About The Denver Foundation

The mission of The Denver Foundation is to inspire people and mobilize resources to strengthen our community. The Denver Foundation has been taking care of the future since 1925.

As Colorado’s largest and most experienced community foundation, we help people give back to Metro Denver in ways that are meaningful to them and to the community. The Denver Foundation is a 501(c)3 nonprofit organization.

About the Colorado Health Access Fund

The Colorado Health Access Fund is a field of interest fund of The Denver Foundation. Established in 2014 with an anonymous gift of $40 million, the Fund is dedicated to improving health outcomes for underserved Coloradans by increasing access to behavioral health services. Between 2015 and 2022, the fund will award up to $5 million per year to initiatives that increase access to health care and improve health outcomes for populations with high health care needs across the state. Over the course of eight years (2015-2022), the Fund is committed to allocating resources among rural, urban, and suburban areas.

The Fund includes four focus areas for funding of projects:

• **Improved access** to care, particularly in rural communities;
• **Transitions** in care to behavioral health services;
• **Innovation** of care delivery; and
• **Education** of those with high health needs, as well as their families and caregivers.

These areas of focus were informed by an asset and gap analysis commissioned by The Denver Foundation and conducted by CHI in 2014. The goal of the analysis was to glean a concrete understanding of Colorado’s diverse health care landscape and to guide the development of the funding strategy. This report, “Flashpoints and Fixes: An Asset and Gap Analysis of Barriers to Care for Coloradans with High Health Needs,” continues to inform the direction of the Fund.

The Fund is dedicated to enabling work that supports people who have an identified behavioral health issue and are a member of at least one of the populations that are known to be un/underserved. This includes those with multiple chronic or acute health conditions; those that lack health insurance coverage, have inadequate coverage, or have significant barriers to accessing coverage; those who have low incomes and/or are experiencing homelessness; and individuals who have a disability and/or have limited proficiency in English.

In 2015-2017, funding opportunities included project/program support, capital improvements for hospital or facility expansions, general operating, and support for multi-organization collaboratives. Grants may be up to three years.

In its second year, the Fund supported 36 grantees across Colorado, up from 27 grantees in Year One.
Dear Stakeholders,

The Denver Foundation is pleased to share the second annual evaluation report on the Colorado Health Access Fund. As a result of the community partnerships profiled in this report, 17,000 Coloradoans accessed direct behavioral health and/or substance use treatment in the Fund’s second year. This brings the total number of individuals reached by the Colorado Health Access Fund to almost 50,000 people across the state.

While increasing behavioral health treatment access is a key driver of the Fund, learning and evaluation are core values that power ongoing improvement. Based on what we have learned since the Fund launched at The Denver Foundation in 2015, we've made changes to how we approach grantmaking and partnerships. We funded fewer—but larger—grants to support expansion projects more holistically. We've also narrowed our focus to increase the sustainability of projects. Hiring and retaining providers, especially for rural communities and those serving special populations, is a real challenge, and we continue to talk with partners on how best to address this difficulty. One strategy we implemented in Year Two was to modify our application process by inviting organizations to demonstrate their community leadership. We also increased outreach to rural communities and those serving vulnerable populations.

The demand for behavioral health services continues to be largely unmet for those with the greatest barriers to care. These are uncertain times in health care, but there is good momentum across the state to address behavioral health. The Colorado Health Access Fund will continue to evolve as a partner to best support this progress.

Christine Márquez-Hudson
President and CEO
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INTRODUCTION

A program that connects immigrants in detention and their lawyers with highly trained social workers. An innovative initiative in northern Colorado to build capacity and address a statewide shortage of providers. A new group that connects seniors in crisis with support. A school-based substance use treatment effort for Denver teens that worked so well it’s now expanding to more schools.

These are just a few of the programs supported by The Denver Foundation's Colorado Health Access Fund. The 36 grantees supported during the Fund’s second year are bringing a wide range of behavioral health services to Coloradans who need support for mental health and substance use.

Coloradans need better access to behavioral health services. The state struggles with one of the nation’s highest suicide rates, reaching 20 per 100,000 residents in 2016, an increase from 10 years ago. There were a record 912 drug overdose deaths in Colorado in 2016, including a growing number due to opioids. An estimated 67,000 Coloradans said they needed substance use disorder treatment but did not receive it in 2017.1

Within the state, there are disparities. Coloradans with low incomes, people without health insurance, and Coloradans who identify as African-American, American Indian, or Hispanic were more likely to report that they didn't get needed mental health care on a 2017 survey by CHI.

The Fund is focused on bringing services to those who have had the least access and face the most barriers to care.

The idea is that improved access to behavioral health care will positively affect the overall health of Coloradans, especially those with high health care needs. (See Figure 1.)

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Figure 1. Colorado Health Access Fund Theory of Change

1 2017 ANNUAL EVALUATION REPORT
This evaluation assesses the degree to which grantees are making progress toward the Fund’s strategic goals as the Fund completes its second year. Overall, it finds that the Fund is achieving its stated purpose of improving access to behavioral health care for the Coloradans who need it most.

The work has not been easy, and grantee organizations encountered challenges in the past year. Many had trouble finding or retaining qualified staff, some faced technological challenges, and others had difficulty billing for services provided to some of the state’s neediest residents. Others found that providing the direct services supported by the Fund, such as counseling, came along with a need for case management to help reach and support patients. The grantees are also anticipating changes to state and federal policy, including cuts to Medicaid, that could have profound effects on their services.

The Fund had a smaller-than-intended reach in rural Colorado in its second year. Less than 20 percent of its funds reached rural Coloradans. This will require an increased focus of future grantmaking on rural Colorado, as the Fund’s strategic intent is to provide a fifth of its resources over all years to the state’s Eastern Plains and mountain regions, where it is often hardest to access care and reach people who need support.

The second year also saw a decrease in the overall number of people served. That change reflects the Fund’s evolving strategy. Several large one-year grants ended, and the Fund focused on supporting organizations that offered smaller, more specialized programs targeting communities facing major barriers to care, such as people in detention or the Native American community.

Still, the Fund allowed almost 17,000 Coloradans to gain access to counseling, a psychiatrist, or other behavioral health services in 2016-17.

It is worth highlighting that many of those people would likely not have been reached without the Fund, which directly supported the counselors, social workers, and others who provided these services.

This evaluation report highlights the successes and challenges of the Fund’s second year. The diversity, creativity, and thoughtfulness of the programs supported by the Fund demonstrate its increasing ability to target grantees that have the potential to make the biggest impact on the most vulnerable Coloradans. The grantees’ challenges illuminate potential areas of focus for The Denver Foundation’s broader grantmaking initiatives—and for policymakers and others concerned about the state of behavioral health access in Colorado.

**OUR ANALYSIS**

This is CHI’s second annual evaluation of the Fund. The report addresses 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 goals.**

3. **What are CHI’s recommendations for The Denver Foundation as it enters its third year of Fund grantmaking?**

The report is structured using the plan outlined in CHI’s evaluation framework, “Leveraging Learning.” (See page 7.)

This report summarizes findings from evaluation reports submitted by 35 of the 36 grantees that completed a funding year in 2017. Sixteen of the grantees completed their first year in 2017 and 19 are in the second year of multiyear grants. The 35 grantees are referred to as the Fund’s Year Two grantees in this report.
Tier One: Grantee Contributions

Tier One of the evaluation reviews grantee progress in improving access to behavioral health care. Grantees address a set of standard measures and open-ended questions and submit a self-directed and self-created evaluation.

