



**THE
COLORADO
TRUST**

ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS



2008

Annual Report

2008 Annual Report

ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

» VISION

The Colorado Trust is dedicated to achieving access to health for all Coloradans by 2018.

With our singularly focused vision, we are committed to working closely with many people across the state to see comprehensive, meaningful change that will mean:

- Every child will have a real opportunity to grow up healthy
- Colorado will have a healthy population that contributes to the prosperity of the state
- Affordable health care coverage will be available to all families and individuals
- Accessible, quality care will be the norm
- The health care system will deliver care that is responsive to the needs of all Coloradans.

» HISTORY

When the nonprofit PSL Health Care Corporation was sold to a for-profit organization in 1985, the proceeds of the sale were used to create a foundation dedicated exclusively to the health of the people of Colorado.

Since that time, The Colorado Trust has worked closely with nonprofit organizations in every county across the state to improve health and well-being, ranging from bringing 9-1-1 emergency medical care to 38 Colorado counties to helping foster the development of the state's second largest regional transportation district in the Roaring Fork Valley, and much more.

To build on these efforts and address growing needs to expand health coverage and improve and expand health care within Colorado, The Trust committed to a 10-year goal to achieve access to health for all Coloradans by 2018.

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Message from the Chairwoman & President and CEO



IRENE M. IBARRA

KATHRYN A. PAUL

In 2008, The Colorado Trust announced a new focus for its grantmaking. Through an intensive planning process, we identified opportunities to continue The Trust's long-held mission of advancing the health and well-being of the people of Colorado, while more purposefully focusing on a single vision: *Achieving Access to Health for All Coloradans by 2018*.

This year's annual report is longer than usual as we felt it important to share in some depth the thinking behind our 10-year vision. On the following two pages, we provide an at-a-glance overview of the major barriers and challenges to achieving access to health, as well as the main strategies we are supporting to expand health coverage and to increase and expand health care. This is followed by a detailed look at many of the complex problems within our health care system and the associated Trust strategies. As well, we are pleased to include four thoughtful essays from dedicated Coloradans working hard to improve the provision of quality, affordable health care and coverage, together with hopeful stories of change and improvement from our grantees.

While we have put a lot of thought into the development of these strategies, we recognize that this long-term effort will, by necessity, evolve over time in response to our economic ups and downs, as well as a changing policy and social environment. This was underscored as the recession hit soon after we announced our first funding efforts in support of achieving access to health. This unprecedented economic drop is causing deep stress on families, nonprofit organizations and the government. The biggest challenge is that at the same time workers are losing their jobs and their health care, the government, the business sector and foundations have diminished resources to address increased needs. On the flip side, a positive may well be that the deficiencies of our poor system of health coverage and care have been further exposed and are becoming increasingly difficult to deny.

We know that solving the challenges of access to health for all Coloradans cannot be accomplished by The Colorado Trust alone. Clearly this level of change requires a collaborative approach involving all sectors of society, including individuals, public and private organizations, and the government. Thankfully there are many stakeholders working to address health needs in Colorado.

The bottom line is that good health creates opportunities for a good life. Without good health, we cannot receive a solid education, obtain employment or contribute to our communities.

We believe the time has come to address the full extent of the problem and remain focused until we have realized access to health for all Coloradans.

Sincerely,

Kathryn A. Paul

Chairwoman of the Board of Trustees

Irene M. Ibarra

President and CEO



ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

Our commitment is to work with others to ensure that all Coloradans have adequate health coverage and access to a responsive and comprehensive health care system, including an adequate supply of health care providers who deliver quality, affordable health care services.

HEALTH COVERAGE

Expand Health Coverage

Health insurance is important to health status, yet it is unaffordable for hundreds of thousands of lower- and middle-income Coloradans.



Trust grant strategies include:

- » Research, develop and implement policies that control costs and increase access
- » Strengthen and align diverse voices for health reform, including consumers, providers, and business and policy leaders
- » Increase public awareness and build a strong base of support for access to health

Read more on pages 4-7.

Increase Outreach and Enrollment

A confusing and lengthy enrollment process for Medicaid and CHP+ results in many Coloradans who are eligible for coverage going without health care.



Trust grant strategies include:

- » Simplify and streamline eligibility and enrollment processes for public insurance programs
- » Develop and implement systems and policies to support continuous enrollment
- » Strengthen and expand effective community outreach and enrollment programs

Read more on pages 12-15.

To achieve this vision, The Colorado Trust supports grantees in developing and implementing policies, programs and services that Expand Health Coverage *and* Improve and Expand Health Care.

→ HEALTH CARE ←

Improve Health Systems

A complex, disjointed health care system results in costly waste and duplication of services, making it difficult to navigate and often resulting in poor health outcomes.

Trust grant strategies include:

- » Provide comprehensive preventive services in a timely manner
- » Align high quality, coordinated care with financial incentives for providers
- » Strengthen the ability of health care sites and providers to meet standards of care

Read more on pages 20-23.



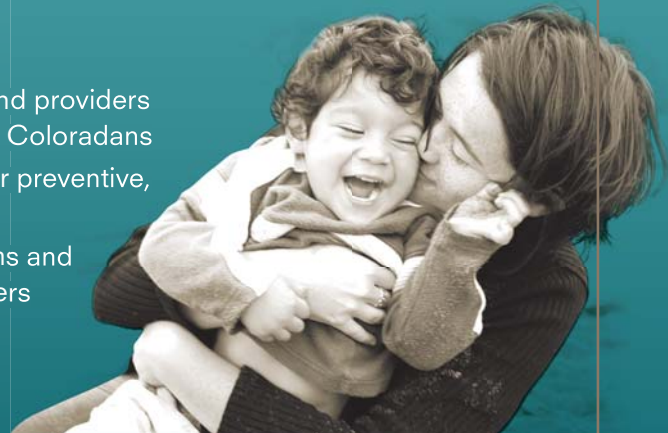
Increase Availability of Care

Economic challenges to the safety-net system, insufficient availability of health care services across Colorado, and a shortage of health care providers make it difficult for some Coloradans to receive health care.

Trust grant strategies include:

- » Strengthen the viability of health care delivery sites and providers to serve uninsured, and publicly and privately insured Coloradans
- » Ensure adequate points of access across the state for preventive, primary, oral and behavioral care
- » Expand education, recruitment and retention programs and policies to increase the number of health care providers available to serve Coloradans

Read more on pages 28-31.



HEALTH COV

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ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

BACKGROUND & TRUST *Strategies*

Health coverage is important to health status, allowing for much greater access to the preventive, diagnostic and treatment services needed to stay healthy. Yet 800,000 Coloradans, mostly low- and middle-income working families, do not have health coverage. According to the Institute of Medicine (IOM), uninsured individuals are less likely to have a usual source of care, less likely to receive recommended preventive services and more likely to delay needed care. Lack of coverage even increases the risk of mortality, contributing to an estimated 22,000 premature deaths in the U.S. in 2006. Additionally, it's estimated that more than 870,000 Coloradans under the age of 65 who have insurance, but spent more than 10% of their pre-tax income on health care this past year, are underinsured. A 2005 Harvard University study found that medical problems were behind more than 1,700 bankruptcies across the country, even though three-quarters of those bankrupt people had health coverage.

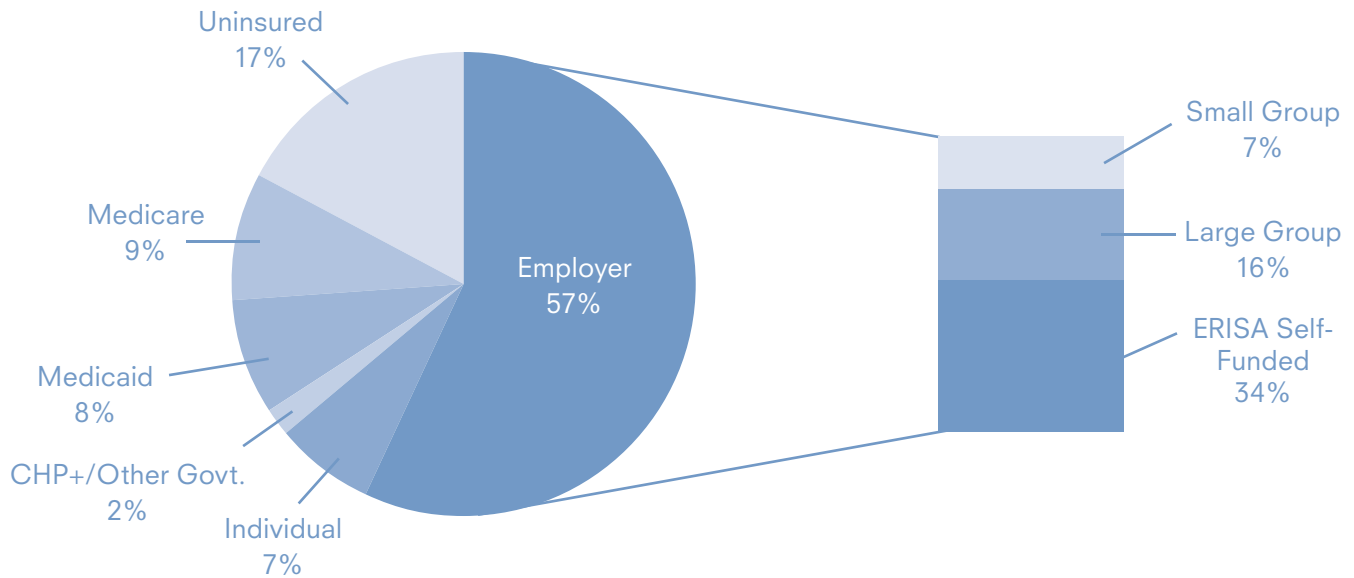
Just as the increasingly out-of-reach expense of health coverage and care is tough on consumers'

pocketbooks, it also causes significant problems for our state's economic outlook. The New America Foundation has estimated that in 2007 our state economy lost as much as \$3.9 billion due to the poor health and shorter lifespan of the uninsured, or nearly \$4,900 per uninsured Coloradan. With each percentage point rise in unemployment, an estimated 19,000 more adults and 1,000 more children become uninsured, and thousands more are added to the roles of Medicaid and Child Health Plan *Plus* (CHP+). In today's economic climate, this means thousands of Coloradans don't have access to critical health services. At the same time, businesses are struggling to maintain their ability to provide adequate, affordable health care coverage to employees due to the rising costs of insurance.

As illustrated in the figure on page 5, the current Colorado insurance landscape is comprised of a complicated array of private insurance markets (large group, small group, individual) and public coverage programs (Medicare, Medicaid, military insurance) that both overlap and leave people out.

ERA G E

» WHERE COLORADANS GET THEIR HEALTH CARE COVERAGE



Sources: Kaiser Family Foundation, 2007; America's Health Insurance Plans, 2007; and Colorado Division of Insurance, 2008.

The vast majority of Coloradans receive coverage that is partially subsidized, either through an employer or the government. However, approximately one-in-five working-age Coloradans neither qualify for subsidized coverage through the workplace nor through a public program. Those who can afford to do so, and have no pre-existing conditions, purchase health insurance directly. This group accounts for fewer than 4% of Coloradans. The remainder, those who cannot afford to pay health insurance premiums entirely out-of-pocket, are uninsured.

This patchwork assortment of coverage options makes policy solutions equally complex and politically challenging. Simplifying and expanding coverage is further complicated as such efforts require consensus about the need for reform, compromise on strategies to achieve coverage and the necessary financing to cover the increasingly large number of people who are uninsured.

Too, the public is not of one mind as to whether or how health reform should be achieved, with public



**HEALTH INSURANCE
PREMIUMS HAVE INCREASED**

at a rate far exceeding wage growth.

**HIGHER
UNEMPLOYMENT
MEANS**

*more adults
and children
become uninsured.*



Expand Health Coverage

opinion polls showing inconsistent findings. On the one hand, some Coloradans view access to basic health care services as a right that should be available to all, rather than a commodity available only to those who can pay. On the other hand, many are wary about committing to specific solutions such as providing more public financing or requiring employers to provide coverage. Support for expanding coverage also is diluted by insured individuals' fear of losing benefits or compromising on quality, and misperceptions about those who are uninsured and what consequences they face as a result.

Nevertheless, consumer advocacy groups are well-positioned to leverage public awareness around coverage issues and to build a strong base of support to drive reform. To ensure that these organizations are informed about the financial and human implications of Colorado's costly and inefficient health system, The Colorado Trust has funded such efforts as analysis of the economic implications of inaction on health reform and the Colorado household survey to collect information about Coloradans who are un- and underinsured. The Trust also has invested in building the capacity of numerous consumer advocacy organizations to ensure that they engage the voices of diverse individuals, groups and communities so that together, they can create and support shared solutions that lead to a healthy future.

Of course, consumers alone cannot fix Colorado's health care system. Businesses, insurers, health care providers and policymakers also have a stake in expanding access to health, but too often have splintered around their different conceptions of "the" central problem: rising numbers of uninsured, escalating health care costs, quality deficits and inefficiencies, access barriers and inappropriate use of services. While many agree that it is important to provide health care coverage to everyone, stakeholder groups often disagree on the extent to which these other issues should take priority or should be tackled simultaneously.

The recent example of the Colorado Blue Ribbon Commission for Healthcare Reform demonstrates that achieving consensus across diverse stakeholder interests is possible if health care reform recommendations are comprehensive and strive to balance the many competing policy priorities. In fact, the challenges associated with access, cost and quality are complex and interdependent. Tinkering with one dimension of the system may affect another in unforeseen ways.

Through its grantmaking, The Trust seeks to partner with nonprofits, government entities, coalitions, commissions and communities to achieve the goal of providing affordable, quality health coverage for all Coloradans. With this in mind, it has supported multi-sector efforts such as



UNINSURED INDIVIDUALS ARE LESS LIKELY

to have a usual source of care or receive recommended preventive services.



DIVERSE VOICES ARE NEEDED

to reach shared solutions for a healthy future.

the Partnership for a Healthy Colorado and the Colorado Blue Ribbon Commission for Healthcare Reform. Both of these initiatives facilitate dialogue, identify common ground, elucidate alternative policy solutions and their respective trade-offs, develop a shared policy agenda and define a path toward implementation.

