THE BELL POLICY CENTER PRESENTS

Accessibility of Care in Colorado

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Care provided across generations, through direct care (support for older adults and people with disabilities) or early childhood education (ECE), is crucial to our communities. Both types of care allow family members to work and have positive spillover effects in economic security, health, and well-being for the recipients of care and their family members.

The positive impacts of care are hindered by a lack of accessibility. Accessible care means that people can find and receive care that meets their needs with reasonable effort. Currently in Colorado, partially due to a care worker shortage and a lack of funding, not everyone has access to the care they need. This is particularly true in rural areas, regions with higher populations of Hispanic and Latino Coloradans, and low-income communities. While informal care, provided by friends and family, has helped to make care more accessible, challenges still remain for many Colorado families.

Accessibility, affordability, and quality of care are closely tied and impact one another. As such, accessibility is difficult to define excluding these measures. However, for the purpose of this brief, we aim to define and explore the level of accessibility in Colorado, and analyze affordability and quality in future briefs.

What Does Accessibility Mean?

Research funded by the U.S. Department of Health and Human Services (HHS) defines access to ECE and child care as the ability for parents "with reasonable effort and affordability, [to] enroll their child in an arrangement that supports the child's development and meets the parents' needs." While this definition was meant for child care specifically, it also can be applied to those who need direct care: Aging adults, people with disabilities, and the families of people in both categories can, with reasonable effort and affordability, find and successfully utilize care that supports and meets their needs.

Despite this definition, accessibility is difficult to measure as personal preferences vary and impact the use of care. To measure access, we break it down into two main components:

Can care be found with reasonable effort:

To find care with reasonable effort suggests that there are enough care options in a desired area. This speaks to the adequacy of supply. The most straightforward way to measure the adequacy of supply is by examining the number of people in need of care compared to the number of available workers, classroom seats, etc. Are there enough places or care workers to meet the need? For ECE this can be measured by the capacity in licensed child care facilities compared to the number of children in need of care. For direct care, we can look at waitlists for Home and Community Based Services (HCBS) waivers as well as the population with a potential need for care compared to available workers. Notably, supply often varies by region, with some areas experiencing more severe gaps known as care deserts.

Does care support and meet the needs of recipients:

To meet the needs of recipients, care must be culturally responsive, meet the schedule needs of a family, and meet the learning and health needs of recipients. Need and preference varies by individual and therefore does not have a single measure.

Why is Access Important?

Accessible care is important for a person's quality of life and is considered a social determinant of health. This is true for both the recipient of care as well as the unpaid family members (also commonly referred to as informal caregivers) who may be providing support or searching for care for their loved ones. For older adults and people with disabilities, accessible care can allow them to live as independently as possible. It enables individuals to live in their community of choice, maintain social connections, and remain healthy. For children, accessing ECE means they are engaged in activities, growing socially and emotionally, and acquiring foundational skills for their continued education. Access to quality child care is linked to higher academic outcomes and improved future earning potential.

Accessibility of care also impacts family members. If care is inaccessible, a family member often will step in to provide care. When this is the case, family members often will reduce their work hours to provide care, occasionally leave the workforce altogether, and forego wages. This can greatly impact economic security and mobility. For example, parents and families who are unable to access child care are more likely to struggle with food security, housing security, and holding a job.

In addition to economic impacts, access to formal care impacts health outcomes. The 2021 Community Health Access Survey (CHAS) found that 5.6 percent of Coloradans with a child under 14 could not schedule a health care appointment because they were unable to find child care. This percentage increased for women, Hispanic/Latino people, and low-income parents. This is similar for family members who may be caring for an older adult or person with a disability. Informal caregivers in Colorado report barriers to respite care because of a lack of providers. Respite care allows the primary caregiver to take a needed break, run errands, and attend their health appointments. Without access to respite care, the informal caregiver's health, economic mobility, and overall well-being can be negatively impacted and is linked to higher levels of emotional distress.

