Denver's Safety Net Clinics:
Responding to a Changing Healthcare Landscape

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Contents

Executive Summary

Denver's safety net clinics provide critical services to the city's most vulnerable populations. This report summarizes how safety net clinics and the organizations supporting them in Denver have responded to the expansion of coverage under the Patient Protection and Affordable Care Act (ACA). It also identifies the current state of integrated care among Denver's safety net clinics and challenges that clinics are currently facing when trying to secure specialty care for their patients, to inform the future work of the Integrated Care and Specialty Care Access Working Groups of the Mile High Health Alliance.

Who are the Safety Net Clinics?

Safety net clinics in Denver range from small clinics with a few exam rooms to large health care systems with multiple clinic sites across the city. The populations they serve vary greatly with respect to culture, religion, and socioeconomic status. They include homeless people, recent immigrants and refugees, those living in poverty, people who speak rare languages and dialects, undocumented persons, people without health insurance, and people of every age group. The safety net clinics provide a range of services including physical health care, mental health care, substance abuse treatment, dental care, educational classes, and social services.

This report summarizes data collected by an email survey and through key informant interviews with leaders in eleven safety net clinics and organizations in Denver. A list of the clinics included in the research is provided in Appendix A.

Safety Net Capacity and Changes after the Implementation of the Affordable Care Act

- Denver's safety net clinics are seeing more Medicaid patients and fewer uninsured since the expansion of coverage that started of 2014.
- Most clinics have seen an increase in demand for their services over the last two years, and when possible have increased staff and facilities to respond to this increased demand.
- Despite the increases in coverage, clinics are still seeing large numbers of uninsured patients. Most of the remaining uninsured are ineligible for Medicaid or exchange subsidies due to their documentation status, and are unable to afford insurance.
- The average wait time for an appointment for a new patient is 20 days, and all clinics reported having a waitlist. This situation has improved from three years ago, when the average wait time was four weeks.[1] Two clinics reported having often to turn patients away. However, all clinics offered same-day appointments for urgent matters.

Integrated Care

- 85% of the clinics in the study offer their patients at least co-located behavioral health care on site, while five clinics have completely integrated behavioral health into their practices.
- All clinics reported having used grant money to initially fund their integrated care programs. Most are continuing to use grant money to support these programs, while some have absorbed the costs

of the programs into their regular operating budgets. None of the programs is fully financially sustainable under the current payment models.

- Only one clinic is able to offer substance abuse treatment services at this time, but many clinics would like to expand into this area.

Access to Specialty Care

- For the adult population, the specialties identified as most in demand but hardest to secure were Neurology and Orthopedics.
- For the pediatric population, the specialty identified as most in demand but hardest to secure was Developmental Pediatrics.
- Clinics noted that many specialists will see Medicaid patients in principle, but in practice will take only one patient per month, which leads to very long wait times.

Conclusions

Overall, safety net clinics in Denver are financially stable and are growing to meet the increased demand for care that has accompanied the expansion of coverage starting in 2014. Despite the increase in coverage, a substantial number of uninsured patients continue to use these safety net clinics and are ineligible for coverage, due mainly to their documentation status. Substantial challenges remain in clinics' ability to provide or secure complete care for their patients, particularly in the areas of fully integrated care on site and access to specialty care on or off-site. Current payment models do not support the sustainability of the existing integrated care programs.

Introduction

Denver's Community Health Improvement Plan (CHIP) lays out a set of health goals and objectives in two areas – access to care and reducing childhood obesity – which the city aims to achieve by the end of 2018. One of the objectives in the access to care area of the CHIP is to "assess and build the capacity of safety net providers in Denver to deliver primary, specialty, and behavioral health care to persons newly covered starting in 2014, and to those who remain uninsured".[2] This research report contributes to the achievement of this objective, by assessing the capacity of Denver's safety net providers and providing recommendations for increasing their capacity to deliver care.

Where do Safety Net Clinics fit within the Public Health System in Denver?

The public health system in Denver, like in many other metropolitan areas, is complex and involves public, private, and non-profit entities all working together through various relationships and connections (see Figure 1). Each entity has its particular strengths and weaknesses, and the actions of all intersect in numerous ways to promote health and provide health care to the whole population. This system is not seamless, and safety net organizations play an important role in assisting people who fall through the gaps in the system.