RE-AIM+P Model

Findings are organized within the RE-AIM+P evaluation framework. RE-AIM is an established evaluation framework that examines a program’s Reach, Effectiveness, Adoption, Implementation and Maintenance. CHI added a Policy component to help identify policy hurdles and opportunities in behavioral health.

Using the RE-AIM+P framework, the evaluation team collected both quantitative and qualitative metrics for measuring how well projects funded by the Colorado Health Access Fund:

- Reach the target population: How many—and what proportion—of people with high health care needs are being served by the Fund?
- Demonstrate effectiveness: To what extent are programs increasing access to care among people with high health care needs? How does effectiveness vary at the community level? What key achievements were made possible by the grant?
- Are adopted: To what extent were programs adopted by all target staff and partners, such as administrators? If they were not adopted by all, why not?
- Are implemented: To what extent do fund grantees implement the programs described in their Request for Proposals (RFP) applications? What implementation challenges have programs faced?
- Are maintained: Will the programs be sustainable once the funding cycle ends? To what extent will efforts be scaled up in the future? Will new programs or program expansions continue without Colorado Health Access Fund support?
- Adapt with the policy environment: Does the rapidly changing policy context contribute to or detract from program effectiveness? What policy barriers or opportunities exist?

Tier Two: Fidelity to the Fund’s Intent

Tier Two of the evaluation focuses on whether the Fund has stayed true to its original intent, including helping Coloradans with high health care needs, targeting the four focus areas, and allocating grants equitably among rural, urban and suburban areas.

The evaluation team compiled both quantitative and qualitative information collected through Tier One activities and grantee forums.

The team aggregated this information to answer the following questions:

- Has the work of the Colorado Health Access Fund adhered to the requirements outlined by the donor?
- Has the Colorado Health Access Fund targeted efforts to improve access to needed services and health outcomes among Coloradans with high health care needs?
- Are the funds equitably allocated among rural, urban and suburban areas? Do grantees reflect the state’s geographic differences?
- Does the collective work of grantees address each of the four focus areas (access to care, transitions, innovation in delivery, and education)?

This section reviews the grantees’ collective contributions as well as the progress made by The Denver Foundation as the steward of the Fund.

Tier Three: Moving the Needle

Tier Three of the evaluation focuses on changes across the state since the implementation of the Colorado Health Access Fund of The Denver Foundation.

A set of state-level indicators captures whether access to health services for Coloradans with high health care needs has improved since the Fund was established and puts in context the Fund’s contribution to the improvement of behavioral health among those Coloradans.

There are limitations to this level of evaluation. New policies, new programs, and changing demographics are among environmental factors that influence health care in Colorado. This complexity limits our ability to isolate direct causality between grantee initiatives and changes in access to behavioral health care.
THE EVALUATION

Tier One: Grantee Contributions

RE-AIM+P: Reach

Guiding Questions:
How many people were served by programs supported by the Fund in Year Two? What are their demographic, geographic, and health status characteristics?

Key Findings:
• The Fund provided access to behavioral health services to almost 17,000 Coloradans.
• Grantees successfully served Coloradans with high health care needs and those with barriers to care.

Supporting Evidence:
In its second year, the Colorado Health Access Fund’s grantees served almost 17,000 Coloradans. That tally includes telehealth encounters, in-person counseling sessions, school-based counseling, and psychotherapy. It does not include indirect services such as screenings or education campaigns run by grantees.

Fewer people were served in the Fund’s second year than in Year One, when grantees reported serving 32,000 Coloradans. Though the Fund supported a larger number of programs with more money in Year Two, this set of grantees served fewer people on average, and several one-year grants that served large numbers of Coloradans ended in 2016. This reduction was expected and is in line with the Fund’s intent to focus its efforts on high-needs populations.

About half of the Year Two grantees are in their first year of multiyear grants, and it is anticipated that some will serve more people as their programs develop.

Reaching Those with High Health Care Needs

The Fund aims to increase access to behavioral health care for Coloradans with high health care needs.2 All grantee programs supported in Year Two serve one or more groups of Coloradans who are likely to face multiple barriers to behavioral health care, such as those with multiple chronic or acute health conditions, those with low incomes, and those who lack health insurance coverage. (See Figure 2.)

Figure 2. Which Populations Are Grantees Reaching? (Grantees Could Target More Than One)

People earning low incomes or experiencing unemployment 57%
People of color 51%
People who are un/underinsured 37%
Children 37%
Adolescents 34%
People with limited English proficiency 29%
People experiencing homelessness or housing insecurity 26%
Seniors 17%
People who are trauma-affected or justice-involved 17%
Families 14%
People living in rural/underserved regions of the state 14%
People who are homebound/disabled 11%
Each person detained at the immigration detention center in Aurora is at a crossroads, waiting to learn whether he or she will be allowed to stay in the United States. Some struggle with lifelong mental illness or long-ago trauma. Others are stressed by the experience of being detained.

The Rocky Mountain Immigrant Advocacy Network (RMIAN), a nonprofit that serves adults with low incomes and children in immigration proceedings, created the Social Service Project in 2010. It pairs social workers with immigration lawyers at the detention center, which is run for U.S. Immigration and Customs Enforcement by the private GEO Group and houses people who have been arrested for immigration violations and those seeking asylum.

Most detainees—some 2,000 annually—go through RMIAN’s Legal Orientation Program, which informs them of their rights. RMIAN master’s-level social workers Megan Hope and Alexis Sanchez talk to detainees who show signs of cognitive impairment, depression, substance dependence, or other conditions.

The detainees experience is often traumatic. More than one detainee has told the social workers about abuse or being raped as a child. The Social Service Project assisted nearly 50 people from Mexico, Haiti, China, India, Nepal, Pakistan, and other countries over the past year.

The social workers offer therapeutic services, such as coping strategies and suicide risk assessments. They also provide support for clients’ legal cases. For example, they create post-release plans to help immigration judges envision the type of life people will have in the United States if they are allowed to stay.

Hope described one man who was shaking throughout his intake. “He could barely articulate anything. But each visit got better, and by the third visit, he was talking freely. Now he’s in a much better condition to endure detention and to fight his legal case.”

The Social Service Project is one of the first programs in the country to pair social workers with immigration lawyers. The support of the Colorado Health Access Fund allowed RMIAN to hire Sanchez as a second full-time social worker.

Hiring the right social worker for the project was a challenge. Hope said it is difficult to find someone who is bilingual and able to handle the unpredictability and bureaucracy of the immigration system and the high level of trauma among detainees.

Laura Lunn, the managing attorney of RMIAN’s Detention Program, said the social workers have transformed how the attorneys work with clients.

“They work miracles,” Lunn said. “As a law student, you don’t take classes on how to understand trauma and its impact on your clients.”
The Colorado Health Access Fund

Some programs are broadly focused: Northwest Colorado Health, for instance, used its grant in 2017 to provide counseling services to more than 1,100 patients, many of whom identified as Hispanic or Latino (30 percent) or uninsured (35 percent).

Other programs are more targeted, such as the Senior Reach program administered by Jefferson Center for Mental Health, which provided more than 300 individual therapy sessions to 52 older adults living in rural areas and experiencing mental health or substance use issues. And the Counseling and Education Center based in Grand Junction provided more than 500 counseling sessions in 2017 for 94 people with the support of this grant. Many were survivors or witnesses to violence or sexual abuse, and almost all reported living below 175 percent of the federal poverty line (about $42,500 annual income for a family of four).