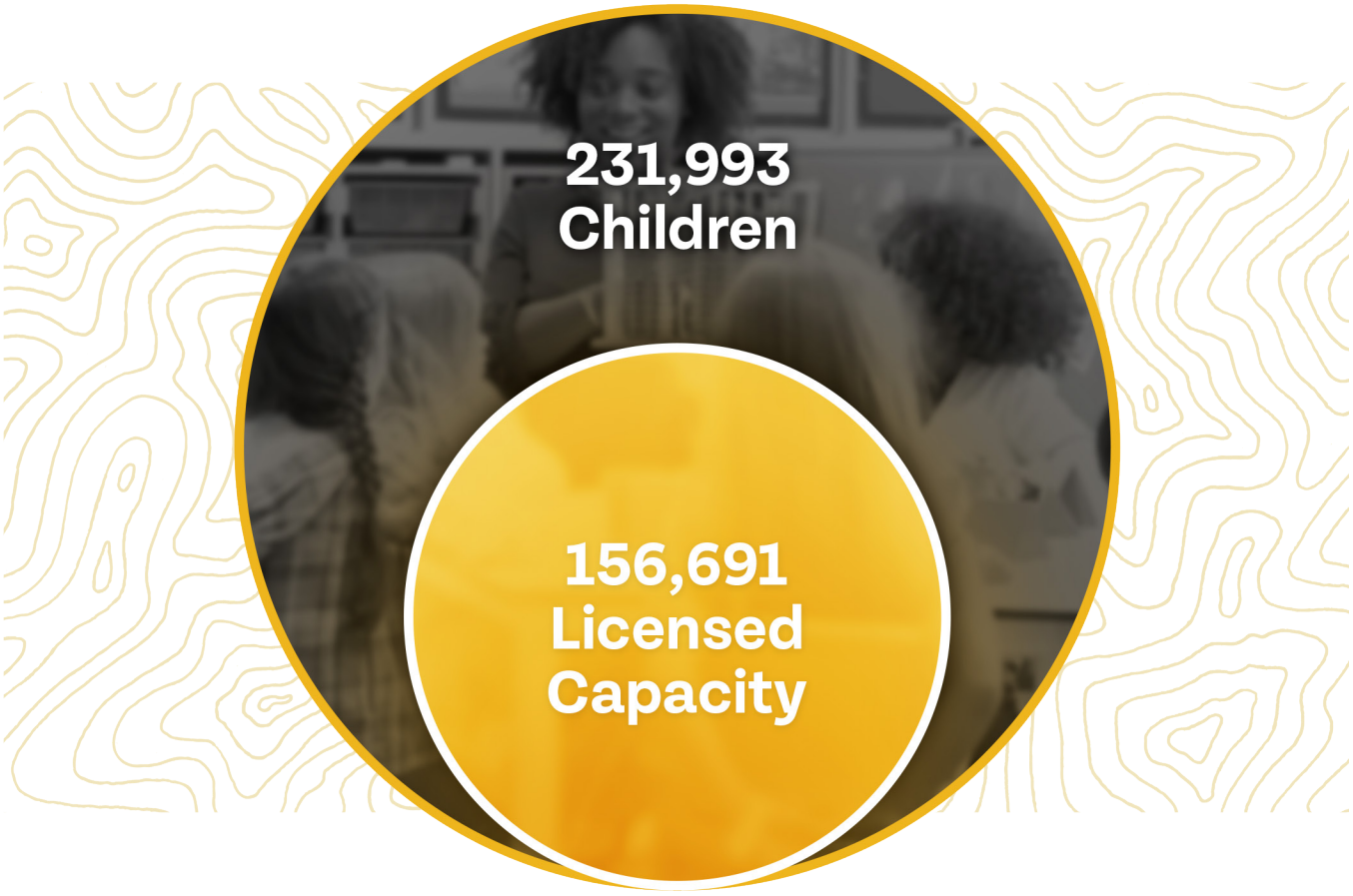
Accessible care allows people to remain healthy, stay in their communities of choice, positively impacts the development of children, and leads to higher levels of health and well-being for family members and those who step in to provide informal care.

Can Care be Found with Reasonable Effort?

There is a caring workforce crisis in Colorado. The caring workforce (a group inclusive of both ECE and direct care workers) earns low wages, suffers from poor workplace conditions and therefore, has high turnover and recruitment challenges. This in turn has led to significant workforce shortages and supply gaps across the state.

What does the current supply of care look like?

As mentioned above, one component of adequacy relates to supply, which can be assessed by examining the availability of care compared to need. For ECE, this involves comparing licensed capacity to the number of children under 6 who have all parents in the workforce and are therefore more likely to need paid care. As it currently stands, the total licensed capacity for child care is 156,691 compared to the 231,993 children under 6 with all parents in the workforce. This is a gap of 75,302 children who do not have an available seat with a licensed childcare provider. This gap has been decreasing over the last couple of years due to a drop in the number of children as well as an increase in child care spots. Prior to the pandemic, in 2019, the Bipartisan Policy Center calculated a gap of 94,887 children without a licensed child care slot. In 2021, the Bell calculated a similar gap of 94,000 fewer slots than children under 6 with working parents. It should be noted that this gap is likely an underestimate as it only represents those most likely to need care and does not include children in two-parent households with only one working parent, even though they may still need paid care.



In the direct care space, it is difficult to determine supply gaps. From the Bureau of Labor Statistics, we know that in Colorado, 60,650 people in 2021 were employed as direct care workers, though it is difficult to calculate how many individual clients they support. Additionally, while the population of older Coloradans is growing, there is no exact data on how many need a direct care worker. According to the HHS, approximately 70 percent of older adults will need some form of long-term care at some point. In Colorado, that means there are approximately 616,000 people currently 65 and older who either currently need, or are likely to need care at some point in the future.