Figure 1: Public Health System in Denver

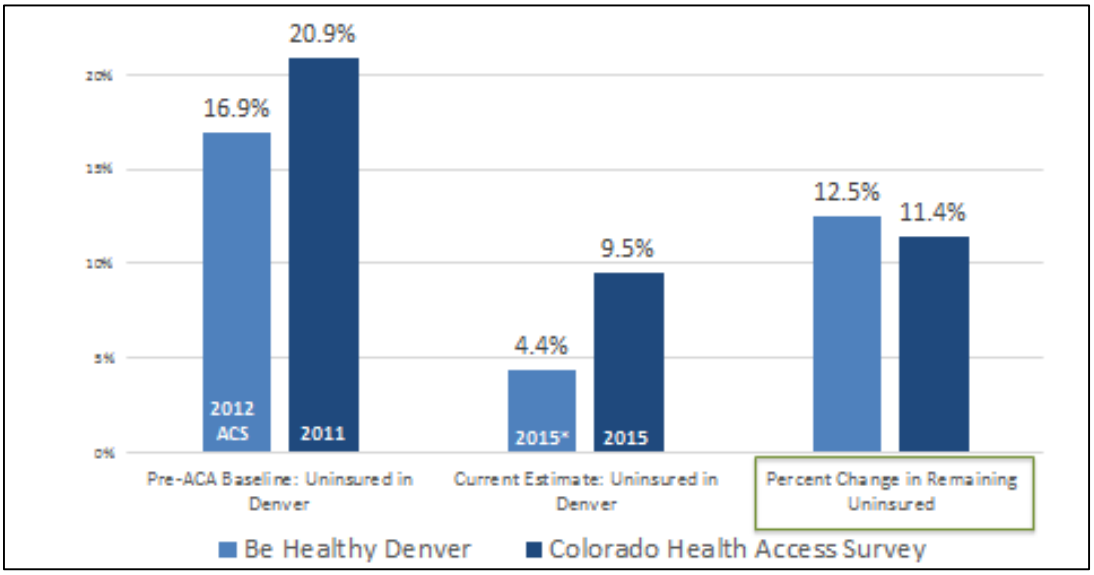
The Colorado Health Institute described safety net clinics as organizations and clinics that "typically offer medical, dental and mental health care to low-income, uninsured and/or underinsured residents as well as people enrolled in publicly funded health insurance programs, regardless of their ability to pay."[3]

Background

The current research builds on the work of the Denver Access to Care Task Force, as documented in its 2013 Progress Report.[4] The 2013 report, which was based on key informant interviews with the leaders of 17 safety net clinics in Denver, identified challenges faced by the clinics prior to the expansion of coverage under the ACA, as well as projected gaps in access to care with the expansion of coverage that was due to begin in 2014.

Prior to the expansion of coverage in 2014, between 17 and 20% of Denver residents lacked health insurance, whereas this figure has dropped to between 4.4 and 9.5% in 2015, according to estimates based on the American Community Survey and the Colorado Health Access Survey (see Figure 2). These two data sources use different methods and have different starting points for the pre-ACA rate of uninsured in Denver, with ACS showing a lower rate of uninsured than CHAS, but both show a similar magnitude of the drop in percent uninsured before and after the ACA, 12.5% and 11.4% respectively.

Figure 2: Change in Rate of Uninsured in Denver County using the American Community Survey (ACS) and the Colorado Health Access Survey (CHAS)



*The Be Healthy Denver estimates are based on enrollment information through 7/31/15 from the Department of Health Care Policy and Financing, Connect for Health Colorado, the Kaiser Family Foundation, and the Department of Health and Human Services.

The key informant interviews of 2013 revealed that 60% of Denver's safety net clinics had waiting lists for new patients, and that the average wait time for a new patient to be seen was four weeks. Clinics were preparing at that time for an increase in their patient populations with the expansion of coverage in 2014, with 82% of clinics planning to take on new Medicaid patients. The report found that most clinics were expecting better financial results in 2014 and beyond, with more revenues coming in from patients and the possibility of greater self-sufficiency for clinics.[5]

The current report updates this research in the post-ACA environment and adds two additional features: (1) an examination of the current state of integrated care programs and (2) a study of current challenges related to specialty care access at Denver's safety net clinics.

