The Colorado Trust Environmental Scan

October 2012

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Introduction

> ***"Health and health care disparities continue to exist and, in some cases, the gap continues to grow for racial and ethnic minorities, the poor, and other at-risk populations. Beyond the heavy burden that health disparities represent for the individuals affected, there are additional social and financial burdens borne by the country as a whole. These burdens constitute both ethical and practical mandates to reduce health disparities and achieve health equity.***[1]

The Colorado Trust's (The Trust's) mission is to advance the health and well-being of the people of Colorado with a vision dedicated to achieving access to health for all Coloradans by 2018.[2] As noted in the quote above, *access to health for all* cannot be achieved until the issues surrounding health equity are addressed.

While Colorado is ranked ninth in *America's Health Rankings* by United Health Foundation and has the lowest prevalence of obesity in the United States, significant health disparities exist.[3] Specifically, more than a quarter of the state's population is "disproportionally affected by disease, disability and death."[4] The population that is disproportionally affected includes Hispanics/Latinos, African Americans/ Blacks, American Indians, Asian Americans, and Pacific Islanders. "The problem is getting more extreme because we know that the percent of our population that is minority is increasing every year."[5] Minority ethnicities are forecasted to represent 43.3% of Colorado's population by 2040.[6]

With the passage of the Patient Protection and Affordable Care Act (ACA), Colorado has a unique opportunity to address health care inequity and health disparities in the state. Although implementation of the ACA is only partially complete, Coloradans have already seen benefits of this historic law. For example, more than 40,000 young adults in Colorado have gained health insurance, nearly 1,200 Coloradans with pre-existing conditions now have coverage, and nearly one million Coloradans with private health insurance received coverage for preventive health care with no out-of-pocket cost.[7]

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[1] National Partnership for Action. National Stakeholder Strategy for Achieving Health Equity; 2011 Retrieved from: http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

[2] The Colorado Trust. (2012). About Us. Retrieved from: http://www.coloradotrust.org/about

[3] America's Health Rankings. (2011). The Rankings: Colorado. *United Health Foundation.* Retrieved from: http://www.americashealthrankings.org/CO

[4] The Colorado Trust. (2012). Overview: Equality in Health. Retrieved from: http://www.coloradotrust.org/grants/show-grant?id=49

[5] Calonge, Ned. (30 August 2012). Opening Remarks at Community Forum in Fort Collins.

[6] Colorado Department of Local Affairs. (2012). Colorado & Counties: Forecasts. Retrieved from: http://www.colorado.gov/cs/Satellite/DOLA-Main/CBON/1251593300475

[7] Calonge, Ned. (6 June 2012). Open Letter to Grantees on Upcoming Supreme Court Decision. The Colorado Trust. Retrieved from: http://www.coloradotrust.org/news/blog/blog-entry/open-letter-to-grantees-on-upcoming-supreme-court-decision

With the ACA and health care reform continuing to move forward in Colorado, The Trust is uniquely positioned to leverage its financial resources through targeted investments addressing health equity and realize its vision of health care for all. The Trust believes *now* is the time for action.

In July 2012, The Trust charged John Snow, Inc. (JSI), a health care consulting firm, with conducting an environmental scan of Colorado to help refine The Trust's vision, priorities, and future grantmaking decisions regarding health equity. The Trust defines health equity as "ending inequalities affecting racial/ethnic, low-income, and other disadvantaged populations, so all Coloradans can achieve optimal health."

The scan was designed to ascertain what initiatives The Trust could support to improve health equity in Colorado, with a focus on health care services, data and information, and advocacy and policy. The environmental scan examined two factors related to health care services: 1) the key issues and gaps in health care service delivery for the populations experiencing inequities and the solutions for addressing them; and 2) the organizational capacity necessary to sustain health care services for racial/ethnic, low-income, or other disadvantaged populations. For data and information, the scan considered what data and information would be useful to assist communities in identifying health care inequities and addressing health equity. For advocacy and policy, the scan determined how advocacy could be used to further policies that address health inequities and promote health equity.

The environmental scan gathered input from Colorado stakeholders ranging from consumers, to health care service providers, to representatives of other health care related sectors. This report summarizes the results of the scan and provides The Trust with recommendations from these stakeholders for improving health equity.

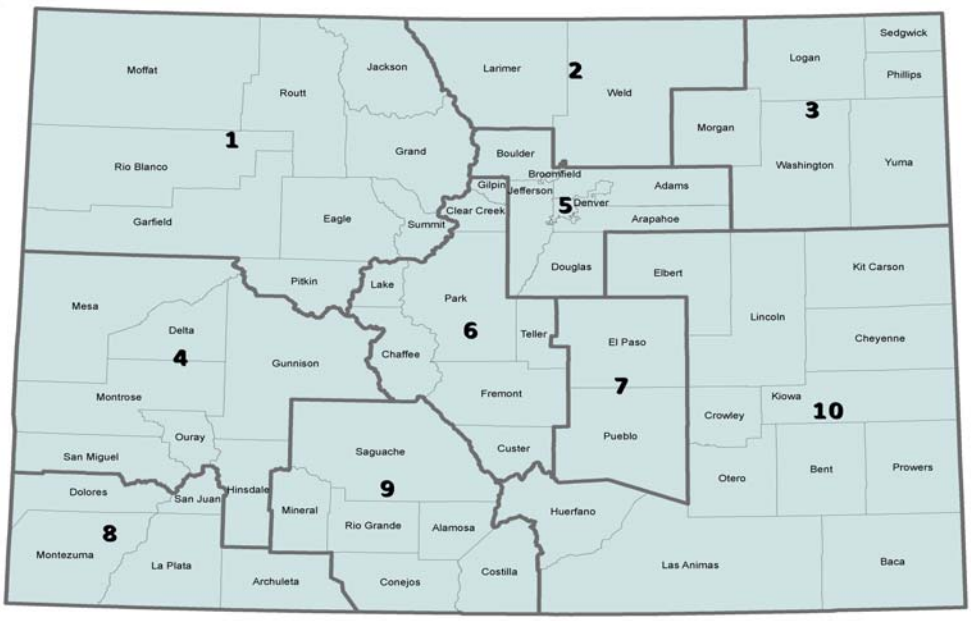
The report is organized into six sections. The **methodology** section describes the methods used to implement the scan and analyze the findings. The remainder of the report is organized around the objectives of the scan: to explore the **definition of health equity** in Colorado; to identify **challenges to addressing health inequities**; to suggest **sustainable solutions for improving health equity**; to propose the **role of The Trust in facilitating solutions to improve health equity**; and lastly, to outline **recommendations** for The Trust to move forward based on collected and analyzed data from the environmental scan.

Methodology

JSI and The Trust used three complementary methodologies to conduct the environmental scan with each methodology targeting different audiences. The methodologies included: forums and informal conversations with community-based organizations, health care leaders, and community leaders across Colorado; focus groups and key informant interviews with leaders of health care and health care related organizations across all sectors; and a statistically significant statewide telephone survey of consumers. Through all three methodologies, 1,033 individuals participated in the environmental scan.

The forums and informal meetings, collectively referred to as community conversations, were held in each of the ten regions The Trust uses in its grantmaking. (Please see map below outlining The Trust's regions).

Map of Colorado Trust Designated Regions



JSI facilitated and documented 15 forums across the ten regions with a total of 286 individuals. The Trust staff led and documented 14 informal meetings across the ten regions with a total of 92 participants.

All focus groups and key informant interviews were hosted in Denver, but provided the opportunity for phone participation for those not able to attend in person. JSI conducted nine focus groups and four key informant interviews (collectively referred to as focus groups) that included a combined total of 79 individuals.

JSI worked closely with The Trust staff to develop a discussion guide for the focus groups and the community conversations to ensure that the methodologies were complementary in addressing the scan objectives. The discussion guide for the community conversations focused predominantly on health care services and health equity while the focus group discussion guide primarily focused on data and information, advocacy and policy and health equity. Once all the focus groups and community conversations were completed, JSI imported the finalized notes into Atlas.ti© and analyzed the notes based on a standardized set of codes. For both the focus groups and community conversations, JSI identified overall themes and patterns in each individual methodology, in addition to correlating any themes from both methodologies. The findings from the focus groups that are captured in this report centered on themes that arose in three or more focus groups or interviews. The findings from the community conversations that are included in the report reflect themes that were identified in at least four of The Trust's ten regions. In addition, where applicable, themes were analyzed across regions and regional differences are noted in the report.

The statewide telephone survey was implemented to provide consumers, particularly those experiencing health inequities, with the opportunity to provide input to the scan. The focus of the survey was to gauge Coloradans' awareness of and experiences with health equity and to understand consumer perspectives on a set of possible solutions to address health inequities. JSI subcontracted

with Anderson, Niebuhr & Associates, Inc. (ANA), a nationally recognized health care survey research firm with 35 years of experience and a distinguished reputation for rigorous methodologies in custom-designed research to help develop and implement the survey. Between August 2 and August 29, 2012, the survey staff at ANA completed 576 telephone interviews with randomly selected adults 18 and older throughout the state of Colorado. The interviews included an oversampling of 52 African Americans/ Blacks and 82 Hispanics/Latinos in order to ensure that the survey results could be stratified by race/ethnicity.

The results from the survey were analyzed in two samples: one sample based on overall statewide responses and one comparing different race/ethnic groups. The survey analysis included descriptive statistics and tests for statistical significance. This report identifies findings of statistical significance using comparison terms such as "most" or "least" likely.

Please see Appendix A for a more in-depth description of each methodology, including the discussion guides for the community conversations and focus groups and the telephone survey questionnaire.

Definition of Health Equity

The Colorado Trust defines health equity as ***ending inequalities affecting racial/ethnic, low-income and other disadvantaged populations, so all Coloradans can achieve optimal health.***

Using this definition as a guide, the environmental scan sought to gain further insight into the definition of health equity. Community conversation participants identified the undocumented, the disabled, refugees, the under-insured, the elderly, transients, rural residents, and pregnant women as examples of disadvantaged populations that experience inequity. In addition, they suggested that social determinants significantly affect health equity and should not be ignored. Focus group participants emphasized that health equity conveys fairness, equal status, equal treatment, and opportunity for equal health outcomes. According to the statewide survey, more than half (57%) of the respondents believed that inequities, based solely on race/ethnicity, income, or geographic setting (urban or rural) exist in the health care people receive. Sixty percent of African American/ Black respondents, 56% of Caucasian respondents, and 52% of Hispanic/ Latino respondents believed that inequities exist related to race/ethnicity, income, and/or geographic setting. However, only about two in ten telephone survey respondents indicated that they had heard or read anything in the past year about health care inequity in Colorado based solely on race, ethnicity, income, or where somebody lived. A similarly low percentage of African American/Black, Hispanic/Latino, and Caucasian survey respondents indicated they had heard or read about health care inequity.

Results from all three scan methodologies provided further insight into the underpinnings of health inequity in Colorado, including race/ethnicity, income, geographic setting and social determinants of health. This section describes the findings related to these factors and their impact on health equity in further detail.

