Meeting Coloradans Where They Are

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

2018 Annual Evaluation Report

March 2019

COLORADO HEALTH INSTITUTE
Informing Policy. Advancing Health

COLORADO HEALTH ACCESS FUND
THE DENVER FOUNDATION
About the Colorado Health Institute

The Colorado Health Institute (CHI) is a health policy research organization that is a trusted source of independent and objective health information, data, and analysis. CHI is primarily funded by the Caring for Colorado Foundation, Rose Community Foundation, and The Colorado Trust.

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 to rural, urban, and suburban areas.

The Fund includes four focus areas for the projects it funds:

- **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 gain a concrete understanding of Colorado’s diverse health care landscape and to guide the development of the funding strategy. The 2014 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 who 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 those who have a disability and/or have limited proficiency in English.

Between 2015-2018, the Fund has supported specific projects and programs, capital improvements for hospital or facility expansions, general operating funds, and multi-organization collaboratives. Grants may be up to three years. In its third year, the Fund supported 38 grantees across Colorado, up from 36 grantees in Year 2 and 27 grantees in Year 1.

About This Evaluation

The Denver Foundation retained CHI to independently evaluate the Colorado Health Access Fund, a $40 million field of interest fund of The Denver Foundation dedicated to expanding behavioral health care access for Coloradans with high health care needs. The evaluation measures the reach and effectiveness of the Fund’s grantees and puts the Fund’s work in the context of behavioral health needs in Colorado. It also examines how well the Fund adheres to its strategic intent.

This third evaluation report by CHI examines the work of the Fund’s third year (2017-18). It is based on data from evaluation reports submitted by 37 of the 38 grantees that completed a funding year in 2018. (One grantee completing funding in 2018 had to terminate its grant and is not included.) Some grantees completed their first year of funding in 2018 and others are in their second or third year of multiyear grants.

The Colorado Health Access Fund also supports several “out-of-cycle” grantees — programs that were awarded funding through a different process from the standard Request for Proposal. These account for close to $2 million in funding. They are not included in this report.
Acknowledgements

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Executive Summary

Access to behavioral health care in Colorado is a persistent challenge. In 2017, nearly one in eight Coloradans experienced poor mental health in the past month, according to the Colorado Health Access Survey, and one in 13 did not get the mental health care they needed.

The Denver Foundation’s Colorado Health Access Fund aims to change that by supporting the work of more than three dozen organizations throughout Colorado that provide care for mental health and substance abuse issues to those who need it most.

The 37 grantees included in this evaluation offer therapy and other treatments for behavioral health issues, create innovative ways to help people or increase the reach of behavioral health services, ease transitions between different parts of the health care system, and educate people about behavioral health needs and services.

In 2017-2018, the Fund’s third year, these programs were successfully increasing access to behavioral health care in many Colorado communities.

Grantees around the state were more stable and more were planning to sustain programs after the grant’s end than in the Fund’s first two years. They were increasingly achieving the goals and benchmarks they laid out for their programs. And the programs altogether served more Coloradans than in the previous year.

In Year 3, grantees spent about the same amount of money annually and supported about the same number of programs as in previous years. But the Fund increased its focus on rural parts of the state, and programs were more evenly distributed across the Fund’s four focus areas: 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.

This evaluation conducted by the Colorado Health Institute (CHI) examines how the Colorado Health Access Fund is doing in Year 3. It asks:

- What contributions have grantees made to increasing access to behavioral health services for Coloradans with high health care needs?
- 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.
- What are CHI’s recommendations for the Fund — and for CHI as the evaluator — as the Fund enters the its fourth year of grantmaking?

Some highlights from the Fund’s third year include:

- 25,000 individuals were served by Fund-supported programs in 2017-18.
- The Fund’s grantees are reaching people in need of more access to behavioral health care: Most individuals served are young, most are Medicaid members, and the overall population served is racially diverse.
- The Fund supported 81,221 unique direct services to Coloradans in 2017-18, including one-on-one therapy or counseling sessions, teletherapy sessions, and clinical assessments.
- A higher portion of the Fund’s resources were devoted to programs in rural parts of the state.
- The Fund supported a variety of programs that increase access to care, including direct behavioral health care services, “extended” direct services like teletherapy and care in non-traditional settings, and strengthening connections to services through behavioral health integration and transitions to care.
- Two-thirds of grantees (65 percent, or 24 grantees) have identified a clear or partial sustainability strategy that will allow them to continue programming after their Colorado Health Access Fund grant ends. That’s up from 43 percent of grantees in 2016-17.
Common themes in what makes grantees thrive or struggle have become evident in the first three years of the Colorado Health Access Fund. Some of the most successful grantees — those serving greater numbers of individuals or with increasingly sustainable programs — attributed their success to intensively supporting their staff and connecting to others in the community. The challenges that prevented grantees from reaching more people were similar to past years, including difficulty hiring the right staff, contextual issues like changing funding environments, and policy barriers related to reimbursement and billing.

Policies and dynamics outside of grantees’ control play a role in programs’ ability to reach more Coloradans. For example, grantees cited changes to Colorado’s Medicaid program, Health First Colorado, that aim to streamline management of behavioral and physical health services as an important factor in increasing access to behavioral health care in 2018.

However, grantees said some other recent policy changes may be deterring patients from seeking services. One example is the September 2018 Department of Homeland Security proposal that would allow the government to consider whether a would-be green card or visa holder is likely to be a “public charge” due to their use of public programs such as Medicaid or the Children’s Health Insurance Program (CHIP). Though the rule is not final yet, critics fear a chilling effect that impels immigrant families to disenroll or avoid needed care.

Three profiles included at the end of this report explore a theme of the Fund in Year 3: “Meeting Coloradans where they are.” Fund-supported programs are using increasingly diverse methods to improve access to care and behavioral health outcomes for those who need it most. The three profiles illustrate the Fund’s legacy in action.
**Introduction**

In its third year, the Colorado Health Access Fund had a watershed year. The Fund increased its support for programs in rural Colorado and reached diverse populations with high health care needs. It supported behavioral health services for over 25,000 Coloradans, an increase from 17,000 the prior year. And it accomplished these goals while maintaining a similar funding level — $3.8 million in Year 3, compared with $3.9 million in Year 2.

The Colorado Health Access Fund’s support for innovative behavioral health programming couldn’t come at a better time. Almost one in eight adults in Colorado reported poor mental health in 2017, up from 9.9 percent in 2015. Also, in 2017, almost a third (31.4 percent) of Colorado high school students reported feeling so sad or hopeless almost every day for at least two weeks in the past year that they stopped doing usual activities, according to the Healthy Kids Colorado Survey.1

There is a gap between Coloradans’ needs and their access to services. According to the Colorado Health Access Survey, about one in 13 Coloradans (7.6 percent) and one in six Medicaid members (15.0 percent) did not get needed mental health services. More than 67,000 Coloradans reported needing services for alcohol or drug use but not receiving them. When asked why, people cited lack of insurance, stigma, or confusion about what services insurance plans like Medicaid will cover.2

The Colorado Health Access Fund supports programs that are filling this gap by providing vital services and resources and support the well-being of people around Colorado. The programs it funds are diverse and tailored to local needs. One grantee used telemedicine to bring cutting-edge knowledge about addiction to rural communities, while another supported a pipeline of bilingual counselors, and a third created support groups and services for women in the postpartum period.