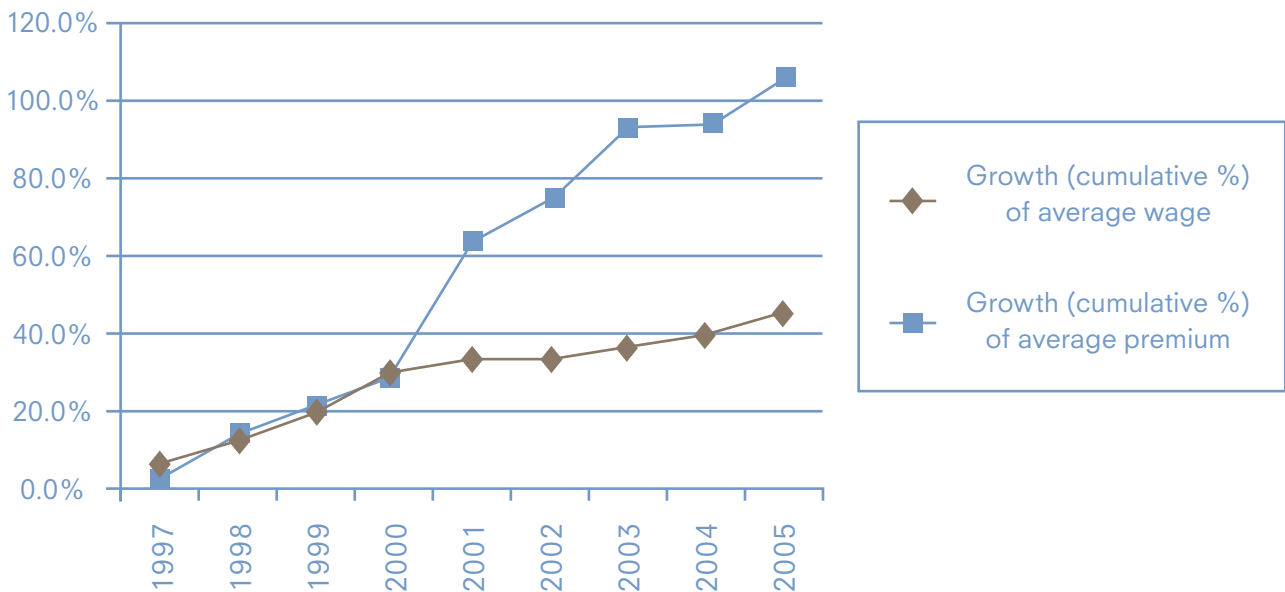
Together with achieving consensus on need and broad strategies for change, the associated financing implications must be addressed. Many coverage expansion efforts, especially at the state level, have failed due to lack of affordability or financing (or both). Indeed, affordability of coverage for families and financing requirements are opposite sides of the same cost "coin." Surveys of the uninsured indicate that escalating costs are a major barrier to coverage and that low- and middle-income families are more likely to enroll if insurance is subsidized by an employer or a government agency. However, more generous government subsidies lead to greater public price tags.

According to U.S. Census figures, three-quarters of the people without health insurance live in low- or middle-income families. Many of these families cannot afford the rising cost of health insurance if they do not have an employer or a public program to help with health insurance premiums. As the graph below shows, health insurance premiums have increased at a rate far exceeding wage growth in recent years.

To inform decisionmaking around these trade-offs, The Trust has invested in studies on affordability of health care and health insurance, and federal financing options. This type of research is important in order to continue to make strides toward expanding health coverage, particularly for Colorado's most vulnerable populations. A critical component of achieving access to health, coverage must be considered in the broader health system context.

Grantees receiving support from The Colorado Trust to Expand Health Coverage are listed on page 38.

» **WAGE GROWTH AS COMPARED TO INCREASES IN HEALTH INSURANCE PREMIUMS (1997-2005)**



Source: Colorado Business Group on Health.

COMMUNITY *Insight*



DEDE DE PERCIN,
*Executive Director,
Colorado Consumer Health Initiative*

» **A UNITED VOICE ALLOWS ALL COLORADANS TO BE PART OF THE SOLUTION**

By Dede De Percin

There are two kinds of people in the world: those who need access to health care right now, and those who will need it eventually. We are overdue for a substantial, comprehensive discussion on health care reform, and the Colorado Consumer Health Initiative (CCHI), in partnership with our members and partners, is working to ensure that inclusive dialogues take place throughout our state.

Nearly one in three Coloradans younger than 65 went without health insurance in part of 2007 or 2008, a troubling increase of more than

2%. Colorado families are being squeezed between rising health care expenses (premiums, deductibles, co-pays and out-of-pocket costs) and falling incomes. Health care premiums rose nearly five times faster than median earnings between 2000 and 2007. The number of uninsured is rising as the sagging economy shows no sign of rapid recovery. Furthermore, fiscal and budgeting restraints unique to Colorado exacerbate our economic challenges and keep us from collecting and spending revenues in ways that are smart, strategic and best for the state.

Going without health insurance means insecurity. When you are not well, how can you succeed in anything? Performance in school, in the workplace, in taking care of family, in contributing to community are all thrown into jeopardy without health.

Everyone should have access to health care that is appropriate, affordable and accessible – in the most profound sense of those words. Increasingly, consumers and patients are using their voices, their experiences and their power to help create solutions to our health care crisis.

Health care is singularly intimate: people experience barriers to access in very personal, disparate ways. This can be a challenge to empowering consumer advocates. A person may dispute a bill with a hospital or the quality of care from a provider. But many people don't generalize their individual experience to the larger, underlying failure of the health care system.

In fact, we don't have a health care system, rather we have many disparate, discrete, disorganized pieces. We have different coverage systems. There are separate health care programs for veterans, for the young, for seniors and for those with disabilities. There are public insurance programs, such as Medicaid and CHP+. There is access to care for the uninsured, through the Colorado Indigent Care Program and community

clinics. There is small group insurance regulated by the state, and large group insurance governed by federal laws. There is the individual market and CoverColorado, our high-risk pool that provides insurance to eligible Coloradans who are unable to get private coverage due to a pre-existing condition.

It can be daunting to figure out strategies and policies to achieve substantial, significant changes to such a massive, failing structure. Tweak one part and there may be consequences to another part that were never intended, because while not integrated, the parts are interrelated.

What can effective advocacy do? The Paycheck Away project is an example of a collaborative effort with 10 nonprofit partners to understand and reveal the issues facing low-income Coloradans. During town hall meetings in six communities, the coalition found that three issues pose persistent challenges: adequate food, shelter or housing resources, and access to affordable health care. These Coloradans are one paycheck away from hunger, homelessness and forgoing needed health care.

“EVERYONE SHOULD HAVE ACCESS TO HEALTH CARE THAT IS APPROPRIATE, AFFORDABLE AND ACCESSIBLE

in the most profound sense of those words. Increasingly, consumers and patients are using their voices, their experiences and their power to help create solutions to our health care crisis.”

CCHI worked with our partners to produce a video documenting some of the stories we heard from Coloradans around the state. Sharing these personal experiences with legislators contributed first to the development of the Poverty Caucus in the Colorado General Assembly and, ultimately,

to the passage of House Bill 09-1064, which creates a legislative committee to study poverty issues and address economic opportunity. Real Coloradans brought the intersection of poverty and the economy into sharp focus. Understanding how poverty plays into the dynamics of health care access is critically important to creating solutions that work for everyone.

CCHI has been working for more than a year with the Colorado Center on Law and Policy to shine a “Spotlight on Health Care” by touring cities and towns across the state with a compelling presentation about why health care reform is so important. Rather than endorsing any particular proposal or solution for health care reform, this facilitated discussion aims to give participants a framework with which to understand this complex system and the various policy solutions being considered.

To date, Spotlight on Health Care has reached more than 700 consumers through 22 presentations in urban, rural and frontier communities across the state. We are giving Coloradans outside the health care policy world real tools they can use to contribute to health care reform. We are working to connect people to the policymaking and legislative arenas, so that elected officials see the faces and hear the voices of the people behind the statistics. Policy decisions have a real impact on access to health care and the lack of access to health care in Colorado. Expanding civic engagement in health care reform efforts demands and encourages the political will for change.

Yes, changing the health care system is challenging. If consumers aren’t involved in health care reform, the changes won’t meet the needs of the people who use it: us.

Advocacy matters. A united consumer voice can create health care security for all and will strengthen Colorado’s kids, families, communities and the economy at a time when it is needed most – right now.

The Colorado Consumer Health Initiative is a nonprofit organization dedicated to expanding access to barrier-free, quality health care that is affordable to all.

Expand Health Coverage

GRANTEE *Story*



**MITCH GARCIA,
DIRECTOR,
FARMWORKER
SERVICES**

*and Health
Education,
Valley-Wide
Health Systems,
Inc.*



**A POPULAR NEW CLINIC
PROVIDES URGENT CARE**

for people in and near Alamosa.

» **COLORADO STATE UNIVERSITY: SOUTHERN COLORADO COLLABORATIVE**

A new health advocacy partnership is taking a regional approach to expanding access to health care in Colorado's poorest counties: they're going straight to consumers.

With a three-year grant from The Colorado Trust, the Hasan School of Business at Colorado State University-Pueblo, the Action 22 Foundation, the San Luis Valley Immigrant Resource Center and the Center for Immigrant and Community Integration administered by the Catholic Charities Diocese of Pueblo have come together to address the health needs of 22 counties in southeastern Colorado. The Southern Colorado Collaborative is engaging hundreds of people to learn how best to improve access to care in their communities, and working to duplicate effective programs.

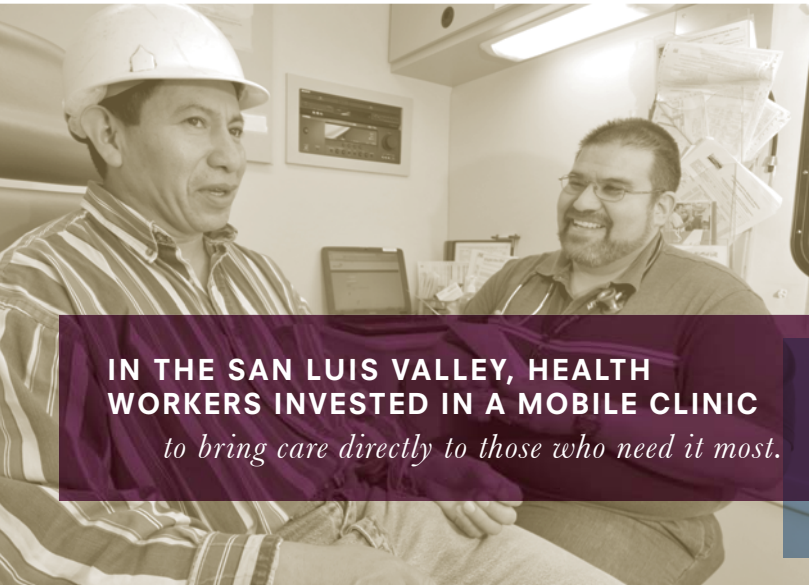
"Seven of these 22 counties don't have a hospital and mental health care is almost nonexistent in some areas," said Deborah Watson, PhD, who coordinates the collaborative and directs CSU-Pueblo's Center for Leadership and Community Development. "A lot of our counties have the highest poverty and unemployment rates, and the lowest education and median annual income statewide.

"Southern Colorado has many challenging issues. Health is not a top priority if people don't have jobs, a roof over their heads or food for their families."

Collaborative leaders are tapping into community groups that have already formed for other purposes, encouraging them to also advocate for health care and health coverage. For example, in Huerfano County, home to Walsenberg and La Veta, a strong alliance had formed to resist the U.S. Army's plans to expand the Piñon Canyon Maneuver Site outside Fort Carson. The collaborative hopes to harness the same group, along with others, to push for a new clinic in the county.

The collaborative will also bridge diverse counties facing similar issues. In the San Luis Valley, for example, some people who live in remote areas struggle to travel to the largest city in the area, Alamosa, when they need health care. The partnership found the same issues in Rocky Ford where farm workers spend their days far from health clinics. Now, the two communities are helping each other find the best way to deliver care.

In the San Luis Valley, health workers invested in a mobile clinic to bring care directly to those who needed it most. "Year-round, we go to potato



IN THE SAN LUIS VALLEY, HEALTH WORKERS INVESTED IN A MOBILE CLINIC

to bring care directly to those who need it most.



OUTREACH WORKERS HELP FILL OUT PAPERWORK

so people can tap health programs for which they qualify.

warehouses in the winter and do full dental and medical screenings,” said Mitch Garcia, Director of Farmworker Services and Health Education for Valley-Wide Health Systems, Inc. in Alamosa. “We go to homeless shelters, migrant worker housing locations, motels, festivals, parades, agricultural fields, grocery stores and churches. It’s rewarding to see how grateful people are to have access to these services.”

In addition to the health screenings, outreach workers help fill out paperwork so people can tap health programs for which they qualify. The clinic even has a satellite dish on top, enabling a direct link to Valley-Wide’s electronic health records via the Internet.

Valley-Wide Health also has a new, popular Convenient Care Clinic in Alamosa where people can seek help for urgent needs from early in the morning until 10 p.m. on weekdays and through the weekend, diverting patients from costly visits to the emergency room.

As part of the collaborative’s efforts to listen and understand the unique health needs of the region, Garcia also helped identify consumers to participate in “discovery dialogues.” Many of the dialogues were conducted in Spanish to engage more migrant farm workers and, so far, the dialogues in the San Luis Valley have shown that people want more programs like the mobile clinic.

“We need to preserve and expand our safety net, convenient care and mobile clinics,” Garcia said. “But people also need much better, and more affordable, access to quality diagnostic and lab services, along with access to specialists.”

The collaborative appeals to people’s hopes. “We’re not so much focused on the chaos of the health care crisis,” Watson said. “Rather, we’re asking ‘what are our opportunities?’”

THE SOUTHERN COLORADO COLLABORATIVE IS ENGAGING HUNDREDS OF PEOPLE

in 22 communities to learn how best to improve local access to health care, duplicate effective programs and encourage existing community groups to advocate for health care and health coverage.

HEALTH COV

Increase Outreach and Enrollment

A confusing and lengthy enrollment process for Medicaid and CHP+ results in many Coloradans who are eligible for coverage going without health care.

