Survey of Urban Health Alliances in Colorado

For the Denver Access to Care Task Force

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COMMUNITY HEALTH MATTERS

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Introduction

Key informant interviews were conducted with six health alliances in urban areas of Colorado, to gather information about their formation, how they are structured and funded, their membership, and the roles they are playing in coordinating health activities in their communities. The purpose of the research was to gather information to inform the possible creation of a health alliance in Denver. The research was limited to alliances in urban areas of Colorado, given that their experiences would be most comparable to what might be faced when forming a health alliance in Denver.

Two of the alliances were located in the Denver metropolitan region - one in the city of Aurora and the other in Arapahoe and Douglas Counties in the southern metropolitan area. Two were located in northern Colorado - one in the city of Longmont and the other in Weld and Larimer Counties. And two were located in southern Colorado -one in the city of Colorado Springs and the other in Pueblo County. Table 1 lists the names of the six alliances interviewed and key information about their structure and operations.

Table 1: Summary Information on Health Alliances Interviewed

Name of Alliance *Mission*	Geographic Area	Date Founded	Organizational Form	Employees	Membership	Funding	Programs/Focus Areas
Community Health Partnership ***Improve the health of the community through collaboration***	**Colorado Springs**	**1992**	Non-Profit 501(c)(3) Member-based Coalition Model 13-member Board of Directors with 6 founding and 7 elected members	14 Executive Director Chief Operating Officer Chief Financial Officer Business Manager Administrative staff Nurses Chief Medical Officer Medical Officer Medical Advisory Coordinator Program Manager Program Evaluation Manager CATCH Program Staff	24 members - organizations and individuals Hospitals, safety net clinics, private clinics, behavioral healthcare providers, public health department, medical society, private physicians, university, fire department	Membership dues based on annual revenue of the organization	RCCO for four counties Care management for high utilizers Electronic Health Records Access to primary and specialty care for un- and underinsured Training primary care providers Reducing emergency department visits, readmissions, imaging Mental health gap analysis and triage Emergency crisis service
North Colorado Health Alliance ***Cultivate the health of the community, improve patient experience, and insist on quality care and reduced and sustainable cost***	**Weld and Larimer Counties**	**2002**	Non-Profit 501(c)(3) Collaborative with only organizations as members No individual membership 12-member Board of Directors	40 Chief Executive Officer Chief Medical Officer Chief Operating Officer Associate Medical Director Care Management Director Connect for Health Colorado Coordinator Health Campaign Coordinator Business Analyst Care management staff - nurses, community workers, behavioral health workers Health generation team Community care core team Health data analyst Accounting staff	13 organizational members, no individual members 60 involved organizations Hospitals, governmental agencies, clinics, medical society, university, RCCO, CBOs	Grant funding from Colorado Health Foundation Per member per month payments through RCCO Member dues	Care coordination with RCCOs Connect for Health CO assistance and hub Health information exchange Integrating provider practices Community health campaign Opiod best practices Prenatal at risk Community health assessment

