



THE DENVER FOUNDATION



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INSTITUTE

Building From the Baseline

The Inaugural Cohort of the
Colorado Health Access Fund
of The Denver Foundation

THE COLORADO HEALTH ACCESS FUND 2016 ANNUAL EVALUATION REPORT

FEBRUARY 15, 2017



About the Colorado Health Access Fund

The Colorado Health Access Fund (the Fund) is a \$40 million initiative of The Denver Foundation to expand behavioral health care access to Coloradans with high health care needs.

The Denver Foundation retained the Colorado Health Institute (CHI) to independently evaluate the impact of the Fund. The evaluation measures the extent to which the Fund is moving the needle in behavioral health across the state. It also measures how well the Fund adheres to the donor's intent.

This first evaluation report provides results from the inaugural cohort of grantees. It synthesizes data from evaluation reports submitted by 27 grantees completing their first year of funding on September 1, 2016.

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.



THE DENVER FOUNDATION

Dear Stakeholders,

The Denver Foundation is pleased to present “Building from the Baseline,” the Colorado Health Access Fund’s 2016 Annual Report.

Established in 2015 with an anonymous gift of \$40 million, the Colorado Health Access Fund is dedicated to improving health outcomes for underserved Coloradans. Between 2015 and 2022, the fund will award up to \$5 million per year to initiatives that serve high-needs populations across the state. The Colorado Health Access Fund is a Field of Interest Fund managed by The Denver Foundation, which is entrusted to oversee its grantmaking and evaluation.

“Building from the Baseline” is an evaluation of the activity and impact of the Colorado Health Access Fund’s inaugural cohort of 28 grantees from across the state, who shared in nearly \$2.2 million in multi-year grants. Prepared in partnership with the Colorado Health Institute, Colorado’s experts in health and health evaluation, “Building from the Baseline” is the first of what will become an annual evaluation of the activity and impact of the fund.

Providing behavioral health services in Colorado—especially in rural and underserved communities—is no easy endeavor. In sharing this analysis with the community, The Denver Foundation aims to be transparent about the Colorado Health Access Fund’s successes as well as challenges. These findings will inform how we progress toward our goals in 2017 and beyond. They also advance the fund’s objectives by contributing to a collective body of knowledge on behavioral health programming in Colorado.

The past year has brought major new developments to the field of behavioral health in Colorado, including the opening of the National Behavioral Health Innovation Center at the University of Colorado Anschutz Medical Campus; the implementation of the State Innovation Model, designed to integrate behavioral and physical health across the health care system; and the launch a statewide crisis hotline championed by Governor John Hickenlooper.

We are proud to be part of this moment of change and forward momentum in the field of behavioral health. The Colorado Health Access Fund will continue to pursue its goals in partnership with grantees, experts, and the community to improve the health and lives of thousands of Coloradans.

Christine Márquez-Hudson
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Building From the Baseline

The First Year of the
Colorado Health Access Fund
of The Denver Foundation

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Providing behavioral health services in Colorado — especially in rural and underserved communities — is no easy endeavor.

Workforce shortages, lack of reimbursement, and the constant battle against stigma are among the most pressing challenges faced by providers on the front lines. In addition, the burden of mental illness and the barriers to Coloradans seeking necessary care are significant — for children, adolescents, and adults alike.

Yet there are bright spots. The Colorado Health Access Fund is one of those.

The evaluation by the Colorado Health Institute (CHI) of the Fund's first cohort of grantees has revealed many of the persistent challenges. But it has found that successes — and lessons learned — are significant as well.

This evaluation's key findings show the impact of the first cohort of the Fund as well as CHI's recommended changes for future grantmaking and learning:

- The Fund is generally on track to meet its mission of expanding behavioral health care access to Coloradans with high health care needs. Almost 32,000 people received services via the first cohort of grantees thanks in part to the funds made available.
- Grantees are diverse and serve a variety of populations. With some exceptions, however, they are not geographically dispersed across the whole state. To meet the intent of the donor, future grantmaking should take this into account.
- Grantees said that adequate staffing and financing were key ingredients to success — both for rolling out programs and ensuring a sustainable future after the Fund's support ends.
- Policy barriers do exist. Grantees raised opportunities to shape the way behavioral health providers are reimbursed and certified as Medicaid providers.

- Program interventions were wide-ranging, but all focused on at least one of the Fund's core focus areas. The most common focus area was improved access to care, with more than four of five grantees (81 percent) reporting targeted action in this area.

Many grantee achievements were attributed to common themes. Despite their diversity, many grantees valued:

1. Strong partnerships in the community and trust in clients;
2. Hiring — and retaining — experienced and culturally sensitive staff for programs;
3. Being able to adapt to the changing needs of their clients; and
4. Understanding the context in which they worked.

These findings will shape CHI's evaluation efforts in the coming year — and should inform future grantmaking by The Denver Foundation and Colorado's philanthropic community at large.

CHI's evaluation of the first cohort of the Fund's grantees illustrates one of the main objectives: to cultivate learning. This evaluation process is bringing grantees together to share best practices and to learn from challenges. The evaluation report is forming the basis for a shared body of knowledge on behavioral health programming in Colorado.

The Colorado Health Access Fund: A Patient's Story from La Clínica Tepeyac

In September, an existing patient came into the clinic with his wife. She had attempted to jump out of the window of their home, with the intent of committing suicide.

She was overwhelmed with the stress of providing for her family's basic needs on the low income that they managed to earn. In fact, she felt that there were times that she was forced to choose between food and medication. The woman was highly depressed, anxious, and desperate. The strength of our medical-behavioral health integrated care model was highlighted as medical and behavioral health staff collaborated to intervene in this crisis; medical staff had been trained to identify behavioral health crises and the streamlined process for effectively transferring care from one provider to another was demonstrated. Most importantly, though, this patient was able to receive crisis intervention and then longer term treatment for her behavioral health needs. She is now coping with the challenges of her life much better, and she knows that she will always have the support of staff at La Clínica Tepeyac.

This culture of learning extends beyond grantmaking. CHI will be responsive to the issues grantees raised during this first year of the Fund to make iterative changes to its evaluation approach.

This evaluation looks for what works and what doesn't in behavioral health care in Colorado. What's equally meaningful are the stories of Coloradans with high health care needs who are now able to access the care they need. Above all, it's those stories that reinforce grantees' successes.

Our Analysis

This annual evaluation report for the Fund is the first of its kind. The report's purpose is to address three questions:

1. What **contributions** have grantees made to increasing access to behavioral health services for Coloradans with high health care needs?
2. To what extent has the Fund been **implemented as expected**? This includes identifying successes, barriers, unintended consequences, administrative challenges, and how well grantees met their original goals within the Fund's four focus areas.
3. What are **recommendations** for The Denver Foundation as it enters the second year of Fund grantmaking?