Trust grant strategies include:

- » Simplify and streamline eligibility and enrollment processes for public insurance programs
- » Develop and implement systems and policies to support continuous enrollment
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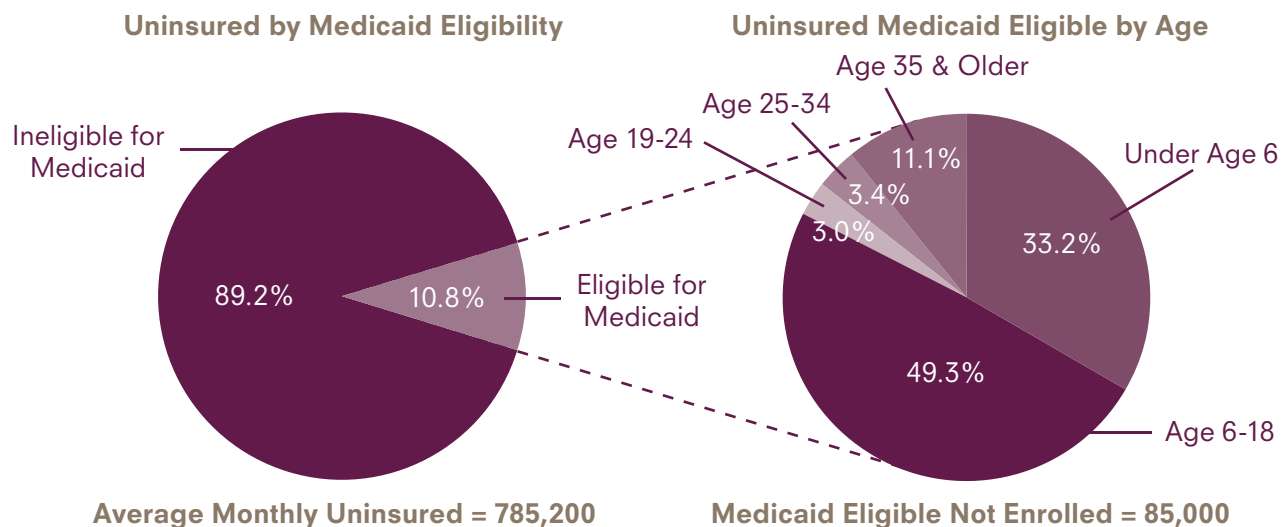
ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

BACKGROUND & TRUST Strategies

Expanding coverage to make affordable, quality options available to all Coloradans will be a significant achievement. However, ensuring that all Coloradans are successfully enrolled in these expanded coverage options by 2018 will require simultaneous investments to make outreach and

enrollment processes more effective. The difficulty Colorado has had with enrolling and retaining currently eligible children into existing free and low-cost insurance options is illustrative of the challenge ahead.

» AVERAGE MONTHLY UNINSURED BY MEDICAID ELIGIBILITY STATUS



Medicaid includes SCHIP

Source: Adapted from "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System," The Lewin Group, 2007.

ERA G E

As shown in the figure on page 12, most Coloradans who currently lack health coverage are not eligible for existing public programs because their income is too high to qualify. However, approximately 11% of the uninsured, mostly children, are eligible for Medicaid or Child Health Plan *Plus* (CHP+) and successfully connecting them to these existing coverage programs would reduce the number of uninsured children by more than 80,000.

The pathway to eligibility, enrollment and renewal in Colorado's Medicaid and CHP+ programs is complex and fraught with opportunities for confusion, error or other system failures that result in a lack of consistent coverage for low-income children. Outreach efforts are necessary to educate parents about eligibility, help families to enroll, and provide application assistance to families who need help navigating a difficult and paper-intensive system. Simultaneous efforts need to tackle arcane policy and inflexible computer systems in order to simplify and streamline the processes for eligibility, enrollment and renewal, and to develop better methods for monitoring the entire enrollment process.

Given Colorado's complicated and constantly changing system of public coverage, a persistent outreach and enrollment gap exists. This gap means that children and adults who are eligible for health coverage may not receive the preventive care, treatment for chronic or acute conditions and health outcomes to which they are entitled.

While application assistance sites and other formal mechanisms exist to help families navigate the Medicaid and CHP+ eligibility process, it remains a challenging undertaking with multiple barriers. Families attempting to sign up for care for the first time may not be familiar with public programs or may be frustrated by a confusing and lengthy enrollment process. Others within low-income communities have a long history of mistrust of the system. Additionally, approximately half of the uninsured children in Denver who are eligible but not enrolled in public programs have parents who are not U.S. citizens. Recently immigrated parents face additional barriers to enrolling their citizen children in coverage, including language difficulties, and for undocumented parents, fear of detection and mistrust of government.

Therefore, a critical component at the local level is to support not only the mainstream and government systems in enhancing outreach and enrollment efforts, but also to work with community-based organizations that are trusted by vulnerable populations. To this end, The Trust is actively supporting local programs in using the outreach methods that work best in their particular community to reach parents who may be unaware that their children qualify for public coverage or who face other barriers to enrollment. In 2008, The Trust made three-year grants to sites where children and families already have an existing and trusting relationship in their communities.

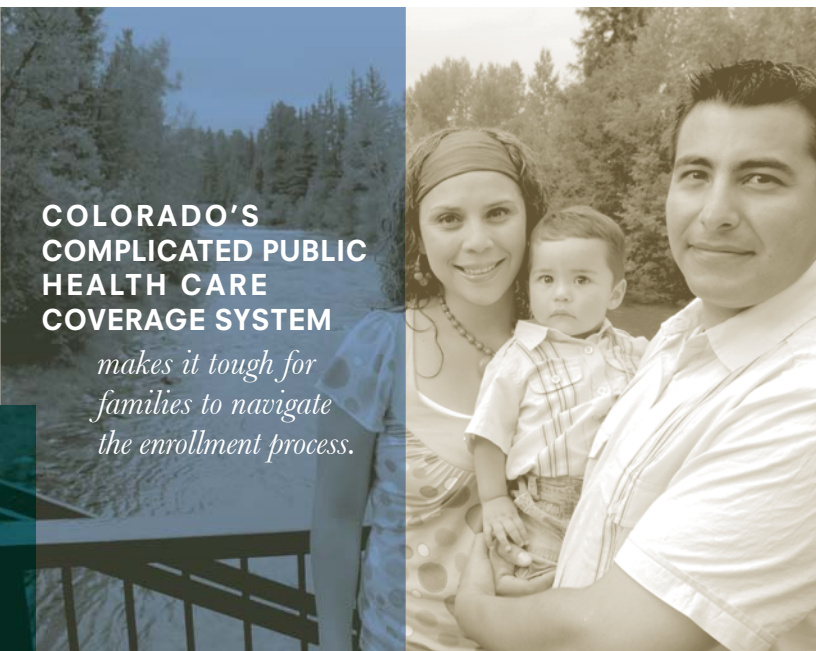


CONNECTING CHILDREN TO MEDICAID OR CHP+

would reduce the number of uninsured children in Colorado by more than 80,000.

COLORADO'S COMPLICATED PUBLIC HEALTH CARE COVERAGE SYSTEM

makes it tough for families to navigate the enrollment process.



Increase Outreach and Enrollment

The intent of these resources is to support sites to expand their services and capacity to include outreach and coverage application assistance. Eighteen diverse grantees include after-school programs, clinics, public agencies serving low-income families, a school district, a hospital, an affordable housing provider and county-coordinated collaborations.

Yet, even innovative outreach is not sufficient on its own to ensure continuous enrollment in, and retention of, health coverage. It is equally important that policies and systems effectively support this objective. Unfortunately, Colorado's Medicaid and CHP+ processes are cumbersome for all involved, from administrators, to families without coverage who want to determine their children's eligibility, to providers who wish to confirm patient enrollment in coverage.

The eligibility processes for Medicaid and CHP+ differ and state staff must work with 65 separate entities (64 county offices for Medicaid and a private vendor for CHP+) to determine eligibility. Although intended to complement each other (CHP+ fills coverage gaps left by Medicaid), the programs were created at different times, with different rules, income thresholds and coverage philosophies. The resulting piecemeal development and inconsistent administration of these programs has created a complicated maze of barriers for Medicaid and CHP+ applicants.

The reasons that the system is difficult to navigate are several and varied, including:

- Age-based eligibility rules that result in families with one child in CHP+ and another in Medicaid
- Documentation and citizenship requirements that are challenging to meet and costly to families
- Children cycling between Medicaid and CHP+ as a result of small changes in family income
- A complicated renewal process that results in lapses in coverage
- Computer software that cannot accommodate the level of complexity in current eligibility rules
- Inconsistent processing of applications at the county level and an over-burdened workforce.

Simplifying the eligibility process requires the development of policy and technological recommendations to streamline the system at all stages of the enrollment process. The Trust funded a study by Colorado Covering Kids and Families to examine barriers to the current Medicaid and CHP+ enrollment system, together with recommendations for reform. One clear



SIMPLIFYING THE ELIGIBILITY PROCESS

requires policies and technologies that streamline the system.

OUTREACH PROGRAMS INFORM PARENTS

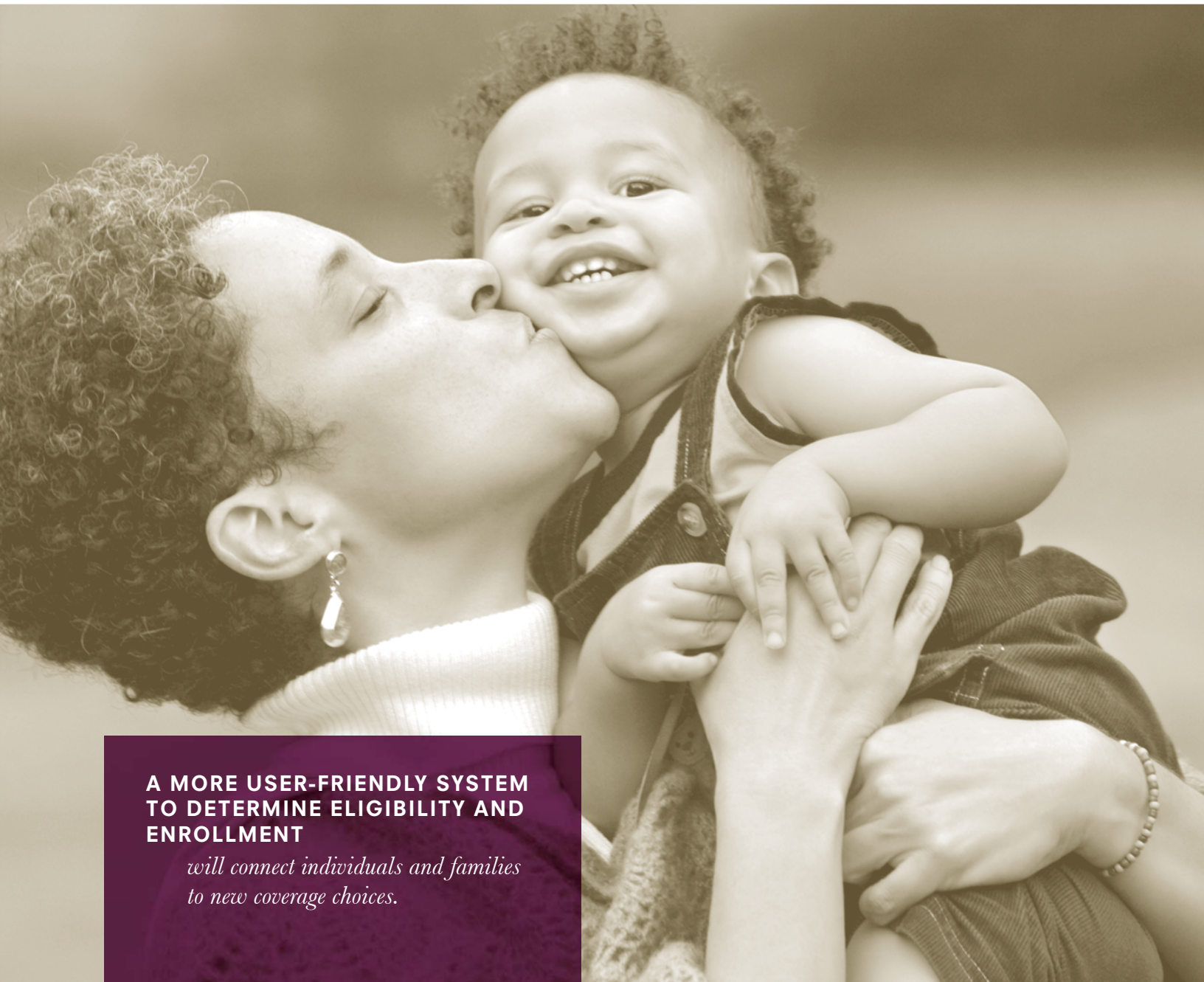
who may be unaware that their children qualify for public coverage.

area for improvement is application and renewal processing delays associated with the state's computer-based eligibility system, known as Computer Benefit Management System (CBMS). For this reason, The Trust is supporting the state's efforts to examine additional means of streamlining eligibility determination and enrollment processes, and to enhance CBMS to expedite enrollment and minimize erroneous lapses in coverage.

The need for clear information and assistance will continue even as new coverage options become available in the next decade. In fact,

more coverage choices could create even greater demands for clarity and understanding among potentially eligible Coloradans. Tailored outreach strategies and a more user-friendly system to determine eligibility and enrollment will go a long way toward connecting individuals to these new opportunities.

Grantees receiving support from The Colorado Trust to Increase Outreach and Enrollment are listed on page 38.

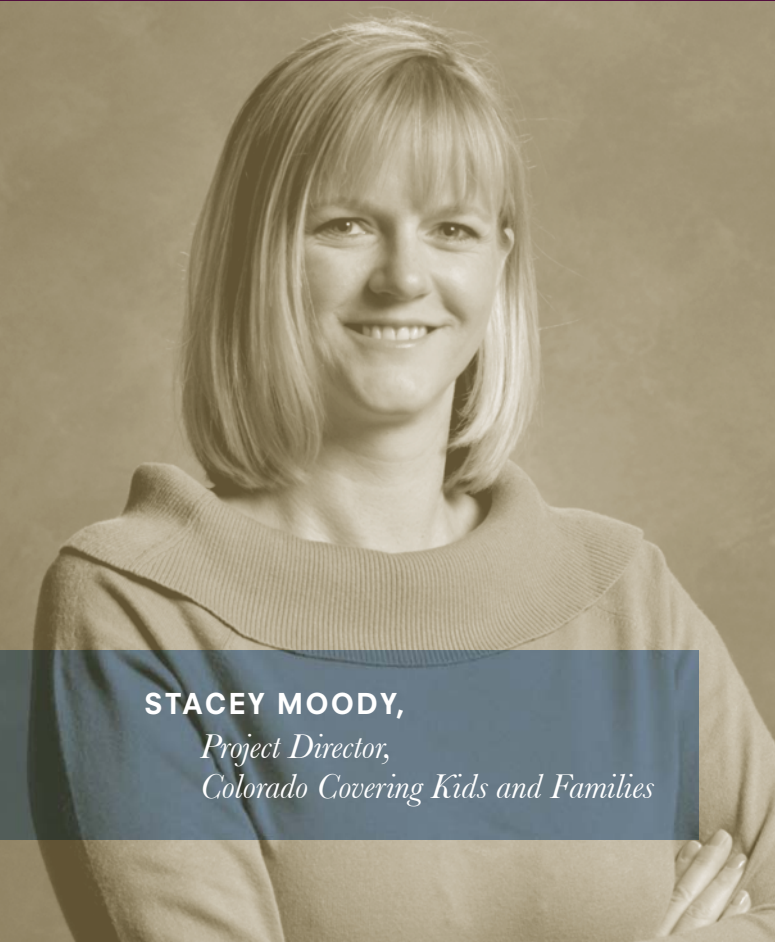


**A MORE USER-FRIENDLY SYSTEM
TO DETERMINE ELIGIBILITY AND
ENROLLMENT**

*will connect individuals and families
to new coverage choices.*

Increase Outreach and Enrollment

COMMUNITY *Insight*



STACEY MOODY,
*Project Director,
Colorado Covering Kids and Families*

» PREVENTING COVERAGE LAPSES IS KEY TO CONNECTING FAMILIES WITH CARE

By Stacey Moody

An old, familiar children's ballad goes like this:

*There's a hole in my bucket, dear Liza, dear Liza,
There's a hole in my bucket, dear Liza, a hole.
Then fix it, dear Henry, dear Henry, dear Henry,
Then fix it, dear Henry, dear Henry, then fix it.
With what shall I fix it, dear Liza, dear Liza?
With what shall I fix it, dear Liza, with what?
~Traditional*

As the ballad continues, Liza provides common sense responses to Henry's questions about how to solve this perplexing problem. The failing bucket

is an apt, if troubling, metaphor for one facet of Colorado's Medicaid and CHP+ outreach and enrollment maze.

