CASE STUDY
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Health Care Improvement in Pueblo, Colorado: Building on Common Ground

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The high-desert region encompassing Pueblo in southeastern Colorado was one of only 14 out of 306 regions nationally to improve on a majority of performance measures tracked by the Commonwealth Fund's *Scorecard on Local Health System Performance, 2016 Edition*. Socioeconomic challenges and geographic isolation have fostered a sense of interdependence among local health care providers, who have leveraged the state's Medicaid expansion to enhance access to care while improving coordination. Providers have also joined with public health and social service agencies, businesses, educators, and nonprofits in creating the Pueblo Triple Aim Corporation, an improvement collaborative that uses data to define problems and create shared accountability for solving them. The group engaged the community in youth development programs as part of an effort that reduced the teen pregnancy rate by more than half. This and other collaborative efforts tap state policy to accomplish local priorities while seeking to build community pride.

KEY TAKEAWAYS

- **Pueblo's providers have leveraged Colorado's Medicaid expansion to enhance access to care while improving coordination.**
- **Local improvement collaboratives use data to define problems and promote shared accountability for solving them.**

PUEBLO PROFILE

HEALTH SYSTEM PERFORMANCE

Improved on
17 OF 32
indicators tracked over time — second-most among all regions

HEALTH SYSTEM RANK

128 OF **306** regions in 2016

vs.

181 OF **306** regions in 2012

DEMOGRAPHICS (2014)

170,798 residents (including 161,875 in Pueblo County)

- **55%** white (vs. 62% nationally)
- **41%** Hispanic (vs. 17% nationally)
- **3%** other non-Hispanic (vs. 8% nationally)
- **2%** Black (vs. 12% nationally)

$44,623 median household income (vs. $58,489 nationally)

46% living on incomes below 200% of the federal poverty level (vs. 34% nationally)

Note: Race/ethnicity data may not sum to 100% because of rounding. Data: D. C. Radley, D. McCarthy, and S. L. Hayes, *Rising to the Challenge: A Scorecard on Local Health System Performance, 2016 Edition* (The Commonwealth Fund, July 2016); and American Community Survey, 2014 1-year estimates, www.factfinder.census.gov. Unless otherwise noted, data on the Pueblo hospital referral region are derived from the *Scorecard*.

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BACKGROUND

The high-desert city of Pueblo, home to over 108,000 residents in southeastern Colorado, is a world apart from the buzzing economy that lines the Denver-to-Boulder corridor just a few hours north. Once known as the "Pittsburgh of the West," the region evolved around the steel industry, with the largest mill owned by John D. Rockefeller. It suffered through many boom-and-bust cycles in the 19th and 20th centuries, but the collapse of the steel market in 1982 and the recent recession were the worst blows, shuttering all but one of the mills and draining away thousands of jobs. For the past several decades, many of the region's residents have lived in generational poverty; nearly half (46%) subsist on incomes that are less than twice the federal poverty level.

Hispanics make up a large portion of the population (41%). One of four adults smoke and nearly a third are obese, both risk factors for diabetes, which is twice as prevalent among adults in Pueblo County as in Colorado (13.6% vs. 6.8%).[1] Many residents suffer from disabilities, whether from the complications of disease, injuries from steel jobs, or self-harm due to substance abuse.[2] Community leaders say that while Colorado's legalization of marijuana has added jobs, it has also strained social services by attracting homeless and drug-seeking populations to the region, where the cost of living is lower than in other parts of the state.

This case study is part of a series exploring the factors that may contribute to improved regional health system performance. It describes how Pueblo's health care provider organizations have joined forces with government agencies including the public health and fire departments, as well as business leaders, social service agencies, philanthropists, and educators to address the community's health and social problems. Deliberate efforts to use data to define the problems and secure engagement from diverse leaders seem to have helped cut the teen pregnancy rate by half and curbed unnecessary hospital use, for example.

The creation of the Historic Arkansas Riverwalk of Pueblo — a 32-acre waterfront promenade — has been part of the city's downtown revitalization.

The new Comanche solar farm, one of the largest in the United States east of the Rockies, is part of the region's effort to diversify its economy.

"There is a nucleus of people here who are exceptionally devoted to collaboration," says Rev. Linda Stetter, director of mission and spiritual care for St. Mary–Corwin Medical Center, one of two hospitals in Pueblo. "I don't think I've lived in another community where the collaboration is this intentional." Such collaborative efforts build on providers' commitment to health care quality improvement, first pursued in the 1980s at Parkview Medical Center, and subsequently taken up by other local institutions.[3]

It's also notable that Pueblo's economy has improved somewhat in recent years; its steelmaking equipment has been repurposed to recycle scrap metal and build wind turbines, and a large solar farm opened there in 2014. This recovery may have played a role in the improvements tracked in the *Scorecard*.

