Grants   | Additional Details on Grantmaking   |
| <ul style="list-style-type: none"> <li>• Arts</li> <li>• Children</li> <li>• Education</li> <li>• Environment</li> <li>• Families</li> <li>• Leadership</li> <li>• Future plans for health grantmaking</li> </ul>   | N/A  | <b>Future areas:</b> <ul style="list-style-type: none"> <li>• Access to health care</li> <li>• Behavioral health services</li> <li>• Education on how to manage chronic conditions</li> <li>• Long-term care</li> <li>• Oral health</li> <li>• Healthy eating</li> <li>• Increased physical activity</li> <li>• School health</li> </ul> | SCCF supports Pueblo Community Health Center and Spanish Peaks Health Facilities.   |
| Telluride Foundation/Tri-County Health Network  |  |  |   |
| Funding Priorities  | Methods of Funding   | Areas of Health Grants   | Additional Details on Grantmaking   |
| <ul style="list-style-type: none"> <li>• Arts</li> <li>• Capitol/infrastructure</li> <li>• Children</li> <li>• Economic development</li> <li>• Education</li> <li>• Environment</li> <li>• Families</li> <li>• Health (accounts for 30% of grants)</li> </ul> | <b>Types of grants:</b> capital; direct services<br><b>Populations of focus:</b> <ul style="list-style-type: none"> <li>• Children/youth</li> <li>• Low-income</li> <li>• All residents within certain geography</li> </ul>  | <ul style="list-style-type: none"> <li>• Access to health care</li> <li>• Behavioral health services</li> <li>• Education on how to manage chronic conditions</li> <li>• Oral health</li> <li>• School health</li> <li>• Health information technology</li> </ul>  | (No grant titles/detail provided.)  |
| The Community Foundation Serving Boulder County   |  |  |   |
| Funding Priorities  | Methods of Funding   | Areas of Health Grants   | Additional Details on Grantmaking   |
| <ul style="list-style-type: none"> <li>• Arts</li> <li>• Children</li> <li>• Education</li> <li>• Environment</li> <li>• Civic engagement</li> <li>• Health and human services (Health accounts for 25% of grants)</li> </ul>                                 | <b>Types of grants:</b> direct services<br><b>Populations of focus:</b> <ul style="list-style-type: none"> <li>• Children/youth</li> <li>• Immigrants/refugees</li> <li>• Low-income</li> <li>• People with disabilities</li> <li>• People with high health care needs</li> <li>• Seniors</li> </ul> | <ul style="list-style-type: none"> <li>• Access to health care</li> <li>• Behavioral health services</li> <li>• Oral health</li> <li>• School health</li> <li>• Health information technology</li> </ul>   | Facilitates the Boulder County Health Improvement Collaborative (BCHIC) – a network of Boulder County providers and human services looking to improve patient outcomes. |
| Western Colorado Community Foundation   |  |  |   |
| Funding Priorities  | Methods of Funding   | Areas of Health Grants   | Additional Details on Grantmaking   |
| <ul style="list-style-type: none"> <li>• Children</li> <li>• Education</li> <li>• Environment</li> <li>• Families</li> <li>• Hunger</li> <li>• Plans for health in 2015</li> </ul>  | N/A  | <b>Future area:</b> access to health care  | <b>Access:</b> improved access in rural areas   |



## Next Steps

This asset and gap analysis conducted by the Colorado Health Institute and the resulting recommendations are intended to support The Colorado Health Access Fund as it moves forward in crafting a grantmaking strategy and begins to fund the projects and programs that can help to make a true and lasting difference.

A notable feature of this project is its aggressive time frame, and the Colorado Health Institute is pleased to continue its support of The Colorado Health Access Fund to ensure that all deadlines are met and the grantmaking moves forward.

First up will be the review of the report by The Denver Foundation. We are standing by to answer any questions or provide any additional information you may need. The Colorado Health Institute will be pleased to present the findings to The Denver Foundation staff members and its board.

We have mindfully created a strong role for the Advisory Committee, expecting that members will weigh in on the final decision points. We recommend this strategy in order to ensure statewide knowledge and support of the strategic direction of The Colorado Health Access Fund. We believe that Advisory Committee members will serve as champions within their communities for the funding goals.

The Colorado Health Institute proposes helping the committee members think through the data and recommendations and then helping the committee draft a final strategy. We consider this within the scope of our contracted work.

After The Denver Foundation and its Advisory Committee has settled on a grantmaking strategy, we will provide assistance in designing the request for proposals for The Colorado Health Access Fund.

The Colorado Health Institute recommends that The Colorado Health Access Fund RFP be structured based on these foundational principles:

- **The data and the evidence.** Applications should address evidence-based solutions. In addition, they should describe the regional factors that may have contributed to the need and the best practices or evidence supporting the approach to improving access to care.
- **Identified areas of need:** Depending on final decision points, these needs may focus on access to care “flashpoints,” subpopulations or innovations.
- **Vision, goals and objectives:** Goals must be specific, measurable, attainable, relevant and time-bound (SMART).
- **A plan for evaluating results.** The Colorado Health Institute’s forthcoming Evaluation Framework will help ensure that this key success factor is addressed.
- **A plan for sustainability.** A description of how the grantee plans to fund its program after The Colorado Health Access Fund grant ends.

Successful applicants should demonstrate:

- Clear leadership.
- A commitment to regional collaboration.
- Skills and expertise in working within the region or with a population with high health needs.

The Colorado Health Institute is developing an Evaluation Framework for The Colorado Health Access Fund. The framework will incorporate findings from this report as well as input from The Denver Foundation and The Colorado Health Access Fund’s Advisory Committee.

We also have submitted a proposal under separate cover for a two- to four-page summary publication of findings from this research to be made available to key informants and community dialogue participants.



## Conclusion

Colorado is a diverse state. Its people share some common health needs, but priorities vary by region. Demands on care will only continue to grow as more people gain insurance, the population ages and the state continues to grow. We heard from experts statewide and traveled across Colorado to listen to community members at ground zero of the battle to ensure that Coloradans have access to health care.

We developed The Colorado Health Access Fund Decision-Making Pyramid, which is built on a theory of change model framed around the six flashpoints; identifies an effective grantmaking strategy; and recommends specific funding opportunities based on the areas of highest need.

These are cross-cutting strategies that will reach thousands of Coloradans, including those with high health care needs, and that incorporate the four focus areas of interest identified by The Colorado Health Access Fund: health education, care transitions, delivery innovations, and improved access to care.

The Colorado Health Institute was honored to do this important work. We look forward to continuing to support The Colorado Health Access Fund moving forward, both in helping to select the final grantmaking focus and in developing the evaluation framework.



## End Notes

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# Appendix A

## Summary of Community Dialogues

The Colorado Health Institute conducted regional community dialogues with health care leaders in all parts of the state, plus a session with our Safety Net Advisory Committee in Denver. Participants were asked to prioritize the top three problems and solutions for access to care in their communities.

The conversations focused on the following questions:

- *What are the most pressing health care needs within your community?*
- *What access to care barriers has your community experienced?*
- *Do certain people or populations experience these barriers more than others?*
- *What strategies have been effective at addressing access to care issues in your community?*
- *What activities would you prioritize?*
- *What needs to be considered to encourage and support innovative long-term solutions?*

Here are summaries from each dialogue.

### Community Dialogue: **Alamosa**

**Date:** October 22, 2014

**Location:** Kavleys Business and Tech Center

**Attendees:**

**Carol Pfaffly** - Integration Specialist,  
West Central Mental Health

**Kay Martin** - Chief Operating Officer,  
West Central Mental Health

**Tony Sullivan** - Clinical Supervisor,  
West Central Mental Health

**Ellen Pedersen** - Coordinator and Community Health Worker, Gunnison County, Multicultural (DHHS)

**Connie Edgar** - Director,  
Conejos County Public Health Department

**Della Vieira** - Director,  
Alamosa County Public Health Department

**Reginaldo Garcia** - Community Research Liaison,  
University Partner, UCD - CCTSI

**Kathy Rogers** - Director of Development and PR,  
San Luis Valley Health

**Jackie Rheaume** - Grant Program Manager,  
San Luis Valley Health

**Gordon Hildebrant** - Director of Outreach,  
Centura Health

**Donna Wehe** - Patient Access Manager,  
Hub Coordinator for Connect for Health Colorado,  
San Luis Valley Health

**Audrey Reich** - Behavioral Health Program Manager,  
San Luis Valley Health

#### Takeaways

- Access to primary care and behavioral health services are important priorities in the San Luis Valley. While numerous barriers were discussed, one of the most popular solutions was finding a way to pay for behavioral health provided in the primary care setting. This was related to the broader goal of providing more preventive care – for both behavioral health and medical care – as well as education and support for self-care.
- There was a significant interest in having more case managers to help with transitions in care. This was part of a broader interest in helping people understand and access the health care system, from navigators to help with insurance enrollment, health insurance literacy and financial planning, to community health workers helping people get connected to community supports and providing



education for management of chronic illnesses.

- Having primary care providers do home health visits to help with transitions was also a popular solution. This would not only support transitions but also access to primary care and could be an opportunity to provide education and coaching on management of chronic conditions.
- Attendees also want to see a single state standard for credentialing providers to reduce time and paperwork needed to get providers credentialed by insurance. This would increase access to care by making it easier for people to find a provider that accepts their insurance. Care providers – particularly behavioral health providers– say private insurers claim to have enough providers credentialed in the region to see their patients, but patients can't get an appointment with a provider that accepts their insurance. It was pointed out that since most insurers are privately operated companies, this change in business practice could not be mandated and would be difficult if not impossible to achieve.
- Community partnerships and coordination of efforts are necessary to improve access to care in the San Luis Valley.

### Quotes

- “We have lost the art of self-care. Who is teaching the patient about their disease and how they can self-manage? Even taking Tylenol, I find a lot of people don't understand how to take that.”
- “Health coverage guides are funded by a grant out of Connect for Health, the new exchange, but what more can they do? How can they sit down and explain to people this is what your deductible is, this is when open enrollment comes and you could look for other plans that maybe could be more affordable.”
- “In small communities, when you're used to working with nothing, it's amazing what we can do with something.”
- “A lasting change at the disease level and at the cost of care level is going to have to focus on work on building personal responsibility, prevention and self-care.”