The report is structured using the plan outlined in CHI's evaluation framework, *Leveraging Learning*. Findings are organized within the RE-AIM evaluation framework, which was adapted by including an additional aspect examining policy context. RE-AIM stands for Reach, Effectiveness, Adoption, Implementation, and Maintenance.

The RE-AIM+P framework is commonly used to translate research into practice. It examines programs that have worked in certain circumstances to improve future program planning. It does this by measuring validity — both internal and external. In other words, it looks for programs that have reached their intended outcome (internal validity) and that are generalizable (external validity).

Internal validity is addressed largely in the sections on Reach, Effectiveness, and Adoption. External validity is discussed in the last sections on the program's Implementation, Maintenance, and Policy.

This evaluation synthesizes data from evaluation reports submitted by 27 grantees who completed their first year of grant funding on September 1, 2016. This report refers to these 27 grantees as the Fund's first — or inaugural — cohort of grantees. Also included are takeaways from two Learning Circle gatherings during the year in which grantees shared best practices and opportunities for improving their programs and evaluation efforts.

Figure 1.

Tier One: *Grantee Contributions*

The focus of the evaluation is on the work of individual grantees. Tier One reviews grantee progress and measures its impact on access to behavioral health care. Each year, grantees address a set of standard measures and open-ended questions, alongside a self-directed evaluation that they create.

Tier Two: *Fidelity to the Fund's Intent*

The second tier focuses on whether the Fund has stayed true to its original intent:

- Is the Fund effectively aimed at efforts to improve access to needed services and health outcomes among Coloradans with high health care needs?
- Has grant-making targeted the four focus areas?
- Are grants equitably allocated among rural, urban and suburban areas?

This analysis includes a review of the grantees' collective contributions as well as the progress made by The Denver Foundation as steward of this Fund.

Tier Three: *Moving the Needle*

The third tier of the evaluation examines a set of state-level indicators capturing improvements in Coloradans' access to care. The two guiding questions for Tier Three are:

- Has access to health services for Coloradans with high health care needs improved since the Fund was established?
- In what ways has the Fund contributed to the improvement of behavioral health among these Coloradans?

The Evaluation

Tier One

Grantee Contributions

This evaluation includes findings from the three tiers of evaluation displayed in Figure 1. Special emphasis is given to Tier One – grantee contributions.

Included are key results under each of the six assessment areas in the RE-AIM+P framework, as well as supporting evidence and spotlights on grantee achievements or areas for improvement.

In light of these findings, the analysis offers recommendations for the Fund's future grantmaking.

1. Reach

The Fund focuses on Coloradans with high health care needs. This section describes the populations targeted by grantees. Guiding questions include:

- Approximately how many people were served by programs funded by the Fund?
- What are the demographic, geographic and health status characteristics of the target populations served by grantees?

Key Findings:

- The Fund provided almost 32,000 Coloradans access to behavioral health services.



Finding Common Ground: Christian Mueller, Executive Director of the Counseling and Education Center in Grand Junction, Colorado, seeks guidance from fellow grantees on how to address barriers to his program's implementation. Over 50 staff representing new and continuing grantees of the Fund gathered in November 2016 at the second Learning Circle of the year.

Photo: Flor Blake

- The Fund supported programs targeting Coloradans with high health care needs and who are at risk of facing barriers to care.
- Though the Fund served diverse clients, it could improve its geographic diversity.

Supporting Evidence:

Programs supported by the Fund served 32,000 people. This figure includes direct services provided at least in part by the grant, including counseling sessions, warm hand-offs, scaling up of existing programs, and development of individual care programs. In addition to direct care, programs delivered 31,000 screenings that did not lead to behavioral health interventions, and education campaigns that reached almost 600 people.

The first cohort of grantees¹ directed services to diverse populations. Interventions targeted people at risk of facing barriers to care, including Coloradans who are homeless, disabled, minorities and non-English speakers, and those with chronic disease. These populations match the intent of the Fund, which was directed towards Coloradans who:

- Have multiple chronic or acute health conditions;
- Lack health insurance coverage, have inadequate coverage, or have significant barriers to accessing coverage such as documentation status;
- Are low-income and/or homeless;
- Have a disability;
- Come from a culture different from the mainstream;
- Don't speak English well.

All grantees focused on a number of these target populations. The majority — 71 percent — of the Fund's dollars supporting the inaugural cohort of grantees went to programs targeting low income or unemployed Coloradans (Figure 2).

All grantees targeted Coloradans who are low-income, lack adequate insurance, and/or are at risk for behavioral health problems. Some grantees honed in on specific groups, or more than one:

- Two of every five grantees (41 percent) targeted minority clients, including immigrants, many of whom do not speak English.
- Three programs focused on homebound or disabled residents, and three other programs targeted homeless Coloradans.
- Almost a third (30 percent) focused on families, including parents and children. Others targeted individual groups like kids, teens, and seniors.

Recommendation:

After the first large cohort of grantees, the Fund has been supporting a smaller number of programs. Fewer grantees will mean even more targeted grantmaking. With that strategy, The Denver Foundation **should place even greater importance on where the behavioral health demand is greatest.** This may mean making grants to programs that serve broad populations or those serving a specific vulnerable population that represents the greatest need for behavioral health services.

Figure 2. Percentage of Funds Allocated to Grantees Focusing on Specific Populations, 2015-2016

All Grantees Could Target Multiple Populations

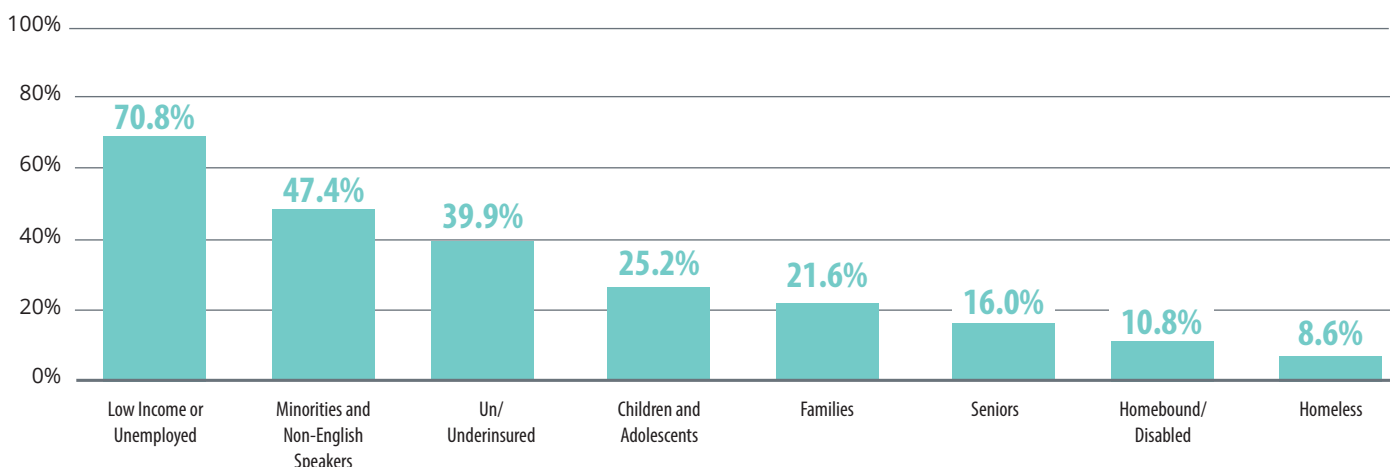


Figure 2 illustrates the percentage of funds allocated to grantees that focused on specific populations. The majority — 71 percent — of the Fund's dollars in the first year supported grantees that targeted low income or unemployed Coloradans.