Despite the availability of Medicaid and CHP+, more than half of Colorado's 170,000 uninsured children are eligible for but not enrolled in the programs. Recognizing the importance of health care coverage in the lives of children and families, many decisionmakers in the state are zeroing in on how to close this gap, including Governor Ritter, legislators, health care and community agencies, health care providers, foundations and advocates.

Recently Colorado Covering Kids and Families published findings from a study funded by The Colorado Trust – *The Maze: The Barriers that Keep Colorado's Eligible Children and Families Out of Medicaid and CHP+ and Recommendations to Create a Direct Path to Enrollment* – that examined the barriers to Medicaid and CHP+ coverage. Why? Because before you can solve a problem, you've got to understand the nature of it and no one has ever attempted to create a comprehensive portrait of this critical and complicated process. Plus, a thorough understanding of Colorado's enrollment barriers provides the framework for developing and testing strategies to increase enrollment.

Accessing Medicaid or CHP+ coverage is comprised of four steps: outreach, eligibility determination, enrollment and renewal. Barriers exist in each stage of the process, but critically important is renewal – if we're going to invest resources in removing barriers, this is where we'll get the biggest return on our investment.

There is a tacit assumption underlying our desire to enroll kids who are eligible that, once covered by Medicaid or CHP+, they are taken care of. In fact, lapses in coverage are all too common. In too many cases, outreach and enrollment resources are used to re-enroll the same children over and over. Those precious resources could be used more wisely in

connecting those in need of coverage who have not had previous contact with these programs.

If we don't have an effective means to retain those who are eligible and, more importantly, to provide continuity of care for these children and families, then we are defeating our purpose.

According to our study and the 2008 CHP+ audit, a startling one-quarter of eligible children either did not reapply, or experienced a lapse in coverage between April 1, 2006 and March 31, 2007. The burden to renew is on the covered individual or parent. When the system is working, a renewal packet is sent prior to the 12-month enrollment expiration date by the county Medicaid eligibility office or CHP+.

The information requested can be very confusing for families. Add to that the fact that 65 different sites re-determine eligibility for the two programs and you've got a multitude of points in the system where something can go awry.

Consider this Pueblo County family's experience. The children have been covered by CHP+ since 2005. In 2008, when the family submitted the required renewal application, they had no income due to a loss in their family business and were advised that they would likely be income-eligible for Medicaid. After submitting the renewal application, the mom received several notices from the state but did not respond to the confusing CHP+ letters because she thought her kids were enrolled in Medicaid and thus these letters no longer applied to her.

When the mom tried to fill an asthma prescription for one of her kids, the pharmacist told her that the child was not covered by Medicaid. Fortunately for this family, they had worked with Pueblo StepUp, a community health service organization of Centura Health, which intervened and contacted the county's Medicaid technician to explain the family's self-employment income, correct the case and get the children enrolled in Medicaid.

The renewal process does not need to be this complicated and confusing. Colorado has the opportunity to create a streamlined renewal process that will help close gaps in coverage and, happily, we are making progress in this area:

- A recently passed regulation requires a simpler, internal ex parte renewal, whereby administrators must rely on existing information from other public programs (e.g., food stamps) and databases to confirm continued eligibility for coverage at their annual renewal rather than requiring the client to complete a renewal form.
- Certain Colorado counties are already leading the way in developing more integrated systems at the community level to ensure children and families have the support they need to apply, determine eligibility, enroll and renew.
- In 2008, the state legislature approved funding for online enrollment, a customer call center, and the infrastructure and training to support it.

Those who may fear changing our antiquated and dysfunctional system need only look outside Colorado to others who have gone before us. For example, Louisiana has substantially improved retention rates while keeping the burden on families to a minimum. Their state agency relies on an ex parte renewal process and, when additional data is needed, eligibility technicians telephone the client or parent. The result? Louisiana has reduced renewal denials of eligible children from 22% to less than 1%.

The current process for renewal in Colorado, like Liza's leaky bucket, is overwhelming and burdensome for all who have a stake in it – from the family denied coverage at the door of the provider, to the provider trying to absorb a sick patient without coverage, to the eligibility determination technician with an unmanageable caseload. As Liza subtly suggests to Henry, a little common sense can go a long way. If we think about simplifying, streamlining and using available technology appropriately, we can solve the renewal conundrum. We all have a part in fixing what's broken and we can do that by working together.

Straightening out this path in the maze will be a giant step toward reaping returns on previous investments made to ensure enrollment for all Coloradans who are eligible for Medicaid and CHP+.

Colorado Covering Kids and Families is a statewide coalition led by the Colorado Community Health Network.

Increase Outreach and Enrollment

GRANTEE *Story*



**CATHY STORY,
DIRECTOR,
*Hilltop
Community
Resources***



**THROUGH HILLTOP,
SABRINA MEADE
QUALIFIED FOR CHP+
*and received health coverage
during her pregnancy.***

» HILLTOP COMMUNITY RESOURCES

Sabrina Meade works full-time in a nursing home caring for patients afflicted with Alzheimer's Disease and severe dementia. As a Certified Nursing Assistant, she offers her patients comfort and stability.

"It's a rewarding job," said Meade, 24, who lives in Clifton. "You become their family."

Yet when she needed health care herself, she found that her hourly salary of \$10.50 didn't stretch far enough to afford health insurance. Pregnant with her first child in 2007, Meade worried about how she and her husband would pay \$20,000 out-of-pocket for the baby's birth.

Then, she found out about Hilltop Community Resources in Grand Junction. Hilltop's Child & Family Center helped Meade qualify for CHP+, which provided health coverage during her pregnancy.

She loved being able to pick her own doctor and knowing that her baby would have access to medical care after the birth. Little Vada Schuman, now 13 months old, arrived nearly two weeks late. "I ended up needing an emergency C-section," Meade said. "Thankfully, she came out a very healthy baby."

The nonprofit agency helped Meade's husband, too. Jason Schuman, 32, used to work on the oil rigs across western Colorado. But tumbling oil prices and the declining economy have drastically reduced the number of jobs in the oil and gas industry. Hilltop's Workforce Center helped Schuman get retrained as a nursing assistant. Now he works day shifts at the same Palisade nursing home where his wife works in the evening. They take turns caring for their daughter.

"It's a miracle," Meade said of Hilltop. "It's a warm, family atmosphere. They really care about people and want to help. When you're working-class, sometimes you get shoved aside. I made a little too much to qualify for Medicaid. It was a good thing I got CHP+."

Now pregnant with her second child, Meade is once again receiving help from Hilltop, which serves nearly half of all pregnant women in Mesa County. Hilltop's free B4 Babies & Beyond program reaches out to pregnant women in innovative ways, from providing application assistance for Medicaid and CHP+ health care programs and helping patients find a physician, to providing information on nutrition and healthy choices during pregnancy, and offering transportation and translation services for Spanish-speaking moms.



BABY VADA IS GROWING UP HEALTHY,

thanks to Hilltop's B4Babies & Beyond program.



EACH YEAR, HILLTOP HELPS ABOUT 1,700 FAMILIES

enroll in government-funded programs or get placed with primary care providers.

“Eligibility is key,” said Cathy Story, who directs Hilltop’s Child and Family Center. “We offer a temporary card to pregnant women or children while we wait for their Medicaid cards to arrive in the mail. We don’t want anyone to have to wait to access the health care services they need.”

Each year, Hilltop helps about 1,700 families enroll in government-funded programs or get placed with primary care providers. With a three-year grant from The Colorado Trust, Hilltop has hired outreach workers to boost enrollment of eligible patients in Mesa County from 75% to 85%.

“We have 2,200 babies a year,” Story said. “Their moms may or may not know how the system works. It’s our job to reach out to them, stay with them and become their central point of medical and dental care.”

With a goal to qualify patients for health care programs in fewer than 14 days, Hilltop seems poised to accomplish just that, and serve as a model for the rest of the state.

WITH A THREE-YEAR GRANT FROM THE COLORADO TRUST,

Hilltop has hired outreach workers to boost enrollment of eligible patients in Mesa County from 75% to 85%.

HEALTH CARE

Improve Health Systems

A complex, disjointed health care system results in costly waste and duplication of services, making it difficult to navigate and often resulting in poor health outcomes.

Trust grant strategies include:

- › Provide comprehensive preventive services in a timely manner
- › Align high quality, coordinated care with financial incentives for providers
- › Strengthen the ability of health care sites and providers to meet standards of care



ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

BACKGROUND & TRUST *Strategies*

Though it seems contradictory, Americans still widely believe that they receive the best health care in the world, even as they express dissatisfaction with the affordability, safety and equity of health care delivery and financing in the United States. Indeed, even as U.S. medical technology is second to none, Americans' medical bills are higher and patient outcomes are poorer compared to other developed countries.

According to the Institute of Medicine (IOM), quality health care is that which is safe, timely, effective, efficient, equitable and "patient-centered," meaning that all people have equal access to cost-effective care that is based on research, responsive to their individual needs, preferences and cultures, and that patients are engaged as partners in care decisions. According to a recent Commonwealth Fund state scorecard on health system performance, Colorado performs less well than most states on quality (30th), access (35th) and equity (43rd) indicators.

In Colorado, as nationally, quality of care is often inconsistent. Quality "report cards" issued by the federal Agency for Healthcare Research and

Quality and the Colorado Business Group on Health indicate that while pockets of consistently high quality services exist (e.g., care after heart attack), care is variable at best. Similarly, data reveal consistently poor performance in certain maternal and child health indicators and nursing home care. According to the IOM, many of these indicators show that quality of care is often lower for communities of color due to cultural and linguistic barriers and provider bias.

The current health care system consists of many different components (e.g., hospitals, primary care physicians, specialists, outpatient clinics, rehabilitation centers, long-term care) that largely function independently with little coordination. Such an environment makes it difficult for providers to communicate and share important health information, and increases the chance for medical errors, waste and duplication of services and procedures. For patients, this disjointed system can be confusing, nearly impossible to navigate and often fails to produce positive health outcomes. Patients with limited English language proficiency are at a particular disadvantage.

» EXAMPLES OF QUALITY INDICATORS THAT COLORADO NEEDS TO IMPROVE UPON

The shortage of primary care providers compromises the ability of Coloradans to receive timely care, especially low-income and rural families. This factor may contribute to statewide first-trimester prenatal care rates that are below both the federal government's Healthy People 2010 standards and the national average. However, even when one gains access to care, many Coloradans do not receive the "right" care. For instance, quality indicators suggest that fewer than half of adults are getting recommended preventive health care services.

According to the Colorado Business Group on Health, care may not be as safe and efficient as it could be because not all hospitals have adopted computerized medical record systems that help prevent medication errors. Finally, some Coloradans struggle to find care that is culturally appropriate. For example, some clinical sites that accept low-income patients lack translators for patients who need them and others have long waiting times. Access and quality barriers combine with social factors to produce pronounced differences in health outcomes across income, race, ethnicity and insurance groups in Colorado.

An integrated model for clinical care is one where physicians are supported to practice care collaboratively within and across care settings. Transitioning to a more integrated system may require financial incentives and cultural changes to facilitate teamwork among providers and patients, reorganization of staff and adoption of

health information technology (HIT) to enhance information sharing, reduce costs and improve quality care and patient satisfaction.

According to the Institute for Healthcare Improvement, more than 40,000 incidents of medical harm occur daily in the United States.



AN INTEGRATED HEALTH SYSTEM REDUCES COSTS

and improves quality care and patient satisfaction.



QUALITY HEALTH CARE IS EQUITABLE

and responsive to individual needs.

Improve Health Systems

Many of these adverse events could be prevented with more attention directed to patient safety and the coordination of care. To address these issues, The Trust funded the Colorado 5 Million Lives campaign that encouraged hospitals to adopt up to 12 interventions to improve care. These interventions include rapid response at the first sign of patient decline, ensuring that patients receive the right medications, implementing best practices known to prevent hospital-acquired infections and providing leadership support and training to sustain these efforts.

There are few incentives to better coordinate services, improve the health care delivery system or provide care that is responsive to patients' individual preferences and cultures. Typically, Colorado health care providers are paid based on the number of services they provide rather than the quality of care. Yet, payment-per-service encourages providers to respond to missing test results by ordering additional testing, rather than investing in improved information sharing. Ironically, medical complications and poor outcomes often result in higher payments. The providers who "do the right thing" and coordinate care for their patients (provide a true "medical home") are largely uncompensated for providing integrated medical care, even when their efforts result in better health for patients and savings to the system.

Public and private payment policies need to be reformed to reward quality and value, and remove incentives to provide more care than necessary. For example, The Trust supports the Colorado Clinical Guidelines Collaborative (CCGC), a multi-payer, patient-centered medical home initiative that aims to reward value. CCGC provides technical assistance to help medical practices implement clinical guidelines, health information technology and enhanced payment to 17 medical home pilot sites across the state. Through a rigorous evaluation, the project's findings have the potential to improve local and national payer reimbursement for primary care.