The examination of integrated care programs was conducted to support the work of the Integrated Care Working Group of the Mile High Health Alliance, which is working to support Denver's safety net clinics to adopt and expand the use of integrated care models in their practices. It is also in alignment with current efforts under Colorado's State Innovation Model (SIM) grant, which aims to improve the health of Coloradans by providing access to integrated care, with the goal of assisting 400 primary care practices in the state by 2019.[6] Many of Denver's safety net clinics had already put integrated care programs in place before the SIM grant was awarded in December 2014, having recognizing the need for these services in the populations they serve, but the SIM grant has highlighted the importance of integrated care and provided some new resources for facilitating its expansion.

The study of current challenges related to specialty care access will assist the Specialty Care Access Working Group of the Alliance to further develop its plans for launching a pilot specialty care referral network in Denver, to increase access to specialty care for Denver's underserved residents.

Methods

Denver's safety net clinics were identified using the Colorado Health Institute's 2015 Safety Net Database.[7] Some clinics were excluded because they were very specialized, for example focusing only on HIV patients or dental care. A list of clinics included in the research is included in Appendix A.

Interviews were conducted with 17 key informants from eleven safety net clinics and organizations in Denver, after having requested pre-interview data by an email survey. All but two interviews were performed on-site at the respective clinics. A set of semi-structured interview questions was used for the interviews, with questions tailored to that particular clinic or modified based on previous answers. The interview questions are provided in Appendix B.

Safety Net Capacity and Changes after ACA Implementation

Over the last two years, Denver's uninsured population has dropped by about half. Data gathered by email as well as through key informant interviews aimed to identify how the recent changes in the health insurance landscape have affected safety net clinics in Denver.

Consistent with the findings of the Colorado Health Access Survey, Denver's safety net clinics are now seeing more patients who are covered, mostly through Medicaid, and fewer patients who are uninsured. While in 2013, 39% of patients had either Medicaid or CHP+,[8] in the current study 47% of patients were covered by Medicaid. In 2013, 52% of patients were uninsured or on CICP, while in the current study, only 37% of patients were uninsured.

Most clinics have seen an increase in demand for services over the last three years, and when possible have been increasing their staff and facilities in order to respond. Several clinics are having trouble attracting providers, due to their inability to offer competitive salaries, which in turn hinders their ability to grow. Additional factors limiting growth include financial and physical limitations such as building space.

Clinics are still seeing large numbers of uninsured patients. One clinic was seeing 100% uninsured patients in 2013 but that number had dropped only to 89% in 2015. Most of the remaining uninsured are ineligible for Medicaid or exchange subsidies due to their documentation status, and they are also unable to afford purchasing insurance on their own.

The average wait time for an appointment for a new patient is now 20 days, with all organizations in the current study reporting that they have a wait list. This wait time has improved since 2013, when it took four weeks on average to get an appointment,[9] but the number of clinics that report having a wait list has increased, from 60% in the previous study[10] to 100% now. Two clinics reported having to often turn patients away. However, all clinics offered same-day appointments for urgent matters.

Four clinics had either expanded their dental programs or offered new dental programs in the last two years, citing the new Medicaid dental benefit as the primary reason for the expansion. Many clinics have also started or expanded their integrated care programs.

Current Integrated Care Arrangements

What is Integrated Care?

The Agency for Healthcare Research and Quality (AHRQ) defines integrated care as "The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population."[11]

Discussions with the leaders of Denver's safety net clinics revealed that integrated care has an even broader definition than this. Many clinics included dental care as a part of what they considered to be integrated care in their practices, while many emphasized that behavioral health care should also

include substance abuse treatment. Some safety net clinics even include education classes, housing, and other social services as part of what they consider to be integrated care.

Levels of Integration

A widely accepted framework for integrated care, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) identifies five levels of integration into which clinics may fall, ranging from Minimal Collaboration at the low end to Fully Integrated Care at the high end.[12] Figure 3 outlines the characteristics of these different levels of integration.