HEALTH SYSTEM PERFORMANCE IN PUEBLO

The Pueblo hospital referral region (HRR), a regional market for health care, includes the city and surrounding Pueblo County as well as parts of adjacent counties.[4] On the Commonwealth Fund's *Scorecard on Local Health System Performance, 2016 Edition*, the region stands out for achieving significant improvements on a majority (17 of 32) of measures for which trend data exist. It was one of only 14 regions among 306 studied by the *Scorecard* to achieve this distinction — a finding even more notable given the region's high poverty rate, since higher income usually correlates with better health and health care. The *Scorecard* found wide variation among HRRs on indicators of health care access, quality, avoidable hospital use, costs, and outcomes.

DELIVERY SYSTEM: SPIRIT OF "CO-OPETITION"

Because of Pueblo's relatively small size and geographic isolation, health care services tend to be concentrated within a few institutions, including two nonprofit hospitals: the independent Parkview Medical Center and St. Mary–Corwin Medical Center, part of the Centura network of faith-based hospitals. Together with Pueblo Community Health Center, a federally qualified health center (FQHC), and Health Solutions, a community mental health center, they are Pueblo's safety net. At Parkview, for example, about 80 percent of admitted patients are covered by Medicare or Medicaid or are uninsured.

Pueblo, Colorado, Hospital Referral Region Local Scorecard Performance

Ranking Summary (of 306 Local Areas)

	Quintile		Rank	
	2012*	2016	2012*	2016
OVERALL	**3**	**3**	**181**	**128**
Access & Affordability	4	4	193	191
Prevention & Treatment	5	2	270	115
Avoidable Hospital Use & Cost	1	1	45	56
Healthy Lives	3	3	182	177

Change in Performance[a]

	Pueblo		Average of HRRs in the U.S.	
	Count	Percent	Count	Percent
Indicators with trends	32		33	
Area rate improved	17	53%	11	33%
Area rate worsened	5	16%	3	9%
Little or no change in area rate	10	31%	19	58%

* Rankings from the 2012 edition of the *Scorecard* have been revised to match methodology and measure definitions used in the 2016 edition.
[a] Improved or worsened denotes a change of at least one-half (0.5) of a standard deviation (a statistical measure of variation) larger than the indicator's distribution among all HRRs over the two time points. Little or no change denotes no change in rate or a change of less than one-half of a standard deviation. For complete results, visit the Health System Data Center.

Data: D. C. Radley, D. McCarthy, and S. L. Hayes, *Rising to the Challenge: A Scorecard on Local Health System Performance, 2016 Edition* (The Commonwealth Fund, July 2016).

High demand for services, coupled with lean reimbursement and workforce shortages, foster interdependence among Pueblo's health care organizations. A spirit of "co-opetition" — a willingness to work together to pursue common interests, while competing for patient loyalty — is evident in the two hospitals' practice of sharing medical specialists, who are scarce resources in this region. Both have made a commitment not to divert patients from their emergency departments, since there is nowhere else for patients to go. Such efforts are enabled by routine meetings of the CEOs and an open-door policy among leaders at both institutions to discuss community concerns. "Both hospitals have a significant role to play to address the large community health burden in Pueblo," says Matt Guy, former executive director of the Pueblo Triple Aim Corporation, a health care improvement collaborative, and now president of the consulting firm Accelerated Transformation Associates.

Expanding Access to Care

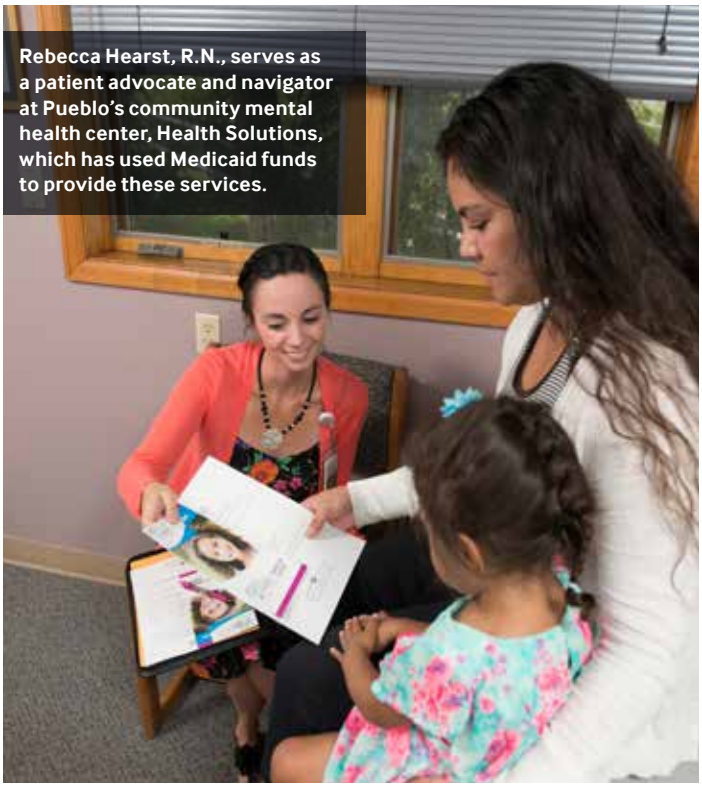
Local providers have worked to enroll people in health coverage, building on Colorado's efforts to expand Medicaid. These began in 2010 with the institution of a hospital provider fee that draws additional federal matching funds to expand coverage to more low-income children and adults and enhance reimbursement to providers, thereby reducing uncompensated care.[5] This has helped Pueblo's safety-net hospitals expand access to care, while also rewarding them for improving quality. In 2014, Colorado further expanded Medicaid to more low-income adults through the Affordable Care Act.