## Community Dialogue: Denver

**Date:** October 21, 2014

**Location:** The Denver Foundation Community Room

### Attendees:

- Adrienne Christy** – Health Coverage, Tri-County Health Network
- Tracy Johnson** – Director of Health Care Reform Initiatives, Denver Health
- Christie Donner** – Executive Director, Colorado Criminal Justice Reform Coalition
- Norma Portnoy** – Executive Director, Kids First Health Care
- Brooke Powers** – Program Manager, ClinicNet
- Sharon Adams** – Executive Director, ClinicNet
- Wendy Nading** – Nurse Manager, Tri-County Health Department
- Adela Flores-Brennan** – Executive Director, Colorado Consumer Health Initiative
- Joe Mauro** - JFM Consulting
- Jess Meyer** – Program Assistant, Colorado Coalition for the Medically Underserved (CCMU)
- Aubrey Hill** – Director of Health Systems Change, Colorado Coalition for the Medically Underserved
- Mona Allen** – PI Director, Integrated Community Health Partners
- Katy Valentyn Burlingame** – Manager, Clinical Quality, Colorado Community Health Alliance/Physician Health Partners
- Maggie Reyes-Leczinski** – Program Manager, Colorado Pediatric Collaborative /Physician Health Partners
- Mindy Klowden** – Director, Office of Healthcare Transformation, Jefferson Center for Mental Health
- Neysa Bermingham** – Access to Care Manager, Kaiser Permanente Colorado
- Jeanne Granville** – Executive Director, Fresh Start Inc.
- Kelly Marshall** – Senior Strategic Initiatives Analyst, Colorado Access
- Kristin Paulson** – Senior Manager of Policy & Initiatives, Center for Improving Value in Health Care
- Jim Garcia** – Executive Director, Clinica Tepeyac

**Moe Keller** – VP of Public Policy,  
Mental Health America Colorado

**Leo Kattari** – Health Policy Manager, One Colorado

**Lisa McCann** – Adviser, Mile High Health Alliance

**Charlene Shelton** – Researcher,  
University of Colorado Denver

### Takeaways

- There was a lot of interest in funding for facilitated meetings. This topic included time for providers to meet to improve coordination and integration, meetings for providers to learn what other practices are doing, broader community discussions to document successes and create a foundation for future innovation as well as facilitation of solutions tailored to specific community needs.
- There was also significant interest in education for patients and providers. This is a cross-cutting solution that could help address a range of access challenges, including health insurance literacy, increasing integration between behavioral health and primary care, and improving transitions in care. Care navigators/care coordinators were mentioned as one approach to provide this education. Meetings for providers were also discussed.
- Telehealth was also a popular solution to help increase access to specialty care, particularly in rural areas.
- Strengthening the safety net, which provides care for people regardless of insurance status, was also a priority. Discussion of this topic included the need for general operating dollars to support existing safety net work as well as expanded capacity. Collaboration between safety net providers was also mentioned as a necessary step to sustain safety net services.
- Using existing systems and better data sharing was a priority to help people maintain health insurance coverage. The discussion focused on the need to address Medicaid churn by identifying people before they lose coverage and help them submit the necessary paperwork to maintain Medicaid coverage or transition to private insurance.

### Quotes

- “How do we find out before someone falls off (Medicaid) that they’re about to? We haven’t been able to figure out how to do that, but that’s knowable.”
- “If I were a funder, I would want to look at what is needed for the health care delivery system to function better and how can I invest to get providers talking with each other to create a health care system in a community.”
- “I believe innovation exists, and we have not had the dollars and the bandwidth to document it and share it ... We haven’t done a good job of sharing what has already occurred.”

## Community Dialogue: Durango

**Date:** October 22, 2014

**Location:** Durango Community Recreation Center

### Attendees:

**Amita Nathwani** - Private Practitioner,  
Surya Health & Wellness

**Lisa Barrett** – Care Coordination Program Manager,  
San Juan Basin Health Department (SJBHD)

**Jessica Coker** – University of Denver Southwest Intern,  
SJBHD

**Pattie Adler** – Executive Director,  
Citizens Health Advisory Council

**Pam Wise Romero** – Chief Clinical Officer,  
Axis Health System

**Liane Jollon** – Executive Director, SJBHD

**Tara Jackson** – Pediatric Partners

**Kathleen McInnis** – Executive Director, Southwest  
Colorado Area Health Education Center (AHEC)

**Mary Dengler-Frey** - Special Projects Manager, SWC  
AHEC

### Takeaways

- Southwest Colorado is strengthened by the community’s collaboration, partnerships and

cooperation. This enables rural communities like Durango to innovate in areas such as developing care coordination, patient navigator and community health worker models.

- Southwest Colorado struggles with substance abuse, yet there is no inpatient respite, rehabilitation or detox in the region to help with treatment, especially for adolescents. Patients are often referred to Pueblo or Grand Junction.
- Telemedicine and telepsychiatry are in high demand but lack the funding to meet this demand. Telemedicine and telepsychiatry also have the potential to fill a large gap in pediatric specialists.
- Transportation is a huge barrier in the community's ability to access care. It is only getting worse as the cost of living outpaces wages of the community, and there is no place to house a workforce. The region's seniors and low-income populations are being pushed farther out to small rural communities, where a lack of transportation and communication is especially problematic.
- There's a "middle income group" of people who aren't getting their health needs addressed. These people earn enough that they don't qualify for public insurance or financial assistance to purchase private insurance, but they still cannot afford health insurance. Even those who receive tax subsidies cannot afford the high deductibles for care. The high cost of living in Durango contributes to this issue.

### Quotes

- "Housing and homelessness is an issue in resort communities with high rent and low-wage jobs. There is no place to go or live when individuals come out of psychiatric care."
- "There are no public health wellness programs, outreach, or education – it doesn't exist here, especially for low-income individuals."
- "Transportation is why people 'no-show' for their appointments. This problem will only get worse. We have no place to house a workforce – the cost of living has far outpaced wages of the community."

## Community Dialogue: Fountain

**Date:** October 28, 2014

**Location:** Peak Vista Community Health Center

### Attendees:

**Maria Hernandez** – Resource Navigator Supervisor, Peak Vista Community Health Center (PVCHC)

**Angelia Velasquez** – Resource Navigator, PVCHC

**Lindsay Reeves** – Community Engagement Director, Pueblo Triple Aim

**Michelle East** – Program Coordinator for Integrated Services, Pueblo Community Health Center

**Peggy Herbertson** – Executive Director, SET Family Medical Clinics

**Carrie Schillinger** – Program Assistant, Pikes Peak Area Council of Governments, Area Agency on Aging

**Matt Guy** – Managing Director, Pueblo Triple Aim

**Melissa DeSutter** – Marketing and Communications Manager, Rocky Mountain Health Care Services

**Lynn Procell** – Director of Community Health, Pueblo City-County Health Department

**Erin Taylor** – Development Manager, Tri-Lakes Cares

**Randy Hylton** – Director of Communications, PVCHC

**Venita Pine** – Vice President of Administration, PVCHC

**Mia Ramirez** – Community Benefit, Senior Community Health Specialist, Kaiser Permanente Colorado

**Kim Weiss** – Care Manager, PVCHC

**Kelley Vivian** – Community Strategies Director, Community Health Partnership

**Jeff Martin** – Executive Director, Open Bible Medical Clinic, TLC Pharmacy, Colorado Springs Fire Department

### Takeaways

- There is a shortage of primary care providers and certain specialists (psychiatrists, neurologists and pain management). Recruitment for the area needs to be ramped up not only for primary care providers but also mid-level providers.
- Transportation is difficult between Pueblo and Denver. There is no single solution. Medicaid pays

for a bus from Pueblo to Denver, but patients still have to make their own way from the bus stop to the appointment.

- Two populations of interest in the area are inmates and the undocumented. Participants mentioned that there are few resources for undocumented families. Recently incarcerated people either lost benefits or never had benefits. Programs that can send a navigator with a Medicaid application before the person is released hold promise.
- The safety net is still a very important resource and continues to need funding. Participants believe that there is a misconception that high-deductible plans and high churn are not affecting people.
- Care coordination needs more structure. To do this and ensure that care coordination is sustainable, payment needs to shift away from fee-for-service to an outcomes-driven system.
- Non-medical barriers such as housing, transportation and safety were this group's highest priority.

### Quotes

- "Each client needs a team, and every client needs a different team."
- "There are no resources for those undocumented families. Big centers have turned down children for care because they're simply not a U.S. citizen. This has been a huge piece that we struggle with."
- "If patients themselves aren't ready, they can be their own worst barrier. I've needed to learn where a patient is at and not jump ahead of them. Unless the patient is on board, you're at a standstill, even if you know the solution. Through patient navigation courses, we've learned some techniques to get to root of issues."

## Community Dialogue: Greeley

**Date:** October 29, 2014

**Location:** Community Foundation Serving Greeley and Weld County

### Attendees:

**Mark Wallace** – CEO/Executive Director, North Colorado Health Alliance (NCHA) /Weld County Department of Public Health and the Environment

**Judy Knapp** – President, Community Foundation Serving Greeley and Weld County

**Joanna Martinson** – Director of Care Coordination, NCHA

**Rand E. Morgan** – Volunteer, Community Foundation Serving Greeley and Weld County

**Erica Siemers** – Senior Director, Poudre Valley Hospital and Medical Center of the Rockies Foundation

**Lyle Smith Graybeal** – VP of Community Impact, United Way of Weld County

**Carol Plock** – Executive Director, Health District of Northern Larimer County

### Takeaways

- The undocumented are a population of special interest in the area. They are living in a cash economy that creates difficulties in obtaining needed care. There is also fear, which limits the system's ability to help undocumented families.
- Obtaining insurance coverage and education about how to use it, what it does and does not cover are important, fundamental needs.
- Participants expressed a strong desire for a more connected health information exchange. There needs to be more training around the sharing of health information, clarifying what information can and cannot be shared under HIPAA and other state and federal statutes. Agencies need to work together.
- Community members living in poverty require a different approach to care. The point was made that more flexible systems are needed to care for those with high health needs, because the current system does not always meet their needs.
- Substance abuse and behavioral health are of particular concern in this area. People with high health needs and chronic disease often are experiencing substance use or mental health issues. The region needs more residential facilities to treat

dual disorders of behavioral health and substance abuse. Behavioral care is not complete without psychiatrists, especially for people with high health needs, and there is a shortage in this specialty.