Interviews with clinic administrators revealed that the 85% of Denver's safety net clinics have at least co-located integrated care, placing them at the mid-level (Basic Collaboration) or higher. Five clinics have programs in place that would be considered to be at Level 4 or 5 (Partly or Fully Integrated), as they have taken significant strides to integrate on a system-wide level. Four clinics described being able to refer for behavioral health but not having any behavioral health on site, placing them at level 2 (Basic Collaboration from a Distance). These clinics reported funding constraints that do not allow them to start an integrated care program at this time, but they are actively looking for funding to do so. One clinic will soon be bringing in a behavioral health counselor one day a week, and hopes to expand further.

Figure 3: A Standard Framework for Levels of Integrated Care

MINIMAL COLLABORATION	BASIC COLLABORATION FROM A DISTANCE	BASIC COLLABORATION ONSITE	CLOSE COLLABORATION/ PARTLY INTEGRATED	FULLY INTEGRATED
▸▸ Separate systems ▸▸ Separate facilities ▸▸ Communication is rare ▸▸ Little appreciation of each other's culture	▸▸ Separate systems ▸▸ Separate facilities ▸▸ Periodic focused communication; most written ▸▸ View each other as outside resources ▸▸ Little understand-ing of each other's culture or sharing of influence	▸▸ Separate systems ▸▸ Same facilities ▸▸ Regular communication, occasionally face-to-face ▸▸ Some appreciation of each other's role and general sense of large picture ▸▸ Mental health usually has more influence	▸▸ Some shared systems ▸▸ Same facilities ▸▸ Face-to-Face consultation; coordinated treatment plans ▸▸ Basic appreciation of each other's role and cultures ▸▸ Collaborative routines difficult; time and operation barriers ▸▸ Influence sharing	▸▸ Shared systems and facilities in seamless bio-psychosocial web ▸▸ Consumers and providers have same expectations of system(s) ▸▸ In-depth appreciation of roles and culture ▸▸ Collaborative routines are regular and smooth ▸▸ Conscious influence sharing based on situation and expertise

Source: SAMHSA-HRSA Center for Integrated Health Solutions, 2013.

Models of Integration

Most clinics in Denver have a similar model of integrated care, with behavioral health counselors on-site and available for spontaneous appointments with patients when identified to be in need of these services by the primary care provider (PCP). Behavioral health providers also have scheduled visits in the clinics with returning patients. Patients who need long-term therapy or potentially complicated psychiatric care are generally referred out to other organizations with better access to psychiatric care. When designing workspaces, some clinics have placed physical and behavioral health care providers in the same work space, in order to facilitate open and frequent communication between them.

Five clinics have dental services on site as a part of their integrated care models. Clinics that serve specific populations (homeless persons, people from specific cultures) also often provide other social services such as housing support, health education classes, chronic disease management, job training, English classes, and transportation to and from appointments. One clinic also has an on-site respiratory therapist to support its population with pulmonary disease care.

Only one clinic had a substance abuse treatment counselor, who was grant-funded, although every clinic leader considered this type of care to be a critical part of integrated care. Significant barriers to clinics' being able to offer substance abuse treatment included the lack trained counselors and of funding to engage them.

Funding Integrated Care

The most cited challenge to getting an integrated care program up and running was financial constraints. All clinics with integrated care programs reported having used grant money to initially fund their programs. Most are continuing to use grant money to run the programs, while some have absorbed the costs of the programs into their operating budgets, and as such take a loss from these programs. None of the existing integrated care programs is fully "financially sustainable" under the current payment models.

Many clinics started or expanded their dental programs after Medicaid began to pay for dental services in 2014.

Other Challenges in Integration

Clinic leaders noted several other challenges with starting up and sustaining integrated care programs. For programs that are not fully integrated, documentation is likely to be kept in separate records systems, inhibiting written communication between physical and behavioral health providers. Additionally, it is difficult to measure and isolate the outcomes of integrated care programs, such as return on investment and showing the effects of these programs on various measures of health.

Clinic leaders also described differences in the cultures of physical and behavioral health care, which can lead to stress and conflict between providers when establishing an integrated care program. Physical and behavioral health care providers have traditionally practiced in separate locations and with little

interaction between them. Few have been formally trained in integrated care arrangements, which require adjustments from both types of providers to seek out, involve, and accommodate the needs of the other. Additionally, behavioral health care provided in an integrated primary care setting differs from that provided in a purely behavioral health care setting, with more spontaneity needed for providers to respond to unforeseen needs, shorter appointment times, and a smaller number of total visits between the behavioral health care provider and the patient.