While difficult to determine how the current need for care compares to supply, there are reasons to believe there will be challenges in the coming years. From 2018 to 2030, the population of people 65 years-old and older is projected to increase three times faster than 16- to 64-year-olds, which comprises the traditionally conceptualized labor pool. To keep up with the growing population of those 65 and older and maintain the current number of direct care workers for each Coloradan 65 and older would require a 40 percent increase in the workforce. This suggests there will continue to be a higher need for direct care workers compared to the supply.

Waitlists for HCBS waivers are another way to gauge how many people are waiting to access state-funded, paid direct care. Currently, according to Colorado's Department of Health Care Policy and Financing (HCPF), the only HCBS waiver that has a waitlist is the Developmental Disability (HCBS-DD) waiver. While only one waiver has a waitlist, this does not actually indicate how many people with funding are able to utilize care. In one example reported by the Colorado Sun, a person on the Developmental Disability waiver had enough funding for four days of their adult day program. However, that person was only able to access services for three days due to a lack of workers and limited availability at the center.

Both of these measures for ECE and direct care are not indicative of people forgoing care. This gap does not mean that 75,000 children are without care, or that those on the HCBS-DD waitlist are not receiving any care, but rather points to the proportion of people likely relying on informal support from family, friends, and neighbors.

"From 2018 to 2030, the population of people 65 years-old and older is projected to increase three times faster than 16- to 64-year-olds"

How Does Supply Differ Across the State?

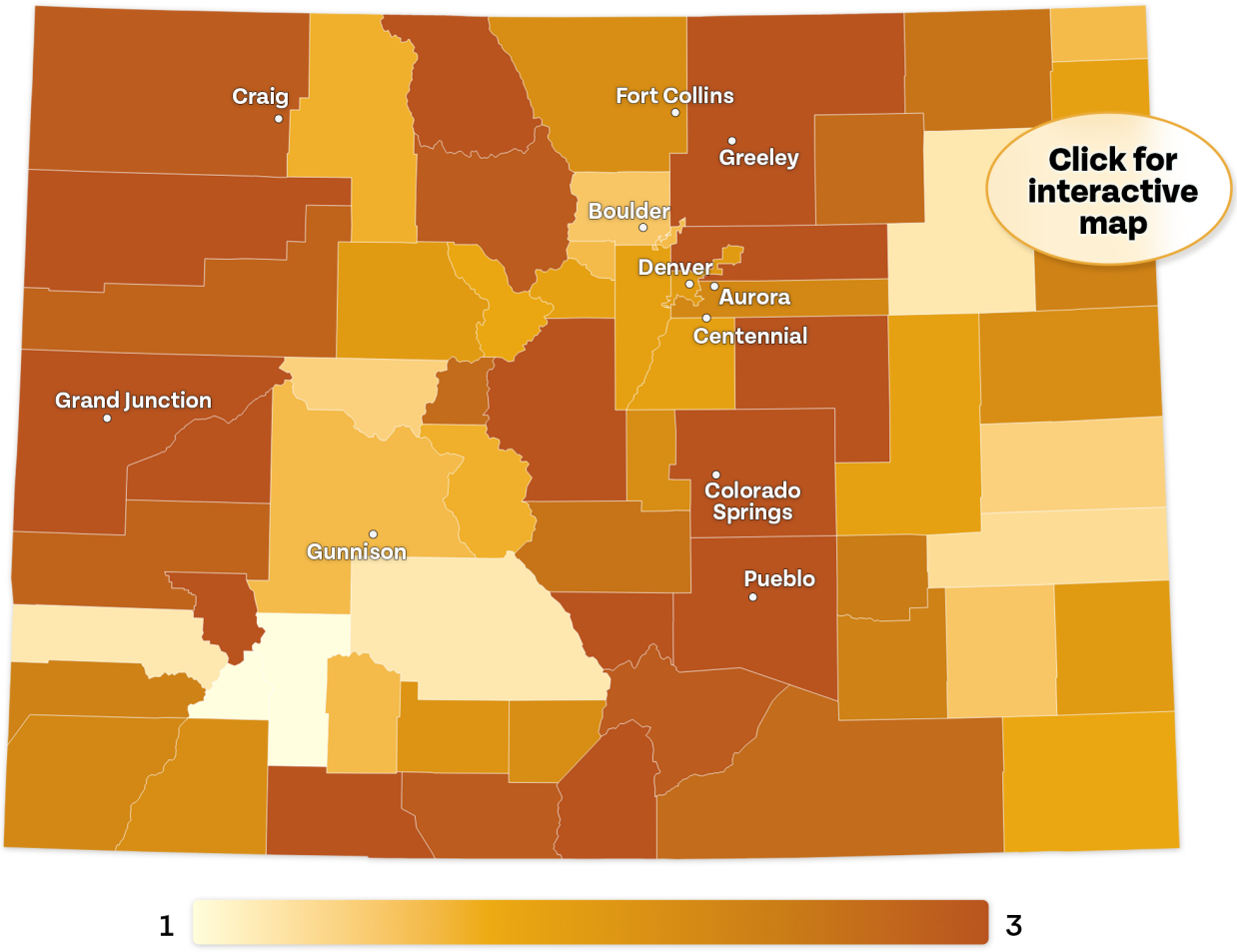
Child Care Deserts

It is clear that there is a gap between the need and availability of care. However, the struggle in accessing care is not experienced equally across the state.