- Intense, personalized coordination is needed to reach the highest need population. This should be accomplished using not just a single patient navigator, but a team that can follow the person's care very closely.

### Quotes

- "I caution foundations against being so evidence-based that it stifles innovation."
- "People tend to think if you take the highest needs population and educate them a little, they'll be fine alone. That's not true. Those with the highest needs have behavioral health issues and really intense needs that require continual work with care management."
- "If you're looking for high health need population, you must look at behavioral health. We have a critical shortages of psychiatrists."
- "When reaching out to Latinos, we missed the mark in trying to do outreach. We put a white middle class spin on insurance. Latinos don't use the Internet to order things as much as the white middle class. They aren't sensitive to purchasing in the way we sold it (Connect for Health Colorado) to them."

## Community Dialogue: La Junta

**Date:** October 24, 2014

**Location:** Arkansas Valley Regional Medical Center

### Attendees:

**Claire Chadwell-Bell** – Regional Clinical Care Director, Integrated Community Health Partners (IHP)

**Janette Bender** – CFO, Arkansas Valley Regional Medical Center

**Doreen Gonzales** – Executive Director, Southeastern Area Health Education Center (AHEC)

**Jerry Sitton** – Action 22

**Debbie Channel** – Clinical Manager, Spanish Peaks Regional Health

**Rick Veatch** – Grant Manager, Spanish Peaks Health Care Systems

**JC Carrica** – Chief Operations Officer, Southeast Health Group

**Lynn Crowell** – CEO, Arkansas Valley Regional Medical Center

**Barry Shiohita** – CFO, Southeast Health Group

**Terry L. Miller** – Business Manager, Rocky Ford Family Health

**Karen Tomky** – Family Nurse Practitioner, Centennial Family Health Centers

### Takeaways

- Transportation is a top barrier in southeast Colorado. Suggestions for alleviating this problem included funding for health navigators who can transport people to and from appointments or visit them in their own homes.
- The region is experiencing a provider shortage, which includes a shortage of primary care providers as well as specialists of all types, but especially psychiatrists. Telehealth seems to be working as one solution to this problem, but more exploration might be needed on what type of telehealth would be best to fund.
- Many are weary of taking grant-funded positions and want something more sustainable. The program becomes an expectation in the community, and if it's taken away when a grant ends, it damages the reputation of health care groups that supported the grant.
- Health literacy is a large concern in the region. There is a high number of non-English speakers, migrant farm workers and people with low educational attainment. Participants voiced a need to send digestible information. Patient navigators are a promising solution.
- The depressed economy of the area means that health care is unaffordable for many. Co-pays are a barrier. Despite the region's influx of enrollees in Medicaid, another issue is pride – people don't want to go on government-funded programs. Some people need health insurance literacy programs to explain benefits.

## Quotes

- “Transportation is a big issue. It sounds kind of odd that people can’t drive 30 miles, but we’re the poorest county in state and a fair amount of people don’t have cars.”
- “What we need is access to capital. Even though we’re seeing a lot of influx of money coming in the door, I’m not sure how it’s going to be in two years or three years. So that’s the uncertainty.”
- “It’s a bit like frontier medicine. You have to be everything for everybody.”

## Community Dialogue: Rifle

**Date:** October 28, 2014

**Location:** Rifle Public Library

### Attendees:

**Margie Joy** – Pioneers Medical Center

**Susanne Morrison** – Program Director,  
Aspen Community Foundation

**Kay Ramachandran** – Executive Director, Marillac Clinic

**Sara Brainard** – Garfield County Public Health

**Jess Hankins** – Public Health Specialist,  
Garfield County Public Health

**Ross Brooks** – CEO, Mountain Family Health Center

**Dave Norman** – Area Agency on Aging of Northwest  
Colorado

**Jean Hammes** – Director, Alpine Area Agency on Aging

**Jenny Nate** – Senior Communication Strategies Leader,  
Rocky Mountain Health Plans

**Chriss Flynn** – Director of Marketing,  
Mind Springs Health

**Jackie Sievers** – Director of Community Resources,  
Hilltop Community Resources

**Annick Pruett** – Community Relations,  
Grand River Health

**Courtney O’Brien** – Director of Development,  
Mind Springs Health

## Takeaways

- There was significant interest in community health workers and health navigators who could help people get connected to a source of care, get connected to other community resources, get health insurance, and understand insurance options and how to use their benefits. RMHP support for care managers is an example of success.
- The skilled workforce is too small – not just doctors but also behavioral health providers, pharmacists and physical therapists. Funds are needed to expand the workforce through recruiting and sufficient pay.
- Foundation funding could help increase access to care by underwriting risk to accelerate innovation. Organizations, including nonprofits that operate on slim margins, would be more likely to try major innovations – such as payment reform or new models of care – if there was funding to help support some of the financial risk.
- People in the region want sustainability and integration of efforts – not a narrow, isolated grant-funded program that is not integrated with other efforts and programs.
- Collaboration and partnering within the community are essential. The community has many assets in its nonprofit sector, but the disparities and diversity within the region were identified as challenges.

## Quotes

- “Transportation is a big issue for us because there are services, but because of the geographic challenges, sometimes getting people to those services is an issue.”
- “Dental is a huge issue. With the expansion of Medicaid to adult Medicaid dental, I think the foundation would probably like to have a look at that.”
- “There are lots of things happening concurrently but not always connected or integrated. So how we can build that infrastructure? It is really about building that infrastructure, but also about finding out who’s doing similar things to reduce any duplication.”

- “There is a lot of good innovation happening around this, but it’s scary for each of our businesses to do all of these things because we’re used to protecting decades worth of our silos.”
- “Rural areas of the state typically do not have available funds to continue projects – so even if an innovative program is started with grant funding, it’s hard to continue as the sustainability within the community just isn’t there. We need the funds to continue and expand the work already being done rather than creating brand new projects.”
- “Community-based navigators can be very powerful in working across systems and can help break down those silos. We want to make sure people are established in care, whatever kind of care they need.”

## Community Dialogue: Safety Net Advisory Committee Learning Lab

**Date:** October 16, 2014

**Location:** Colorado Health Institute, Denver

### Attendees:

**Peggy Herbertson** – SET Family Medical Clinics

**Gary VanderArk** – Doctors Care

**Adam Bean** – Colorado Community Health Alliance

**Annie Taylor** – Caring for Colorado

**Elizabeth Baskett** – Colorado Department of Health  
Care Policy and Financing (HCPF)

**JD Besk** – HCPF

**Russ Kennedy** – HCPF

**Maureen O’Brien** – Telligen

**Doug Booth** – University of Denver

**Sheila Davis** – University of Denver

**Lori Roberts** – Integrated Community Health Partners

**Alexandra Channerings** – Colorado Hospital  
Association

**Jessica Dunbar** – Rocky Mountain Youth Clinics

**Carl Clark** – Mental Health Center of Denver

**Sarah Freeman** – Bell Policy Center

**Brooke Powers** – ClinicNET

**Deborah Costin** – Colorado Association for School-  
Based Health Care

**Sharon Steadman** – The Steadman Group

**Amber Burkhart** – Colorado Consumer Health Initiative  
(CCHI)

**Lila Cummings** – HCPF

**Christian Koltanski** – HCPF

**Lesley Reeder** – The Steadman Group

**Jerry Ware** – HCPF

**Sean-Casey King** – Kaiser Permanente Colorado

**Neysa Bermingham** – Kaiser Permanente Colorado

**Colleen Church** – Caring For Colorado

**Jess Meyer** – Colorado Coalition for the Medically  
Underserved (CCMU)

**Aubrey Hill** – CCMU

**Chet Seward** – Colorado Medical Society

**Claire Mylott** – Ground Floor Media

**Mindy Klowden** – Jefferson Center for Mental Health

**Dara Hesse** – The Colorado Health Foundation

**Joanna Martinson** – North Colorado Health Alliance

**Erin Lantz** – Colorado Community Health Network

**Dan Tuteur** – Colorado HealthOP

**Sharon Adams** – ClinicNET

**Debra Judy** – CCHI

**Lynn Doan** – CCHI

### Takeaways

- Among safety net experts, there is great interest in using community health workers to improve access to care and transitions in care. In addition to helping people navigate the often complex health care system, community health workers were also seen as a way to increase engagement and health literacy, which would help not only with access to care but increase self-management of chronic conditions.
- Access to specialty care, particularly for people covered by Medicaid, was also seen as a major problem. One proposed solution was having

specialists enroll in a program that requires them to see Medicaid patients, and in return specialists would receive a monthly payment for each Medicaid patient under their care, in addition to the fee-for-service payment they get each time a patient has an actual appointment.

- Network adequacy for private insurance coverage is a priority, because even people with private insurance often have trouble getting an appointment with a provider who is in network. A proposed solution was to define what an adequate network is for private insurance sold through Connect for Health Colorado.
- Transportation was widely recognized as a challenge to accessing health care, in both rural and urban areas. Finding ways to increase availability of

nonemergency medical transport was prioritized by the group, but there was no clear consensus on how to do this. One suggestion to improve transportation for the Medicaid population was to change state regulations to allow regional care coordination organizations (RCCOs) to provide transportation, instead of requiring them to use the statewide contractor.

- Linking non-medical and medical services is a holistic approach that would increase access to coverage and care, improve transitions and get people the care they need – be that medical care, transportation, food, housing or other services. If organizations providing one kind of care can recognize the need for other services and connect people to those resources, health and access to care can be improved for all.