Matt Guy, former executive director of the Pueblo Triple Aim Corporation, a health care improvement collaborative, says that local health care providers have come together to work on shared goals such as reducing emergency department use.

While the *Scorecard* did not detect a substantial drop in the region's uninsured working-age adult population from 2012 to 2014, the rate fell to 10 percent in 2015 — better than state (12%) and national (13%) rates.[6] The *Scorecard* found improvements from 2011–12 to 2013–14 on two related indicators: an increase in the share of adults with a usual source of care (from 77% to 81%), as well as a steep decline in the share of at-risk adults who went without a physician visit in the past two years (from 21% to 13%) — in both cases besting state and national rates. Parkview may have contributed to this improvement by providing Pueblo County's urgent care and emergency facilities with lists of local primary care physicians, information on school-based clinics, and health department resources to share with patients.

Health care providers have also expanded primary care capacity. In 2012, Parkview established an internal medicine residency program, which retained over half its graduates in its first two years. (This program complements a longstanding family medicine residency at St. Mary–Corwin.) The hospital also opened another primary care clinic and "leased" one of its staff endocrinologists to the FQHC for a few days each month, enabling easier access to this in-demand service. During the period the *Scorecard* measured, many of the practices affiliated with St. Mary–Corwin established themselves as patient-centered medical homes, part of an initiative to make after-hours care more available and chronic disease management and preventive services more accessible.[7]

Medicaid expansion also helped the FQHC hire more nurse practitioners and physician assistants to work on care teams in an expanded facility, thereby eliminating a waiting list for accepting new patients. Today the community health center is able to provide same- or next-day appointments for urgent issues and schedule most routine visits in less than 21 days, though it still faces capacity challenges given its difficulty in hiring primary care providers.[8] Since 2009, it has operated five school-based clinics in a partnership with Parkview Medical Center that provide primary care, vaccinations, birth control, sports fitness exams, prescriptions, and referrals for specialty care.



Rebecca Hearst, R.N., serves as a patient advocate and navigator at Pueblo's community mental health center, Health Solutions, which has used Medicaid funds to provide these services.

Mike Baxter is president and CEO of Parkview Medical Center, which has earned national recognition for its efforts to improve quality and promote evidence-based care.

Improving the Quality of Care

Pueblo's most notable gains were on measures assessing the delivery of preventive care and evidence-based treatment. Improvements on 10 of 12 indicators vaulted the region from the fifth to the second quintile of performance on this domain. This progress suggests that quality improvement has become embedded in the local health care culture. This may be attributable, in part, to deliberate steps taken by Parkview Medical Center, which retains the largest market share in the region, to reduce variation and promote evidence-based care.[9] Leaders say Parkview's commitment to quality improvement — and national recognitions it received as a result — spurred others to improve. "Several thousand people visited to see what the hospital was doing," says Michael Pugh, who served as CEO in the 1990s.

During the years tracked by the *Scorecard,* Parkview set goals to reduce patient harm and improve clinical quality and service, reporting progress monthly to all staff and its board.[10] Among other efforts, staff members began checking on patients every hour and making bedside shift changes to promote clear and continuous communication among providers and between patients and providers.

With incentives from public and private insurers to improve the quality of care, Pueblo Community Health Center has achieved its goal of performing above the national median among FQHCs for nine of 15 indicators tracked by the federal government. Through Colorado Medicaid's Accountable Care Collaborative, created in 2010 to improve care while expanding coverage, the FQHC receives per member per month funding (in addition to fee-for-service reimbursement) to coordinate care for its 20,000 Medicaid patients. It uses a web-based system and claims data to identify gaps in care — for example missed postpartum appointments or well-child checks — and to work with frequent emergency department or hospital users to offer chronic care management and other support.[11] In 2011, the FQHC received recognition

Parkview Medical Center Fiscal Year 2017 Quality and Service Goals

PILLAR	GOAL BY June 30, 2017	Operating Measure	Year-to-Date Actual*
QUALITY	**REDUCE PATIENT HARM**		
	Central Line–Associated Bloodstream Infections (CLABSIs)	Reduce total number of CLABSIs 20% or more from 10 to fewer than 8	Goal is being met
	Reduce Catheter-Associated Urinary Tract Infections (CAUTIs)	Reduce total number of CAUTIs 14% or more from 20 to fewer than 17	Goal is being met
	IMPROVE CLINICAL OUTCOMES		
	Reduce Readmission Rate	Reduce overall readmission rate 10% or more from 11.1 to 10.0 or less	Goal is not being met
	Reduce Sepsis Mortality Rate	Reduce sepsis mortality rate from 11.1% to 10%	Goal is being met
	Achieve Hand Hygiene Compliance	Increase hand hygiene compliance based on internal surveillance to 94% or higher	Goal is not being met
SERVICE	Increase Overall Service Score	Overall HCAHPS from 75.3 to 76.3 or higher HCAHPS data (Note: 2-month lag)	Goal is being met
	Improve Physician Communication Score	HCAHPS score from 75.45 to 79.45 or higher HCAHPS data (note: 2-month lag)	Goal is being met
	Improve Hospital Cleanliness Score	HCAHPS score from 79.7 to 80.7 or higher HCAHPS data (note: 2-month lag)	Goal is being met

Notes: Goals not shown for people (employees), growth, and finance. HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems.
* Actual as of Sept. 2016.
Data: Parkview Medical Center.

as a medical home by the Accreditation Association of Ambulatory Health Care for its efforts to expand access and improve the quality of care.