Name of Alliance *Mission*	Geographic Area	Date Founded	Organizational Form	Employees	Membership	Funding	Programs/Focus Areas
South Metro Health Alliance ***Unite the community for better access to health care for all***	**Arapahoe and Douglas Counties, except Aurora**	**2009**	Applied for Non-Profit 501(c)(3) status Fiscal agent is the Colorado Coalition for the Medically Underserved (CCMU) 14-member Board of Directors	2 Executive Director Head of Communications and Membership	45 members – organizations and individuals Safety net clinic, health care providers, CBOs, health and wellness educators, university, RCCO, mental health provider, health department	Grant funding from Colorado Health Foundation and Rose Community Foundation Member dues, individual and organizational Fees from training and workshops	Community Accessing Resources Together – resources to uninsured Enrichment workshops on health care topics Health information exchange Mental Health First Aid training Transitions of Care – avoiding unnecessary ambulance transports
Aurora Health Access ***Improve the health care system to meet the needs of all residents***	**City of Aurora**	**2010**	Applied for Non-Profit 501(c)(3) status Fiscal Agent is CDPHE Informal, broad coalition 17-member Board of Directors Workgroups	0.5 Admin Assistant	450 organizations and individuals on the listserv. Safety net clinics, RCCO, hospital, mental health center, CBOs	Grant funding from Colorado Health Foundation	Access and care coordination Community health integration Coverage Community education & and mobilization
Pueblo Triple Aim Coalition ***Increase quality of care, decrease health costs, and improve health outcomes***	**Pueblo County**	**2010**	Non-Profit 501(c)(3) 18-member Steering Committee 9-member Board of Directors 3 sub-groups on obesity, tobacco, and teen pregnancy	2.5 Managing Director Portfolio Manager Community Liaison	15 organizations Hospitals, safety net clinics, private providers, governmental agencies, chambers of commerce, BHOs, CBOs, university	Grant funding from Colorado Health Foundation, Kaiser Permanente, and Packard Foundation	Obesity Tobacco cessation Teen/unintended pregnancy
Longmont Community Health Network ***Alternatives to the ED, better serve uninsured, underinsured, and those with chronic medical problems***	**City of Longmont**	**2011**	Informal network of partners No fiscal agent but supported by Longmont Fire Department 12-member Steering Committee	0 No dedicated employees Supported by Longmont Fire Department	15 organizations, 3 individual members Public safety department, hospital, urgent care clinics, safety net clinic, private clinics, mental health center, governmental agencies, physicians	No external funding Supported by Longmont Fire Department	Alternatives to the Emergency Room Care coordination Mental health and substance abuse Health portals – limited service clinic Data gathering and analysis

Founding

The longest-standing urban health alliance in Colorado is Community Health Partnership in Colorado Springs, established in 1992. The second-oldest is the North Colorado Health Alliance in Weld and Larimer Counties, established in 2002. These alliances are also the largest in terms of the size of their operations and the number of staff they employ.

Both of these alliances have gone through major expansions in the past two years, as a result of taking on care coordination duties, either directly as the designated Regional Care Collaborative Organization (RCCO)[1] for their region (Community Health Partnership) or in cooperation with the RCCOs (North Colorado Health Alliance). The North Colorado Health Alliance has additionally taken on duties in 2013 as a regional hub and assistance site for Connect for Health Colorado, the state's new health insurance exchange, which precipitated another significant expansion. The remaining alliances were more recently formed, in 2009 or later.

The alliances were formed in a variety of ways, and in response to different needs in the various communities. Several started out as informal gatherings of health care leaders in their communities and later evolved into formal organizations. Even the larger alliances started out small and lacked designated staff in the early years, similar to the current situation for the emergent alliances. These were some of the reasons prompting the formation of the alliances:

Reasons for Starting Health Alliances

- **Insufficient access to care for uninsured and Medicaid/CICP holders - wait lists at the Federally Qualified Health Centers (FQHCs), lack of providers to see patients**
- **Inappropriate use of ambulance services and emergency rooms - need to redirect people to primary care clinics**
- **Burden of uncompensated care at the city-owned hospital**
- **Private and public health plans that leave many uncovered and do not make the best use of scarce resources**
- **Need for care coordination for individuals with high needs**
- **Need for coordination between systems of care**
- **Limitations of existing meetings for promoting prevention – infrequent and passive**
- **Need for resilience in the community in the face of recurring state and federal budget crises**
- **Intention to implement the Triple Aim Initiative from the Institute for Healthcare Improvement (IHI) – Improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care**
- **Need for health and wellness initiatives for city residents**
- **Need to address social determinants of health in the community in addition to healthcare needs**
- **Need for assistance with electronic health records and health information exchange**

[1] Seven RCCOs were established in Colorado in 2011 as part of the Accountable Care Collaborative (ACC) Medicaid reform program to improve Medicaid clients' health and reduce costs. RCCOs connect Medicaid clients to providers, help them find community and social services in their areas, and assist them with care transitions. They receive a per member per month fee for their care coordination duties.

Missions

The current mission statements for the health alliances interviewed are listed below. All involve improving the health of the community, while many focus on providing greater access to care, either for all residents or for underserved populations. Two mission statements specifically reference the Triple Aim of improving patient experience and quality of care, improving health, and reducing the cost of care. One specifically aims at creating alternative destinations for care than the hospital emergency department.

