

ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

November 2012

EVALUATION

Improving Access to Health Through Collaboration:

Lessons Learned from
The Colorado Trust's
Partnerships for Health
Initiative Evaluation

(APPENDICES ONLY)

> KEY LESSONS LEARNED

Evaluation findings generated from the wide array of public and community-based organizations that participated in The Colorado Trust's Partnerships for Health Initiative offer important lessons to help health care organizations better coordinate and align their services and systems and, in turn, to improve health outcomes. Key factors that were considered important to strengthening and sustaining local health collaboration were:

LEADERSHIP – The participation of key community leaders was critical to providing collaboratives with insights and understandings unique to their community needs and potential solutions, and conferred a greater sense of credibility to each collaborative's efforts.

BUY-IN – Ownership of the process of the collaboration, as well as the outcomes of the collaborative's efforts, were essential to success. Such buy-in allowed partners in community collaboratives to form relationships and develop trust, resulting in their ability to focus on the work of the collaborative, and to look beyond the needs of their individual organizations.

AFFING – In many cases, the collaboratives' efforts were significantly advanced by a formal project coordinator who could devote time to organize activities of the collaboration, and provided the supports necessary to maximize stakeholder participation.

DATA - The collection and use of data was crucial to many of the collaboratives in being able to accurately identify community needs, implement their respective projects and to make appropriate decisions.

TECHNICAL ASSISTANCE - External technical assistance was a critical supporting factor for all of collaboratives. In particular, meeting facilitation by a neutral party, especially at the outset, was cited as important.

THE COLORADO TRUST

The Colorado Trust is a grantmaking foundation dedicated to achieving access to health for all Coloradans.

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TRIWEST GROUP

TriWest is a human services evaluation and management consulting company in Boulder, Colorado.

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> APPENDIX A

CASE STUDY METHODOLOGY, INITIAL KEY INFORMANT SURVEY QUESTIONS, COLLABORATIVE SURVEY PROCESS

Case Study Methodology

The case study approach decided upon during discussions with The Trust for Phase II planning and realignment of the evaluation work plan. In the initial round of key informant interviews the case study approach was intended to further inform some of the more relational, dynamic aspects of the systems being evaluated to supplement the system relationships and structure captured by the Blueprints approach. Subsequent interviews included questions to capture, from the perspective of participants, the kinds of changes taking place in the four grantee systems and their relationship to collaboration, access-related outcomes and health care reform. The sites included Chaffee County, Ignacio/Southern Ute Community Action Programs, Northwest Colorado Visiting Nurse Association, and San Luis Valley. In preparation for the initial key informant interviews, questions were developed, discussed, and reviewed by Coordinating Agency staff and The Trust and finalized. Question content was based on published work in system change, 12,13 and key informant questions focused on obtaining information about system structures, norms and resources, regulations, power and decision-making processes, operations, and interdependences.

Consensus was sought and reached about which representatives from each site would be interviewed. Coordinating Agency facilitators and project directors of the case study grantee sites decided on a priority list of key informants to contact for interviews. Lists for each site included grantee facilitators and project directors for the targeted sites, and additional key informants that were involved and knowledgeable of the projects in each site. Eight to ten people in each site were interviewed in the first round

After completing the initial round of key informant interviews in 2010) and while drafting the grantee-specific case study reports, The Trust clarified the evaluation questions as presented previously. The case study reports were revised to address the new set of evaluation questions. Once finalized, the case study reports were distributed to grantees and meetings were offered to all four grantees and held with two grantees to discuss the case studies and obtain additional feedback from grantees.

Case study reports were updated with a follow-up round of key informant interviews during the final year of the project (fall of 2011). In this round four to five people were interviewed at each site that had indepth knowledge of the respective site's efforts to improve health care access. The follow-up interview questions were updated to ask specifically about the revised evaluation questions and the impacts and grantee efforts to prepare for or to be involved in health care reform. TriWest Group evaluators worked with project directors to update the list of key informants to contact for interviews. Once interviews were conducted, the case study reports were updated with material from the second round of key informant interviews.

Potential Limitations

The case study approach in this case was a qualitative method implemented to attempt to collect information about the subject of improving access to health care in selected communities, using a collaborative approach to system change. A standard set of questions was used to solicit observations and experiences from key informants about aspects of their programs such as collaboration, barriers, successes and recommendations they would make for future similar efforts.

The usefulness of the responses rests on the degree to which they accurately reflect the activities, experiences, influences and results of the efforts to improve health care access. The accuracy of key informant responses does not appear to be in question with these grantees. That statement is based on consistency within key informants for each grantee site and similarity of themes between grantee sites. It is also based on the degree to which key informant responses fit the picture from collaboration surveys, blueprints and outcome indicator data. Funding, legislative support and awards from other sources such as federal funding (for the FQHC), foundation funding (Colorado Health Foundation), State legislative support (CarePoint) and award recognition (Colorado Collaboration Award) all corroborate information from key informants.

One potential limitation could be that the perspectives obtained did not reflect those of non-participants or of people receiving services. Non-participants were not sampled and only a couple recipients were interviewed. Recipient interviews supported overall conclusions for that particular site. Non-participants may have provided addition instructive feedback.

Partnerships for Health Initiative Phase II Evaluation: Key Informant Interview Questions

SYSTEM STRUCTURES:

■ Does the current system Blueprint for your project depict the relevant and necessary structural pieces of the system? If additional detail is needed, what other structures need to be added?

SYSTEM NORMS AND RESOURCES:

- What assumptions and values are made by people in different parts of the local system of care (i.e., by organizations, stakeholders) about the way the system works, and how do their assumptions and values influence the way these parts behave?
 - How do these assumptions and values support the change your collaborative is trying to achieve?
 - How do these assumptions and values impede the change your collaborative is trying to achieve?
- What knowledge and skills do collaborative participants have that help carry out or maintain the system changes you seek to make?
- What knowledge and skills do others in the community who are not collaborative participants have that would help enact or maintain the system changes you seek to make?
- How do collaborative members influence change in the system? What positional or other advantages do members have that allow them to influence these changes?
 - What aspects of the local system support the development of relationships among members that cause or maintain the system changes you seek to make?
 - What aspects of the local system hinder the development of relationships among members that would cause or maintain the system changes you seek to make?
- How are the needs of the local system of care prioritized, and by whom?
- How do these decision makers come to be in such a position?
- What, if any, changes in funding approaches have occurred in the last three years? Is it expected to change in the future?

SYSTEM REGULATIONS:

- Have you identified any policies or practices in the local system that contribute to the problem that your collaborative is working to address?
 - Do these policies or practices in some way also support change in the system? How? Are there other current policies or practices that support change?
 - How do these policies or practices impede change in the system?
- Has your collaborative identified or made changes to the policies or practices of the local system of care in order to help bring about the system change you seek? What are some of these changes that have been identified or made?

SYSTEM POWER AND DECISION-MAKING PROCESSES AND OPERATIONS:

- By which system participants are decisions made about the control of resources in the local system of care?
- What factors go into the making of these resource-control decisions?
- Is the support of any particular individual leaders critical to the system change efforts of your collaborative?
- What challenges has your collaborative faced in the current change efforts?
 - How are these challenges related to existing power and decision-making structures?
- Have the power structures been altered in the local system of change since the project began? If so, how? Are these changes positive or negative?
 - What is needed to maintain the positive or respond to the negative changes made in the power structures?
- Are there any other decisions that are important to discuss? If so, where are they made? How are they made?

SYSTEM INTERDEPENDENCIES:

- Describe changes made to any one part of the system that may have affected other system parts and ultimately facilitated the change that your collaborative seeks to implement.
- Describe changes made to any one part of the system that may have affected other system parts and ultimately undermined the change that your collaborative seeks to implement.
- How do you see those pieces as being related or interdependent?
- What other relationships or interdependencies among pieces of the system of care are most likely to affect overall system change? How would this play out?
- What relationships or interdependencies among pieces of the system of care are most likely to support overall system change? How does that happen? Describe any feedback mechanisms you have observed that support the system change your collaborative seeks.
- What relationships or interdependencies among pieces of the system of care are most likely to impede overall system change? How does that happen? Describe any feedback mechanisms you have observed that impede the system change your collaborative seeks.

CASE STUDY UPDATE KEY INFORMANT SURVEY QUESTIONS

Partnerships for Health Initiative Phase II Evaluation: Case Study Update: Key Informant Interview

- I. Did the grantees' access-to-health outcomes improve as a result of system changes? [Note to Interviewer: This section will be supplemented by outcome indicator material from the grantee progress reports.]
 - a) How has access to care increased in the community?
 - b) How would you assess the outcomes achieved?
 - c) What's most necessary to sustain the outcomes achieved (conditions, policies)?
- **II.** Did the work of local collaboratives contribute to these improvements in their local health system? [Note to Interviewer: This section is supplemented by collaboration survey results and blueprints.]
 - a) How did collaboration (i.e., the collaborative process) contribute to changes in the system? How did this help improve access to care in the community?
 - b) Could these changes have taken place without a collaborative in place (e.g., via a new program)? Why or why not?
 - c) Did the collaboration create challenges in improving the local health system (if so how) collaboration?
- III. What factors have led to or impeded improvements to local health systems?
 - a) Are there particular characteristics of the local system that affect (positively?, negatively?) the system change effort?
 - b) Has the support/involvement of any one participant (individual, organization) been critical to the system change efforts of the collaborative? If so, what characteristics (personal, leadership style) made that person's involvement critical?
 - c) What, if any, changes in funding approaches have taken place in the last three years, either for ongoing funding of the collaborative or as a result of the collaboration? Is it expected to change in the future?
 - d) Have there been any new challenges over the past year?
 - e) Have there been any new facilitators over the past year?
- W. What recommendations can be made to The Trust about how to fund and design systems-change strategies?
 - a) What are some things that could be done in the future to ensure successful system change and increased access to care? What are things that should be avoided?
 - b) What are the biggest lessons you have learned about collaboration throughout this effort?
 - c) What are the biggest lessons you have learned about access to care throughout this effort?
 - d) What recommendations would you offer about the type and level of involvement by the funder in future initiatives of this sort?
- **V.** We also have some general questions about collaboration and health care reform, exploring opportunities for collaboration, or for the collaborative, resulting from reform.
 - a) What new opportunities for collaboration for your project do you see as a result of health care reform?

- b) What opportunities do you see for your existing collaborative to support health care reform efforts in your local area?
- **VI.** We also have questions related to the implications of specific health care reform provisions for the project.
 - a) How do you see health care reform having an impact on access to health care in your system? How do you see your project managing / leveraging this to increase access?
 - b) Are there any specific health care reform provisions that you think will impact your efforts more than other provisions? If so, how will they impact your efforts?
 - c) Are there health care reform provisions that you expect will impact your efforts indirectly (but still noticeably)? If so, how?
 - d) Are there other trends (such as population growth, workforce supply, demographic changes, or other policy changes) that will affect your efforts? If so, what are they?
- **VII.** We also have some questions about the relationship between your local collaboration and health care reform. [Note to Interviewer: If any of these were discussed in response to previous questions, do not repeat].
- VIII. Has your collaborative discussed dealing with any of the following provisions of health care reform? If any are not applicable in your view, just let me know). [Note to Interviewer: This time, specifically ask the respondent about all of these. If the collaborative has discussed any of these, immediately following acknowledgement, ask: What is your collaborative doing as a result of these discussions? Are there specific plans in place?]
 - a) Expansion of access to care under health reform (either Colorado's 2012 plan to expand Medicaid eligibility for adults without dependent children to 100% of FPL or the planned 2014 federal expansion of Medicaid and subsidized insurance exchanges under the Patient Protection and Affordable Care Act),
 - b) Medical homes or health homes,
 - c) Medicaid Regional Care Collaborative Organizations (RCCOs),
 - d) Other accountable care organization models,
 - e) Other integration efforts (for example, behavioral health and primary care),
 - f) Health Information Exchanges.
- IX. "Finally, is there anything else you would like to share regarding this initiative to help The Trust understand the impact of the initiative?"

COLLABORATIVE PROCESS SURVEY

The Collaboration Survey aimed to assess the quality of the collaborative process at the grantee level, based on the Process Quality Rating Scale and the Working Together Scale developed by Drs. Carl Larson and Darrin Hicks. The online survey also included nine items intended to assess each group's development on structural elements identified through TriWest's previous work on collaborative groups, including assessing the needs of the community, monitoring progress, community awareness and linkages, project sustainability, cultural diversity, and service population member and family representation. The survey also included items intended to assess perceived changes in respondents' level of awareness of and involvement in their respective projects over time.

Collaboration Survey Partnerships for Health Initiative

Thank you for agreeing to respond to this survey about your community's collaboration experience as part of The Colorado Trust's Partnerships for Health Initiative. The Partnerships for Health Initiative is designed to help improve the coordination of health services at the community level. This initiative, an expansion of The Trust's Colorado Healthy People 2010 Initiative, supports 14 community health partnerships statewide, consisting of local health departments, community-based organizations, government agencies and community members.

The Colorado Trust has contracted with TriWest Group to conduct an evaluation of this initiative, and we would like your cooperation in answering questions about the planning and implementation process undertaken by the partner agencies in your community. Your answers will help The Colorado Trust to identify factors that lead to successful partnerships, and in turn, to help other communities. Because the survey is intended to look at changes in the planning and implementation process over time, it is

possible that some of the items may not seem to relate to your project at this time or your participation in that project. That is ok, as you will be able to let us know that in your responses. Your answers are very important to us, even if you don't think that you yet know a lot about your community's project under this initiative.

This survey consists of short statements that you will be asked to rate in terms of how much you agree with them (or find them to be true) for your community's planning and implementation process. It is estimated to take 15-20 minutes to complete. Your participation in this survey is voluntary, and your answers are confidential. We will combine your responses with the responses of others when we report them to others.

If you have any questions or comments about the survey or your participation in it, you may contact Jesús Sanchez, PhD by email at <code>jsanchez@triwestgroup.net</code>, or by telephone at (303) 544-0509, ext. 5. Thank you for your help.

A. Process of Collaboration

The following set of items looks at the overall quality of a process of collaboration. "Process" refers to how a group of people is working together to deal with a problem they have in common or a goal they are trying to achieve. When you rate the following items, you should be thinking of the group of partners that your community formed to address one of more Healthy People 2010 goals under the Partnerships for Health Initiative of The Colorado Trust.

There are no right or wrong answers to the items below. Regardless of what you think, you can be sure that there are others who will agree with you. Please rate all of the items. If you are unsure about how to respond, you have the option to select "Don't Know." You may also select "Not Applicable" for those items that do not apply to you or your group at this time. When you have finished each page, please look back over the items one more time, to see if you have left any items unrated. Please respond by circling the option on each scale that best represents your evaluation of the partnership process.

A1. The people involved in the process usually are focused on broader goals, rather than individual agendas.

Strongly Agree	Agree More	Disagree More	Disagree	Strongly	Don't	Not
Agree	Than Disagree	Than Agree		Disagree	Know	Applicable
A2. The process	is free of favoritis	sm.				
Strongly Agree	Agree More	Disagree More	Disagree	Strongly	Don't	Not
Agree	Than Disagree	Than Agree		Disagree	Know	Applicable
A3. Often decision	ions are made in a	dvance and simpl	y confirmed by the	e process.		
Strongly Agree	Agree More	Disagree More	Disagree	Strongly	Don't	Not
Agree	Than Disagree	Than Agree		Disagree	Know	Applicable
A4. In the proce	ss, everyone has a	an equal opportun	ity to influence de	cisions.		
Strongly Agree	Agree More	Disagree More	Disagree	Strongly	Don't	Not
Agree	Than Disagree	Than Agree		Disagree	Know	Applicable
A5. The process	gives some peop	le more than they	deserve, while sho	ortchanging others	S.	
Strongly Agree	Agree More	Disagree More	Disagree	Strongly	Don't	Not
Agree	Than Disagree	Than Agree		Disagree	Know	Applicable
A6. The process	responds fairly to	the needs of its n	nembers.			
Strongly Agree	Agree More	Disagree More	Disagree	Strongly	Don't	Not
Agree	Than Disagree	Than Agree		Disagree	Know	Applicable

A7. Decisions made in the process are based on fair criteria.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A8. In the process, some people's "merits" are taken for granted while other people are asked to justify themselves.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Strongly Don't Not Applicable

A9. In the process, strings are being pulled from the outside, which influence important decisions.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A10. The allocation of resources is decided fairly.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A11. The criteria for allocations are fairly applied.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A12. In the process there is sufficient opportunity to challenge decisions.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A13. In discussions about decisions or procedures, some people are discounted because of the organization they represent.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A14. The decisions made in the process are consistent.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A15. Decisions are based on accurate information.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A16. My rights are respected when decisions are made.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A17. I am treated with dignity by everyone involved in the process.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A18. Decisions are made based upon facts, not personal biases and opinion.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

A19. I am able to influence the decisions made.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not

Agree Than Disagree Than Agree Disagree Know Applicable

A20. I am given an opportunity to express my views before decisions are made.

Strongly Agree Agree More Disagree More Disagree Strongly Don't Not Agree Than Disagree Than Agree Disagree Know Applicable

B. Working Together

For the next set of items, the response options are different, but the instructions remain the same. Please respond by circling the option that best represents your opinion about how your partnership group (the group about which you answered questions in the previous section) is working together. Please try to respond to all the items.

B1. Our collaborative effort was started because we wanted to do something about an important problem.

True More True More False False Don't Not

Than False Than True Know Applicable

B2. Our group's top priority is to have a concrete impact on the real problem.

True More True More False False Don't Not
Than False Than True Know Applicable

B3. The membership of our group includes those partners affected by the issue.

True More True More False False Don't Not

Than False Than True Know Applicable

B4. Our membership is not dominated by any one group or sector.

True More True More False False Don't Not Than False Than True Know Applicable

B5. Our collaboration has access to credible information that supports problem solving and decision making.

True More True More False False Don't Not
Than False Than True Know Applicable

B6. Partners have agreed on what decisions will be made by the group.

True More True More False False Don't Not
Than False Than True Know Applicable

B7. Partners have agreed to work together on this issue.

True More True More False False Don't Not
Than False Than True Know Applicable

B8. Our group has set ground rules and norms about how we will work together.

True More True More False False Don't Not
Than False Than True Know Applicable

B9. We have a method for communicating the activities and decisions of the group to all partners.

True More True More False False Don't Not
Than False Than True Know Applicable

B10. There are clearly defined roles for the partners.

True More True More False False Don't Not

Than False Than True Know Applicable

B11. Partners are more interested in getting a good group decision than improving the position of their home organization.

True More True More False False Don't Not

Than False Than True Know Applicable

B12. Partners are effective liaisons between their home organizations and our group.

True More True More False False Don't Not

Than False Than True Know Applicable

B13. Partners trust each other sufficiently to honestly and accurately share information, perceptions, and feedback.

True More True More False False Don't Not
Than False Than True Know Applicable

B14. Partners are willing to let go of an idea for one that appears to have more merit.

True More True More False False Don't Not

Than False Than True Know Applicable

B15. Partners are willing to devote whatever effort is necessary to achieve the goals.

True More True More False False Don't Not

Than False Than True Know Applicable

B16. Partners are willing to devote the necessary resources (e.g., staff, time, funding, supplies) toward achieving sustainability goals.

True More True More False False Don't Not

Than False Than True Know Applicable

B17. Divergent opinions are expressed and listened to.

True More True More False False Don't Not

Than False Than True Know Applicable

B18. The openness and credibility of the process help partners set aside doubts and skepticism.

True More True More False False Don't Not

Than False Than True Know Applicable

B19. We set aside vested interests to achieve our common goal.

True More True More False False Don't Not

Than False Than True Know Applicable

B20. We have an effective decision making process.

True More True More False False Don't Not

Than False Than True Know Applicable

B21. Our group is effective in obtaining the resources it needs to accomplish its objectives.

True More True More False False Don't Not

Than False Than True Know Applicable

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B22. The time and effort of the collaboration are directed at obtaining the goals rather than keeping the collaboration in business.

True More True More False False Don't Not
Than False Than True Know Applicable

B23. Our partnership assessed the needs of our community while deciding what problems to address.

True More True More False False Don't Not
Than False Than True Know Applicable

B24. Our partnership has a clear way to monitor the progress it makes on addressing the problems on which it focuses.

True More True More False False Don't Not
Than False Than True Know Applicable

B25. Our partnership includes efforts to promote community awareness of services available in the community.

True More True More False False Don't Not Than False Than True Know Applicable

B26. Our partnership is attempting to link and coordinate the new project with existing services.

True More True More False False Don't Not
Than False Than True Know Applicable

B27. Our partnership is currently planning for the sustainability of the project beyond the period of grant funding.