Collaborative efforts to promote preventive care and to improve care coordination across settings have also been launched. Pueblo's public health department partners with the residency programs at Parkview and St. Mary–Corwin to promote colorectal cancer screenings through a chart review and tracking system, which led to an increase in the number of adults screened.[12] Case managers at the FQHC coordinate care for high-risk obstetric patients by scheduling appointments for them at St. Mary–Corwin's high-risk obstetrics clinic, making sure they attend, and helping them adhere to recommended treatment.

Since 2001, the FQHC has been the first point of contact for hospitals when they discharge patients who do not have an identified source of primary care. In recent years, Parkview added a dedicated team to contact patients after discharge to ensure they understand their treatment plan and have a follow-up appointment scheduled. In 2015, the Southeastern Colorado Transitions of Care Consortium (launched by the Pueblo Triple Aim Corporation) brought together Pueblo's urban and regional hospitals, community mental health center, and the FQHC, physician groups, insurers, and the Medicaid Regional Care Collaborative Organization to align and improve their care coordination efforts.

Pueblo's fire department has joined the consortium, prompted by a growing number of 911 calls, which increased from 2,000 in 2008 to 21,000 in 2015. Some came from residents who would repeatedly fall in their homes; others came from people who simply needed a way to access the health system.[13] This resulted in the 2016 launch a pilot program called Directing Others to Service, or DOTS, in which fire department staff and providers connect frequent users of the emergency response system with medical homes or other sources of help. Fire department staff also visit frequent 911 callers to identify needs — such as a grab bar in their bathroom or an eyeglass prescription — that could be addressed to head off future emergencies.[14]

Quality-of-Care Performance for Pueblo Community Health Center and Ranking Compared with Federally Qualified Health Centers Nationally

	2013	2014	2015	Adjusted Quartile Ranking	
Quality of Care Measures				**2014**	**2015**
Perinatal Health					
Access to Prenatal Care (First Prenatal Visit in 1st Trimester)	75.6%	79.2%	81.1%	2	2
Low Birth Weight	9.5%	10.1%	9.0%	4	3
Preventive Health Screening & Services					
Cervical Cancer Screening	48.4%	68.0%	64.1%	1	2
Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents	6.0%	18.1%	63.6%	4	2
Adult Weight Screening and Follow-Up	27.4%	84.6%	90.0%	1	1
Adults Screened for Tobacco Use and Receiving Cessation Intervention	—	73.9%	80.9%	3	3
Colorectal Cancer Screening	24.1%	36.4%	42.1%	2	2
Childhood Immunization	85.8%	89.1%	80.2%	1	2
Depression Screening	—	5.9%	18.2%	4	4
Dental Sealants	—	—	30.0%	—	3
Chronic Disease Management					
Asthma Treatment (Appropriate Treatment Plan)	50.5%	100.0%	94.0%	1	2
Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease)	52.6%	66.4%	92.4%	4	1
Heart Attack/Stroke Treatment (Aspirin Therapy for Ischemic Vascular Disease Patients)	20.6%	51.5%	80.0%	4	3
Blood Pressure Control (Hypertensive Patients with Blood Pressure < 140/90)	66.6%	65.2%	69.0%	2	2
Uncontrolled Diabetes (Diabetic Patients with HbA1c > 9%)	38.4%	33.4%	32.0%	—	3
HIV Linkage to Care	—	100.0%	100.0%	—	—

Note: Quartile ranking is out of Health Resources and Services Administration (HRSA)-funded health centers nationwide; 1st or 2nd quartile of performance is above the national median.

Data: HRSA Health Center Program, Pueblo Community Health Center 2015 Profile.

COLLABORATING REGIONALLY TO COORDINATE CARE FOR MEDICAID PATIENTS

Colorado in 2010 created a Medicaid Accountable Care Collaborative (ACC) to promote care coordination and efficiency while expanding coverage for Medicaid beneficiaries.[a] The ACC comprises seven regional care collaborative organizations (RCCOs) selected by the state, which pays them a fee of up to $12 per member per month (PMPM) to oversee medical management, provider network development and support, and performance reporting. RCCOs contract with primary care providers, who receive $3 PMPM from the state (on top of fee-for-service reimbursement) for participating in care coordination and quality improvement activities. Both may also earn financial incentives for meeting performance targets.