There has been significant research regarding child care deserts. Definitions vary, however for this brief, we define a child care desert as a community or area with three or more children 5 years old and younger for each available child care slot.

Child Care Deserts

Number of Children per Licensed Child Care Slot (ranging from 1 to 3 or more children)



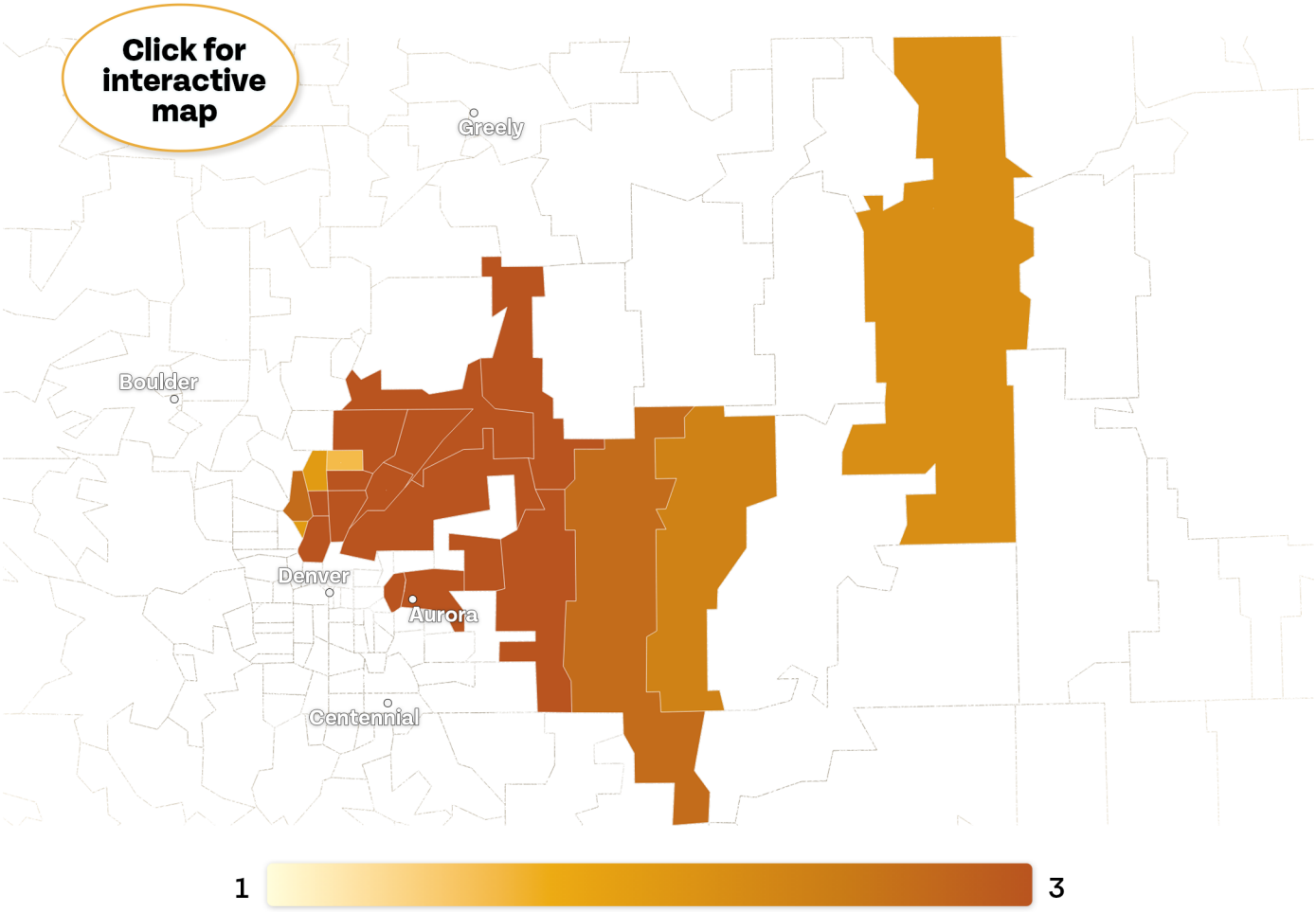
Source: Bell Policy Center analysis of State Demography Office population estimates (2023) and Department of Early Childhood's licensed capacity (2023)

The map above highlights the degree to which Colorado counties are experiencing a lack of licensed ECE providers, ranging from one child five or under for each available child care slot to three or more children five and under for one available licensed child care slot. While only a handful of Colorado counties are considered deserts, it should be noted that almost all counties still have a significant gap in licensed child care with two children per available slot. Notably, only two counties have enough licensed child care capacity to serve the number of children in the county: Hinsdale and San Juan, both of which have fewer than 30 children age 5 and under.