True More True More False False Don't Not
Than False Than True Know Applicable

B28. Our partnership is doing specific things aimed at the needs and strengths of all major cultural and ethnic groups involved.

True More True More False False Don't Not
Than False Than True Know Applicable

B29. Our partnership includes members of the service population as collaborative members.

True More True More False False Don't Not
Than False Than True Know Applicable

B30. Our partnership includes families of members of the services population as collaborative members.

True More True More False False Don't Not
Than False Than True Know Applicable

B31. Our partnership includes as members agencies and organizations that work specifically with members of the service population.

True More True More False False Don't Not
Than False Than True Know Applicable

in parentheses): Centennial Area Health Education Center (Educational and Community-Based Programs)
Chaffee County Department of Health and Human Services (Access to Quality Health Services)
Crowley County (Substance Abuse)
Gunnison County Public Health (Public Health Infrastructure)
Lutheran Hospital Association/San Luis Valley Regional Medical Center (Access to Quality Health Services)
Mesa County Health Department (Environmental Health)
Metro Community Provider Network (Access to Quality Health Services)
Northwest Colorado Visiting Nurse Association (Access to Quality Health Services)
San Juan Basin Health Department (Substance Abuse)
Southern Ute Community Action Programs (Mental Health)
Spanish Peaks Regional Health Center/Southeast AHEC (Access to Quality Health Services)
Tri-County Health Department (Older Adult Fall Prevention)
UCHSC Oral Health (Oral Health)
UCHSC/WONDER Babies (Maternal, Infant, and Child Health; Mental Health)
Please select the categories that best describe your role in the collaborative (check all that apply):
Direct service provider
Line supervisor
Administrator
Collaboration project staff
Teacher / School personnel
Elected official
Law enforcement personnel
Judge / Magistrate / Court personnel
Business person
Representative of a faith-based organization
Volunteer
Concerned community member
Primary Caregiver (parent, guardian, kin, etc) of service recipient
Person receiving services
Other:
If you describe yourself as coming from an agency or organization, with what type of organization are you most closely associated?
Local health department
County public health nursing service
School district or local schools
A publicly-funded provider of medical services

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A private non-profit or for profit provider of medical services
Other health care organization
A private non-profit or for profit human service provider (e.g., mental health provider, wrap-around provider, job training program)
Department of Human Services / Child Welfare / Social Services
Other state, county or regionally-affiliated human service provider
Community Mental Health Center
Other behavioral health provider, including mental health and substance abuse providers,
The justice system
Local government
Existing coalitions or collaboratives
A private business
A faith-based organization
An advocacy organization
Other community-based service organizations
Other:
Each of the partnerships has been holding collaborative meetings as part of their planning process. Collaborative meetings refer to meetings with other partners working on the same collaborative goals under this initiative, including both general meetings involving all the partners and workgroup meetings involving a smaller number of partners.
Do you attend collaborative meetings?
Yes No
If you attend collaborative meetings, approximately how many collaborative meetings for this project have you attended
In the past two months? In the past six months?
Other than attending collaborative meetings, do you get information about the partnership's collaborative activities and meetings from any of the following sources? (check as many as apply)
Reading meeting minutes / "group memory" documents from collaborative meetings
Reading other written materials about the partnership (reports, planning documents)
Reports from other people in your agency who are involved in collaborative meetings
Other. Please specify:
This concludes the survey. Thank you for your help!

ENDNOTES

- Foster-Fishman P, Nowell B, Yang, H. Putting the system back into systems change: a framework for understanding and changing organizational and community systems. American Journal of Community Psychology. June 2007; 39: 3-4:197-215.
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> APPENDIX B COMPLETE CASE STUDIES

PARTNERSHIPS FOR HEALTH INITIATIVE CHAFFEE PEOPLE'S CLINIC PROJECT CASE STUDY

I. Overview of the Chaffee People's Clinic Project

In 2005, a group of community leaders in Chaffee County, CO, secured funding from The Colorado Trust (The Trust) through its Partnerships for Health Initiative (PHI) to improve access to health care services in Chaffee County. Through an assessment of needs, including review of data from a 2003 county health assessment, information about emergency room visits to the local hospital, dialogue with community residents, and their own knowledge of the conditions in the community in regards to access to health care, the group developed a commitment and a plan to create the Chaffee People's Clinic (CPC), a community-based provider of primary care services for uninsured and underserved people living in Chaffee County. After a planning period, the CPC opened in October 2006 with operations in Salida and Buena Vista. CPC offered day and evening clinic hours in space provided by the county's health department and staffed mostly by volunteers, including a volunteer medical director and medical providers.

Since its inception, the CPC project has formed a board of directors, has registered as a 501(c)(3) nonprofit entity, and has developed relationships with other providers in the community, including the local hospital, physicians, dentists and pharmacies, to better meet the needs of the local communities in which it operates. While some providers initially questioned whether the number of people in need warranted the opening of a community clinic for uninsured persons, the medical community has become more supportive over time and now uses it as a referral destination. After its first year of operation, however, the Buena Vista site experienced a period of decreased demand for services, requiring a temporary reduction in clinic days from two days per week to one day per week. Project staff were unsure about the reasons for this reduction in demand, but nevertheless focused more effort on outreach and marketing efforts in that community in order to increase demand for services at that site, which resulted in later expansion in clinic hours. Demand has been greater at the Salida site, and use of office space has been facilitated by the public health department for clinic operations, now housed in the county's community services building that opened in the Spring of 2010.

Progress reported by the CPC indicates a steady increase in the number of persons seen for services since the inception of the clinic. By the end of May 2010, the clinic had logged over 4,600 clinic visits and had provided services to over 1,400 new patients. Consistent with its goal of increasing access to care in a clinic setting and reducing the incidence of people seeking care through a hospital emergency room, the CPC surveyed clinic patients in mid-2008 and determined that 14% of the patients receiving services through the CPC at that time listed the emergency room as their source of medical care prior to obtaining services from the CPC.

II. Assessing Health Care Access and System Change and the Case Study Approach

Through PHI, The Trust is seeking to promote improved access to health care in Colorado by funding projects such as the CPC. The Trust hired TriWest Group to assist them in evaluating the success of the PHI projects and to further understand system change efforts. In Phase II of the PHI, TriWest Group has worked with The Trust and four projects to answer four central evaluation questions:

- Does the work of local collaboratives contribute to improvements in their local health system?
- What factors lead to or impede improvements to local health systems?
- Do the grantees' access-to-health outcomes improve as a result of these system changes?
- What recommendations can be made to The Trust and TA providers about how to fund and manage systems-change strategies?

A number of tools have been used to help answer these central questions. The four tools listed here have been employed throughout both Phase I and Phase II. They include the following.

- Collaboration among stakeholders has been assessed annually over the course of the project. To assess collaboration, project stakeholders completed an annual online survey consisting primarily of Drs. Carl Larson and Darrin Hicks' Process Quality Rating Scale and their Working Together index of collaboration, aimed at assessing the quality of the collaborative process at the grantee level.
- Project Blueprints visually depict the system's structures and relationships. Comparing Blueprints over time, as they are updated, illustrates changes in the structure of the system of care.
- Regular reports of the status of each project are submitted to The Trust by each project. These summarize progress and issues facing the project.
- Key informant surveys of project participants have provided data for a case study. Initial and follow-up key informant surveys sought to solicit data about the nature of system change efforts and specifically to better understand the relationship dynamics and operational factors involved in facilitating system change. The data from the case study approach provides more content and context to the other components of the evaluation to aid in determining how the work of local collaboratives may contribute to improvements in their local health systems, what factors lead to or impede improvements to local health systems, and whether grantees' access to health improves as a result of changes in the local systems. Initially, key informants were interviewed using a semi-structured interview format to assess respondents' perceptions in the areas of values and norms within the system, system resources, system regulations, system power and decision-making processes and operations, and interdependencies that exist within the system. A second key informant survey was conducted to update the case studies through the end of Phase II and to include more detail about the influence of health care reform.

The help of the CPC Project Director and of the Coordinating Agency Facilitator was enlisted to jointly develop a prioritized list of recommended key informants, considered to be stakeholders who would have a view of the system and sufficient conceptual knowledge of how it has changed to be able to discuss these areas with the interviewers. In addition to interviewing the Project Director and the Coordinating Agency Facilitator, others interviewed consisted of board members, clinic management and clinic provider staff. Respondents were assured of the anonymity of their responses, and their responses have been combined to inform the discussion in the sections that follow.

Combined with material gathered via collaboration surveys, project Blueprints, and grantee progress reports, the evaluation team made use of key informant material gathered to answer the evaluation questions listed below in Sections III through V, and to offer recommendations in Section VI. In particular, responses from key informants have been useful in telling the story of their experience.

III. Did the grantees' access-to-health outcomes improve as a result of these system changes?

As was the case for all Partnerships for Health Initiative grantees, the Chaffee People's Clinic project selected the problem it would address from among Healthy People 2010¹⁴ focus areas, which includes "Access to Quality Health Services." While the Healthy People 2010 focus area structure includes a variety of indicators of access to health care, each project chose its own objectives and developed indicators within their respective focus area, and these did not always align with specific Healthy People 2010 indicators. The Chaffee People's Clinic chose as its indicators the number of people receiving services from the Clinic (with a goal to increase the number over time) and the number of people going to an emergency room for non-urgent care (with a goal to reduce this number as more people used the CPC as their ongoing source of care). While these indicators do not align exactly with the federal Healthy People 2010 indicators, they are roughly consistent with Healthy People 2010 Indicator 1-5 ("Increase the proportion of persons with a usual primary care provider") and Indicator 1-6 ("Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members").

Access to health care services as defined by those two indicators has improved in the community as indicated by the Chaffee People's Clinic (CPC) project via their self-reported indicator results, and this improvement can be attributed to the establishment of the clinic, as described in more detail below. However, the CPC also used other data to inform its initial goals that have not been updated since the original planning period. When the establishment of the Chaffee People's Clinic was proposed by the collaborative group in 2005, its implementation plan cited figures the group obtained from the Heart of

the Rockies Regional Medical Center (HRRMC). They estimated that 55% of emergency room visits at HRRMC were for non-urgent concerns and that 20% of people presenting for services in the emergency room did not have health care coverage, suggesting that community members were using the emergency department as their primary source of care. The group's implementation plan also referred to a 2003 Chaffee County Community Health Assessment to estimate that 25% of Chaffee County residents lacked any kind of health insurance coverage (including those without work-based coverage). The CPC has not tracked these data over time.

Instead, outcome tracking focused on the two access indicators defined above. Progress reported by the project since then indicates a steady increase in the number of people to whom health care services are provided since the inception of the clinic in October 2006. By the end of May 2010, the clinic had provided services to over 1,400 new patients and had logged over 4,600 clinic visits, as shown on the project-provided table below.

Cumulative Report Since Clinic Inception

	2006 Oct - Dec	2007 Jan - Dec	2008 Jan - Dec	2009 Jan - Dec	2010 Jan - May	Totals
Total New Patients	82	393	315	420	194	1,404
Total # Patient Visits	122	940	1,117	1,580	850	4,609

Also, consistent with its goal of increasing access to care in a clinic setting and reducing the incidence of people seeking care through a hospital emergency room, the CPC surveyed clinic patients in mid-2008 and determined that 14% of the patients receiving services through the clinic at that time had previously been relying on the hospital emergency department as their primary source of medical care prior to obtaining services from the CPC. In fact, people are now routinely referred to the CPC from the hospital emergency department for management of chronic conditions, creating an opportunity for patients to establish an ongoing source of care and enhanced care continuity through their use of the CPC.

Overall, the number of new patients seen and the number of patient visits at the CPC have increased over time, despite operational challenges, such as the need to secure adequate space for the Salida clinic to conduct business, and a temporary drop in demand at the Buena Vista site that necessitated scaling back available clinic hours there until marketing and outreach efforts could take hold and result in an increase in demand, ultimately leading to the placing of an additional provider at that site.

There have been other specific changes in the local system that reach beyond the clinic to support broader coordination of care, including:

- The CPC has instituted an emergent dental care voucher system accepted by all the dentists in the county, whereby a \$100 voucher is provided to clinic users for emergency dental care.
- There is also a voucher system with two local pharmacies to provide patients with needed medications at a lower cost.
- There is an agreement with an ophthalmology practice to see CPC patients with diabetes at a reduced cost.
- In addition, the clinic has established a patient assistance fund to aid patients in accessing specialty medical care beyond those services offered by the CPC.
- At the broader level, community physicians who were involved in the planning and early implementation continue to be involved as consultants to clinic staff and as a sort of point of entry to clinic services, referring patients to the CPC when appropriate and volunteering to provide direct services at the CPC.
- The West Central Mental Health Center is also now working with the CPC to provide better coordinated and continuous mental health services.
- Rocky Mountain Planned Parenthood is reported also to work with the CPC by accepting referrals for well-women exams and serving as a source of referrals for CPC services.
- Although stakeholders have expressed the desire for a closer collaboration with the local hospital, the Heart of the Rockies Regional Medical Center also assists the effort by providing low cost laboratory

tests for CPC patients, which are billed directly to the clinic. The hospital also assists clinic patients to access the Colorado Indigent Care Program.

As clinic operations continue to develop, local leaders anticipate that there will be more opportunities to identify points of intervention for further enhancing the local care system beyond the nucleus that the CPC has created. To the extent that the CPC has had a close and long-standing working relationship with the county government and its public health department as a key partner instrumental in the system change effort, this relationship continues to help improve access countywide in the future in a reciprocally beneficial manner, as well as to position the county for planning to respond to health care reform opportunities and challenges. Currently, clinic and public health department services complement each other to an extent, as the clinic provides medical services that the public health department does not offer. That relationship has become even more established with the purchase by Chaffee County government of the old hospital building to turn it into office space for government agencies. As part of that the Salida clinic has moved there and is directly co-located with the departments of Social Services and Public Health. That proximity has made it much easier to refer patients between those departments and the clinic, as well as strengthened the clinic's relationships with the employees of those two key agencies. That these relationships are reciprocal is evidenced by referrals made by the clinic for services traditionally offered by the public health department (e.g., vaccinations). Similarly, as linkages continue to develop, the CPC relies on the county's Department of Human Services (DHS) to offer social services to its persons served (e.g., enrollment in benefits programs), while DHS relies on the clinic to provide medical services to DHS clients who need them. The public health department has been and continues to be an instrumental partner in the effort to establish the CPC.

Still, unintended consequences can also occur. As the clinic continues to think about its long-term sustainability and about ways it can diversify its revenue streams, it is faced with considering the option of seeking Medicaid revenues. This is seen by some as possibly leading to renewed competition for resources and threaten the collaboration, as local physicians and the clinic would be competing for the same group of persons to serve, and support for the clinic could erode among them. However, as health care reform is expected to shift uninsured persons to Medicaid (under 133% of the Federal Poverty Level / FPL) or to private payers through health insurance exchanges (over 133% of FPL), the role of the CPC post-reform will need to be addressed.

Access Update (based on key informant interviews in September of 2011 and the final project report in October). Key informants were asked about how access to health care has improved as a result of system change efforts. They were also asked about health care reform. Their responses and information from the final report were reviewed and summarized for this update. It is clear that CPC efforts to improve access to care are active and will continue well beyond the end of PHI funding.

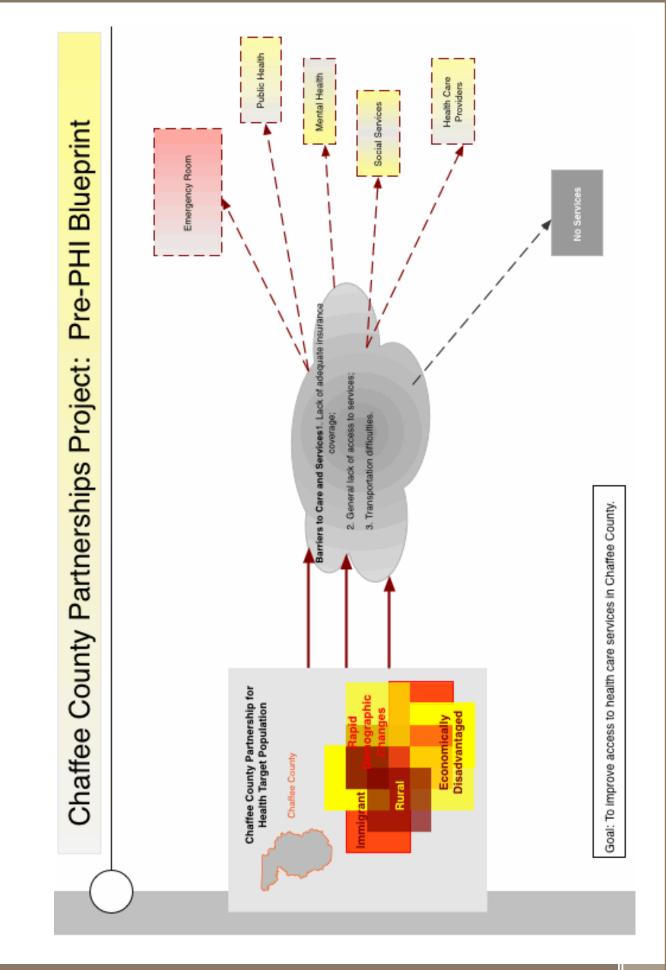
Respondents were still working through the potential impacts of health care reform and how the CPC will be affected and/or participate. They believe their primary role as a safety net provider of services will still exist, even though they believe many of the people they serve will increasingly be able to qualify for Medicaid. However, even if all (or nearly all) of people have coverage (an outcome which is not at all certain, given state cuts to its previously planned 2012 Medicaid expansion and continued uncertainty about federal plans), there is likely to still be a role to keep people engaged in the system, to help people navigate the system, and to assist people in becoming eligible for services. There are also many unknowns that may result in CPC having a role in providing direct services. For example, although most of the providers in their area accept Medicaid, there may be a shortage of providers and, as a result, may not be able to provide services to enough people. And certainly in the short term (through 2014) and possibly in the longer term, not all impoverished uninsured residents will qualify for Medicaid.

The CPC continues to explore their role in a reformed environment and have begun changes that will allow them to be participants. For example, in 2011 they received a grant from Colorado Rural Health Care to expand the use of health information technology. The \$50,000 grant is being used to increase CPC's capacity to provide primary care by "implementing a health information technology project that includes an electronic medical records component.¹⁵

IV. Did the work of local collaboratives contribute to these improvements in their local health system?

One major facilitating factor related to positive changes in the local system was the development of a good collaborative effort. The Process Quality Rating Scale and their Working Together index of collaboration from the online survey of collaboration among stakeholders showed first-year collaboration among stakeholders to be above the threshold for characterization as "good" (i.e., having an open and credible process). Scores increased between the first and second years of the project, with survey respondents giving high scores to the fairness of the process and the dignity with which participants were treated, in addition to their view of participants as being focused on broader goals, rather than individual agendas. Collaborative respondents also indicated increased involvement with the project during the initial implementation phase than they had during the planning phase, pointing to maintained energy around the effort. By the third year of the project, collaboration scores remained within the range indicative of a good collaborative process, with survey respondents giving high scores to items pointing to the continued focus of the group on the broader goals that brought them together, rather than on individual agendas, as well as a desire to have a concrete impact on a problem. Survey respondents indicated greater awareness of and involvement in the project than they felt they had the previous year, indicating that the project's momentum continued among stakeholders. Most recently, the CPC collaboration survey results for 2010 final survey show a continued pattern of responses consistent with a good collaborative process among respondents, with a continued focus on having a concrete impact on a defined problem, as well as indications of project maturity based on a new focus on sustainability beyond the period of grant funding. Clearly a sound level of collaboration was achieved from the start that grew over time.

service access (depicted in the gray cloud in the middle), with limited access to needed care resulting in persons going without services (gray box in lower to health care services. The pre-clinic project Blueprint diagram (below and in Appendix 7) shows a population in need encountering various barriers to Nevertheless, the structures depicted on project Blueprints show changes in processes since its inception related to the extent and manner of access Structurally, the local care system has not changed substantially since the establishment of the physical clinic locations in Salida and Buena Vista. right) or seeking care through an emergency room (red box to upper right).



Phase II Goals:
1) To strengthen the project infrastructure to ensure sustainability. Ongoing.
2) To expand project capacity to reach a larger service population. Have significant capacity as of August 2011.