Integrated Community Health Partnership, LLC, is the RCCO serving Pueblo and 18 other counties in southeastern Colorado. Its members include a behavioral health organization and four community mental health centers as well as a consortium of three FQHCs.[b] The RCCO passes a portion of its fee to the FQHCs to coordinate care for their Medicaid patients and to the community mental health centers (Health Solutions in Pueblo) to coordinate care for other Medicaid beneficiaries. For example, Health Solutions hired 10 registered nurses to serve as patient advocates and navigators primarily on behalf of dually eligible Medicare and Medicaid clients. They spend time in providers' practices and connect clients to resources to meet their medical and nonmedical needs.

To date, the most beneficial aspect of the RCCO has been to bring the partners together to identify what is and isn't working in their communities, according to Chris Senz, CEO of Integrated Community Health Partnership. The program has enabled FQHCs such as the Pueblo Community Health Center to create a care coordination infrastructure that was not possible under traditional fee-for-service reimbursement, according to Donald Moore, its CEO. The ACC program saved an estimated $37 million statewide in fiscal 2014–15, according to the state of Colorado.[c]

[a] D. Rodin and S. Silow-Carroll, *Medicaid Payment and Delivery Reform in Colorado: ACOs at the Regional Level* (The Commonwealth Fund, March 2013).

[b] The consortium is known as the Colorado Community Managed Care Network.

[c] Colorado Department of Health Care Policy and Financing, Legislative Request for Information, Nov. 1, 2015; J. Lloyd, R. Houston, and T. McGinnis, *Medicaid Accountable Care Organization Programs: State Profiles* (Center for Health Care Strategies, Oct. 2015); National Academy for State Health Policy, Colorado ACO.

Donald Moore, CEO of Pueblo Community Health Center, says Colorado's Medicaid Accountable Care Collaborative has enabled the health center to invest in the infrastructure needed to coordinate patient care.

Addressing Social Determinants

Pueblo's health care providers have also moved to address the social determinants of poor health, including poor nutrition. In response to evidence that 17 percent of Pueblo residents lacked access to healthy food, St. Mary–Corwin in 2013 launched a farm stand in its own neighborhood, which is considered both a food desert because of its lack of healthy food options and a food swamp because of its abundance of cheap, low-nutrition options.[15] The hospitals' physicians are able to write prescriptions for high-risk patients, including those who are obese and/or diabetic, to receive free fruit and vegetables there.[16] Parkview has also sought to promote better nutrition by sending nurses to worksites and public venues to offer dietary advice and free diabetes screenings. Such work is reinforced by the public health department's efforts to help local food retailers purchase freezers or make other changes necessary to sell healthier products, and successful lobbying of Walmart to open a store in one of Pueblo's poorest neighborhoods.

St. Mary–Corwin has also partnered with the city to enforce code violations against landlords for problems that impact health, like mold and bug infestations. And Stetter has led an effort to educate Pueblo's religious leaders about health issues and enlist them in supporting members of their congregations.

COLLECTIVE ACTION ACROSS SECTORS

Several leaders note that Pueblo has a history of collaborative efforts, most notably the One Community Pueblo initiative, begun in 2008, involving health providers, educators, law enforcement officials, and judges in supporting healthy child and youth development, in part by promoting access to mental and physical health services. The effort involves collecting extensive data and reporting it on a public dashboard.[17]

Rev. Linda Stetter, director of mission and spiritual care for St. Mary–Corwin Medical Center, at the hospital's farm stand. St. Mary–Corwin physicians can write prescriptions for patients to receive free fruit and vegetables.

ENGAGING FAITH COMMUNITIES, TRYING COMPLEMENTARY APPROACHES

When Rev. Linda Stetter came to Pueblo to become the director of mission and spiritual care for St. Mary–Corwin Medical Center in 2013, she started church-hopping on Sundays. Thus far she's visited more than 90 of the city's 125 churches. Having worked in communities with strong interfaith associations, Stetter knew that religious leaders could serve as community partners for hospitals such as hers — offering pastoral care to sick members of their congregations or speaking to congregants about good nutrition and other healthy behaviors. She began offering quarterly symposia to clergy on such topics and now receives requests from them to be educated about issues like autism that are of concern to their congregants.

Stetter hopes to try the Memphis Model in Pueblo, an approach developed at Methodist Le Bonheur Healthcare in Memphis, Tenn. Through the hospital's Congregational Health Network, members of some 500 Memphis churches, many African American, have agreed to help chronically ill congregants, in part by checking up on them after hospitalizations. "They are cared for like neighbors used to care for neighbors," says Stetter. Methodist Le Bonheur has reported that over a three-year period patients served through this network had shorter hospital stays, longer intervals between hospitalizations, and significantly lower mortality rates.[a]

Stetter also helps direct St. Mary–Corwin's use of complementary therapies such as acupuncture and mindfulness in the intensive care unit, emergency department, and elsewhere to help those dealing with addiction, pain, and stress. Such approaches have been especially needed to help the hospital's pain management clinic treat a population of opioid-dependent patients. In 2007 two local doctors were forced to close their practices over alleged overprescribing, and Pueblo has received negative publicity as the highest drug-prescribing city in Colorado.[b] The hospital's commitment to complementary therapies — including the services of a harpist — is an effort "to help people cope with their chronic illnesses and their mental conditions beyond the hospital walls," says Stetter.