Measuring quality is a challenging endeavor due to expense and a lack of consensus about appropriate indicators. Data that would be useful to pinpoint the problem areas are frequently trapped in paper files or stored in many separate and often propriety databases. Data on quality of care are increasingly available for health plans and hospitals, yet few private physician offices collect quality data on their patients due to prohibitive costs and the limited availability of technology. However, provider-specific data are often necessary to better understand the reasons behind poor outcomes observed in a larger health system, such as the fee-for-service Medicaid programs.



INCIDENTS OF MEDICAL HARM CAN BE PREVENTED

with more attention directed to patient safety and coordinated care.

PUBLIC AND PRIVATE PAYMENT POLICIES

need to be reformed to reward quality and value, and remove incentives to provide more care than necessary.



To provide apples-to-apples quality comparisons and better troubleshooting information at all levels of care, Colorado must:

- Reach consensus on quality measures
- Resolve proprietary concerns
- Standardize data collection practices
- Merge data from different sources to provide a full picture
- Routinely analyze and publicly report results.

The Trust is investing in strategies and partners that seek consensus on how to measure and improve quality. In addition to the work of CCGC, The Trust

supports the Center for Improving Value in Health Care (CIVHC) in its effort to change fundamentally the way care is provided in Colorado. CIVHC is a new, multi-stakeholder initiative to identify and pursue effective strategies for quality improvement and cost containment. By connecting and convening those engaged in quality improvement efforts already underway, CIVHC is well-positioned to identify health outcomes most in need of improvement, as well as potential solutions.

Improving systems can lead to better health outcomes for Coloradans while simultaneously achieving higher quality and cost containment.

Grantees receiving support from The Colorado Trust to Improve Health Systems are listed on page 38.



**HEALTH INFORMATION TECHNOLOGY,
FINANCIAL INCENTIVES AND CULTURAL
CHANGES THAT FACILITATE TEAMWORK**

*among providers and patients can help lead to
a more integrated health care system.*

COMMUNITY *Insight*



JAY WANT, MD,
President and CEO,
Physician Health Partners, LLC

» **WHY WHAT YOU ACCESS MATTERS**

By Jay Want

It's been a whirlwind year in health care reform, a more tumultuous one than in any recent memory. One shift some might have missed is the change from providing access as the major goal of reform, to a more refined goal of providing access to a well-functioning system. The latter, as it turns out, is much more challenging than simply finding financing for universal coverage.

A well-functioning system is one that adheres to the Institute of Medicine principles: care should be safe, timely, effective, efficient, equitable and patient-centered. The hard reality is that very few

Americans – perhaps about 10% of us – have access to a system that is all of these things. Those fortunate few are served mostly by large multi-specialty groups, like Denver Health or the Group Health Cooperative of Puget Sound. The data are clear that these delivery systems produce higher quality, lower costs and higher patient satisfaction.

So what are the rest of us to do? The answer is to foster the development of systems in our own communities that have the same characteristics. Here are some of the attributes these systems share:

- They excel at coordinating care, and use electronic health records to streamline communication and minimize duplication
- They live within a global budget that provides an incentive to get exactly the right care to people as efficiently as possible and to fix things right the first time
- When a system of care is flawed, people have a natural incentive to solve the problem together, rather than thinking, "I'm just responsible for my piece."

The reality is that the best medical systems are those that behave as communities, not as individuals. They cooperate with one another, they are stewards of common resources and they problem-solve together to serve common goals, including cost, quality and patient satisfaction. There is a term for this you will hear over the next couple of years: "accountable care organization." Many are working on what it will take to foster ACOs, and create access to them for everyone in Colorado. One group is the Governor's Center for Improving Value in Health Care. Another is the Colorado Clinical Guidelines Collaborative, which has been working on one component of ACOs, the patient-centered "medical home" – continual care that is managed and coordinated by a primary care physician.

The ACO approach will require changing the way we pay for care, the way we organize it and the way care systems work with the communities they serve. The tricky part is getting from where we are today, with most of our care disorganized, to a desired future state, where most is organized.

What should we do to accelerate this transformation?

- First, help physicians and hospitals recognize that they already function in systems of care that are currently unaccountable. Elliott Fisher, MD, MPH, at the Dartmouth Institute for Health Policy and Clinical Practice has studied care patterns nationally. He finds that 75% of Medicare beneficiaries receive their care from definable aggregations of hospitals and physicians who practice together. Requiring some physicians to declare a more formal affiliation with their local hospital will create measurable units with which to evaluate and establish standards for cost and quality.
- Second, aggregate data across all payers to measure differences between unaccountable care organizations (UCOs) carefully and meaningfully. By aggregating all data, one stands a better chance of getting a statistical result that actually indicates a difference in practice pattern. These differences can then be reported back to the UCOs so they can investigate and correct the root causes. (Process improvement methods might be new to some systems, and they may require some technical assistance.)
- Third, begin paying for care on a pre-determined, bundled basis. By paying for a whole episode of care, or a year's worth of care for a chronically ill individual, one removes the incentive to do more to get more payment. This in turn creates a market for efficiency rather than the existing market for inefficiency. This is the beginning of living on a budget, which is what most other industries do to provide value, and what most other national health care systems do around the world. What we need to make health care sustainable for the state is for every Colorado care system to live on a budget.

The best system I know of in Colorado is in Grand Junction. Thirty years ago, geography conspired to make plain to the community's residents that they are dependent on each other to keep themselves healthy. They started Rocky Mountain HMO to give themselves a payment mechanism, and began organizing their care around primary care, not hospital or specialty care. Studies then and now show primary care is much more cost-effective than specialty and hospital care. They set budgets, designed systems to get the most out of the money they spent and set a goal that everyone in the valley should have access to care. Today, Grand Junction is recognized as the most efficient and effective region in the country for Medicare beneficiaries. Their costs are two-thirds of the national average, and they get better outcomes, including patient satisfaction.

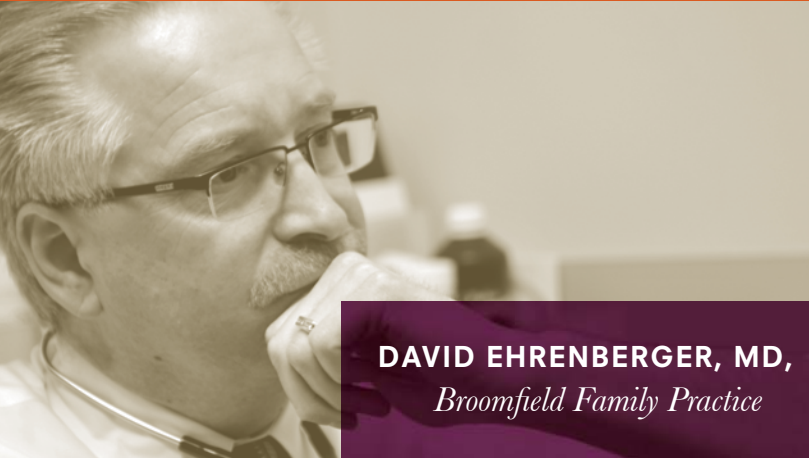
“THE BEST MEDICAL SYSTEMS ARE THOSE THAT BEHAVE

as communities, not as individuals. They cooperate with one another, they are stewards of common resources and they problem-solve together to serve common goals, including cost, quality and patient satisfaction.”

Can all Colorado communities become like Grand Junction? The jury is still out, but by doing the things I suggest above, I think we stand the best chance of changing the way providers win: from doing more, to doing exactly the right thing at exactly the right time. That, I believe, would produce access to care that is accountable, high-value and sustainable.

Physician Health Partners, LLC, is a management services organization serving over 50,000 covered lives in Colorado.

GRANTEE Story



DAVID EHRENBERGER, MD,
Broomfield Family Practice

A PATIENT-CENTERED MEDICAL HOME

provides patients with comprehensive, coordinated care through a primary care team.



» COLORADO CLINICAL GUIDELINES COLLABORATIVE: PATIENT-CENTERED MEDICAL HOME PILOT

Imagine a doctor's office that revolves around the patient. A caring team knows your name, greets you with a plan to achieve your health goals, answers emails quickly and provides same-day appointments so you can see your doctor immediately when you're sick.

David Ehrenberger, MD, of Broomfield Family Practice is eager to provide such service under a groundbreaking national pilot program. Supported by The Colorado Trust, along with The Commonwealth Fund and the Harvard School of Public Health, the pilot will test a health care delivery system called "patient-centered medical homes."

At a practice that adopts the medical home vision, patients should feel like they've found a partner to heal them when they're sick, and set a course to keep them well.

"It's like Marcus Welby on steroids," Ehrenberger said of the concept, describing both its patient-centered focus and the powerful technology that will boost communication, cut errors and increase cooperation among health professionals.

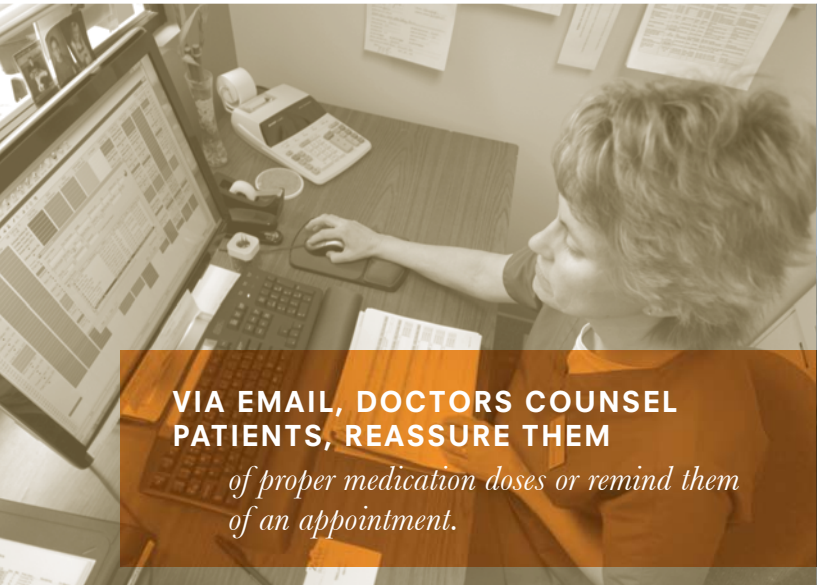
Ehrenberger became a family doctor so he could build relationships with patients like Welby, the legendary TV doctor. Two decades into his career, he found himself sprinting on a treadmill, trying to see more and more patients each day to keep up with costs. Increasingly, paperwork and insurance snafus were bogging him down.

Under the medical home system, Ehrenberger envisions a much saner system. He'll actually get paid to keep patients well, not to simply shuffle them in and out as fast as possible.

"We're definitely pioneers," he said. "You can't just say you're doing it. You have to prove it. It's nothing short of a revolution."

Among the significant changes Ehrenberger expects to see:

- **Open schedules.** Patients will be able to see their own doctor when they are sick. Traditionally, doctors are scheduled months in advance, leaving few slots for sick people who need to be seen immediately. Ehrenberger's practice will turn that system upside down and adopt what's called an open schedule. For example, a mother who has been up all night with a sick baby can call



VIA EMAIL, DOCTORS COUNSEL PATIENTS, REASSURE THEM

of proper medication doses or remind them of an appointment.



PERSONALIZED CARE

emphasizes prevention and managing long-term chronic conditions.

first thing in the morning, talk with a member of her health team and schedule a same-day appointment with her regular doctor.

- **Focus on wellness.** Under the current medical model, insurance companies reimburse doctors most fully for time spent doing procedures, rather than talking with patients. When a doctor sits down for 30 minutes with a diabetic patient to teach critical dietary lessons, the doctor sacrifices income. Under the medical home model, doctors will be rewarded for keeping patients healthy by coordinating care with other providers.
- **Team approach.** Each morning, Ehrenberger and his colleagues meet for a “team huddle.” They try to anticipate their patients’ needs, proactively prepare necessary immunizations or medical tests and help set goals for their patients. That’s a dramatically different model than having doctors put out medical fires all day, with little time to help patients ponder health goals.
- **Integrated technology and medical records.** Ehrenberger uses a laptop to document each patient’s medical history. Patients will have access to their medical

records and can log in to check results for lab tests. If a patient has an emergency and visits a hospital, Ehrenberger will automatically get a notice in his email inbox of the hospitalization. His system will be linked to the hospital’s records, so he’ll be able to access his patient’s chart and lab results.

The two-year pilot program is being tested in 17 family medicine and internal medicine practices along Colorado’s Front Range. The Colorado Clinical Guidelines Collaborative (CCGC) provides technical assistance to help the practices apply for and receive certification as a medical home, as well as ongoing coaching as they work to achieve an integrated delivery model. CCGC brings together multiple national and local insurance companies, along with physician and patient representatives with the goal to improve the delivery and adequate reimbursement of primary care.

“Our health care system isn’t sustainable,” said Marjie Harbrecht, MD, who helped get the pilot established as CCGC’s Medical/Executive Director. She says more personalized care will put the emphasis on prevention and managing long-term chronic conditions. “As one of our doctors said, ‘It’s the kind of care you’d want your Mom to have.’”

HEALTH CARE

Increase Availability of Care

Economic challenges to the safety-net system, insufficient availability of health care services across Colorado, and a shortage of health care providers make it difficult for some Coloradans to receive health care.

Trust grant strategies include:

- › Strengthen the viability of health care delivery sites and providers to serve uninsured, and publicly and privately insured Coloradans
- › Ensure adequate points of access across the state for preventive, primary, oral and behavioral care
- › Expand education, recruitment and retention programs and policies to increase the number of health care providers available to serve Coloradans



ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

BACKGROUND & TRUST *Strategies*

Maintaining good health requires access to care when it is needed. Yet, care is more difficult to find for some Coloradans because of where they live or their ability to pay. Achieving coverage for 800,000 uninsured Coloradans will place increased demands on a health care system that already struggles to deliver quality care in all areas of the state.

With economic conditions threatening the survival of safety-net providers, such as school-based clinics and community health centers, there is an immediate need to maintain the viability of health care delivery sites and providers to serve low-income children and families. A systemic, longer-term fix also is needed to ensure that sufficient numbers of providers are trained in primary care and needed specialties, and recruited and retained in underserved areas.

Distance and geographic barriers often limit rural Coloradans' ability to reach health care facilities. According to the Colorado Rural Health Center, 13 of Colorado's 64 counties do not have a hospital, 28 have no community health center

and three are without local health care resources of any kind. Urban and suburban communities also face significant challenges with many health care facilities that serve low-income populations operating at capacity, leaving patients with long delays for appointments. Because of poor reimbursement, administrative hassles and other factors, many private providers limit the number of publicly insured people they are willing to serve, even as the number of uninsured and publicly insured Coloradans has grown during the economic recession.