Race/Ethnicity

Less than half (four out of nine) of the focus groups conducted identified significant inequities related to race/ethnicity and few community conversations raised the issue of how this population experiences inequity. While community conversation participants recognized that communities of color experience

health inequity, they were more focused on factors of inequity that are experienced by other segments of their communities such as low-income community members. Even when prompted, community conversation participants did not engage in discussions of racial inequity, although they did acknowledge that racial/ethnic groups encountered the same challenges as other disadvantaged groups, especially low-income groups. However, as noted above, 60% of African American/ Black, 56% of Caucasian, and 52% of Hispanic/ Latino survey respondents believed that race/ethnicity based health inequities do exist along with income based and geographic based inequities.

Income

In the statewide telephone survey, among those who indicated that they had read or heard something about health care inequity, the most common inequity was related to income (30%). Community conversation participants affirmed this finding of low income as a key factor influencing health inequity in all regions, particularly in the Denver and Region 3 forums. Participants in resort community conversations noted that in their economies many people who are not technically low income were unable to afford health care services because of inflated costs in their regions. In discussing the need to include low income in the definition of health equity, community conversation participants observed that income affected people's abilities to prioritize health care costs and things that contribute to health (such as healthy foods) over other basic needs and that other needs and priorities made it difficult for low-income families to adopt healthy lifestyles and focus on prevention.

Community conversation participants also identified uninsured and underinsured populations as experiencing health inequity in all regions, particularly Regions 1, 4, 6 and 7. Twenty-one percent of survey respondents identified inequities based on health care insurance.

Low-income, as well as uninsured and underinsured populations were identified in all the focus groups as groups who consistently experience health inequity.

Geographic Setting

Geographic setting (urban or rural) was a consideration in health equity that was raised across all three methodologies. It was the third most common basis of inequity identified by 19% of telephone survey respondents. Community conversation participants in rural communities as well as in one of the urban forums highlighted rural status as an important factor related to health equity. Focus group participants noted that access to care was a problem for those living in rural areas not only because of limited availability of services and providers but also because of a lack of cultural competency among providers. Focus group participants felt that while a patient in a rural area may have "coverage" to seek medical attention, they may not truly have access to equitable care.

Social Determinants of Health

Community conversation and focus group participants identified social determinants of health as an important underpinning of health equity. The issue was raised in more than half of the focus groups, and in all but one of the regions' community conversations.

Community conversation participants noted that income, education, nutrition, health literacy, and access to transportation have an important effect on health. They identified population groups such as seniors, refugees, immigrants, undocumented persons, children, people with complex health needs, veterans, pregnant women, homeless individuals, and transient populations as being negatively affected by social determinants of health. Community conversation participants also noted that community

values and culture can affect community members' health, where the culture does not support healthy activity or nutrition options.

Focus group participants described the effect of education on health equity as the inability for patients to understand the benefit of preventive care or comprehend how to navigate the system in a way that promotes health equity. Focus group participants also expressed feelings that social determinants of health should be incorporated into workforce education and that providers should be knowledgeable about factors such as food and housing that have a direct effect on health.

SOCIAL DETERMINANTS OF HEALTH:

The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.

Challenges to Addressing Health Inequities

Key to improving health equity is gaining an understanding of the barriers and challenges to all Coloradans in achieving optimal health. This section discusses the service challenges facing populations that experience inequity, as well as the data and information and the advocacy and policy challenges to improving health equity.

Service Challenges

Based on an analysis of input across all three methodologies, Coloradans experiencing health inequity in their communities face a number of challenges related to health care services. These challenges encompass affordability, availability and accessibility of services.

- Affordability of services was primarily related to whether individuals had health insurance coverage.
- Availability and accessibility of services were influenced by the following challenges:
    - Geographic setting;
    - Limited capacity for health care services;
    - Workforce issues;
    - Complexity of the health care delivery system;
    - Health literacy; and
    - Cultural bias

Affordability

Based on the statewide telephone survey results, income was a major factor in health insurance coverage. Fifty-two percent of survey respondents from households living below 133% Federal Poverty

Level (FPL) saw health insurance affordability as a challenge compared to only 16% of those from households earning more than 400% of FPL.[8] Survey respondents from households with incomes over 400% of FPL (71%) were also most likely to report having private health insurance, while those with lower incomes (below 400% FPL) were most likely to have either a publicly funded health plan (58%) or no plan at all (20%).

The telephone survey data also revealed that the type of insurance coverage people had differed by race/ethnicity. Of the survey respondents, Caucasian respondents (60%) were more likely to have a private health plan than African American/ Black (48%) or Hispanic/ Latino respondents (41%), whereas African American/ Black respondents were most likely to have some form of government-sponsored health insurance. Hispanic/ Latino respondents were the most likely to be uninsured. Even though 16% of Hispanic/ Latino respondents were uninsured, those that had a private insurance plan were most likely to be covered under their employer-sponsored plan.

Nearly three in ten Coloradans responding to the statewide telephone survey believed that being able to afford the cost of health insurance was a *major problem* for them. Hispanic/ Latino (42%) and African American/ Black (39%) respondents were more likely than Caucasian respondents (26%) to believe that being able to afford health insurance was a *major problem* for themselves. Telephone survey respondents who reported the most dissatisfaction with out-of-pocket costs, were Hispanic/ Latino respondents (59%) reporting that they were *dissatisfied* or *very dissatisfied* compared to Caucasian respondents (32%) and African American/ Black respondents (19%).

Community conversations provided additional context to these telephone survey findings. Participants in all community conversations identified lack of health care insurance as a challenge. Unaffordability of health care services was one of the top challenges raised in the community conversations in all of the regions, particularly in rural areas, with the exception of Region 2. Several community conversations identified undocumented persons and self-employed individuals as important uninsured sub-populations.

In the focus groups, participants also identified the affordability of health care as a challenge. Several focus groups expressed that even though people talk about keeping costs down, the issue of affordability for disadvantaged populations remains an issue. Focus group participants suggested that insurance coverage was directly related to economic barriers because of the relationship between health insurance and either employment and/or adequate financial resources to buy insurance and to cover the costs of co-pays and deductibles. For employers represented in the focus groups, the cost to provide health insurance for employees had risen substantially in recent years. Focus group participants also noted that those who are unemployed, underemployed, or otherwise struggling financially believe that they are often denied access to care, particularly to specialty care because providers are reluctant to serve people who are in unusual situations and who might have limited financial resources.

[8] Residents were asked for their income range and family size. Poverty level is based on 2012 Federal Poverty Guidelines; 133% of Federal Poverty Level was $30,657. Department of Health and Human Services, http://aspe.hhs.gov/poverty/12poverty.shtml.

Availability and Accessibility

In community conversations and focus groups, availability and accessibility of services were identified as important challenges to health equity. Focus group participants described availability and accessibility as being "uneven" among ethnically diverse, low-income, undocumented immigrants, homeless, uninsured, and otherwise vulnerable populations. Examples offered by focus group participants included limited hours in which services were offered, location of the services (especially in relation to available transportation), lack of services in languages other than English, and long wait times or waiting lists to gain access to services. Community conversation participants also noted that for low-income persons, the inaccessibility of services after hours resulted in lost wages since their jobs did not typically offer sick leave that can be used to seek care. The telephone survey identified that respondents from households living below 133% of FPL (22%) were three times more likely to have *major problems* with access to care compared to those respondents from households living above 400% of FPL (7%).

Based on the three scan methodologies, availability and accessibility of services were influenced by geographic setting, limited capacity for health care services, workforce issues, complexity of the health care system, health literacy, and cultural bias. Although not all factors were raised in all three methodologies, if the factor was raised in three of the focus groups, four of the community conversations or had a statistically significant finding in the telephone survey, it is included in the discussion below.

Geographic Setting

Satisfaction with distance from a doctor or other health care provider was higher among telephone survey respondents living in urban settings (44%) compared to those in rural settings (31%). This difference was also significant for satisfaction with accessing care from a specialist when needed (urban 36% vs. rural 29%). Having enough doctors and other health providers nearby was more likely to be reported as a *major problem* for survey respondents living in rural areas (17%) compared to urban survey respondents (8%).

FRONTIER AREA:
Frontier areas are defined as places having a population density of six or fewer people per square mile.

Rural Assistance Center
North Dakota School of Medicine and Health Sciences

The community conversations and focus groups also noted that availability of services is an issue in rural and frontier areas where providers and services are limited. Rurality was referred to in about half of the focus group discussions as a barrier to equal access to care not only due to limited services and providers, but also because of a lack of cultural competency.

Rural participants in the community conversations noted that they faced particular challenges related to health equity because of limited availability of primary care and other services and because of cultural norms and perceptions that shape the way people in rural areas seek (or do not seek) care. Rural community conversation participants also noted lengthy distances to health care service sites, higher costs of services in rural and frontier regions, and challenges related to establishing care sites in rural areas.

One of the top challenges in all the community conversations, especially rural areas and Region 7, was limited availability of transportation. Community conversation participants noted that for communities with limited transportation services, often the routes and hours of operation are not a viable option for accessing care. Other community conversations identified a lack of viable solutions to address transportation scarcity. Some community conversation participants framed lack of transportation

differently; they framed it as limited capacity in the community for health care services within a feasible driving distance.

Limited Capacity for Health Care Services

Telephone survey results revealed that only about one in ten survey respondents believed that having enough health care providers near where they live or being able to get needed medical care is a *major problem* for themselves. A similar percentage of African American/ Black (12%), Hispanic/ Latino (11%), and Caucasian (10%) respondents reported not having enough doctors and other health providers near where they live.

However, limited availability of services was a strong theme that emerged in both rural and urban settings in the community conversations. Community conversation participants conveyed that limited availability of services affected the entire community. As noted above, the challenge of service availability was of particular concern to community conversation participants in rural areas. Urban community conversation participants also identified capacity as a key concern for meeting the needs of low income, underinsured, and uninsured populations, noting that in some communities, sufficient primary care capacity existed for the privately insured population, but not for the publicly insured (Medicaid or Medicare), developmentally challenged, and uninsured populations.

Services identified in the community conversations as having limited (or no) availability included:

- Specialty providers for publically insured and uninsured patients, especially in rural areas;
- Dental care, especially for adults but in some instances for children;
- Mental health services for adults and children;
- Services tailored to the senior community; and
- Substance abuse services for adults.

Focus group participants said that there were more shortages in certain provider types and services in rural and frontier areas, resulting in a significant effect on the quality of care received in those areas.

Workforce Issues

Community conversations identified workforce issues as another set of challenges for those individuals who experience health inequity. In conversations across the state community conversation participants noted a need for bilingual service providers, translators, or other ways to make services accessible to those who speak languages other than English (primarily Spanish), as well as an overall shortage of primary care providers for uninsured and/or publicly insured community members. Rural community conversation participants felt that shortages of certain provider types and services in rural and frontier areas resulted in a significant effect on the quality of care received in those areas.

Focus group participants noted a lack of effective use of limited health care resources, i.e., advanced practice nurses who could potentially provide the type of care needed in some communities. In cases where providers and services are available, focus group participants noted that access to providers who are skilled and knowledgeable in providing services for disenfranchised populations and people of color was limited.

The telephone survey data indicated that African American/ Black (92%) and Hispanic/ Latino (90%) respondents were more likely than Caucasian (75%) respondents to believe that helping the health care workforce reflect different cultures and teaching the health care workforce about the cultural values

and beliefs of different groups of people (as well as expanding Medicaid to cover more people) would be effective at reducing health care inequities.