Several factors, both internal to the Fund and external, contributed to the Fund’s ability to support this kind of programming for more Coloradans in Year 3. For instance, Fund staff reached out directly to organizations in rural areas in order to meet its goal of directing at least 20 percent of funding to programs serving rural Coloradans. Many grantees that started programming in Year 1 or 2 had more established workflows and procedures by Year 3 and have been able to implement their programs more robustly or bring them to more people. The Foundation also hired an additional staff member to provide increased internal support for the Fund.

There are persistent roadblocks to implementing the kinds of programs supported by the Fund. Grantees have reported consistent challenges, including behavioral health workforce shortages, securing Medicaid reimbursement for services, and difficulty identifying strategies to sustain grant-funded programs after the grant has ended.

Those common challenges and successes led the Fund to create a new cohort of nine grantees focused on policy and advocacy starting in January 2019. The experiences of grantees supported in the first years of the Fund illuminated various issues that are ripe for systems-level change, such as maintaining an adequate behavioral health workforce and sustainably paying for services. The new cohort of grantees is working on policy and advocacy approaches to address these and others systemic barriers to care. The cohort has the potential to make 2019 another significant year for the Fund’s lasting legacy.

Still, several policy developments elicited cautious optimism among many communities and grantees. These include:

- **ACC Phase Two**
  The launch of the Regional Accountable Entities (RAEs) in as part of Medicaid’s Accountable Care Collaborative (ACC 2.0) presents new potential for partnership and the development of behavioral health provider networks to serve Health First Colorado members.

- **Local ballot initiatives**
  Voters in 10 communities across Colorado passed ballot initiatives that finance mental health services.
Federal investment in substance use disorder treatment
The federal 21st Century Cures Act, signed into law in December 2016, allocated funding to states to help address the opioid crisis. Over the past two years, the Colorado Office of Behavioral Health has received and administered these dollars and others — some $60 million in federal grants — to address the opioid epidemic. Successes have included increasing access to naloxone in communities, training crisis service staff to serve people with an opioid use disorder, and providing medication-assisted treatment in jails.

In an ever-changing policy environment, the Colorado Health Access Fund continues its commitment to supporting critical, innovative behavioral health care programming and bringing it to those who need it most.

This report includes three grantee profiles that capture the diversity of programs supported by the Fund and the vital role they are playing for the populations they serve. The theme of this year’s profiles, and this report, is “meeting Coloradans where they are.” Fund-supported programs are using increasingly diverse methods to increase access to care and improve behavioral health outcomes for those who need it most. That diversity highlights the Fund’s unique legacy and its commitment to reaching all Coloradans in ways that meet their needs.

This evaluation from the Colorado Health Institute (CHI) explores the reach and impact of the Fund’s programs, identifies dynamics that have contributed to the Fund’s successes in its first three years and key opportunities for the future, and provides a set of recommendations about how the Fund can provide leadership in behavioral health care in Colorado through 2022.

Our Analysis
This is CHI’s third annual evaluation of the Colorado Health Access Fund. 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 goals.

3. What are CHI’s recommendations for the Fund — and for CHI as the evaluator — as the Fund enters its fourth year of grantmaking?

The report also assesses the extent to which the Fund has stayed true to its original intent: Helping Coloradans with high health care needs, targeting its four focus areas, and allocating grants equitably among rural, urban, and suburban areas. Those assessments are made throughout the report.

The evaluation team used quantitative and qualitative information from reports submitted by each grantee, forums of grantees held by The Denver Foundation, and other data collected in partnership with the Fund’s team to answer these evaluation questions.
RE-AIM Plus P Model

This report is organized under the RE-AIM Plus 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 Plus P framework, the evaluation team collects 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 in Colorado 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? If a program was 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 to the Policy Environment**: Does the rapidly changing policy context contribute to or detract from program effectiveness? What policy barriers or opportunities exist?

The Evaluation

Reach

**Guiding Questions**: How many people were served by programs supported by the Fund in Year 3? What are their demographic, geographic, and health status characteristics? What portion of funds supported services in rural areas?

**Key Findings**:

**In its third year, the Fund provided access to behavioral health services to more than 25,000 Coloradans.**

That number includes those who received direct services like in-person counseling sessions and telehealth therapy. It excludes indirect services, like screenings for mental health or substance use challenges.

Colorado Health Access Fund grantees reported serving 32,000 Coloradans in Year 1 and 17,000 in Year 2. As noted in last year’s evaluation report, the dip between Years 1 and 2 was due in part to the end of several large one-year grants and the launch of a number of new grantees that needed time to ramp up programs.

The increase between Years 2 and 3 shows the increasing stability and strength of many Fund-supported programs. As programs grew more established, grantees hired providers, streamlined workflows, and improved billing processes. Some were able to identify other areas of need or ways to improve or expand their programs.

One example of that stabilization is the Aurora Mental Health Center’s program for people who are homeless. The Aurora Mental Health Center served about 250 people in Year 3, up from 60 in Year 2, its first year of funding. The Center attributes its growth in part to expanding its services. While it previously offered only drop-in services, it now
takes referrals from Aurora Day Resources Center, Tri-County Syringe Exchange program, and other groups serving people in crisis.

The Fund’s grantees served Coloradans with the highest health needs and most significant barriers to care, such as Coloradans affected by trauma, people with substance use disorders, and immigrants and refugees.

As Figure 1 illustrates, more than three-quarters (78 percent) of programs are expressly focused on serving trauma-affected populations — groups of people who have potentially experienced the lasting effects of past events or circumstances that were physically or emotionally harmful. Grantees defined “trauma-affected” independently and broadly, so examples of programs are diverse — including Denver Indian Health and Family Services, which supports court-involved families, and a youth-focused trauma services program at the Aurora Mental Health Center.

Two-thirds of grantees’ services are directed towards families and/or adolescents. About the same proportion are serving people experiencing substance use disorder. More than two-thirds of grantees are focused on serving people of color. Valley Settlement’s peer group, for instance, serves only Latina women in the postpartum period.

All 37 grantees programs focused on providing services for people with low incomes.

Other grantees aimed to reach other groups with known barriers to accessing behavioral health care, including Coloradans who are homebound, underinsured, or disabled; LGBTQ Coloradans; and seniors, children, or adolescents with behavioral health needs.

These categories are not mutually exclusive — many grantees serve a number of different populations.

**Figure 1: Who Are Grantees Aiming to Serve?** (Grantees could target more than one group)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma-affected populations</td>
<td>78%</td>
</tr>
<tr>
<td>People with substance use disorders</td>
<td>68%</td>
</tr>
<tr>
<td>People of color</td>
<td>68%</td>
</tr>
<tr>
<td>Adolescents</td>
<td>65%</td>
</tr>
<tr>
<td>Families</td>
<td>65%</td>
</tr>
<tr>
<td>Seniors</td>
<td>62%</td>
</tr>
<tr>
<td>People with limited English proficiency</td>
<td>59%</td>
</tr>
<tr>
<td>People experiencing homelessness or housing insecurity</td>
<td>59%</td>
</tr>
<tr>
<td>Children</td>
<td>57%</td>
</tr>
<tr>
<td>People experiencing unemployment</td>
<td>54%</td>
</tr>
<tr>
<td>People who are homebound or disabled</td>
<td>51%</td>
</tr>
</tbody>
</table>

Coloradans served by Fund-supported programs are diverse, disproportionately young, and likely to be Medicaid members.

For the first time since the Fund’s inception, grantees reported demographic information on the 25,000 people they reached in Year 3. Not all grantees could report the same types of information or level of detail, but the results provide some insight into who is benefiting from the Fund’s supported programs (see Figure 2).