# Appendix B

## Summary of Key Informant Interviews

The Colorado Health Institute conducted interviews with 22 experts on access to care in Colorado in two rounds. The questions asked in the first round were:

1. How has access to care changed in Colorado since state and federal health reforms were implemented? What Coloradans still experience access to care barriers?

*Probe for regions and/or population characteristics.*

2. Based on the work that you do, what are specific barriers to ensuring access to care? How do barriers vary in the different regions of the state?

*Probe for policy, regulatory, resources, workforce, technology, human capital.*

*Question may be revised based on key informants' area of expertise. For example, may ask specifically about transitions in care if that is area of expertise.*

3. Which Colorado organizations are leading efforts to improve access? Are they statewide or region-specific?

*Question may be repeated or revised based on key informants' area of expertise in the following: Patient/caregiver education, innovations in care delivery, care transitions.*

4. Are there specific interventions, programs or activities that would provide the greatest return on investment or are most effective to improve access to care? What changes, if any, would be needed to replicate/scale these activities?

*Repeat question for three innovations: Patient/caregiver education, innovations in care delivery, care transitions.*

5. If you were going to provide direct funding to two organizations or efforts underway to improving access to care, who or what would you select and why?

6. Are there communities or organizations that we should look at to learn more? Who are the game changers in Colorado when it comes to promoting/increasing/improving access to health care?

7. Is there anything that we did not discuss today or that I have not asked you about that you would like to share?

## Round One Interviews (Statewide Experts)

### Key Informant: Chris Adams

**Title:** President of Engaged Public

**Expertise:** Health policy consulting and facilitation

**Date of Interview:** October 14, 2014

#### Takeaways

- The first step to improving access is through programs that engage people to get covered and teach them how to use their coverage. But even with expanded coverage many vulnerable individuals are left uninsured or unaware of how to use coverage if they do have it, especially lower-income populations.
- Technology apps and tools can help educate patients who have a provider and those who do not. For example, tools can help improve a patient's relationship with his or her provider. For uninsured people without a provider, technology can help reach them. HCPF and the Colorado Health Foundation are working to introduce various portals, such as a smart phone app aimed at eligible but not enrolled individuals.
- Community-based leaders play an important role in improving health care literacy, especially physicians and providers. There is an opportunity to develop leadership with the human capital we already have – the providers. Grand Junction and Weld and Larimer counties exemplify communities that have active organizations, institutions and provider leaders who are committed to making health care accessible to all.

#### Quote

- "With the information revolution and expanded coverage right now, the next frontier is with consumer and patient engagement, getting people to understand their own role as a consumer."

## Key Informant: Don Mares

**Title:** (Former) President and CEO of Mental Health America of Colorado

**Expertise:** Legislation, access to care, behavioral health

**Date of Interview:** October 7, 2014

### Takeaways

- Coverage increased with Medicaid expansion and the ACA, but the challenge now is getting people through the door, especially for behavioral health. Community mental health centers had waiting lists before health reform, but waits have increased terribly with the newly covered Medicaid population that often has mental health needs.
- Two main barriers hinder access to behavioral health care: societal stigma and the lack of awareness and education around mental health, what it is, what defines a mental health issue, and how effective treatment can be. Addressing stigma and increasing population awareness around behavioral health can be effectively done in schools. Minorities and ethnic communities (e.g., Latinos, Native Americans, etc.), rural populations, new mothers, seniors, young children and men tend to face greater behavioral health barriers.
- Transitions in care is a huge issue in mental health. Gaps are especially large on both ends of the spectrum of severity of need. On the front end, there's no attention to behavioral health resources and education for people until they reach a critical state. Then, once they get into these facilities with 24/7 lockdown, there's no transition or follow up afterwards.
- Health care innovations such as telehealth and integrated care offer an opportunity to improve behavioral health care. The New Mexico ECHO project is an exemplary telemedicine program. Successful models of integrating care are Marillac Clinic in Grand Junction and Clinica Tepeyac. Funding should go toward nonprofits doing innovative integration work such as these two.

### Quote

- "Available funding should go to nonprofits doing

innovative integration work – clinics like Salud and Clinica are worthy of another look. You get more for your dollar [with these nonprofits] than the narrowly focused efforts like suicide prevention efforts. Fund more upstream efforts that target broader issues and younger ages, such as organizations doing [mental health] education in schools."

## Key Informant: Edie Sonn

**Title:** (Former) Vice President, Strategic Initiatives at Center for Improving Value in Health Care

**Expertise:** Payment reform, payment systems

**Date of Interview:** October 9, 2014

### Takeaways

- State reform has moved Medicaid toward accountable care, which has pushed delivery markets toward coordinated care and bundled payment models. These changes have the potential to improve outcomes by enhancing coordination and communication among providers. Improving transitions of care will depend on also improving communication and health information exchange between settings.
- The greatest opportunity for improving access is in policy. Colorado should use state policy levers that are available for change such as the essential health benefits in the exchange. The Colorado exchange should be used to drive payer behavior, and we can analyze how states have used their exchange as an active purchaser.
- There are opportunities to expand the community paramedic model, especially if they are aligned with community health worker initiatives.

### Quote

- "Major barriers to improving care transitions are communication and information exchange – the lack of health information exchange connectivity between care settings and real and perceived barriers to the kind of information that can be shared. Most providers err on the side of caution when sharing patient information. The common thought is, 'when in doubt, don't share.'"

## Key Informant: Elisabeth Arenales

**Title:** Health Program Director at Colorado Center on Law and Policy

**Expertise:** Advocacy and litigation focused on health care, especially for the poor

**Date of Interview:** October 17, 2014

### Takeaways

- Think creatively about how to increase access to care, especially in rural communities where you should make use of resources that they already have such as EMTs and paramedics to help monitor people who are homebound, school buses for transportation, and school health centers as a community's primary point of care. Other opportunities for improvement include telemedicine and integration of care.
- The Denver Foundation has previously worked on grants that focus on social factors. Integrate this work and understanding with health and health care because health is so closely linked to social factors such as poverty, transportation and connection to community resources.
- Coverage is the best proxy we have for access to care. Do deep, community-specific work to get people covered and know what it really means for them to have access. Promote ground-level, consumer-oriented, cultural competency work so that people understand how to use their own coverage and why coverage is important.

### Quote

- "As a foundation, you can do a lot to drive the conversation. If you're going to be working in particular communities, that's who you'll need to talk to. Where are their priorities? If you're trying to change access in communities, then talk to people in that community."

## Key Informants: Iva Conner, Kathy McCafferty

**Title:** CNIC Health Solutions

**Expertise:** Connecting patients with high health needs to care. CNIC was the third party administrator for CoverColorado.

**Date of Interview:** October 13, 2014

### Takeaways

- CoverColorado provided coverage to members with pre-existing conditions who were unable to obtain coverage elsewhere. Due to the pre-existing conditions, the average talk time in customer service and care management for CoverColorado members was akin to a Medicare population. CoverColorado members typically had multiple diagnoses and thus multiple needs. We found that this population was well served when pooled together and managed by a team versed in working with members with higher level service needs.
- CoverColorado covered a lot of patients who suffered from severe and ongoing mental health issues. Many of them were difficult to work with and couldn't get coverage besides CoverColorado because of their pre-existing mental health condition. They also didn't have the patient education or finances to follow prescription directions. Patient education and a general fund where people can apply to get additional financial assistance would help with this.
- Patients under CoverColorado didn't have many issues getting specialty care and they usually didn't have to travel far to get to a specialist. This may be because they weren't Medicaid patients, though CoverColorado also had a large provider network. Patients near state borders could also go out of Colorado to get care at discount prices.
- We need to support transitions in care, such as setting people up in long-term care facilities and paying for equipment and maintenance of equipment. Home care is cheaper than in facilities, but families need to be taught about how to care for and transfer their family members.

### Quote

- "Are there any studies about whether people under CoverColorado continued with new plans, and how many are out there without coverage again? This is a big concern. Lots of individuals said the exchange's premiums were too expensive."

## Key Informant: Fernando Pineda-Reyes

**Title:** CEO of CREA Results (Community Research Education Awareness)

**Expertise:** Education, public health campaigns

**Date of Interview:** October 15, 2014

### Takeaways

- Many people want to get coverage but don't know how. Others who have gained coverage do not have the time nor the resources to understand their coverage and how to access care. We need culturally relevant awareness and education campaigns that authentically engage communities around health coverage, access and prevention.
- The primary care medical home should be where patient medication, navigation and health care management all live. These clinic sites should have more nurses and assistants who are culturally competent and educated on best practices of community engagement. There's a position for community health workers, but right now it's outside of the current health care system.
- Grant money should be awarded to individuals and organizations you trust. Conduct site visits and meet with people face-to-face before giving the grants. Receiving grant awards generally comes down to writing the RFA, but often, these RFAs don't reflect who will actually deliver on what is requested.

### Quotes

- "Sometimes it's not about moving the needle, it's about creating a new needle."
- "Base the decision (of grant recipients) on an individual's experiences and successes – on their resume and history. Also take some risks. People will pleasantly surprise you and will step up to the task. ... Are you going to give a grant to the person who writes the best grant, or to the person who will do what you actually want them to do and will help you move the enterprise?"

## Key Informant: Grant Jones

**Title:** Founder and Director of Center for African American Health

**Expertise:** Community-based health work

**Date of Interview:** October 20, 2014

### Takeaways

- Access to care is not just about having coverage or proximity to coverage; it's also about addressing cultural barriers and offering people a trusted and culturally competent place for care whenever possible. Community-based health organizations are more suited to engage patients around health prevention, chronic disease management, and education in community settings, such as their local church or community center. Working from the ground up to determine community-level fixes is perhaps the most effective way to know what health issues exist and what will solve those issues ... close to where people live, worship and play.
- Evidence-based programs focused on prevention and chronic disease management are among the most promising not only for patients, but also for financially supporting the program's host organization. In the experience of the Center for African American Health, increased funding relied on whether programs were evidence-based. Community-based prevention and wellness programs—meeting people where they are with culturally proficient education and support—are a necessary supplement to traditional health care.
- There is room to improve transitions between diagnosing patients in the traditional health care setting and referring them to community-based services. We need a systematic referral method between clinics and community programs and we need process and commitment to value based payments for services provided, particularly when they are evidence-based and coordinated with the established health providers and hospitals and clinics.