Complexity of the Health Care System

Community conversation and focus group participants identified a number of challenges related to the structure of health care services, including complexity of the system, misaligned incentives, and organizations working in an uncoordinated fashion. System complexity was an issue in all community conversations and was the top challenge identified in urban community conversations. Descriptions of the complexity included the care system itself, as well as enrollment and eligibility processes, the challenges in understanding and using insurance (public and private), and the lack of service integration and collaboration among providers. Community conversation participants noted that the complexity of the system results in misaligned incentives for providers and patients because current payment systems do not reward improved outcomes. Community conversation participants were also concerned about the challenges faced by both service providers and patients navigating uncoordinated services, and they noted a duplication of efforts and resources. Community conversation participants regularly noted the lack of coordination among various health care services within a community, including mental health services and social services.

In addition, complexity of the health care system was a challenge raised in more than half of the focus groups. The participants described scenarios in which patients do not know how to navigate the system in a way that promotes health equity. A potential consequence raised in several of the focus groups was a lack of understanding the system or how to navigate it, resulting in emergency departments becoming the primary access point for medical care.

Health Literacy

Community conversation participants identified health literacy as a particular challenge for patients, especially for those who require specialty care or have complex health conditions. Community conversation participants recognized that health literacy is a challenge for disadvantaged populations, and even for those who have a basic (or sometimes even a sophisticated) understanding of the system.

> HEALTH LITERACY:
> Whether a person can obtain, process, and understand basic health information and services that are needed to make suitable health decisions. Health literacy includes the ability to understand instructions on prescription drug bottles, appointment cards, medical education brochures, doctor's directions, and consent forms. It also includes the ability to navigate complex health care systems. Health literacy is not simply the ability to read. It requires a complex group of reading, listening, analytical, and decision-making skills and the ability to apply these skills to health situations
>
> *U.S. Department of Health and Human Services, Healthy People 2010: Understanding and Improving Health. 2000, Government Printing Office: Washington, DC: U.S.*

Community conversation participants noted that many people know about available services but do not know how to engage the health care system as an advocate for themselves. Community conversation participants also noted challenges with ensuring information about available services as well as the services themselves reach those who most need them.

While health literacy was not named as a challenge in the focus groups, participants in five focus group discussions did recommend engaging with communities and consumers to provide an opportunity to

raise the health literacy levels among health consumers, implying that health literacy is a challenge to achieving health equity.

Cultural Bias

Several of the community conversations and focus group discussions expressed that just because an individual may have access to care, they do not necessarily receive the same care as others once in the system. Community conversation and focus group participants alluded to cultural bias, and preconceived notions as factors in whether or not an individual of a different race, ethnic background, income bracket, or immigration status received the same type of services as their counterparts.

Community conversation participants also identified differences in cultural norms related to the use of services (for example, stigma around accessing mental health services), a lack of cultural competence in health care providers, and a mistrust of the system among communities of color as challenges. While many of the examples community conversation participants provided related primarily to Hispanic/Latino communities and recent immigrants, they also mentioned cultural norms of rural and American Indian communities.

The statewide telephone survey demonstrated cultural differences in respondents' perceived satisfaction and problems with health care in Colorado. The survey found that 56% of survey respondents rated the health care services in their areas as *excellent* or *very good*. However, Hispanic/Latino respondents (38%) and African American/ Black respondents (35%) were less likely than Caucasian respondents (60%) to believe that the quality of health care services in their area was *excellent* or *very good*.

More than 90% of telephone survey respondents reported satisfaction with the respect their doctors or other health care providers gave them and this feeling did not differ based on race, income, or geographic setting. However, Caucasian respondents (50%) were more likely to report being *very satisfied* with quality of care compared to Hispanic/ Latino (35%) and African American/ Black (31%) respondents. Caucasian respondents (36%) were also more likely to report satisfaction with getting care when needed, compared to African American/ Black (27%) and Hispanic/ Latino (19%) respondents. Twenty percent of Hispanic/ Latino respondents reported that getting needed medical care was a *major problem*, compared to 14% of African American/ Black respondents and only 10% of Caucasian respondents.

Telephone survey respondents living in households below 133% FPL were less likely to report satisfaction with the quality of care they get from their doctor, health care provider, and hospital compared to respondents living in households above 400% FPL. They were also less likely to report satisfaction with the amount of time they are able to spend with their doctor or other health care provider.

Challenges Related to Data and Information

In the context of identifying challenges to improving health equity in health care services, community conversation participants noted that the data that is available does not address nuances in the service challenges faced at the community level because the data is reported at the aggregate level which "washes out" the needs of subpopulations and, depending on the size of the population, whole

communities. Community conversation participants also noted that most available data does not capture the needs of those who move through a community during a year or a season.

In the focus groups, data and information challenges were directly addressed. Focus group participants were aware of data being collected at various levels (i.e., local, state, regional, national), but felt these data are not standardized or complete; for example, race or ethnicity information is not consistently available. Furthermore, focus group participants said that even when data is available, data analysis expertise can be very expensive and difficult to access. All nine focus groups talked about the need for "better" data, such as standardizing the way in which data is collected and shared, expanding on the granularity in which data is collected, including more explicit data on minority populations and incorporating qualitative data from the community perspective to supplement quantitative data that only tells part of the "story."

Challenges Related to Advocacy and Policy

Community conversation participants noted that local or regional efforts to improve health equity in services can be hampered by state and national policies or regulations or funding priorities such as, policies regarding safety-net and public insurance funding; and scope of practice and liability issues that limit the ways in which providers operate. Community conversation participants also noted that workplace policies can affect the ability of individuals to access care appropriately, such as policies regarding paid leave to seek care during work hours. These challenges were raised in relationship to the complexity of the current health care system, a top issue identified in community conversations across all regions. In addition to the challenges posed by the existing policies, community conversation participants noted that it can be challenging for communities to advocate for policy change and understand how to engage policy makers.

Three of the focus groups expressed a desire to see more regulations and policies that promote health equity but acknowledged that the challenge may lie in the interpretation and enforcement of such policies.

Sustainable Solutions for Improving Health Equity

The statewide telephone survey, community conversations, and focus groups confirmed that health inequities pose challenges to individuals based on race/ethnicity, income, geographic setting and other social determinants. Community conversation and focus group participants were asked to suggest solutions for addressing the challenges they raised with regard to inequities. The statewide telephone survey asked respondents to describe the perceived effectiveness of a set of proposed solutions provided by the telephone interviewer. Table 1 below outlines a summary of the strategies for improving health equity that were proposed in the community conversations and focus groups as well as by the telephone survey respondents. The strategies primarily address suggestions for improving health equity in services, although a few strategies for improving health equity through data and information and policy and advocacy are included. Solutions for improving health equity through data and information and policy and advocacy were discussed more comprehensively by the focus groups and in the community conversations in relation to the role that The Trust could play in improving health equity and are therefore discussed more fully in the next section.

Table 1. Solutions for Improving Health Equity, The Colorado Trust Environmental Scan, 2012.

Service Solutions	• Health care insurance coverage for all
	  ➢ Lower the cost of insurance premiums and co-pays
	• Workforce development
	  ➢ Culturally competent workforce
	• Transportation
	• Payment reform
	• Health system reform
	  ➢ Service integration
	  ➢ Medical home model
	  ➢ Support for evidence based care/
	  ➢ Support for new practice models
	• Provide comprehensive primary care
	• Coordination among providers
	• Locate care where people are
	• System navigation
	  ➢ Patient navigators
	• Improve health literacy
	  ➢ Improve understanding of health care

Data and Information Solutions	• Health equity data workgroup • Information exchange
Policy and Advocacy Solutions	• Community/Consumer engagement • Educate people about inequities

In general, rural community conversation participants were particularly interested in solutions involving coordination of care, cultural competency, and system navigation, while urban participants expressed more interest in system change, advocacy, and workforce development solutions. Based on the telephone survey results, low-income respondents felt that improving transportation and educating people about health inequity would be effective solutions; African American/ Black respondents thought that lowering the cost of insurance premiums and co-pays would be very effective; and Hispanic/ Latino respondents felt that helping the health care workforce reflect different cultures would be very effective solutions.

The remainder of this section describes in detail the context for the solutions outlined above.

Service Solutions

In the statewide telephone survey, cultural differences emerged with regard to the proposed service solutions. African American/ Black and Hispanic/ Latino respondents were more likely than Caucasian respondents to believe that the solutions proposed in Table 2 would be effective ways to at reduce health care inequities.

Table 2. Perceived Effectiveness of Proposed Solutions to Addressing Health Equity in Colorado: By Race/Ethnicity, The Colorado Trust Environmental Scan Survey, July/August 2012.

Percent Very Effective/Effective	African American/ Black	Hispanic/ Latino	Caucasian
Lowering the cost of health insurance premiums and co-pays	98%	88%	84%
Helping the health care workforce reflect different cultures	92%	90%	75%
Improving patients' and consumers' understanding of health care	92%	88%	87%
Provide transportation to and from health care facilities	92%	88%	79%
Providing care in the patient's native language	92%	88%	81%
Expanding Medicaid to cover more people	91%	76%	62%
Teaching the health care workforce about the cultural values and beliefs of different groups of people	90%	84%	75%
Teaching people about the health care differences that exist in Colorado	88%	81%	78%

Survey respondents with different incomes also differed in their perspectives on effective solutions to health inequity. Addressing **transportation issues** (85%) and **educating people about health inequity** (83%) were considered as *very effective* or *effective* solutions more commonly among those respondents from households with incomes below 133% of FPL, compared to those with incomes above 400% of FPL. Only 78% of respondents from households with incomes above 400% of FPL agreed that addressing transportation issues would be *very effective* or *effective*, and only 75% of this higher income group believed that teaching people about health inequity would be *very effective* or *effective*.

Views on solutions also reflected differences based on the telephone survey respondents' geographic setting. Respondents living in urban settings (85%) were more likely to report **ensuring that people had health insurance** as a *very effective* or *effective* solution to improving health equity compared to their rural counterparts (74%).

Of the solutions outlined in Table 2 as being effective, the solution identified by Hispanic/ Latino survey respondents as the *most effective* solution was **lowering the cost of health insurance premiums and co-pays**. This solution was also identified by African American/ Black and Caucasian respondents, but more African American/ Black respondents identified transportation and cultural sensitivity as most effective compared to Hispanics/ Latino and Caucasian respondents (Table 3).

Table 3. Coloradan's Views on Effectiveness of Solutions, by Race/Ethnicity, The Colorado Trust Environmental Scan, July/August 2012.

Percent Most Effective	African Americans/ Blacks	Hispanics/ Latinos	Caucasians
Lowering the cost of health insurance premiums and co-pays	34%	31%	29%
Ensuring that more people have health insurance	10%	13%	17%
Provide transportation to and from health care facilities	7%	2%	5%
Teaching people about the health care differences that exist in Colorado	7%	3%	2%
Expanding Medicaid to cover more people	2%	11%	4%
Ensuring that people are able to keep their health insurance	2%	10%	5%
Getting more health care professionals to work in locations that need them	2%	3%	7%

Ensuring affordability of health care services was also a solution proposed by the community conversation participants and focus groups, particularly in ways that revolved around **payment reform**. In more than half of the focus groups, participants strongly recommended payment reform to reward good health outcomes rather than high volumes of complex procedures.