Some 57 percent of the programs are targeting Coloradans with lower incomes or who are unemployed. (See Figure 2.) About half (51 percent) provide access to people of various racial and ethnic backgrounds, including those who identify as Hispanic, African American, and Native American. Other target populations include those with known barriers to accessing behavioral health care—including Coloradans who are homebound, underinsured, disabled, those who have experienced trauma, and children or adolescents with behavioral health needs.

RE-AIM+P: Effectiveness

Guiding Questions:
To what extent are programs increasing access to care among people with high health care needs and what approaches are they using? How are programs tailored to meet the unique characteristics of the region they serve? How do grantees develop high-quality and sustainable programs?

Key Findings:
• The Fund supports programs that increase access to effective approaches to behavioral health care.
• Grantees use a mix of approaches, including telehealth, in-person counseling, and integrated care to tailor their programs to their target populations.
• Grantees said that strong relationships within and outside of organizations are important for quality and sustainability.

Supporting Evidence:
All of the grantee organizations in the Fund’s second year focus on increasing access to behavioral health care using approaches such as counseling and integrated care. Each organization takes a different approach based on the needs of its target population. More than half of grantees had more than one focus.

Counseling and Direct Behavioral Health Services: Three quarters of the Year Two grantees—26 in all—used the funds to offer counseling and direct behavioral health services.

Some are expanding services in traditional clinics and inpatient psychiatric hospitals. For example, Poudre Valley Health System renovated space at the Mountain Crest Behavioral Health Center in Fort Collins to add three inpatient psychiatric beds thanks to the Fund. As a result, psychiatric patients may be less likely to be transferred to a hospital that’s hours away, resulting in more family support, less travel time, and better continuity of care.

Other grantees are making therapy available in nontraditional settings like schools and homes. For example:
• The Seniors’ Resource Center of Denver provides comprehensive support services such as transportation and housekeeping to older adults. The Fund supports counseling services for seniors at the Center.
• Jewish Family Services expanded its school-based behavioral health program, KidSuccess, to two southeast Denver schools, Hamilton Middle School and Joe Shoemaker School. The program has translators and health navigators to ensure that care is tailored to students’ social, cultural, and linguistic needs.

One innovative way the Fund is expanding access to counseling is by supporting four grantees implementing telehealth—the delivery of health care by a remote provider through technology like
video conferencing. Health Solutions in Pueblo, for example, uses its grant to support a psychiatrist and five psychiatric nurse practitioners to assess patients and prescribe and manage medications using a secure video link.

**Transitions to Behavioral Health Services:** Twelve of the Year Two grantees focused on strengthening transitions to behavioral health services. These programs link vulnerable Coloradans with behavioral health services using call-in centers, social workers, and other staff. They create referral partnerships between community organizations and behavioral health care providers to remove barriers to care.

For example, staff at the Colorado Coalition for the Homeless engage with clients and build trust during the critical transition period between living on the streets to living in housing. They use this as an opportunity to connect clients to needed physical and behavioral health services.

**Integrating Behavioral Health Care Into Primary Care:** Nine grantees are focusing on integrating behavioral health care into primary care. This approach involves primary care and behavioral health care providers working collaboratively to care for a patient’s health holistically. Integrating behavioral health and primary care can address barriers to behavioral health care. For instance, it makes services easier to access for patients who lack transportation, and it can lessen the stigma of using behavioral health services.

One example: Inner City Health Center of Denver integrates counseling services into its medical, pediatric, and prenatal programs. Physical health care providers are trained to identify patients with behavioral health symptoms and refer them for on-site care and education. During the 2016-2017 grant year, the Center reported 515 “warm handoffs,” meaning the primary care provider introduced the patient to a behavioral health care provider. Those interactions resulted in short therapeutic interventions, education, and, when necessary, full therapy sessions.

About two-thirds of grantees (23 of the 35) pursued multiple strategies.

Grantees were also 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 are effective strategies.

This year’s grantees focused on strengthening internal and external relationships and on improving operations.

**Strengthening Relationships:** Grantees consistently said that building and maintaining strong relationships with the community, program staff, and clients are vital to creating effective programs.

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**Figure 3. Primary Program Approach of Grantees, 2016-17**

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This chart represents the distribution of primary program approaches among the grantees for the 2016-2017 period.
At a new Denver court for child custody cases involving American Indian children, Shelly Solopow is there to meet families at one of the toughest chapters of their lives.

Solopow is a Licensed Professional Counselor and a Level II Certified Addiction Counselor with Denver Indian Health and Family Services (DIHFS). “When parents have kids removed, they’re often struggling with mental health or substance use,” Solopow said. “It’s very difficult, because Native folks are often not trusting of human services or the court system.”

Judge Donna Schmalberger began Denver’s Indian Child Welfare Act (ICWA) court—only the third such court in the country—in 2017. The ICWA was passed in 1978 to address a pattern of Native children being removed from their families without the input of tribes or consideration of cultural issues. But the law hasn’t always been applied successfully. The new ICWA court in Denver was created to ensure these sensitive cases get the attention and expertise they require. Adams County also opened its own court within the past year.

Now, with the support of the Colorado Health Access Fund, Solopow attends every session of the Denver and Adams County ICWA courts. She talks to American Indian parents who are involved with the child welfare system and tells them about therapy, substance abuse treatment options, and other health services. She arranges to meet people who might not be able to visit the clinic’s Denver location. And she describes families’ progress to the court.

Judge Schmalberger said that having Native providers like DIHFS in the courtroom makes a difference. “We couldn’t do what we do without them,” Schmalberger said.

Schmalberger said DIHFS provides culturally appropriate treatment to the people who come to her court—a requirement of ICWA. “The folks I see in front of me are almost always adults who were traumatized as children and didn’t get the help they needed. Places like DIHFS, they get that.”

Solopow, who is Native, said that culturally appropriate care can be crucial, including offering the spiritual lens provided by traditional medicine. “Native people are spiritual beings on a physical journey,” Solopow said. “I don’t want to generalize, but you’d be hard-pressed to find a tribe that didn’t believe that. If you don’t offer anything spiritual, you’re not bringing healing to that person.”

DIHFS’ traditional medicine program is still evolving. In the past several months, DIHFS has started to host star quilt classes and restorative talking circles for women who have experienced domestic violence. Meanwhile, Solopow said she is committed to continuing care for those she meets at ICWA courts and elsewhere.

“You have to get to the people who are out there,” she said. “It doesn’t matter that it’s hard to do.”
Recommendations adapted from grantees’ reports include:

• In clinical settings, every staff member—from physicians to medical assistants to behavioral health providers—should be trained on how to integrate behavioral health into primary care. This could mean educating providers on how to conduct joint physical and behavioral health visits, or ensuring all providers are equipped to use behavioral health screening tools.

• When delivering a youth-focused program, engage youth in the design and rollout. Mental Health Center of Denver, for example, said its youth clients provided helpful input into deciding opening hours, available activities, and design of the space to make it more welcoming and less “clinical.”

• Select the right staff. They need to be coachable and willing to learn and adapt to new approaches such as changed evaluation processes or integration techniques such as “warm handoffs.”

• Ensure that providers are culturally competent.

• Hire locally if delivering a rural program.

• Support providers in the Medicaid credentialing process.

Internal operations: Grantees suggested diversifying funding and being open to modifying programs as needed.

Recommendations adapted from grantees’ reports include:

• Diversifying funding can help programs be sustainable in a changing environment. For example, several grantees feel that the current national health care debate means the future of Colorado’s Medicaid program, Health First Colorado, is uncertain, so finding multiple funding sources may be a way to avoid funding gaps.