On average, programs reported that more than half (57 percent) of the people they served use Medicaid or Child Health Plan Plus (CHP+) as their primary insurance. That’s compared to about one in five (21 percent) Coloradans using those insurance types statewide.

Two in five people (40 percent) served by the Fund identified as Hispanic or Latino/a. About one in five (22 percent) Coloradans identified as Hispanic or Latino/a in 2016.
Almost half (44 percent) were under 18. By comparison, about one in five (23 percent) Coloradans were under 18 in 2016. Though most programs serve a broad range of ages, several served mostly children and adolescents. For instance, 62 percent of those who received integrated behavioral health services from Doctors Care — some 569 people in the Denver Metro area — were under 18.

**Figure 2: Who Are Fund-Supported Programs Serving?**

*Select demographic estimates as reported by grantees and analyzed by CHI using weighted averages. Not all grantees reported all indicators. Colorado health insurance data are from the 2017 Colorado Health Access Survey. Colorado gender, age, and race data are from the Colorado State Demography Office’s 2016 estimates. Colorado ethnicity and language data are from the 2017 American Community Survey.*

**Health Insurance**

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Grantee Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/CHP+</td>
<td>21%</td>
<td>57%</td>
</tr>
<tr>
<td>Private</td>
<td>49%</td>
<td>8%</td>
</tr>
<tr>
<td>Medicare</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>7%</td>
<td>12%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
<td>14%</td>
</tr>
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**Gender**

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<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Grantee Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>50%</td>
<td>41%</td>
</tr>
<tr>
<td>Female</td>
<td>50%</td>
<td>55%</td>
</tr>
<tr>
<td>Unknown or Other</td>
<td></td>
<td>4%</td>
</tr>
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</table>

**Age**

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Grantee Reported</th>
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</thead>
<tbody>
<tr>
<td>Up to 18 Years Old</td>
<td>23%</td>
<td>44%</td>
</tr>
<tr>
<td>18 + Years Old</td>
<td>77%</td>
<td>47%</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td>9%</td>
</tr>
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</table>

**Ethnicity**

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Grantee Reported</th>
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</thead>
<tbody>
<tr>
<td>Hispanic/Latinx</td>
<td>22%</td>
<td>40%</td>
</tr>
<tr>
<td>Non-Hispanic/Latinx</td>
<td>78%</td>
<td>44%</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td>16%</td>
</tr>
</tbody>
</table>

**Race**

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Grantee Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>84%</td>
<td>44%</td>
</tr>
<tr>
<td>Multiple races or other race</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>African American</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td>3%</td>
</tr>
</tbody>
</table>
The Fund supported 81,221 unique direct services to Coloradans in 2017-18, including one-on-one therapy or counseling sessions, teletherapy sessions, brief clinical assessments, and other touch points.

Grantees provided these services to some 25,000 people across the state. The Fund also supported some or all the salaries of 529 behavioral health providers, with the expectation that grantees identify sustainable revenue support for these positions over time. It supported 80 sites across Colorado with integrated physical and behavioral health services.

Of the more than 81,000 services provided, the most common was one-on-one in-person counseling sessions with a behavioral health professional. The Fund supported 27,000 of these services in Year 3. Grantees facilitated another 12,000 behavioral health services remotely via telehealth (15 percent) in the 2017-18 time period (see Figure 3).

Grantees also provided “warm handoffs,” where a primary care clinician or other medical professional identifies a patient’s behavioral health need and introduces the patient to a behavioral health professional in the same visit (16 percent). Behavioral health professionals also provided about 12,000 brief clinical assessments to determine whether patients needed further therapy, counseling, medication, or other interventions (15 percent).

In addition, grantees reported more than 12,000 services supported by the Fund that did not cleanly fit into any of these categories.

For instance, Mental Health Partners in Boulder partnered with local law enforcement to co-respond to situations in which people may need behavioral health services; Kids First Health Care provided family therapy, crisis interventions and psychoeducation services; and Asian Pacific Development Center provided behavioral health education on intergenerational conflict, identity struggles, suicidal ideation, and how to access behavioral health services.

Figure 3: What Services Did Colorado Health Access Fund Grantees Provide?
Five Year 3 grantees were headquartered in rural areas, including Carbondale, Telluride, and Durango.

As in past years of the Fund, mountain rural areas were better served than the Eastern Plains. In fact, in Year 3, there is only one grantee expressly focused on the Eastern Plains.

**A Focus on Rural Colorado**

The Colorado Health Access Fund aims to support access to behavioral health care throughout Colorado – including in rural, suburban, and urban areas. In Year 3, how are the funds allocated among different geographic regions? Do grantees reflect the state’s geographic diversity?

Year 3 of the Fund marks a high point in the proportion of funding supporting rural Colorado. Almost a third (29 percent) of this year’s funds targeted rural parts of the state (see Figure 4). That’s up from closer to one in 10 dollars (12 percent) in the previous year. In total, about one in five dollars (22 percent) from the Fund so far have supported rural parts of the state.

Major drivers of this achievement include significant grants going to Mind Springs Health, which serves the western slope, Tri-County Health network in rural southwestern Colorado, and Mountain Family Health Centers in the Glenwood Springs area.
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 a variety of programs that increase access to care, including direct behavioral health care services, “extended” direct services like teletherapy and care in non-traditional settings, and strengthening connections to services with programs funded for behavioral health integration and transitions to care.
Direct Services

Though most grantees focused on multiple approaches, the most common approach is to offer direct counseling and behavioral health services such as in-person therapy at a health care clinic (see Figure 5).

For example, the Health District of Northern Larimer County hired a behavioral health provider to serve children and young adults in the Fort Collins region. Mountain Family Health Centers supported a behavioral health provider to serve patients in Glenwood Springs and the surrounding rural area.

Many grantees offered direct substance use disorder services. The Medication Assisted Recovery Center (MARC) at Health Solutions in Pueblo, for one, treated 260 people in the first 12 months of operation, more than twice what the organization projected for 2017.

Extended Direct Services

Many grantees are extending behavioral health services into non-traditional settings to meet Coloradans where they are — whether that’s in school, in court, during a law enforcement encounter, or in their homes.

For example, the Jefferson Center for Mental Health’s Senior Reach clinician offered behavioral health services in non-traditional environments by sustaining partnerships with a broad set of agencies across the region, from Christian outreach groups to senior residences, human services groups, and primary care providers. The Aurora Mental Health Center used funding to provide therapy, trauma services, and substance use treatment to youth with therapists and a bilingual Licensed Addiction Counselor in schools.

Grantees also provided behavioral health care via telehealth to extend the state’s limited workforce. For example, St. Mary’s Hospital in Grand Junction recruited 12 clinics to participate in its telehealth program to increase access to a certified addiction medicine specialist and doctorate level pharmacist. Pueblo-based Health Solutions is now offering telepsychiatry services in Trinidad and Walsenburg.

Strengthening Connections to Services

Innovative behavioral health integration — collaboration between health care professionals from different specialties — continues to be a focus of Fund grantees. For example, Peak Vista Community Health Centers in Colorado Springs has integrated behavioral health services into a family dental care clinic. In the first year, more than
200 dental patients were identified as needing behavioral health services, and 90 percent of them followed up with treatment.