According to the Commonwealth Fund State Scorecard (2007), just over half of Colorado children (57.7%) received both a preventive medical and dental visit in 2003. The Colorado Children's Healthcare Access Program (CCHAP) is helping to increase the availability of care for publicly insured children. With support from The Trust, CCHAP has helped to increase from 20% to 90% the number of Front Range pediatric and family medical practices that care for children


enrolled in Medicaid and Colorado Health Plan *Plus* (CHP+). Preliminary results show that pediatric and family medical practices participating in CCHAP have cut in half the emergency room visits of the publicly insured children they see, and have achieved other cost savings with an increased focus on well-child visits and preventive care. These savings are used to provide higher reimbursements to doctors, making it possible for them to see more children covered by Medicaid and CHP+. CCHAP is now poised to help provide needed medical homes to children in underserved areas across the state.

Increased private provider participation in public programs does not, however, increase the availability of care for people without insurance. According to the Center for Studying Health Systems Change, in 2005 less than 20% of urban primary care physicians nationwide provided more than 10 hours of free care per month, and 40% did not provide any free care. Further and ironically, increasing private care options for Medicaid patients is a double-edged sword, as it may have an unintended impact of diverting paying (Medicaid) patients from safety-net providers that offer free and reduced-price care to the uninsured.


Many community and rural health centers rely on the Medicaid revenue stream to subsidize discounted care to uninsured Coloradans. Ensuring the financial viability of publicly supported clinics

is vital to achieving access to care for low-income families, including the uninsured and publicly insured. With this in mind, The Trust balances investments in private sector approaches with efforts to strengthen safety-net provider capacity throughout the state. As well, The Trust recognizes that broader improvements in the health care system, such as covering the uninsured and provider payment reform, are ultimately necessary to ensure that an adequate network of public clinics and private providers exist to serve all Coloradans.

Additional underserved children are receiving consistent primary, mental and dental health care thanks to the work of the Rocky Mountain Youth Clinics (RMYC). Through community clinics, mobile health care vans that serve rural and metro-area counties, and by establishing and servicing new school-based health centers, The Trust is supporting RMYC to provide care to uninsured and underinsured children in their communities. Additional funding to the Colorado Department of Public Health and Environment matches and leverages state funding to further increase and expand school-based health centers, and supports the School Health Leadership Task Force, which is working to create a comprehensive state plan to strengthen the system of integrated school health. A set of Trust grants also is supporting 14 diverse safety-net clinics, including faith-based clinics, school-based health centers, local public health departments and federally



A SUFFICIENT NUMBER OF PROVIDERS
trained in primary and specialty care is vital to achieving access to health for all Coloradans.



STRENGTHENING THE CAPACITY OF SAFETY-NET PROVIDERS
helps meet the immediate needs of low-income patients.

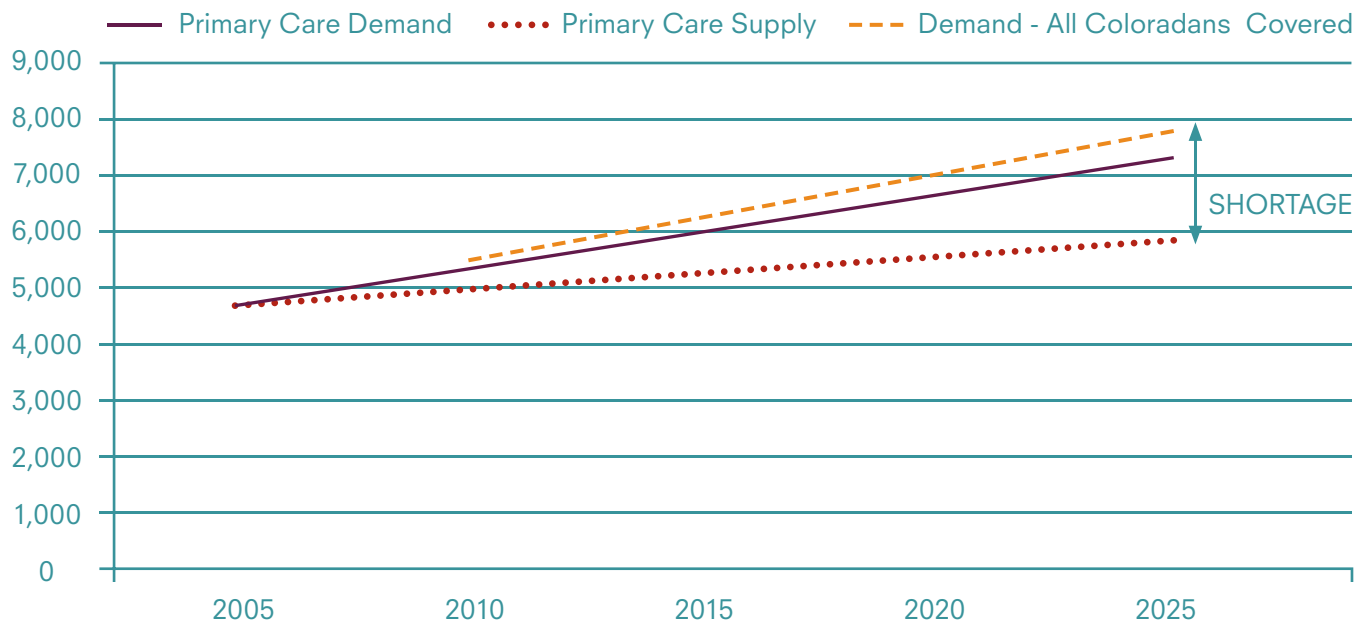
Increase Availability of Care

qualified health centers. By the end of the three-year grant period, these organizations anticipate that 18,000 children who do not now have access to health care will annually receive preventive, primary, oral and behavioral health care services.

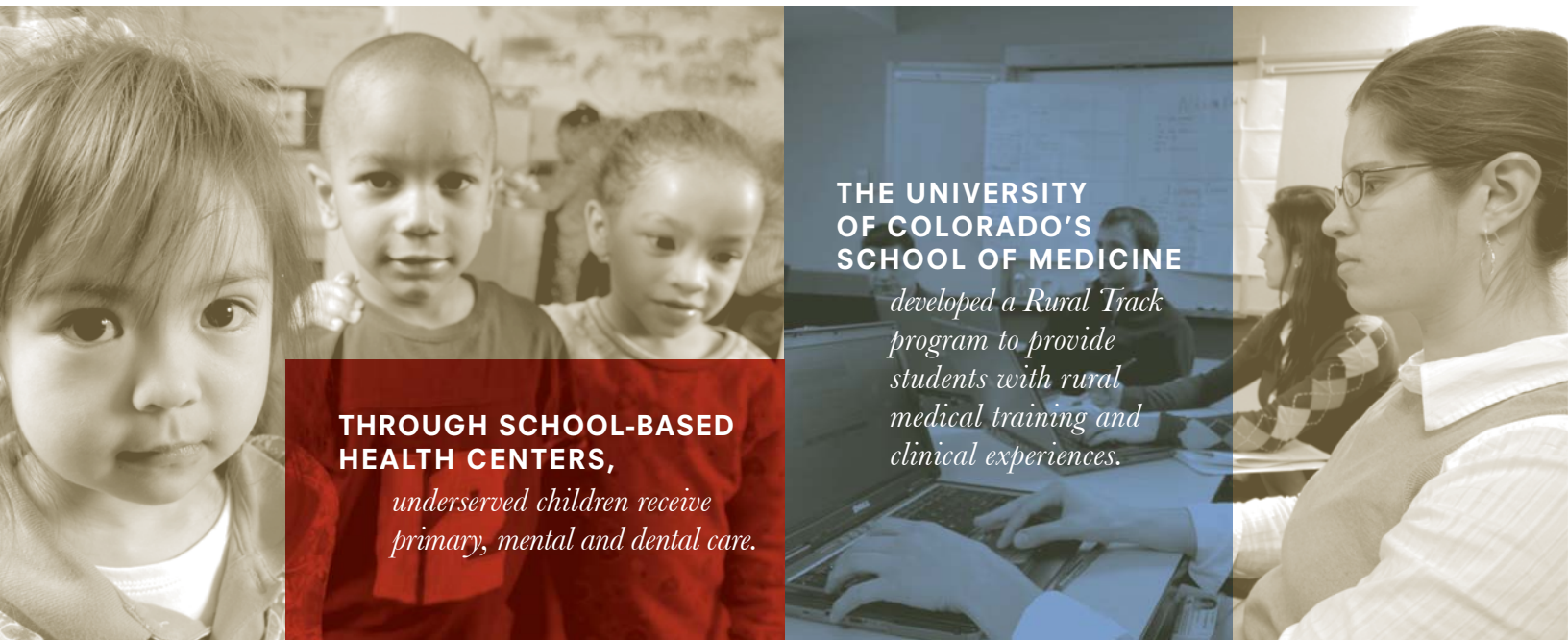
Expanding the capacity of the health care delivery system to care for a growing number of patients also requires addressing an increasing shortage in the health professions workforce.

Estimating that 17% of all health care workers in Colorado are expected to retire over the next decade, the Colorado Department of Labor and Employment forecasts shortages of physicians, nurses and other allied health professionals that will exacerbate existing workforce gaps in certain areas and create new ones. As shown on the graph below, based on projected physician retirements and future demand for services, the Colorado Health Institute (CHI)

» ALL COLORADANS COVERED, PRIMARY CARE PHYSICIANS, 2005-2025



Source: Colorado Health Institute, 2009.



THROUGH SCHOOL-BASED HEALTH CENTERS,
underserved children receive primary, mental and dental care.

THE UNIVERSITY OF COLORADO'S SCHOOL OF MEDICINE

developed a Rural Track program to provide students with rural medical training and clinical experiences.

estimates that between 2005 and 2025 the shortage in Colorado will grow by an additional 1,500+ primary care physicians, with yet another 390 primary care physicians needed if health insurance coverage is expanded to include everyone.

According to the Center for Research Strategies, sustaining an adequate workforce in the coming years will require shoring up the health professions “pipeline” (introduce young students to health professions careers, increase math and science education, and provide mentoring throughout the academic years and upon entering the workforce). Given the scope of the workforce shortage and the breadth of possible strategies to address the problem, The Trust convened the Colorado Health Professions Workforce Policy Collaborative. Comprised of representatives of hospitals, government agencies, research and policy organizations, educational institutions and health education centers, the Collaborative is researching health professions workforce challenges and opportunities, and developing a policy agenda to address workforce issues. Initial recommendations by this group include strengthening and expanding scopes of practice, increasing clinical placements, increasing funding for health professions education, expanding health professions workforce supply and demand data, and improving loan repayment opportunities.

AN IMPORTANT COMPONENT OF EXPANDING THE CAPACITY OF THE HEALTH CARE SYSTEM

to care for a growing number of patients is addressing the increasing shortage of health professionals.

More immediate solutions are needed to stem the tide of provider retirements. A recently published Collaborative Scopes of Care Study, developed by CHI and funded in part by The

Colorado Trust, identified opportunities to improve access to care through greater utilization of allied health professionals. For example, Colorado is addressing policy and regulations to expand the ability of advanced practice nurses to write prescriptions, and also looking to expand the direct reimbursement of dental hygienists to provide preventive oral health services, especially in rural communities where provider shortages are most prevalent.

Special attention also needs to be given to the unique challenges faced by rural residents. In addition to the limited health care delivery sites, Colorado Rural Health Center data show that 15 rural counties have two or fewer physicians, and 25 counties have two or fewer dentists. Through research, we know that expanding students’ exposure to health care needs in rural communities increases the likelihood they will decide to practice there. With this in mind, The Trust supported the development of a multidisciplinary rural track for students at the University of Colorado Denver School of Medicine. The rural track recruits qualified students from rural communities in Colorado, and across the nation, and offers them education and clinical opportunities to explore and plan for a career in rural health care. Additionally, The Trust’s three-year Health Professions initiative made grants to 22 organizations, including hospitals, clinics, universities and community colleges to support and expand existing health professions training programs and to develop new programs that increase education, training and advancement opportunities, especially for individuals from disadvantaged backgrounds and from rural areas.

A continued commitment is needed to meet the immediate challenges of the insufficient availability of health care services across Colorado, as well as longer-term efforts to re-shape our health care system to deliver responsive, quality, affordable and timely health care services.

Grantees receiving support from The Colorado Trust to Increase the Availability of Care are listed on page 38.

Increase Availability of Care

COMMUNITY *Insight*



RUSSELL W. JOHNSON,
CEO,
San Luis Valley Regional Medical Center

» PROACTIVE APPROACHES TO WORKFORCE CHALLENGES CREATE STRONGER COMMUNITIES

By Russ Johnson

The health care workforce once was a simple equation of supply and demand. Many doctors practiced medicine for 20, 30 years or more in Alamosa, making it their home. Their relationship to the hospital was one of practical convenience and necessity in terms of caring for their patients. In a span of 15 years or so, this scene has changed dramatically.

I don't believe physicians, primary care or specialty, will move into rural communities and join a practice or start their own again as they once did. That is a

bygone era. The risk is too high and the debt to get through medical school has become too great. Additionally, provider temperaments have changed. Today physicians emerging from training seek balance in their lives and are less inclined to embrace the whole package: private practice, being on call, working in both hospital and clinic settings, and managing patients and administration.

With a population of 47,000, the San Luis Valley has about 55 physicians in active, full-time practice. Of those, all but four or so are employed by hospitals or the community health clinic. This trend marks a major shift in who employs the provider workforce.

Four years ago, the San Luis Valley Regional Medical Center employed four physicians: Emergency Room doctors who provided 24/7 coverage in the trauma center. Now, we employ more than 40 providers and are actively recruiting more. If 10 physicians in the right specialty areas walked into my office and said, "We'd like to work here," I would hire them all. Providers and hospitals are no longer autonomous in our community. We recognize our interdependence and thus the hospital is willing to make a commitment to these providers and share in more of the risk related to providing operating infrastructure, recruitment, training, overhead and, ultimately, revenue.

By and large, rural providers serve patients covered by Medicare and Medicaid, with a modest number of privately insured patients and many people who have no coverage at all. The uninsured rates for people under age 65 in rural areas is more than 60% higher than in suburban areas, according to the U.S. Census. While suburban providers have some flexibility in determining how many uninsured and publicly insured patients they will see, rural providers simply do not have this option as there are not enough privately insured patients to sustain most of their practices. Also, I would argue, many of us feel compelled by ties to our small communities to avoid turning patients away.

The fact is, huge disparities exist between hospitals and providers based on where they are located and, consequently, who pays the medical bills.