One clinic noted significant problems in being able to retain its behavioral health counselors, saying that after training counselors in its integrated care model, the counselors are quickly offered jobs in other organizations at a higher pay level, given the high value of this training in the marketplace.

Future Directions in Integrated Care

Clinics with minimal integration at this time are either planning to add a behavioral health counselor in the near future or are actively seeking funding to expand their services. Several clinics are looking to incorporate substance abuse treatment into their current integrated care models. Clinics are also thinking about ways they can incorporate integrated care arrangements into their outreach efforts in the communities they serve.

Current Challenges with Specialty Care Access

Introduction

According to key stakeholders from Denver's safety net clinics, access to specialty care for their patients is a persistent and pressing problem. This report identifies some of the challenges surrounding specialty care access, and will inform the work of the Specialty Care Access Working Group of the Mile High Health Alliance as it proceeds to create a specialty care referral network to increase access to specialty care for underserved Denver residents.

Findings

For the adult population, the specialties identified as most in demand but hardest to secure were Neurology and Orthopedics, with 40% of clinics identifying these two. Next in line were the surgical sub-specialties Urology and Neurosurgery. Also identified were Oncology, Nephrology, Cardiology, Dermatology, and Physical Therapy.

For the pediatric population, Developmental Pediatrics was the specialty most in demand but hardest to secure, while Pediatric Neurology was noted to have particularly long wait times.

Even when referrals are secured, patients are not guaranteed to receive the care they need. Several clinics described situations in which patients secured and attended specialist appointments and had procedures recommended for them by the specialists, but were unable to afford the recommended procedures. One clinic referring patients to Nephrology noted that the specialty care clinic would only

begin charity dialysis when patients are already showing symptoms of kidney failure, even when the lab results show that intervention is needed at an earlier stage.

Stakeholders also noted that there is sometimes a lack of follow-up after a completed referral, with the PCP not getting the records, recommendations, and instructions back from the specialist regarding the care needed for the patient after the visit. Moreover, clinics often do not have the resources needed to proactively seek these items from specialists.

Finding specialists who will take patients with Medicaid was a pressing issue brought up by all the clinics. Some specialists may take Medicaid in principle, but cap these patients at one per month, which leads to long wait times. Other challenges included arranging for transportation to ensure that patients get to appointments, and for interpreters in the case of rare languages or dialects. One clinic was concerned about losing patients to a larger health system when making referrals.

One clinic reported that it has been successful using the High Value Care Coordination (HVCC) toolkit from the American College of Physicians,[13] which provides detailed guidelines for PCPS when requesting specialty care referrals for a variety of specialties and conditions.[14] These guidelines instruct primary care physicians regarding tests, histories, and physical exam findings that should be conducted prior to requesting a referral to a specialist. The toolkit also provides sample care coordination agreements between PCPs and specialists.

CORHIO Connectivity

Less than half the safety net clinics in the study are currently connected to the Colorado Regional Health Information Organization (CORHIO), the state's health information exchange, which provides for the exchange of clinical data between providers. This connectivity will be required for participation in the new specialty care e-consult program being developed by the Department of Health Care Policy and Financing, and could also be selected to host the platform for the planned specialty care referral network of the Mile High Health Alliance. However, all clinics that are not currently connected to CORHIO have plans to connect in the future. A list of current CORHIO connectivity for the clinics in the study is included in Appendix A.

Findings Regarding a New Referral Network

Providers were asked about their level of interest in participating in the planned specialty care referral network of the Mile High Health Alliance.

Overall there was great excitement about the prospect of expanded specialty care referral services in Denver, since the clinics see this as a key area where access to care for their patients is lacking. All clinics expressed interest in participating, but some expressed concerns, such as having to adopt a new system that puts an increased burden on their providers or care coordination staff, potential costs for using the system, and how long it will take to get referrals using the new system.

Clinic administrators agreed that an e-consult system would benefit PCPs by allowing them better access to specialists to ask short clinical questions about their patients. However, they also had concerns about an e-consult system, such as difficulties they may encounter when adding a new and perhaps cumbersome technology in their clinics, and whether in-person referrals can be arranged when a health issue cannot be resolved through an e-consult.