Complex Care in the Mountains

Jefferson Center for Mental Health provides outpatient counseling for individuals and families, psychiatric medication evaluation and management, group therapy and 24-hour crisis services for Coloradans in Jefferson, Clear Creek and Gilpin counties. The Center submitted the excerpt below which highlights the complex needs associated with social isolation, especially in rural areas.

During a community event, an individual approached [the clinician] and expressed concerns about his neighbor, "Beth." Beth had arrived to their little mountain town a few months prior and lived in a tent. With winter approaching, the Sheriff and distant family members helped her move into a decrepit cabin. There, she kept to herself and was rarely seen.

[The clinician] visited the cabin and spent a couple of hours establishing rapport with Beth. [The clinician] learned that the cabin was in severe disrepair, and Beth had very little food and no means to cook it. She immediately called the local Meals on Wheels, and they were able to start delivering food the same day. Over the course of her work with Beth, the clinician connected her with community resources, including social services, Seniors' Resource Center, and healthcare providers. Beth is now able to make her own medical appointments, has a good relationship with Meals on Wheels, and she regularly sees a social worker.

2. Effectiveness

The Fund invests in programs that enable Coloradans with significant health issues to get the care they need. This section discusses how well grantees hit the mark. Among the guiding questions:

- To what extent are programs increasing access to care among people with high health care needs?
- To what extent are the programs effective?
- How are programs tailored to meet the unique characteristics of the region they serve?



During the November 2016 Learning Circle for grantees, Maristela Smith and Margo Casey share their experience delivering care at Inner City Health.
Photo: Flor Blake

Key Findings:

- The Fund made possible a variety of programs that are tailored to their target populations to increase access to behavioral health care.
- To rollout effective programs, grantees made recommendations focused on client relationships, program staff, community context, and program agility.

Supporting Evidence:

Grantee programs increased access to care using a variety of evidence-based interventions:

- Most programs provided direct care or a combination of direct care and integrated behavioral health and primary care. Of the 27 inaugural grantees submitting findings, 17 (63 percent) reported direct care, including home health or school-based counseling, or therapy for populations like seniors, teens or families. Almost another third (30 percent) of grantees worked toward integration of behavioral health services into physical health care.
- Remaining grantees delivered other programs, such as telehealth and screening services.

These programs met the unique needs of the target population by overcoming each region's barriers to care:

- Multiple grantees introduced behavioral health care services to more accessible places, such as schools and at home.

- Programs worked to overcome social barriers to care, such as lack of transportation. One grantee introduced a shuttle to transport patients to regional behavioral health care providers.

Grantees were asked to provide recommendations to other organizations trying to replicate this type of program in their communities. Their suggestions provide insight into what they feel was effective. They fall into four focus areas:

1. Cultivate Client Relationships

- Bring services to clients, such as in their school or home; meet them where they are. Introduce a sliding fee scale. Ensure program staff can bring services to patients despite geographic barriers faced in rural areas, like long travel times.
- Build trust in clients. Stigma is a real barrier to increasing care access. Relationships with providers and program staff can help overcome this challenge.

2. Engage Program Staff

- Engage staff in program design and implementation. Celebrate program successes early and publicly.
- Anticipate staffing challenges. For example, hire specialists who are credentialed Medicaid providers and who are culturally sensitive to the target population's needs.

3. Acknowledge the Community Context

- Build and maintain a strong organizational reputation in the community.
- Coordinate and build relationships with partners.
- Anticipate stigma around mental health. Raise awareness of the issues. Integrate behavioral health discussions into primary care.

- Be aware of existing social barriers (e.g. transient clients, transportation, housing).

4. Be Agile

- Evolve the evaluation strategy with the organization's needs. Introduce routine evaluation like a Plan, Do, Study, Act (PDSA) model, which tests out small changes during a program's implementation.
- Consider linking evaluation to existing electronic health record (EHR) systems by capturing data points required for evaluation, such as treatment plans and patient progress towards them.
- Provide the right level of expertise at the right time. Use masters level staff wisely to maximize patient care and reimbursement.

Recommendation:

The difficulty in finding qualified behavioral health staff — especially in rural communities — is discussed throughout this report. Grantees are more likely to be successful when they are willing to work with The Denver Foundation to identify alternate solutions to significant barriers. Therefore, **The Denver Foundation should ensure its grantee review process evaluates how well an organization:**

- Possesses the ability to plan ahead and adapt if things don't go as expected.
- Has thought out a Plan B and Plan C, particularly if unable to find the appropriate staff.
- Demonstrates the capacity to learn from self-evaluation and make mid-course corrections, if warranted.
- Is willing to work with The Denver Foundation to find alternate solutions, if needed.

Moving Forward Despite Adversity

The Center for Mental Health (Midwestern Colorado Mental Health Center) targeted three health care facilities to identify patients and provide needed behavioral health care. More than 1,700 patients in mountain communities were provided with care, despite a tragic event at one center.

The program was fully implemented in River Valley Family Health Center and in the Uncompahgre Medical Center. Sadly, the Basin Clinic is a different story. Right after receiving these grant funds, the Director of the Basin Clinic died very suddenly and unexpectedly. The Interim Director [...] stated that she was not prepared to implement integrated care at the Clinic and that the integration project would have to be postponed. This information was relayed to [...] The Denver Foundation [...]. After several attempts to re-engage the Basin Clinic, we learned on September 16, 2016 that [the Interim Director] was ready to begin having a full-time therapist at the Basin Clinic with a move toward full integration.

3. Adoption

For a program to make an impact on behavioral health care needs in Colorado, the target audience needs to opt in. This section addresses the following question: Out of all people eligible to participate in programs funded by the Fund, what portion opted in? This section looks at whether eligible people elected to participate — including community partners and Coloradans in need of care.

Key Findings:

- The Fund reached roughly six percent of Coloradans age 5 and older reporting poor mental health.
- Over 90 percent of grantees saw the large part of their target patient population and community partners opt into their programs — and their success could be linked to strong relationships with other actors working in their community.
- Stigma and geographic barriers were reported as common challenges to program adoption.

Supporting Evidence:

About one of 10 (9.9 percent) — or 478,000 Coloradans age five and older — report poor mental health, defined as having eight or more days of poor mental health in the past month.² And out of those residents, the inaugural programs supported by the Fund reached roughly six percent during its first year of implementation — 32,000 Coloradans.