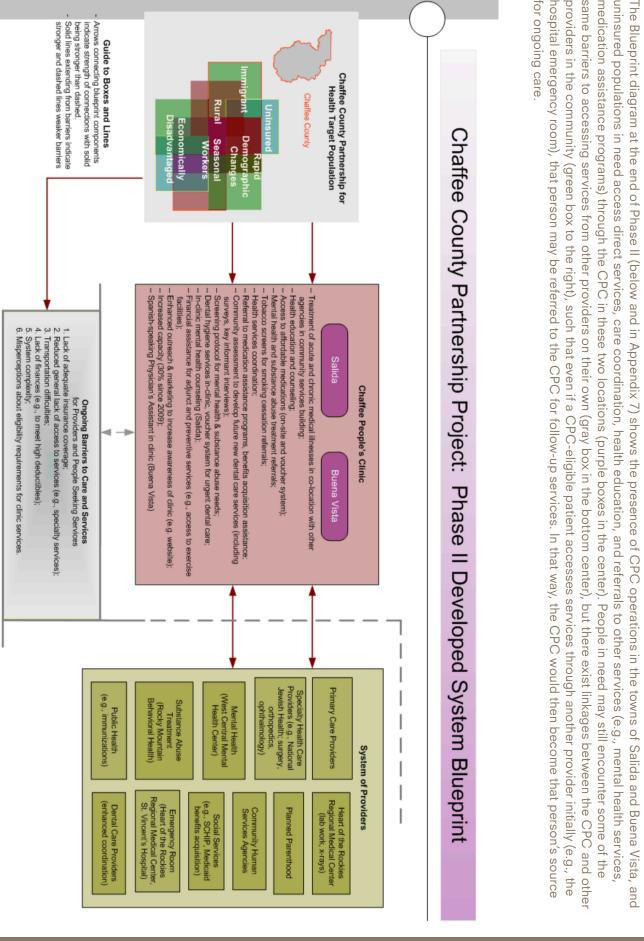
Phase II Project Indicators:

1) Number of people seen for services at the Chaffee People's Clinic:

2) Number of referrals from the Chaffee People's Clinic to a community provider for additional services;

3) Number of people reporting use of ER for non-urgent care prior to

hospital emergency room), that person may be referred to the CPC for follow-up services. In that way, the CPC would then become that person's source providers in the community (green box to the right), such that even if a CPC-eligible patient accesses services through another provider initially (e.g., the same barriers to accessing services from other providers on their own (gray box in the bottom center), but there exist linkages between the CPC and other medication assistance programs) through the CPC in these two locations (purple boxes in the center). People in need may still encounter some of the uninsured populations in need access direct services, care coordination, health education, and referrals to other services (e.g., mental health services The Blueprint diagram at the end of Phase II (below and in Appendix 7) shows the presence of CPC operations in the towns of Salida and Buena Vista, and



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previous year);
2) 181 referrals were made to partnering agencies and specialty care 3) 192 patients (9.1%) identified the ER as their prior source of care.

providers during 2010;

1) There were 2,109 patient visits during 2,010 (a 33.5% over the Phase II Indicator Progress as of November 2010:

- Project blueprints primarily present structural views of the system. As a result, the key informant survey was conducted to collect data to inform our understanding of the relationships between system structures, and between participants and how those relationships facilitate system change efforts. From that data, specific examples emerged about how collaboration contributed to improvements in the local system:
- Collaboration brought participants together to share and discuss information about their perspectives on service needs, including system change needs. With the opportunity to apply for a Partnership for Health Initiative grant, some Chaffee County physicians and community leaders, along with the Department of Public Health, began discussions about how health care services could better be accessed by community residents who lacked insurance coverage and went without care, relying on the hospital emergency room when they required treatment. Those discussions also involved sharing information about each agency, the people they served and their ability to provide services. For example, while the public health department provided preventive services such as immunizations, they did not provide other services that could meet the medical needs of the local community. Local physicians provided routine care, but were limited in their capacity to provide pro-bono care to the community, and the local emergency room provided medical care, but costly emergency services may not have been needed by the uninsured seeking services at the time. That information helped develop a shared understanding of realistic expectations of the existing providers and what they could provide, as well as a clearer picture of the gaps that needed to be filled.
- Collaboration enabled the expression, development and reinforcement of shared values that serve as the basis for system change efforts. Stakeholders began their collaborative work from the perspective that Chaffee County residents without health insurance coverage needed access to health care options in addition to the existing options (i.e., physician practices, the public health department, and the hospital emergency room), and it was their role as leaders in the community to help develop these options, starting with a community clinic. Despite initial misgivings about the potential for the clinic to compete directly with local physicians for Medicaid revenue, they worked together guided by their belief that it was their responsibility to expand access to health care for fellow Chaffee residents lacking access options.
- Finally, CPC stakeholders developed an understanding that in addition to the identification of common goals (e.g., increasing access to health care for uninsured Chaffee County residents), it would be necessary to affect the system by continuing to work together to bring about structural changes, such as the establishment of brick-and-mortar clinic locations that has happened in Buena Vista and Salida, and also relational changes, such as those evidenced by the medical and other expertise volunteered to maintain clinic operations.

V. What factors lead to or impede improvements to local health systems?

Overall, the work of the local collaborative for the Chaffee People's Clinic clearly led both to structural changes in the form of establishment of clinic operations and increased access to care for the local population. While the collaboratives' work correlates with improved access to health care, the group also encountered difficulties during the formative stages of the change effort that could have derailed it.

Key Factors That Supported Improvements to the Local Health System

- Keep in mind that health care reform is a fluid and locally variegated process. While much of the attention in the past two years has been on federal and state health reform efforts, it remains the case that all health reform must ultimately occur at the local level, in the ways that local care providers, local health facilities, and local residents provide, experience and pay for care received. Furthermore, state and federal plans continue to evolve, so communities cannot base their planning solely on these necessarily fluid potential resources. Given this, The Trust's support of regional collaborative planning entities such as CPC are essential so that local communities can (1) weave state and national health reform efforts with local needs and resources and (2) continue local planning to build on emerging opportunities and respond to continued policy and funding changes.
- Community Buy-In. One factor that seems to have helped with collaborative momentum is that of general community buy-in for the CPC project. While initially there were differing perceptions of the need for a community clinic, the planners persisted in their efforts, and eventually established the clinic. While planners could have proactively promoted the clinic in an effort to garner support in the community, key informants indicated that the CPC and its executive director adopted a strategy of

focusing on providing services and letting the work of the clinic speak for itself in an effort to increase buy-in and enhance its positive perception in the community. This strategy seems to have paid off, and as the value of the CPC to the community is continually demonstrated through increased availability of care, its credibility appears to have increased among providers, potential patients, and other stakeholders in the system based on feedback given to us by the key informants. One example of this is the increasing willingness of providers to volunteer services. This has enabled them to offer services 18 hours a week combined between the Salida and the Buena Vista offices. Various community activities also indicate increased support for the CPC. For example, a cookbook titled "Chaffee County's Finest" was published with proceeds going to the clinic. The Ark Valley High Rollers roller derby team also donated a portion of their proceeds to the CPC.

- Community Leader Involvement and Commitment. The involvement of influential community leaders appeared to serve as the catalyst to the system change effort of the CPC that ultimately transcended the many initial concerns noted below. This involvement lent further credibility to the CPC and helped it to be more widely perceived as a grassroots collaborative effort originating within the community. Volunteer physicians from the community also used their influence and positions to help the project move along at the planning phases, and additional volunteers also provided momentum along the way. The CPC effort was perceived to have grown out of local concerns and ideas, where community leaders and some local physicians saw the need for access to medical care among the uninsured with whom they worked, and as they became energized, they energized others to give this need high priority and seek foundation funding to effect system change to meet this need.
- Organizational Linkages. Stakeholders also reported linkages between the clinic and structures and institutions that were previously established within the system, strengthening relationships and the level of interaction regarding continuity of care. In this manner, the collaborative effort seems to be perceived more as a renewed effort for these entities to work together with the creation of the clinic as a vehicle. The relationships with public health and the local DHS were previously noted above with the collation of the CPC in Salida. There are still some limits to the extent to which the different stakeholders are fully collaborating, however, with the local hospital perceived as an entity that could be more involved in the effort. While the local hospital is said to informally acknowledge that the clinic has helped to reduce the hospital's amount of unreimbursed care, the relationship between the two has not been formalized to become a more substantial reciprocal relationship (although the hospital is reported to provide laboratory work at reduced rates to the clinic, as noted above). Ongoing funding efforts with foundations such as the Colorado Health Foundation also strengthen the ability of CPC to sustain their ability to provide services. For example, CPC was awarded a \$105,000 grant by the Colorado Health Foundation for general operating support in 2011.
- Formal Project Leadership. Another key factor was the formal leadership available to the project. While the initial planning group provided the guidance and leadership necessary for the collaborative to form and to work towards the development of the clinic, some perceived tension remained around the issue of competition between the clinic and community providers for billing revenues. A critical element in continuing to address this perceived competition was the hiring of an executive director for the project, who focused her efforts on being a liaison with community physicians and others to "smooth things over" on an ongoing basis. The executive director played multiple roles: a physician relations manager with community physicians, a liaison to the community, and a technically skilled leader of the CPC effort. Her skill at enhancing relationships, maintaining a community perspective, and maintaining clear roles has been cited as significant by stakeholders. In this case, the fit between the needs of the project and the skills of the leader seems to have been optimal. However, the need for good leadership raises implications regarding the extent to which the funder could or should exert influence over the selection of project leadership, rather than limiting itself to providing technical assistance to enhance leadership skills locally.
- Informal Project Leadership. More informally, some individuals within the collaborative were perceived to be naturally influential figures because of their professional standing and personal credibility within the community. Aside from initiating and energizing the effort early on, these influential figures were also seen as providing continuity and stability to the effort. This added level of stability was needed at critical points in the development of the effort, such as when the clinic needed to relocate to a different space early in the project because of space restrictions, a process that was said to tax the personal resources and relationships among board members and staff due to the pressures of a high workload. Their stabilizing influence highlights the importance not only of capable formal leadership, but also of more informal but stabilizing agents.

■ Technical Skills. Aside from the human resources available for the effort, another factor important in facilitating the effort is that of the technical skills of collaborative members needed to be able to carry out the change effort. While several local physicians were involved in the planning and early implementation of the clinic, and volunteer physicians continue to engage in critical service provision functions, there is also a need for technical knowledge and support skills to make continued change easier to achieve. Key informants referred to needs in the legal, marketing, and administrative realms, which would provide them with guidance to comply with complex and sometimes changing legal and statutory requirements as they continue to grow and establish working relationships with other providers in the community, with a means to effectively provide information to other providers and to the community about the work of the CPC, and with the administrative support to carry out the day-to-day operation of the clinic efficiently. These needs seem to have been perceived as secondary, except when progress was slowed by the need for technical knowledge and skills unavailable at the time.

Key Factors That Impeded Improvements to the Local Health System

- Lack of a History of Successful Collaboration. Interestingly, there does not seem to be any discernible sense of a historically cohesive effort for change in the local system, with past efforts at system change being described as having been siloed and fragmented, with different sets of stakeholders tending to look after their own defined interests. That is also how the current change effort was perceived initially, which makes it rather remarkable that system change has taken place to the extent that it has, as potential reactions to perceived competition for financial resources, if they had taken hold, would have effectively impeded system change efforts.
- Mixed Assessments of Need. Initially, there were perceived differences about the need for the clinic on the part of community physicians and the clinic planners, as community physicians were described as believing that their efforts to care for the uninsured through their practices were sufficient, while clinic planners saw a pressing unmet need. Also, there were different perceptions of need for the clinic in other community quarters, including with potential patients, who were described as being potentially sensitive to feeling stigmatized and hesitant to present for services at a clinic they perceived as "low-cost." In Chaffee County, one in four people are at or below 200% of the federal poverty level. Respondents reported that they did not think the public understands the extent of the need, and getting people to see themselves as qualifying for CPC services is difficult.
- Stigma of "Public" Services. Adding to other barriers was the issue of stigma perceived by community members about presenting for services at a "low-cost clinic" that, because of its colocation with Chaffee County Public Health (CCPH), was perceived to be a part of the public health department. Ironically, this potentially stabilizing partnership was seen by some community members as a drawback.
- The Challenging Economic Context. Ultimately, the context within which the CPC operates cannot be ignored, and the role that the local economy plays in terms of limiting the type and amount of system change that can take place is said to be great. Both the need for the clinic and the impact that it can have are inextricably tied to factors beyond the reach of the CPC and the funder, namely the economic base and condition of the community. The job base in the community was described as having a large proportion of seasonal jobs tied to the tourism industry, which offer no health insurance, so already there was a segment of the population in need of care, but who lacked coverage. As the economy worsened nationwide, the local economy experienced similar effects, and to the extent that people previously having coverage lost their jobs and along with those jobs their health coverage, the number of Chaffee County residents without health care coverage grew.
- The Rural Area Challenge. Key informants reported that they have learned that they can establish and fund a clinic and that people will use the clinic. However, informing people of the existence, location and how access to the clinic has been complicated by the rural nature of the area. Everyone knows where the hospital is because it has been there a long time and is highly visible. Marketing a new clinic is important in making services available. Transportation has also been a barrier to access. Having the clinic in two locations helps in this regard. The last point here has to do with the availability of professional provider staff. They are not as available in rural areas, particularly when it comes to specialty care. As a result, volunteer providers are an important resource and are now providing services at CPC. This effort has taken time to achieve and has required collaboration, patience and a demonstration of the need for the clinic.

Current Structural Limitations. Other factors beyond the reach of the project include the proportion of people with insurance coverage, but with high deductibles (again tied to the local economic base), that make it prohibitively expensive to seek medical care, rendering them essentially lacking coverage for routine care. As such, it is important to recognize that despite the system changes already achieved (for example, establishment of the clinic, increase in the number of people who are able to access medical care) there are also limits to the reach of the project and the amount of system change it may be able to achieve. The interventions and the level at which these are attempted should be realistic. The clinic may not be able to improve access for all segments of the community in need (for example, workers with coverage but with high-deductible plans), given that its main focus is on the uninsured population. However, it is clearly making a difference in the extent to which access to health care is available to the uninsured residents of Chaffee County.

Mixed Factors

- Tension Between Competition and Collaboration. One recurring theme that arose from interviews with key informants was that of competition versus cooperation in the establishment of the clinic. On the one hand, there was a cooperative spirit perceived by some in the planning of the clinic and in the overall effort to increase access to health care services in the local community, which was seen as much-needed. On the other hand, there was a simultaneous undercurrent of competition and skepticism during discussions between clinic proponents and physicians in the community. While some agreed with the need to bring medical services to the uninsured in the community through the establishment of a clinic, there was reportedly also the perception among some physicians that local medical practices were already meeting this need, and they questioned whether an additional clinic was needed at all. To some, this difference in views represented a competition for funding between local physicians and the clinic planners, if only as a means to remain in business, rather than as a means to maximize profits. Had this issue between opposing interests not been resolved, establishment of the clinic may not have come to pass, and the collaborative process appears to have supported a clarification of roles among the parties. During the planning process, there was an acknowledgement that even though the local physicians were providing for the needs of the uninsured to some extent by writing off some patient debt, there were limits to the extent that this could be done while still allowing the physicians to remain in a viable business. Therefore, there still existed a need for services to be accessed by the uninsured. By clearly articulating the role of the clinic as a provider of services only to the uninsured, it was understood by all parties that there would not be an overlap (or competition for resources) between the clinic and community physicians. In this manner, not only was current capacity maintained in the system so physicians could continue to meet the needs of the uninsured to the extent that they could, but the CPC would not compete with them for insured patients. With this balance, the work of the collaborative could continue to move forward.
- Support of Key Local Institutions. The current collaborative effort has been aided by the support of institutional backers and collaborators. The CPC effort has had a good working relationship with the county government and with the public health department, from which it has also receives financial support. The lack of these linkages and supports would have represented a major obstacle to the success of the project, and although it enjoys a mutually beneficial relationship with county government structures, stakeholders wish that a closer relationship existed with the local hospital (Heart of the Rockies Regional Medical Center), as the hospital stands to benefit from a decrease in its provision of unreimbursed emergency care as more patients seek ongoing care through the CPC. However, because stakeholders perceive the possession of financial resources and existing relationships with those having these resources as the main predictors of decision-making power and resource-control, cultivating key relationships is all the more important. As the CPC gains recognition and credibility, and continues to build relationships with decision-makers in the system, it has been able to leverage the relationships it has developed towards CPC enhancement (e.g., improved physical space in the community services building). Still, respondents seem to recognize that, in their case, recognition and credibility do not equal power in the decision-making structures of the system. The local hospital is still seen as the "biggest player" in the system, and although it was not mentioned as a critical support to propel the establishment of the CPC, it was spoken about as a stakeholder that could be very beneficial in the continued development and sustainability of the CPC as a system change agent. While the benefits inherent in receiving institutional support are clear for the current viability of the project, the established alliances also have implications in terms of perceived and actual project independence. This could also have implications for long-term

sustainability. If people perceive the clinic to be a publicly-funded entity as a result of its close ties to the county government, then less attention could be paid to the fund-raising needs of the CPC, which would negatively impact clinic sustainability.

Overall Analysis

Stakeholders are also cognizant that current national health care policies can potentially affect access to care at the local level, and perhaps could have a greater impact than any locally-specific policies that they might be able to identify. On the one hand, the planning process and level of collaborative success achieved to date appear to be serving as a basis and catalyst for successful navigation of the opportunities and challenges of health care reform, particularly with the widespread discussion, planning and the need to actively engage with the system to receive services. On the other, the inherent tensions and competition within the system (especially around any perceived competition for the same revenue streams) could limit such opportunities. The local planning process is at a critical crossroads. Primary among these is preparation for the planned expansion of Medicaid access in 2012 to adults without dependent children up to 100% of the federal poverty level under the Colorado Health Care Affordability Act of 2009. It may also help the community be a better partner within the Regional Collaborative Care Organization (RCCO) contracts awarded in December 2010 by the Department of Health Care Policy and Financing (HCPF) as a means for promoting the development of person-centered health care homes in primary care settings and improved coordination of care among providers over time. The ability of the CPC and its community partners to access additional financial supports to support health care home activities within that primary care setting will be a direct function of their ability to collaborate within the broader RCCO, in this case Integrated Community Health Partners, for their region. In addition, HCPF has determined a Statewide Data and Analytics Contractor (Treo Solutions) in 2011 that will be able to provide enhanced information supports to coordinate care across clinical settings. The CPC and broader health care community in Chaffee County should be able to position better within the emerging RCCO because of their collaboration.

VI. What recommendations can be made to The Trust and technical assistance providers about how to fund and manage systems-change strategies?

The following recommendations are offered to build on the successes achieved and promote continued planning and collaboration to translate initial successes into broader efforts, in line with the opportunities of health care reform. Although developed with the local circumstances of the CPC project and the experiences and perspectives of the local stakeholders in mind, these recommendations are broad enough to apply to other system change efforts, especially those involving local systems similar to that of Chaffee County.

Factor into the process opportunities for ongoing decision-making by The Trust. At project outset, The Trust selected the grantees based on an assessment of the impact that funding was expected to have within the local system over time. While the initial funding decision is critical, there are nevertheless other opportunities at various points in the implementation of projects for a funder to influence system-level change that could be as important as the initial decision to fund a project, particularly in a time of heightened system change such as that surrounding state health reform efforts and national efforts more recently, in particular. As such, we see the role of the funder requiring more of an ongoing role in decision-making through which to adjust and respond to evolving system structure and opportunities over time. The grantee clearly valued the involvement of The Trust through TA and through the program officer in planning and decision-making and would have liked to have had The Trust even more involved. Ultimately, funding decisions should be dependent on the goals of the funder. If the funder maintains ongoing involvement and influence on the project, funding can be structured incrementally, such that funding would be provided to a grantee for feasibility assessment and planning purposes within goal parameters set with the oversight of the funder on a regular basis (for example, annually). Initial implementation funding could then be provided based on the results of the grantee's readiness to embark on system change efforts that would be consistent with initiative goals and be a good fit with technical assistance mechanisms set up by the funder. Later, ongoing implementation funding would be available to projects in accord with the extent to which the system change effort and results are consistent with parameters defined by the funder. While the funder's role may diminish over time in terms of the amount or proportion of funding it provides to the project,

it can also continue to play an important role in terms of non-financial contributions it can make, such as technical assistance and guidance. It may also determine opportunities for additional targeted investments to respond to emerging opportunities, particularly in a longer-term effort necessary for system change and sustainability. In the case of the Chaffee People's Clinic or a similar project, the funder could exert more influence at the planning stages to maximize the potential for success in the context of a rapidly changing health-care environment, for example by requiring that the appropriate stakeholders be sufficiently involved in the effort early on (e.g., the local hospital). In later stages of project development and evolution, the influence of the funder could continue to focus on maximizing the project's chances for success, but also ensuring that the project evolves within the initiative goals and parameters specified by the funder.