Conclusions

The number of uninsured people in Denver has decreased dramatically, and safety net clinics are seeing more patients since the expansion of coverage under the ACA in 2014. However, despite these increases in coverage, Denver still has a significant population of uninsured and under-insured persons.

Safety net clinics in Denver have made great strides in providing integrated physical and behavioral health care for their patients, recognizing the need for these programs to better serve their populations well before the Colorado SIM grant was awarded. However, they have depended largely on grant funding up to now to set up and maintain these programs. Some clinics have committed some of their operating budgets to support the cost of these programs, which leaves less funding for other services these clinics might be able to provide. It is clear that the current payment models do not support the existing integrated care programs to be sustainable, and that better models must be developed.

Access to specialty care is a critical need for patients in Denver's safety net clinics, which are hampered by a lack of options when attempting to refer their patients, including the lack of available specialists and extremely long wait times for their patients to get appointments.

The development of a specialty care referral network by the Mile High Health Alliance to facilitate better access to specialty care would greatly benefit patients in Denver's safety net clinics. While setting up the network, it will be important to explore how to improve the incentives for specialists to serve both Medicaid holders and uninsured populations. The proposed referral network will be stronger if participating primary care clinics employ a set of standard guidelines to manage the referral process, such as the High Value Care Coordination (HVCC) toolkit.

Appendix A: Clinics Included in the Research

No.	Organization	Connected to CORHIO	Services Provided					
			Primary Care	Specialty Care	Referral System to Specialty Care	Mental Health Care	Substance Abuse Treatment	Dental Care
1	Arapahoe House	Yes					x	
2	Asian Pacific Development Center	No	x		x	x		
3	Caritas, Bruner, Seton and General Surgery Clinics at St. Joseph's	Yes	x	x (General Surgery and OB/GYN)	x			
4	Colorado Alliance for Health Equity and Practice (CAHEP)	No	x	x (Allergy and Immunology)	x			x
5	Clinica Tepeyac	Yes	x		x	x		
6	Stout Street Health Center	Yes	x		x	x	x	x
7	Denver Health Internal Medicine	2016	x		x	x	x	
8	Denver Health Family Medicine	2016	x		x	x		
9	Denver Health Pediatrics	2016	x		x	x		
10	Inner City Health Center	No	x	x (Orthopedics)	x	x		x
11	Mental Health Center of Denver	No	x			x	x	
12	Rocky Mountain Youth Clinics	No	x		x	x		x
13	Uptown Primary Care	No	x		x	x		

Appendix B: Semi-Structured Interview Questions

Survey of Denver's Safety Net Clinics, September 2015
Interview Questions

Steven Krager, MD

Part I – Safety Net Capacity and Changes after the Expansion of Coverage

- Refer to the data already provided by email

1. What populations does your clinic serve? Do you serve homeless persons? Do you serve undocumented persons? If yes to either, please give some details about the numbers of each what proportion they make up of your total patient population, if known.
2. (In coordination with pre-interview survey data, if the clinic has seen an increase in the patient population since December 2013). How has your clinic responded to the increased patient caseload, in regard to staffing and allocating resources? (e.g., more providers, other staff, please give details).
3. Are you planning to add more providers, staff, or additional resources in the near future? If so, please give details.
4. Have you changed, expanded, or removed any of the services you provide since December 2013? (Primary care, specialty care, behavioral, dental)
5. Do you plan to change, expand, or remove any services in the near future?
6. How long is the average wait time for an appointment in your clinic? Do you ever turn patients away? Are certain patient populations given priority over others when giving appointments?
7. Have you had any difficulties billing for Medicaid or private insurance? Have you added staff for this purpose since December 2013 to handle the increased caseload? If so, please give details.
8. How do you currently manage payment for uninsured patients? Has this changed since December 2013? Do you have programs or resources in place to help people who are uninsured get coverage? If so, please describe.
9. Are you currently connected to CORHIO? If not, do you plan to apply to get connect in the near future?
10. Do you have an electronic health records system, and if so, what is the name of the software you use for this?
11. Any specific questions regarding data already provided.