To address the challenges related to availability and accessibility of services, many community conversation and focus group participants suggested a range of health care **system reform** strategies, including **service integration**, implementation of **medical home models,** and other **innovative practice models**. Integrating substance abuse and mental health with primary care, as well as integration between primary care, specialty providers, and hospitals were identified as solutions to accessibility challenges. Similarly, community conversation and focus group participants were interested in creating broad partnerships at the community level to support integrated service delivery. All but two of the focus groups proposed ideas for collaborative partnerships, most of which were based on replicating successful models from other organizations or areas.

Community conversation and focus group participants were particularly interested in exploring ways to support a **robust primary care infrastructure**, to secure a comprehensive role for primary care along the lines of the medical home model,

MEDICAL HOME:

The Patient Centered Medical Home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

National Committee for Quality Assurance

or to use innovations such as the "hot spotters" model to provide intensive case management to high care utilizers. They also recommended creating training opportunities on innovative care models and supporting the adoption of **evidence-based practices**.

In addition, community conversation and focus group participants advocated for **providing primary care in locations and settings convenient to the patient** or, as some participants stated, "where they are." Specific strategies identified included establishing "one-stop shop" services with medical and other social-services, providing prevention and health services in schools, expanding primary care hours and locations, and, particularly in rural areas, providing services through visiting physicians or telemedicine. **Transportation** was also suggested in the community conversations as a solution that would improve the accessibility of care.

To overcome the challenge of navigating a complex system, focus group and community conversation participants suggested educating communities about the ACA benefits and health system navigation in general. Potential solutions around **system navigation** came up in almost half of the focus groups conducted, in which participants suggested that patient navigators could help by assisting patients with eligibility and coverage forms; having patient navigators in non-traditional settings (i.e., the Medicaid office); and creating a clearinghouse of information for both providers and patients regarding available services. Both community conversation and focus group participants acknowledged a need to train patient navigators and to build organizational capacity to maximize the effect of navigation. Participants identified the need for **navigation services** to support everything from facilitation of public program enrollment to assistance navigating medical services to improving patient understanding of prevention.

Workforce development solutions were suggested in six of the nine focus group discussions. Participants expressed a strong feeling that social determinants of health should be incorporated into workforce education and that providers should be knowledgeable about factors such as food and housing that have a direct effect on health. Community conversation and focus group participants suggested that **workforce development** strategies, such as loan repayment or funding for safety net providers, could play a critical role in ensuring that services are available to low income and rural communities.

Focus group participants also recommended a further understanding of the level of diversity in the health care workforce. Although only a few community conversations focused on cultural competency as a proposed solution to addressing health inequity, focus groups identified the need to develop a **culturally competent workforce** in order to address the challenge presented by lack of cultural competency. Focus group participants suggested that technical assistance and training be provided to improve cultural competency among existing providers. They also suggested that strategies to diversify the future health care workforce should be implemented. One strategy suggested was to provide coaching and mentoring of minorities to address the barriers preventing minorities from entering health care professions and taking on health care leadership roles.

Data and Information Solutions

To address the challenges raised regarding data collection, sharing, and analytics, every focus group that was conducted suggested ways to potentially improve and strengthen the data that informs the health equity issue. Focus group participants suggested setting up a workgroup to improve the capacity of data collection systems and practices to describe health inequities. Once data collection has been strengthened, focus group participants recommended developing an effective information exchange

process to provide utility to the data in order to use data to provide a picture on all levels: state, region, community, and neighborhood and make a stronger case for health equity.

Advocacy and Policy Solutions

All but one of the focus groups expressed a desire for changes to policy and advocacy around health equity. To encourage that action be taken on issues surrounding health equity, many community conversation and focus group participants agreed that it would be critical to engage communities and consumers in formats such as town meetings and focus groups to ask what their concerns are, what their experiences in the health care system have been, and how they would like to receive health information. Participants felt that **engaging with communities and consumers** provides an opportunity to raise the **health literacy** levels, educate people how to advocate for themselves, and support a community-level approach to improving health equity.

Role of The Colorado Trust in Facilitating Solutions to Improve Health Equity

Community conversation and focus group participants were asked to discuss ways in which The Trust could support the solutions that were proposed and, in particular, to think about a role for The Trust other than the funding of direct services. Communities were not asked to prioritize the solutions they proposed; thus the solutions are not presented in any order. Community conversation and focus group participants identified a number of roles for The Trust, ranging from actions The Trust could take to raise the profile of the challenges faced by populations experiencing inequities, to supporting the dissemination of best practices and knowledge transfer for improving health equity. The suggested solutions sought to leverage The Trust's extensive research capabilities in making the case and being a resource to support change. Overall, the suggested Trust roles reflect its strong track record as a change agent giving vulnerable populations a voice and bringing the local perspective to the policy decision-making table.

Many communities noted that they had organizations and/or coalitions that were already working to address the challenges and implement solutions, such as the Community Health Partnership in Colorado Springs, and the North Colorado Health Alliance. Community conversation and focus group participants suggested that The Trust build on these existing community assets by supporting staff time to pursue innovative efforts, as well as providing technical assistance on topics required to address prioritized solutions. Rural areas in particular noted that The Trust could play a critical role in addressing vital service, data and information, and advocacy and policy gaps affecting primary care, dental, and oral health services.

Specific themes that emerged across the community conversations and focus groups are organized by services, data and information, and advocacy and policy and are described in more detail below.

The Colorado Trust's Role in Improving Health Equity in Services

Support Collection and Knowledge Transfer of Promising/Best Practices

Community conversation and focus group participants felt The Trust has a role in making accessible relevant and actionable information on what other communities are doing, on best practices, and on lessons learned. In addition, participants felt The Trust could support local efforts by helping communities better identify and build on assets within their communities and by facilitating the development of community partnerships or coalitions committed to action. Community conversation and focus group participants also suggested that The Trust could serve as a conduit for communities to access federal funds and initiatives focusing on health equity by communicating funding opportunities, supporting collaborative efforts, and providing technical support for proposal development.

In several community conversations, participants noted that the community had made efforts in the past to address challenges and/or implement solutions with mixed success. They noted that an understanding of past efforts and challenges, successes, and lessons learned (either in their community or in others) would help future efforts garner success. They noted that The Trust funding could help with the identification and sharing of those experiences and lessons and drive the implementation of evidence-based programs and best practices.

Focus groups also suggested that The Trust build awareness about important health equity issues throughout the state including health insurance coverage, service availability, and wellness. Focus group participants noted a need to fund communication with and education of the broader community regarding available services and preventive health. Examples included the creation of resource inventories, development of public service announcements, implementation of prevention efforts, and sharing of information among agencies and/or providers in a community or region.

Support Innovative Care Delivery Models

Community conversation and focus group participants noted that innovative care delivery models and other leading edge approaches are not usually supported by existing funding streams. Participants, especially those in urban areas, felt The Trust could play a critical role in supporting early implementation or refinement of new models and/or supporting proven models while payment systems to support them are being developed. Participants felt it would be appropriate for The Trust to "take risks" and support critical efforts that are not otherwise sustainable and/or to help develop sustainability models. One example given by focus group participants was to provide "bridge" funding for new or innovative programs during the development phase.

Support System Navigation

Community conversation participants recognized a need to assist patients in navigating the system as it currently exists, but also recognized that the implementation of health insurance exchanges and new service models would bring additional navigation challenges. Community conversation participants acknowledged a need to train patient navigators, and to build organizational capacity to offer proven navigation services that are culturally and linguistically tailored to certain population groups. Solutions identified by community conversation participants include disseminating best practices in patient and system navigation among organizations, grant support for navigation staff and programs, creating or supporting the creation of a community-level clearinghouse of information regarding available services that would be readily accessible to service providers and consumers, and providing education to consumers on available services. It was also noted by community conversation participants that

payment reform would be critical to the sustainability of navigation services, as would training programs to prepare navigators. Community conversation participants also noted streamlining or simplifying the current health care system would be helpful in lessening the need for system navigation.

Support Providing Care Where People Are Located

More than half of the focus groups, including those with nurses, doctors, and staff from school-based health centers, hospitals and advocacy organizations as participants, raised the idea of providing care where people are located as one significant strategy to improving health equity. In order to help provide care where people are located, community conversation and focus group participants suggested potential roles for The Trust would be support and promote strategies for one-stop shopping and integrated care. For example, focus group participants suggested that The Trust could support investment in telehealth and school-based nurses and/or health centers. Focus group participants also thought that The Trust could support a clearinghouse of resources for physicians to be able to refer consumers to available resources. Community conversation participants recommended that The Trust support web-based strategies to share information about health care resources and to connect community members to each other.

Support Technical Assistance/Training on Cultural Competency

To address cultural bias in health care settings, focus group participants suggested that The Trust could support direct technical assistance in targeted areas where cultural competency is a particularly intractable issue.

Focus group participants also recommended that The Trust consider a development program to foster more recruitment and development of diverse individuals at the board leadership level for hospitals, major foundations, and other organizations.

Community conversation participants felt The Trust has an important role in supporting the development of culturally appropriate services and programs. They suggested that The Trust could play a role in training providers to understand the culture of poverty, and working to ensure that medical home and other care models are culturally competent. Community conversation participants also identified a need to develop liaisons between communities and providers through community health workers or similar approaches.

Support Workforce Development

Similar to the recommendation for The Trust to develop future leaders from diverse backgrounds, community conversation and focus group participants recommended that The Trust assist communities with workforce development by increasing the capacity of the community to diversify its workforce. Community conversations suggested that The Trust could partner with academic programs to train and certify individuals as lay health promoters or patient navigators. In both community conversations and focus groups, participants felt that for rural areas, The Trust could assess the current workforce and support recruitment and development to address gaps in providers in areas of high need.

Advocate for Payment Reform and System Reform

Community conversation and focus group participants suggested that The Trust could advocate for payment reform that supports payment based on value as opposed to volume. Community conversations suggested that this could be accomplished by providing policy briefings and research to policymakers in the state legislature. Likewise, participants from both community conversations and

focus groups felt that The Trust could advocate for system reform to improve health outcomes for populations experiencing health inequity and support health coverage for all populations.

The Colorado Trust's Role in Improving Health Equity Through Data and Information

Improve Data Collection and Information Exchange

More than half of the focus group participants identified a need to perform comprehensive data collection activities and support additional research to better identify where the problems are. Focus group participants recognized a role for The Trust in identifying, collecting, and sharing data, in addition to assisting communities in addressing local challenges, including facilitating the availability of local-level data. Focus group participants recommended that The Trust emphasize use of existing data to help communities tell their stories about their own health disparities to policy makers as well as to each other.

Focus group participants also suggested that The Trust could play a role in helping organizations collect, extract, and analyze data from different sources and develop algorithms to identify relationships between various data sources to show the relationship to social determinants of health. The participants also suggested that The Trust could provide grants to support organizations that do not have electronic data systems and assist them with implementing electronic health records. They suggested that The Trust could also advocate for more effective state data systems.

The Colorado Trust's Role in Improving Health Equity Through Advocacy and Policy

Engage Communities and Consumers

A convening role for The Trust garnered especially strong interest from community conversation participants. Along with valuing The Trust's ability to convene sectors and stakeholders at the state level, participants encouraged The Trust to support local convening efforts among health care providers and across sectors, including the business community. Participants discussed the value of short-term convening efforts to explore problems and solutions, and the establishment and/or support of long-term community efforts to address the identified challenges.