Several grantees are focused on strengthening transitions to behavioral health services from other facilities or health care settings. Seniors’ Resource Center of Denver, for example, connects older Coloradans with behavioral health care and other social services via an outreach hotline that helps people reach providers like Mental Health Partners and Jefferson Center for Mental Health.

Other Focuses

At least one grantee continues to use the Fund’s support to promote behavioral health screening — an important step in connecting patients to appropriate care, but not a service which is specifically supported by the Fund.

Figure 5: Behavioral Health Services Supported by the Fund

These categories are mutually exclusive. However, many Fund-supported programs offer multiple service types.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling and Direct Behavioral Health Services</td>
<td>14</td>
</tr>
<tr>
<td>Behavioral Health Care in Non-traditional Settings</td>
<td>10</td>
</tr>
<tr>
<td>Behavioral Health Integration</td>
<td>8</td>
</tr>
<tr>
<td>Strengthen Transitions to Behavioral Health Services</td>
<td>3</td>
</tr>
<tr>
<td>Telehealth</td>
<td>2</td>
</tr>
</tbody>
</table>

Grantees that were most effective in meeting the unique characteristics of the regions they serve reported two important strategies: Hire staff who can meet the needs of target populations and address common barriers to accessing care such as transportation and appointment hours.

Many grantees reported hiring staff who speak multiple languages, share cultural values or religious practices, and are culturally responsive to the target population.

For example, the Asian Pacific Development Center’s program focused on engaging Vietnamese community members. That effort could not be successful without staff with strong connections to that community, which has a diverse set of backgrounds, beliefs, barriers, and strengths. The different backgrounds of the two community navigators APDC hired with the support of the Fund made it easier for the Center to connect with the diverse community — one was born in Vietnam and practices Buddhism, while the other was born in Colorado and practices Catholicism.

Grantees also reported that addressing the social determinants of health, such as child care issues, transportation, and social isolation, led to more successful programs.

This was especially true for participants in the Coalition for the Homeless’ field work program, which aimed to engage people without stable housing in behavioral health services. People experiencing homelessness often struggle to meet basic needs while seeking mental health treatment. The Coalition connected people not just to mental health care but to other social services to address those barriers. As a result, all clients in the Coalition’s Housing First program now have access to psychiatric care and a majority maintain stable housing.
**Investing for Impact**

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

It’s easier to track access to care through the Fund’s evaluation than it is to track health outcomes.

**Improved Access**

In 2017-18, the Fund granted approximately the same amount of money as during the 2016-17 period but across more grantees. The Fund granted $3.8 million to expand access to behavioral health services in 2017-18, compared to about $3.9 million in 2016-17. The number of grantees increased from 36 in Year 2 to 38 grantees in Year 3 (2017-18).

As explained in the Reach and Effectiveness sections, the Fund has stayed true to its mission of improving access to needed services for Coloradans with high health care needs. Despite the same amount of money and stable numbers of grantees, the Fund served more Coloradans.

New grantees for Year 3 were not particularly large, serving about 270 patients per grantee on average. That’s compared to the average across all Year 3 grantees serving more than 600 patients per grantee on average. But continuing grantees from past years increased their reach in Year 3. For example, Marillac Clinic in Grand Junction served about 700 more people than in Year 2. Summit Community Care Clinic served almost 400 more Coloradans than in the previous year.

They attribute their increased scale to a variety of factors, including more funding, low staff turnover, increasing referrals, or restructured workflows to enable behavioral health care providers the flexibility to see patients either as part of a primary care visit or before or after the primary care provider.

**Outcomes**

Measuring health outcomes — especially at a population level — is a challenge, given that many outcomes may take years to be realized. But in general, signs are promising that the Fund is having an impact on individuals’ health outcomes.

Many grantees shared positive indications of impact from their self-directed evaluation results. For example, children benefiting from Jewish Family Service’s KidSuccess program reported decreased anxiety, depression, psychosis, and manic behavior, as well as improvements in their socialization and overall function. And Mind Springs Health in Grand County tracked its patient outcomes using the Patient Health Questionnaire 9 to identify a reduction in depression symptoms among the hundreds of patients served.

**Adoption**

**Guiding Questions**: To what extent were programs adopted by all target staff and partners? If a program was not adopted by all, why not?

**Key Findings**: 

**Almost 90 percent of grantees reported that their programs were adopted as planned or exceeded expectations.**

In Year 3, nine in 10 grantees said the program’s target health care providers, patients, external partners like schools, and referral partners “bought in” to the program.
For some, that meant that staff at a primary care clinic willingly increased the use of behavioral health providers. For others, it meant introducing a new service line that was adopted voluntarily by other partners. St. Mary’s Hospital, for instance, engaged 11 of 12 target clinics to participate in its substance use treatment telehealth program.

Other organizations introduced a new program to a non-traditional location successfully. Rocky Mountain Immigrant Advocacy Network (RMIAN) brought a social worker directly into a detention facility and exceeded its goal of serving more than 35 immigrant detainees with direct legal representation and social services support. It served 42 in the grant year.

**Grantees reported that clear communication and coordination can streamline program adoption.**

For example, Denver Children’s Advocacy Center met its goal of offering mental health services through Florence Crittenton by engaging with the teachers and administrators there to address client needs and by creating strong lines of communication with the Denver Health clinic at Florence Crittenton to ensure continuity of care. Therapists notified medical staff of any mental health concerns, and Denver Health’s clinic staff alerted the Center’s therapists to issues such as medication changes or physical conditions that may impact behavioral health.

Grantees like Inner City Health Center that are promoting integrated behavioral health services recommended increasing program adoption by equipping provider “champions” or “early adopters” of integration with resources and leadership opportunities.

**When the program wasn’t adopted as planned, challenges were often deeply entrenched or out of the grantees’s control.**

Mind Springs Health overcame a series of challenges in increasing its program’s adoption in the community by maintaining clear communication with its partners in the law enforcement community.

Mind Springs had partnered with the sheriff’s office to hire and train non-law enforcement staff to transport patients to psychiatric, detox, and other inpatient behavioral health facilities — including providing a car that was not marked like a police car to remove the association of criminal justice with psychiatric care. But a fire in a local jail led the Sherriff’s office to direct resources to recovering from that unexpected event instead of towards Mind Springs’ program. The collaborative was directed to another private medical transportation company to transport patients to inpatient care.

The Chanda Plan Foundation’s behavioral health service program for people living with disabilities, on the other hand, reported that stigma was a challenge. Patients indicated needing behavioral health services but declined making an appointment, reporting that “they were not crazy.” Other patients reported feeling that their physical health was a higher priority than their behavioral health — meaning they were less likely to seek those services.

Other adoption barriers were environmental issues unrelated to the program. For example, Mental Health Partners experienced a series of challenges with its co-responder model, which staffs a behavioral health specialist on all law enforcement calls. Boulder police officers did not always request the program’s support even when there were opportunities for mental health co-response. And the City of Longmont received a grant from the Colorado Department of Human Services to create its own co-responder program and ended its partnership with Mental Health Partners in the spring of 2018.
Implementation

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

Key Findings:

Most grantees reported successful program implementation. Many attributed their success to effectively supporting, connecting, and caring for their staff.

Organizations with the most successful program implementation secured the tools and resources needed to set their staff up for success.

Clinica Family Health reflected in its grantee report that having a new behavioral health consultative provider required devoting time and resources for that provider to establish trust with a range of clinicians.

Mountain Family Health Centers reported that having robust funding relationships and strong referral connections with external partners led to its newly created behavioral health clinician position being sustained into the future.