Mission Statements

Improve the health of the community through collaboration

Cultivate the health of the community, improve patient experience, and insist on quality care and reduced and sustainable cost

Unite the community for better access to health care for all

Improve the health care system to meet the needs of all residents

Increase quality of care, decrease health costs, and improve health outcomes

Alternatives to the emergency department and better serve the uninsured, underinsured, and those with chronic medical problems

Organizational Structure

Three of the six alliances interviewed were registered as 501(c)(3) non-profit organizations. Two had applied but were still pending this status, and were operating in the meantime with the help of other organizations serving as their fiscal agents.

All but one of the alliances had a Board of Directors to oversee their work, while the newest alliance was overseen by a Steering Committee. Board members tended to be executive-level managers in the organizations they represented, and to serve on a volunteer basis. Several alliances had work groups or task forces working on specific issues, often made up of program-level staff in the organizations they represented.

The number of staff employed by the alliances varied from 40 in one of the oldest alliances to none in the newest alliance. The two alliances with the most staff (13 and 40 employees) had diversified their operations into several program lines, with a large part of their staff devoted to work as the RCOO or in cooperation with the RCOOs. This expansion took place in the past two years after the RCCOs were established in Colorado, whereas before that time their size and staffing levels were much smaller.

Alliances were typically run by an Executive Director or CEO and had staff devoted to community outreach or membership and administration, as well as a variety of program staff depending on the types of programs they were pursuing. Those involved in care management programs employed nurses and other medical staff. The types of staff members employed by the various alliances are listed in Table 1.

Membership

Some of the alliances allowed membership only for organizations, while others also allowed membership for individuals. Some were very deliberate about who could be a member, while others were willing to accept as members any organizations or individuals with an interest in the work of the alliance.

Based on the different membership criteria, the number of members in the alliances varied widely, from as few as 13 organizations in one alliance with a more restrictive membership determination, to as many as 450 in another alliance that recognized all persons and organizations on their listserv as de facto members of their community-led organization.

Some alliances charged membership dues based on the type of membership or the size of the organization's revenue, while others did not charge any fee for membership. Following is a list of the types of organizations and individuals participating in the health alliances interviewed.

Table 2: Types of Members in Health Alliances

Health Care Providers:	
Safety net clinics and Federally qualified health centers (FQHCs)	**County behavioral health care organizations**
Private clinics	**Private behavioral health care organizations**
Urgent care clinics	**Private physicians**
Non-profit hospitals	**Medical societies**
Private hospitals	**Nurses**
Governmental Entities:	
County public health departments	**Public safety departments**
County human services departments	**School districts**
Fire departments and paramedics groups	
Other:	
Non-profit and community-based organizations	**Health insurance providers**
RCCOs and Behavioral Health Organizations (BHOs)[2]	**Universities**
Health and wellness educators	**Chambers of Commerce**

[2] Behavioral Health Organizations (BHOs) are designated for five regions in Colorado to administer the state's specialty mental health benefits under Medicaid. They contract with local behavioral health providers to provide services to Medicaid clients, and they receive a per-member-per-month fee for their care coordination duties.

Funding

The health alliances interviewed were funded predominantly by foundation grants, with most being funded by the Colorado Health Foundation. Other funders included Kaiser Permanente, the Rose Community Foundation, and the Packard Foundation. Some had planning grants to help get their alliances formed, followed by implementation grants to support operating costs and staff salaries for an initial period.

Many alliances were also supported by dues from member organizations, based on the type of membership or the annual revenue of the organization. Member organizations also contributed in other ways, such as participating on the Board and on task forces and working groups, donating office space, giving administrative support, and sometimes even paying staff salaries.

The more established alliances also derived income from the programs they administer, such as care management programs for which they receive a per member per month payment, and from trainings they conduct and events for which participants pay a fee to attend.

Programs

The alliances interviewed were engaged in a wide variety of programs to serve out their missions to improve the health of their communities, provide greater access to care, improve patient experience and quality of care, and reduce the cost of care. A summary of activities and program types undertaken by the alliances surveyed is include in Table 3.