Many of the counties that are child care deserts are considered rural or frontier counties, while the Front Range, Denver to Larimer County, and some urban counties have fewer child care deserts. Using 2021 census data, the counties experiencing more severe care gaps or child care deserts generally have lower median household incomes and have larger Hispanic populations. This fits the national trend that finds families in rural areas face the greatest challenges and have the highest concentration of child care deserts, while high-income suburban areas are the least likely to have child care shortages. However, if data in urban areas is further disaggregated, it is also clear that many of these communities experience significant child care gaps. Notably, those who live in the lowest income urban neighborhoods are almost as likely to experience child care deserts as rural areas. Below, Adams County, which is considered to be a child care desert, is disaggregated by zip code and shows that within the county, residents do not experience child care deserts equally.

Adams County Child Care Deserts

Number of Children under 6 for Every Licensed Child Care Slot (1 to 3 or more)

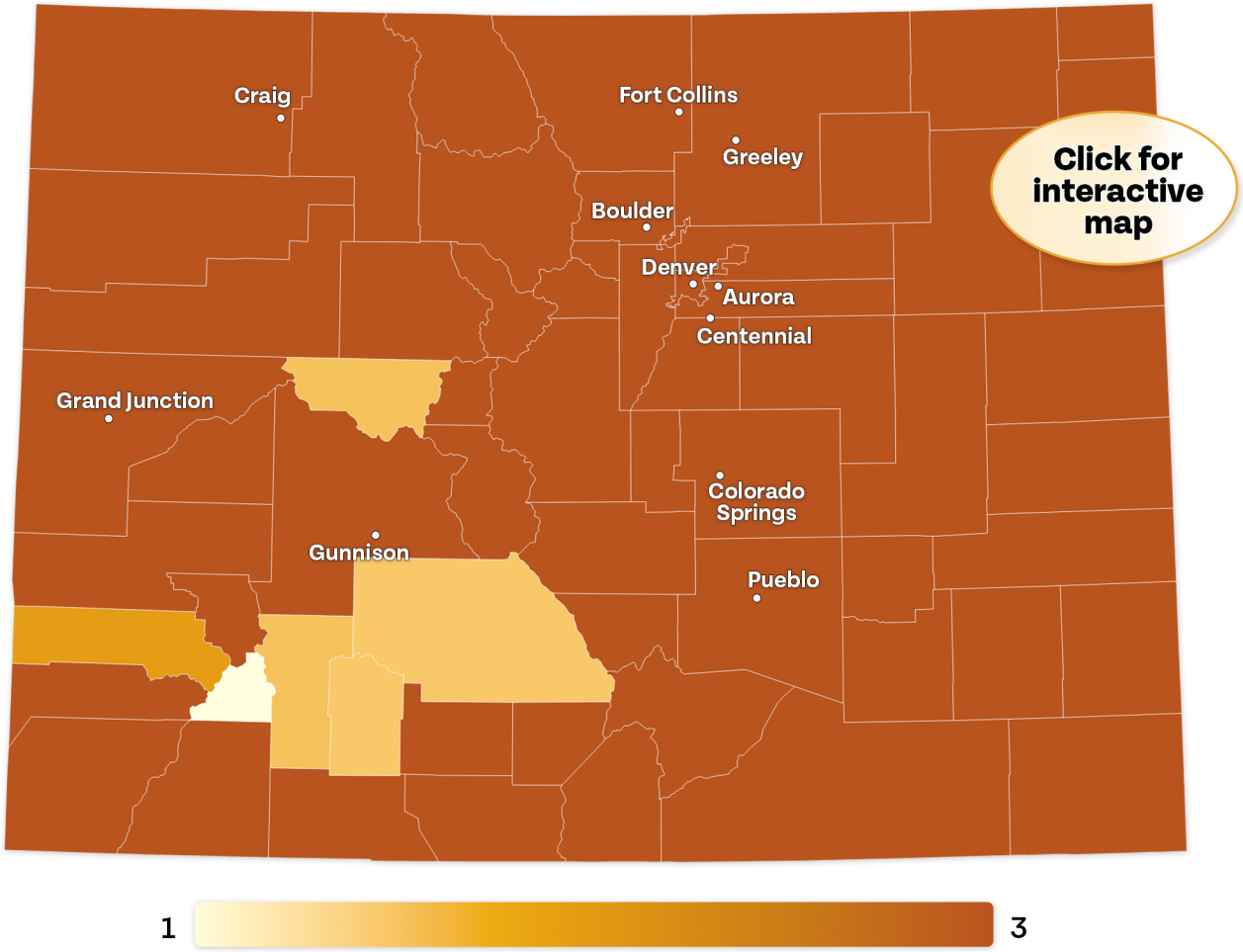


Source: Bell analysis of 2021 American Community Survey data and Department of Early Childhood's Licensed Capacity (2023)
Note that some zip codes overlap with other counties (such as Weld and Morgan counties. Weld County is also considered a child care desert while Morgan County is just below the child care desert definition)

The prevalence of child care deserts also looks different if the gap of licensed child care slots is broken down by age. The image below shows which counties are considered child care deserts specifically for infant and toddler care.