[a] A. Halperin, "It Really Does Take a Village: How Memphis Is Fixing Healthcare," *Salon,* Sept. 3, 2013.

[b] L. Sword, "Pain Specialist Plans Doctors' Class," *The Pueblo Chieftain,* Oct. 9, 2013.

In 2010, Pueblo's two hospitals conducted their first community health needs assessments, a requirement for nonprofit institutions under the Affordable Care Act, and the public health department created a new community health improvement plan. These analyses cast into stark relief the breadth and depth of Pueblo's health problems and prompted leaders to move beyond ad hoc efforts to take collective action. After hearing about the Institute for Healthcare Improvement's Triple Aim — for improved care, improved population health, and reduced per capita costs — leaders founded the Pueblo Triple Aim Corporation, a nonprofit with a dedicated staff and infrastructure.[18] Leaders from the business community, social services, philanthropy, economic development, and education, as well as Latino and other community groups, have joined.

The group uses a data dashboard to track key population health indicators for Pueblo County residents, compare Pueblo's performance with other counties, and set goals for improvement.[19] At this stage, some targets — such as a reduction in the premature death rate — appear to be largely aspirational, while others — such as reducing the rate of preventable hospitalizations — may be influenced in part by initiatives such as the care transitions consortium described above.

To guide their work, members worked with the ReThink Health initiative, a nonprofit promoting regional health improvement, to model the long-term effects of various health policies on Pueblo residents' lives, health care costs, quality of care, equity, and productivity.[20] This exercise helped convince employers facing rising health costs and overburdened safety-net providers that making long-term and even modest investments in better health could yield significant financial returns. "The big thing that became evident through the modeling was that to have impact they would have to move upstream and look at those social determinants of health," says Randy Evetts, senior program officer for the David and Lucile Packard Foundation, which financed the development of the dashboard and supports a number of causes in Pueblo, the birthplace of David Packard, Hewlett-Packard's cofounder. The Pueblo Triple Aim Corporation has leveraged grants from a number of foundations to fund its work.[21]

Pueblo Triple Aim Corporation: Triple Aim Metrics

Indicator	Baseline rate*	Recent rate**	Target rate
POPULATION HEALTH			
Years of Potential Life Lost (before age 75; rate per 100,000, age-adjusted)	8,435	8,552	7,940
Percent of Residents Reporting Fair to Poor Health	16%	18%	13%
PATIENT EXPERIENCE			
Clinical Care: Access and Quality (composite rank among 60 Colorado counties)	13	12	10
Percent of Residents with No Insurance	14%	15%	13%
COST OF CARE			
Population Health and Resource Use (illness burden score compared to statewide average)	1.25	1.34	1
Preventable Hospital Stays (rate per 1,000 Medicare enrollees)	68	35	33

* Baseline rate represents the 2010 reporting year.

** Recent rate represents the 2016 reporting year, except for Population Health and Resource Use (illness burden score compared to statewide average), which represents the 2012 reporting year.

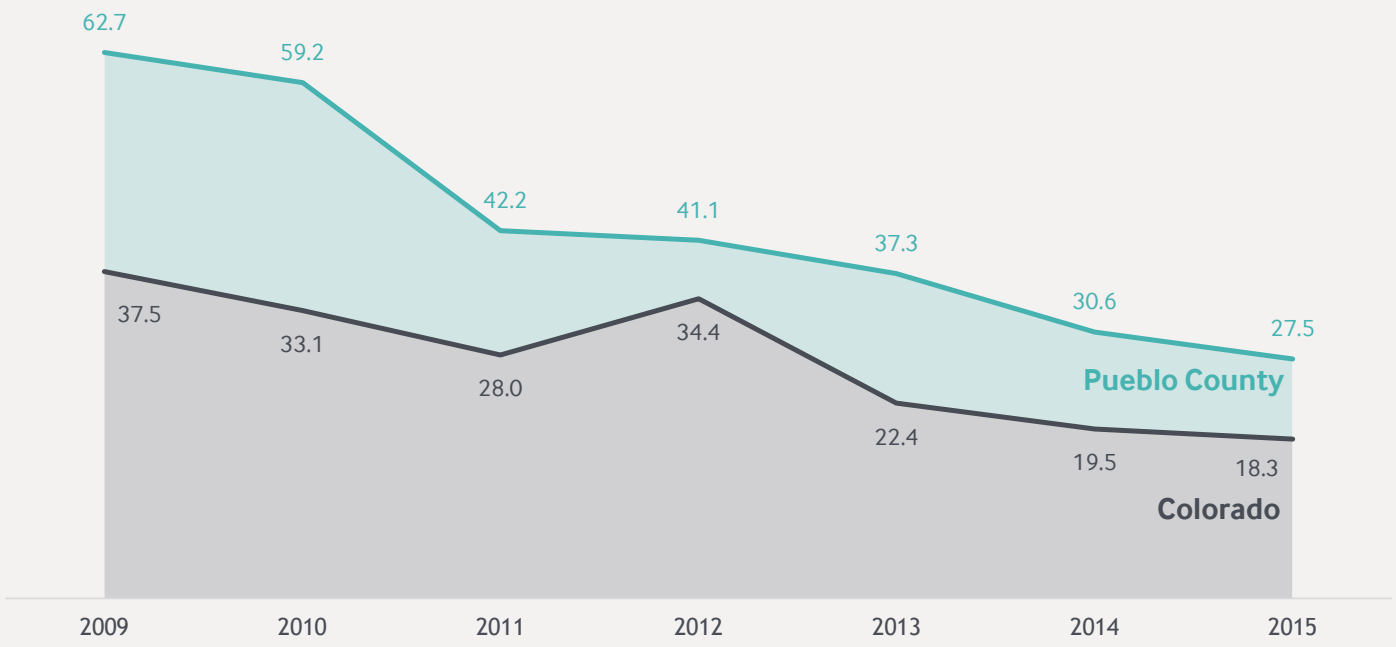
Data: *Triple Aim Measures* (Pueblo Triple Aim Corporation, n.d.).