All of the alliances acted as conveners of the relevant stakeholders in health care and public health in their communities, including hospitals, community health centers, private clinics, public health departments, county human services departments, public safety departments, and community-based organizations. Some also took on the role of coordinating care arrangements for uninsured and underinsured persons among the various providers in the region.

The alliances were involved in numerous initiatives to increase access to care in their communities, starting with activities to increase enrollment in benefits and insurance programs. Many helped to connect people to primary care, specialty care, and non-medical community resources, and some undertook formal care management duties for individual patients and clients - as the RCCO for their area, in coordination with the RCCO, or as a part of other care management programs. Some alliances had programs for mental health triage and emergency crisis services, and one was preparing for direct provision of primary and urgent care for underserved populations.

Alliances also served public health functions, such as doing support work for Community Health Assessments, aligning programs around priorities identified in the Community Health Improvement Plans for their areas, and conducting education and outreach campaigns on public health issues.

Finally, alliances fostered the development of electronic health records among their members and coordinated health information exchange among health care providers in the community.

Table 3: Summary of Programs Managed by Health Alliances

Coordination:	
Convening health stakeholders from hospitals, community health centers, private clinics, public health departments, county human services departments, public safety departments, and community-based organizations	Care coordination among service providers in a region for un- and underinsured
Access to Care:	
Increasing enrollment in Medicaid and insurance	Reducing emergency department visits, readmissions, and expensive imaging - providing alternative primary care destinations
Acting as Connect for Health Colorado Assistance site, Regional Hub	Mental health gap analysis
Connecting un-and underinsured to community resources, primary care medical homes, specialty care.	Mental health triage
Care management services – for Medicaid holders, high utilizers of emergency departments, chronically ill, special populations, eg prenatal - as the RCCO, for the RCCO, and through other programs.	Emergency crisis service
Training primary care providers	Direct provision of primary and urgent care for un- and underinsured
Public Health:	
Data gathering and analysis on population health, support to county health departments for Community Health Assessments	Programs to reduce obesity. tobacco use, teen pregnancy (CHIP priorities)
Community education and mobilization, community health campaigns	
Technology:	
Assisting members to establish Electronic Health Records	Coordinating Health Information Exchange for a region

Strengths and Keys to Success in Health Alliances

The following key strengths were noted among the alliances interviewed, showing many ways that they bring value to their communities.

Strengths of Health Alliances and Value Added

- **Serving as a neutral convener for diverse members with different and potentially competing interests, to come together and work on important health issues in the community**
- **Being a catalyst for change and new directions in managing health care and addressing the social determinants of health in the community**
- **Providing a venue for networking, information-sharing, and problem-solving around health issues in the community**
- **Supporting organizational members to deal with difficult issues**
- **Avoiding duplication of members' efforts**
- **Sharing out burdens in the community, such as providing primary, specialty, and emergency care for uninsured and underinsured persons and bearing the costs of uncompensated care**
- **Reducing competition among organizations performing similar functions in the community, e.g., competition for patients or grant funding**
- **Having a well-defined geography and a community that is self-contained in terms of needed and available health care services**

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Alliances had the following words of wisdom for new alliances, based on their own experiences.

Advice for New Health Alliances

- **Find out what the highest public health priorities are in the community and work on them.**
- **Choose viable projects early on that can show tangible results in a reasonable time frame, to build relationships and develop momentum for more difficult and longer-term issues.**
- **Be tenacious, proceed with projects without insisting on perfection, and return again to difficult issues that resist solutions.**
- **Find inspired and committed leaders for the Board and executive management who are willing to take responsibility for population health in the community as a higher goal that prevails over individual and organizational interests.**
- **Ensure that Board members are persons with the highest level of authority in their organizations – CEOs, COOs, and other decision-makers with access to financial resources, human resources, and data. This level of participation is crucial for the viability of the alliance.**
- **Ensure that task forces and working groups include program-level staff with the specific knowledge and skills to oversee projects.**
- **Ensure that the alliance's director and senior staff members have the needed skills for outreach and networking with diverse members of the community, and for raising funds. The executive leadership does not have to be a health care professional.**
- **Broaden the alliance beyond health care providers, to include other sectors that also affect quality of life and public health – public health departments, human services agencies, public safety and paramedics, community-based organizations, city planners, housing authorities, economic development corporations, and business and employer groups.**
- **Be patient, as it may take many years to develop strong, cooperative relationships and to effectively tackle complex health issues in the community.**
- **Address legal issues early on, for example if the alliance plans to take on care coordination duties in the community and must have legal agreements in place to do so.**
- **Clearly articulate and communicate to members and stakeholders what the alliance does and how it has been successful - through a website, brochures, handouts, and other communication tools.**