Infant/Toddler Child Care Deserts

Number of Infants/Toddlers per Licensed Infant/Toddler Child Care Slot (1 to 3 or more)



Source: Bell analysis of State Demography Office population estimates (2023) and Department of Early Childhood's licensed capacity (2023).

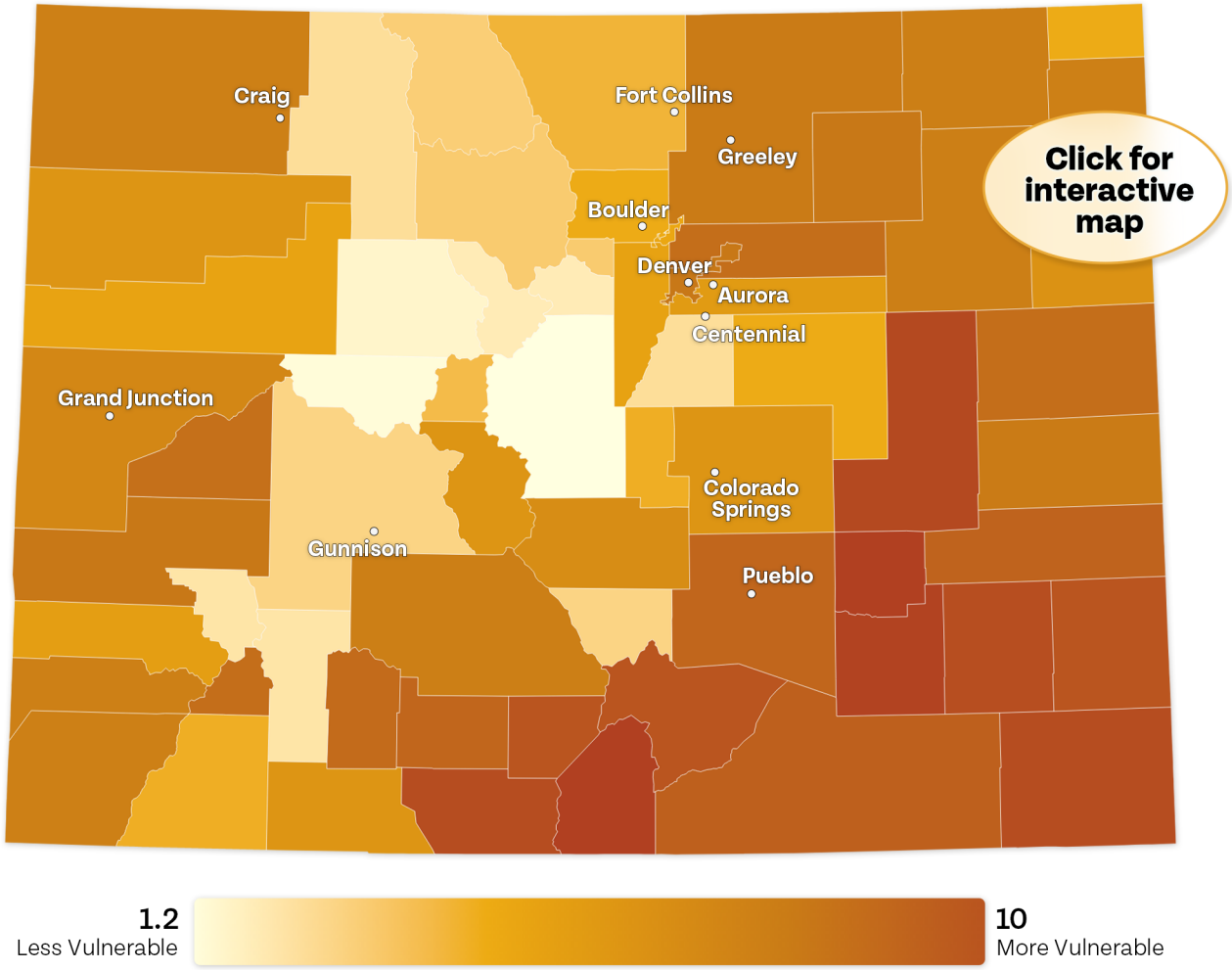
Almost every county in Colorado is considered a child care desert for licensed infant and toddler care, with three or more children ages 0 to 2 for every licensed slot. The supply of infant and toddler care is generally more limited compared to care for older children because it is more costly to provide care for infants and toddlers as it requires a higher staff ratio per child.

Though these analyses provide valuable information, it should be noted that child care deserts are not a perfect measure of the adequacy of supply. For example, child care deserts are determined by looking at the availability of care compared to the number of children who live in a county or zip code. However, families and parents may cross these boundaries when accessing care for their children.