### Quote

- "Access to care is not just about the place or distance of care ... Access is if it's close to where people live, and if it's trusted and culturally competent."

## Key Informant: Gabriel Kaplan

**Title:** Colorado Department of Public Health and Environment, Chief, Prevention Health Policy, Systems and Analytics Branch; Chief, Healthy Living and Chronic Disease Prevention Branch

**Expertise:** Statewide health policy issues and health prevention

**Date of Interview:** October 16, 2014

### Takeaways

- Since implementation of the ACA, three Colorado populations still experience access to care barriers – the undocumented, people who were unable or unwilling to get coverage, and people who obtained coverage but live in an underserved area. Because health reform brought an overall increase in coverage, some of our safety net programs – such as breast and cervical cancer screening programs – have seen a significant decrease in the numbers of people who qualify because now they have coverage.
- There is an opportunity to find and fund other care delivery models that go beyond the traditional members of the clinical care team and traditional care settings, such as community-based models with patient navigation programs, community health workers (CHWs) and community-based and health systems-based pharmacists. It's important that health providers and clinics understand and are aware of the community-based resources available to their patients and are willing to refer patients to them. Funding in this area should support organizations doing innovative health work, such as the Patient Navigator Community Health Worker Collaborative, Clinica Tepeyac, Marillac and other federally qualified health centers and rural safety nets trying to get innovations in patient care off the ground.
- Innovative models of care would benefit from institutionalized programs that offer education and certification to CHWs or patient navigators. To really incorporate these models into our health care system, they need to receive reimbursement that's built into the underlying costs of care. There is also an opportunity to do more research and evaluation around evidence of such models and the way non-clinical health workers are used in the medical setting.

### Quote

- “Don't just look to put funding towards direct care or services and forget to fund efforts that will move systemic change forward.”

## Key Informant: Katherine Mulready

**Title:** (Former) Health Policy Advisor, Office of Gov. John Hickenlooper

**Expertise:** Health policy, research and legislative affairs

**Date of Interview:** October 17, 2014

### Takeaways

- Look at the quality of the care provided, not just the quantity, to evaluate the return on investment. Is the care timely? Effective? Equitable?
- We're terrible at scaling effective projects and aligning existing resources. For example, consumers are sent to care coordinators to understand the system, but now coordinators need coordinating. Consumer education shouldn't be about accessing resources and understanding the system; that's an unrealistic expectation and something the health care system should take care of. Effective consumer education requires sharing the right amount of information to the right sub-populations. It's difficult to individualize consumer education so people understand how to appropriately utilize, but not overuse, their coverage.
- The State Innovation Model project is a great opportunity develop community buy-in for integrating behavioral and primary care. There's already public buy-in and readiness, but federal funding won't be enough to align the SIM project with community needs.

### Quote

- “This fund shouldn't be for new things, but rather to leverage what we've already done. We don't need new projects, we need proliferation of and coordination with existing projects. The coordination aspect is really huge and important.”

## Key Informant: Julie Reiskin

**Title:** Executive Director of Colorado Cross-Disability Coalition

**Expertise:** Access to care, health innovations, patient/caregiver education, care transitions, behavioral health

**Date of Interview:** October 8, 2014

### Takeaways

- Communities of color (including migrants and tribal communities in southwest Colorado), rural residents and patients with psychiatric and physical complications have a harder time getting care. People with disabilities especially have a difficult time finding doctors, even in the Denver Metro area. Doctors can now choose from a larger population of Medicaid patients, and they aren't choosing chronically ill or disabled patients.
- There is no statewide patient education program in Colorado. People need to understand how to use their coverage, especially with our system's lack of care coordination and new Medicaid population. Education opportunities could include online tools, webinars, advocacy training, a public campaign and clearer pathways to get necessary information.
- Increasing access to care often starts with primary care. Doctors, mid-levels, and physician assistants need training around disability competency, independent living and local community-based programs. Care managers and community promotoras can help increase access. However, promotoras are often too constricted in how they can help patients. Truly effective case managers need really low patient caseloads and the ability to work beyond health and help with social supports.

### Quotes

- "The barriers to accessing care aren't the cultural characteristics of patients; the barriers are the lack of cultural competency in the system."
- "People need to know there is a [health care] system for them, even if they don't know everything about the system. People need to know there are options."

## Key Informant: Marjie Harbrecht

**Title:** CEO, Health TeamWorks

**Expertise:** MD, physician manager; health care delivery innovations

**Date of Interview:** October 16, 2014

### Takeaways

- Achieving Triple Aim goals under the ACA, particularly reducing costs, is about reducing inappropriate emergency department visits, hospital admissions and readmissions, unnecessary testing and other inefficient uses of care, which requires increased access to a "usual source of care" (i.e., primary care team). This takes different strategies. To reduce ED visits we need to offer after-hours care and ensure patients know about it, engage patients in their own care to improve health and reduce inappropriate use of services, and provide a care management team for high-risk high-need people.
- Foundations need to work toward a common vision and align their efforts to build on what already exists and fill gaps where needed. With the State Innovation Model, which is focused on integration of primary and behavioral health care, and the BC3 collective impact work through the Colorado Health Foundation, this is a perfect opportunity for foundations to work synergistically to determine where their resources would make the most impact.
- Grantees and communities should also align their resources and funding needs. The Colorado Health Extension Services is a proposed example of this effort where they are centrally organizing grantees who provide practice transformation services, and locally using a community organizer to identify local communities' needs and connect them to those and other available resources. This is similar to what COREC did to spread services for meaningful use of medical records across the state, positioning Colorado as a top national performer in this area.

### Quote

- "Rather than thinking project by project, we need to develop a comprehensive statewide vision and strategy that is long term, sustainable and continues to build upon important foundational pieces that drive us toward our shared goals of improving health and health care across the state."

## Key Informant: Michelle Mills

**Title:** CEO of the Colorado Rural Health Center

**Expertise:** Access to care in rural areas, care transitions behavioral health

**Date of Interview:** October 7, 2014

### Takeaways

- Access varies between rural areas and within regions, but there is no clear variation at the larger regional level. Rural areas have communities of Hispanic, Native American and aging populations that especially experience access barriers. Hispanic and Native American communities experience cultural and communication barriers, but the unmet needs of Hispanic populations stand out most in rural Colorado. The elderly are also the only growing population in rural communities. With increasing disease and health problems in the aging, we need to come up with a model that sustains care.
- There are several areas where funding would help rural communities:
  - Local public health priorities have been identified in various communities. Funding could follow through on these needs and record the outcomes.
  - Support communities implementing health information technology. There's no more funding to help with Stage 2 meaningful use.
  - Community health workers/care coordinators/patient navigators. Promising programs include iCARE and Impact Spanish Peaks.
  - Workforce. Rural residencies help increase and recruit doctors, while loan repayment isn't sustainable long term.
  - Telehealth/telemedicine, especially for specialty care and behavioral health care.
  - Critical access clinics and rural health clinics need support as they move to a payment model that keeps them sustainable and keeps health care in the community. They've been cut out of the budget, and people don't realize the life-and-death necessity of them in rural areas.

### Quote

- "There is no one indicator to measure access to care in rural Colorado. The access varies between rural areas. Access is beyond whether a clinic exists nearby, but rather can the clinic meet the needs of the community?"

## Key Informant: Russ Johnson

**Title:** Senior Vice President for Network Development and Outreach, Centura Health

**Expertise:** Access to care, with an emphasis on rural and workforce issues; health innovations and technology

**Date of Interview:** October 15, 2014

### Takeaways

- Medicaid and coverage benefits still aren't being fully realized in rural and urban communities. In rural areas, most specialists are employed by hospitals and they must take Medicaid, but there are not enough full-time specialists. Outside of rural areas, many providers and specialists don't take Medicaid.
- Telehealth is a big opportunity that's starting to take off, especially because the technology is effective and it's now being reimbursed. Telehealth can advance important areas such as behavioral health supports, virtual primary care access, remote monitoring for chronic diseases and specialty care. To hasten the adoption of telehealth, we need a cultural acceptance and adoption among providers. We need to train providers on telehealth, and we need champions among physicians who will push for a culture change.
- The delivery system has been poor at transitions in care, partly because of the payment structure. Centura is building a group that helps with these warm hand-offs and creates an integrated system. It is also piloting a program in hospitals with 24/7 nurse navigation. Centura's work involves analyzing areas where transitions are most important and engaging physicians and providers in patient instruction and navigation.

### Quote

- "For the last 30 years, telehealth has been a technology on the come. We hear about it, but it hasn't actually come to fruition. Lately, that's changing, principally around reimbursement."

## Key Informant: Suzanne Brennan

**Title:** (Former) Medicaid Director, Colorado Department of Health Care Policy and Financing

**Expertise:** Coverage, delivery system innovation, long-term services and supports

**Date of Interview:** October 8, 2014

### Takeaways

- To have a sustainable health care model in rural communities, it is important for county leadership to understand what is happening in health care. This will allow them to make informed and sustainable decisions about the health care services in their community. The Leadville hospital and the Custer County clinic are two good examples where the community has struggled with how to provide an appropriate level of services that are financially sustainable.
- Telemedicine and remote monitoring can be more convenient for clients who don't have to make long drives to see specialists. It can address doctors' backlogs of Medicaid patients, but perhaps more importantly it is about improving the quality of care. Project ECHO and Doc-to-Doc (from Oklahoma) are two examples of innovative telemedicine.
- There are perverse reimbursement incentives within care transitions. Medicare will only pay for 30 days of post-hospital care for nursing facility care. Furthermore, nursing facilities get paid more from Medicare than Medicaid. As a result, nursing facilities receive higher reimbursement when their residents who are dually enrolled in Medicare and Medicaid are hospitalized. After the hospitalization and the dually enrolled resident returns to the nursing facility, the facility is reimbursed at the higher Medicare rate for the first 30 days.
- Funding should go to organizations doing innovative work such as ClinicNET, Colorado's version of Project ECHO, and Clinica Tepeyac's promotora model. Community health workers and chronic disease self-management are needed.