Part II – Specialty Care Access

- Show the brief about the plan for the Specialty Care Referral Network that was provided in advance of the meeting, and to the data already provided by email

1. How do you currently arrange for the referral of your patients to specialty care?
    a. What works well about your existing arrangements?
    b. What does not work well and could be improved?

2. Do you have any guidelines in place that your providers follow when assessing whether a patient needs to be referred to a specialist? If so, please briefly describe.
3. What are the three or four sub-specialties that are currently most in need for your patients, but hardest to secure? Does this differ by insurance type of the patient? If so, please explain.

4. Please describe your interest in participating in:
    a. E consults between your providers and specialists
    b. Face to face visits between your patients and specialists

5. Please describe the level of need for specialty care at your clinic for the following groups of patients, by type of coverage, and give any relevant details about the specialty care needs of each group:
    a. Medicaid holders
    b. Uninsured persons
    c. Under-insured persons

6. Do you have care managers, care coordinators, case managers, or patient navigators in your clinic? If so, please briefly describe the staff you have place in these areas and if they would be able to help your providers with referrals in the proposed network.

7. What features would you like to see in the proposed referral network that would facilitate your clinic's ability to participate? Possible factors to be considered:
    a. The referral system interfacing with your Electronic Health Record
    b. Your clinic's connection or lack of connection to CORHIO, the likely platform for the referral network
    c. How easy it will be for providers and/or care managers/coordinators/ patient navigators to log in, schedule appointments, and get feedback from the specialist
    d. Care management/coordination and patient navigation to ensure that specialists have the needed health data on patients, and that patients make it to appointments.
    e. Liability issues for your providers
    f. How the cost of specialty care visits will be covered for patients with different types of insurance coverage, or who are uninsured
    g. How PCPs will be able communicate with specialists and get feedback about the outcome of the specialty care visit.
    h. How to ensure that my patient remains in my clinic as his/her medical home
    i. Any other issues

8. Do you have any recommendations for specialists who may be interested in providing are in this referral network? Please give names of physicians and their practices.

9. Do you have any questions or concerns about participating in a such a referral network?

10. Would your clinic be willing to participate in this referral network?

Part III - Integrated Care

- Show the document explaining the six levels of integration, and to the data they already provided by email

1. Which level of integration best describes the integrated care arrangements at your clinic?
2. (If the clinic already has an integrated care model in place):
    a. Please describe your integrated care model.
    b. Did you face any challenges in the process of establishing your model?
    c. How did you finance the establishment of your current model? How do you sustain it now?
    d. Did you hire any new providers to establish your model? Do you plan to hire more providers in the near future? (Please give numbers and types of providers in each case).
    e. Did you provide any training to your existing providers when establishing your model? If so, please describe.
    f. Are you interested in expanding your model further? If so, please describe.
3. Is your clinic currently in the process of integrating care? If yes:
    a. Describe the model you are seeking to adopt, if known.
    b. What challenges have your encountered so for in your planning process?
    c. What resources do you have now, or expect to have in the near future, to implement this new model? How do you plan to sustain it once it is in place?
    d. Did you hire, or do you plan to hire, any new providers to establish your model?
    e. Did you or will you provide any training to your current providers to establish your model? If so, please describe.
    f. Do you need any assistance in proceeding with your plans? If so, please describe.
4. (If clinic has NOT commenced any process of integration) Are you interested in implemented an integrated care model in your clinic? If yes:
    a. What barriers have you already faced, or do you expect to face, when trying to implement an integrated care model?
    b. What kind of support do you think you will need to plan for and implement an integrated care model? (e.g, identifying models, finding funding, finding appropriate staff, training existing staff)

Appendix C: Resources for Clinic Administrators and Policy Makers

- The Colorado Health Foundation, Report: The Colorado Blueprint for Promoting Integrated Care Sustainability (Denver, CO, 2012).

- Department of Family Medicine, University of Colorado Denver, Advancing Care Together (ACT) Findings (2015).

- SAMHSA-HRSA, Community Health Center and Community Mental Health Center Current Procedural Terminology (CPT) Codes for Colorado (2014).

- SAMHSA-HRSA and CSI Solutions, The Business Case for the Integration of Behavioral Health and Primary Care (2013).

Notes

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[4] McCann, *Op. cit*.

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