Most programs supported by the Fund experienced a high level of uptake by local partner organizations and Coloradans seeking care. Grantees attributed successful uptake of their programs to collaboration with community partners. These partnerships helped grantees by:

- Making connections to existing stakeholders, so that grantees worked with their efforts, not against them.
- Educating grantees on what had been attempted in the community, so that they knew what worked and what didn't.
- Increasing referrals to grantee programs, leading to deeper client trust and more sustainable relationships with community members.

When adoption was low, it often came down to barriers to implementing programs in the target population. Programs serving rural communities are prime examples. For example, long travel times meant a

grantee could only serve a few patients at a time. Also, stigma often prevented patient engagement.

Recommendation:

The Denver Foundation should consider making grants to programs that can demonstrate their community leadership. Before rolling out their grant program, applicants should already have the necessary partnerships in place for successful implementation. If not, they should submit a letter of support or some other indication that key relationships are being cultivated.

The Importance of Partnerships

In their evaluations, most CHA Fund grantees underscored the importance of developing partnerships with other organizations in their community. The Denver Children's Advocacy Center, led by bilingual and bicultural Executive Director Dr. Gizane Indart, found that key ingredients in establishing those partnerships are time and trust. This was very important for a program providing mental health interventions for children in community settings such as homes and schools. Here's what the Center suggests:

[I]nvest time in planning and in getting to know community partners gradually before embarking on a major collaborative project. We have been most successful with the partnerships that evolved slowly so that joint expectations are clearly understood. Where there isn't the luxury of time to move slowly, we still advocate for a very careful and honest planning process that recognizes how much time and effort is involved for each partner.

4. Implementation

This section examines the collective progress that grantees have made toward their original goals and objectives. The guiding questions include:

- To what extent do Fund grantees implement the program described in their Request for Proposals (RFP) applications? Is there consistency?
- What significant challenges have grantees faced over the past year? For example, demographic changes, program challenges or community issues beyond their control?

Key Findings:

- Most grantees made progress toward goals they set in their applications.
- When objectives weren't met, grantees cited some common problems, including staffing their programs, billing for services, and other contextual issues like stigma, geography, and social barriers.

Supporting Evidence:

Nine of 10 (89 percent) grantees reported progress toward their original program goals.

- Two of three grantees (59 percent) said they made progress and a third (30 percent) exceeded their goals.
- Several grantees said they did not meet their objectives, and some reports did not make clear whether goals were met.

Some grantees experienced problems implementing their programs — especially when it came to financing services and finding and keeping the right staff. Among the issues:

- 63 percent of grantees reported challenges hiring and retaining experienced and credentialed staff members.
- A third (33 percent) of grantees said turnover was a problem. Organizations serving a largely rural population felt it the most. Over half of those grantees (57 percent) said they had trouble holding onto staff, possibly due to challenges related to living in and delivering services to rural parts of the state.
- Recruitment and hiring was the second most cited problem. Grantees said finding staff with appropriate levels of specialization, certification, and cultural

sensitivity proved difficult. They cited a shortage of behavioral health providers and the “burdensome” process of certifying staff as Medicaid providers.

Almost a third of grantees (30 percent) said financing service delivery was another major barrier. Specific issues included financing uncompensated care provided to non-billable patients, billing for behavioral health services, and securing other revenue sources.

- Many grantee interventions focused on integrating behavioral and physical health care — initiatives that require services that can't always be reimbursed.
- For example, “warm hand-offs” between a primary care provider and behavioral health provider aim to reduce stigma and missed appointments. Though not all clinics can pay for a behavioral health clinician to be on hand at any moment. Some grantees reported that a more traditional model of 50-minute counseling sessions were better for keeping the lights on in the clinic since longer sessions are more often reimbursable by insurance. However, this approach keeps the provider busy for most of the day and leaves little time for ad-hoc discussions with the primary care provider.
- Many clients served by the Fund lack insurance, can't pay for care, or are undocumented. This makes it even harder for grantees to bill insurance and stay in the black.
- These financing challenges lead grantees to supplement regular billing with sources of external funding, which are often earmarked and unpredictable.

Finally, contextual issues like social barriers, stigma, and geography also made program implementation a challenge. More than half (52 percent) of all grantees said these elements were barriers to successful implementation.

- Grantees listed a variety of underlying issues that raised obstacles, such as a lack of housing and transportation options.
- Both stigma and geographic obstacles created problems for delivering care in clinics or at private homes, especially in rural areas. Grantees in some regions said lengthy travel times and poor cell service made it difficult to coordinate service delivery.
- Grantees also said the need for behavioral health services is overwhelming available resources.

Recommendation:

When awarding and managing grants, The Denver Foundation should bear in mind the implementation challenges of staffing, financial sustainability, and geographic and social barriers. **The first goal should be to set up programs for success by encouraging grantees to plan for long-term financial sustainability.**

Another strategy is to match grantees with peer organizations undertaking similar interventions.

This will require The Denver Foundation to continue devoting staff resources to active management of grants, including working with grantees to address problems as they arise and tracking how each organization is faring with hiring, financing, and contextual barriers.

CHI's future evaluation efforts will also work to dig deeper into these challenges to program implementation and highlight innovative ways grantees are dealing with them.

Denver Health's Effective Expansion

Denver Health applied to the CHA Fund after identifying significant demand for substance use treatment among adolescents in its school-based health centers (SBHCs). The organization's evidence-based intervention that combined motivational interviewing and behavioral therapy reduced substance use, attention-deficit/hyperactivity (ADHD), depression and post-traumatic stress disorder (PTSD). The program was so successful that Denver Health has secured funding from other sources to implement it at two additional school-based health centers.

5. Maintenance

This section looks beyond the funding horizon of the Fund. It examines whether funded programs will have a life after the Fund's support ends and whether a program has potential to be scaled to a larger group of Coloradans. Guiding questions include:

- Will the programs be sustainable without Colorado Health Access Fund support?
- If so, what will be the impacts?

Key Findings:

- Though many grantees have a clear plan to ensure their programs will continue after support comes to an end, the majority will need to strengthen their long-term sustainability plan.
- Ensuring a smooth transition will often mean hiring additional staff or finding alternate funding sources.

Supporting Evidence:

More than half of grantees do not have a strong plan for future scale up or maintenance of their current grant programs.

- Two of five grantees (41 percent) have a clear plan in place to sustainably transition after the Fund ends.
- Almost as many (37 percent) have not yet clearly outlined how their programs will continue after the end of the grant.
- And one of five grantees (22 percent) — six programs funded in the first cohort — do not have any sustainability plan in place.

Grantees without long-term financial and staffing plans are less likely to maintain gains achieved under the Fund's support. Creating those long-term plans may require changes in staffing and revenue sources.

