EXTERNAL THEORY OF CHANGE
2018-2020

*This reflects our best thinking on **what needs to change in the world** for our long-term goal to be achieved. Careful analysis of our strengths and unique position, as well as what the highest-impact changes would be, identified areas of work on which to focus our efforts.*

LONG-TERM GOAL

our vision of success

People who experience preventable health disparities due to historic and systemic injustices have access to timely, high-quality[1], and affordable[2] health care services that meet their needs[3].

PRIMARY PRECONDITIONS

conditions that must exist in order for us to meet our goal

SECONDARY PRECONDITIONS

conditions that must exist in order for us to achieve our primary preconditions

Personal and structural barriers[4] to receiving quality health care services are eliminated

- SDOH[11], as defined by communities, that limit access to health care services are diminished
- **SDOH[11] and historical and systemic oppression are recognized[12] as driving factors in access to care and health disparities**
- **Health care workforce is culturally-responsive**
- Health care entities use SDOH screening and navigation interventions
- Referral relationships between health care, social services, and community-based entities are created, maintained, and sufficiently resourced
- **Health care workforce is increasingly demographically-reflective of the population it serves**

Health care payment system drives value, equity, and performance[5]

- Providers, health plans, and systems recognize the need to move beyond fee-for-service payment models
- Quality and performance include equity components
- **Colorado's fiscal constraints are alleviated**
- **Value-based payment models that are replicable to our focus population and that drive equity are widely adopted**
- Quality metrics exist that are designed and driven by focus population

Population of focus experiences seamless care[6], at an appropriate time[7] and place[8]

- **Adequate health care workforce[13]**
- Access to patient-centered, team-based care including primary and specialty services
- Providers are practicing at the top of their scope[14]
- Appropriate health care infrastructure (beds, clinics, durable goods)
- Existence of more people-oriented insurance plans[15] that are easy to use
- Sufficient health insurance literacy to use insurance in the appropriate ways
- Collaborative work is focused on specific populations[16]
- **Approaches to care that drive equity are widely adopted (non-traditional providers[17], group visits, telehealth, tech aids, SDOH[11])**

100% of population of focus is covered by affordable[9] and quality[10] health insurance

- **Public insurance programs, like Medicaid and CHP+, are maintained and available**
- **Coverage options for immigrants without documentation**
- Increased enrollment of those who are eligible but not enrolled in coverage
- Adequate availability of affordable, high-quality health plans
- Existence of a more people-oriented[18], transparent, and responsive enrollment system
- Sufficient health insurance literacy[19] to navigate the enrollment system and obtain coverage
- Public and political will supports health care as a basic human right