RMIAN recommended maintaining staff wellness by implementing policies that enable self-care, like flextime, generous sick and vacation time, and access to mental health resources for staff.

Valley Settlement successfully used a telecommunications platform to strengthen its postpartum behavioral health support program with an expert trainer in the Washington, D.C., area.

Others reported clear workflow decisions that led to patient retention in their program.

Grantees made those workflow changes by assessing the barriers faced by parents and adapting their processes and care delivery to overcome the challenges.

Health Solutions’ Medication-Assisted Recovery Center (MARC) removed transportation barriers for patients by connecting them to the pharmacy next door to the Center to receive substance use disorder recovery medications like buprenorphine and suboxone and to supervise the first administration of the drug. The accompanying counseling services were already integrated into the Crestone clinic before the MARC opened, leading to convenient connections for patients.

Jewish Family Service of Colorado offered interpreters for all therapy sessions working in its Refugee Mental Health program and recommended staffing the same interpreter for an individual patient if possible.

On other hand, where program implementation didn’t happen as planned, most barriers were also related to program staff — hiring new staff, retention of existing staff, and staff buy-in to the program.

Having the right staff allowed programs to thrive – and struggling with staff caused difficulties for grantees. Marillac Clinic in Grand Junction reported difficulties recruiting staff due to the rural location and low salaries that the clinic can offer.

After Children’s Hospital’s Young Mothers Clinic saw its first licensed clinical social worker resign in September 2017, it had trouble hiring an appropriately trained master’s level clinician. The best replacement it found was a psychologist, which is more expensive for the clinic to maintain.

Staff buy-in also posed a challenge for some grantees. In some cases, not all staff believed that the program’s new care model or workflow changes were the right investments to make. For example, Kids First Health Care improved referral processes across its seven school sites, but it reported that one behavioral health provider will not be returning to the grant program because they did not buy into aspects of the new approach.
The Fund’s Focus Areas

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?

All grantees addressed at least one of the Fund’s core focus areas. (See Figure 6.) Categories are not mutually exclusive: Many grantees are working on several focus areas.

As in Years 1 and 2 of the Fund, most grantees reported serving the access to care focus area. But as grantees have broadened their scope to the other focus areas, the proportion of grantees directing attention to access to care has declined slightly each year.

This year, the same share of grantees focused on innovative care delivery as access to care (76 percent).

More grantees worked on transitions in care in Year 3 than Year 2, including several programs focused expressly on this issue. Grantees also have slightly increased their focus on education of patients and families.

Figure 6: Percentage of Grantees Working in Each Focus Area, 2015-2018

*Grantees could select more than one focus area.*
Maintenance

Guiding Questions: Will the programs be sustainable once the funding cycle ends? Will new programs or program expansions continue without Colorado Health Access Fund support?

Key Findings:

Compared with 2016-17, a greater number of grantees have a clear or partial plan in place to sustain their programs after the Colorado Health Access Fund’s support ends that is not solely reliant on additional grant funding.

On average, the Fund represented the largest portion — about 43 percent — of grantees’ program budgets in 2017-18 (see Figure 7). This is notable because the Fund is intended to provide temporary financial support to programs that expand access to behavioral health services. The hope is that the Fund will stimulate program growth and achieve revenue-based financial stability to ensure these services will continue beyond the term of the grant.

Figure 7: Average Fund-Supported Program Budget by Revenue Source, 2017-2018

Two thirds of grantees (65 percent, or 24 grantees) have identified a complete or partial strategy for continuing their program after their Colorado Health Access Fund grant ends (see Table 1). That’s up from about 43 percent of grantees in 2016-17.

Of those 24, 15 have clear plans in place for sustainability.

The factors CHI considered in assessing sustainability included having a relatively predictable source of funding, such as seeking reimbursement from Medicaid or private insurance; securing a mix of multiple financing sources; and/or incorporating the program’s budget into an organization’s overall budget.

For example, Marillac Health in Grand Junction has strengthened its revenue streams by ensuring that all behavioral health providers are credentialed and able to seek reimbursement for services from Medicaid. The clinic indicates an ability to sustain its four existing behavioral health providers and also recruit two additional providers.

Health Solutions’ Medication Assisted Recovery Center in Pueblo has similarly diversified its revenue streams beyond grant funding. It has begun billing Medicaid and commercial insurance, and it also has received a grant from the University of Colorado School of Nursing to participate in a legislatively established pilot program for medication-assisted treatment of substance use. To accommodate the growing demand, the organization plans to expand the facility.

Despite the uptick in sustainability plans, many grantees did not identify robust sustainability strategies. Almost a quarter (24 percent, or 9 grantees) focused their sustainability plans on securing future grants rather than
identifying more predictable sources of revenue. Another 19 percent (seven grantees) did not include enough information in their description to make an assessment.

Some of the seven grantees indicated they were exploring funding options but did not have concrete plans. Others indicated they would be reviewing a return on investment assessment or evaluation results to determine the level of sustainability needed to support programs after the end of their Colorado Health Access Fund grant.

### Table 1: Status of Grantee Sustainability Plans, as Classified by CHI, 2017-18

<table>
<thead>
<tr>
<th>Status of sustainability plan</th>
<th>Number of Grantees</th>
<th>Percentage (n=37)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear plan</td>
<td>15</td>
<td>41%</td>
</tr>
<tr>
<td>Some plan</td>
<td>9</td>
<td>24%</td>
</tr>
<tr>
<td>Depends on future grants</td>
<td>6</td>
<td>16%</td>
</tr>
<tr>
<td>Unclear</td>
<td>7</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### Policy

**Guiding Question:** What policy opportunities or barriers did grantees identify?

**Key Findings:**

**Recent immigration and detention issues may deter patients from seeking services.** The Fund’s reach to those who need it most might have been even greater had it not been for these concerns.

Multiple grantee organizations identified clients’ fear and confusion around immigration policies as barriers to getting needed care. Some noted decreases in the number of clients who are covered by Medicaid. CHI’s recent analysis of a proposed change to the so-called “public charge” rule, which would allow the use of public benefits, such as Medicaid and CHP+, to be considered when approving a person’s permanent residency (green card) application — estimated that upwards of 75,000 Coloradans may become uninsured because of new federal rules. Although the rule itself applies to very few Coloradans, evidence shows that confusion over similar rule changes in the past had a widespread carry-over effect to families. Even if a family member is eligible for a service, he or she may not enroll (or enroll a child) due to fear of uncovering a family member who may be residing in the U.S. without proper documentation.

This policy tempers the potential impact of grantees in the community. The Mental Health Center of Denver (MHCD) summed up the concern saying that “we strongly feel that the climate with our current administration has hindered people without documentation. MHCD serves all that are willing to participate in services, however we have noticed tension on the topic of documentation and are concerned that families are hesitant to receive services from us due to their immigration status.”

**Some grantees credit Health First Colorado — the state’s Medicaid program — for successfully expanding access to services, while many cite it as a hindrance.**

In Year 3, some grantees cited the benefits of Colorado’s expansion of Medicaid to many working-age adults under the Affordable Care Act. They indicated that they are now able to secure Medicaid reimbursement for elements of care such as screenings and indirect consultations between a counselor and provider. Doctors Care, for instance, expanded the age limit for patients, serving more adults than ever before: “We have a growing roster of new Medicaid members that contribute financially, but more importantly [we] also afford more access to care for all.”