• Altering the program approach as needed. Mile High Behavioral Healthcare gave the example of changing course in its homeless youth-focused program to meet the needs of the increased number of young clients exploring their gender identity. And given the growing need, Health Solutions of Pueblo is using telepsychiatry to increase referrals to substance use services.

• Changing the evaluation approach when a program changes.

RE-AIM+P: Adoption

Guiding Question:
To what extent were programs adopted by target staff and partners, such as administrators? If a program was not adopted by all, why not?

Key Findings:

• More than 70 percent of grantees said their programs were adopted as planned in their organization.

• Many grantees attributed successful adoption to staff buy-in.

• Difficulty in hiring and retaining staff was the most frequently cited barrier to adoption.

Supporting Evidence:

Nearly three quarters of the Year Two grantees (70 percent) said that their organization adopted their grant-funded program fully or that their program was adopted more successfully than expected. Another 20 percent of grantees said their organization made progress towards adoption. The remaining grantees experienced major barriers, such as difficulty finding a provider, that prevented their program from being adopted as intended.

Grantees that had the most success attributed it to strong staff buy-in. Children’s Hospital Colorado, for example, now offers integrated behavioral health services to teenage mothers thanks to a behavioral health clinician supported by the Fund. The team engaged with and trained its medical staff early on to integrate the behavioral health provider into the care team. The hospital’s medical staff now conducts joint medical and behavioral health care for young pregnant women—coordination that wasn’t possible before the grant.

Among grantee organizations where the program was not adopted as expected, the most common challenge was staffing. More than a third of grantees reported this issue. Organizations cited challenges with staff retention, staff resistance to changes in workflow, the difficulty of integrating mental health and primary care, and hiring or recruiting staff.

But other grantees found that they could get around
staffing challenges by using innovative delivery models. For example, Health Solutions in Pueblo reports that its Fund-supported telepsychiatry program is an important recruiting and retention tool. Its psychiatrist and nurse practitioners enjoy the flexibility of providing care from their homes or other remote locations.

**RE-AIM+P: Implementation**

**Guiding Questions:**
To what extent have grantees made progress toward implementing their programs? What implementation challenges have grantees faced?

**Key Findings:**
- Twenty-six of the Year Two grantees reported that they fully or mostly implemented their program as planned.
- While most organizations reported barriers to implementing programs, only nine were unable to fully or mostly implement their programs.
- The biggest barriers to implementing programs were staff turnover, recruitment, and hiring. Grantees also reported technical and workflow challenges related to electronic health records and clinical technology platforms.

**Supporting Evidence:**
Most grantees were able to fully or mostly implement their programs as planned despite any barriers they faced. They found the right staff, delivered necessary training, and introduced services as they proposed. But about one-quarter of grantees fell short of implementing their plans.

**Staffing:** More than two-thirds cited staffing as a barrier to program implementation. Finding the right staff is critical for these programs, especially in situations where behavioral and physical health care are being integrated.

The most commonly cited issues were staff turnover (43 percent of grantees) and recruitment and hiring of staff (37 percent of grantees). (See Figure 4). Aurora Mental Health Center’s homelessness transition program, which helps homeless Coloradans access behavioral health services, planned to hire a therapist, but it took more than nine months to find the appropriate provider.

**Electronic Health Records and Technology:**
Electronic health records (EHR) and other technological challenges were problematic for close to a third of grantees. Grand Junction’s Counseling and Education Center, for example, implemented several technology tools (the Feedback Informed Treatment (FIT) patient evaluation platform and the “My Outcomes” data system) alongside a counseling program. Though the center reported that the programs are showing promise for improving patient care, they also caused challenges for staff, and one therapist even elected to retire rather than use the new tools.

**Billing:** Seven grantees (20 percent) reported challenges billing for services provided. For example, Denver Indian Health and Family Services said that legal requirements prevented its behavioral health clinician from billing for time spent off-site at detox facilities, where the grantee had hoped to reach more of the target population facing major barriers to care. As a result, the team had to seek these patients out in different ways. This grantee worked with The Denver Foundation throughout this process, allowing the program’s funding to continue as planned.

**RE-AIM+P: Maintenance**

**Guiding Questions:**
Will the programs be sustainable once the funding cycle ends? To what extent will efforts be scaled up in the future? Will new programs or program
Summit County’s snowy peaks and rushing streams are so striking that Dr. Cassie Comeau, the chief behavioral health officer at Summit Community Care Clinic, says residents joke that visitors think it’s like Disney World.

But Disney World isn’t always the easiest place to live.

The area’s high cost of living and low-paying, often-temporary jobs put pressure on residents. The county also lacks key mental health resources, including psychiatric services, bilingual counseling, and emergency mental health facilities.

As the only community health center in the county, Summit Community Care Clinic provides behavioral, physical, and dental services to many who can’t afford treatment.

The clinic has experienced budget pressures. It wasn’t reimbursed by Medicaid for behavioral health services at a time when 75 percent of its behavioral health visits were from Medicaid patients. In early 2016, it furloughed its behavioral health staff at five school-based health centers for two weeks. And almost half of the clinic’s patients don’t have insurance.

The Colorado Health Access Fund grant for the Summit clinic’s operating costs helps it do more than keep its doors open. The clinic has expanded services, including at the school-based health centers. And Comeau has been evaluating its behavioral health programs to make sure they are meeting community needs.

Julie McCluskie, the director of communications and community engagement in Summit County’s 3,500-student school district, said the clinic’s school-based therapists are invaluable. Two students died by suicide in recent years, and McCluskie said there has been a sharp increase in the number of students expressing anxiety, depression, stress, and suicidal thoughts.

McCluskie said there’s no way the district could fund anywhere close to the 120 hours of mental health support per week provided by clinic staff. Without the Fund’s support, it is likely that many students would have a harder time accessing care outside of the schools.

“Because they've been in the buildings, because we've been able to retain them, the students trust them,” McCluskie said.

In a field and region where staff turnover is common, Comeau has created a training program for behavioral health workers.

“We know when people feel like a cog in the machine, satisfaction goes down,” she said. The clinic has regular professional development, and Comeau makes pathways for behavioral health staff to advance as they gain licensure.

“Words can’t express how lucky we are to have this team,” she said.
expansions continue without Colorado Health Access Fund support?

**Key Findings:**

- Some grantees are funding their programs through a combination of charging for services and contributions from other partners.
- Several grantees aim to expand their programs to serve more people and increase earnings.
- Many programs depend on the Fund’s financial support, raising concerns about their sustainability.

**Supporting Evidence:**

Grantees’ plans for sustaining their programs vary.

Fifteen grantees have a plan to sustain their program that is not based entirely on future grants—whether by increasing earned revenue, by ensuring all providers can bill Medicaid, or by planning to fund the program through their own budgets, as Denver Health proposes to do with its telehealth program.

Twelve of 35 grantees (34 percent) focused their sustainability plans entirely on securing future grants rather than building on earned income.

Another eight grantees (23 percent) do not have a clear plan for sustainability. These grantees reported efforts like potential partnerships with other local organizations that could help them sustain referrals of billable patients, for example. But others suggested there were many unknowns. One grantee suggested trying to increase earned revenue without a clear idea of how to do that.