- Develop new goals and opportunities to maintain the collaborative process over time. A related need is the development and maintenance of the collaborative process. As noted above, the CPC project had to establish a balance between being competitors for resources and collaborators working toward the same goals. Once a balance is reached, it needs to be maintained in light of ongoing system changes and evolution. In the case of this project, system change overall appears to consist of a series of incremental changes and subsequent attempts to once again reach a balance as interventions are implemented (e.g., possibility of the clinic seeking Medicaid revenue and the ultimate need to respond to the changing payer mix of health care reform), which affect the tension between these factors within the collaborative effort. Technical assistance efforts should therefore help the grantee evolve and develop new goals and opportunities over time, as well as to fully consider the consequences, intended and unintended, of strategic changes they may implement. While the current balance in the collaborative effort was influenced actively by the work of the local project director who exhibited the skills necessary to "smooth things over" and lead a collaborative effort, there may be instances in which new opportunities such as those inherent in health care reform require new knowledge and structured reconsideration of goals in order to respond to a fast changing environment.
- Expand the scope of the community planning process. It has been observed that all health care reform is ultimately local, so the ability of communities to respond to the unprecedented opportunities and challenges of the federal health care reform efforts will depend on the ability of local communities to develop planning processes sufficient to the task of developing the needed local solutions. In a time of such rapid and critical change at the broader system level, it may be necessary for The Trust to be able to work with influential community leaders and help build their capacity to exert positive influence toward system change. The funder should, at a minimum, continue to monitor such needs and have the capacity to respond to unanticipated opportunities, such as that posed by the national health care reform efforts. This will require the funder to work with community leaders regarding their level of involvement in and endorsement of potential system changes not only at the early stages of planning, but on an ongoing basis. The funder is a key partner in the system development process and should explore the potential of allying more formally with grantee communities, doing so in a manner that maintains the autonomy of these leaders while at the same time increasing the probability of success for the project in accordance with the overall goals of the funder.
- Develop a capacity for targeted technical assistance. Besides relationship-building and personal credibility, technical knowledge and skills are necessary to ensure successful system change. However, over time, as needs and opportunities change, the necessary knowledge or skills may not be available from the local stakeholders or from the technical assistance providers initially designated by the funder. As a result, the funder should develop a process that identifies changing technical assistance needs of the project over the life of the project and not only at the planning and early stages of the project. This would also require a technical assistance capacity beyond the specific skill set of the project coordinator (for example, a flexible pool of funds to purchase technical assistance), as it is not realistic to expect a single entity to possess all needed technical assistance resources. This is particularly true in a time of rapid system change, such as that of the current period.
- Formally assess the strategic opportunities of the broader environment. Because factors beyond the reach and control of the project can and will ultimately influence the success of the system change effort, the opportunities posed and the limitations imposed by extraneous factors should be taken into consideration on an ongoing basis. During the planning phase, the funder should take into account the extent to which the system is ready not only to begin the proposed system change effort, but to deal with extraneous factors and their unintended consequences, especially around policy

The Colorado Trust

issues, as the proposed project may be too narrow in scope and not take these factors into account. A clear and thorough readiness assessment will also help with initial funding and later technical assistance decisions, but the funder should keep in mind that the amount of system change that can be achieved is limited by the broader environment, in both a potentially negative manner (in the example of the negative economic environment) and in a potentially positive manner (in the example of health care reform). Local context is also critical. As noted earlier, financial resources weigh heavily on perceptions of decision-making power in the system, and the funder has such decision-making power. However, the funder is but one of a number of entities with such power in the local system, especially in the later stages of development of system change efforts. As a result, the funder should understand its role in the context of the entire local system, and work within the existing power structure of the system, for example by working with and leveraging resources made available by other system structures, such as by structuring matching funds mechanisms. This would enable the funder also to identify and cultivate critical relationships with various parts of the system in an effort to effect positive change over time.

PARTNERSHIPS FOR HEALTH INITIATIVE IGNACIO COMMUNITY COLLABORATION CASE STUDY

I. OVERVIEW OF THE IGNACIO COMMUNITY COLLABORATION PROJECT

The Ignacio Community Collaboration (ICC) project was initially organized in the fall of 2005 as part of The Colorado Trust's Partnerships for Health Initiative (PHI) to increase access to mental health services in the Ignacio, CO area. Ignacio is described as a "tri-ethnic" community, with a roughly equal ethnic split among American Indian, Hispanic, and Caucasian residents. The new partnership focused on the difficulties related to the shortage of mental health resources available locally and associated access issues, and embarked on a planning process for the geographic community defined by the boundaries of the Ignacio School District (a community 24 miles from Durango, CO). The new partnership involved the following partners:

- Ignacio High School,
- Ignacio Public Schools,
- Ignacio School District,
- Ignacio Senior Center,
- La Plata County Department of Human Services,
- Peaceful Spirit Treatment Center,
- Southern Ute Community Action Programs (SUCAP),
- Southern Ute Health Clinic,
- Southern Ute Montessori Head Start and Early Head Start,
- Southern Ute Tribal Court, and
- Southwest Colorado Mental Health Center (SWCMHC; now known as Axis Health Systems).

The planning process initiated by the partnership after selection by The Colorado Trust (The Trust) was primarily organized by SUCAP, and involved the development of needs assessment tools for residents (206 respondents) and for professionals (51 respondents) to determine the needs of the community and aid in their prioritization. Because respondents ranked the availability of emergency mental health services most highly, and professionals ranked the need for psychiatric services most highly, strategic planning focused on these needs, and planning began to increase availability of emergency mental health services locally.

The ICC's goals also focused on sustaining a collaboration over time to enhance the local system of care through the development of a system for delivering and coordinating initial emergency mental health intervention locally for children and adults as a major step in improving the local system of care. The collaborative's vision also included the eventual expansion of mental health services to early childhood populations and the development of training and education services for professionals and community members.

Collaborative partners were engaged and became involved in the interest of improving outcomes and reaching goals in their respective areas of work (e.g., education, mental health), especially since some partners had clients with multi-agency involvement and scarce resources to provide services to the local community.

The project faced difficulties initially in recruiting and hiring a mental health therapist who would be knowledgeable of and able to address issues faced by a rural, tri-ethnic community, and was unable to hire a provider until mid-2007. However, that therapist stayed on the job only three months. One major challenge faced initially was that the mental health service component was subcontracted to the Southwest Colorado Mental Health Center (SWCMHC, the community mental health center for the catchment area that includes Ignacio), but the therapist was primarily based and supervised in Durango (24 miles away), which effectively resulted in no real change in terms of the local availability of mental health services.

With the departure of the first mental health therapist after three months of service, the project was faced with the need to revisit its initial plan. During this brief service implementation period, based on their service use experience and feedback received from the departing mental health therapist, the ICC concluded that there was more of a need for routine mental health counseling provided locally than for

emergency services. According to one interviewee, it is possible that the community survey findings highlighting the need for emergency services were influenced by the occurrence of high-visibility crisis events in the community about the time of the survey. As a result, the ICC revised its plan, and focused it on providing initial and routine counseling services. More importantly, the ICC decided to base the therapist position in Ignacio (rather than in Durango with SWCMHC). As a consequence, the subcontract with SWCMHC was terminated, and the position was brought in under the local supervision of SUCAP. That move has yielded results, with services having been provided to an increasingly large caseload in the community since the inception of services. In addition, over the life of the project, the focus on providing early childhood services has increased, as well as on the provision of education and training for local professionals and community members, as evidenced by the hiring of a child therapist who also has close professional ties locally to Head Start, the implementation of education and training activities, and the emphasis seen on planning for both in the progress reports submitted by the ICC.

Aside from turnover at the therapist position, the project has adjusted to other staff changes, such as a change in project director in 2010, and the decreased involvement of some tribal agency representatives. As it continues to mature, the ICC has come to define itself as more a facilitator and coordinator of social services with community agencies and as a resource to the community, rather than primarily a provider of mental health services. As part of this branding effort to become a coordination point, the ICC sponsors an online resource/information center (www.mentalhealthignacio.org).

II. ASSESSING HEALTH CARE ACCESS AND SYSTEM CHANGE AND THE CASE STUDY APPROACH

The Trust is seeking to promote improved access to health care in Colorado by funding projects such as the ICC through the Partnerships for Health Initiative. The Trust has hired TriWest Group to assist it in evaluating the success of the PHI projects and to further understand their system change efforts. In Phase II of the PHI, TriWest Group has worked with The Trust and four projects to answer the following central evaluation questions:

- Does the work of local collaboratives contribute to improvements in their local health system?
- What factors lead to or impede improvements to local health systems?
- Do the grantees' access-to-health outcomes improve as a result of these system changes?
- What recommendations can be made to The Trust and TA providers about how to fund and manage systems-change strategies?

In order to help answer these questions, TriWest has relied on a number of tools. The four primary tools listed below have been used during Phase I and Phase II of the evaluation of the PHI, with key informant interviews first being used during Phase II.

- Throughout the course of the project, TriWest has assessed collaboration among stakeholders. Project stakeholders complete an annual online survey consisting primarily of Drs. Carl Larson and Darrin Hicks' Process Quality Rating Scale and their Working Together index of collaboration, aimed at assessing the quality of the collaborative process at the grantee level.
- Project Blueprints have also been developed throughout the course of the PHI evaluation. These diagrams visually depict the system's structures and relationships. Comparing Blueprints over time, as they are updated, illustrates changes in the structure of the system of care.
- Regular reports of the status of each project are submitted to The Trust by each project. These summarize progress and issues facing the project.
- Key informant interviews of project participants have been used to gather data for a case study. The initial and follow-up key informant interviews seek to solicit data about the nature of system change efforts and specifically to better understand the relationship dynamics and operational factors involved in facilitating system change. The data from the case study approach provides more content and context to the other components of the evaluation to aid in determining how the work of local collaboratives may contribute to improvements in their local health systems, what factors lead to or impede improvements to local health systems, and whether grantees' access to health improves as a result of changes in the local systems. Initially, key informants are interviewed using a semi-structured interview format to assess respondents' perceptions in areas such as values and norms within the system, system resources, system regulations, system power and decision-making processes and operations, and interdependencies that exist within the system. A second key informant survey was conducted to update the case studies through the end of Phase II and to include more detail about the influence of health care reform.

TriWest enlisted the help of the ICC Project Director and of the coordinating agency coaches to jointly develop a prioritized list of recommended key informants, considered to be stakeholders who would have a view of the system and sufficient conceptual knowledge of how it has changed to be able to discuss these areas with the interviewers. In addition to interviewing the ICC Project Director and the two coordinating agency coaches, the five most highly-prioritized respondents were interviewed: three direct service providers, an agency director, and a staff member of the school system. Respondents were assured of the confidentiality of their responses, and their responses have been combined to inform the discussion in the sections that follow.

Together with material gathered via collaboration surveys, project Blueprints, and grantee progress reports, the evaluation team made use of the key informant material gathered to answer the evaluation questions listed below in Sections III through V, and to offer recommendations in Section VI. In particular, responses from key informants have been useful in telling the story of their experience.

III. DID THE GRANTEES' ACCESS-TO-HEALTH OUTCOMES IMPROVE AS A RESULT OF THESE SYSTEM CHANGES?

The ICC selected the problem it would address from among Healthy People 2010¹⁸ focus areas, as was the case with all PHI grantees. While the Healthy People 2010 focus area structure included a variety of indicators of access to health care, each project chose its own objectives and developed indicators within their respective focus area, and these did not always align with specific Healthy People 2010 indicators. With the overall goal of increasing the number of persons receiving mental health care in the Ignacio area, the ICC chose as its access to care goals the following:

- Increase the proportion of adults age 19 and over with mental disorders who receive treatment,
- Increase the proportion of youth age birth to 18 with mental disorders who receive treatment.

While the goals listed above align with the federal Healthy People 2010 Goal 18-9, the ICC has routinely reported on the number of persons to whom it provides mental health services in any given reporting period through its progress reports to The Trust. The ICC did not have information on community rates of persons with mental health issues who needed treatment, nor did it have community rates of persons in treatment, so it chose to track the unduplicated number of persons receiving mental health services through the ICC project as indicators of access to services, and modified its access-related goals as follows:

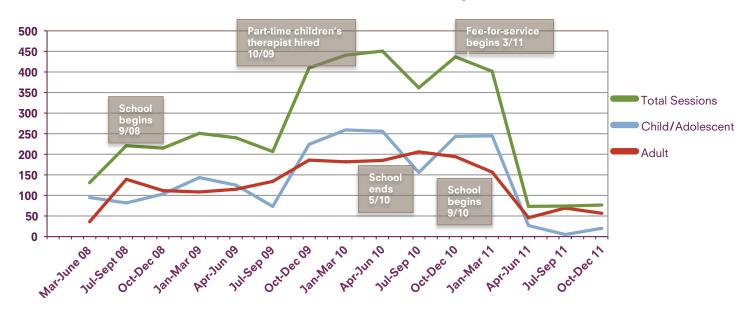
- Increase the number of adults age 18 and above who receive mental health services,
- Increase the number of children and youth under the age of 18 who receive mental health services.

The ICC final progress report indicated that a total of 282 unduplicated persons received services; 143 adults and 139 youth. Key informants shared that the number of people seeking services has decreased due to the attempt to implement a fee-based service model. As presented in their final progress report ". . . many here benefit from free services of many kinds because of their status as tribal members. Others here find it difficult to pay for services even though we have developed a generous sliding fee scale and a low base rate. There is a need for a paradigm shift toward the value of services before many community members are willing to pay for mental health services." Based on key informant responses, the ICC continues to work to find a solution to sustaining the program.

The graph on page 49 shows the number of sessions provided by quarter over the course of the project. This data is presented to make two points. The first is that the number of sessions provided increased over the course of the project until March of 2011. The addition of a part-time children's therapist in October of 2009 contributed to that along with the positive trend for sessions to adults. The second point is to display how dramatic the reduction in sessions was after a fee-for-service system was implemented in March of 2011 as an attempted sustainability effort.

Throughout most of the project, access to mental health care services improved in the community, and this increase can be attributable to the increased availability of locally based mental health services through the ICC. The numbers dropped in the most recent six months, demonstrating the difficulty in implementing a fee-based funding strategy.

ICC Mental Health Sessions by Quarter



As noted above, the goals of the ICC also included the eventual expansion of mental health services to early childhood populations, and the development of training and education services for professionals and community members. As of the most recent progress report submitted by the ICC (October 2011), the ICC continues to have an Early Childhood subcommittee consisting of 20 local professionals, focusing on strategies to make a positive impact on early childhood relationships and learning. The ICC has also formed a Training Committee that focuses on early childhood, cultural competence, and suicide prevention. Trainings for professionals have been held, such as an intensive training on Filial Therapy (an alternative treatment method for children that uses the parent as an ally in the therapeutic process, where the parent is the primary therapeutic agent). Related community training efforts also include the work of two ICC members as trainers for suicide awareness and prevention efforts (under a separate community grant).

IV. DID THE WORK OF LOCAL COLLABORATIVES CONTRIBUTE TO THESE IMPROVEMENTS IN THEIR LOCAL HEALTH SYSTEM?

The development of a good collaborative effort was credited, by all key informants, with contributing to the success that the ICC has achieved in making mental health services more accessible to the community. Ongoing assessment of the local collaborative process by the evaluation team via online administration of the Process Quality Rating Scale and the Working Together index of collaboration shows that first-year collaboration among stakeholders was rated to be above the threshold for characterization as "good" (i.e., having an open and credible process), although analysis of low-scoring individual items showed some skepticism about the level of mutual trust among collaborative participants and the extent to which they were willing to devote whatever effort and resources were necessary to achieve group goals and sustainability.

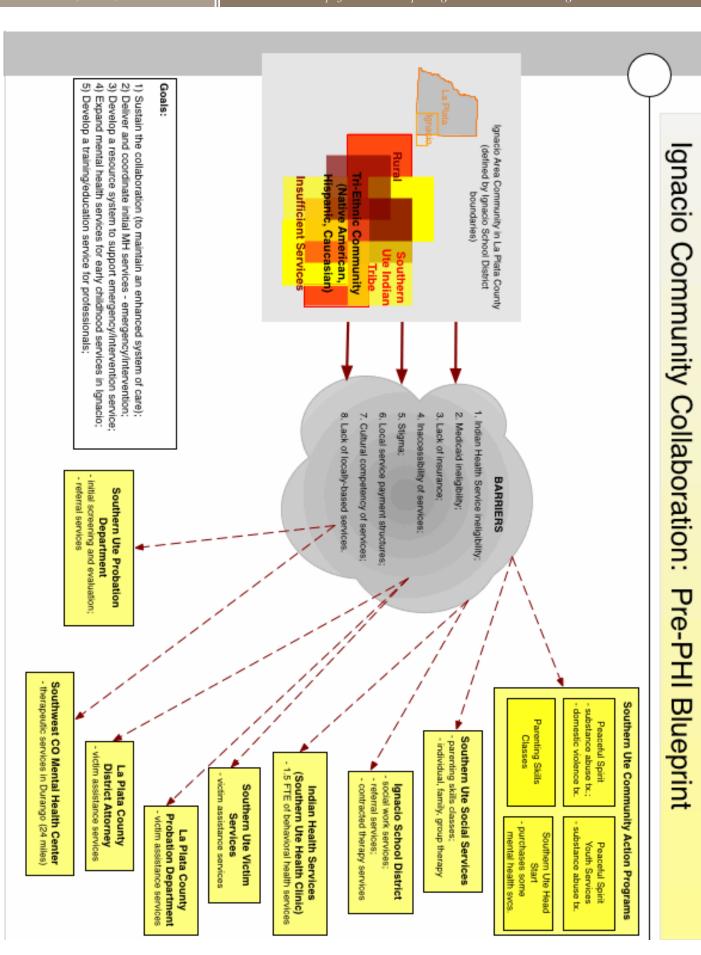
During the second year of the project, collaboration survey scores remained essentially the same, and individual item analysis revealed that the same skepticism about participants' willingness to devote effort and resources to the effort remained. By the third year of the project, collaboration survey scores remained within the range indicative of a good collaborative process, and even increased somewhat. The previous skepticism revealed by analysis of individual items was no longer evident. In fact, the highest-scoring items on the survey referred to the process being free of favoritism and decisions being based on fair criteria. Survey respondents also indicated greater awareness of and involvement in the project than they felt they had the previous year, suggesting that the project had gained more momentum as it matured. These results also coincide with the time that the ICC based its provision of mental health services in Ignacio.

Most recently, the overall collaboration survey scores for 2010 for the ICC increased, remaining in the range indicative of a good collaborative process. Overall, viewed in the perspective of consistent annual collaboration survey scores in the good range, the project overall has manifested a sound level of collaboration from the beginning that has been maintained over the life of the project.

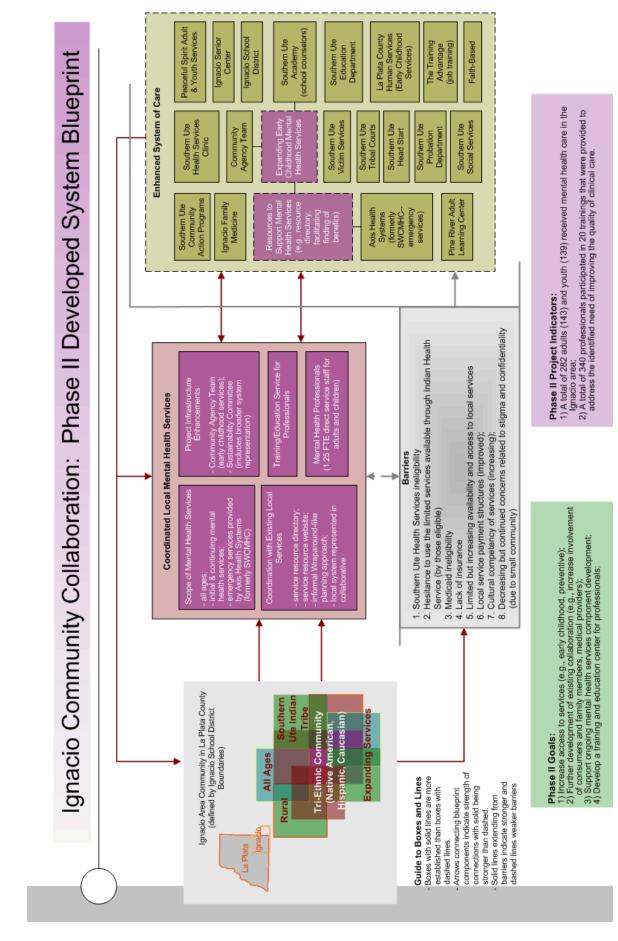
More informally, participants have credited the success of the project in increasing access to mental health care services to the collaborative effort undertaken by the participants. While this raises the question as to what extent the formation of a collaborative effort is necessary to establish a service delivery component, as opposed to an agency establishing a program to provide needed mental health services to the community, key informants are convinced that a collaborative effort was necessary for the success of this project, for a number of reasons:

- The collaborative effort allowed the group to more clearly sharpen its focus on the real needs of the community. Because of the tri-ethnic nature of the community, the unique needs of the population may not be as readily apparent or solutions to issues as accessible as initially thought by any one agency or leader. Also, because of the involvement of different agency representatives championing the effort, the spreading out of a sense of ownership and responsibility increases the chances of participation and buy-in.
- Related to this, the collaborative process allowed participants to develop a sense of ownership of the project, and others to see the effort as driven from within the community (rather than driven externally). Because of the participation of community leaders in the decision-making process of the collaborative, the decisions made were reported by respondents to "make sense" in the context of the needs of the community. Also, the community-driven nature of the effort reportedly has resulted in decreased perceptions of stigma associated with the use of mental health services, and therefore to increased use of services. This same sense of ownership of the project was expected to increase the chances of successful implementation of sustainability efforts. Efforts to effect sustainability have met with difficulties on three fronts: 1) Resources in the community have decreased, and agencies are not able to support ICC financially, even though they see the need and have a sense of ownership; 2) ICC implemented a sliding fee scale for services, and that has resulted in a marked decrease in people served, reportedly due to two primary factors (lack of resources on the part of potential users and participating agencies and the history of having received services at no cost from ICC and from the Tribal agencies); and 3) ICC attempts to qualify their providers for Medicaid and insurance reimbursement have taken much longer than anticipated, and this delay, combined with the unexpected negative impact of the fee structure and the impact of the economic downturn on people and agencies in the community, may result in the program being unable to sustain.
- The collaborative group also provides an opportunity for participants to become familiar with the nature of the services developed and to contribute to their use by providing a built-in referral base and network to disseminate information about the project. Also, because the effort is now also focusing on community education and training, the participants can collaborate on making use of the resources and expertise available within the group.