Community conversation participants across all regions, and especially those in urban areas, felt that an important role for The Trust would be to advocate for reform of the existing health care system and to champion important aspects of care such as care coordination or medical homes. Although community conversation participants were interested in local or community-level efforts to address and reduce challenges in the existing health care system, they recognized that state and national level policy and dynamics greatly affect how care is provided and felt The Trust could leverage its status and leadership role to influence those factors.

Additional advocacy efforts suggested by focus groups included prioritizing health equity at all levels and keeping abreast of how policies and regulations influence health care services. Focus groups suggested examples such as 1) focusing on advocating for integrating mental health services for populations covered by Medicaid or Medicare and 2) looking at models for addressing health equity in other countries.

In a number of communities, community conversation participants identified a role for The Trust to build public will around health equity solutions and to convene critical stakeholders. Examples ranged from convening groups around prevention strategies to convening cross-sector groups to develop a long-term vision of what health care should look like in Colorado in the future.

Overall, community conversation and focus group participant recommendations reflected The Trust's strong track record of convening and engaging community voices to support Colorado's most vulnerable. This track record was recently acknowledged by The Council on Foundations 2011 Wilmer Shields Rich Award for effective communications to build public will. Clearly, this strength of The Trust is widely acknowledged across the state and should be leveraged as The Trust shapes its role for the future.

Recommendations

Through the environmental scan, The Trust explored the definition of health equity in Colorado; identified the challenges to addressing health inequities; solicited sustainable solutions for improving health equity; and garnered suggestions for The Trust's role in facilitating the suggested solutions. Based on an analysis of the scan results, juxtaposed against the current health care environment the recommendations outlined in Table 4 below are proposed for The Trust to consider.

The recommendations focus on strategies to improve health equity in Colorado in relation to health care services, data and information, and advocacy and policy. Each recommendation encompasses a specific strategy supported by rationale from one or more of the three scan methodologies in the environmental scan. Although the recommendations are grounded in the suggestions offered through each methodology, they are enhanced to reflect a synthesis of all the information collected. The strategies are not listed in order of priority; rather they provide a comprehensive set of recommendations that are widely applicable in communities across Colorado.

Table 4. Recommendations to Improve Health Equity in Colorado, The Colorado Trust Environmental Scan, 2012.

Services	
Strategies	**Rationale**
1. Support health professions schools and health care providers to integrate cultural competency into their training and practices.	In order for cultural competence to be a part of standard health care practice, this topic needs to be included in training [Community Conversations and Focus Groups].
2. Increase the representation of communities of color in the health care workforce.	Communities of color expressed a preference for providers who reflect their culture, thus increasingly the likelihood of culturally sensitive care [Telephone Survey].
3. Serve as a conduit for communities to access federal funds and initiatives focusing on health equity by communicating funding opportunities, supporting collaborative efforts, and providing technical support for proposal development.	Individual communities need partners and/or assistance to participate in national funding opportunities [Community Conversations].
4. Provide access to health care services where people are located, such as in school-based health centers, workplace clinics, and other locations.	Providing care where people are located helps break down barriers to accessing health care such as transportation or hours of operation [Community Conversations, Focus Groups and Telephone Survey].
5. Create an interactive repository for best practices and innovative solutions to improve health equity.	Sharing best practices helps communities engage in discussions about health equity and implement evidence-based solutions [Community Conversations and Focus Groups].
6. Support innovative practice models that improve health equity.	Innovative care delivery models and other leading edge approaches are not usually supported by existing funding streams [Community Conversations and Focus Groups].
7. Support system navigation initiatives.	Navigation services could assist in addressing the complexity of the health care system through a range of services from facilitating public program enrollment, through navigating medical services [Community Conversations and Focus Groups].
8. Support community-based workforce development initiatives for lay health workers.	Community-based workforce development helps build leadership capacity from diverse backgrounds and initiates a pipeline into other levels of providers in health care [Community Conversations and Focus Groups].

Data and Information	
Strategies	**Rationale**
9. Convene data work groups to address data collection and information exchange needs around health equity.	There is a need to perform comprehensive data collection and improve the capacity for information exchange [Focus Groups].
10. Facilitate the availability of local-level data from public sources.	Local-level data would assist communities in addressing local challenges [Focus Groups].
11. Develop algorithms to identify relationships between health equity and social determinants of health.	Connections with social determinants of health could result in focusing on the root causes of inequities [Focus Groups].
12. Serve as a repository for health equity data and information.	A centralized resource for health equity data and information supports sharing knowledge and practices that could improve health equity [Community Conversations and Focus Groups].

Advocacy and Policy	
Strategies	**Rationale**
13. Host community conversations with those experiencing inequities.	Sustainable solutions will be most effective when the target populations are involved in developing them [Community Conversations and Focus Groups].
14. Assist communities in convening around health inequity to identify challenges and develop solutions specific to their local needs.	Health organizations lack the resources and capacity to address health inequities in their communities [Community Conversations and Focus Groups].
15. Develop an awareness campaign around health equity with co-brandable marketing materials that communities could use locally.	Awareness of health equity was low among respondents to the telephone survey and communities expressed a lack of capacity to use existing data to tell their stories about their own health disparities to policy makers as well as to each other [Community conversations and telephone survey].
16. Support system and payment reform by providing policy briefings and research to policy makers.	The Trust has the capacity and credibility to advocate for payment and policy reform [Community Conversations and Focus Groups].

Appendix A

Detailed Description of Environmental Scan Methodology

Detailed Description of Environmental Scan Methodology

The lens of health equity guided the research methodologies that JSI utilized in the environmental scan. In order to ensure that the environmental scan would provide The Colorado Trust (The Trust) with robust information to inform its priorities and future grantmaking, JSI and The Trust staff developed a set of research objectives for the scan to address. The research objectives focused on health equity and explored the three areas of interest to The Trust: services, data and information, and advocacy and policy.

JSI and The Trust used three complementary methodologies to address the research objectives; each targeted different audiences. The methodologies included: focus groups and key informant interviews with leaders of health care and health care related organizations across all sectors; forums and informal conversations with community-based organizations, health care leaders, and community leaders across Colorado; and a statewide telephone survey of consumers. Table 1 outlines the environmental scan's research objectives and identifies which methodology addressed each of the objectives. Following the table, a detailed description of each methodology is provided.

Table 1. Research Objectives Addressed in each Methodology, The Colorado Trust Environmental Scan, July/August 2012.

Research Objectives	Focus Groups	Forums and Informal Meetings	Statewide Consumer Survey
Overall Purpose: Inform The Colorado Trust's vision, priorities, and future grantmaking.			
1. **Services**: Determine a) the key issues and gaps in health care service delivery and solutions for addressing them, and b) the necessary organizational capacity to sustain health care service delivery for racial/ethnic, low-income, or otherwise disadvantaged populations.	X	X	X
1.1. Determine the key issues and gaps in delivering health care services to achieve optimal health for racial/ethnic, low-income, or otherwise disadvantaged populations.	X	X	X
1.2. Determine the challenges experienced in implementing services that achieve health equity.	X	X	X
1.3. Outline sustainable solutions for addressing the challenges.	X	X	X
1.4. Determine the types of grant investments necessary to create a sustainable model of health care service delivery.	X	X	X
1.5. Determine the organizational capacity needed to implement the proposed solutions.	X	X	X

Table 1. (Continued) Research Objectives Addressed in each Methodology, The Colorado Trust Environmental Scan, July/August 2012.

Research Objectives	Focus Groups	Forums and Informal Meetings	Statewide Consumer Survey
1.6. Identify service-related initiatives that The Colorado Trust could implement to promote innovative and sustainable solutions to eliminate health disparities and achieve health equity.	X	X	X
2. **Data and Information**: Determine what data and information would be useful to assist communities with identifying and addressing health care inequalities and achieving health equity.	X	X	
2.1. Determine how and if data and information is being used to advance health equity.	X		X
2.2. Determine what data and information would be useful to have to be able to address health disparities and achieve health equity.	X		
2.3. Identify initiatives that The Colorado Trust could implement to facilitate the availability and use of data and information for the purpose of promoting health equity.	X	X	
3. **Advocacy and Policy**: Determine how advocacy could be used to further policies that address health care inequalities and promote health equity.	X	X	
3.1. Determine how advocacy is being used to promote health equity.	X		
3.2. Determine the successes and challenges in advocating for health equity.	X		X
3.3. Better understand the effectiveness of health care advocacy efforts for health equity.	X		X
3.4. Outline what is needed to build capacity to advocate for health equity.	X		
3.5. Identify initiatives that The Colorado Trust could implement that would facilitate building capacity to advocate for health equity.	X	X	X

Table 1. (Continued) Research Objectives Addressed in each Methodology, The Colorado Trust Environmental Scan, July/August 2012.

Research Objectives	Focus Groups	Forums and Informal Meetings	Statewide Consumer Survey
3.6. Determine how to foster or improve health care advocacy efforts outside of Metro Denver in support of health equity.	X	X	X
3.7. Better understand how to improve the coordination of health care advocacy efforts for health equity.	X	X	

Focus Group Methodology

The intent of the focus groups was to gather input from health and health care-related organizations with a statewide focus. With the exception of the focus group including racial/ethnic-serving organizations, each focus group was organized by a key statewide organization (Appendix A). JSI solicited information from these organizations to determine how The Trust could direct its resources to improve health equity in the areas of services, data and information, and advocacy and policy. The focus groups identified:

- Challenges faced by individuals, communities and stakeholders in accessing services, measuring health equity issues, and advocating for equitable health policy;
- Lessons learned from past successes and potential future solutions to the health equity issues, with particular attention on organizational capacity and sustainability;
- Perspectives on the most pressing health equity issues in Colorado; and
- Potential roles for The Trust in future health equity initiatives.

The Trust identified an initial list of 10 different sectors to include in the focus group invitation process. The invitation list included representation from organizations throughout Colorado, and the focus groups were held in the Denver metro area since it was most accessible for the participants. The Trust invited key contacts within the following sectors:

- Businesses and Chambers of Commerce
- Hospitals and hospital associations
- Local and county health departments
- Local government
- Nurses and nursing associations
- Payers and brokers
- Physicians and medical associations
- Policy and advocacy coalitions
- Public health entities
- School-Based Health Centers

JSI followed up directly with the primary contact at each organization via email and phone to address any questions about the focus group objectives and to further explain the process. The invitee then identified and recruited as many colleagues and/or partners as possible in order to recruit 6 to 12 participants for each group. Most of the groups met this goal with the exception of one group that only had 5 participants and two groups with 2 participants each that were rescheduled to one-on-one phone interviews instead. JSI managed the RSVP process and coordinated all the meeting logistics. JSI led nine focus groups and four key informant interviews that included a combined total of 79 individuals. Participants outside the Denver-Metro area were offered the option to participate in their respective sector's group discussion, by phone, though only one participant utilized this method.

To facilitate the focus group discussions, JSI worked closely with The Trust staff to develop a discussion guide (Appendix B). The purpose of the guide was to ensure consistency in conversations and process and to ensure the discussions addressed the established research objectives.

Each focus group lasted between 90 and 120 minutes. The discussion format for the focus groups began by grounding participants in their own (or their organization's) experience regarding health inequities and then moved on to identifying specific challenges surrounding health equity and potential solutions, including the potential role of The Trust in facilitating the solutions.