Several grantees plan to use reimbursement for services to sustain their current structure and clinical staff. It is unclear if these programs will be able to maintain all aspects of their Fund-supported programming once the grant has ended. For example, Kids First Health Care of Commerce City plans to expand into two new school districts over the next two years with a full-time behavioral health provider at each school. Team leaders recognize, however, that under current behavioral health reimbursement structures, they can’t expect to earn traditional billing income for these school-based behavioral health services. So, like many Fund grantees, they plan to support their program expansion with grants and fundraising.

While the evaluation did not ask about organizations’ revenue sources, several programs included this information in their annual reports. These organizations reported that earned income—from insurers and cash payments from patients—made up just 20 to 40 percent of the program budget. The remainder comes from grants.

**RE-AIM+P: Policy**

**Guiding Question:**

Does the rapidly changing policy context contribute to or detract from program effectiveness? What policy barriers or opportunities exist?

**Key Findings:**

- Grantees cited local, state and national policies ranging from a failed local ballot initiative to federal immigration reform as challenges in 2017.
- Changes in Medicaid policy have a significant impact on grantees. Upcoming and potential changes to the program were a source of uncertainty for many grantees.
- Grantees tended to identify the policies that hindered the implementation of their program rather than those that helped. Policy opportunities that hold promise for long-term sustainability were even more elusive.

**Supporting Evidence:**

Grantees reported that federal, state, and local policies all had an impact on their programs.

**Medicaid:** Nineteen grantees mentioned Medicaid at least once. The specific context varied. Five mentioned the second phase of the Accountable Care Collaborative (ACC), Colorado’s initiative to reform Medicaid, saying they were unsure how it would impact their program. (See sidebar on page 18.)

**Federal Policy:** Eight grantees mentioned the Affordable Care Act (ACA), citing the uncertainty created by Congressional health reform efforts about whether Colorado could sustain its 2014 Medicaid expansion, through which many grantees’
clients receive their insurance. CHI anticipated that more grantees would mention this as a policy challenge, given the prominent debates over Medicaid expansion that took place most of the year. However, many grantees may have focused their evaluations on the impact of policies already in place instead of on the debates.

Nine grantees cited the impacts of other federal policies. These included Medicare billing guidelines, data-sharing restrictions and community health center funding. Five grantees highlighted concerns about changing immigration and detention policies. And the Denver Children’s Advocacy Center cited a new federal rule requiring Head Start to provide full-day classes, which is making a positive impact on children’s behavior and emotional well-being.

**Local and State Policies:** Grantees also cited a wide variety of local or state policies that affected their program’s implementation. Among the examples:

- St. Francis Center reported Denver’s enforcement of its camping ban made it more difficult to reach clientele experiencing homelessness.
- The Health District of Northern Larimer County saw a ballot issue fail that would have funded a new behavioral health and detox center and increased resources in the community.
- Health Solutions in Pueblo identified marijuana legalization as a catalyst for an influx of patients, many of whom have high behavioral health needs.

While many policy barriers are easily identifiable, policy opportunities are harder to identify in the evaluations.

Nine grantees identified state and local policy successes or opportunities in their reports. Some examples include:

- “Housing as health care”: Cities are addressing homelessness by hiring a dedicated homeless coordinator or by building affordable housing.
- Credentialing: Doctors Care helps private practice behavioral health providers in the area get credentialed with Medicaid as a way to increase available resources.
- Organizational policy: Heart of the Rockies Foundation increased access to behavioral health care by changing a policy requiring a referral from a primary care provider.
- Payment reform: Multiple grantees cited proposals to reform how health care is paid for as the key to their programs’ sustainability. A few are looking to Medicaid ACC’s Phase Two as an opportunity to sustain behavioral health services.

CHI will be working with The Denver Foundation to identify additional policy opportunities in the coming year.

**Tier One: Recommendations for The Denver Foundation**

Staffing and sustainability are persistent challenges for grantees. CHI recommends the Fund continue to partner with grantees and connect them with external resources to help address these challenges when possible. CHI’s 2018 research should also focus on these issues.

**Staffing:** Grantees said that hiring and keeping behavioral health staff is difficult but is critical to success.

CHI Recommendations:

- Continue to work closely with grantees with staffing challenges that may prevent them from meeting their goals.
- Direct CHI to conduct a deep dive into this issue in its mid-Fund research in 2018, known as the “Asset and Gap” report. This research should examine staffing issues affecting behavioral health access statewide, such as workforce shortages, geographic distribution, salary differentials, and alternative staffing approaches.

**Sustainability:** Many grantees depend on the support of the Fund and other gifts and donations to sustain their programs. Some also feel uncertain about the current and future opportunities to bill for Medicaid services. This revenue structure suggests that these programs may not be able to continue after the Fund ends.
Medicaid Billing for Behavioral Health: The Present and the Future

Over a fifth of Coloradans—more than 1.3 million people—are covered by Medicaid. Providers’ willingness to accept Medicaid has significant implications for access to behavioral health services. Uncertainty about the program’s future was cause of concern for a number of the Fund’s grantees.

Nationally, the future of the ACA’s Medicaid expansion in 2014—which allowed Colorado’s expanded coverage for adults—was at the center of policy debates about the law’s future.

In Colorado, the structure of Medicaid is changing in a way that will affect if and how behavioral health visits can be billed by primary care providers, including those supported by the Colorado Health Access Fund.

Currently, Colorado is divided into five regional Behavioral Health Organizations (BHOs), which receive a lump sum to provide behavioral health services to all Medicaid members in their region. Behavioral health providers such as therapists and counselors who want to bill Medicaid must be enrolled in their regional BHO through an often-cumbersome process called credentialing.

Some providers avoid this process by deciding not to see Medicaid members. Others receive approval from the state Medicaid department but have trouble obtaining BHO certification.

But the process is about to change. The state’s big Medicaid reform effort—the Accountable Care Collaborative (ACC)—is beginning a phase aimed at connecting primary and behavioral health care. The first step for the ACC is to create seven new oversight organizations called Regional Accountable Entities (RAEs). RAEs will replace the BHOs in July 2018 and will be responsible for connecting members to a primary care provider, among other things.

The Fund’s primary care provider grantees are anticipating the ability of primary care providers to bill Medicaid directly for up to six behavioral health visits. They argue that this will help with the long-term financial sustainability of programs that integrate primary and behavioral health care.

2018 will be a year to watch these changes in Medicaid, how the RAEs develop their networks of providers, and whether they affect access to care.

Additional information is available in CHI’s publication “The Route to the RAEs” at coloradohealthinstitute.org.
LEARNING CIRCLES

CHI convenes an annual in-person Learning Circle for grantees to share lessons learned in an environment that fosters creativity and connection with other grantees. The Learning Circle provides an opportunity to support the Fund’s grantee partners in their evaluation practices, address themes in their annual reports, and discuss current policy issues.

In November 2017, 43 grantee representatives attended CHI’s third Learning Circle in Denver. The day-long seminar addressed learning and adapting to changes in health care and health policy, such as a new presidential administration, growing or shrinking populations, new organizational leadership or the evolution of public programs like Medicaid. The Learning Circle included a panel discussion on evaluation and opportunities for grantees to discuss their programs, best practices, and improvement efforts.

A variety of themes emerged from the 2017 Learning Circle. These themes provide context and insight into the grantees’ work. Three key takeaways include:

• **An environment of change:** Many grantees adapted to noteworthy changes in the past year. These included everything from switching computer systems to forming new partnerships or implementing new policies. These developments often required subsequent changes to how grantees implement and evaluate their programs and collect data.

• **Evaluation challenges:** Many grantees struggle with how to evaluate the impact of their programs. For example, how should a grantee evaluate whether offering primary care and behavioral health care services in the same place (a practice known as care integration) increases their patients’ access to care? Many expressed interest in evaluation techniques that assess how their program contributed to a particular outcome.