In terms of its structural elements, the local system of care has not changed substantially since the ICC facilitated the provision of additional locally based mental health services. However, the project Blueprints below show changes in processes and effort organization when compared to the time prior to the inception of the project. The pre-ICC project Blueprint diagram (See page 52 and in Appendix 7) shows a population in need of mental health services encountering various barriers to service access (depicted in the gray cloud in the middle). Although there were services available in the community, a number of barriers, including eligibility for services and geographical accessibility, rendered those services out of reach for many community residents. In addition, the services array was perceived as lacking coordination.



The Phase II Final Blueprint diagram (below and in Appendix 7) shows the presence of more coordinated local services through the ICC, including not only the availability of additional locally based direct services, but other coordination efforts, such as the formation of a Community Agency Team (focusing on the expansion and coordination of early childhood services), and greater inclusion of involved providers in service planning meetings for clients. Although perceived to be more coordinated as a result of the additional contact and collaboration that parts of the system experience through their participation in and professional education and training (report somewhere on these numbers, probably above, or repeat from above). The available service array is now the community continues to face some of the same barriers to service access as in the past, the services developed by the ICC have not only become a part of the local system of care, but have served to enhance and support other parts of that system through additional components such as community



V. WHAT FACTORS LEAD TO OR IMPEDE IMPROVEMENTS TO LOCAL HEALTH SYSTEMS?

Overall, the work of the local collaborative effort of the ICC is regarded by respondents as having led to increased access to mental health services for the community. The effort has dealt with a number of factors that evolved from the collaborative process, as well as factors that are inherent to or characteristic of the local system of care that have affected the development of improvements to the local system. Below, we outline some key factors that supported improvements to the local system, other factors that could impede progress, and some factors with mixed effects.

Key Factors That Support Improvements to the Local Health System

- Community Ownership and Empowerment. As noted above, the collaborative effort facilitated community buy-in and ownership of the work to implement locally based mental health services by sharpening its focus on the real needs of this unique tri-ethnic community, and drawing on the local knowledge and expertise of its participants to develop a solution. While the effort initially involved basing the services 24 miles away in Durango, CO, that situation contributed to the broader sense that Ignacio "gets the short end of the stick" with regard to resources and service availability and that service decisions are often made in Durango without this community in mind. While the resignation of the therapist who was based in Durango and supervised by SWCMHC after three months of service early in the implementation of the project was initially experienced as a setback, the subsequent decision to base and center services in Ignacio, under the supervision of SUCAP, contributed to a feeling in the community that the effort was now "theirs" and that the community had the power to set its own course.
- Support and Structure Provided by the Funder. Another factor that was noted by key informants as having contributed to the success of the project is the level of support and structure provided by The Trust for this effort. Aside from noting the amount of funding provided as a facilitating factor (especially in contrast to some past collaborative efforts having few or no financial resources), informants pointed to two other features that have helped. One was the planning phase that was built into the collaborative process to clarify goals and to develop an implementation plan. Not only was a planning phase helpful in their view, but the time-limited nature of the phase is said to have prodded the group to focus (and avoid entering a lengthy period of planning without action that could have led to reduced interest and participation). While the time-limited planning phase was noted, the opportunity to continue development efforts into Phase II of the initiative with essentially the same focus and project as in Phase I was also described as a major contributor to the current success of the project, as it allowed for a 5-year effort, rather than two separate 2.5-year efforts. In addition, the facilitation, coaching, and technical assistance provided by the coordinating agency were described as contributing to the success of the project. According to key informants and consistent with TriWest's experience in other projects, collaborative efforts in many small communities can tend to be more personality-driven, the involvement of the coordinating agency coaches is said to have helped to professionalize the effort by providing structure and leading an orderly, deliberate process.
- Collaboration Based on Relationships and Trust. Because of the rural setting in which the ICC operates, the joint work of community stakeholders has traditionally relied heavily on the quality of relationships established, and on a sense of mutual trust. As a result, a lack of trust or underdeveloped relationships can impede progress. However, the ICC has been mindful of the need to develop positive relationships among stakeholders and the community, and interviewees described the efforts of project leadership in cultivating relationships and participation from the early stages of the project. While respect may be earned by doing a good job, trust is important, and is developed over time through relationship building. Paralleling personal relationships in many cases, professional linkages have been enhanced, with closer work being done between the schools (in a position to identify family needs and provide referrals) and the ICC, as well as between SUCAP (and the various agencies under its umbrella) and the ICC. Service providers and caregivers are doing a better job every day in working together across agencies and departments. The ICC may be helping to overcome some of the competitive perspectives between agencies. There are consistently 12 to 15 people at the ICC meetings. While stakeholders attribute much of the project's success to the relationships built and continuing to be enhanced, there are some relationships that were mentioned by informants as needing strengthening, such as with the local public health department, which is not involved currently with the ICC and has no physical presence in Ignacio. Toward that end, the ICC sees opportunities for the provision of future services jointly with the public health department.

Local capacity to respond to health care reform. While much of the attention in the past two years has been on federal and state health reform efforts, it remains the case that all health reform must ultimately occur at the local level, in the ways that local care providers, local health facilities, and local residents provide, experience and pay for care received. Furthermore, state and federal plans continue to evolve, so communities cannot base their planning solely on these necessarily fluid potential resources. Given this, The Trust's support of regional collaborative planning entities such as ICC are essential so that local communities can (1) weave state and national health reform efforts with local needs and resources and (2) continue local planning to build on emerging opportunities and respond to continued policy and funding changes.

Key Factors That Impede Improvements to the Local Health System

- Staff Turnover and Lulls in Energy of the Effort. One periodic (and continued potential) threat to progress is staff turnover, both within the ICC staff (such as the past change in project director), and more broadly (such as decreased participation on the part of some agency representatives). Interviewees indicated that staff changes tended to take momentum away from implementation activities, which in turn led to a general lull in the energy of the effort. A related threat was the expectation of the paid project staff as being the main drivers of the effort, and as such, being primarily responsible for carrying out the activities of the project (as opposed to seeing the responsibility for carrying out project tasks as being more evenly distributed). Key informants report that the workload distribution for project tasks can be uneven, with some stakeholders being less willing to take on activities, affecting project progress.
- Lack of a History of Successful Community-Wide Collaboration. The current effort was described by stakeholders as being unique in that it is a community-driven and community-owned collaborative effort. In contrast, they described past efforts as having been more agency-focused and agency-organized. Even if these efforts brought different stakeholders together, the benefits were seen as being more focused on or favoring one agency more than others. As a result, organizers could be perceived as looking after their own defined self-interests, rather than collective interests.
- Ongoing Need for Technical Expertise. While the availability of technical assistance provided by the funder has been cited as a facilitator to progress, respondents also noted a need for ongoing technical expertise to help the project's sustainability. Key informants referred to technical expertise needs, particularly in sustainability strategies (such as the expansion of funding streams and leveraging of local funding, particularly in an environment where much of the funding is siloed), expertise in quality assurance/quality improvement for services developed and provided by the ICC (a reason that SWCMHC was overseeing the mental health services originally), and expertise in compliance with various regulations and requirements related to services developed in the future by the ICC.
- Organizational Policies and Practices. There are some organizational factors that either contributed to the original problem of lack of access to mental health services in the community, or that created barriers once the project was ongoing. The service provision practices of SWCMHC basing services far from Ignacio provide an example. While Ignacio is within the mental health center's catchment area, there were no mental health center services available locally, requiring residents to travel to Durango to access intake, emergency, and ongoing services. Even after the start of the project, because the mental health services were supervised by SWCMHC, they were still based largely in Durango. While fiscal and demand considerations may necessitate such practices, they nevertheless contributed to low service use and the related perception among some that resources and decision-making powers were Durango-based. Not only were geographical distances difficult to overcome, but psychological distances also played a factor for Ignacio residents, who did not consider Durango as being within reach for services.
- Rural Setting of the Service System. The challenges involved in providing services and effecting system change in a rural setting were often mentioned by key informants, and are also discussed in this report. The setting also seemed to affect indicator results, which were seen in a previous section to include relatively low numbers of persons seen for services. Lulls in demand resulting from factors such as whether the school year is in session may also be more strongly felt in rural settings. Overall, this can also result in lowered efficiency in regard to the use funds, as services will be more costly to deliver, and affect return on investments made by funders in the local system.

■ Financial Factors. The decreasing availability of state and local funding to support project activities has been a barrier to sustainability by limiting the ability of ICC to secure financial support for the program. The following three areas are examples of financial barriers: 1) Agency resources to pay for health care in the community have decreased, and, as a result, agencies are not able to support ICC financially, even though they see the need and report a sense of ownership; 2) ICC implemented a sliding fee scale for services, and that has resulted in a marked decrease in people served, as explained above; 3) ICC attempts to qualify their providers for Medicaid and insurance reimbursement have taken much longer than anticipated, threatening ICC sustainability.

Mixed Factors

- Coexistence with the Southern Ute Indian Tribe. As noted above, the Ignacio community is described as "tri-ethnic," with roughly equal proportions of Hispanic, American Indian, and Caucasian residents. Yet, the presence of the Tribe is a major factor that could greatly affect the prospects for the success of a collaborative effort due to the community's perceptions of the Tribe. Because of its ownership of a casino and other holdings, the Tribe is perceived by some in the community as having sufficient financial resources to be able to fund additional services, but it is also perceived as being hesitant to do so, or to be hesitant to be involved in efforts for non-Tribal members, which, according to key informants, can lead to some resentment on the part of the larger community. Key informants reported that at one time Tribal department representatives to the collaborative had their participation questioned by the Tribal Council, which led to their withdrawal from the effort, and participation to lag. Still, it must be kept in mind that the Tribe is a sovereign nation and that establishing linkages and relationships with it is more complex than establishing relationships with organizations and agencies in the community. It may require additional steps to be taken, such as seeking additional endorsements from the Tribal Council. While dealing with the Tribe is perceived to be complex and at times difficult, there is also a perception that there are limits to what can be accomplished without buy-in from the Tribe. Still, Tribal Departments continue to be involved in the ICC (e.g., Tribal courts, Tribal social services), and their involvement is seen as supportive of the effort. A factor that tended to limit Tribal member participation in services was the implementation of a sliding fee scale. Tribal members do not have to pay for most services from the Tribe and that change resulted in decreased use of ICC services.
- Support of Key Local Institutions. While the effort of the ICC has been aided by the involvement of both Tribal and non-Tribal collaborators, it must be kept in mind that there are other Tribal and city/county authorities and structures coexisting in the community. While on the one hand this may present additional opportunities to establish linkages, there is also added complexity, as incompatible or competing interests between these additional entities could put strain on existing relationships or influence the establishment of new ones.

Overall Analysis

Stakeholders are also cognizant that current national health care policies can potentially affect access to care at the local level, and perhaps could have a greater impact than any locally specific policies that they might be able to identify. On the one hand, the planning process and level of collaborative success achieved to date could serve as a basis and catalyst for successful navigation of the opportunities and challenges of health care reform. On the other, although they are thinking about collaboration with the Regional Collaborative Care Organization (RCCO), their perceived separation from broader decisionmaking (such as at the regional level) could limit such opportunities. The local planning process is at a critical crossroads. Primary among these is the effort to sustain the program and the fact that multiple approaches are either not being successful or are occurring too slowly. Also to be considered is the planned expansion of Medicaid access in 2012 to adults without dependent children up to 100% of the federal poverty level under the Colorado Health Care Affordability Act of 2009 (which is being implemented in a narrower form given state budget cuts). Although key informants felt removed from broader regional health care reform efforts, it may still help the community to attempt to position themselves as a partner within the RCCO as it relates to contracts awarded in December 2010 by the Department of Health Care Policy and Financing (HCPF) as a means for promoting the development of person-centered health care homes in primary care settings and improved coordination of care among providers over time. The ability of the ICC and its community partners to access additional financial resources to support health care home activities to integrate primary and mental health care could

possibly be improved by collaboration within the broader RCCO, in this case Rocky Mountain Health Plans, for their region. In addition, HCPF has determined a Statewide Data and Analytics Contractor (SDAC, Treo Solutions) in 2011 that will be able to provide enhanced information supports to coordinate care across clinical settings. The ICC and broader health care community in the Ignacio area might be in position to explore their involvement within the emerging RCCO because of their collaboration to date. This collaboration could help support the develop of an ongoing collaborative planning process necessary to help local communities (1) plan for state and national health reform efforts based on local needs and resources and (2) facilitate ongoing local planning to build on emerging opportunities and respond to continued policy and funding changes

VI. WHAT RECOMMENDATIONS CAN BE MADE TO THE TRUST AND TECHNICAL ASSISTANCE PROVIDERS ABOUT HOW TO FUND AND MANAGE SYSTEMS-CHANGE STRATEGIES?

Although the following recommendations were developed with the local circumstances of the ICC and the experiences and perspectives of the local stakeholders in mind, they are broad enough to apply to other similar system change efforts.

Ensure that the collaborative effort is community-driven and local. The current project provides some lessons related to project implementation in a rural setting, where there previously existed a sense that service decisions were imposed from the outside and that "local" services were still outside the reach of the community. This system change effort gained momentum when the collaborative perceived more ownership over it, and when services became more locally based. Especially in rural settings, perceived at times by the community as being more susceptible to decisions being made externally, the funder can aid in the process by helping to clarify which local stakeholders are needed at the table to enhance the group's sense of ownership of a project and local control. Local key stakeholders needed should be identified during an initial readiness assessment, and efforts made to ensure that they are a part of the collaborative effort be considered as part of the funding decision-making process.

Be mindful of the importance of a Tribal component. For collaborative efforts based in communities where there is an American Indian Tribe or Nation (even if not involved with the collaborative effort), the importance of the Tribe in the community must be kept in mind and its sovereignty respected. In addition to being mindful of different cultural needs, stakeholders should keep in mind that establishing linkages and relationships with a Tribe is more complex than establishing relationships with organizations and agencies in the community given the sovereign status of the Tribe. Additional steps such as seeking formal endorsements from the Tribal Council may be necessary or allying with a local person or group who has established trust with the Tribe and can assist the effort as a representative or ambassador may be helpful. Depending on the local circumstances and the role of the Tribe in the community, the funder may also want to seek consultation on how best to address involving the Tribe to ensure the success of the collaborative effort, keeping in mind that there may be tribal and other authorities and structures coexisting in the same community.

Structure initiatives to include ongoing involvement and decision-making by The Trust. In a previous case study, TriWest noted that while the selection of grantees and initial funding decision are critical, the funder should avail itself of opportunities at various points in the implementation of projects to influence system-level change that could be as important as the initial decision to fund a project. We saw the role of the funder as requiring ongoing involvement in decision-making through which to adjust and respond to evolving system structure and opportunities over time. The current case study provides some additional examples of funder decisions and involvement by The Trust (though mostly indirect) that have contributed to project success and stakeholder satisfaction. In a rural setting such as this, where the stakeholders may have limited experience undertaking collaborative efforts that are well-funded or targeted at system change (as opposed to discrete service development), the provision of technical expertise and structure was welcomed by the collaborative. A structured, time-limited planning period facilitated by funderprovided coaches was attributed by key informants as resulting in a clearer definition of the problem to be addressed and a concrete implementation plan. Along the same lines, the opportunity to expand the time horizon to complete implementation (essentially from a 2.5-year phase to a 5-year phase) was seen as a major contributor to the success that the project has experienced. It could be that the lack of community experience with similar efforts necessitated a longer implementation window, and it is recommended that a similar model be used in the future. This ongoing involvement in decision-making and flexibility

regarding the project's second phase was essential. A theme that came up in the recent key informant interviews was the need to have begun sustainability efforts sooner. They have experienced barriers to those efforts along various fronts, most of which have to do with the limited available resources or the length of time it takes to qualify for reimbursement. Key informants recommended that The Trust require sustainability efforts to be implemented sooner in the project so as to have a better chance of success. In hindsight, they felt that they might have had more options to deal with the economic downturn had they begun sooner.

Plan to provide technical assistance on an ongoing basis throughout the life of the project. The ICC has benefited from the technical expertise provided by the funder via the coordinating agency coaches, and the project continues to report an ongoing need for technical assistance regarding both knowledge and skills necessary at this time for ongoing implementation, as well as future sustainability of the project. While some technical assistance needs, such as with sustainability strategies, should perhaps have been anticipated and built into the project earlier on, there is also a need to continuously identify the changing needs of projects for technical expertise and to develop technical assistance capacity to address these changing needs. Continued involvement of the funder, either direct or indirect (for example, through the coordinating agency), would facilitate the early identification of ongoing technical assistance needs.

The Colorado Trust	
PARTNERSHIPS FOR HEALTH INITIATIVE: NORTHWEST COLORADO COMMUNITY HEALTH PARTNERSHIP CASE STUDY	
TriWest Group	

PARTNERSHIPS FOR HEALTH INITIATIVE NORTHWEST COLORADO COMMUNITY HEALTH PARTNERSHIP (NCCHP) PHASE II CASE STUDY

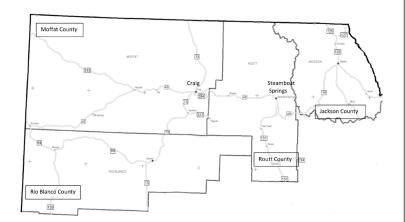
OVERVIEW OF THE NORTHWEST COLORADO COMMUNITY HEALTH PARTNERSHIP (NCCHP)

In 2005, a group of community leaders in the Northwest Colorado four-county area of Jackson, Moffat, Rio Blanco and Routt counties, led by the Northwest Colorado Visiting Nurse Association, secured funding from The Colorado Trust through its Partnerships for Health Initiative (PHI) to improve access to health care services in that area. During the six-month planning period that began in December of 2005, the group conducted ongoing meetings of 25 to 30 participants from 15 organizations. That planning process marked the beginning of Phase I of the PHI, and through it they completed an environmental scan of the positive and negative political, economic, technological and social factors related to access in their area. They developed a list of values and principles, agreed on a mission, and formed a steering committee to oversee the project they named the Northwest Colorado Community Health Project (NCCHP). Their mission statement is as follows:

"The mission of the Northwest Colorado Community Health Partnership is to address the health care needs of the underinsured and uninsured of the four county region of Northwest Colorado."

The NCCHP is currently led by seven primary partners, all representatives of local and regional health and human service agencies who comprise the Steering Committee. These partners are:

- Northwest Colorado Visiting Nurse Association
- Colorado West Regional Mental Health
- The Memorial Hospital
- Independent Life Center
- Yampa Valley Medical Center
- Northwest Colorado Dental Coalition
- Routt County Department of Social Services



The goals they developed during that initial planning period have carried throughout the course of the project and focus on improving access to health care for the underinsured and uninsured in Northwest Colorado.

- 1. Develop a regional network of care,
- 2. Provide health-related consumer information,
- 3. Expand the use of technology to support accessible health care services and communication, and
- 4. Sustain the regional network of care.