- Many grantees cited plans to increase staffing to continue to scale up their grant-funded program. Some proposals included training an additional counselor to serve a new target population or hiring an additional director-level staff member to continue to expand the program funded by the grant.
- Other long-term plans are aimed at future funding. Often, the Fund makes up more than half of a program's support, leading to the risk of financial shortfalls when the grant ends. Grantees cited efforts to seek short-term grant funding or diversify existing funding. Plans included identifying new external funders, increasing billing to private insurance, and extending services to more billable patients.

Recommendation:

The ability to scale an effective program often leads to additional financial support (see sidebars on Denver Health and the Summit Community Care Clinic). If not already doing so, **The Denver Foundation should consider strengthening its assessment of grantee sustainability and scalability.** A few strategies include:

- Assessing an applicant or grantee's ability to expand a successful intervention to new locations or populations.
- Requiring awardees to identify a specific milestone-based plan to ensure sustainability — particularly pertaining to financial solvency and the right staffing.
- Developing a collection of best practices that grantees have employed to scale and sustain their programs with support from the Fund.

Summit's Sustainability

The Summit Community Care Clinic (SCCC) serves patients in five central mountain counties. It applied to the Fund for general operating support to compensate for unreimbursed behavioral services to uninsured and other vulnerable residents. SCCC was able to expand its services to Lake County and form a broad-based sustainability plan:

Increased uninsured rates created an impetus to further engage community stakeholders in program sustainability, resulting in \$400,000 in donations from private donors, Summit County Government, Summit School District and local towns (Breckenridge, Frisco, and Silverthorne). This outreach enhanced understanding of the community-wide responsibility for behavioral health and motivated a desire to increase access. While this campaign prevented immediate cuts, high uninsurance rates will remain a challenge to sustainability.

SCCC recently achieved the ability to bill Medicaid for behavioral health. This and continued collaborations at State, Federal and local levels are essential to maintaining and expanding access to these critical services.

6. Policy

The Fund represents a unique opportunity to identify key policy hurdles and opportunities in behavioral health. The Fund cannot be used to advocate for policy changes. However, identifying policy opportunities can inform longer-term strategies to continue grant activities after funding ends.

This section focuses on three guiding questions:

- Does the policy context contribute to or detract from program effectiveness?
- What policy barriers or opportunities exist?
- Can the philanthropic community be an advocate?

Key Findings:

- Grantees cited recent legislation as positive steps toward adequate payment and reduced barriers to accessing behavioral health care.
- But barriers remain. Changing the way behavioral health practitioners are reimbursed and credentialed as Medicaid providers could increase behavioral health care access in Colorado.

Supporting Evidence:

Grantees frequently cited the policy environment as a barrier to program implementation. Grantees also cited examples of recent legislation that has reduced these barriers:

- The State Innovation Model is a positive effort to remove barriers to accessing behavioral health care.
- Grantees also applauded the federal Mental Health Parity and Addition Equity Act of 2008 that prevents insurers from imposing less favorable reimbursement limitations on mental health or substance abuse disorder benefits.³

Covering the costs of delivering services was a frequently cited barrier. Increasing or changing the way behavioral health services are reimbursed could be a policy lever.

- Proposals to reduce the financial burden included increasing reimbursement rates for providers and incentivizing facilities to provide uncompensated care.
- Grantees suggested that transitioning to completely integrated care is not fully supported by current payment structures. They said moving to a different

payment model that serves the whole patient could improve sustainability and patient outcomes.

- Some grantees also said that equating physical and behavioral health providers was a necessary cultural shift that would lead to a more a sustainable payment structure.

Finding a Medicaid-credentialed behavioral health practitioner was also cited as a key challenge to program success. Spending resources on credentialing was described as “burdensome” and a barrier to implementation. Policy changes in this area could be a lever.

- One grantee proposed making it easier for providers to become Medicaid credentialed. This would lighten the load on providers and increase supply for Coloradans with high health care needs.
- Grantees also suggested changing training incentives to increase the number of providers. One proposal was to increase scholarships for new providers, rather than forgiving large loans only after years of service.

Recommendation:

Potential policy changes affecting the way behavioral health services are delivered and

financed could increase access to behavioral health care in Colorado. Experiences of Fund grantees point to a handful of policy levers for future philanthropic action.

CHI will continue to monitor policy developments and inform the discussion of policy implications for Fund grantees.

Tier Two *Fidelity to the Fund's Intent*

Part of The Denver Foundation's charge is to adhere to the original donor's intent for the Fund: to improve access to care and health outcomes for Coloradans with high health care needs.

Accordingly, part of this evaluation assesses the extent to which that has happened. Simply put, CHI's findings show that the Fund did meet this goal in managing its first cohort of grantees.

Grantees also demonstrated innovative work in the Fund's four focus areas of education, access to care, transitions, and innovative care delivery. But the distribution of Funds — by population center and across the state — could be an area of focus for future grantmaking.

The Integration of Care: Two Perspectives

Two safety net providers — Doctors Care and Salud Family Health Centers — are very different grantees that both used their CHA Fund awards to expand their behavioral health programs. Both have embraced the integration of primary care and behavioral health care services. And both have identified some policy implications.

Doctors Care — serving Medicaid enrollees and other indigent patients in the south Denver metro area — assists behavioral health counselors to gain credentials to bill Medicaid. Credentialing is often a cumbersome process that limits the number of counselors to whom Doctors Care can refer Medicaid patients.

Salud Family Health Centers — operating health centers throughout rural northeast Colorado — recently gained the ability to bill insurance carriers, a development that will help secure the sustainability of its program.

Many grantees echoed the importance of reimbursement through Medicaid or other payers to be sustainable. They want to ensure that integrated services are reimbursable, because they see the promise of the model. As Salud points out, it encourages patients who are often nervous because of stigma to seek mental health services in a primary care setting. “Integrating behavioral health ‘normalizes’ the importance of mental [health] care to patients.”

Guiding Question: Has the Fund adhered to the donor's requirements and targeted efforts to improve health outcomes and access to needed services among Coloradans with high health care needs?

Yes, with room for improvement.

Grantees focused their interventions on Coloradans with the highest needs, including low-income or unemployed residents and the uninsured or underinsured.

Interventions were wide-ranging within the four focus areas of the Fund. Most focused on direct treatment, or integration of behavioral health into physical health care.

The majority of grantees — about nine of 10 of them — made progress towards or exceeded their original program goals.⁴

The donor's intent was also met by an innovative partnership between the Fund and the State Innovation Model (SIM). These two funders joined forces this past year to provide dual support to grantees, extending the impact of their programs.

However, the first year of the Fund was not without grantmaking setbacks.