The group's initial effort, led by the public health department, sought to reduce teen pregnancy rates, which for years were among the highest in the state. Past efforts to address the issue had splintered, in part over disagreements about whether to promote contraception or abstinence-only approaches (many in the community identify as Catholic or evangelical Christian).[22] Cognizant of this history, the Triple Aim group recast the issue as not just preventing pregnancies but promoting positive youth development — including mentoring initiatives, efforts to educate teens about their career options, and a sexual health educational campaign.[23]

The community's effort to reduce teen pregnancy gained momentum from Colorado's groundbreaking policy to make long-acting reversible contraception (LARC) free to low-income teenagers and women through family planning centers, which led to a 50 percent drop in the state's teen pregnancy rate from 2009 to 2015.[24] Pueblo County more than halved its rate during this time, representing a much larger decline in absolute terms (a reduction of 35.2 per 1,000 in Pueblo vs. 19.2 per 1,000 for the state). The local public health department helped promote use of LARC, in part by talking to providers. "We found that teens were very scared and reluctant to even come in to a clinic and talk about their sexual health," says Sylvia Proud, director of Pueblo City-County Health Department. "We have done a lot with how to talk to teens, how to make clinics more teen-friendly environments."

Members of the Pueblo Triple Aim Corporation are also working to increase healthy behaviors and reduce obesity. Pueblo was the first Colorado city to ban smoking in public spaces; the group is now working with the housing authority to make low-income housing units smoke free. The organization also participates in national learning collaboratives on health improvement.[25]

Teen Pregnancy Rate per 1,000 Ages 15–19: Pueblo County vs. Colorado State



Data: Pueblo City-County Health Department, based on vital statistics data collected and reported by the Colorado Department of Public Health and Environment.

The public health department has played a leading role in reducing teen pregnancies. From left to right: Public Health Director Sylvia Proud, Program Manager Zak VanOoyen, Public Health Nurse Desiree Wolfe, and Nurse Practitioner Janet Pippenger.

LESSONS

Cross-sector coalitions can help communities build the will needed to take collective action.

The Pueblo region has worked to create a positive identity in the face of long-standing social problems that can wear down the spirit of volunteerism over time. Improvement efforts have gained traction in recent years as community leaders have found common ground, helped to a great extent by coalitions such as the Pueblo Triple Aim Corporation.[26] Cross-sector efforts have built on one another to develop leaders' capacity for public–private collaboration, nurtured by financial support from foundations, local charities, and an insurer. To make progress in a collaborative way, community leaders need to cultivate a sense of "patient urgency," says Guy, by slowly building trusting relationships while immediately taking incremental steps toward achieving agreed-upon goals for improvement.

Supportive state policies lay the groundwork for local improvement.

Pueblo has benefitted from supportive state policy, most notably Colorado's health care reforms that expanded Medicaid before and after enactment of the Affordable Care Act, as well as the creation of the Medicaid Accountable Care Collaborative and policies such as support for the use of long-acting reversible contraceptives. But the grassroots efforts led by Pueblo's community leaders have ensured there is fertile ground for localizing state policy to serve the priorities of this independent region, which can be wary of receiving dictates from state government. "There is a very fierce Pueblo culture of, 'We are going to do it our way,'" says Guy. "We will take your help, but this is our community, and we are going to do it our way."

NOTES

1 Colorado Department of Public Health and the Environment, *Visual Information System for Identifying Opportunities and Needs, Data by County, Diabetes — Adults, 2013–2015*.

2 J. Puzzanghera, "Low Pay? Disabilities? Video Games? Researchers Seek Answers," *The Pueblo Chieftain,* Dec. 3, 2016.

3 B. J. Ivey, "Improving Quality at Parkview," *Journal for Healthcare Quality,* Sept./Oct. 1992 14(5):56–62.

4 The Pueblo hospital referral region also includes parts of Crowley, Custer, El Paso, Fremont, Huerfano, Las Animas, and Otero counties.