On the other hand, at least a dozen grantees reported problems with Health First Colorado. Many cited significant delays in receiving payment during the grant period due to the 2017 transition by the Department of Health Care
Policy and Financing (HCPF) to a new electronic billing and information system. Another grantee cited extensive evaluation and paperwork requirements as a hindrance in enrolling and providing services to people experiencing homelessness in particular.

**Grantees were divided on whether Health First Colorado’s new Regional Accountable Entities (RAEs) align with their own goals of integrated physical and behavioral health.**

In July 2018, HCPF launched the Accountable Care Collaborative Phase Two, which established seven new RAEs responsible for managing the care of Medicaid members within their regions (see sidebar). The RAEs are administering behavioral and physical health care together for the first time and replace a former system in which two separate entities had administered physical and behavioral health. (See sidebar)

About a half dozen grantees cited the advent of the RAEs as a notable policy development. Grantees that are integrating or have integrated behavioral health services into their existing physical health services cite the RAEs as a positive development.

For instance, Peak Vista wrote that it anticipates the RAEs “will result in a more coordinated and efficient system for individuals seeking access to physical and behavioral health care under Health First Colorado.”

Another half dozen grantees worried about the uncertainties that come with the RAEs — such as their program’s ability to predict revenue generated under the new model, unclear provider qualifications required to bill the RAEs, and other worries.
Keeping an Eye to the RAEs and ACC Phase Two

Health First Colorado launched the second phase of its efforts to reform the state’s Medicaid system — called the Accountable Care Collaborative (ACC) — in July 2018.\textsuperscript{11}

The launch included the establishment of the RAEs, which are responsible for connecting Medicaid members to behavioral health and primary care services, coordinating their care, and monitoring quality and cost goals through data. They replace the Behavioral Health Organizations (BHOs) and Regional Care Collaborative Organizations (RCCOs), which previously administered these services separately.

The launch of the ACC Phase Two is significant to many Fund grantees for two reasons.

First, RAEs are building statewide networks of behavioral health providers to serve members. They also facilitate payment through the behavioral health capitation they receive from HCPF. Many small and independent behavioral health providers see this as a positive development because RAEs (instead of BHOs) will be in charge of the approval process — called credentialing — to be able to bill Medicaid through the capitated system.

Previously, many smaller or independent providers felt shut out of Health First Colorado because they could not get credentialed through the BHO, which oversaw the provision of behavioral health services through their networks of providers. There is increased hope that RAEs will streamline the process and open up the networks to include more providers.

Second, Health First Colorado now allows primary care providers to bill Medicaid directly for up to six behavioral health visits provided to a member in a primary care setting. This is an effort to increase access to behavioral health services in a location where patients are already being seen.

CHI’s research so far has found that this policy change has gone relatively well, but that major questions remain. For instance, how do patients get connected with care if they need more than six visits in the calendar year? How are care and payment coordinated when a patient seeks behavioral health services at more than one primary care provider?

2019 is certain to include many more questions about how the ACC is functioning and whether it is achieving its goals.\textsuperscript{9}

Recommendations

CHI’s recommendations for the Fund fall into three themes:

- Build on key successes.
- Develop relationships and partnerships.
- Reflect on how to sustain and further the Fund’s reach.

**Theme 1: Build on Key Successes**

**Continue dedicated outreach to rural areas to maintain momentum.** Consider encouraging past grantees with a proven record to apply again with another project.

**Maintain or increase dedicated Fund staff support.** This may require additional philanthropic staff to oversee the new advocacy portfolio.
Promote grantee best practices. Continue to connect grantees to each other or available resources to address workforce challenges. One idea is to transform the Peer-to-Peer Learning Network into a grantee mentorship program to address challenges with sustainability, evaluation, and workforce recruitment.

**Theme 2: Develop Relationships and Partnerships**

Pursue partnerships with grantees in areas where local behavioral health ballot initiatives passed to ensure the Fund’s efforts are complementary and not duplicative.

Identify, reach out and build relationships with the governing bodies/entities overseeing the provision of funding from these ballot initiatives. Consider inviting representatives to be on the advisory board. CHI’s legislative staff can help identify these entities if needed.

**Theme 3: Reflect on How to Sustain and Further the Fund’s Reach**

Connect the new advocacy/policy cohort to current grantees. This new cohort represents an ideal opportunity to strengthen the core grant program’s focus on gaps and areas in need of innovative programming.

Build upon The Denver Foundation’s philanthropic experience to identify factors that contribute to financial sustainability. CHI’s tracking of local ballot initiatives will provide additional insights into emerging behavioral health initiatives and opportunities for the Fund to leverage local investments.

Focus the annual Learning Circle on program sustainability. CHI and Fund staff can strategize on following up with past grantees to see if their programs have continued.

**Conclusion**

In the Colorado Health Access Fund’s third year, grantees took innovative approaches, served diverse populations, and continued to bring vital behavioral health services to people throughout Colorado.

Grantee stories highlight those creative approaches to reaching Colorado’s diverse communities, especially those that have been marginalized or underserved.

As the steward of the Fund, The Denver Foundation will continue to have opportunities for partnership with statewide and local leaders and leadership across the behavioral health funding community. With the recent focus on behavioral health initiatives in the 2018 midterm election, the Fund has already taken the mantle by monitoring behavioral health investments created by ballot initiatives and other funding opportunities to ensure the Fund complements those initiatives.

These developments demonstrate a growing interest and willingness of Coloradans to take action in their local areas to support behavioral health services. The Fund can harness this momentum into the future to sustain the important work begun by the Fund and its supported grantees.
<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Grant Purpose</th>
<th>Headquarters</th>
<th>Grant Service Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Pacific Development Center</td>
<td>Asian American, Native Hawaiian, Pacific Islander health services provider</td>
<td>Improve behavioral health access for the Vietnamese community through culturally and linguistically appropriate outreach, education, and treatment.</td>
<td>Denver</td>
<td>Metro Denver</td>
</tr>
<tr>
<td>Aurora Mental Health Center (youth)</td>
<td>Behavioral health services provider</td>
<td>Address behavioral health and SUD for high-needs youth with Aurora Public Schools and Rocky Mountain Youth Clinics.</td>
<td>Aurora</td>
<td>Metro Denver</td>
</tr>
<tr>
<td>Aurora Mental Health Center (homeless)</td>
<td>Behavioral health services provider</td>
<td>Support innovative linkages to behavioral health services for people experiencing homelessness.</td>
<td>Aurora</td>
<td>Metro Denver</td>
</tr>
<tr>
<td>Axis Health Systems</td>
<td>Community mental health center</td>
<td>Integrate behavioral health services into primary health care.</td>
<td>Durango</td>
<td>Archuleta County</td>
</tr>
<tr>
<td>Centennial Mental Health Center</td>
<td>Behavioral health services provider</td>
<td>Co-locate behavioral health services in three rural primary care practices.</td>
<td>Sterling</td>
<td>Metro Denver</td>
</tr>
<tr>
<td>Chanda Plan Foundation</td>
<td>Services provider for people with physical disabilities</td>
<td>Provide behavioral health services for individuals with long-term physical disabilities.</td>
<td>Lakewood</td>
<td>Metro Denver</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>Pediatric hospital and health services provider</td>
<td>A three-year grant increasing behavioral health services to families of the Young Mother’s Clinic and the Colorado Adolescent Maternity Program.</td>
<td>Aurora</td>
<td>Metro Denver</td>
</tr>
<tr>
<td>Colorado Coalition for the Homeless</td>
<td>Homeless services provider</td>
<td>Expand behavioral health services in the Housing First program.</td>
<td>Denver</td>
<td>Metro Denver</td>
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<td>Colorado Health Network</td>
<td>HIV/AIDS health and services provider</td>
<td>Expand access to behavioral health care at Front Range clinics for people with substance abuse and behavioral health needs.</td>
<td>Denver</td>
<td>Front Range</td>
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<td>Denver Children’s Advocacy Center</td>
<td>Childhood trauma and abuse services provider</td>
<td>Expand interventions at Florence Crittenton school for school-age mothers experiencing trauma.</td>
<td>Denver</td>
<td>Metro Denver</td>
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<td>Denver Indian Health and Family Services</td>
<td>Urban American Indian health services provider</td>
<td>Support culturally competent integration of behavioral health and traditional healing practices.</td>
<td>Denver</td>
<td>Metro Denver</td>
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<td>Doctors Care</td>
<td>Community safety net clinic</td>
<td>Improve and expand integration of behavioral health care into the primary care setting.</td>
<td>Littleton</td>
<td>Metro Denver</td>
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<td>Health District of Northern Larimer County (CAYAC)</td>
<td>Regional health services provider</td>
<td>Expand services to children and adolescents in collaboration with Poudre School District and SummitStone Health Partners.</td>
<td>Fort Collins</td>
<td>Larimer County</td>
</tr>
<tr>
<td>Health Solutions (telehealth)</td>
<td>Behavioral health services provider</td>
<td>Expand tele-behavioral health in Pueblo, Las Animas, and Huerfano counties.</td>
<td>Pueblo</td>
<td>Pueblo, Las Animas, and Huerfano counties</td>
</tr>
</tbody>
</table>
Health Solutions (MARC)
Behavioral health services provider
Grant Purpose: Hire nursing and prescribing staff for the Medication Assisted Recovery Center serving people with substance use disorders.
Headquarters: Pueblo
Grant Service Region: Southern Colorado