- One vetted grantee closed after a year of grant implementation due to inability to pay its bills.
- Managing four cohorts of grantees during the first year of the Fund proved to be no easy feat. After starting out with an inaugural cohort of 28 grantees, The Denver Foundation found that was too many programs for them support effectively. The Fund became more selective in awarding new grantees — and each of the remaining cohorts included just 12 or fewer.
- Beyond changing vetting processes, The Denver Foundation has taken additional steps to improve grant management efforts for current and future grantees — such as providing feedback and technical support for grantees that raise red flags when programs don't go as planned. This will be an area for continued monitoring.

Guiding Question: Are the funds equitably allocated among rural, urban and suburban grantees?

Yes, and future grantmaking should keep equity in mind.

Screening Was Not the Intent of the Donor, But it Was Still Funded

The Fund is intended to support direct services in behavioral health — not screening.

But at least four Fund grantees delivered screening interventions — such as survey tools like the Patient Health Questionnaire 9 (PHQ-9) and Generalized Anxiety Disorder 8-item Scale (GAD7), or self-assessment surveys delivered via handheld e-tablets. At least one grantee focused its primary grant-funded intervention on screening.

These programs were awarded despite the Fund's efforts to consistently review proposals. This raised a red flag for The Denver Foundation to update its review processes.

Still, screening is an essential element — and often the first step — towards delivering behavioral health services that are integrated into primary care. It is sometimes it's unclear where screening ends and direct service begins.

The Fund has updated the way they review grantee proposals so that since April 2016, no grantees have been funded for screening activities.

Two thirds of grantees (18 of the 27 programs, or 67 percent) serve primarily urban Coloradans. Seven grantees (26 percent) serve primarily rural clients, and two are statewide initiatives.

The dollar breakdown was almost identical to the distribution of grantees. Almost \$2.5 million dollars were allocated to the Fund's first cohort of grantees— 26 percent for rural grantees, 66 percent for urban and suburban grantees, and the remaining nine percent were allocated to statewide initiatives.

At least two percent of the grant dollars going to the first cohort of grantees — or \$50,000 — was directed to capital investments, such as expanding a facility to integrate behavioral health services.

These allocations meet the original intent of the donor, which was to distribute at least twenty percent of grant funds to programs serving rural Colorado. Figure 3 shows that 26 percent of the Fund’s dollars going to the first cohort of grantees went to those located in rural areas of the state. The Denver Foundation should continue to monitor these funding decisions to ensure the Fund meets donor intent across all years of the Fund.

Guiding Question: Do grantees reflect the state’s geographic differences?

Yes, with room for improvement.

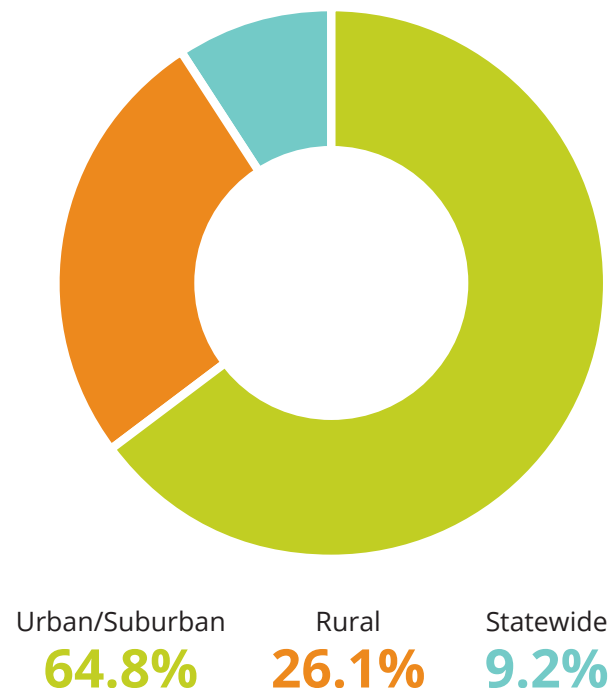
Figure 5 displays the home location of grantees for all cohorts awarded in 2015-16. It highlights that grantmaking for the first cohort focused on the Interstate 25 corridor. In the first cohort, 20 of 27 programs were primarily serving residents there.

Grantmaking did not extend much beyond this region. Five grantees (19 percent) served residents of the central and northwestern regions of the state. Four programs (15 percent) served clients in Eastern Plains, southwest, and San Luis Valley during the first year of assessment.⁵

Note that some grantees operate multiple locations which are not displayed on the map. Other grantees serve large geographic areas or make their services available to anybody living in Colorado.

Guiding Question: Does the collective work of grantees address each of the four focus areas:

Figure 3. Percentage of Funds by Grantee Location, 2015-2016



education of patients and caregivers, access to care, transitions in care and innovation in delivery?

Yes.

All grantees addressed at least one of the Fund’s core focus areas, though not all focus areas were supported equally (Figure 4).⁶

- The most represented area of work was increasing access to care, with more than four of five grantees (81 percent) reporting interventions in this area.