In their Phase I Final Report, the partnership reported many positive accomplishments, including:

- Obtaining designations for Routt, Moffat and Jackson counties as Medically Underserved Populations (MUP),
- Obtaining HPSA (Health Professional Shortage Area) designations for Moffat County for medical and dental providers,
- Establishing the Northwest Colorado Community Health Center (NCCHC) in Moffat County, a Federally Qualified Health Center (FQHC),
- Establishing a common eligibility process among safety net providers in Moffat County,
- Developing a Health and Human Services Resources Guide for Moffat and Routt Counties,
- Developing an Integrated Mental Health project at NCCHC (with Colorado West Regional Mental Health Center),
- Completing a regional Health Information Technology Assessment with John Snow, Inc.,
- Establishing and completing youth wellness initiatives and activities in Routt, Moffat and Jackson counties, including completion of the Healthy Kids Colorado Survey in all middle and high schools, and

Working with consultants from Ray and Associates to develop a business plan that includes recommendations for the further development of NCCHP as a regional system of care.

II. ASSESSING HEALTH CARE ACCESS AND SYSTEM CHANGE AND THE CASE STUDY APPROACH

Through PHI, The Colorado Trust (The Trust) is seeking to promote improved access to health care in Colorado by funding projects such as the Northwest Colorado Community Health Partnership. The Trust hired TriWest Group to assist them in evaluating the success of the PHI projects and to further understand system change efforts. In Phase II of the PHI, TriWest Group has worked with The Trust and four projects to answer four central evaluation questions:

- Does the work of local collaborative contribute to improvements in their local health system?
- What factors lead to or impede improvements to local health systems?
- Do the grantees' access-to-health outcomes improve as a result of these system changes?
- What recommendations can be made to The Trust and TA providers about how to fund and manage systems-change strategies?

A number of tools have been used to help answer these central questions. The four tools listed here have been employed throughout both Phase I and Phase II. They include the following.

- Collaboration among stakeholders has been assessed annually over the course of the project. To assess collaboration, project stakeholders completed an annual online survey consisting primarily of Drs. Carl Larson and Darrin Hicks' Process Quality Rating Scale and their Working Together index of collaboration, aimed at assessing the quality of the collaborative process at the grantee level.
- Project Blueprints visually depict the system's structures and relationships. Comparing Blueprints over time, as they are updated, illustrates changes in the structure of the system of care.
- Regular reports of the status of each project are submitted to The Trust by each project. These summarize progress and issues facing the project.
- Key informant surveys of project participants have provided data for a case study. Initial and follow-up key informant surveys sought to solicit data about the nature of system change efforts and specifically to better understand the relationship dynamics and operational factors involved in facilitating system change. The data from the case study approach provides more content and context to the other components of the evaluation to aid in determining how the work of local collaboratives may contribute to improvements in their local health systems, what factors lead to or impede improvements to local health systems, and whether grantees' access to health improves as a result of changes in the local systems. Initially, key informants were interviewed using a semi-structured interview format to assess respondents' perceptions in the areas of values and norms within the system, system resources, system regulations, system power and decision-making processes and operations, and interdependencies that exist within the system. A second key informant survey was conducted to update the case studies through the end of Phase II and to include more detail about the influence of health care reform.

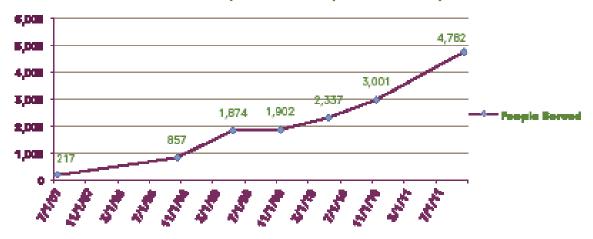
Combined with material gathered via collaboration surveys, project Blueprints, and grantee progress reports, the evaluation team made use of key informant material gathered to answer the evaluation questions listed below in Sections III through V, and to offer recommendations in Section VI. In particular, responses from key informants have been useful in telling the story of their experience.

III. DID THE GRANTEES' ACCESS-TO-HEALTH OUTCOMES IMPROVE AS A RESULT OF THESE SYSTEM CHANGES?

Access-to-health has clearly improved in a number of ways. The NCCHP selected their access to health focus area from the Healthy People 2010 and Healthy Colorado 2010¹⁹ indicators of access to health care. They chose as their objective in this area to increase the proportion of persons who have a specific source of ongoing care. While this indicator does not align exactly with the federal Healthy People 2010 indicators, it is roughly consistent with Healthy People 2010 Indicator 1-5. The indicator for that objective was initially operationalized as a reduction in the "percent of people who report going without needed care." That data was collected for a time but was changed, with approval from The Trust, to the unduplicated number of patients seen at Northwest Colorado Community Health Center (NCCHC).

NCCHC was established through project efforts and became the means by which people were able to have a specific source of ongoing care. By July 1, 2007 the NCCHC) had provided health services to 217 individual clients. That number has increased consistently to the point where over 4,700 unduplicated clients were served as of October 12, 2011, as shown in the figure below. The subgroup of people who received behavioral health care increased over that period from 60 in November 1 of 2008 to over 1,300 by October 12 of 2011.

Cumulative Unduplicated People Served by NCCHC



Access-to-health outcomes also have improved indirectly. Implementing the health center and serving new clients rippled throughout the community and brought about further positive change. In this case, as reported by key informants, serving people in the health center has resulted in a decreased use of emergency care for health care access and improved resource utilization through the eligibility process, and ultimately increased support from the Yampa Valley Medical Center through not only participation in the collaborative but also by financial support for transportation to the health clinic for people who have no transportation. Another example of improved resource utilization resulted from the development and implementation of a shared sliding fee eligibility process. That process has meant that each agency no longer has to assess eligibility when a person presents for services. Once eligibility is established the person simply presents an eligibility card.

Beyond access to care, the project also improved the integration and coordination of access and provision of health care across providers through:

- At the point of initial access, a common eligibility screening process developed by NCCHC is utilized at NCCHC and three other community health care agencies: the Northwest Colorado Dental Coalition, the Colorado West Regional Mental Health and the Memorial Hospital. This common eligibility process facilitates access to care by utilizing a "no-wrong door" approach to health care access. Uninsured clients undergo eligibility screening at NCCHC, and their NCCHC sliding fee scale card is honored at participating agencies.
- To ensure ongoing enhanced integration of care, a Community Medical Case Manager coordinates access to care and assists patients in obtaining specialty care and ancillary services.
- Coordinated delivery of care is also enhanced by the integration of mental health and primary care services. A behavioral health therapist employed by Colorado West Regional Mental Health provides services at NCCHC. This therapist provides a key link between primary care and mental health services, promotes access to behavioral health services by providing onsite care and coordinates the delivery of care among providers. With the addition of a behavioral health services at the NCCHC, 1,322 people have received behavioral health care as of October 12, 2011, increased from 60 as of November 1, 2008.

Access Update (based on key informant interviews in August and September of 2011 and the final project report in October). Key informants were asked about how access to health has improved as a result of system change efforts. Their responses and information from the final report were reviewed and summarized for this update. It is clear that NCCHP efforts to improve access to care are active and positioned to continue well beyond the end of PHI funding given their planned reapplication for

FQHC funding for a clinic in Steamboat (the first application was not funded) and plans to resubmit that application.

NCCHP has developed substantial local community support. The Yampa Valley Medical Center in Steamboat, as part of NCCHP Medical Transportation Committee plan, began providing funding in early 2011 to provide transportation services to the clinic in Craig once a week.²⁰ The Community Health Center schedules appointments for the weekly van service and provides transportation to and from the clinic for an average of six people per week.

Key informants mentioned and their final project progress report described Eligibility Committee efforts to expand enrollment in Medicaid and CHP Plus in response to the expanding Medicaid population locally. Those efforts have resulted in a Medicaid technician being placed with the presumptive eligibility technician at the Northwest Colorado Visiting Nurse Association. This effort is funded by the Colorado Health Foundation and has "helped to expand Routt County's capacity to process Medicaid applications, has greatly decreased the amount of time it takes for presumptive eligibility applicants to receive Medicaid and has had a positive effect on communication between the two programs. Since its implementation, enrollment in Medicaid and CHP+ has increased by 30% based on key informant feedback." This is an area of need, as demonstrated by the percent of Medicaid eligible people who are as of yet unenrolled.

Other updates to committee efforts to increase access to health care are reported in the project Goals and Objectives updates in the final report. Those include the Behavioral Health Committee developing a proposal to the Colorado Health Foundation to train medical providers in (1) depression and substance abuse screening and (2) providing case management to identified patients to facilitate access to needed care.

There is also considerable work to integrate NCCHP activities with health care reform, including the Health Care Policy and Financing Accountable Care Collaborative²¹ for Medicaid and health information exchange (HIE) efforts. The Accountable Care Collaborative (ACC) is a new Medicaid program to improve clients' health and reduce costs. Medicaid clients in the ACC will receive the regular Medicaid benefit package, and will also belong to a "Regional Care Collaborative Organization" (RCCO). Collaborative efforts in the area of health care reform have been extensive. They include an outreach campaign called "Do you have a Medical Home?" to encourage people without insurance to seek assistance in accessing Medicaid or CHP+ coverage. As part of that media effort, the collaborative distributed 750 Healthwise Handbooks to schools, physician offices and at public health events. The Health Information Exchange subcommittee is working with Quality Health Networks (QHN) and the Colorado Health Foundation to help local physicians to form an Independent Physician Association (IPA) to facilitate HIE adoption and to help physicians become more involved in health improvement initiatives. A representative of the IPA now sits on the NCCHP Steering Committee. A HIE plan has been completed, and the Yampa Valley Medical Center has signed a contract with QHN with HIE implementation to begin in January of 2012.

IV. DID THE WORK OF THE NCCHP COLLABORATIVE CONTRIBUTE TO THESE IMPROVEMENTS IN THEIR LOCAL HEALTH SYSTEM?

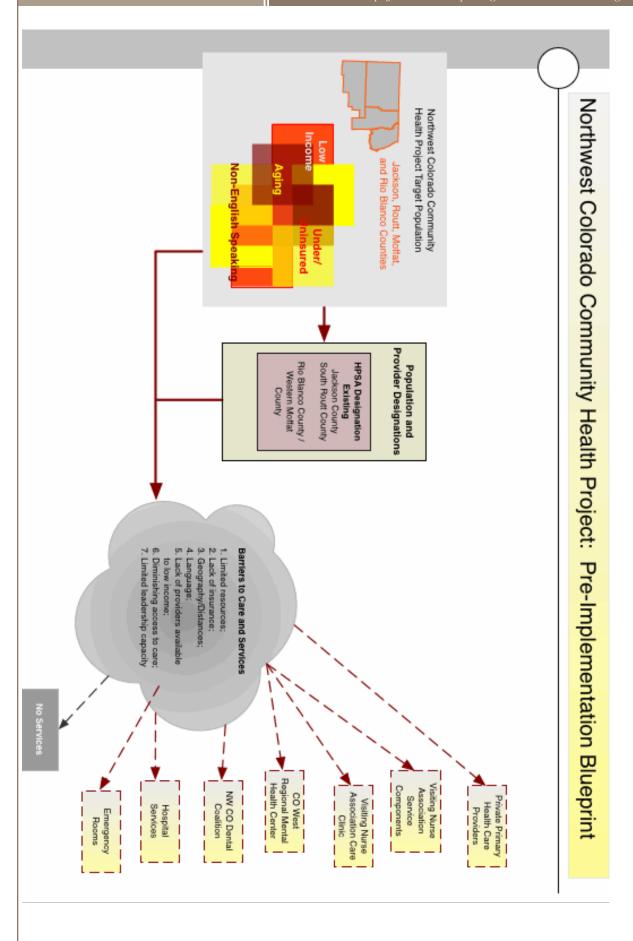
It is clear that the NCCHP has worked collaboratively to improve health care access and the local health care system. That is the case as documented by results of stakeholder collaboration surveys and structurally by changes over time in the NCCHP system documented by the Blueprints. Additionally, interviews of key stakeholders found that working collaboratively has been one of the most important factors in the success of the system improvement effort. As stated by one stakeholder:

"Outside the collaborative there is not really a system of care. The collaborative is trying to pull together the local entities that are primarily soloed and work on their own or on project to project efforts."

The Process Quality Rating Scale and their Working Together index of collaboration from the online survey of collaboration among stakeholders showed consistent "good" collaboration (i.e., having an open and credible process) from the first year (2006), through 2009 and through the final survey in 2010.

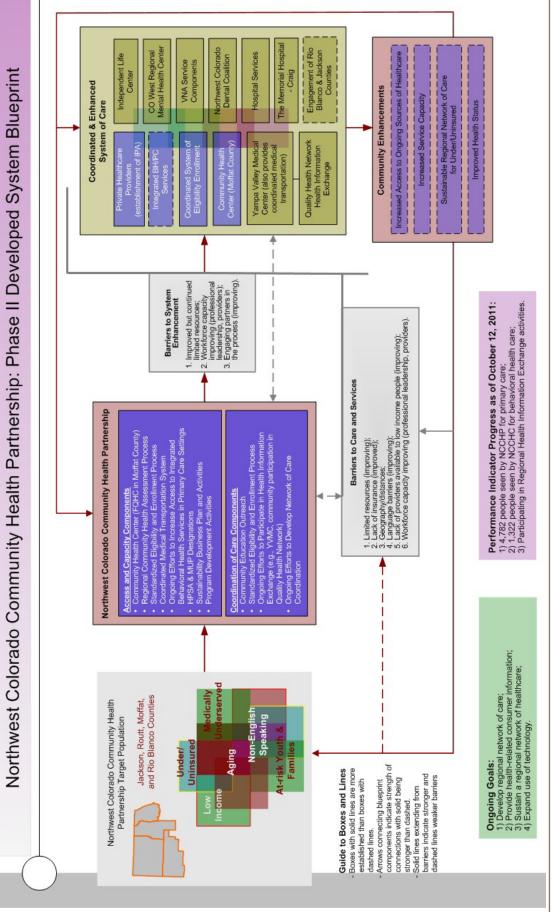
over-reliance on the hospital's emergency department. implementation (below and in Appendix 7), reveals that the status of the system was through the project Blueprints. The initial system Blueprint, prior to project correlated with specific changes over time in the system structure as documented having to seek services through a fragmented array of unconnected services, including perceived to result in too many under- and uninsured people going without services or The collaborative efforts of the NCCHP to improve access to health care are

The initial Blueprint shows a population in need encountering multiple and various barriers to service access and an array of providers and agencies that was not systematically collaborating.



engagement in the process, but the system is functioning differently and enhanced community-level outcomes are achieved (purple box to lower right). The system logic reflects the documented level of good collaboration and makes sense of the outcomes achieved. collaborative project (purple box in the center of the blueprint) mirrors the increased organization described by system informants as less impactful, mitigated by improved health care access and enrollment, integrated mental health / primary care and the development of an IPA). Resources health status and an increasingly sustainable regional system of care. The organization of the are still limited, the workforce still encounters limitations, and partners are in various levels of blue boxes highlighted (Community Health Center in Moffat County, coordinated eligibility of the enhanced system of care (green box to the right), with particular success in the four Although still present at the end of Phase II (blueprint below), the barriers to care were

developed and coordinated system of care. shows an established Northwest Colorado facilitating an enhanced and much more The Blueprint at the end of Phase II Community Health Project that is



Project blueprints primarily present structural views of the system. As a result, two key informant surveys were conducted about a year apart to collect data to inform our understanding of the relationships between system structures, and between participants and how those relationships facilitate system change efforts. From that data, specific examples emerged about how collaboration contributed to improvements in the local system:

- Respondents reported that project efforts, and particularly the planning and steering committee meetings, resulted in increased collaboration by bringing participants together to share and discuss information about their perspectives on service needs, including system change needs. Those discussions also involved sharing information about each agency, the people they served and their ability to provide services. That information helped develop a shared understanding of realistic expectations. For example, participants realized that they needed to focus on some objectives before others, such as opening the CHC in Craig first and then focusing on getting funding for a second health clinic in Steamboat and extending the clinic services to the more rural parts of the four county area.
- Collaboration enabled the expression, development and reinforcement of shared values that served as the basis for system change efforts. Those values ranged from simply valuing the health care system to as complex as seeing the importance of exchanging agency specific data and needs assessment information obtained through the project to determine the degree and extent of the needs in the community as a catalyst to moving towards more effectively meeting those needs. Participants also gain experience with and an understanding of what may happen (such as competition) when values aren't shared or when values are not clarified. They have learned to be patient and to continue to encourage involvement. That patience has paid off for them by accomplishing project objectives that may have seemed impossible earlier on.
- One final example of how collaboration contributed to an improved health system was the understanding developed by NCCHP participants and other stakeholders that the nature of successful system change required an iterative process of identifying and prioritizing goals and objectives through planning over time and subsequently working to achieve those goals. The key informant expressed that in this way: "As a collaborative, we have done surveys and collected data and used organizational knowledge about who is most in need and what areas need change the most." From related key informant responses about how needs are prioritized, it is apparent that those shared efforts and experiences appears have brought about a shared understanding of the long term nature of the effort and the prioritization required to bring about system change.

V. WHAT FACTORS LEAD TO OR IMPEDE IMPROVEMENTS TO LOCAL HEALTH SYSTEMS?

The initial and follow-up key informant surveys were conducted with the purpose of identifying more specific factors that either supported or impeded the project progress, that is supported or impeded changes sought and brought about by grant efforts to improve the local health system.

Key Factors That Supported Improvements to the Local Health System

- Community Leader Participation and Skills. Particularly key was the importance of the skills, knowledge and influence of the participants involved in the NCCHP effort. Respondents perceived the participating community leaders to be critical to system change because those leaders brought agency support, and through their interconnections, were able to advocate for the project in other community efforts.
- Project Coordinator Effectiveness. In addition, the project coordinator's skill at bringing participants together and coordinating and managing project activities enabled the project's work to get done while maximizing the effects of the community leaders' participation.
- Technical Assistance (TA) Related to Information Technology. Technical assistance provided by the project facilitators was seen as critical to the system change effort. Key informant respondents cited examples of needed technical knowledge and skills that would make continued change easier to achieve. In particular, information technology expertise in the health information exchange area was needed by the project and less available in their area. They employed a consultant to provide that expertise and are applying for grant funding to support desired changes in that area.
- Information-Based Decision Making. In terms of identifying project priorities and planning, the importance of information-based decision-making and planning was often mentioned by key informants. Respondents felt that it was important to base decisions on needs assessments and other community and agency data, and expressed that bringing together assessment pieces, health

- disparities and organizational knowledge, input from focus groups and key informant interviews and discussions with consumers about their needs ensures a broader understanding of needs and facilitates discussion of how to better meet those needs. In this manner they were better positioned to set priorities based on documented needs.
- Specific Coordination and Integration Supports. Coordination and integration of services were mentioned by key informants as being very important and greatly facilitated by the collaborative process. Collaboration is seen as increasing the likelihood that the project will be successful in coordinating and/or integrating services, as service agencies provide services to many of the same people. Through the NCCHC, primary care, mental health and dental care services can be more
 - integrated and the case manager can assist individual clients and agencies to better coordinate needed services. A central example of this was the development of a shared eligibility process and card. That made it much easier for everyone to complete the eligibility process and engage in service provision, both as providers and consumers of services. Respondents pointed to this shared eligibility process as an example of a means to improve health care access without adding providers in an area where health care providers are scarce.

Once eligibility is determined, the person has a card that eliminates the necessity of applying for eligibility with each participating agency. This improves service acess by making the process more efficient, decreasing costs and burden.

Explicit Planning Regarding Funding and Sustainability. As the project evolved and experienced success, decisions about priorities and additional funding efforts began to include discussion about funding and sustainability. The funds from the Colorado Trust have served as a catalyst to get the project going and to support ongoing change efforts. Technical assistance has also been provided throughout the course of the project. Together, funding and technical assistance allowed agencies to come together for the purpose of improving access to care, and ongoing Colorado Trust funding and technical assistance have enabled the project to evolve and support changing priorities. The importance of experiencing success in project activities focuses and reinforces efforts to apply for additional funding when new priorities are identified. This is especially relevant with the advent of health care reform as the partners are able to collaborate and coordinate activities that keep them involved and integrated with health care reform changes. An example of this is their work with QHN and the Colorado Health Foundation to plan for and move forward with the Yampa Valley Medical Center participation with QHC in Health Information Exchange. While much of the attention in the past two years has been on federal and state health reform efforts, it remains the case that all health reform must ultimately occur at the local level, in the ways that local care providers, local health facilities, and local residents provide, experience and pay for care received. And, since state and federal plans continue to evolve, local communities cannot base their planning solely on current plans for these resources. Given this, The Trust's support of regional collaborative planning entities such NCCHP is essential so that local communities can (1) approach state and national health reform efforts in light of local needs and resources and (2) carry out ongoing local planning to build on emerging opportunities and respond to continued policy and funding changes

Key Factors That Impeded Improvements to the Local Health System (the follow-up key informant survey resulted in updates on the status of factors that were acting as impediments to improvements as discussed below).