FOCUS AREAS for our leadership and resources

SUPPORT AREAS for leadership by others

PERIPHERAL AREAS for future work by us or others

EXTERNAL THEORY OF CHANGE 2018-2020

DEFINITIONS

1. Quality health care services are safe, patient-centered, timely, effective, affordable, and equitable.
2. Health care is affordable if a patient doesn't skip necessary services due to cost.
3. Health care services that meet people's needs include those that are appropriate for the patient, including preventive, primary, and specialty care services that address wellness, as well as acute and chronic disease needs. They also include seamless integration of behavioral, oral, and physical health services.
4. Personal and structural barriers might include money, geography, language, transportation, discrimination, or access to technology, among others.
5. Alternative Payment Models (APMs) or Value-Based Payment (VBP) is a strategy used by purchasers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments, to payments that are more closely related to outcomes. Examples of such payments include pay-for-performance programs that reward improvements in quality metrics, and bundled payments that reduce avoidable complications.
6. Seamless care would exist if wait times were appropriate, referrals were successful, all patients had a usual source of care, and health systems were making investments in the right types of medical goods.
7. Care received at an appropriate time includes reasonable wait times for appointments, referrals, and services, accessibility out of regular business hours.
8. An appropriate place includes places that make the most sense for people's lives, including a provider's office, the patient's home, a hospital or clinic, community setting or via telehealth, whichever will ensure the patient's health care needs are met.
9. Affordable health insurance allows families to spend less than 10% of annual income (for those earning at least 2x FPL) and less than 5% of annual income (for those earning less than 2x FPL) on out-of-pocket health care expenses.
10. Quality health insurance includes consumer protections against lifetime caps or exclusion for preexisting conditions, benefits that cover a patient's essential needs, including mental health, prevention, and other high-value health care interventions, as well as network adequacy and ease of navigation.
11. SDOH, or Social Determinants of Health, are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems that shape health, including availability of transportation, food, translation services, housing, income, education, safety, healthy environments, social supports, and other conditions as defined by community members.
12. Recognition includes understanding and taking action around the relevant topic.
13. An adequate health care workforce exists when there are no shortages across geography or in any primary, behavioral health, or specialty services.
14. Providers are practicing at the top of their scope when they are delivering services in line with the highest level of their training.
15. People-oriented insurance plans are easy to use and understand regardless of literacy level or primary language spoken, are culturally responsive, and provide transparent details on copays, deductibles, other cost-sharing, and other pertinent information that affects access to or receipt of care.
16. Specific populations that have been placed at the margins of access to care include immigrants, incarcerated and recently incarcerated individuals, non-English speakers, those who have historically disproportionately lacked health insurance, rural individuals, low-income individuals, among others.
17. Non-traditional providers include community paramedics, community health workers, promotores de salud, patient navigators, and other types of providers that are not traditionally recognized members of the health care workforce yet fill important gaps in access to care.
18. A people-oriented enrollment system is one that is responsive to the needs of individuals working to get enrolled in high-quality, affordable health plans. This includes culturally responsive navigators, and correspondence and information that are clear and easy to understand, regardless of literacy level or primary language spoken.
19. Health insurance literacy refers to the degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health insurance plans, select the best plan for their situation, and use it once enrolled.

ASSUMPTIONS

A. Even when not explicitly noted, preconditions in the Theory of Change must specifically be met with regard to our population of focus in order to reach our long-term goal.

B. The needs and resources of each community in Colorado are unique and require catered solutions.

STRATEGIC FRAMEWORK
2018-2020

*This is our three-year plan of **where we will focus our leadership and resources** in order to have the greatest impact on our long-term goal. Our work in these priority areas is guided by our organizational values and commitment to health equity.*

MISSION & VISION

our primary purpose

We create opportunities and eliminate barriers to health equity so all Coloradans have the opportunity to live a healthy life.

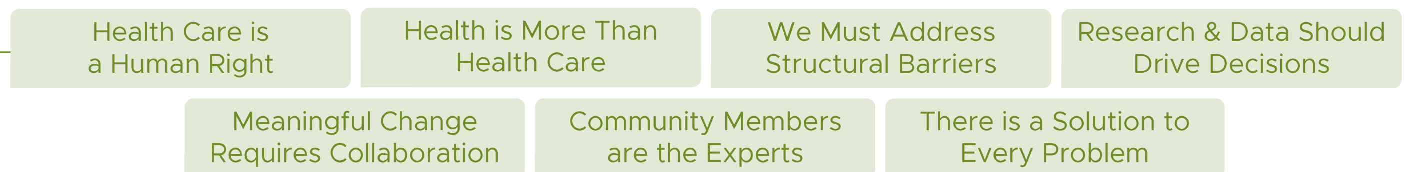
PRIORITIES *for* CHANGE

the areas of work that we will focus on in order to achieve our mission

LONG-TERM GOAL	People who experience health inequities due to historic and systemic injustices have access to timely, high-quality, and affordable health care services that meet their needs.		
PRE-CONDITIONS OF OUR GOAL	Equity of Health Care Access	Value-Based Payment Reform	Universal Health Insurance Coverage
INTERMEDIATE GOALS	**Social determinants of health and systemic oppression are recognized as drivers of access to care and health inequities**	**Colorado Medicaid payment reform addresses social determinants and includes payment for upstream health factors**	**Health systems change to better meet immigrant needs, building allyship and momentum toward a coverage campaign**
ONGOING GOAL	**Center for Health Progress is sustainable and has effective operations consistent with our organizational values**		