### Quote

- "We must think about how to change the model of

care delivery ... to shift from a health care perspective to a health perspective. We need to shift our focus to helping people live healthier and take better care of themselves, so they don't need more intense, invasive, and costly health care services."

## Round Two Interviews

*These interviewees were selected for their expertise in specific areas, to verify or probe on particular barriers, challenges or regions of the state. Interview questions were customized for the interview. Some interviewees were recommended by community dialogue participants.*

## Key Informants: Gordon Hildebrant and Samantha Lippolis

**Titles:** Director of Outreach and Telemedicine Program Manager, Centura Health

**Expertise:** Delivery system innovation, telehealth

**Date of Interview:** November 5, 2014

### Takeaways

- Start-up grants to bring telemedicine to more areas of Colorado would increase access to specialty care. Based on Centura's experience partnering with various clinics, a grant should fund start-up costs, including equipment and staff for project management, operations and training. But Centura cautions against providing grant funds to pay for direct health care services. To build a sustainable program, all services should be billed under current codes or contracted with insurers, ACO, RCCO, so a relatively short-term grant of about two years would only fund capital investment, project planning, operations staff time and training.
- Navigation services to help patients find and use the services they need are also important. Navigators understand what can be done locally and when resources from outside the community are needed. They would recommend funding health care navigation services to support both access to care and transitions in care.
- Transportation is also a major barrier in many



communities to smooth transitions in care, as well as accessing care. While insurance will pay for emergency transportation, even to services out of town, insurance does not cover transportation home. There is interest in a way to make nonemergency transportation more available, possibly through a voucher system.

- Successfully providing access to care is all about relationships, including those between providers, insurers and clinics, patients and providers, navigators and patients, and navigators and community resources. Establishing those relationships is critical, and it takes time. A proven track record of strong relationships, such as written agreements and clinical integration of some kind, can be important when considering awarding grants.

## Key Informant: Jamie Gulick

**Title:** Vice President of Programs and Community Resources, Mental Health America of Colorado (MHAC)

**Expertise:** Access to mental and behavioral health care in Colorado communities

**Date of Interview:** October 27, 2014

### Takeaways

- Mental Health America Colorado's priorities are to increase preventive care for mental health conditions, reduce stigma that prevents people from getting needed mental health services, and support integration of physical wellness and mental wellness. Stigma is a barrier to care for many people, but particularly for minority communities. MHAC is particularly interested in prevention efforts focusing on children and youth.
- Mental Health America Colorado is working with some specific programs to help improve and maintain mental wellness and improve access to mental health services as soon as they are needed. These programs include Check Your Head, an educational program for sixth- to ninth-graders, and Mental Health First Aid, an educational program to help adults understand mental health.
- Mental Health America Colorado has used grant

funding in Pueblo and Glenwood Springs. The organization has learned from this experience that relationships are key to the success of these programs. It is important to have a paid employee based in that community, preferably someone from that community.

## Key Informant: Joe Sammen

**Title:** Director of Community Initiatives, Colorado Coalition for the Medically Underserved

**Expertise:** Statewide community work around health care access for vulnerable Coloradans

**Date of Interview:** October 14, 2014

### Takeaways

- Health literacy and health insurance literacy is an increasing barrier across Colorado, especially for newly insured populations and in situations where people churn between coverage types. Promising initiatives across the state include the Coalition for Culturally Appropriate Response and Enrollment Services (CCARES), which provides presentations and education in English and Spanish to Latino communities, as well as promotora and community health worker models that focus on improving health literacy through building relationships and connecting patients to community resources.
- In addition to continuing barriers to access to primary care services for uninsured and underinsured individuals, access to specialty care is an issue in both urban and rural areas. Some community-based health alliances across Colorado – such as the Mile High Health Alliance in Denver – are working to create collaborative specialty care referral networks to address this issue.
- Many communities are working to create patient-centered approaches targeting “high utilizers” of services across Colorado. Examples include Rocky Mountain Health Plans' support of a nurse navigator pilot program, the North Colorado Health Alliance's nurse visitation program, and Bridges to Care in Aurora, which helps manage chronic conditions, getting patients out of the emergency room and into primary care.

## Key Informant: Doug Miller

**Title:** Owner and Nurse Practitioner, Rocky Ford Family Health Center

**Expertise:** Rural health, care for vulnerable and high needs populations in southeast Colorado

**Date of Interview:** October 23, 2014

### Takeaways

- Southeast Colorado faces multiple barriers given the depressed economy and rural area. The population is poorer. A recent article called southeast Colorado “Our Detroit.”
- The biggest needs are for specialty care, in particular, dermatology, pain doctors and psychiatrists. One solution would be telehealth, specifically teledermatology and telepsychiatry. Money is the biggest barrier – how to bill on both ends of the visit. Broadband access isn’t an issue.
- A barrier to people getting mental health care is stigma or lack of understanding. People don’t think they need mental health care, or they resist getting counseling. With integration between primary and behavioral health, a “warm hand-off” between primary and mental health is difficult when the patient doesn’t want it. It is difficult to implement patient education because there aren’t enough resources and time to sit and talk with the patient.
- Many people are on Medicaid in southeast Colorado. If older adults have long-term Medicaid, they’re in pretty good shape. If they don’t qualify, they struggle.
- Connectivity with other providers through electronic medical records holds promise, but it takes significant investment of time and financial resources.

## Key Informant: Julie Dreyfuss

**Title:** Executive Director, Community Connections (Durango)

**Expertise:** Care for individuals with intellectual disabilities in Durango

**Date of Interview:** October 29, 2014

### Takeaways

- Access to care for people with intellectual disabilities

is poor in southwest Colorado. The mental health system does not know how to provide services for these people and will often blame the disability for poor outcomes. Sometimes these people will go to jail instead of getting the mental health services they need.

- The region is isolated due to weather.
- Solutions include training a mental health provider on how to work with intellectual disabilities or to hire a trained psychiatrist. Another need is for a respite house in the community for mental health emergencies.
- Telemedicine is a promising opportunity, but providers are resisting, possibly due to liability, payment, scheduling or technology challenges. A telemedicine pilot program – or any other pilot program that addresses the needs of individuals with intellectual disabilities – would be welcomed.

## Key Informant: Jayla Sanchez Warren

**Title:** Executive Director, Denver Area Agency on Aging, Denver Regional Council of Governments

**Expertise:** Challenges facing seniors in the Denver area

**Date of Interview:** November 6, 2014

### Takeaways

- Denver’s senior community is experiencing the most significant split between the haves and have-nots in recent memory.
- Basic needs – such as securing affordable housing, transportation and health services – are the biggest challenge facing Denver’s aging population. Housing is in very short supply, and seniors are getting evicted because they can’t pay the increases in rent. Patients can’t get home- and community-based services if they don’t have a home.
- Seniors who don’t qualify for Medicaid are falling through the cracks and not getting needed services.
- Securing transportation to health care and other services is a challenge. Nonprofit organizations such as Seniors Resource Center and Volunteers of America operate transportation services, though additional staff “door-to-door” training is needed for people

who require assistance getting from the door of their home to the vehicle.

- A funding opportunity is to support innovative approaches that happen in the home: medical vans that take blood pressure, foot care, oral health services and blood draws, for example.

## Key Informant: Andrea Dwyer

**Title:** Executive Committee Member, Colorado Patient Navigator and Community Health Worker Collaborative; Co-Director, Colorado Colorectal Screening and Navigation Program

**Expertise:** Policy, research, policy and community innovation in patient navigation and community health worker models

**Date of Interview:** November 5, 2014

### Takeaways

- There are many variations of patient navigator and community health worker programs already in operation around Colorado. The evidence suggests that CHW and PN are effective at increasing screening and early detection of disease. There isn't as much data known about the impact of patient navigation after disease diagnosis or management of late stage disease, but in general it appears patient navigation makes an impact in improved outcomes.
- There is a lot of requests for information about details regarding return on investment. This is an area of interest and under investigation, but it's somewhat unclear at this time.
- The benefits of the lay community health workers and patient navigators are that they can allow nurses, doctors and other health professionals to practice at the top of their license while allowing CHWs and PNs to help with barrier reduction. They also play a role in improved health literacy of patients and often with connecting in a more culturally competent manner.
- The greatest need for philanthropic support is for efforts to make CHW and PN sustainable vs relying only on philanthropic dollars to directly support PNs and CHWs. This can happen by conducting return on investment analysis, work motion studies, developing common evaluation metrics, and credentialing and certification work.

- The work of the Patient Navigator and Community Health Worker Collaborative is a good resource to come learn who is doing what, what the sustainability challenges are and the opportunities to move the model forward.

## Key Informants:

### Liz Tansey and Sitora Rashidova

**Title:** Outreach and Enrollment Coordinators, Covering Kids and Families

**Expertise:** Connecting vulnerable children and families with public and private insurance coverage

**Date of Interview:** October 30, 2014

### Takeaways

- Barriers to enrolling in coverage include stigma about being on Medicaid, people who wait and see if something works before they try it, and the real or perceived cost of private insurance. Coloradans who have not had coverage for an extended period, who used to be qualified for the Colorado Indigent Care Program, and those who churn eligibility from Medicaid often find private insurance and related out-of-pocket costs unaffordable.
- Lack of health literacy and health coverage literacy are big challenges, especially for refugees and other immigrants who don't speak English or Spanish. A potential solution is having a case manager, community health worker or patient navigator who is from the community and speaks the language.
- There are a number of opportunities to address coverage literacy. Peer Health Insurance Rights and Education (PHIRE) is a curriculum designed to educate high school sophomores and juniors about health insurance – how you use it and what it costs. Students then educate their families, especially in areas where students speak English and parents do not. A coalition called Denver Outreach Partners is promoting the curriculum in the metro area.
- Another opportunity includes funding positions at hospitals or insurance companies who could call new members and walk them through their coverage. Connect for Health Colorado's health coverage guides can help people select a plan but are not equipped to assist the newly insured on how to use their coverage.