- Transportation and Resource Limitations. The project continues to experience challenges related to the nature of the mostly rural four-county area, particularly with transportation and resources for the two most rural counties involved in the project. For example, the need to establish the health center in a location central to more people means that people from farther away in the more rural areas have to travel farther to get to the center. The NCCHP has found that providing transportation to assist people to travel to the center increased the likelihood that people will receive needed services. At the time of the initial key informant survey, implementing transportation services had been identified as a need. Since then the Yampa Valley Medical Center has provided funding for a van service to transport people to the community health clinic once a week.
- **Provider Participation.** Obtaining desired participation from one of the hospitals and from private providers has been a challenge that the collaborative has continued to work to address. Progress has occurred. For example, concerns about potential competition between one hospital and the new FQHC initially were expressed, but ultimately resolved by continually sharing information and

reaching out to discuss the system change efforts. Levels of participation by partners continue to vary, though, apparently due to the natural variability in resource demands within individual agencies and the priorities of the project at any given point in time. Regarding the participation of independent physicians, it was noted above that a representative of the new IPA now sits on the NCCHP Steering Committee.

■ Reduced Resources Due to the Economy and State Funding. The decreasing availability of state and local funding to support project activities has been both a challenge and an impetus to participate in the system change effort in order to utilize available resources most effectively. That status was still the case in the follow-up key informant interviews. However, progress is being made. Participants felt that a likely key to their ongoing success was the partnership itself, both their ongoing collaboration and continued efforts to be inclusive and involved. Respondents reported that their efforts, successes and recognition have made it easier to continue to move forward, even when funding is scarce. A prime example of this was their receipt of the first ever Colorado Collaboration Award in 2011 for excellence and community impact from the Colorado Nonprofit Association.²² This recognition includes a cash award of a \$50,000, which NCCHP will use to continue their efforts (see press release in Appendix B).

Overall Analysis

The challenges that remain for the NCCHP are endemic to the situation of providing health care in a largely rural area of the state during a time in which a difficult economy makes funding more challenging. In the key informant interviews it was clear that maintaining resources to provide care to clients was high on the list of importance for all agencies. That reality meant that project participants recognized the need to and utility of working together to improve services. Together they were able to improve access to health care through the efforts documented in this report that could not have been accomplished as individual agencies working alone.

However, the gains achieved in terms of expanded access to primary care, expanded access to integrated behavioral health supports within a primary care setting (such as providing not only health care through the clinic but behavioral health care and dental care), improved communication at the policy level (for example, developing the shared eligibility process), improved coordination at the care delivery level (for example, integrated behavioral and primary health), and information technology improvements (such as the establishment of the subcommittee on health exchange to enable them to move forward with efforts to share information electronically) all strengthen the local care delivery system and enhance its capacity to respond to the opportunities and challenges of health care reform. Looking forward, these efforts may help the community be a better partner within the Regional Collaborative Care Organization (RCCO) contracts awarded in December 2010 by the Department of Health Care Policy and Financing (HCPF) as a means for promoting the development of person-centered health care homes in primary care settings and improved coordination of care among providers. The ability of the local community partners to access additional financial supports to support health care home activities within NCCHC and other local primary care settings will be a direct function of their ability to collaborate within the broader RCCO, in this case Rocky Mountain Health Plans, for their region. In addition, HCPF has determined a Statewide Data and Analytics Contractor (Treo Solutions) in 2011 that will be able to provide enhanced information supports to coordinate care across clinical settings and the health information exchange may be able to access additional information and data support through that infrastructure. The solid level of collaboration and continued commitment of local leaders to this process provides a forum and foundation for continued population- and system-level planning to improve health care access, develop health homes and the infrastructure for an accountable care collaborative envisioned by the RCCO. An example of this is the award by the Colorado Department of Health Care Financing²³ to 14 Colorado communities to "educate families about public health insurance, to inform and aid children and families in their communities with health coverage options, and to assist current clients with re-enrollment." NCCHP partner Northwest Colorado Visiting Nurse Association received this award in August of 2011. Based on Colorado Health Institute estimates²⁴ using 2005-2007 data, Routt County in particular is in need of this kind of effort. This is an example of efforts of partners to align and to be involved in health care reform and to be actively involved as the partners seek to position better within their RCCO (Rocky Mountain Health Plans) and to leverage their collaboration to date to support ongoing reform.

VI. WHAT RECOMMENDATIONS CAN BE MADE TO THE TRUST AND TECHNICAL ASSISTANCE PROVIDERS ABOUT HOW TO FUND AND MANAGE SYSTEMS-CHANGE STRATEGIES?

The following recommendations are offered to build on the successes achieved by the NCCHP and to promote continued planning and collaboration to translate initial grantee successes into broader Colorado Trust efforts in line with the opportunities of health care reform. These recommendations are based on the unique circumstances of the NCCHP, the perspectives and experiences of project participants, the priorities developed and addressed during the project and the work remaining to be done. The recommendations seem applicable to funding and system-change efforts and strategies more broadly, and also for local areas similar to the more rural northwest Colorado area in which the NCCHP operates. It is likely that the relevance of each recommendation is more a matter of the degree to which it is applicable to a specific system-change effort, rather than whether or not it is applicable at all. Thus the recommendations are built from unique circumstances of northwest Colorado communities, but are meant to be considered more broadly by The Trust and its technical assistance providers

- Consider strategic opportunities to promote greater organizational alignment in light of health care reform opportunities. Health homes and accountable care organizations are the building blocks of health care reform, and they require redefinition of provider roles and formal integration across expanded primary care capacity, better coordinated specialty care, and higher performing hospitals. While the local system has moved forward in many of these areas, it is unclear if the local planning process is fully leveraging the opportunities for improved system alignment in these areas and others (such as information technology) offered by health care reform. The Trust should consider explicitly discussing this issue with local health care system leaders and exploring whether their role as a transitional funder within the system change process should evolve with the project or remain stable in light of potential opportunities. When this project was initiated in 2005, the substantial progress toward health reform at the state and national levels achieved in the last three years had not yet begun. As a result, Phase I planning and technical assistance could not take these opportunities into account. The project's progress to date suggests capacity for continued improvements, but the degree to which The Trust could support these improvements has not yet been assessed. While The Trust put in place a process for making initial funding and technical assistance decisions and for ongoing involvement, there is not a formal mechanism for considering opportunities that have since presented themselves. While this recommendation did not come directly from respondents, it is clear from the interviews that the project has matured greatly, including obtaining funding from other funders, and the funder should consider how best to continue working with the project and other involved stakeholders in light of the emerging post-reform environment. Such ongoing assessment of the funder's involvement in the project and project activities would enable the funder to obtain a broader picture of the project, as well as how the funder's activities and support is complemented by support from other funders and their activities. Key informant respondents suggested considering pooling and coordinating use of resources across funders in order to leverage the most effective use of resources. An alternative could be to communicate with other funders involved with similar priorities in an area in order to align or complement efforts. Communication between funding agencies was encouraged to some extent by the project technical assistance providers in this project. Additional efforts at a project or initiative level could provide information useful to the funder about their ongoing involvement. As discussed in the next bullet, this could inform ongoing goals of the project as well.
- Develop new goals and opportunities to keep community leaders engaged. Ultimately, the success of a collaborative is built upon achieving mutual goals. Participating community leaders recognized the opportunities in this project to improve access to health care through the PHI, and that goal has been their incentive for willing and active participation. Participation has been expressed in various ways, from occasional involvement in order to respond to a meeting or two of interest, to ongoing involvement by serving on the Steering Committee and as subcommittee leaders. Participation does have a cost, primarily the time commitment involved and the personnel resources necessary to participate, particularly for the outlying rural areas. The benefits of incurring those costs have been in improvements to the ability of their agencies and the system to provide and coordinate care. As project goals have been achieved, the purpose of ongoing collaboration was less clear at the time of the initial key informant interviews. However more recent interviews indicate that there is much that remains for the collaborative to accomplish, particularly with regard to health care reform planning and implementation. Their efforts in that regard remain central to continuing to improve health care access. Related to the prior recommendation, The Trust should consider the possibility

of identifying new goals to spur continued and, in some cases, improved involvement. This would require more involvement of The Trust in planning efforts in order to develop consensus with the grantee upon potential new directions. The same could be said of broader initiative efforts that impact all grantees, to involve grantees in shaping the direction of the initiative. The applicability of this recommendation may vary by the geography of the community and other local factors. For rural northwest Colorado, project goals to extend the availability of the health center to more rural areas are likely to increase the involvement of the providers in those more rural areas. While different grantees may not have the rural issues to deal with, it is likely that this recommendation will be relevant because leaders across a community seem more likely to be engaged at different stages of project implementation as the project more directly impacts them.

- Assess ongoing technical assistance needs and assist grantees in meeting those needs identified throughout the course of the project. Respondents felt that project coordinating agency facilitators provided by The Trust were very helpful to them in providing ongoing meeting support and facilitation of planning efforts. Also included in the facilitators' scope of work was planning and facilitation of access to content-specific technical assistance where needed. This area was important to project success as technical knowledge and skills are necessary to ensure successful system change by meeting ongoing emerging needs. For example, key informant responses and progress reports observed that, in some specific skill areas such as health information exchange and needs assessment, the community leaders participating in the project and their agencies were not able to provide the range of necessary knowledge and skills for continuing project success, given how the project and project priorities have evolved over time. Each agency has information technology expertise to support information systems within their agencies, but health information exchange between agencies/providers is an area where specific consultation was needed and was obtained. To be more specific, TA was very helpful, and could have been more so had The Trust regularly identified what the needs were through discussion with the grantee. Another area that required additional technical assistance was the area of needs assessment in assessing the community's health. While the medical community is represented on the project, they need additional consultation to develop an assessment instrument to help them gather data on indicators of health needs in their community. That data is important to them to enable informed decision making for planning and funding efforts.
- A more flexible approach to technical assistance where not all of the technical assistance is delivered by a single agency and which can flex over time to respond to emerging needs would be preferable. The Trust should consider expanding the current model to identify the technical assistance needs of grantees that cannot be met by dedicated technical assistance providers, and assess opportunities to expand the range of technical assistance available to respond to the broader array of assessed needs.
- Base decisions on updated needs assessment and other community and agency data. One key to responsive health care reform is ongoing population-level planning to guide reform efforts. Such planning depends on an ongoing process based on a broad array of data including assessment of health disparities, sharing of agency-level data, and input from focus groups, key informants and other discussions with consumers about their needs. Explicit attention to a broad array of information will help ensure a broad understanding of the needs and facilitate discussion of how to better meet those needs. Data to represent the many perspectives of a community may not be available from the beginning, but ongoing planning should address how to obtain multiple perspectives and systematically incorporate them over time. Program indicators should also be assessed in an ongoing way to collect data that is most helpful to the program and The Trust. For example, when the eligibility card was introduced it would have been helpful to count how many cards were issued in addition to the number of people served. More ongoing collaboration with the evaluator (TriWest) in determining indicators may have helped to address this. The evaluator provided technical assistance about grantee indicators but was removed from indicator monitoring and review during the grantee process of implementing the indicators. That was the purview of the Coordinating agency.

PARTNERSHIPS FOR HEALTH INITIATIVE: SAN LUIS VALLEY HEALTH ACCESS PROGRAM: CAREPOINT CASE STUDY

TriWest Group

PARTNERSHIPS FOR HEALTH INITIATIVE SAN LUIS VALLEY HEALTH ACCESS PROGRAM: CAREPOINT Phase II Case Study

I. OVERVIEW OF THE SAN LUIS VALLEY HEALTH ACCESS PROGRAM: CAREPOINT²⁵

In Phase One of the Partnership for Health Initiative, the four agencies at the top of the Board members list below partnered as the San Luis Valley Rural Health Network to improve health care assess in the six-county San Luis Valley. Those initial partners invited a wide range of community individuals and agencies to attend and participate in the planning process. Together

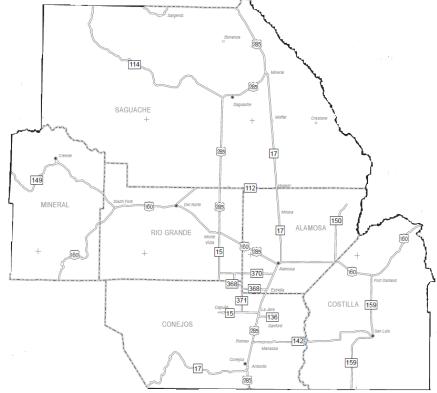
CarePoint

that larger group developed the strategic plan, budget, and governance structure for the initial phase. In Phase Two of the Partnership for Health Initiative, the new San Luis Valley Health Access Program called CarePoint began enrolling employers and employees and providing access to health care services. Their mission statement is as follows:

"To provide an affordable basic health care program targeted to qualified employer groups so that we improve the lives of thousands of valley residents by 2015. We will accomplish this through our community partners and resources."

The San Luis Valley Partnership for Health Initiative has grown and is currently led by a twelve member Board of Directors consisting of representatives of local and regional health and human service agencies, the County Commissioners, business leaders, and the faith community. These partners are:

- San Luis Valley Regional Medical Center
- Conejos County Hospital
- Rio Grande Hospital
- Valley-Wide Health Systems
- San Luis Valley HMO
- Colorado Health Networks, San Luis Valley Comprehensive Mental Health Center
- Business Owners
- Consumer Representative
- Living Water Bible Fellowship
- San Luis Valley Board of County Commissioners



In Phase One, project participants

increased from four to six (first six on the list of board members above). That resulted in the participation of the community mental health center and the health maintenance organization for the Valley (San Luis Valley). Their focus was to not reinvent the wheel, but rather to build on what services were already available to address gaps in access to health care. One of their main accomplishments was to improve the coordination of healthcare resources in the Valley. That involved working with community groups such as 211, the school SCHIP enrollment program and the Immigration Resource Center to "ensure that individuals are aware of what healthcare programs they may be eligible for." Working together on those efforts allowed the partners to strengthen their relationships and build more trust to strengthen their collaboration.

What turned out to be one of their most significant accomplishments was laying the foundation for developing a proposed health access program. They explored various access models that had been implemented in other states. Partners then attended the Bighorn Leadership Program and developed

a legislative solution to place before the State Legislature in the 2009 session. The bill was sponsored by Representatives Tom Massey, Edward Vigil and Ellen Roberts (now in the Senate) in the House and passed as House Bill 09-1252. The bill enabled the expansion of the "Local Access to Health Care Pilot Program Act" to allow the creation of a program to provide health care access to individuals employed by employers in the San Luis Valley. Prior to that bill there was one such pilot Health Access Program in Pueblo.

In passing that bill, the Colorado General Assembly stated that it is important to establish pilot programs in rural counties in the state to provide access to health care for individuals and families who may not otherwise have access to health care in order to develop a model that may to used to provide access to health care for similarly situated individuals and families in other parts of the state.

Phase Two activities have intensively focused on developing and implementing the CarePoint health access program. Activities have included holding community meetings to obtain input as to the services to include in the benefit package, working with the San Luis Valley HMO to provide third party administration services, deciding on reimbursement rates, and developing formal relationships with health care providers to provide services to enrolled employers and employees. In addition the collaborative obtained non-profit 501c(3) status for the CarePoint program. Marketing and enrollment began and services started May 1, 2010 with five participating employers and 55 employees enrolled. Those numbers have grown to 27 employers and 97 employees as of August 15, 2011.

As reported in the Valley Courier newspaper in the week of March 15, 2010 "Through CarePoint, local employers are able to offer their currently uninsured employees health coverage for \$150 a month. The employer pays \$50 monthly, as does the employee. The third \$50 portion comes from the community and is funded through a federal grant. The donation from the HCF will reduce the employees' monthly share by \$10 for up to one year for the first 100 members who enroll." The HCF referred to in the article is the Alamosa-based Health Care Foundation that donated \$12,000 to reduce employee shares. The federal grant referred to in the article is a Health Resources and Services Administration (HRSA) grant obtained by the collaborative to cover the final third of the cost of the coverage. In Phase II, CarePoint was informed by HRSA that the funding period would be shortened to two years instead of five, ending August 31, 2012. The collaborative is discussing ways to continue without HRSA funding and are hopeful to do that. There is a high level of commitment to CarePoint with the Board being confident about the sustainability of the program.

Early in Phase Two there was a change in leadership for CarePoint with Crestina Martinez moving from the San Luis Valley Board of County Commissioners to take over the Executive Director position with CarePoint. Most recently Crestina left her position as of September 16, 2011. The program is in the process of deciding how to fill that administrative support.

II. ASSESSING HEALTH CARE ACCESS AND SYSTEM CHANGE AND THE CASE STUDY APPROACH

Through PHI, The Colorado Trust (The Trust) is seeking to promote improved access to health care in Colorado by funding projects such as the San Luis Valley Partnership for Health Initiative. The Trust hired TriWest Group to assist them in evaluating the success of the PHI projects and to further understand system change efforts. In Phase Two of the PHI, TriWest Group has worked with The Trust and four projects to answer four central evaluation questions:

- Does the work of local collaboratives contribute to improvements in their local health system?
- What factors lead to or impede improvements to local health systems?
- Do the grantees' access-to-health outcomes improve as a result of these system changes?
- What recommendations can be made to The Trust and TA providers about how to fund and manage systems-change strategies?

A number of tools have been used to help answer these central questions. The four tools listed here have been employed throughout both Phase One and Phase Two. They include the following.

Collaboration among stakeholders has been assessed annually over the course of the project. To assess collaboration, project stakeholders complete an annual online survey consisting primarily of Drs. Carl Larson and Darrin Hicks' Process Quality Rating Scale and their Working Together index of collaboration, aimed at assessing the quality of the collaborative process at the grantee level.

- Project Blueprints visually depict the system's structures and relationships. Comparing Blueprints over time, as they are updated, illustrates changes in the structure of the system of care.
- Regular reports of the status of each project are submitted to The Trust by each project. These summarize progress and issues facing the project.
- Ney informant surveys of project participants have provided data for a case study. The initial and follow-up key informant surveys sought to solicit data about the nature of system change efforts and specifically to better understand the relationship dynamics and operational factors involved in facilitating system change. The data from the case study approach provides more content and context to the other components of the evaluation to aid in determining how the work of local collaboratives may contribute to improvements in their local health systems, what factors lead to or impede improvements to local health systems, and whether grantees' access to health improves as a result of changes in the local systems. Initially, key informants were interviewed using a semi-structured interview format to solicit respondents' perceptions in the areas of values and norms within the system, system resources, system regulations, system power and decision-making processes and operations, and interdependencies that exist within the system. A second key informant survey was conducted to update the case studies through the end of Phase II and to include more detail about the influence of health care reform.

Combined with material gathered via collaboration surveys, project Blueprints, and grantee progress reports, the evaluation team made use of key informant material gathered to answer the evaluation questions listed below in Sections III through V, and to offer recommendations in Section VI. In particular, responses from key informants have been useful in telling the story of their experience.

III. DID THE GRANTEES' ACCESS-TO-HEALTH OUTCOMES IMPROVE AS A RESULT OF THESE SYSTEM CHANGES?

Access-to-health has improved. In Phase One the indicators for success identified in the strategic plan were:

- Process Indicator: Involve and integrate San Luis Valley Organizations in the program to be developed.
 - Measured by active participation, integration and willingness to share and active promotion.
- Health Indicator Identify, educate and enroll people for health care coverage.
 - Measured by an increased number of people with health care coverage.

From a review of the final Phase One report, it appears that activities related to the process indicator were most prevalent and may have resulted in some positive movement on the health indicator. A number of activities were reported including those below.

- What turned out to be one of their most significant accomplishments was laying the foundation for developing a proposed health access program. They explored various access models that had been implemented in other states and one in Pueblo, Colorado. Partners then attended the Bighorn Leadership Program and developed a legislative solution to place before the State Legislature in the 2009 session. The bill subsequently passed as House Bill 09-1252 and enabled the partnership to move forward in Phase Two with increasing health care access for employers and employees through the CarePoint health access program.
- School-based enrollment program. Sought to enroll families in SCHIP, Medicaid, sliding scale and other medical programs at the local school districts.
- Coordination of healthcare resources. Worked with many community groups such as 211 and the Immigration Resource Center to ensure that individuals are aware of the healthcare programs they may be eligible for.
- Colorado Regional Health Information Organization (CORHIO). This effort to develop a regional information system that each of the electronic medical records systems can tie into to create a valley-wide health information system could be very important in the future.