VALUES

the beliefs that guide our work



COMMITMENT *to* HEALTH EQUITY

our promise to Coloradans

We champion the values, policies, and practices that eliminate health inequities and inequitable access to health care, especially for those who have historically faced health inequities based on race/ethnicity, age, ability, sexual orientation, gender identity, poverty, geography, citizenship status, or religion.

INTERNAL THEORY OF CHANGE
2018-2020

*This is our three-year plan of **what we will work to change and how** so that our long-term goal can be achieved. These intermediate goals are drawn from the highest-leverage secondary preconditions identified in our external theory of change.*

INTERMEDIATE GOALS

Social determinants of health and systemic oppression are recognized as drivers of access to care and health inequities

- **GRASSROOTS LEADERS** develop as champions that take action on social determinants of health and systemic oppression
- **HEALTH SYSTEMS STAFF AND BOARD** develop as champions that take action on social determinants of health and systemic oppression
- **HIGH-IMPACT DECISION MAKERS** develop as champions that take action on social determinants of health and systemic oppression
- The naming of systemic oppression and institutional racism is normalized into **COLORADO'S PUBLIC AND POLITICAL NARRATIVE**
- Colorado's **HEALTH CARE DELIVERY AND WORKFORCE** are transformed to be more equitable

Colorado Medicaid payment reform addresses social determinants and includes payment for upstream health factors

- **CENTER FOR HEALTH PROGRESS STAFF** have the basic internal knowledge about payment reform and its opportunities to drive equity
- **GRASSROOTS LEADERS** build campaigns to hold Medicaid accountable to their needs and priorities for payment reform
- **LOCAL HEALTH CARE SYSTEM CHAMPIONS** are primed to work with grassroots leaders to drive change
- **NONPROFIT ADVOCATES** partner to apply external pressure on Medicaid and systems toward equitable payment reform
- Colorado's **FISCAL RESTRAINTS** are alleviated

Health systems change to better meet immigrant needs, building allyship and momentum toward a coverage campaign

- **LOCAL GRASSROOTS ORGANIZING** lead to local wins, building momentum toward policy change for coverage
- **ADVOCATES, HEALTH SYSTEMS, AND IMMIGRANT RIGHTS ORGANIZATIONS** align to support immigrant rights, safety, and health
- The **PUBLIC AND POLITICAL NARRATIVE IN DENVER, PUEBLO, AND FORT MORGAN** is inclusive and protective of immigrants
- Colorado's **PUBLIC INSURANCE PROGRAMS**, like Medicaid and CHP+, are maintained and available

ONGOING GOAL

Center for Health Progress is sustainable and has effective operations consistent with our organizational values

- **CENTER FOR HEALTH PROGRESS BOARD, STAFF, AND RESOURCES** are maintained and strengthened
- An **ACTIVATED GROUP OF GRASSROOTS LEADERS** co-develops Center for Health Progress's strategic direction
- **CENTER FOR HEALTH PROGRESS STAFF** can measure the impact and outcome of work in a way that directly informs strategic planning
- **CENTER FOR HEALTH PROGRESS BOARD AND STAFF** are committed to and invested in to becoming an equitable organization
- **CENTER FOR HEALTH PROGRESS** is running efficiently and effectively

COLOR KEY	STATEWIDE LEADERSHIP	LOCAL LEADERSHIP	SUPPORT EFFORTS	ORGANIZATION-WIDE	COMMUNITY ORGANIZING	COMMUNITY PARTNERSHIPS	HEALTH SYSTEMS CHANGE	COMMUNICATIONS