For example, a historically successful, multi-practice group had run into this “wall” characteristic of rural medicine. They had done everything right: hired strong leadership, started a surgery center, opened radiology suites, expanded their laboratory, added specialists, and relocated in a modern and attractive office building. They were “it” for doctors in the San Luis Valley. But in September 2006, they closed their independent practice as it was impossible to competitively operate a multi-specialty group while serving three times the number of uninsured and Medicaid patients compared to providers in other areas. As physician incomes decline, recruiting physicians to rural areas is increasingly difficult and the capital needed to invest in electronic medical records and state-of-the art surgical equipment simply isn’t available.

As it turns out, the closing of the multi-specialty practice was a wakeup call for the San Luis Valley Regional Medical Center and it helped us to redefine who we are.

The hospital is no longer a cloistered organization that, although ready to take care of whoever walked in the door, was otherwise disengaged from the community. The multi-specialty group determined it was no longer a separate, independent (and often adversarial) colleague to the hospital. We discovered that what we thought of as separate and distinct purposes were actually very much aligned: to serve the community and to enjoy life. We also learned that there were many opportunities to support one another in pursuit of our shared goals. And we began to think of ourselves as one, and to work in ways that helped each other and our community.

First, we fully embraced the physician group, which became a new division of the hospital. We shared best practices and economies of scale that reduced hospital operating costs and improved services. We also shared technology and joined together to plan and prioritize our future needs, including:

- Building a new clinic, including space for a community health clinic

- Engaging physicians in decisionmaking for hospital operations and governance
- Hiring a full-time recruiter to bring in additional medical staff.

We found that our scope of work and thinking expanded into areas beyond health care. For example, hearing that the quality of our schools was affecting the ability to recruit physicians with young families, hospital leaders got involved in a campaign to build two new grade schools and hire a new superintendent. Active grassroots involvement led to the successful passage of a \$25-million bond issue in a slow economy of our rural community to fund the new school construction.

Further, the hospital is developing videos that will be used for introducing the community to our health care workforce, for new employee orientation, and in new physician and provider recruitment efforts.

Workforce is perhaps our greatest health care challenge in the next decade. Although capital for technology will be scarce, health care is, first and foremost, a people business. With all the macro-level indicators heading in the wrong direction for there to be an adequate health professions workforce, we cannot overstate this challenge; I see it as our number one priority.

We must do all we can to attract and retain skilled professionals in our industry. And we must never forget that these individuals and their families can choose to live anywhere they wish. By partnering with our providers and creating an organization of which they are proud to be a part, we’ll serve our community better, improve our health care quality and attract the physicians, nurses and other professionals we will need in the decade ahead.

It is an exciting challenge and a great opportunity to become a better rural hospital and contribute to a thriving community in ways never before imagined.

The San Luis Valley Regional Medical Center is a full-service facility that serves a rural, southern Colorado alpine valley of 47,000 people in 8,000 square miles.

Increase Availability of Care

GRANTEE *Story*



**SARAH VAINE,
EXECUTIVE
DIRECTOR,**

*Summit
Community
Care Clinic*

SAFETY-NET CLINICS REACH OUT

*to the working poor, encouraging them
to get help early.*



» **CLINICNET**

Steve Crain's life spun out of control last fall. When the economy took a dive, this self-employed carpenter and handyman had no health insurance.

For Crain, 51, regular health care was a luxury that came only rarely when he scored a long-term job, like building a school. Otherwise, he prayed to stay well and paid his own way.

But he was suddenly faced with a one-two punch. A stubborn kidney stone tortured him for several weeks. Then, a friend's unexpected death sent him reeling. For the first time in his life, Crain sought help at one of Colorado's safety-net clinics, the Summit Community Care Clinic, which offers integrated medical, dental and mental health care to the working poor.

Health experts at the clinic, which charges patients based on their income, helped Crain endure the kidney stone and reduced his trips to the ER where bills would have been in the thousands. They also counseled him as he quit drinking and overcame the depression triggered by his young friend's death.

Then, the clinic literally saved his life. Doctors insisted that Crain get a free colonoscopy through the statewide Colorado Colorectal Screening

Program (CCSP). They removed pre-cancerous polyps and are currently monitoring him to keep this dangerous, but preventable cancer at bay. "The clinic saw me through," Crain said. "They saved my life."

As the economic downturn has gripped communities across Colorado, more and more working people have turned to safety-net clinics for help. In Summit County, Executive Director Sarah Vaine has seen previously self-sufficient realtors and business owners, like Crain, walk through the door.

"We have a beautiful facility and everyone is treated well, but it can be a blow to someone's pride to need help," Vaine said. "Our patients work. Many are working a lot – two or three jobs – but they don't qualify for Medicaid and can't afford insurance, or pay for their own care."

Clinics across Colorado are also treating sicker patients as people put off doctor visits too long. Vaine has seen case after case where a small problem festers, resulting in higher costs when health problems escalate. For example, a man was bitten by a dog and, because he had no insurance, he didn't see a doctor. An infection took hold and he ended up in the hospital with a \$10,000 bill.



HEALTH EXPERTS AT A LOCAL COMMUNITY CLINIC HELPED

Steve Crain endure a kidney stone and reduced his trips to the ER.



**STEVE CRAIN,
BACK AT WORK**

*as a carpenter
and handyman
in Summit County.*



“For a person living paycheck to paycheck, a bill like that is crippling,” Vaine said. “The initial visit would have been \$20 and the antibiotics would have been \$8.” So she and managers at clinics across Colorado are reaching out to the working poor, to encourage them to get help early.

Colorado’s 66 non-federally funded safety-net clinics are affiliated with ClinicNET, a nonprofit service organization that works on behalf of the clinics to improve their visibility and recognition as key health care providers to Colorado’s most vulnerable populations.

With a three-year grant from The Colorado Trust, ClinicNET Executive Director Sharon Adams will facilitate online and in-person meetings among clinic managers to share information about health care policies, best practices and programs that improve patient care.

ClinicNET also helps clinics track and share data about their patients – including income, employment and location – to more fully quantify the care they deliver. Data gathering and reporting also help clinics to qualify for support from sources such as the Primary Care Fund, which directs tobacco tax revenue to expand health care for children and low-income populations.

Additionally, Adams is working with clinics to institute programs like CCSP that proved so critical to Steve Crain. “I couldn’t have made it on my own,” he said. “You feel welcome at the clinic. They don’t make you feel bad if you can only pay \$10. If you want help, you can get it.”

AS THE ECONOMIC DOWNTURN IMPACTS COMMUNITIES ACROSS COLORADO,
more working people are turning to safety-net clinics for help. The Summit Community Care Clinic offers integrated medical, dental and mental health care to the working poor.

ADDITIONAL PROGRAMS

Since 1985, The Colorado Trust has worked closely with nonprofit organizations in every county across the state to advance the health and well-being of the people of Colorado. The Trust continues to support a number of long-term programs that advance the health and well-being of Coloradans through:

- School-based health care
- Immigrant integration
- Suicide prevention
- Safe2Tell, and more.

2008 evaluation findings and highlights of these efforts are detailed in the following publications (available at www.coloradotrust.org):



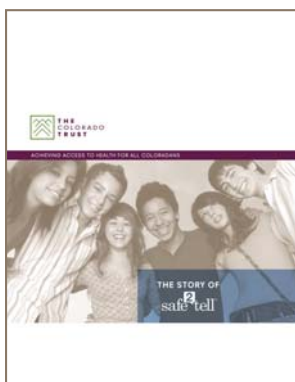
» SOLVING COLORADO'S SHORTAGE OF HEALTH PROFESSIONALS

This report includes final evaluation findings from The Trust's Health Professions effort, and recommended strategies to increase and sustain Colorado's health professions workforce. These strategies include identifying and monitoring shortages within health professions disciplines; encouraging collaboration among health care employers, workforce centers, educational institutions, insurers and others; and identifying policy options to improve health workforce development.



» BUILD TRUST, END BULLYING, IMPROVE LEARNING

This evaluation of The Trust's three-year, statewide Bullying Prevention initiative shows that bullying declined when adults and students were willing to intervene, treat each other fairly and show they care. The findings also show that schools with less bullying had higher scores on the Colorado Student Assessment Program in reading, writing and math. Major findings are highlighted from this intensive initiative, including tips on how educators, parents and policymakers can help to prevent bullying.



» THE STORY OF SAFE2TELL

This publication highlights the successful Safe2Tell program, including the far-reaching impact of providing students in all Colorado schools an increased ability to both prevent and report violence by making anonymous calls to 1-877-542-SAFE. The report also illustrates through stories and interviews the value of Safe2Tell among families and communities, necessary steps and resources to implement the program, and the hotline's long-term sustainability achieved through legislation.

Grantees receiving support from The Colorado Trust for Additional Programs are listed on pages 39-41.

M S & G R A N T M A K I N G



THE DIFRC HAS SERVED

some 513 families and 1,265 children since 2000.

PHOTO ABOVE: (left to right): Isabelle Medchill, Program Development Manager; Sidney Stone Brown, Child and Family Therapist; Phyllis Bigpond, Executive Director; and Susan Yellow Horse, Clinical Services Supervisor.

» 2008 JOHN R. MORAN, JR. GRANTEE LEADERSHIP AWARD

The Colorado Trust announced the Denver Indian Family Resource Center (DIFRC) as the recipient of its 2008 John R. Moran, Jr. Grantee Leadership Award. The annual award of \$25,000 is made in recognition of exemplary leadership by a current grantee of The Colorado Trust, and is being used by the DIFRC to expand its child welfare services and promote behavioral health.

The DIFRC provides culturally appropriate therapy for American Indian and Alaskan Native families, especially children and youth who show symptoms of serious emotional and behavioral disorders.

G R A N T M A K I N G

The Colorado Trust's strategic grantmaking supports the development of a coordinated system of policies, programs and services that expand health coverage, and improve and expand health care.

- Nonprofit organizations that are exempt under Section 501(c)(3) of the Internal Revenue Code and are classified as "not a private foundation" under Section 509(a)
- Independent sponsored projects of a nonprofit 501(c)(3) organization acting as a fiscal agent
- Government and public agencies.

In response to an RFP or an individual invitation issued by The Trust, the following types of organizations are eligible to apply for grants:

The Trust issues Requests for Proposals (RFP) and welcomes responses from nonprofit organizations and governmental entities across Colorado. When a competitive funding opportunity is available, a detailed RFP with related instructions and specific application deadlines is posted to our website. Sign up to be automatically notified by email of future funding opportunities.

The Trust also asks organizations that are focused on strategies specific to achieving access to health to submit individual, non-competitive proposals. Please note that The Trust does not accept unsolicited requests for funding.

GRANTEES

Following is a listing of 2008 Colorado Trust grantees. For additional information about the work of these grantees, grant timeframes and amounts, please visit www.coloradotrust.org.

HEALTH COVERAGE

Expand Health Coverage

Striving to expand health coverage first to people who are the most vulnerable and disadvantaged, including children and low-income working families, and ultimately to all Coloradans.

- Business Health Forum
- Colorado Center on Law and Policy
- Colorado Children's Campaign
- Colorado Consumer Health Initiative
- Colorado Department of Health Care Policy and Financing
- Colorado Multi-ethnic Cultural Consortium
- Colorado Rural Health Center
- Colorado State University
- Colorado State University – Pueblo
- Dr. A.J. Kauvar Foundation
- Innovation Network
- Metropolitan Group
- Mountain States Employers Council
- National Conference of State Legislatures
- New America Foundation
- Rocky Mountain Public Broadcasting Network, Inc.
- The Bell Policy Center
- University of Colorado Foundation
- University of Denver's Center for Colorado's Economic Future
- WGBH Educational Foundation

Increase Outreach and Enrollment

Supporting efforts to increase outreach and enrollment to ensure that all eligible children and youth are continuously enrolled in public insurance programs.

- Boulder County Healthy Kids – Boulder County Housing & Human Services
- Boys & Girls Clubs of Metro Denver
- Boys & Girls Club/Girls Inc. of Pueblo County & Lower Arkansas Valley
- Chaffee County Department of Health and Human Services
- Clínica Tepeyac
- Colorado Coalition for the Homeless
- Colorado Covering Kids and Families (Colorado Community Health Network)
- Colorado Department of Health Care Policy and Financing
- Denver Children's Advocacy Center

- Denver Public Schools
- Family Resource Center Association, Inc.
- Hilltop Community Resources
- Hope Communities
- Inner City Health Center
- Interfaith Hospitality Network of Colorado Springs
- Mayor's Office for Education and Children
- Northwest Colorado Visiting Nurse Association
- Parkview Medical Center
- The Gathering Place
- University of Colorado Health Sciences Center, Department of Health and Behavioral Sciences
- YMCA of the Pikes Peak Region

HEALTH CARE

Improve Health Systems

Integrating and coordinating health systems to significantly improve the delivery of timely, cost-effective, quality care so that all Coloradans achieve positive health outcomes.

- Cavity Free at Three
- Colorado Children's Healthcare Access Program
- Colorado Clinical Guidelines Collaborative
- Colorado Department of Health Care Policy and Financing
- Colorado Health Outcomes Program (University of Colorado Health Sciences Center)
- Office of the Colorado First Lady
- Office of the Colorado Governor

Increase Availability of Care

Strengthening the health care system and the health professions workforce to deliver responsive, quality, affordable and timely health care services.

- ACS Community LIFT
- Center for Research Strategies
- Clínica Tepeyac
- ClinicNET
- Collaborative Scopes of Care Study
- Colorado Area Health Education Centers
- Colorado Asian Health Education and Promotion
- Colorado Center for Nursing Excellence
- Colorado Department of Public Health and Environment
- Colorado Health Institute
- Colorado Rural Health Center

- Denver Health and Hospital Authority
- Doctors Care
- Inner City Health Center
- Midwestern Colorado Mental Health Center
- Mountain Resource Center
- Northeast Colorado Health Department
- Northwest Colorado Visiting Nurse Association
- Peak Vista Community Health Centers
- Rocky Mountain Youth Clinics
- San Juan Basin Health Department
- SET Family Medical Clinic of Colorado Springs
- Weld County Department of Public Health and Environment

ADDITIONAL PROGRAMS

Advancing Colorado's Mental Health Care

A joint effort of The Colorado Trust, The Colorado Health Foundation, the Caring for Colorado Foundation and The Denver Foundation to support human services agencies, mental health care providers and others to improve the integration and coordination of mental health services in Colorado communities.