Figure 4. Percentage of Grantees Working in Each Focus Area, 2015-2016

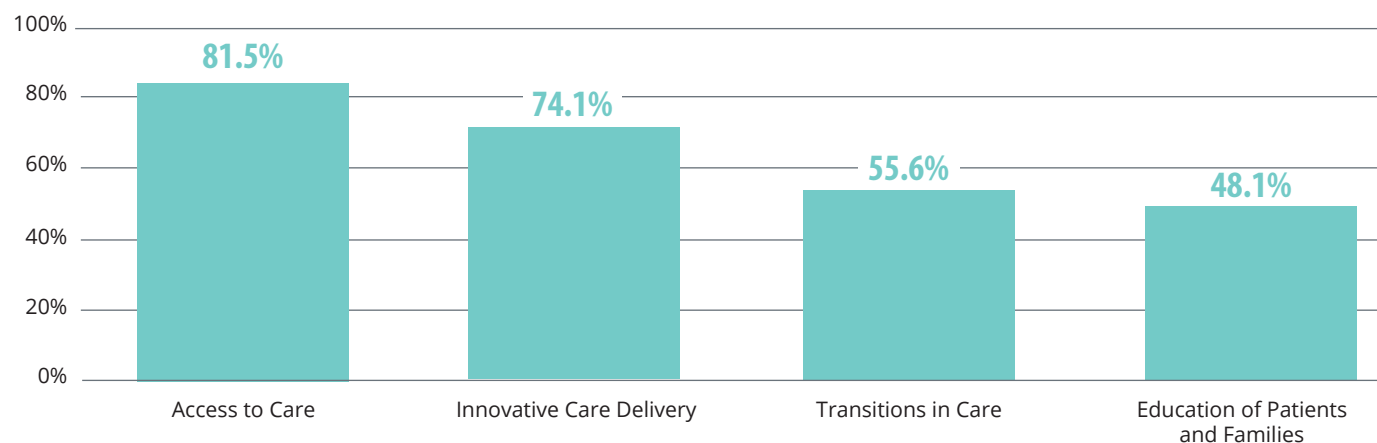

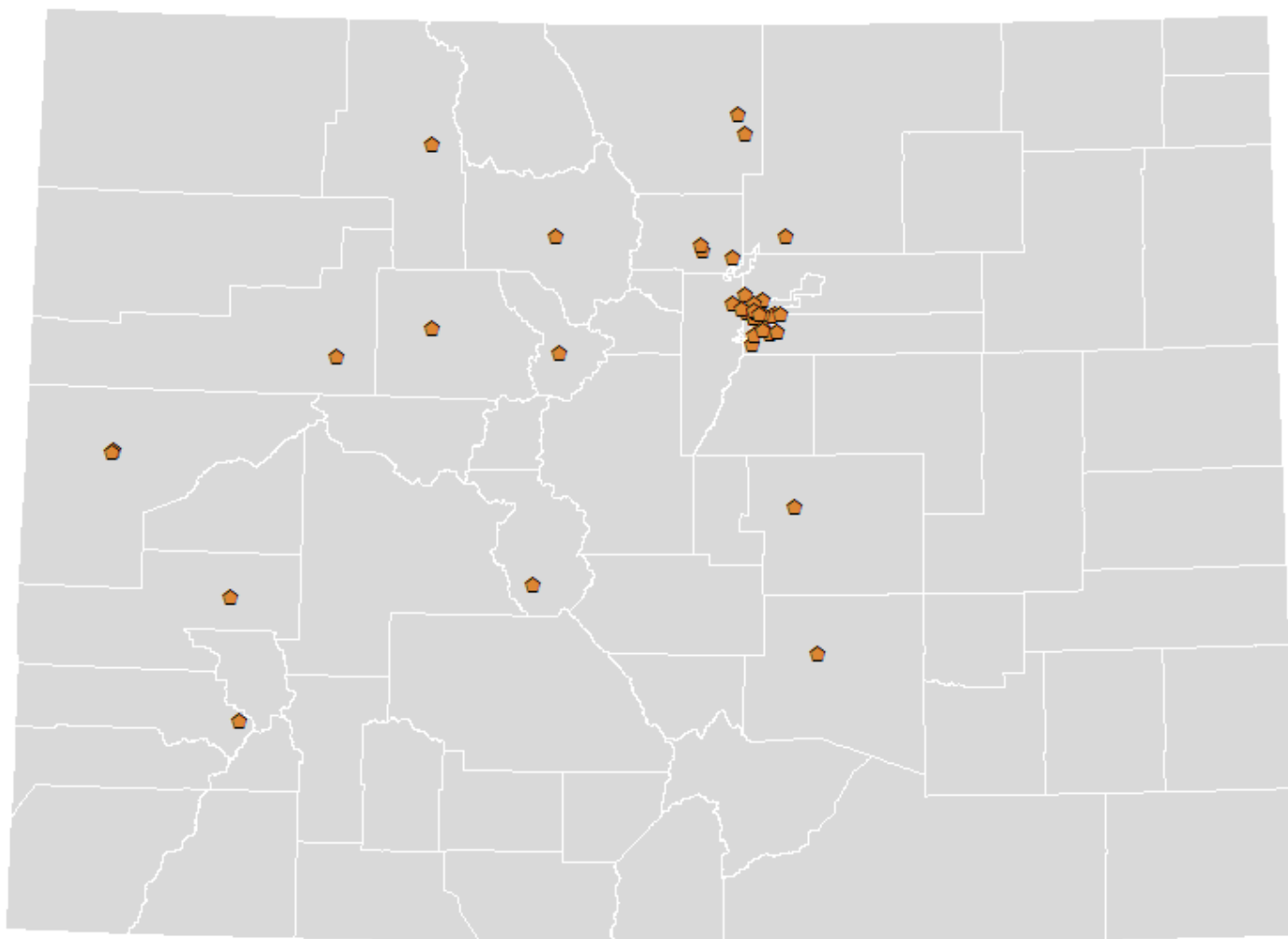
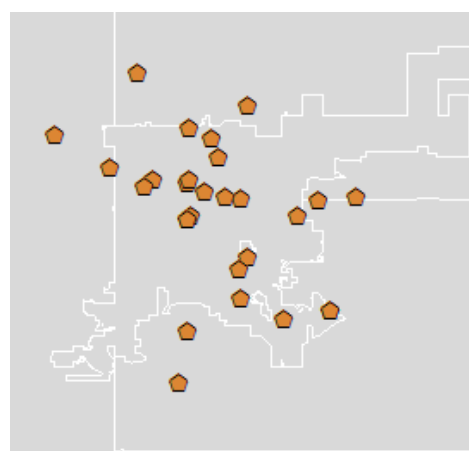


Figure 5. Grantee Locations, 2015-2016

 Grantee*



- About three quarters of grantees (74 percent) reported innovative service delivery interventions, such as telepsychiatry services or a technology solution to measure the progress of an intervention.
- More than half (56 percent) reported a focus on transitions in care, representing efforts to increase continuity of care by strengthening links between physical and behavioral health services.
- Almost half (48 percent) of grantees focused on educating Coloradans with high health care needs and their families. Family counseling and referrals to external resources were examples of these interventions.



Denver County

Recommendation:

Several course corrections were identified for future grantmaking to continue to meet the donor's goals of equitable funding for Coloradans with high health care needs.

1. Future grantmaking should increase focus on educating Coloradans with high health care needs.

Less than half (48 percent) of grantees in the first cohort spent their award on work in this area. The Denver Foundation should leverage the expertise of the Fund's Advisory Committee to inform this focus area. The Advisory Committee could also provide insight into the long-term sustainability and evidence basis of different interventions, leading to increased cost-effective grantmaking.

2. The Denver Foundation should consider the extent to which grantmaking represents all parts of the state – by population density and by geography.

- Two of three current grantees serve primarily urban Coloradans. The Denver Foundation should continue to monitor this distribution. Future grantmaking should serve an equitable population that includes both urban and rural residents.
- Areas for increased geographic focus should include the southern regions of the state as well as

the Eastern Plains. This may require greater study to understand the unique needs of these regions, outreach to potential applicants from other foundations or partnership with efforts already underway in those communities — such as the State Innovation Model.

3. Finally, the Fund should adopt its own internal and iterative measures to report to The Denver Foundation's Colorado Health Access Fund Advisory Committee. Monitoring should encourage consistent grant screening and management processes. Indicators should include operational measures of internal processes.

- An example would be reporting the portion of grants awarded that meet the Fund's agreed standards of grantmaking, such as stable finances, ability to measure progress, strength of community partnerships, and likelihood of carrying out the program.
- To avoid surprises and to actively support grants, the Fund should also report iterative measures during grant implementation. These could include a risk rating of the portfolio or a report on the portion of grantees that may be at risk for poor program outcomes, such as a major delay in hiring.