Direct Care Deserts

The direct care system is much more fragmented compared to the ECE system, as direct care workers often travel from client to client, rather than recipients of care traveling to a care facility (though this can still happen, depending on the type of care). Therefore, deserts cannot be identified in the same way as ECE care deserts. The degree of the care gap instead can be understood by looking at the number of people 65 years old and older for every direct care worker across the state in conjunction with the vulnerability index created by the Colorado Health Institute (CHI). Included in CHI's vulnerability index are the prevalence of need factors (physical or cognitive difficulties) in each county. This offers insight into where there is a need for care while the number of older adults to every direct care worker provides insight into where there is significant infrastructure to provide this care. Though, it should be noted that the vulnerability index is meant for Coloradans 65 and older and does not include people with disabilities.

Colorado Health Institute Vulnerability Index

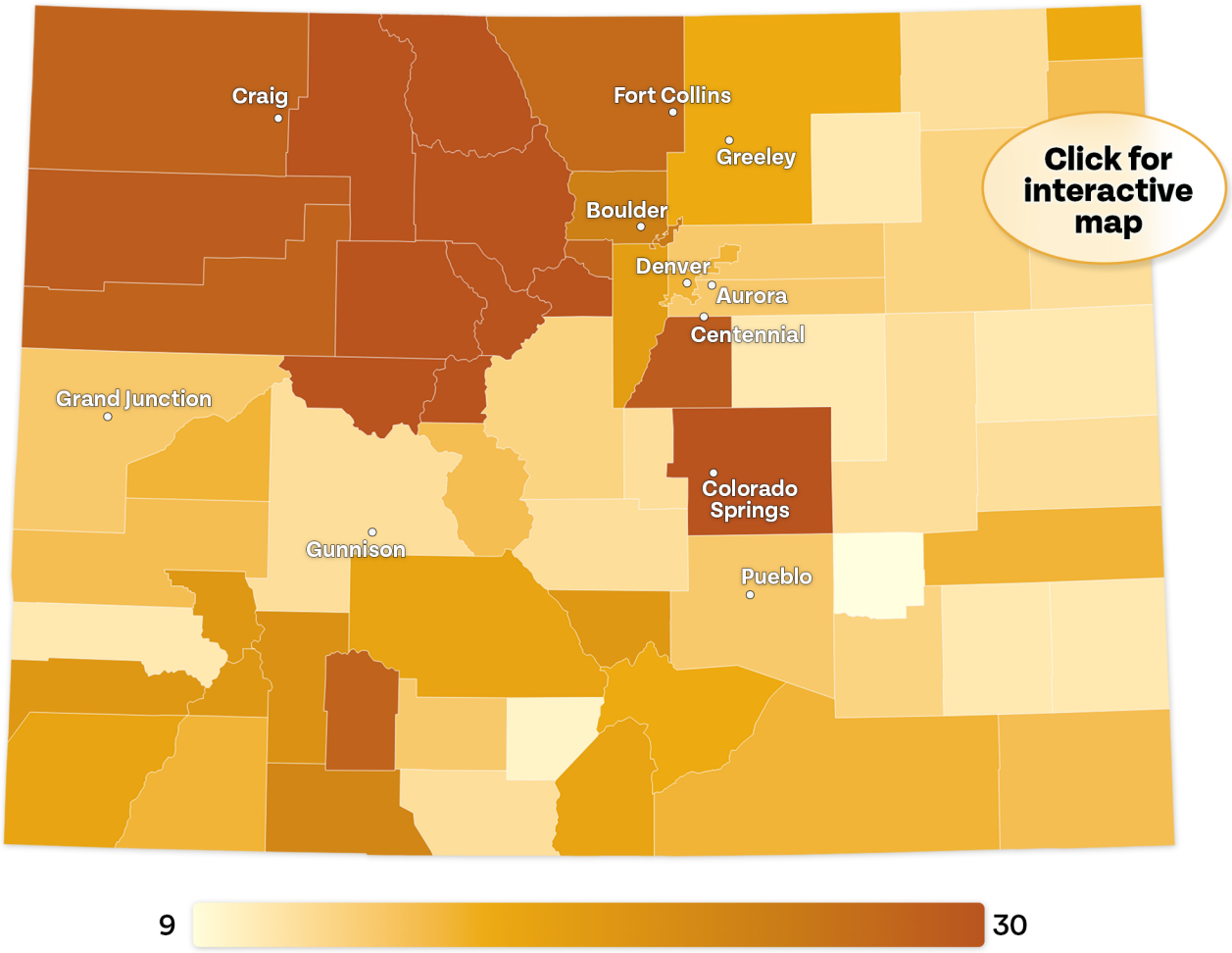


Source: Colorado Health Institute

Based on the vulnerability index above, residents in the southeast and San Luis Valley have the highest needs, and the lowest need is in the Front Range and mountain regions. For example, Crowley County (in southeast Colorado), has the highest need as 40 percent older adults have physical difficulties, 28 percent have cognitive difficulties, and 32 percent have challenges living independently. In comparison, Park County (in the mountain region) has the state's lowest need with 11 percent of older adults experiencing physical difficulties, 2 percent with cognitive difficulties, and 1 percent with self-care limitations.