# Appendix C

## Colorado Health Access Fund: Colorado Community Foundation Survey

The Denver Foundation has asked the Colorado Health Institute to conduct research to help ensure the most effective and impactful grantmaking strategy for its new Colorado Health Access Fund. The goal of the fund is to increase access to health care and improve health outcomes among Coloradans across the state who have the highest health care needs.

The fund will focus on four categories of projects: education of those with high health needs, as well as their families and caregivers; transitions in care; innovation of care delivery; and improved access to care, particularly in rural communities. We anticipate that a request for proposals will be released in early 2015.

Findings from the Colorado Health Institute’s research will support the fund’s commitment to an equitable allocation of resources among rural, suburban and urban areas.

With that in mind, the Colorado Health Institute is administering a short survey to community foundations around Colorado. The purpose is to understand health care needs, current grantmaking priorities, and processes that can support the CHA Fund within your community or communities.

Please complete the survey by Friday, October 17, 2014.

### 1. Respondent Information

- a. First Name:
- b. Last Name:
- c. Title:
- d. Organization:
- e. Email Address:
- f. Phone Number:

### 2. What are your foundation’s current funding priorities? Mark all that apply.

- Arts
- Capital/Infrastructure
- Children
- Economic Development
- Education
- Environment
- Families
- Media/Communications
- Technology
- Other (please specify)

### 3. Is health a current funding priority of your foundation?

Yes/No  
(If selected Yes in Q3, answer Q4 through Q8. If selected No in Q3, skip to Q9)

### 4. In which Colorado Health Statistics Regions does your foundation fund health work? Mark all that apply. Include any additional information in the “Notes” field that you’d like us to know about your engagement in these areas. (Map was included of regions)

| Health Statistics Region Description                          | Check all that apply | Title/Description of Program |
|---|----------------------|------------------------------|
| Region 1: Logan, Morgan, Phillips, Sedgwick, Washington, Yuma |                      |                              |
| Region 2: Larimer   |                      |                              |
| Etc.  |                      |                              |

**5. You indicated that your foundation funds health-related initiatives. In which areas of health do you focus? Mark all that apply and provide the title and short description of the program.**

- Access to health care
- Behavioral health services
- Education on how to manage chronic conditions such as diabetes or asthma
- Long-term care
- Oral health
- Healthy eating
- Increased physical activity
- School health
- Health information technology
- Other (Please specify)

**6. What best describes your foundation's type of health-related grants? Mark all that apply.**

- Advocacy
- Capital
- Direct services
- Evaluation
- Research
- Other (Please specify)

**7. Do your health-related grantmaking activities focus on any specific populations? Mark all that apply.**

- Children/youth
- Immigrants/refugees
- Low-income
- People with disabilities
- People with high health care needs
- Seniors
- All residents within a certain geography
- All Coloradans
- Other (Please specify)

**8. Approximately what percentage of your foundation's annual grantmaking awards are for health-related activities? \_\_\_\_ %**

*(Skip to thank you page.)*

**9. Do you plan future grants in health? (Yes/no)**

**10. If yes, in which areas of health will your grant-making focus?**

*Mark all that apply and provide the title and short description of the program if available.*

- Access to health care
- Behavioral health services
- Education on how to manage chronic conditions such as diabetes or asthma
- Long-term care
- Oral health
- Healthy eating
- Increased physical activity
- School health
- Health information technology
- Other (Please Specify)

**11. When and in what regions will these grants be awarded?**

**12. Are there other organizations or individuals working on access-to-care issues within your community that you would suggest we contact? Is there anything else you'd like us to know?**

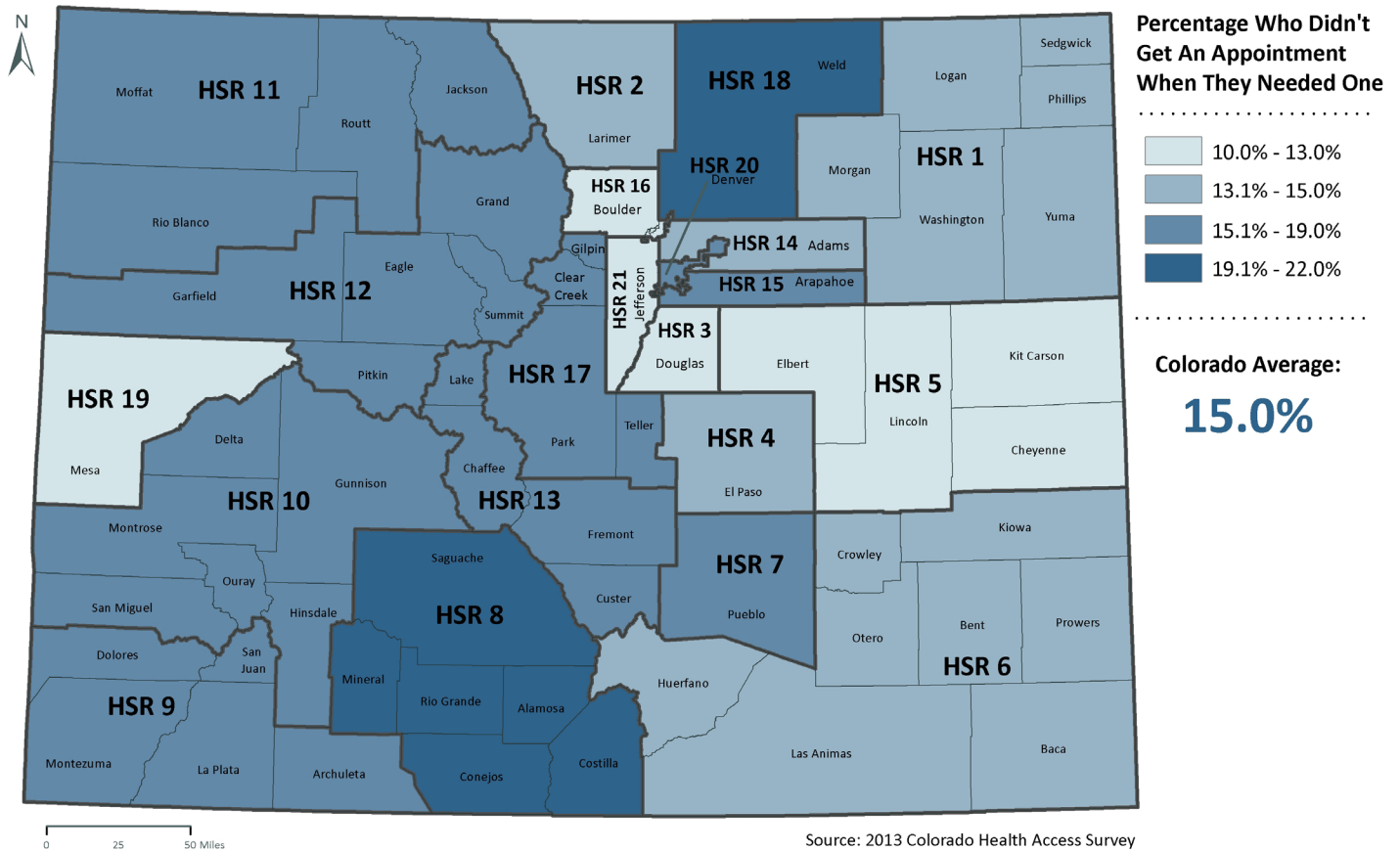
Thank you for your participation in this survey. If you have any questions or further feedback please contact Jeff Bontrager at the Colorado Health Institute. [bontragerj@coloradohealthinstitute.org](mailto:bontragerj@coloradohealthinstitute.org).