5 The Colorado hospital provider fee was enacted in 2009 following recommendations of a bipartisan Blue Ribbon Commission on Health Care Reform. Enabling legislation prohibits hospitals from shifting the fee to clients or insurers. Since enactment of the fee, reimbursement to hospitals for care provided to Medicaid patients has increased from 54% to 75% of costs statewide, while the amount of bad debt and charity care decreased by 58% from 2013 to 2015, according to the state's Hospital Provider Fee Oversight and Advisory Board; see *Colorado Health Care Affordability Act Annual Report,* Jan. 15, 2017.

6 Commonwealth Fund analysis of data from the U.S. Census Bureau, 2015 1-Year American Community Survey Public Use Micro Sample (ACS PUMS); also see S. L. Hayes, S. R. Collins, D. C. Radley, D. McCarthy, and S. Beutel, *A Long Way in a Short Time: States' Progress on Health Care Coverage and Access, 2013–2015* (The Commonwealth Fund, Dec. 2016).

7 *Colorado Health Neighborhoods* (Centura Health, n.d.).

8 The federal government has designated Pueblo Community Health Center as a health professional shortage facility (https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx), and about half of Pueblo County as a medically underserved area (https://www.colorado.gov/pacific/sites/default/files/PCO_HPSA-mua-mup-map.pdf).

9 Use of concurrent review of medical records while patients are still hospitalized enabled timely delivery of education and reminders to staff at the point of care, leading to top performance on measures of care processes for pneumonia and heart in failure in 2007 and 2008. See A. Lashbrook, *Parkview Medical Center: Underscoring the Importance of Communication in Pneumonia Care* (The Commonwealth Fund, Dec. 2009).

10 Parkview was recently noted as one of 49 hospitals nationwide to achieve the lowest rates of hospitalwide readmissions from July 2014 through June 2015; see H. Punke, "49 Hospitals With the Lowest Readmission Rates," *Becker's Infection Control and Clinical Quality,* Dec. 28, 2016.

11 Pueblo Community Health Center is also eligible for quality bonuses from Kaiser Permanente for meeting targets for its Medicare Advantage patients, as well as from other private insurers.

12 The project resulted in the creation of a toolkit for statewide use and paved the way for related collaboration, such as an effort to increase the referral of tobacco users to cessation resources.

13 K. Galer, "Pueblo Fire Launches New Program to Help Decrease Record Number of Calls for Service," KKTV 11 News, Feb. 12, 2016.

14 *Pueblo County DOTS Program* (n.d.).

15 See U.S. Department of Agriculture, *Food Access Research Atlas and County Business Patterns 2012* (USDA, n.d.).

16 The food purchases are funded by local medical practices, accountable care organizations, and a grant from the hospital's foundation. The local food bank also will begin donating food this year.

[17] See One Community Pueblo dashboard (n.d.).

[18] B. Milstein, "ReThinking Health in Pueblo, Colorado: A Stewardship Strategy to Advance the Triple Aim," *Improving Population Health Blog,* Aug. 21, 2012; and K. Mitchell, *Pueblo County Triple Aim: Tips for Population Health Success* (Institute for Healthcare Improvement, Jan. 13, 2016).

[19] See *Triple Aim Measures* (Pueblo Triple Aim Corporation, n.d.).

[20] ReThink Health is an initiative of the Fannie E. Rippel Foundation. For background on the ReThink Health Dynamics model, see: https://www.rethinkhealth.org/resources-list/dynamic-modeling-strategy/.

[21] Major grants have included $709,000 from the Colorado Health Foundation and $565,000 from Kaiser Permanente, which opened medical offices in Pueblo in 2009 to serve its new Medicare Advantage and commercially insured members. The grant from Kaiser helps support efforts to reduce avoidable readmissions and emergency department use and promote community health. Pueblo Triple Aim Corporation also has a $25,000 contract with Colorado's Medicaid agency to further develop community data in conjunction with the Medicaid Regional Collaborative Care Organization.

[22] In the 1990s the community lost a $1 million grant from the Colorado Trust because members of the collaboration formed to use the funds couldn't agree on the best way to address teen pregnancy.

[23] See *The Pueblo County Teen Pregnancy Research Project Final Report* (John Snow, Inc., n.d.).

[24] Data provided by the Pueblo City-County Health Department, based on vital statistics collected and reported by the Colorado Department of Public Health and Environment. The Long-Acting Reversible Contraception Program, originally funded anonymously by the Susan Thompson Buffet Foundation, gained state funding in 2016; see S. Tavernise, "Colorado's Effort Against Teenage Pregnancies Is a Startling Success," *New York Times,* July 5, 2015.

[25] Pueblo is one of 24 communities participating in the SCALE (Spreading Community Accelerators through Learning and Evaluation) initiative led by the Institute for Healthcare Improvement with funding from the Robert Wood Johnson Foundation, and is one of 50 communities participating in the Invest Health initiative sponsored by the Robert Wood Johnson Foundation and the Reinvestment Fund to promote cross-sector collaboration at the neighborhood level.

[26] J. Kania and M. Kramer, "Collective Impact," *Stanford Social Science Review,* Winter 2011.

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