• **Medicaid’s future:** Grantees had many questions about the Colorado Medicaid program’s future. In particular, many expressed interest in an upcoming change that will allow Medicaid to pay for up to six behavioral health visits provided to patients in a primary care setting. (See sidebar on Page 18.)

The Learning Circle also provided CHI with insights into its own evaluation approach. Learning about grantee experiences through their rich, wide-ranging, in-person conversations helps CHI develop a fuller picture of grantees’ work and the Fund’s impact in Colorado communities.

Learning Circle participants, from left: Alexandra Caldwell (Colorado Health Institute), Liz Whitley (Colorado Department of Public Health and Environment), Moe Keller (Mental Health Colorado), Kelci Price (Colorado Health Foundation), Chanda Hinton (the Chanda Plan Foundation) and Charlie Davis (Mental Health Partners). Flor Blake
health care needs. Future grantmaking should build on these gains.

CHI Recommendations:

- Continue funding and supporting grantees that are serving the highest-need populations, including many currently funded programs.

- Use CHI’s mid-point Asset and Gap research in 2018 to ensure future grantmaking is meeting the Fund’s health equity goals by addressing the most pressing behavioral health needs in the state. That research will examine Colorado’s behavioral health needs—in terms of populations, regions and other groups—and will propose potential investment solutions for the Fund to pursue.

- Encourage evaluation techniques that capture the information necessary to monitor how the Fund is addressing health equity goals. The Fund, in partnership with CHI, should help grantees report how many individuals in specific income, race and ethnicity, geography, and other categories were served.

Tier Two: Fidelity to the Fund’s Intent

The Fund set out to improve access to care and health outcomes for Coloradans with high health care needs. The Fund’s goal was to ensure that 20 percent of the grants go to programs serving rural Coloradans. Fund activities must address four focus areas: education, access to care, transitions, and innovative care delivery.

The Fund had mixed results in Year Two.

Guiding Question: To what extent does the Fund target efforts to improve access to needed services and health outcomes among Coloradans with high health care needs?

Answer: The Fund expanded access to behavioral health services by increasing both its financial investment and the number of grantees in Year Two. It reached a smaller number of Coloradans than the prior year.

The Fund distributed $3.9 million for behavioral health services in Colorado, an increase of 77 percent from the nearly $2.2 million spent in the inaugural year. The number of grantees increased as well, climbing to 36 from 27. (This evaluation focuses on the 35 Year Two grantees that submitted reports.)

However, the number of Coloradans served by funded programs in Year Two declined by about half—to 17,000 from 32,000 in Year One. A combination of factors led to this reduction.

First, a third of grantees funded in Year One had single-year grants, meaning that their Colorado Health Access Fund support ended, and they were not included in the Year Two evaluation. These organizations tended to be relatively large, serving an average of about 2,000 people compared with Year Two grantees, which served an average of 470 people.

Almost half of the grantees in Year Two—17 in total—were new grantees. Of these, 13 reported challenges hiring qualified staff. This created a prolonged ramp-up period and meant fewer people were served during the grant year. Two grants had to be terminated because the grantees had not made sufficient progress in implementing their program.

Despite the smaller number of people reached, the grantees funded in Year Two increased behavioral health capacity, expanded the number of services, and promoted integrated care. Grantees generally reported making sufficient progress on implementation. And grantees are serving many of the high-need populations the Fund was intended to reach, including Coloradans with low incomes and people from a variety of racial and ethnic backgrounds.

The second year was not without setbacks. The good news is that The Denver Foundation hired additional Colorado Health Access Fund staff and increased its ability to work with grantees, especially those navigating challenges. For example, one of the terminated grants was transferred to another organization, allowing planned behavioral health programs to continue without significant disruption. Another grantee was placed on a performance plan to ensure progress was made. And a handful of grantees
received no-cost extensions due to difficulties implementing their programs. The Foundation's staff communicates with grantees to ensure that if changes are necessary, they align with the mission of the Fund.

Guiding Question: Are the funds equitably allocated among rural, urban, and suburban areas? Do grantees reflect the state's geographic differences?

Answer: No. The percentage of funds targeting rural Coloradans dropped to about 12 percent from 27 percent in Year One. In Year One and Year Two combined, 17.8 percent of funds went to programs serving rural Colorado. (See Figure 5.) This rate falls short of the Fund's intended 20 percent rural grant funding rate.

A map of grantees allows us to dig deeper. Map 1 displays the locations of Year One and Year Two grantees. Although many grantees serve a large geographic area, the map is helpful in examining the location of their administrative offices. More than three quarters of the Year Two grantees—26 of 35—are primarily serving clients in urban areas along Interstate 25, including Aurora, Denver, Boulder, Fort Collins, and Colorado Springs. Mountain rural areas were better served than the Eastern Plains: In fact, no grantees were expressly focused on the Eastern Plains.

In its Year One evaluation report, CHI recommended ensuring geographic diversity in grantmaking. The Fund responded to this recommendation in 2017 by expanding its outreach efforts, which should be reflected in the next evaluation report. For example, more than half of the 13 new grantees awarded in 2017 are located outside of the Interstate 25 corridor, and many are serving rural clients in southern and eastern Colorado—two areas that were underserved by previous grantmaking.
Finally, it should be noted that each year’s grantmaking process may yield a different mix of urban and rural grantees. The Fund’s strategic intent that at least one-fifth of the grant funds serve rural Colorado will be assessed over the entire life of the Fund.

Guiding Question: Does the collective work of grantees address each of the Fund’s four focus areas—education, access to care, transitions in care, and innovation in delivery?

Answer: Yes. As in Year One, all grantees addressed at least one of the Fund’s core focus areas. (See Figure 6.)

The distribution among focus areas mirrored Year One, except for transitions in care. About 40 percent of grantees reported serving this area in Year Two, down from 56 percent in Year One. This is primarily due to the end of several grants that had focused on this area.

Access to care continued to be the primary focus of the Fund’s grantmaking, with 77 percent of grantees reporting work in this area.

About 69 percent of grantee activities addressed innovations in care delivery. The integration of primary care and behavioral health was a commonly cited innovation.

Finally, 49 percent of grantees focused on education of patients and families, including on mental health issues and resources available to families.

Tier Two: Recommendations for The Denver Foundation

Rural Outreach and Recruitment Strategy: Increasing the Fund’s focus on serving rural Coloradans will continue to be important. CHI recommends three specific approaches:

- Continue investigating the barriers that prevented organizations from applying for a grant or from submitting a successful proposal. Evaluate whether to revamp the application process based on those findings.
- Encourage the subset of grantees that serve geographically diverse populations to focus programming on rural Coloradans.
• Encourage past grantees to apply again, especially if they have a rural focus.

Clear Communication During Times of Change:

• Continue to encourage grantees to talk with Fund staff if their programs are not being implemented as planned. Fund staff can work with grantees to ensure progress or assist with programmatic adaptations that maintain the Fund’s mission.

• Consider investing in a grantee perception assessment to inform the grantmaking and grant management processes in the future—from reporting requirements to site visits to grantee selection.

Monitoring Program Ramp-Up Time: Because there were more new grantees, significant time was spent launching programs, which may have contributed to the decline in the number of Coloradans served compared with Year One.

Monitor ramp-up periods and work closely with grantees to ensure they are meeting program targets.

Increased Grantmaking in Focus Areas:
Opportunities exist for more grantmaking that targets transitions in care and the education of patients and families, two of the Fund's focus areas.