Inner City Health Center
Community safety net clinic
Grant Purpose: A three-year grant to expand integrated 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: Provide behavioral health care through the Senior Reach program for seniors in remote mountain regions.
Headquarters: Lakewood
Grant Service Region: Jefferson, Gilpin, and Clear Creek counties

Jewish Family Service of Colorado
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 Clinic
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 that correspond to emergency calls alongside law enforcement.
Headquarters: Boulder
Grant Service Region: Boulder and Broomfield counties

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

Colorado Crisis Services
Behavioral health and crisis services provider
Grant Purpose: Support the Colorado statewide behavioral health hotline and warm line services with a focus on specific populations including rural populations and teens.
Headquarters: Denver
Grant Service Region: Statewide

Mind Springs
Behavioral health services provider
Grant Purpose: Expand and enhance services to help patients navigate mental health services and provide safe transportation.
Headquarters: Glenwood Springs
Grant Service Region: Grand County

Mountain Family Health Centers
Behavioral health services provider
Grant Purpose: Support behavioral health staff and services.
Headquarters: Glenwood Springs
Grant Service Region: Eagle, Garfield, Pitkin, and Rio Blanco counties

Peak Vista Community Health Centers
Community health center
Grant Purpose: Integrate a behavioral health provider into Peak Vista’s Dental and Family Health Centers at International Circle.
Headquarters: Colorado Springs
Grant Service Region: Arapahoe, Custer, El Paso, Fremont, Jefferson, Otero, Pueblo, and Teller counties

Rocky Mountain Immigrant Advocacy Network
Immigrant health and services provider
Grant Purpose: Support behavioral health services to immigrants in ICE detention centers and their families.
Headquarters: Westminster
Grant Service Region: Statewide
Salud Family Health Centers
Community health center
Grant Purpose: Expand integration of behavioral health into the primary care setting in Metro Denver and northeast Colorado clinics.
Headquarters: Fort Lupton
Grant Service Region: Northeast Colorado

Seniors’ Resource Center, Inc.
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 in a day center for adults experiencing homelessness.
Headquarters: Denver
Grant Service Region: Metro Denver

St. Mary’s Hospital / SCL
Hospital and health services provider
Grant Purpose: Support clinical staff and telehealth services to provide SUD-related care.
Headquarters: Grand Junction
Grant Service Region: Western Colorado

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

Tri-County Health Network
Health care provider network
Grant Purpose: Support behavioral health staff and integration of teletherapy throughout Ouray County.
Headquarters: Telluride
Grant Service Region: Ouray County

Valley Settlement
Immigrant health and services provider
Grant Purpose: Support development of Spanish language counseling program for postpartum Latina moms.
Headquarters: Carbondale
Grant Service Region: Eagle, Garfield, and Pitkin counties

Clinica Family Health
Community health center
Grant Purpose: Expand access to behavioral health care and psychiatric medication prescribing services.
Headquarters: Lafayette
Grant Service Region: Southern Boulder, Broomfield, and western Adams counties
Tonya Cook, a doctorate-level pharmacist, left, and Ryan Jackman, a board-certified addiction medicine specialist, right, test out a telehealth system they use to consult with primary care clinics throughout the region that have less specialized knowledge about how to deal with complex situations or addiction.

Profile 1: St. Mary’s Hospital, Grand Junction

For people who live in Western Colorado, a primary care doctor can be hours away from home. When patients are struggling with a drug-related problem, a qualified provider can be even farther away.

At St. Mary’s Hospital in Grand Junction, Tonya Cook, a pharmacist, and Ryan Jackman, an addiction medicine physician, have launched a telemedicine program called PATH (Providing Access to TeleHealth) with the support of the Colorado Health Access Fund. PATH allows Dr. Jackman and Dr. Cook to consult with patients and doctors in 12 clinics throughout Western Colorado in order to assist them with concerns involving substance use disorders and complex medication regimens.

Cook and Jackman offer providers two major services: Chart reviews, in which they review patients’ histories with the provider and suggest possible treatment options, and “co-visits,” during which they consult with patients and providers together.

Many patients are dealing with chronic pain, which presents a challenge for providers and patients. Often, Cook said, “they’re dependent but not necessarily addicted to opioids.”
The American Academy of Family Physicians has advised family doctors that alternative treatments for pain are preferable to opioids. While the Centers for Disease Control (CDC) and groups like the AAFP have provided guidelines, “there aren’t always practical recommendations for getting from point A to point B. Providers are wanting someone to help them navigate this overlap of treating pain and addiction.” said Jackman.

Using video conferencing, Cook and Jackman help doctors identify whether patients have a disorder and offer recommendations about how to manage pain other than with opioids.

At many clinics, providers are not prepared to treat opioid use disorder. That led Cook and Jackman to organize four buprenorphine waiver trainings in Western Colorado, which providers from PATH sites have attended. These trainings help providers learn how to prescribe a medication commonly used to wean patients off of opioids. While they were not an initial part of PATH's planned programming, they have directly increased the number of buprenorphine prescribers in Western Colorado.

PATH has also given providers the opportunity to discuss complex medication regimens. Cook described one situation in which she spoke with a 45-year-old patient who was taking 45 medications for multiple conditions including chronic headaches. Dr. Cook reviewed the woman’s chart and history to determine which medications were necessary, and then met with the patient and provider who had requested help. She shared with the patient her concern that her headaches were actually being made worse by her medication regimen. After the co-visit the patient agreed to decrease some medications and stop others. At a follow-up co-visit, the patient reported her headaches were better.