Figure 6. Behavioral Health Indicators by Age, Colorado, 2013 and 2015

Population	Metric	Data Source	Geography	Updated How Often?	Statewide result (%)	
					2013	2015
Adults (18 and over)	Had poor mental health (eight or more days of poor mental health in the past 30 days)	BRFSS ⁷	County	Annual	12.9	13.9
	Needed mental health care in the last 12 months but did not get it at that time	CHAS	Health Statistics Regions	Every odd-numbered year	7.8	9.0
	Ever diagnosed with a depressive disorder	BRFSS	County	Annual	18.2	19.3
High School students	One or more days of poor mental health in the past 30 days	HKCS	County	Every odd-numbered year	60.1 ⁸	64.3 ⁹
	Felt so sad or hopeless almost every day for two weeks in a row that they stopped doing some usual activities	HKCS	County	Every odd-numbered year	24.3	29.5
Children (4-14 years old)	Needed mental health care or counseling in the last 12 months	CHS	Statewide	Annual	11.9 ¹⁰	15.3 ¹¹

- These measures should be in addition to regular tracking of the remaining recommendations in this evaluation — such as measures of grantmaking consistency toward focus area interventions and all the state’s regions and population densities.

Tier Three

Moving the Needle on Access to Behavioral Health Care in Colorado

This evaluation looks at the contributions that the Fund makes to impact care access and health outcomes for Coloradans with high health care needs at a state level.

Yet there are limitations to this kind of outcome-level assessment. Changes in state policy, programs, and demographics could impact health care in Colorado regardless of the Fund’s efforts.

The State Innovation Model, Regional Care Collaborative Organizations (RCCOs) and the Accountable Care Collaborative (ACC) are among the ongoing efforts to move the needle on mental health in Colorado. National programs such as Healthy People 2020 are designed to improve treatment access as well as mental health status.¹²

The Fund is working to increase behavioral health care access in a context of great need. The data presented in Figure 6 provide an initial baseline on mental health in Colorado. Compared to 2013, that need is growing. Additional analysis and risk factors are discussed below.

Adults (18 and over)

Many adults in Colorado say they need behavioral health services and aren’t getting them.

- More than one of 10 adults (13.9 percent) have poor mental health, defined as eight or more days of poor mental health in the past 30 days.
- One of five adults (19.3 percent) have been diagnosed with a depressive disorder.
- One of 10 (9.8 percent) needed mental health care in the past 12 months and did not get it at that time.

High School Students

The need for behavioral health services doesn’t end with adults. Adolescents are just as much at risk for both minor and major behavioral health problems. And when it comes to mental health, gender, and sexual orientation make a big difference.

- As of 2015, almost two thirds (64.3 percent) of adolescents had one or more days of poor mental health in the past 30 days.
- Female high schoolers were far more likely (76.5 percent) than high school boys (52.7 percent) to cite mental health issues.
- Students identifying as gay, lesbian, or bisexual were more likely (87.0 percent) to cite poor mental health than their heterosexual classmates (61.6 percent). Students who were unsure of their sexual orientation were also more likely (70.0 percent) to cite days of poor mental health.

Almost a third of adolescents (29.5 percent) felt so sad or hopeless almost every day for two weeks in a row that they stopped doing some usual activities. Again, gender and sexual orientation were important factors.

- Female high schoolers were twice as likely (39.9 percent) as their male counterparts (19.2 percent) to experience this level of poor mental health.
- Sexual orientation was a differentiating factor. More students identifying as gay, lesbian, or bisexual (61.3 percent) cited this extent of poor mental health than students identifying as heterosexual (25.3 percent) or unsure of their sexual orientation (44.0 percent).

Children (4-14 years old)

Even children between the ages of four and 14 are not immune from behavioral health needs. Many children do not have access to care.

- In 2015, more than one of 10 (15.3 percent) of children needed mental health care or counseling in the last 12 months.
- Of those kids in need, almost three quarters (73.9 percent) accessed the care they needed.¹³ But that leaves a quarter without access to care.

It’s clear that the need for behavioral health services in Colorado is significant. These metrics establish a baseline of data for tracking future contributions of the Fund among vulnerable Coloradans.

Conclusion

The Fund's first cohort of grantees saw success, with new and innovative programs rolled out to address the continuing need for behavioral health care in Colorado.

Recommendations to The Denver Foundation should be considered in future grantmaking, but also in the approaching second year of the Fund's day-to-day management of grantee relationships.

The recent election results may mean that the Affordable Care Act (ACA) will be repealed. Sustainability of grantee programs will be more important than ever in the coming years of the Fund.

There is potential for significant policy change in health care and beyond. Grantees will need to be prepared.

Year two of the Fund holds opportunity for behavioral health care in Colorado. A fourth cohort of grantees will put their awards into action. Multiyear grantees will make course corrections using their evaluation results and their first year of grant experience. CHI will raise new lessons learned to the top and share those with program leaders and the state's philanthropic community. Grantees will draw from their collective knowledge, with CHI and The Denver Foundation as the enabling links.

Endnotes

- ¹ Of the 28 grantees awarded in the first year, one was granted an extension to submit their annual evaluation report. This evaluation report includes findings from 27 grantee submissions.
- ² Colorado Health Institute's analysis of the Colorado Health Access Survey, 2013 and 2015.
- ³ Centers for Medicare & Medicaid Services. The Mental Health Parity and Addiction Equity Act (MHPAEA). Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
- ⁴ See the Implementation section for further detail.
- ⁵ Note that some grantees served more than one region.
- ⁶ One grantee identified any Coloradan needing services and did not designate a target population.
- ⁷ Centers for Disease Control and Prevention. Colorado Health Institute's analysis of the Behavioral Risk Factor Surveillance System (BRFSS), 2013 and 2015.
- ⁸ Colorado Department of Public Health and Environment, Colorado Department of Human Services Office of Behavioral Health, Colorado Department of Education and University of Colorado Denver. (2013). Healthy Kids Colorado Survey. http://www.chd.dphe.state.co.us/Resources/yrbs/HS_Tables_10-21-2014.pdf
- ⁹ Colorado Department of Public Health and Environment, Colorado Department of Human Services Office of Behavioral Health, Colorado Department of Education and University of Colorado Denver. (2015). Healthy Kids Colorado Survey. http://www.chd.dphe.state.co.us/Resources/HKCS/HIGHSchool/2015HKCS_HS_CO_15AUG2015.pdf
- ¹⁰ Colorado Department of Public Health and Environment, Center for Health and Environmental Data, Health Statistics and Evaluation Branch. (2013). "Colorado's Child Health Survey." <http://www.chd.dphe.state.co.us/resources/mchdata/2013CHS.pdf>
- ¹¹ Colorado Department of Public Health and Environment, Center for Health and Environmental Data, Health Statistics and Evaluation Branch. (2015). "Colorado's Child Health Survey." <http://www.chd.dphe.state.co.us/Resources/mchdata/chs/2015CHS%20Summary%20Tables%2023JUN2016b.pdf>
- ¹² Healthy People 2020. (2016). "Mental Health and Mental Disorders: Objectives." Available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives>
- ¹³ Ibid.



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