• Target future grants towards these focus areas.

Tier Three: The Fund’s Contributions to Behavioral Health In Context

Guiding Question: How has access to care changed across Colorado since the creation of the Colorado Health Access Fund? Is the fund addressing the state’s biggest needs?

Answer: This section presents the current state of access to behavioral health care in Colorado with a special lens on age, region, and populations of interest to the Fund.

It's a challenge to directly attribute statewide changes in access to care to the Fund's supported programs. That's because the Fund is working alongside multiple local and statewide efforts to achieve the goal of increased access to care:

• The next phase of the state's Accountable Care Collaborative will integrate behavioral health into primary care using the Regional Accountable Entities (RAEs) model.

• The State Innovation Model (SiM) is using telehealth tools to increase integration of behavioral health care in physical health care settings. It's also funding Local Public Health Agencies (LPHAs) and collaborations statewide to reduce stigma, increase outreach and education, and coordinate systems to improve integration.

• Hundreds of local programs are expanding access to services for populations and regions that need it most, including the Nurse Family Partnership, The Incredible Years program for young children, and the Senate Bill 17-074 pilot program training nurse practitioners and physician assistants to deliver medication-assisted treatment for opioid abuse in Pueblo and Routt counties.

Still, a look at the current state of behavioral health care access indicates that the Fund is contributing directly to the areas that need it most. The work of grantees supported by the Fund lines up with many of the populations that lack care. (See Tier One on Page 8.)

Behavioral Health in Colorado: Access and Disparities

The Colorado Health Access Fund's programs specifically aim to increase access to behavioral health services.

CHI's 2015 analysis of gaps in health care access found that some Coloradans are particularly likely to experience barriers to behavioral health care. The groups most in need of care include Coloradans without insurance, those with low incomes, and those who live in rural areas. Other hard to reach groups suffer from similar barriers to care, including LGBTQ Coloradans, children and adolescents, those who identify as American Indian, Alaska Native or multiracial, older adults, and people who are marginalized as immigrants, refugees, or experiencing homelessness.

In the 2016-2017 grant year, programs supported by the Colorado Health Access Fund served thousands...
of these high-need Coloradans. For example:

- **Adolescents:** Mental Health Center of Denver is addressing adolescent behavioral health needs by offering drop-in counseling hours for 14- to 26-year-olds.

- **Immigrants and Refugees:** The Rocky Mountain Immigrant Advocacy Network provides needed services to people at an immigrant detention center in Aurora.

- **Native Americans:** Denver Indian Health and Family Services is serving American Indian Coloradans by offering culturally appropriate, integrated behavioral health care, including access to traditional healing services.

- **Older Coloradans:** Multiple programs are serving the behavioral health needs of older Coloradans, including the Denver Housing Authority, Seniors’ Resource Center, and the Jefferson Center for Mental Health’s Senior Reach program.

Statewide, some 7.6 percent of all Coloradans indicate they could not get needed mental health care, according to the Colorado Health Access Survey (CHAS). (See Figure 7.) When asked why, the most common reasons were lack of insurance, concerns about cost, or that they thought their insurance wouldn’t cover it. Others reported difficulty getting an appointment, and some cited stigma: either they didn’t feel comfortable talking about their personal problems with a health professional or they were concerned about someone finding out they had a problem.

There were variations in these rates by race/ethnicity, income, and insurance type. A higher proportion of American Indian or Alaska Native and multiracial Coloradans reported not being able to get needed care compared with the state average. A smaller portion of Coloradans with private insurance reported not receiving mental health care that they needed. And Coloradans with low incomes were less likely than higher-income Coloradans to receive needed behavioral health care.

This evaluation has pointed out the importance of understanding barriers to accessing behavioral health care at the local and regional level. Residents of rural communities in the southwest, central mountains, and southeast corner of Colorado were
more likely to report trouble obtaining behavioral health services. (See Map 2.) Residents of Denver and the counties immediately to the west also reported higher-than-average levels of unmet mental health needs.

Looking at behavioral health by age is more complicated. (See Figure 8.) The proportion of adults indicating poor mental health increased between 2013 and 2017, according to the Behavioral Risk Factor Surveillance System (BRFSS). However, another source—the CHAS—suggests a decline between 2013 and 2015 and a spike in 2017. Despite the variations, the surveys agree that roughly one of eight adult Coloradans reports poor mental health, and CHAS data shows a sizable number of people who say they needed mental health care did not receive it.

The Healthy Kids Colorado Survey (HKCS) and Colorado Child Health Survey (CCHS) indicate an increase in mental health needs among children and adolescents between 2013 and the present.

All these surveys together point to the continuing need to address access to behavioral health care for Coloradans of all ages.

Map 2. Percentage of Coloradans Who Needed Mental Health Services but Didn’t Get Them by Health Statistics Region (HSR), 2017
### CONCLUSION

In its second year, the Colorado Health Access Fund is supporting grantees that are providing crucial behavioral health services to 17,000 Coloradans. Disparities in access to behavioral health care persist, and data show that many Coloradans struggle with mental health and substance use. Fund grantees are bringing new and expanded programs to some of the Coloradans with the highest health needs and least access to care.

Grantees’ approaches to expanding behavioral health care are as diverse as the people they are serving. There will continue to be much to learn from the programs and people addressing behavioral health with support from the Colorado Health Access Fund.

Still, grantees are working at a time of both policy change and cultural change, and the coming year is likely to offer just as much upheaval. As the Fund’s administrator, The Denver Foundation’s challenge will be to help grantees navigate these changes effectively to ensure that their vital work continues. With this support, the Fund’s grantees will be able to provide access to behavioral health care and improving health outcomes for thousands of Coloradans with high healthcare needs across the state.
GRANTEES
THIS YEAR-TWO EVALUATION REPORT INCLUDES 35 GRANTEE PROGRAMS.

Attention Homes
Homeless youth services provider
Grant Purpose: Increase onsite access to a licensed therapist and addictions counselor for youth experiencing homelessness.
Headquarters: Boulder
Grant Service Region: Boulder County

Aurora Mental Health Center (1)
Behavioral health services provider
Grant Purpose: Address behavioral health of high-needs youth with Aurora Public Schools and Rocky Mountain Youth Clinics.
Headquarters: Aurora
Grant Service Region: Metro Denver

Aurora Mental Health Center (2)
Behavioral health services provider
Grant Purpose: Support innovative linkages to behavioral health services for people experiencing homelessness.
Headquarters: Aurora
Grant Service Region: Metro Denver

Children's Hospital Colorado
Pediatric hospital and health services provider
Grant Purpose: A three-year grant increasing behavioral health services to families of the Young Mother's Clinic and the Colorado Adolescent Maternity Program.
Headquarters: Aurora
Grant Service Region: Metro Denver

Colorado Coalition for the Homeless
Homeless services provider
Grant Purpose: Expand behavioral health services in the Housing First program.
Headquarters: Denver
Grant Service Region: Metro Denver

*No longer active as of February 2018

Colorado Health Network
HIV/AIDS health and services provider
Grant Purpose: Expand access to behavioral health care at Front Range clinics for people with substance abuse and behavioral health needs.
Headquarters: Denver
Grant Service Region: Front Range

Counseling & Education Center
Counseling services provider
Grant Purpose: Expand counseling program for people with low incomes.
Headquarters: Grand Junction
Grant Service Region: Mesa County