# Appendix D

## Additional Maps

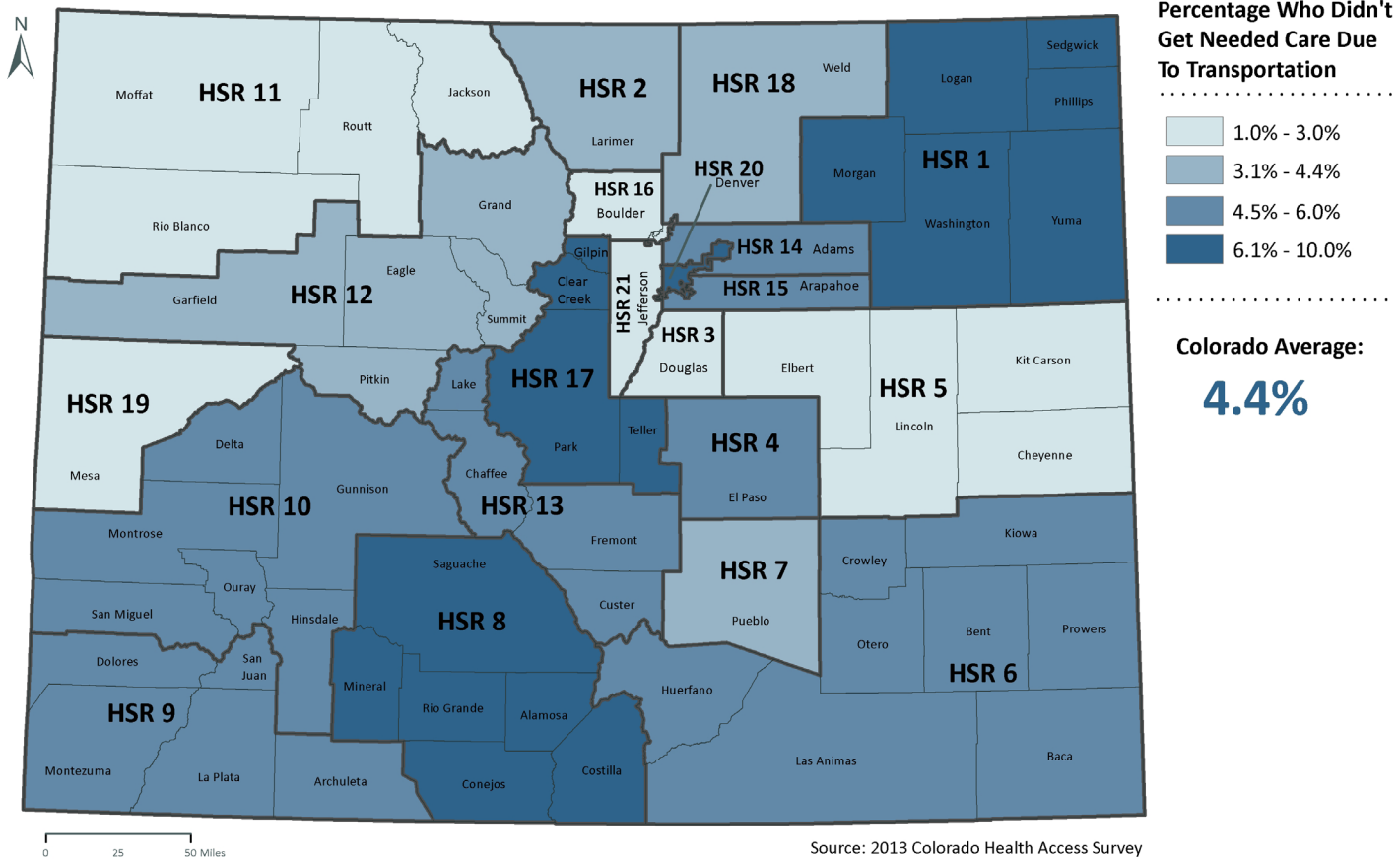
Map 11. Access to Care

Percentage of Coloradans Who Didn't Get An Appointment When Needed, by Health Statistics Region, 2013



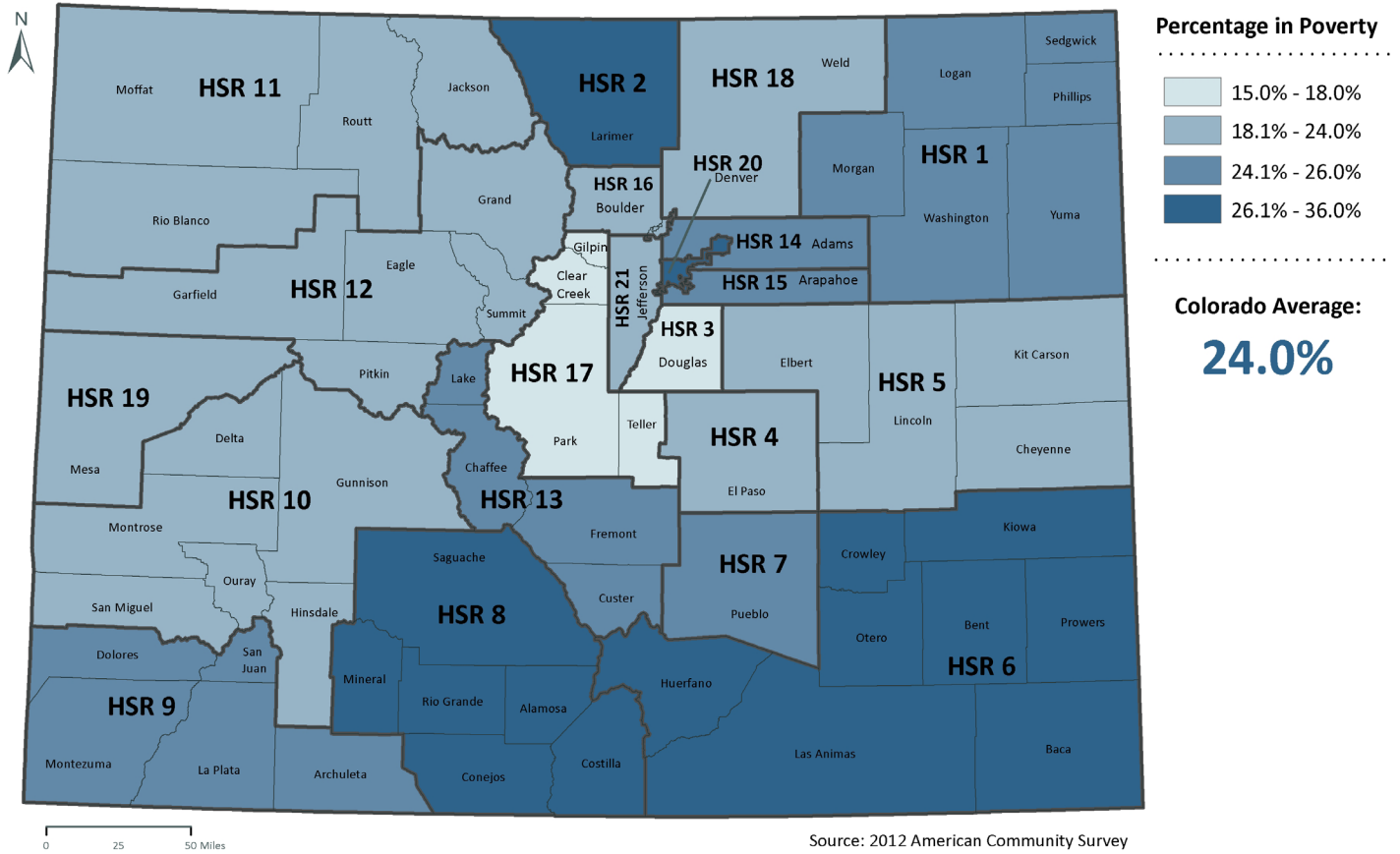
Map 12. Transportation

Percentage of Coloradans Who Did Not Get Needed Care Due to Transportation or Because Doctor's Office Was Too Far Away, by Health Statistics Region, 2013



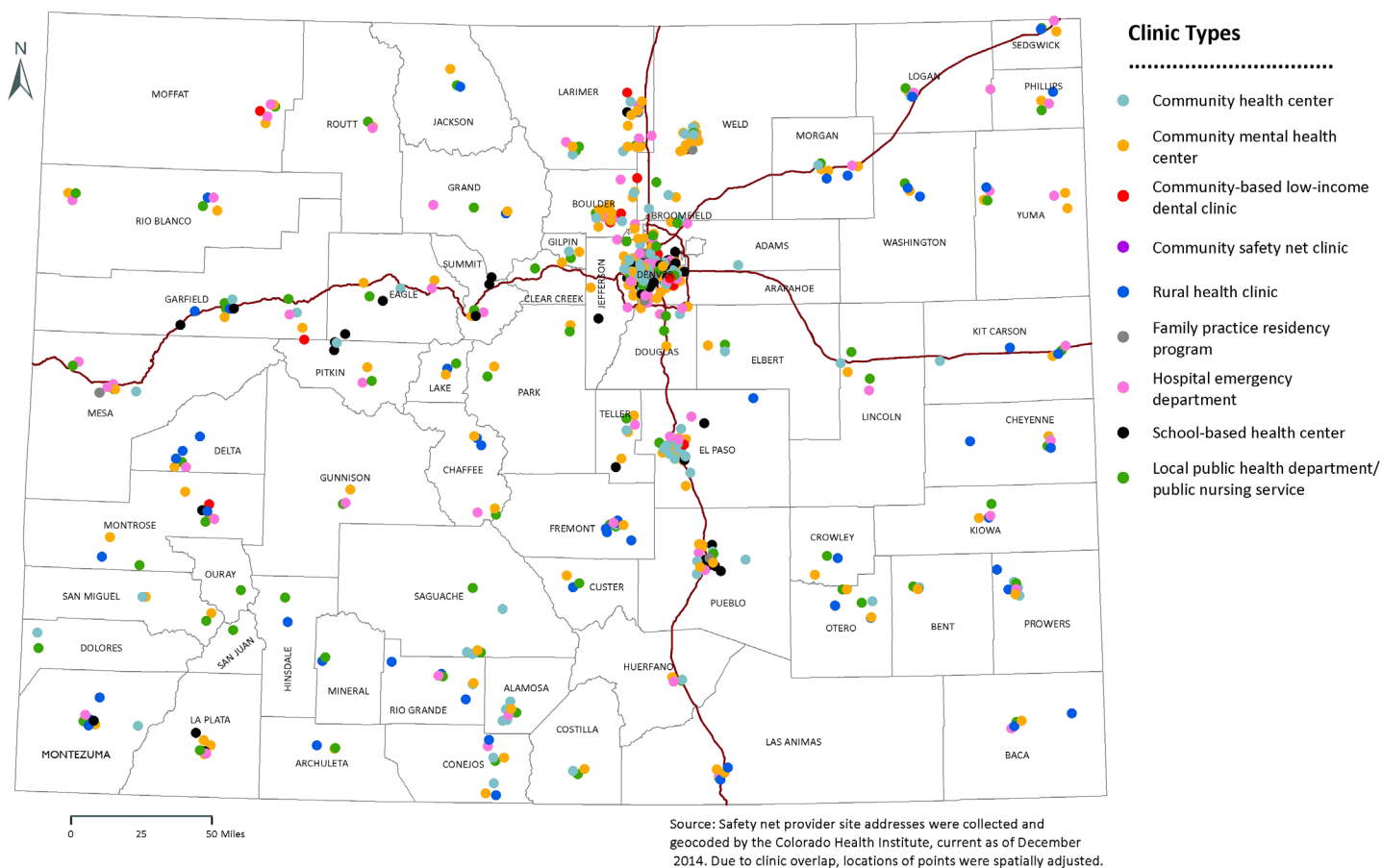
Map 13. Poverty

Percentage of Coloradans At or Below 100 Percent of the Federal Poverty Level, by Health Statistics Region, 2012





Map 14. Safety Net Clinics, Colorado, December 2014



The Colorado Health Institute used its definition of the health care safety net in developing this map. The providers identified on the map are discussed in greater depth in our August 2014 report, *Colorado's Health Care Safety Net*, available at <http://bit.ly/1CSK7hk>.

We also have posted an interactive map that allows users to identify safety net providers in their community. The map is available at <http://bit.ly/1zYFQJ1>.







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303 E. 17th Ave., Suite 930, Denver, CO 80203 • 303.831.4200  
[coloradohealthinstitute.org](http://coloradohealthinstitute.org)