Planning for a Future Health Alliance in Denver

The City and County of Denver lacks a health alliance of the kind examined in this study. The Denver Access to Care Task Force, set up in February 2013 as one of two task forces to assist in developing a Community Health Improvement Plan (CHIP) for the city, has a composition very similar to the health alliances studied here. It includes representatives from medical care providers, behavioral care providers, governmental organizations, and community-based organizations serving lower-income persons in Denver.

The Task Force has focused on many of the same issues as health alliances do, such as facilitating enrollment in the new forms of coverage in 2014 under the Affordable Care Act and studying access to care problems in the city for primary care, behavioral health care, and specialty care. However, the Task Force was set up as a temporary group to plan for improving access to care in Denver and lacks a formal structure for continued collaboration and for implementing the CHIP or other health initiatives for the city.

There are two health alliances in the Denver metropolitan area - the South Metro Health Alliance in Arapahoe and Douglas counties and Aurora Health Access in Aurora – and two emergent alliances in Adams and Jefferson Counties. Each of these metro ring alliances is focused on access to care and other health care concerns in their respective areas. Missing is an alliance to focus on the important health and health care issues of concern to stakeholders in the City and County of Denver, as well as a metro-wide alliance or network of alliances to focus on issues of concern to the entire Denver metropolitan area.

Recommendations

Given these gaps and the many advantages that health alliances bring to a community, it would be beneficial to form a health alliance that would focus initially on health and health care issues in the City and County of Denver, and that could later coordinate with like alliances in the surrounding communities for issues of metro-wide concern.

A strategic planning process should be undertaken to determine the initial priorities of the alliance and the best organizational structure to adopt in order to meet these priorities. This process may be supported by a Convening for Colorado Grant from the Colorado Trust.

Based on the experiences of the alliances studied here, the following issues will be important to explore in the strategic planning process:

Issues to Consider in the Strategic Planning Process

Geographical boundaries

- Given that the boundaries of the City and County of Denver are not significant for patients and clients seeking health care, should the alliance be limited to the City and County of Denver, or also include members from the surrounding metropolitan communities?
- Should the alliance start out with a focus on the City and County and expand at a later stage?

Scope of work

- Should the alliance focus mainly on issues already identified in Denver's CHIP or investigate additional priorities?
- Should the alliance focus mainly on underserved populations or the health of the wider community?
- Should the alliance limit itself to being a convener of stakeholders, or should it also plan for managing programs and providing direct services such as care coordination?
- What are some early projects the alliance might take on to have quick success?

Organizational structure and leadership

- How many and which organizations should be included on an initial Steering Committee to help found the alliance?
- Are there individuals in the community who can offer inspired and committed leadership in the crucial founding period of the alliance? Are they willing and able to sustain their involvement, possibly without a steady source of funding?
- Can the alliance attract executive-level membership for its Steering Committee and Board?
- Should the alliance remain an informal network or should it be formed immediately as a 501(c)(3) non-profit organization?
- How many and which organizations should be included on the alliance's Board of Directors?
- Do work groups need to be formed early to assist the alliance in its work? If so, what are the most important topics for work groups to address?

Breadth of the alliance and membership issues

- Should the alliance consist of a broad group of stakeholders in the community, or a more limited set?
- Should it consist mainly of safety net providers or also include private hospitals, clinics, and physicians?
- Should the alliance include only organizations, or also individual members?
- What should the criteria for membership be? Should there be different tiers or types of membership?
- Should founding members retain a larger share in the alliance's decision-making?

Funding and Sustainability

- Should the alliance charge membership dues from the start, later in its development, or not at all?
- What could the alliance do to sustain itself beyond the grant funding it is likely to get in the initial period for planning and getting established?