Since the overall framework for the discussion was health equity, the facilitators provided participants with information regarding health inequities in Colorado at the beginning of the conversation. All participants received the Profile of Colorado Health Access Survey data describing insurance status by income and race/ethnicity as well as the consequences of being uninsured for Coloradans.

JSI utilized Atlas.ti© to support analysis of the focus group data and identified overall themes and patterns as well as congruencies with the forums and informal meeting results. The primary findings from the focus groups centered around themes that arose in three or more focus groups or interviews.

Forums and Informal Meetings Methodology

Input was sought from community based organizations and health care leaders throughout Colorado through forums and informal meetings, collectively referred to as the community conversation component of the scan. The community conversations solicited information on how The Trust's focus on health equity could be carried out in the areas of services, data and information, and advocacy and policy. Through the community conversations, participants gave their perspectives on:

- Health inequities in their communities;
- Challenges faced by communities and specific populations in those communities related to health care services, including gaps in services for disadvantaged populations;
- Potential solutions for addressing the identified challenges, with particular attention to needed organizational/community capacity and sustainability; and
- Sustainable solutions for addressing the challenges as well as the role that The Trust could play in facilitating the solutions.

The community conversations did not pursue the role of data and information and advocacy and policy as discrete topics. However, the conversations included a discussion of the role of data and information, and advocacy and policy in the context of current challenges, potential solutions, and the role of The Trust in supporting solutions.

The Trust determined invitees, disseminated invitations, and tracked event RSVPs. The target audience for the events included representatives of the groups listed below, although actual participation varied across events:

- Community coalitions working on health care or health access issues
- Consumer advocacy coalitions
- Elected officials
- Federally Qualified Health Centers (Community Health Centers)
- Health care related service organizations (such as oral health or mental health service providers)
- Hospitals
- Local and county health departments
- Non-health care related service organizations (such as childcare referral organizations, senior services, etc.)
- Organizations formerly or currently funded by The Trust
- Primary care practices
- Safety-net health care providers not federally funded
- Secondary education institutions

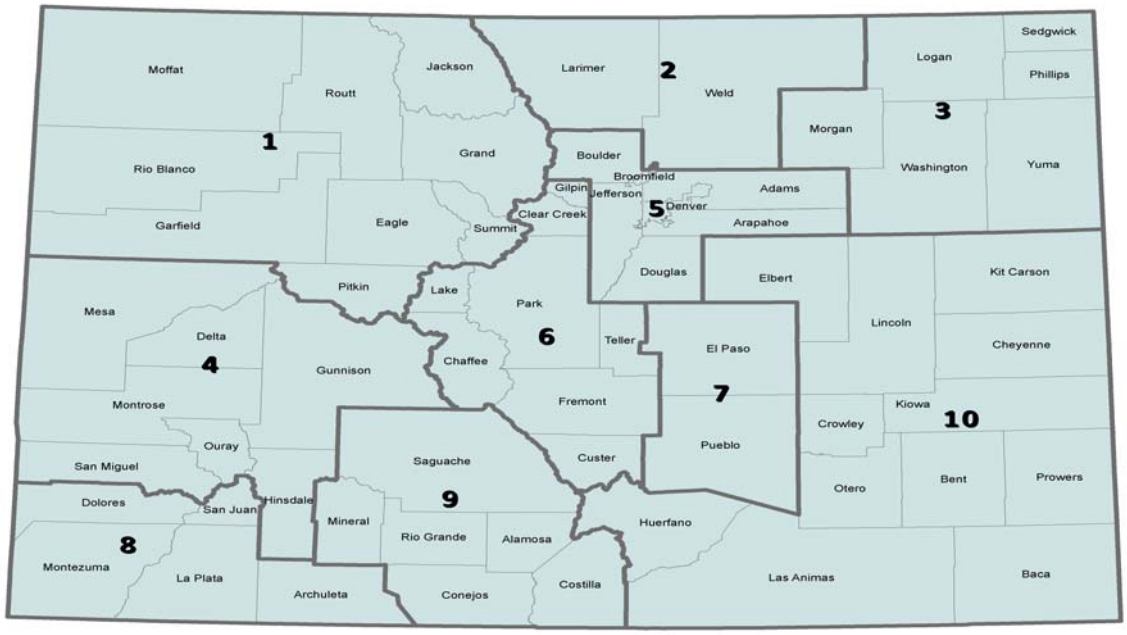
JSI worked closely with The Trust staff to develop a discussion guide for both the forums and informal meetings to ensure consistency in process and content across conversations and to ensure the conversations addressed the research objectives.

The forums were highly structured and were facilitated by JSI staff. The discussion format for the forums began by grounding participants in their community's experience regarding health inequities, then moved on to identification of specific community challenges, and finally to potential solutions, including the potential role of The Trust. Community forums included a combination of facilitation techniques such as individual brainstorming, small and large group discussion, and polling questions designed to encourage participant engagement. The forum discussion guide was piloted at the first forum in Denver and modified for the remaining forums based on feedback provided by forum participants, JSI staff, and The Trust staff.

The informal meetings, while not as structured as the forums, followed a discussion guide with the same topics and flow as the forums. The Trust staff led and documented the informal discussions. All of The Trust staff responsible for leading or recording informal meetings were trained on the discussion guide, facilitation techniques, and documentation expectations by JSI. The discussion guides for the community forums and informal conversations are included in Appendix C and D.

Community conversations were held in each of the ten regions The Trust uses in its grantmaking to ensure statewide coverage. Please see the map below for an outline of The Trust's regions.

Map of The Colorado Trust Designated Regions



JSI facilitated and documented 15 forums across the ten regions with a total of 286 participants and The Trust staff led and documented 14 informal meetings across the ten regions with a total of 92 participants. At least two community conversations were held in each region. Participation in forums ranged from 6 to 40 individuals and from 3 to 11 individuals in the informal meetings. Appendix E outlines the type of event and community participation for each region.

Because the overall framework for the discussion was health equity, facilitators distributed information to participants about health inequities in their communities prior to and at the beginning of the conversations. All participants received a regional profile of the Colorado Health Access Survey data describing insurance status based on income, race/ethnicity, and the consequences of being uninsured for persons in their region. In addition, the Colorado Trust CEO, Ned Calonge, began the community forums with a presentation of health inequities currently faced by Hispanics/Latinos and African Americans/Blacks. This information provided a launch point for the subsequent community conversation regarding health inequities.

Finalized notes documents were imported into Atlas.ti© and coded based on a standardized set of codes by three JSI staff. The data analyst reviewed coding for consistency. JSI analyzed notes from the forums and informal meetings to identify overall themes and geographic-based patterns. Each conversation was coded as to the type of community in which it happened (rural and urban based on the designation of the county where the conversations took place[1]), whether it was an informal conversation or forum, and the region in which it took place. Regions 2, 5, and 7 were identified as urban, as were Garfield and Mesa Counties in the analysis.

[1] Based on 2010 Census data, as identified on the Colorado Rural Health Center website accessed 9/23/12 at http://www.coruralhealth.org/resources/images/countytypemap2012.jpg

JSI identified the top themes in each of the following four areas of analysis: definition of health equity, challenges, solutions, and the role of The Trust. Common themes were identified across the community conversations and the findings represent themes that were identified in at least four or five of the ten regions. The top themes were analyzed to determine any substantial differences in importance across regions, conversation type, and rural/urban areas and any differences noted.

Statewide Telephone Survey Methodology

The purpose of the statewide telephone survey (Appendix F) was to gauge Coloradans' awareness of and experiences with health equity and to understand consumer perspectives on a set of possible solutions to address health inequities. The survey questionnaire focused on health care services, although the results helped to inform concepts related to both data and information and advocacy and policy. The survey solicited information from Colorado residents regarding their insurance coverage or lack thereof; their perceptions on the quality of care they receive; the availability of health care in their communities and their access to it; and their satisfaction with the care they receive.

JSI subcontracted with Anderson, Niebuhr & Associates, Inc. (ANA), a nationally recognized health care survey research firm with 35 years of experience and a distinguished reputation for rigorous methodologies in custom-designed research to help develop and implement the survey.

JSI worked closely with staff from ANA and The Trust to develop a set of questions to address the scan's research objectives. Drawing from past surveys administered by The Trust as well as survey questions from current research related to health equity, the JSI/ANA/The Trust team developed questions to ask the general Colorado population about aspects of health equity, challenges related to health care access for populations experiencing inequalities, and possible solutions to the challenges. Table 2 summarizes the methodology used to administer the survey and analyze the results.

Table 2. Snapshot of Survey Methods, The Colorado Trust Environmental Scan, July/August 2012.

Population	Colorado residents from across the state
Number of Telephone Interviews (N)	576 total interviews with Colorado residents
Accuracy of Results	±5% at 95% confidence level for statewide results
Interviewing Dates	August 2, 2012 – August 29, 2012

Between August 2 and August 29, 2012, the survey staff at ANA completed 576 telephone interviews with randomly selected adults 18 and older throughout the state of Colorado. This included an oversampling of 52 African Americans/Blacks and 82 Hispanics/Latinos in order to ensure that the results could be stratified by race/ethnicity. Respondents were offered a $20 Target gift card as an incentive to complete the survey.

The results from the survey were analyzed in two samples: one sample based on overall statewide responses and one comparing different race/ethnic groups. For the analyses reflecting overall statewide responses, the data was based on responses from a total of 450 interviewees. These data included responses randomly selected from the total sample and included 82 Hispanic/Latino respondents (18%), 18 African Americans/Blacks (4%), and 350 (78%) Caucasians. This sample reflects African Americans/Blacks and Hispanics/Latinos in proportions that are representative of the demographics of the state of Colorado.

For the comparison analyses by race/ethnicity, the sample included responses from everyone who identified themselves as African American/Black, Hispanic/Latino, or Caucasian. Respondents who selected *African American/Black* as their race were categorized as African Americans/Blacks regardless of any other race(s) they may have selected if they selected more than one. Respondents that selected *Hispanic/Latino* as their ethnicity and *Caucasian* or *African American/Black* as their race were categorized exclusively as *Hispanic/Latino* for the comparison analyses. This sample did not include responses from those who selected "Other Race/Ethnicity" or who responded to questions as "Don't Know."

The survey analysis included descriptive statistics and tests for statistical significance. This report identifies findings of statistical significance using comparison terms such as "most" or "least" likely.

Appendix A: List of Statewide Organizations for Focus Groups

The first 7 groups listed show the key contact organization that helped pull the invitation list together from their particular sector. The last two groups didn't have a point-of-contact from any particular organization and The Trust did the invitations for those.