- Denver Public Schools – Integration of School and Mental Health Systems Project
- El Paso County Co-Occurring Disorders Collaboration
- Health District of Northern Larimer County
- Mesa County Consortium on Health
- Prowers County Behavioral Health Integration Project
- Summit County Collaborative

Bullying Prevention

Helping schools, school districts and nonprofit organizations across the state to implement strategies that curb and prevent bullying among children and youth.

- Office of Safe and Drug-free Schools and Communities
- The Partnership for Families & Children

Colorado 5 Million Lives Campaign

Helping hospitals across the state to further strengthen their quality improvement systems, ensuring safe patient care.

- Aspen Valley Hospital
- Avista Adventist Hospital
- Boulder Community Hospital
- Community Hospital – Grand Junction
- Craig Hospital Foundation

- Denver Health
- East Morgan County Hospital
- Estes Park Medical Center
- Exempla Good Samaritan Medical Center
- Exempla Lutheran Medical Center
- Exempla Saint Joseph Hospital
- Family Health West
- Haxtun Hospital District
- Heart of the Rockies Regional Medical Center
- Keefe Memorial Hospital
- Kremmling Memorial Hospital District
- Lincoln Community Hospital
- Littleton Adventist Hospital
- Longmont United Hospital
- Medical Center of the Rockies
- Melissa Memorial Hospital
- Memorial Health System
- Montrose Memorial Hospital
- Mount San Rafael Hospital
- Pagosa Mountain Hospital
- Parker Adventist Hospital
- Parkview Medical Center
- Penrose-St. Francis Health Services
- Platte Valley Medical Center
- Porter Adventist Hospital
- Prowers Medical Center
- Rio Grande Hospital
- Rose Medical Center
- San Luis Valley Regional Medical Center
- Sedgwick County Health Center
- Sky Ridge Medical Center
- Southeast Colorado Hospital/LTCC and Clinics
- Southwest Memorial Hospital
- Spanish Peaks Regional Health Center
- St. Anthony Central Hospital
- St. Anthony North Hospital
- St. Anthony Summit Medical Center
- St. Mary Corwin Medical Center
- St. Mary's Hospital and Regional Medical Center
- St. Thomas More Hospital
- Sterling Regional MedCenter
- The Children's Hospital
- The Medical Center of Aurora
- University of Colorado Hospital
- Vail Valley Medical Center
- Valley View Hospital
- Wray Community District Hospital
- Yampa Valley Medical Center
- Yuma District Hospital

GRANTEES

Technical assistance, and other patient safety and quality improvement grants:

- Colorado Center for Nursing Excellence
- Colorado Center for the Advancement of Patient Safety
- Colorado Department of Labor and Employment – Work, Education and Lifelong Learning Simulation (WELLS) Center
- Colorado Foundation for Medical Care
- Colorado Hospital Association
- Colorado Patient Safety Coalition
- Colorado Rural Health Center

Colorado School Health Improvement

Helping to expand care provided through school-based health centers, including primary and preventive physical, dental and behavioral health care.

- Colorado Children's Campaign
- Colorado Department of Public Health and Environment

Equality in Health

Reducing racial and ethnic health disparities in Colorado by helping health care providers gain the skills necessary to consider unique cultural backgrounds as they provide care.

- Asian Pacific Development Center
- Boys & Girls Club of Craig
- Clayton Family Futures
- Colorado Community Health Network
- Denver Indian Family Resource Center
- Fort Collins Family Medicine Residency Program
- Full Circle Inter-Generational Project, Inc.
- Inner City Health Center
- Jefferson Center for Mental Health
- Kids in Need of Dentistry
- Marillac Clinic
- Metro Community Provider Network
- Montrose County School District RE-1J
- Prowers Medical Center
- Rural Communities Resource Center
- Second Wind Fund, Inc.
- Summit Community Care Clinic
- Telluride Foundation
- The Center for African American Health
- The Children's Hospital
- The Partnership for Families & Children
- Total Oral Prevention Strategies
- University of Colorado School of Medicine
- Upper Arkansas Area Council of Governments
- Valley-Wide Health Systems, Inc.
- Western Colorado AIDS Project
- Women's Resource Center

Healthy Aging

Helping senior-serving organizations meet the needs of the state's growing aging population.

- Aurora Senior Center
- Bent County HealthCare Center
- Catholic Charities and Community Services of Denver
- Colorado Center for the Blind
- Columbine Senior Services, Inc.
- Gunnison County Public Health Department
- Health Service, Empowerment, Transformation
- Huerfano-Las Animas Area Council of Governments
- Jefferson Center for Mental Health
- La Plata County Department of Human Services
- Larimer County Human Services Department – Office on Aging
- Lutheran Family Services of Colorado
- Northwest Colorado Visiting Nurse Association
- Pikes Peak Library District Foundation
- Rebuilding Together Metro Denver
- Senior Resource Development Agency
- SouthWest Improvement Council, Inc.
- Spellbinders
- The Center for African American Health
- Tri-County Health Department
- Visiting Nurse Corporation of Colorado

Homelessness Prevention

Supporting Denver's Road Home and the administration of the Homeless Prevention Activities Program.

- Mile High United Way – Community Appeal to End Homelessness
- Homeless Prevention Activities Program

Immigrant Integration

Achieving successful immigrant integration through collaboration among mainstream institutions, immigrant-serving organizations and individual community members.

- Aurora Mental Health Center
- Aurora Public Schools
- Catholic Charities of Colorado Springs, Inc.
- Catholic Charities of the Diocese of Pueblo, Inc.
- City of Commerce City
- City of Greeley
- City of Littleton
- City of Longmont
- Colorado Department of Education
- Colorado Department of Human Services
- Comunidad Integrada
- Durango Adult Education Center, Inc.

- Family & Intercultural Resource Center
- Family Visitor Program
- Full Circle of Lake County, Inc.
- Gunnison County Public Health
- Gunnison Watershed School District RE-1J
- Hilltop Community Resources
- Midwestern Colorado Mental Health Center
- Montrose County School District RE-1J
- Morgan Community College Downtown Center
- National Civic League
- Place Bridge Academy/Denver Public Schools
- San Luis Valley Immigrant Resource Center
- Skyline High School/St. Vrain Valley School District
- Spring Institute for Intercultural Learning
- Steamboat Springs School District
- Summit School District RE-1
- Telluride Foundation
- Telluride School District R-1
- University of Northern Colorado Foundation
- Weld County School District 6

Invest in Kids

Supporting communities in implementing the Nurse-Family Partnership program.

John R. Moran, Jr. Health Scholarships

Providing scholarships to health professions students.

- Colorado School of Public Health, University of Colorado Health Sciences Center
- Rueckert-Hartman College for Health Professions, Regis University

John R. Moran, Jr. Grantee Leadership Award

Recognizing outstanding leadership in communities served by grantees of The Colorado Trust.

- Denver Indian Family Resource Center

Partnerships for Health

Working to build, strengthen and sustain the infrastructure of Colorado communities to address ongoing public health issues.

- Centennial Area Health Education Center
- Chaffee People's Clinic
- Civic Results
- Crowley County
- Gunnison County Public Health

- Mesa County Health Department
- Metro Community Provider Network
- Northwest Colorado Visiting Nurse Association
- San Juan Basin Health Department
- San Luis Valley Regional Medical Center
- Southern Ute Community Action Programs, Inc.
- The Centers at the University of Colorado Denver & Health Sciences Center
- Tri-County Health Department
- University of Colorado Health Sciences Center

Preventing Suicide in Colorado

Supporting statewide efforts to address the problem of suicide by encouraging people at risk to receive care and improving the care that at-risk individuals receive.

- Colorado West Regional Mental Health Center
- Jefferson Center for Mental Health
- Midwestern Colorado Mental Health Center
- Rural Solutions
- Southeast Mental Health Services
- Suicide Education & Support Services
- Suicide Prevention Partnership of Pikes Peak Region
- The Centers at the University of Colorado Denver & Health Sciences Center
- The Piñon Project Family Resource Center
- Mesa County Suicide Prevention Coalition (Western Colorado Suicide Prevention Foundation)

Qualistar Early Learning

Improving the quality of early childhood learning experiences.

Safe2Tell, Inc.

Providing Colorado students an increased ability to both prevent and report violence by making anonymous calls to 1-877-542-SAFE.

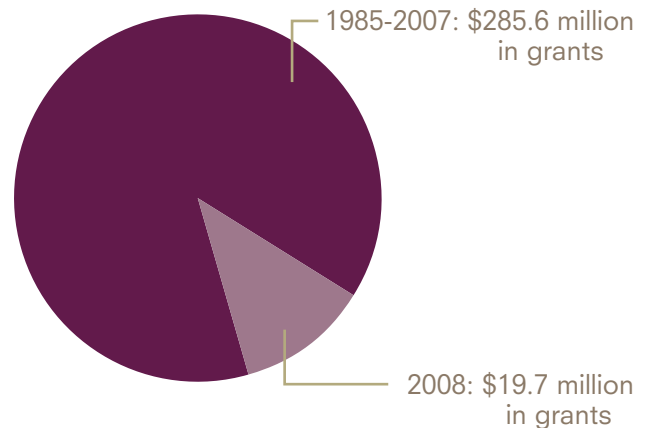
OTHER DISTRIBUTIONS

In addition to its grantmaking, The Colorado Trust makes other distributions to support charitable purposes. As a result of its historical relationship with both the Colorado Episcopal Foundation and the Presbytery of Denver, The Trust makes annual distributions to these organizations for charitable activities of their choice. The foundation also matches contributions to charitable organizations made by members of its Board of Trustees and staff, makes directed contributions to charitable organizations designated by trustees and officers of The Trust, and provides sponsorships and other support for Colorado's nonprofit community and affinity organizations.

FINANCIALS

The Colorado Trust's original endowment of \$191 million was received from the sale of the PSL Healthcare Corporation in 1985. From its inception through 2008, grants totaling \$305.3 million have been made to grantees in every Colorado county.

\$19.7 million in grants were made in 2008 with support being provided to more than 200 grantees.



	2008	2007
TOTAL ASSETS	<u>\$337,239,618</u>	<u>\$513,383,869</u>

» THE COLORADO TRUST STATEMENTS OF FINANCIAL POSITION DECEMBER 31, 2008 AND 2007

ASSETS:	<u>2008</u>	<u>2007</u>
Cash and cash equivalents	\$105,024	\$219,460
Interest and dividends receivable	505,157	1,382,966
Prepaid and other expenses	26,831	17,410
Excise tax receivable	227,619	-
Investments	335,878,816	509,865,623
Other assets	-	233,708
Cash held in custody for others	84,886	87,279
Property and equipment:		
Building improvements	10,068	1,490,029
Machinery and equipment	325,438	375,737
Furniture and fixtures	354,771	354,771
	<u>690,277</u>	<u>2,220,537</u>
Accumulated depreciation	(613,701)	(1,179,021)
Property and equipment, net	76,576	1,041,516
Investments held in trust	334,709	535,907
TOTAL ASSETS	<u><u>\$337,239,618</u></u>	<u><u>\$513,383,869</u></u>

LIABILITIES & NET ASSETS:	<u>2008</u>	<u>2007</u>
Accounts payable and accrued expenses	\$50,785	\$35,413
Other accrued liabilities	174,541	562,489
Deferred gain on sale-leaseback	4,763,219	–
Cash held in custody for others	84,886	87,279
Grants payable	30,260,145	27,019,878
Deferred compensation	334,709	535,907
Accrued excise tax payable	–	275,255
Deferred excise tax liability	–	852,794
TOTAL LIABILITIES	<u>35,668,285</u>	<u>29,369,015</u>
Net assets – Unrestricted	301,571,333	484,014,854
TOTAL LIABILITIES & NET ASSETS	<u>\$337,239,618</u>	<u>\$513,383,869</u>
REVENUES, GAINS & SUPPORT:		
Interest and dividend income	\$14,583,343	\$12,120,155
Net realized and unrealized gain on investments	(167,217,829)	41,332,984
Income from real estate activities	710,798	1,246,694
Other investment income – Sherman Street Properties, Inc.	(287,435)	(289,789)
Other income	(1,015)	43,998
Investment management fees	(914,314)	(\$1,410,682)
TOTAL REVENUES, GAINS & SUPPORT	<u>\$(153,126,452)</u>	<u>\$53,043,360</u>
EXPENSES:		
Program services:		
Access to Health	\$17,260,467	\$670,054
Accessible and Affordable Health Care Initiatives	2,819,892	8,917,545
Strengthening Families Initiatives	3,038,126	\$10,379,065
Other grant expense	3,079,943	3,084,984
Grant administration	2,289,457	2,226,944
TOTAL PROGRAM SERVICES	<u>*28,487,885</u>	<u>**25,278,592</u>
Management and general	1,363,873	1,621,653
Excise tax expense	(534,689)	1,005,170
TOTAL EXPENSES	<u>\$29,317,069</u>	<u>\$27,905,415</u>
Change in net assets	(182,443,521)	25,137,945
Net assets at beginning of year	484,014,854	458,876,909
NET ASSETS AT END OF YEAR	<u>\$301,571,333</u>	<u>\$484,014,854</u>

*Accrual method; actual cash payments for 2008 grants totaled \$19,674,360.

**Accrual method; actual cash payments for 2007 grants totaled \$18,489,210.

» ADDITIONAL FINANCIAL INFORMATION

The Colorado Trust's Form 990-PF, Return of Private Foundation and 2008 Audited Financial Statements are available at www.coloradotrust.org.

TRUSTEES &



PHOTO ABOVE: Back row (left to right): Jack D. Henderson, Esq.; Reginald L. Washington, MD; Irene M. Ibarra, President and CEO; William N. Maniatis, MD; Gail Schoettler, PhD; Patricia Baca, EdD; Jennifer Paquette; Stephen B. Clark. **Front row (left to right):** William Wright, MD; Katherine A. Paul; Rev. R. J. Ross.

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In 2008, The Colorado Trust announced the election to its Board of Trustees of Jennifer Paquette and William Wright, MD. Their five-year terms began January 1, 2009. Paquette and Wright, pictured above, filled two vacancies on The Trust's nine-person board created when the terms of Judith B. Wagner and Jerome M. Buckley, MD, concluded, following 10 years each of exceptional service.

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1600 SHERMAN STREET
DENVER, CO 80203-1604
WWW.COLORADOTRUST.ORG

PHONE 303-837-1200
TOLL FREE 888-847-9140
FAX 303-839-9034

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Research: Tracy Johnson

Writers: Dede de Percin, Hollis Hope, Russ Johnson, Tracy Johnson, Katie Kerwin McCrimmon, Sabine Kortals, Christie McElhinney, Stacey Moody, Jay Want

Editor: Christie McElhinney

Photographer: David Cornwell

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