Phase Two has seen the most impact on increasing healthcare access. As mentioned above, the CarePoint health access program has begun and employers and employees are participating in the program. As of August 15, 2011, 27 employers and 97 employees are participating. From discussions with key informants those numbers continue to increase and positive feedback is coming in about health outcomes.

Key informants were very positive about potential health access outcomes. However, there is agreement that it is too early to have the numbers to show the impacts. They are starting to hear testimonials from people about accessing health care services. In most cases those people did not have access previously to healthcare services, primarily due to the cost of services and a lack of insurance. The benefits include a focus on preventive and wellness care. Through preventive and wellness care, including exams and treatment that they could not previously afford, people have been enabled to address problems that had not been

Employees participating in the program did not previously have access to affordable healthcare services. Employers see the ability to offer health care benefits as having a very positive potential impact on employee health, employee retention and the health of the community.

treated, thus avoiding worsening health status. Key informants report employees are away from work less, and, with benefits available at work, turnover is less likely. These conclusions that productivity is increased with improved health are supported by The Trusts most recent Issue Brief on the economic impact of health reform in Colorado.²⁶

IV. DID THE WORK OF THE SAN LUIS VALLEY COLLABORATIVE CONTRIBUTE TO THESE IMPROVEMENTS IN THEIR LOCAL HEALTH SYSTEM?

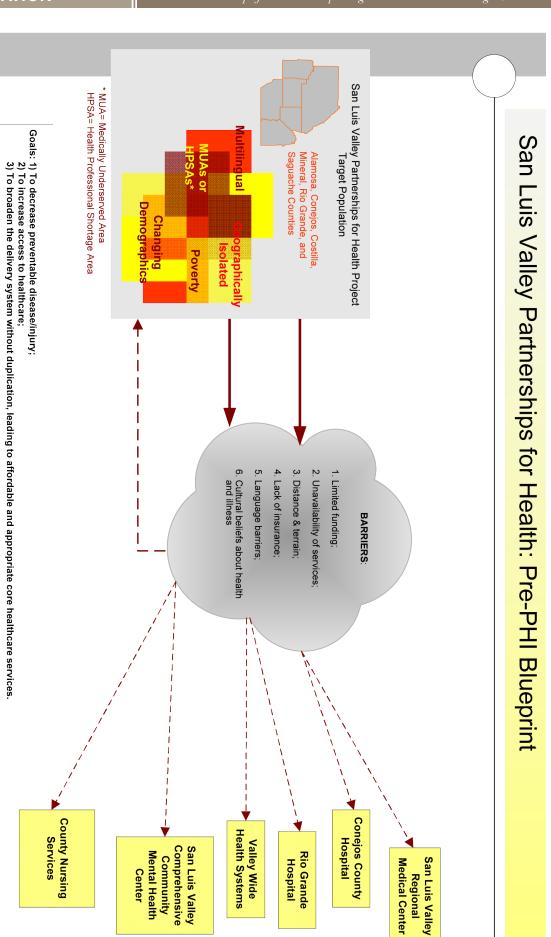
It is clear that the San Luis Valley Health Partnership has worked collaboratively and has contributed to improved health care access and the local health care system. That is the case as documented by results of stakeholder collaboration surveys and structurally by changes over time in the San Luis Valley system as documented by the Blueprints. Additionally, interviews of key stakeholders found that working collaboratively has been one of the most important factors in the success of the system improvement effort. As stated by one stakeholder:

The organizations participating have their own missions and interests, and sometimes those are not completely complementary. However, the fact that the Valley is a rural area with a small population where people know each other and sometimes go back generations gives them a cultural foundation from which they share and act on a common sense of purpose regarding healthcare for the community. "People generally feel that there is a common sense of purpose and mission." This theme was voiced by several stakeholders who felt that there is a shared and significant commitment to the community. As stated by another respondent "the more they do things together, the more that shared value builds and the deeper the dialogue becomes about how to meet the needs of the community."

The Process Quality Rating Scale from the online survey of collaboration among stakeholders showed consistent "good" collaboration (i.e., having an open and credible process) from the first year (2006), through 2009 and through the final survey results in 2010. Their Working Together index of collaboration reached 3.6 (out of 4) in 2010, rebounding from 2.8 in 2009, the only time it was below good, with all prior years being in the good range (above 3.0).

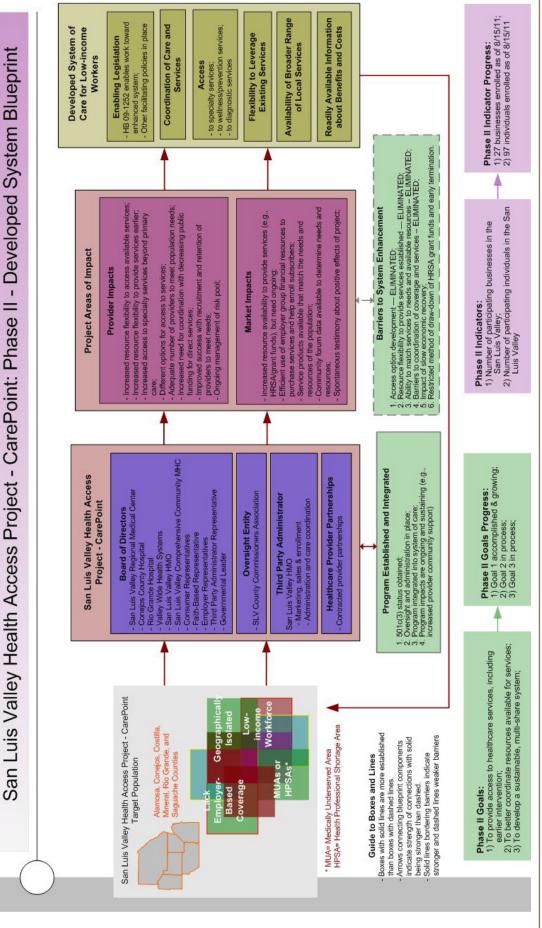
The initial Blueprint shows a population in need encountering multiple and various barriers to service access and an array of providers and agencies that was not systematically collaborating.

The collaborative efforts of the San Luis Valley Partnership for Health Initiative to improve access to health care are correlated with specific changes over time in the system structure as documented through the project Blueprints. The initial system Blueprint, prior to project implementation (below and in Appendix 7), reveals that the status of the system was perceived to result in too many under- and uninsured people going without services or having to seek services through a fragmented array of unconnected services, including over-reliance on the hospital's emergency department.



number of employers and employees and hope to get to a sustainable number of around 200 to 300. The system logic reflects the documented level of organization of the San Luis Valley Health Access Project (purple box) mirrors the increased limited, the workforce still encounters limitations, and partners are in various levels of engagement to care described by system informants were eliminated. However, they are still feeling the impact in the process, but the system is functioning differently and the Phase Two indicators to the lower Although still present during Phase Two (blueprint below and in Appendix 7), many of the barriers of the slow economic recovery and by the elimination of years 3 through 5 of HRSA funds. The right continue to show positive progress since the first year of the establishment the CarePoint program (started services May 1, 2010). Key informants felt that they will continue to grow the organization of the developed system of care (green box to the right). Resources are still good collaboration and makes sense of the outcomes achieved.

facilitating an enhanced and much more collaborative and coordinated system of II shows an established San Luis Valley Partnership for Health Initiative that is The Blueprint for the interim of Phase



Project blueprints primarily present structural views of the system. As a result, two key informant surveys were conducted about a year apart to collect data to inform our understanding of the relationships between system structures, and between participants and how those relationships facilitate system change efforts. From the survey data, specific examples emerged about the community and the local system and how collaboration has contributed to improvements in the local system. A common background observation was made by respondents that the economic status of the Valley was stressed and that that was a contributing factor for the need of the program to provide healthcare access for the low income workforce. As a result, related information is presented in the first bullet from census data or the Colorado Household Survey funded by The Trust and conducted by the Colorado Department of Health Care Policy and Financing.

- The six-county San Luis Valley is wide spread geographically (8,192 square miles), predominantly rural and has a small population (48,438 estimated in 2010).²⁷ About 21% live at or below the federal poverty level (11.2% for the State of Colorado),²⁸ about 59% of families are at or below 200% of the federal poverty level (39.8% statewide), and about 19.7% are uninsured,13.5% statewide).²⁹ Interestingly the unemployment rate in the Valley in 2008 was at 5.2%, below the statewide rate of 9%. Respondents reported that families in the Valley have often resided in the Valley for multiple generations.
- The Board has very diverse representation and realizes it is important to listen to a wide range of perspectives when assessing health care needs and undertaking system change. Respondents reported that, because of the small but established and relatively poor population, people tend to know each other and want to do what they can to help each other. With that as a core value, respondents reported that project efforts, and particularly the discussions and planning efforts in Board meetings and community forums, resulted in increased collaboration by providing an opportunity to share and discuss information about their perspectives on service and system change needs.
- One final example of how collaboration contributed to an improved health system was expressed by one respondent as follows: "The day in and day out missions of their own organizations require them to have to focus on their own interests that may not completely mesh with the program. Some organizations may be competitors at times, but the relationships are good." That respondent and others reported that the participants recognized that there is a need for better health care access in the Valley and the opportunity through the Partnership for Health Initiative enabled them to come together to do something to help meet that need. One additional observation was also relevant because it shared that the time people have to commit as participants may not always be enough. So, it requires more time for the project (over time) to be successful in improving health care access.

V. WHAT FACTORS LEAD TO OR IMPEDE IMPROVEMENTS TO LOCAL HEALTH SYSTEMS?

The initial and follow-up key informant surveys were conducted with the purpose of identifying more specific factors that either supported or impeded the project progress, that is supported or impeded changes sought and brought about by grant efforts to improve the local health system.

Key Factors That Supported Improvements to the Local Health System

- Particularly key was the importance of the skills, knowledge and influence of the participants involved in the San Luis Valley effort. Respondents perceived the participating community leaders to be critical to system change because those leaders brought health care system, agency and community support. Participation may have initially been limited to a few agencies but grew to the point where the entire community is participating; health care providers, business, clergy and employees. The level of in-kind involvement in the project has grown over time, particularly with the passage of the legislation and the development of the CarePoint program, and has been critical to the project success. The San Luis Valley HMO is serving as the third party administrator and each agency has worked with their providers to ensure that services are provided. The San Luis Valley has been involved with the Pueblo health access program. That experience benefited the San Luis Valley effort and has been an important factor in the success of the initiative.
- Collaboration. Leaders and agencies participating in the project were willing to come together and to donate time and resources to the system change effort. They understood the need to look beyond their own agencies, to respect the needs of other agencies, and to see the needs of the community. In addition they enlisted the aid of State Legislators to support the passage of needed legislation to allow them to implement a multi-share approach.
- Technical Assistance (TA) to Facilitate Planning and Roles and Responsibilities. Technical assistance provided by the project facilitators was seen as critical to the system change effort. Key

informant respondents cited the importance of nonpartisan facilitation of Board activities such as the development of the goals and mission statement and making sure each participant was heard. They expressed the desire to have that type of technical assistance continue as it would be very helpful in refining roles and responsibilities as the project evolves with new leadership.

Key Factors That Impeded Improvements to the Local Health System

- Resource Limitations. The slowness of recovery from the recession has had an impact on the level of resources in the Valley. However, one respondent noted that the Valley has always been economically less well off than other parts of the state. That may have limited somewhat the relative impact of the recession, but it also means that businesses and people tend to have fewer resources. When it comes to employers and employees making the decision to use scarce resources for health care, it is not necessarily an easy decision, even if the cost is low.
- Resource Flexibility/Reduction. Participants have worked hard to obtain funding to support the CarePoint multi-share approach of dividing the premium three ways and have been successful. However, they had anticipated more flexibility in how they could use HRSA funds to build up a reserve fund to help them be less at risk in the case of one person requiring high cost treatment. That did not work out as expected and, as a result, their level of risk is higher than they wanted. That requires them to be more cautious about extending their benefit package and the eligibility requirements for employer and employee participation. Key informants shared that the HRSA funds were reduced from a five-year period to only two years. That funding will end August 31, 2012.
- **Provider availability.** The project experiences some challenges related to the availability of providers to all parts of the mostly rural six-county area. Depending on the type of service needed, there may not be a provider within 50 miles of some of the people who need the service. This is particularly the case for people who live in the Western side of the Valley.
- Changes in project management. The CarePoint program has learned the importance of ongoing project oversight and involvement in the community. At the end of Phase II, the project director (.5 FTE) resigned. At the time of the key informant survey, the board was discussing how to fill that position. They recognize the importance of having a person knowledgeable of the project and the community and hope to increase the hours to .75 FTE. The importance of having a person active in building consensus and leading the program was acknowledged. In addition, they have recognized the importance of having sales and marketing expertise actively supporting the program, something that was not previously available. One of the participating agencies has agreed to assign time from their sales/marketing staff to assist in that area. Board membership turnover is taking place and it is important to make sure they preserve the knowledge of the program; its mission and goals.

Overall Analysis

The challenges that remain for the San Luis Valley Partnership for Health Initiative are endemic to the situation of providing health care in a largely rural area of the state during a time in which a difficult economy makes funding more challenging. In the key informant interviews it was clear that maintaining resources to provide care to clients was high on the list of importance for all agencies. That reality meant that project participants recognized the need to and utility of working together to improve services. Together they continue to be able to improve access to health care through the efforts documented in this report that could not have been accomplished as individual agencies working alone.

The gains achieved in terms of expanded access to primary care and behavioral health care all strengthen the local care delivery system and enhance its capacity to respond to the opportunities and challenges of health care reform. Those include:

- communication and advocacy at the policy level (for example, getting the legislation supported and passed),
- improved coordination at the care delivery level (for example, through the involvement of participating agencies in designing, selling and marketing and managing the benefit package and providing services), and
- improved health care access and outcomes for employers and employees in the San Luis Valley and with potential impacts for other areas in Colorado. It is clear from the legislation enabling the CarePoint program that the State hopes to develop a model that "may be used to provide access to health care for similarly situated individuals and families in other parts of the state."

Looking forward, these efforts may help the community be a better partner within the Regional Collaborative Care Organization (RCCO) contracts awarded in December 2010 by the Department of Health Care Policy and Financing (HCPF) as a means for promoting the development of person-centered health care homes in primary care settings and improved coordination of care among providers. The ability of the local community partners to access additional financial supports to support health care home activities within the San Luis Valley and other local primary care settings will be a direct function of their ability to collaborate within the broader RCCO, in this case Integrated Community Health Partners, for their region. The solid level of collaboration and continued commitment of local leaders to this process provides a forum and foundation for continued population- and system-level planning to develop health homes and the infrastructure for an accountable care collaborative envisioned by the RCCO.

The CarePoint collaborative has been discussing health care reform and see some possibilities and some concerns. First of all, it is not clear how successful health care reform will be in expanding health coverage to people in the short and longer term. Colorado has cut back the scope of their planned Medicaid expansion in 2012. Even after 2014, CarePoint key informants think it is unlikely that all people will get

coverage, and they are planning that at least a small percent will still need their services. Secondly, they still see the need for education and outreach to the community to help people access available benefits and care. That is something they have been assisting with that could continue as a role for the program, post-reform. CarePoint key informants were also hopeful that health care system changes will take place, rather than just the insurance coverage side of health care reform. They added the concern that having the insurance industry heavily involved in health care reform could prevent system changes.

Healthcare Reform may open a door, but people will need help stepping through. The collaborative has learned through their involvement in the CarePoint program that, even though health care access is available, people need to be educated about it and assisted in how to use it.

The collaborative is discussing health care reform as it relates to CarePoint, and they are aware that the San Luis Valley is very involved in health care reform initiatives. For example, the San Luis Valley Regional Medical Center is piloting public health reporting through CORHIO and the Colorado Department of Public Health and Environment's (CDPHE) electronic lab reporting (ELR) initiative to support development of the local health information exchange (HIE).³⁰ "By mid-2012, CORHIO and CDPHE expect to move out of the pilot phase, working with every hospital connected to the HIE to benefit from this new functionality. In the future, this service will be standard with all HIE implementations."

VI. WHAT RECOMMENDATIONS CAN BE MADE TO THE TRUST AND TECHNICAL ASSISTANCE PROVIDERS ABOUT HOW TO FUND AND MANAGE SYSTEMS-CHANGE STRATEGIES?

The following recommendations are offered to build on the successes achieved by the San Luis Valley Health Partnership and to promote continued planning and collaboration to translate initial grantee successes into broader Colorado Trust efforts in line with the opportunities of health care reform. These recommendations are based on the unique circumstances of the San Luis Valley initiative, the perspectives and experiences of project participants, the priorities developed and addressed during the project and the work remaining to be done. The recommendations seem applicable to funding and system-change efforts and strategies more broadly, and also for local areas similar to the mostly rural area in which this grant operates. It is likely that the relevance of each recommendation is more a matter of the degree to which it is applicable to a specific system-change effort, rather than whether or not it is applicable at all. Thus the recommendations are built from unique circumstances of this project, but are meant to be considered more broadly by The Trust and its technical assistance providers

■ Keep in mind that health care reform is a fluid and locally variegated process. While much of the attention in the past two years has been on federal and state health reform efforts, it remains the case that all health reform must ultimately occur at the local level, in the ways that local care providers, local health facilities, and local residents provide, experience and pay for care received. Furthermore, state and federal plans continue to evolve, so communities cannot base their planning solely on these necessarily fluid potential resources. Given this, The Trust's support of regional collaborative planning entities such as that involved in the CarePoint project is essential so that local communities can (1)

- weave state and national health reform efforts with local needs and resources and (2) continue local planning to build on emerging opportunities and respond to continued policy and funding changes.
- Consider strategic opportunities to promote greater organizational alignment in light of health care reform opportunities. Health homes and accountable care organizations are the building blocks of health care reform, and they require redefinition of provider roles and formal integration across expanded primary care capacity, better coordinated specialty care, and higher performing hospitals. While the local system has moved forward in expanding primary and behavioral health care access, it is unclear if the local planning process is fully leveraging the opportunities for improved system alignment that may be offered by health care reform. In this and other Partnership for Health Initiatives, The Trust should consider explicitly discussing this issue with local health care system leaders and exploring whether their role as a transitional funder within the system change process should evolve with the project or remain stable in light of potential opportunities. When this project was initiated in 2005, the substantial progress toward health reform at the state and national levels achieved in the last three years had not yet begun. As a result, Phase One planning and technical assistance could not take these opportunities into account. The project's progress to date suggests capacity for continued improvements, but the degree to which The Trust could support these improvements has not yet been assessed. While The Trust put in place a process for making initial funding and technical assistance decisions and for ongoing involvement, there was not a formal mechanism for considering opportunities that have since presented themselves. While this recommendation did not come directly from respondents, it is clear from the interviews that the project has matured greatly, including obtaining funding from other funders, and the funder should consider how best to continue working with the project and other involved stakeholders in light of the emerging post-reform environment. Such ongoing assessment of the funder's involvement in the project and project activities would enable the funder to obtain a broader picture of the project, as well as how the funder's activities and support is complemented by support from other funders and their activities.
- Support the ongoing evolution of the project. Key informants recognized that The Trust has been involved and supportive throughout the course of the project and that The Trust's support and involvement has been critical to the success of the changes they have made. The Trust's support has been evidenced through various activities such as financial support, technical assistance, evaluation support, and ongoing involvement through discussion and approval of project planning, development and other activities. Respondents stressed that those needs are ongoing, especially with regard to technical assistance to assist with changes in staffing and leadership and changes in project activities such as with the need to develop and implement the CarePoint program and to market and inform businesses, employees and the community about the program. Project activities reflect the need for evolving roles and responsibilities of project participants along with project changes and it is important to them that The Trust is aware of the fact that projects evolve, sometimes in unanticipated directions, and that The Trust's support is very necessary to their success.
- Advocate for the sustained success of the CarePoint project. Beyond providing support and flexibility throughout the course of the project, respondents saw a need for The Trust to support their changes beyond the end of The Trust's funding. If there are ways to support long term the multi-share approach to providing benefits/services, such as advocating for the program in other parts of the state or in healthcare reform, it would help if The Trust did that. Respondents feel that the course of change took longer than they anticipated and perhaps longer than The Trust anticipated as well. They now recognize that these types of changes take a long time to happen and become established. They feel that with The Trust's experience in these types of system change efforts, The Trust is in a position to continue to support such efforts.
- Assess the readiness and commitment of the partnership. They are aware that the level of commitment to be successful in projects like theirs' is high. To the degree that The Trust could assess the readiness and level of commitment of a partnership, it might help grantees and make more effective use of grant resources. They felt like they had a realistic understanding of what it would take to make change happen and that kept them at the table and moving forward throughout the course of the initiative.

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