1. Colorado Association for School-Based Health Care
2. Colorado Hospital Association
3. Colorado Medical Society
4. Colorado Nurses Association
5. Commission on Collegiate Nursing Education
6. Minority Health Advisory Commission
7. Colorado Association of Health Plans
8. Ethnic-Serving Organizations (various groups invited by The Trust)
9. Advocacy/Policy (various groups invited by The Trust)

Appendix B: Focus Group Discussion Guide

The Colorado Trust Environmental Scan

Key Informant Focus Group Research Questions

Timeframe: 90-120 minutes
Audience: Sector-based Focus Group

Welcome and Introduction – 10 minutes

- Lead facilitator to introduce self, and other JSI and/or Trust staff (name only). Note that JSI is a health consulting company located in Denver, and is pleased to be part of process.
- Thank you for taking time to talk and share your perspective and experience. The Colorado Trust prioritized 10 Focus Groups by invitation only. We appreciate your involvement in this effort.
- This conversation is part of an environmental scan for The Colorado Trust, and will help to inform The Trust's future grant making.
- Additional components of the scan include Community Forums with Colorado Trust grantees (current and former) and other health care and community stakeholders, a phone survey that will be conducted with a random sample of all Coloradans, and review of available data.
- The research methodologies will gather input from Colorado stakeholders ranging from consumers to health care service providers, and policy leaders to community-based organizations. Discussions will focus on health care **services**, **data/information** and **policy/advocacy** strategies that The Colorado Trust could support to facilitate achieving optimal health for racial and ethnic minorities and low-income populations.
- Over the past few years, The Colorado Trust has focused grant support on efforts to achieve access to health for all Coloradans. The Trust would like to help end inequalities affecting racial/ethnic, low-income and other disadvantaged populations, so all Coloradans can achieve optimal health.
- Note how/when (roughly) findings will be released back to focus group participants. – a public report should be ready to distribute towards the end of the year.
- Note that discussion will be taped in order to assist with data analysis. Nothing said in this discussion will be attributed to an individual. We may, however, include quotes and attribute them to "a participant from X sector / community."
- Review norms for participation (phones off, one person speaking at a time, we will end on time, feel free to use bathroom, etc.)
- Point out that food/drink have been provided and participants are welcome to replenish at any time during the discussion.
- Note location of bathrooms, any other facility-specific reminders.
- Transition to group discussion.

Warm up question #1: When you hear people use the words "health equity" what is the first thing that comes to mind?

Discussion – 90 minutes – 3 Research Objectives for the Environmental Scan (Objectives #2 and #3 are addressed in the focus groups more than Objective #1)

Research Objective: Determine a) the key issues, gaps, existing resources and solutions in delivering health care services and b) the necessary organizational capacity to sustain health care service delivery for racial/ethnic, low-income, or otherwise disadvantaged populations that are preventing them from achieving optimal health.

Research Objective: Determine what data/information would be useful to assist with identifying and addressing health care inequalities and achieving health equity.

*Research Objective: Determine how advocacy could be used to further policies that address health care inequalities and promote health equity.*The focus is on advocacy by nonprofits for health care issues.*

Discussion Questions:

1. Based on your experience, what do you see as the most significant health equity issues in Colorado?

    Prompts: access to care, health outcomes, health care costs and quality of care received
2. What efforts/initiatives do you know of that have been successful in helping to bridge some of the health equity gaps for disadvantaged populations?
3. What do you think are the key challenges to increasing health equity?
4. Are you or your organization directly involved in any activities that help reduce inequalities in health care?
5. Do you have any examples of how you advocate (or have advocated in the past) for health care equity?
    a. How have these efforts been successful?
    b. If they have not been successful, why?
6. What do you see as the biggest challenges in advocating for health equity?
7. What sources of data/information are available to you regarding health equity? (note to facilitator: wait for some responses on data sources before prompting with any specific data sources)
    a. And thinking about the data that is available, is it easy to access? Is it helpful? Is it reliable?
8. How is health equity information shared or communicated at a local/regional/state level?
9. What are the biggest challenges in collecting or using health equity data?
10. What other information could be captured or made available that would be useful to better address health equity?

11. What strategies or solutions could help address the challenges that we've already discussed regarding health equity information or advocacy.
    a. Advocacy prompts: Convening experts to identify solutions; leveraging participation of other agencies, spurring innovation by supporting risk taking, pilots or experimentation; using a systemic approach to address an issue from various perspectives; as a neutral communicator; by providing TA; facilitating communication across communities; filling in gaps in funding opportunities; identify and support evidence-based practice, etc.
    b. Data prompts: improved communication, more coordinated efforts
12. What might organizations need in order to help implement these strategies/solutions?
    a. Prompts: Leadership, workforce, infrastructure, training, cultural competency, partnerships, outreach, service delivery transformation, integration
    b. Is this different between metro Denver and communities beyond front range?
13. How could The Colorado Trust help increase the capacity for health equity advocacy or the availability of valuable data?
    a. Advocacy prompts: Convening experts to identify solutions; leveraging participation of other agencies, spurring innovation by supporting risk taking, pilots or experimentation; using a systemic approach to address an issue from various perspectives; as a neutral communicator; by providing TA; facilitating communication across communities; filling in gaps in funding opportunities; identify and support evidence-based practice, etc.
    b. Data prompts: improved communication, more coordinated efforts

Appendix C: Community Forum Discussion Guide

Colorado Trust Environmental Scan

Community Forum Research Questions and Facilitation Guide

Research Questions

- What populations within Colorado communities experience health inequalities?
- What challenges do populations experiencing health inequalities in Colorado communities face in accessing health care?
- What strategies and capacity are needed to develop and/or sustain services that foster equity in health care (including those data and policy/advocacy related)?
- What types of initiatives and funding opportunities can The Colorado Trust (TCT) employ to facilitate the needed strategies and capacity?

Timeframe: 120 minutes
Audience: The Colorado Trust grantees (current and former), leaders of other health care organizations and elected officials invited by The Trust. Estimated 15-50 attendees.

Facilitation Guide

TCT Introduction and Presentation of Data (Dr. Ned Calonge) – 10 minutes

(To be provided by TCT Communications staff, covering following points)

- Thank you for taking time to talk and share your perspective and experience.
- Note pleasure at being in XXX community, and thank those who made forum happen locally.
- This conversation is part of an environmental scan for TCT, and will inform TCT's future grant making programs and initiatives.
- Additional components of the scan include Focus Groups with representatives of various sectors, a Poll that will be conducted with a random sample of all Coloradans, and review of available data. Please participate and/or encourage community members to participate in the Poll if called – most likely in August.
- Information from all of these sources will be combined to help TCT identify its next set of priorities and initiatives. Note that TCT will carefully consider all the input from the Forums, Focus Groups and Polling. However, decisions about where to focus TCT's efforts will also consider TCT's own focus and the activities of other foundations in Colorado, so identification of an issue at a Forum doesn't guarantee it will be part of TCT's future efforts.
- Describe why TCT is focusing on health equity (using invitation language).
- Throughout its history TCT has engaged people throughout Colorado to help define and focus its work. These conversations are so important that our staff is participating in 15 forums

throughout the state, and I am attending all of them. We appreciate your involvement in this effort.

- Present data points reflecting heath inequalities.
- Note how/when (roughly) findings will be released back to communities.
- Introduce other TCT staff.
- Turn facilitation to JSI staff.

Introduction and Housekeeping (JSI staff) – 5 minutes

- Lead facilitator to introduce self and other JSI staff (name only). Note that JSI is a health consulting company located in Denver, and is pleased to be part of process.
- We look forward to spending a couple of hours together. Findings from interviews will be summarized and reported to The Colorado Trust. As Dr. Calonge mentioned, the findings will be used, in combination with a number of other sources, to help inform future TCT grant making.
- Note that discussion will be taped in order to assist with data analysis. Nothing said in this forum will be attributed to an individual. We may, however, include quotes and attribute them to "a participant from X community or X type of organization".
- Note location of bathrooms, any other facility-specific reminders.
- Briefly outline agenda for forum (this intro, presentation of data, discussion, wrap up) and of facilitation techniques (audience response system, small groups, etc.).
- Ask participants to introduce themselves when they speak, and to note the organization/perspective they are representing.
- Review norms for participation (phones off, listen to understand {not to respond}, feel free to help yourselves to food and use bathroom, just a few at a time so conversation can be sustained), Ask for additions/clarifications to norms, and then for agreement to them.
- Transition to health equity discussion.

Discussion – JSI Staff (100 minutes)

Health Equity – 10 minutes

Show slide with TCT definition of health equity

- Begin with question - use Audience Response System. Who experiences the greatest inequalities in your region?

Group Discussion – (conversation: responses captured in notes)

- Based on the data provided, and your impressions or organization's experience,
    - What are the health care inequalities in your community?
        - Probes: access to care, health outcomes, and quality of care received
    - What gaps in services do racially/ethnically diverse and low-income populations experience?
        - Probe: cost (individual and systemic)

Challenges - 30 minutes

Instructions & Breaking into small groups -5 minutes

- At tables: participants will discuss the question below, record answers on one flipchart page.
- Appoint a scribe and a spokesperson. Be sure all get a chance to contribute.
- 10 minutes to discuss question as a group.
- Prioritize top 3 responses.
- JSI staff will be circulating to make sure you're on track, answer questions.

Small group discussion – 10 minutes

  - What challenges make it difficult for the racially/ethnically diverse and low-income populations in your community to access health care services?

Summary of discussion on question- 15 minutes

- Spokesperson will read top 3 responses for question. After first group, spokes people will only highlight anything that is different from what was already shared.
- Ask for any clarifications. If a critical item didn't get reflected, add.
- Post challenges on wall.
- Transition to discussion of solutions.

Discussion of Solutions – 45 minutes

Instructions - 5 minutes

- Participants will work as a table (or in smaller groups if participant numbers allow).

Activity-40 minutes

- 20 minutes to discuss question and list as a group.
  - 3-5 minutes to list individually
  - 10 minutes to share as a group
  - 5 minutes to identify top 5-7 responses on large sticky notes that are on table. Be sure all get a chance to contribute.
- JSI staff will be circulating to make sure you're on track, answer questions.
- Groups will answer question:
  - What strategies or solutions could address the challenges that were identified?
    - Probes: Data/Information availability & use, policy, advocacy (incudes public awareness, education), direct services.
- 20 minutes for JSI to collect sticky notes and, with participants, group them (give provisional names to groups)
- Use ARS to prioritize solutions.

Discussion of Capacity and Support – 15 minutes

Follow- on questions – brainstorm as large group, record on flip chart

- How could The Colorado Trust support the development of effective strategies?
    - What types of activities should be funded (remembering that input from this Forum is just one part of the information TCT will use in deciding on funding areas and that TCT will be looking for common themes)?
    - What additional capacity is needed in the community to implement these strategies/solutions?
        - Probes: Leadership, workforce, infrastructure, training, cultural competency, partnerships, outreach, service delivery transformation, integration
    - What roles (beyond funding) could TCT have?
        - Probes: Convening to identify unified visions or solutions; leveraging expert advice, leveraging participation of other agencies, spurring innovation by supporting risk taking, pilots or experimentation; using a systemic approach to address an issue from various perspectives; as a neutral communicator; by providing T/TA; facilitating communication across communities; filling in gaps in funding opportunities; identify and support evidence-based practice. etc.)

Wrap-Up Talking Points (5 minutes)

- Thank participant for their time and input.
- Dr. Calonge to briefly:
    - Restate how information will be used, and when scan findings will be disseminated back to communities. Reiterate role of Forums in overall scan activities.
    - Thank participants for their input.

Appendix D: Informal Meeting Discussion Guide

The Colorado Trust Environmental Scan

Informal Meeting Discussion Guide

Research Questions

- What populations within Colorado communities experience health inequalities?
- What challenges do populations experiencing health inequalities in Colorado communities face in accessing health care?
- What strategies and capacity are needed to develop and/or sustain services that foster equity in health care (including those data and policy/advocacy related)?
- What types of initiatives and funding opportunities can The Colorado Trust (TCT) employ to facilitate the needed strategies and capacity?