Denver Children's Advocacy Center
Childhood trauma and abuse services provider
Grant Purpose: Expand interventions at Florence Crittendon school for school-age mothers experiencing trauma.
Headquarters: Denver
Grant Service Region: Metro Denver

Denver Health
Hospital and health services provider
Grant Purpose: Expand Encompass Adolescent Substance Treatment Program in collaboration with Denver Public Schools and University of Colorado.
Headquarters: Denver
Grant Service Region: Metro Denver

Denver Housing Authority
Affordable housing and supportive services provider
Grant Purpose: Expand the Health Navigation program.
Headquarters: Denver
Grant Service Region: Denver

Denver Indian Health & Family Services
Urban American Indian health services provider
Grant Purpose: Support culturally competent integration of behavioral health and traditional healing practices.
Headquarters: Denver
Grant Service Region: Metro Denver
Doctors Care  
Community safety net clinic  
**Grant Purpose:** Improve and expand integration of behavioral health care into primary care setting.  
**Headquarters:** Littleton  
**Grant Service Region:** Metro Denver

Eagle County Public Health*  
Local public health agency  
**Grant Purpose:** Address behavioral and substance abuse issues through the local Total Health Alliance.  
**Headquarters:** Eagle  
**Grant Service Region:** Eagle County

Grand County Health Network*  
Regional health alliance  
**Grant Purpose:** Implement a mental health navigation program in Grand County.  
**Headquarters:** Hot Sulphur Springs  
**Grant Service Region:** Grand County

Health District of Northern Larimer County  
Regional health services provider  
**Grant Purpose:** Expand services to children and adolescents in collaboration with Poudre School District and SummitStone Health Partners.  
**Headquarters:** Fort Collins  
**Grant Service Region:** Larimer County

Health Solutions  
Behavioral health services provider  
**Grant Purpose:** Expand telebehavioral health in Pueblo, Las Animas and Huerfano counties.  
**Headquarters:** Pueblo  
**Grant Service Region:** Pueblo, Las Animas, and Huerfano counties

Heart of the Rockies Regional Medical Center Foundation  
Regional health services provider  
**Grant Purpose:** Implement telepsychiatric services.  
**Headquarters:** Salida  
**Grant Service Region:** Chaffee, Fremont, and Saguache counties

Inner City Health Center  
Community safety net clinic  
**Grant Purpose:** A three-year grant to expand behavioral health capacity in Metro Denver and surrounding areas.  
**Headquarters:** Denver  
**Grant Service Region:** Metro Denver

Jefferson Center for Mental Health  
Behavioral health services provider  
**Grant Purpose:** Expand clinical services to remote mountain regions.  
**Headquarters:** Lakewood  
**Grant Service Region:** Jefferson, Gilpin, and Clear Creek counties

Jewish Family Services  
Social services provider  
**Grant Purpose:** Hire providers to support immigrant and refugee family members at school-based and community care settings.  
**Headquarters:** Denver  
**Grant Service Region:** Metro Denver

Kids First Health Care  
School-based health care provider  
**Grant Purpose:** Increase behavioral health staff and services at Adams County and Kearney middle schools.  
**Headquarters:** Commerce City  
**Grant Service Region:** Adams County

Marillac Health  
Community health center  
**Grant Purpose:** Expand the behavioral health team and increase integration with primary care.  
**Headquarters:** Grand Junction  
**Grant Service Region:** Mesa County

Mental Health Center of Denver  
Behavioral health services provider  
**Grant Purpose:** Support Emerson Street Program for teens and young adults.  
**Headquarters:** Denver  
**Grant Service Region:** Denver
Mental Health Partners
Behavioral health services provider
Grant Purpose: Support Project EDGE, a team of emergency psychiatric clinicians and peer-support specialists serving Boulder and Broomfield counties.
Headquarters: Boulder
Grant Service Region: Boulder and Broomfield counties

Metro Community Provider Network
Community health center
Headquarters: Denver
Grant Service Region: Metro Denver

Mile High Behavioral Healthcare
Behavioral health services provider
Grant Purpose: Expand Beat the Streets, which serves youth experiencing homelessness in Metro Denver.
Headquarters: Aurora
Grant Service Region: Metro Denver

Northwest Colorado Health
Community health center
Grant Purpose: Integrate new bilingual psychologist into health care facilities; provide telepsychiatry.
Headquarters: Steamboat Springs
Grant Service Region: Routt County

Poudre Valley Health System
Hospital and health services provider
Grant Purpose: Capital improvement grant for additional acute and general inpatient psychiatric beds.
Headquarters: Fort Collins
Grant Service Region: Northern Colorado

Rocky Mountain Immigrant Advocacy Network
Immigrant health and services provider
Grant Purpose: Support behavioral health services to immigrants in ICE detention center and their families.
Headquarters: Westminster
Grant Service Region: Statewide

Salud Family Health Centers
Community health center
Grant Purpose: Expand integration of behavioral health in primary care setting in Metro Denver and northeast Colorado clinics.
Headquarters: Fort Lupton
Grant Service Region: Northeast Colorado

Seniors’ Resource Center
Senior services provider
Grant Purpose: Expand call-in center that connects seniors with counseling and support services.
Headquarters: Lakewood
Grant Service Region: Metro Denver

St. Francis Center
Homeless services provider
Grant Purpose: Expand transitional behavioral health care services to adults experiencing homelessness.
Headquarters: Denver
Grant Service Region: Metro Denver

Saint Joseph Hospital — Bruner Family Medicine Clinic
Community safety net clinic
Grant Purpose: Expand the behavioral health team and increase integration with primary care.
Headquarters: Denver
Grant Service Region: Metro Denver

Summit Community Care Clinic
Community health center
Grant Purpose: Expand integration of behavioral health in primary care setting.
Headquarters: Frisco
Grant Service Region: Summit, Lake, Grand, Park, and Chaffee counties

The Aging Center — University of Colorado Colorado Springs*
Adult mental health services provider
Grant Purpose: Improve access to behavioral health for underserved seniors in the Pikes Peak region.
Headquarters: Colorado Springs
Grant Service Region: El Paso County
ENDNOTES

1 The source of the suicide and drug overdose data is the Colorado Department of Public Health and Environment (CDPHE). The source of the substance use data is CHI analysis of the 2017 CHAS.


9 The federal poverty level in 2017 for a family of four is $24,600.


11 The source of all Colorado Health Access Survey (CHAS) estimates cited in this report is the Colorado Health Institute’s analysis of the 2013, 2015 and 2017 CHAS.

12 In the 2016 report “Building from the Baseline,” the 2013 and 2015 figures for this measure reflected all ages and were not limited to adults. The figures have been updated here.


14 Colorado Department of Public Health and Environment (CDPHE). Colorado’s Child Health Survey. CHI obtained data 2013, 2015 and 2016 data from CDPHE.
ACKNOWLEDGMENTS

CHI staff members contributing to this report:
• Jeff Bontrager, Principal Investigator
• Alexandra Caldwell, Associate Director of Program Development and Analysis
• Brian Clark, Associate Director of Visual Communications
• Chrissy Esposito, Data Visualization and Policy Analyst
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• Liana Major, Policy Analyst
• Teresa Manocchio, Policy Analyst
• Emily Morian-Lozano, Policy Analyst
• Jaclyn Zubrzycki, Communications Specialist

Special thanks to:
The Denver Foundation staff for their thoughtful assistance and leadership throughout the Fund’s evaluation.
• Kristi Keolakai, Philanthropic Operations Manager
• Dace West, Vice President of Community Impact
• Cindy Willard, Senior Program Officer

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