The PATH approach has had both pros and cons. The telemedicine approach allows for relatively simple set up due to ease of access to equipment like a speakerphone and a laptop. However, the technology is not foolproof. At times wireless internet is episodic in a clinic, or the microphone doesn’t allow for ideal sound in a crowded room. Scheduling can also present a challenge — no-shows are relatively common.

But the PATH team said they had been able to improve their services over time. Family practices have developed workflows and approaches gleaned from each other’s experiences.

SCL Health and St. Mary’s are exploring ways to continue the telemedicine program. The question now is “how do we sustain a program that’s very popular, that’s made great changes for patients’ overall care, and that insurance isn’t paying for at this time?” Jackman said.
Profile 2: Asian Pacific Development Center

When the Asian Pacific Development Center (APDC) was founded nearly 40 years ago, it focused on supporting Asian and Pacific Islander immigrants with health care, language classes, and more. In 2018, APDC’s staff wanted to reach out more directly to Vietnamese and Vietnamese-American people in Colorado, most of whom don’t live near its Aurora clinic.

APDC used its grant from the Colorado Health Access Fund to partner with Mi Casa Resource Center, a community organization based in southwest Denver, to help make mental health services more accessible to people who had trouble getting to the Aurora clinic. Thanh Nguyen, a mental health provider, offers mental health services in Mi Casa Resource Center’s building, closer to where many Vietnamese markets and restaurants are located and a familiar place for many in the community.

APDC also created its first-ever team focused on reaching out to the Vietnamese community. It used the grant to hire Hue Phung and Thuy Tran as community navigators. Phung was born in America and is Catholic, while Tran is Buddhist and was born in Vietnam. These diverse backgrounds helped the navigators connect with different people in the community through their existing relationships.

Phung and Tran visited churches, temples, schools, universities, shops, doctor’s offices, and pharmacies throughout the Denver metro area to make connections to leaders in the community and educate people about behavioral health. They came into contact with nearly 1,600 people over the course of their outreach.

APDC hosted three focus groups targeted to different age groups to help understand the needs within the communities and how community members thought about mental health.
The challenges they reported took different forms. As APDC expected, transportation was a barrier to seeking mental health care. People who depended on Medicaid for transportation, in particular, reported missing appointments or waiting for long periods of time after services.

Another common thread: Younger and older people shared that it could be difficult to talk to each other about their challenges. Some younger people said that they didn’t identify with the mainstream American culture they experienced at school, but also felt disconnected when they visited Vietnam. Older generations were concerned that their culture might be lost if children or grandchildren were no longer able to speak the Vietnamese language or practice traditions. In some cases, family members had experienced trauma that had affected the entire family.

But stigma and shame often prevent people from talking about such things. “The loss of face is a big thing,” Nguyen said. She said that when challenges hit, people tend to seek support within their families or from trusted leaders in the community.

Nguyen said another challenge is that the concept of mental health is not common in Vietnamese and other southeast Asian cultures. “They focus more on somatic complaints,” she said, referring to physical symptoms like fatigue or pain that may be tied to underlying mental health challenges. That points to a need for more education about mental health, she said.

The APDC team focused on addressing the concerns they learned about through different programs and offerings. They created a wellness program at APDC to support older community members in the Denver area. They shared information about APDC’s behavioral health services with community leaders in an effort to reduce stigma.

They also made direct connections to several community organizations. For instance, members of one church congregation were concerned that some young children were feeling depressed. APDC’s team worked to host a series of workshops at the church on topics such as identity and self-worth, intergenerational conflict, and mental health.

Now, the church is looking into inviting more speakers to talk about mental health. “Before, no one really talked about it,” Phung said. “The atmosphere has changed.”

The Colorado Health Access Fund grant supported therapy and other behavioral health services for 50 people and education about behavioral health issues for more than 360 people. But Nguyen and Phung said the reach of the program extended beyond the numbers.

It sometimes took months for initial conversations to lead to people seeking therapy or communities welcoming a workshop. But over time, Phung said, “we were able to plant those seeds. People are becoming aware of mental health.” APDC is continuing its work in the Vietnamese community, including its services in southwest Denver, even after the end of the Colorado Health Access Fund grant.

Profile 3: Building a Bilingual Pipeline for Behavioral Health

(photos below)

When Yajaira Johnson-Esparza was searching for an internship on her path to becoming a licensed clinical psychologist, she was searching for an organization that shared her mission: to work with Spanish-speaking immigrants in the U.S.
She found Salud Family Health Centers. Founded in 1970 in Fort Lupton, Salud now has 13 clinics throughout Colorado and a mobile unit that brings health care directly to all who need it, especially people with low incomes and migrant and seasonal farmworkers.

Johnson-Esparza completed her internship at Salud and was hired in 2015 as part of a three-year project funded by a Colorado Health Access Fund grant to offer integrated behavioral and physical health care. Now she practices mainly at Salud’s Commerce City clinic, where she also supervises students on the path toward becoming licensed psychologists.

The Colorado Health Access Fund grant allowed Salud to hire Johnson-Esparza and two other behavioral health providers. Salud is now able to cover their salaries without the grant’s support. Salud also streamlined its referral process for behavioral health services and offers psychological testing and evaluations to help improve its overall care.

Jonathan Muther, vice president of medical services at Salud, said the Colorado Health Access Fund has allowed clinics to help patients get behavioral health care more quickly and consistently. Having psychologists in the same clinic as primary care providers lets people access care without having to search for a provider, deal with the complexities of insurers, or face the stigma that can come with seeking help in specialized settings.

Providers hired through the grant have reached more than 1,500 people: 801 in Brighton, 258 in Commerce City, and 595 in Frederick. The grant also allowed Salud to build a stronger pipeline of Spanish-speaking bilingual providers, he said, including by forging relationships with universities in Puerto Rico and Chile.

According to the U.S. Census, there are just 5,000 Hispanic psychologists in the U.S. — just 5 percent of all psychologists — while people of Hispanic origin make up nearly 18 percent of the U.S. population. In Colorado, Hispanics make up about 21 percent of the total population.

“For a long time, I was the only Spanish-speaking student in my program. It was hard to find supervision,” Johnson-Esparza said. Working at Salud has been a different experience. “I’m a little spoiled – it seems like the norm.”

Johnson-Esparza said a psychologist who speaks the same language as patients and understands their cultural backgrounds makes a difference.

She recalled a patient who had migrated from Central America. She was struggling to manage her diabetes, and at the same time was referred to Johnson-Esparza to help work through conflict with her daughter.

“Sometimes people are not adhering to their treatment not because they don’t want to, but because they have a lot they’re trying to deal with, including cultural issues and issues related to families,” she said. After six sessions of therapy, the woman began managing her diabetes more consistently.

Johnson-Esparza said patients regularly tell her they appreciate speaking with someone who “gets” them and their problems.

“It’s important for patients to feel they have a shared experience,” she said.
Yahaira Johnson-Esparza (right), a psychologist, practices and supervises other psychologists-in-training at Salud’s Commerce City location.
The Colorado Health Access Fund allowed Salud Family Health Centers to build its pipeline of Spanish-speaking bilingual behavioral health care providers and offer integrated behavioral health care.
Endnotes


7 Department of Local Affairs data do not capture genders other than male and female.

8 “Non-English Speaking” captures people who reported speaking English “less than ‘very well’” on the 2017 American Community Survey.


11 For more information, see CHI’s report, “The Ways of the RAES.” https://www.coloradohealthinstitute.org/research/ways-raes