Timeframe: 60 minutes (50 minutes of which can be discussion, given meetings likely over a meal)
Audience: TCT grantees (current and former), leaders of other health care organizations and elected officials invited by TCT. Estimated 2-3 TCT attendees and 1-5 community attendees.

Informal Discussion Guide

Introduction by TCT Staff – 5 minutes

- Thank you for taking time to talk and share your perspective and experience.
- Introduce all TCT staff present, and roles: ask participants to briefly introduce themselves.
- This conversation is part of an environmental scan for TCT, and will inform TCT's future grant making programs and initiatives.
- Additional components of the scan include Focus Groups with representatives of various sectors, a Poll that will be conducted with a random sample of all Coloradans, and review of available data. Please participate and/or encourage community members to participate in the Poll if called – in August.
- Information from all of these sources will be combined to help TCT identify its next set of priorities and initiatives. Note that TCT will carefully consider all the input from these discussions, Forums, Focus Groups and Polling. However, decisions about where to focus TCT's efforts will also consider TCT's own priorities and the activities of other foundations in Colorado, so identification of an issue during a discussion doesn't guarantee it will be part of TCT's future efforts.
- Describe why TCT is focusing on health equity (using invitation language).
- Ask permission to take notes and/or record the conversation.
- Note that the final report won't identify who said what. If we do use quotes, they will be attributed to a "community participant".

Discussion on Health Equity – 10 minutes

Health equity (based on TCT's definition) is ending inequalities affecting racial/ethnic, low-income and other disadvantaged populations, so all Coloradans can achieve optimal health.

We'd like to talk a little about health equity in your community. Based on your own and your organization's experience, and the data we've provided:

- What are the health care inequalities in your community: who experiences them, and what do they "look like"?
    - Probes: access to care, health outcomes, and quality of care received
    - Probes: what groups (racial, ethnic, income or others) in your community experience health care inequality?
- What gaps in services do racially/ethnically diverse and low-income populations experience?
    - Probe: cost (individual and systemic)

Transition: Before moving on ask those who have been quiet if they have anything to add.

Discussion on Challenges – 10 minutes

Now that we understand what some of the inequalities may look like in your community, we'd like to talk about the health care challenges those populations experience in your community.

- What challenges make it difficult for the racially/ethnically diverse and low income populations in your community to access health care services?

Transition: Before moving on ask those who have been quiet if they have anything to add.

Discussion of Solutions - 20 minutes

Given what you've shared about health inequalities and challenges, we'd like to spend some time talking about what can be done to address them.

- What strategies/ solutions could address the challenges that have been identified?
    - Probes: Data/Information availability & use, policy, advocacy (incudes public awareness, education), direct services.
- How could TCT support the development of effective strategies?
    - What types of activities should be considered (remembering that input from this discussion is just one part of the information TCT will use in deciding on funding areas and that TCT will be looking for common themes)?
    - What additional capacity is needed in the community to implement these strategies/solutions?
        - Probe: Leadership, workforce, infrastructure, training, cultural competency, partnerships, outreach, service delivery transformation, integration
    - What roles (beyond funding) could The Trust have in these solutions?

- Probe: Convening to identify unified visions or solutions; leveraging expert advice, leveraging participation of other agencies, spurring innovation by supporting risk taking, pilots or experimentation; using a systemic approach to address an issue from various perspectives; as a neutral communicator; by providing T/TA; facilitating communication across communities; filling in gaps in funding opportunities; identify and support evidence-based practice, etc.)

Wrap-Up Talking Points (5 minutes)

- Ask participants if there are any last thoughts they want to share before you wrap up.
- Restate how information will be used. Note that scan findings will be disseminated near the end of the year. Reiterate role of informal discussions in overall scan activities.
- Encourage participants to go to The Colorado Trust website to sign up to get funding announcements.
- Leave a business card, and provide participants with the email address where they can submit additional thoughts. Let them know that their comments should be submitted **within one week** to be included in the analysis.
- Thank participants for their input and participation**.**

Appendix E: Type of Event and Community Participation

Formal Community Forums

Region	Location	Date	Number of Participants
1	Glenwood Springs	08/07/2012	11
1	Steamboat Springs	08/08/2012	10
2	Greeley	08/09/2012	6
2	Fort Collins	08/30/2012	16
3	Sterling	08/16/2012	14
4	Grand Junction	08/21/2012	26
5	Denver	07/31/2012	39
5	Aurora	08/14/2012	35
5	Arvada	08/22/2012	15
6	Salida	08/28/2012	19
7	Colorado Springs	08/23/2012	21
7	Pueblo	08/29/2012	40
8	Durango	08/15/2012	12
9	Alamosa	09/05/2012	7
10	La Junta	09/06/2012	15

Informal Community Meetings

Region	Location	Date	Number of Participants
1	Frisco	08/06/2012	7
1	Eagle/Vail	08/06/2012	3
1	Aspen	08/07/2012	5
1	Craig	08/08/2012	6
3	Yuma	08/15/2012	10
3	Fort Morgan	08/15/2012	3
4	Telluride	08/21/2012	10
4	Montrose	08/22/2012	11
4	Gunnison	08/22/2012	10
6	Leadville	08/28/2012	7
6	Canon City	08/29/2012	4
8	Cortez	08/14/2012	6
9	Trinidad	09/06/2012	5
10	Lamar	09/07/2012	5

Appendix F: Statewide Telephone Survey

The Colorado Trust Environmental Scan

INTRO1. Hello. My name is _____ and I'm calling from Anderson, Niebuhr & Associates on behalf of The Colorado Trust, a statewide health care foundation. We are working on a study about Coloradans' perceptions of health care. The survey will take about 20 minutes, and I assure you your opinions are completely confidential and this is not a sales call.

INTRO2. As a thank you for your contribution to this important research, you will be given a $20 gift card to Target.

INTRO3. If you have questions about the study, I can give you phone numbers now or at the end of the survey that you can call to find out more about the study. **(NOTE PHONE NUMBER FOR THE COLORADO TRUST IS**: **888-847-9140)**.

INTRO4. Are you ready to begin?

a. _____ Yes (**CONTINUE)**
b. _____ No (**Can we call you back at a more convenient time?**)

[If Yes, record date and time you can call back and say you will call back at the scheduled time]

[If No, refusal] **Thank you very much for your time.**

SCREENER:

What is your age? Are you: **(READ a. - h. OR UNTIL A RESPONSE IS OFFERED)**

a. _____ < 18 years **(Terminate)**
b. _____ 18 and 24
c. _____ 25 and 34
d. _____ 35 and 44
e. _____ 45 and 54
f. _____ 55 and 64
g. _____ 65 and 74, or
h. _____ 75 and older?
i. _____ Refused

OBJECTIVE: Awareness of Health Inequalities

1. Overall, how would you rate the health care services available in your area? **(READ a. - e.)**
   a. _____ Excellent
   b. _____ Very good
   c. _____ Good
   d. _____ Fair
   e. _____ Poor
   f. _____ Don't know

2. Do you have a health plan, that is, are you covered by a private health insurance plan or by a government program such as Medicare, Medicaid or Tricare? **(READ a. – e.; IF GIVE MULTIPLE RESPONSES, ASK FOR PRIMARY PLAN)**

   a. _____ YES, Private
   b. _____ YES, MediCARE **(SKIP TO Q4)**
   c. _____ YES, MediCAID **(SKIP TO Q4)**
   d. _____ YES, Tricare **(SKIP TO Q4)**
   e. _____ NO **(SKIP TO Q4)**
   f. _____ Don't Know **(DO NOT READ; SKIP TO Q4)**
   g. _____ Refused **(DO NOT READ; SKIP TO Q4**

3. And is that plan through an employer or a plan you pay for entirely on your own? **(READ a. – b.)**

   a. _____ Employer
   b. _____ Pay on Own
   c. _____ Don't know
   d. _____ Refused

4. In the last year, have you heard or read anything about differences in health care that people receive in Colorado, based solely on their race, ethnicity, income, or where they live?

   a. _____ Yes
   b. _____ No **(SKIP TO Q6)**
   c. _____ Don't know **(SKIP TO Q6)**

5. What have you heard? **(PROBE FOR CLARITY)**

6. Do you personally believe there are differences in health care that people receive in Colorado, based solely on their race, ethnicity, income, or where they live?

   a. _____ Yes
   b. _____ No
   c. _____ Don't know

OBJECTIVE: Problem Identification

7. Thinking about yourself, please tell me if you think each of the following is a Major Problem, Minor Problem, or Not A Problem At All for you: **(READ a. – c.; ROTATE)**

		Major Problem	Minor Problem	Not a Problem At All	Don't know
a.	Being able to afford the cost of health insurance	MP	SP	NP	DK
b.	Being able to get the medical care that you need	MP	SP	NP	DK
c.	Having enough doctors and other health providers near where you live	MP	SP	NP	DK

8. I now want to ask about various elements of health care services. Please tell me whether you are Very Satisfied, Satisfied, Dissatisfied or Very Dissatisfied with each. First is… (**READ a. – j.; ROTATE)**

		Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	Don't know
a.	How far you have to travel to see a doctor or other health care provider	VS	S	D	VD	DK
b.	The respect your doctors or other health care providers give you	VS	S	D	VD	DK
c.	How well you and your doctor or other health care providers are able to communicate with each other	VS	S	D	VD	DK
d.	The quality of care you get in the hospital	VS	S	D	VD	DK
e.	The amount of time you are able to spend with your doctor or other health care provider	VS	S	D	VD	DK
f.	The quality of care you get from your doctor or other health care provider	VS	S	D	VD	DK
g.	Your out-of-pocket cost of health care, such as fees, co-pays, and deductibles	VS	S	D	VD	DK
h.	The number and kinds of treatments your insurance will	VS	S	D	VD	DK

	cover **(ASK ONLY IF 'YES' TO Q2)**					
i.	Getting care when you need it	VS	S	D	VD	DK
j.	Being able to get care from a specialist when you need it	VS	S	D	VD	DK

EVERYBODY SHOULD BE ASKED ALL QUESTIONS; ROTATE ORDER OF AFRICAN AMERICAN, HISPANIC, LOW INCOME, AND RURAL POPULATIONS QUESTIONS

Questions About How African Americans Compare to Coloradans in General

9. Now, I would like to ask you some questions about how the health care experience of African Americans in Colorado today compares to the health care experience of Coloradans in general. For each question, generally speaking, please let me know if you think African Americans are Better Off, Not Different, or Worse Off than Coloradans in general. First is: **(READ a. - c; ROTATE)**

		Better Off	**Not Different**	**Worse Off**	**Don't know**
a.	Personal health	BO	ND	WO	DK
b.	Getting health care	BO	ND	WO	DK
c.	Getting health insurance	BO	ND	WO	DK

10. Still thinking about African Americans, generally-speaking, please let me know if you think each of the following is a Major Problem, a Minor Problem, or Not a Problem At All for African Americans. **(READ a. – d.; ROTATE)**

		Major Problem	**Minor Problem**	**Not a Problem At All**	**Don't know**
a.	Affording health insurance	MP	SP	NP	DK
b.	Having enough doctors and other health providers near where they live	MP	SP	NP	DK
c.	Having a tough time getting care because of race or ethnic background	MP	SP	NP	DK
d.	Having a tough time getting care because of language or culture barriers	MP	SP	NP	DK