To determine whether the supply of direct care workers matches identified need, the map below charts the number of direct care workers per Coloradan 65-plus. As can be seen in this map, the northwest region of Colorado has the least number of direct care workers per older resident, where there are approximately 30 or more older Coloradans for every direct care worker. However, almost all counties in the state have at least 10 older adults for every care worker. In southeast Colorado, where there is the highest need, there are, on average, 13 older adults for every care worker.

Number of people 65+ for every Direct Care Worker



Source: Bell Analysis of CHI's "Closing the Care Gap" and State Demography Office's 2021 population estimates

Further data is needed to identify gaps in direct care. However, these two charts, taken together, suggest that outside of the Front Range and mountain counties, most of the state is experiencing a mismatch between the supply and the need for direct care, though the northwest and southeast regions may experience challenges in accessing care more severely. While southeastern Colorado and the San Luis Valley are experiencing a ratio of direct care workers to older adults similar to other regions in the state, it has the highest demand for care. Conversely, the northwest region sees a much higher number of older adults for every direct care worker but reflects a similar needs level to other regions of the state. Due to different reasons, people in both areas are likely to face more challenges accessing necessary care. The areas of Colorado with a more strained supply of direct care also are counties with lower median household incomes. Additionally, the counties with the highest need for care have larger Hispanic populations.

Medicaid's HCBS waivers are also not used or accessed equally. For instance, users of the HCBS waivers are more likely to be white and English-speaking compared to the overall population as well as the Medicaid population. HCPF is currently conducting an equity study to understand why this is the case, but it reflects additional challenges in accessing direct care for some communities.

Is Care Supporting and Meeting the Needs of Coloradans?

To meet the second component of accessibility, care must be culturally responsive, must fit family scheduling needs, and meet the learning and health needs of recipients. Notably, to access care that meets these qualifications, families often look outside of formal, licensed systems and toward the informal care provided by friends, families, and neighbors (FFN). As the Bell has previously reported with respect to ECE, FFN care is relied upon more often by families of color and families with low incomes. This trend is similar in direct care as well.

In ECE, informal care can better meet the needs of parents searching for child care who have nonstandard schedules (work hours outside of 8 a.m. to 6 p.m. or weekends). Nationally, only 8 percent of center-based ECE providers and 34 percent of licensed home-based providers offer care during nonstandard hours, while 43 percent of children under 18 have parents that work nonstandard hours. Parents working nonstandard hours have limited options for receiving licensed child care during the evenings or weekends and therefore are often more reliant on FFN care.

Seeking informal care also allows families and parents to choose a care provider that speaks their preferred language and has shared cultural understanding. Immigrant, specifically low-income immigrant communities, and dual language families are more likely to rely on FFN care due to a lack of multilingual staff and culturally responsive care in a facility setting. Informal caregivers may be more prepared or already have the desired skills to provide culturally responsive care, despite initiatives to increase cultural responsiveness in formal care

While informal care is an important source of flexible, culturally appropriate child care, formal settings are also able to provide this type of support. The Colorado Shines Quality Rating (QRIS) program, which all licensed ECE providers are subject to, requires certain trainings if providers are to increase their quality ratings. Training options include cultural responsiveness, many of which are provided in English and Spanish. The state has also developed Colorado Early Learning Guidelines that outline the development of children birth through 8 years of age and provide resources to families, caregivers, and educators that are designed to be responsive to diverse needs regarding culture, language, and ability.

For direct care, without informal caregivers, many aging adults would not have the necessary support needed to age in the community of their choice. Due to a variety of factors, including cost and limited availability of paid direct care workers, one in four older adults relies on care from someone other than a paid care worker each day. These informal care providers, whether they are neighbors, friends, or family members, allow older adults to remain in their community of choice and better meet their needs. As the Bell has documented, however, these caregivers often would benefit from a more extensive set of resources so they can continue providing the flexible, tailored care their family members need.

While not specific to direct care, CHI finds that 74 percent of Coloradans receive responsive health care that meets their needs. The state has also started to discuss and implement culturally responsive practices across a range of fields and sectors, which is further described below. These initiatives, in both ECE and direct care, likely increase the cultural responsiveness of formal care; however, because cultural needs vary based on the individual receiving care, it is difficult to identify, in a systematic way, parent and family choice and which providers are offering and using culturally responsive care guidelines.

There is no consensus on what participation rates for formal or informal care should be. Accessibility of care is about ensuring that there are sufficient options and choices for people to make the best decision for their care, and that those providing care are supported in doing so. While formal care settings have the tools to meet different needs and provide culturally responsive care, they are unable to offer this to everyone who needs it. Informal care is filling an important gap. Families report choosing FFN care not only because it is easier to find in some cases, but it is high-quality, competent care that meets their specific needs. Better data is needed about informal care workers to better support families and people in search of care and to better understand the need for care.

> *"Nationally, only 8 percent of center-based ECE providers and 34 percent of licensed home-based providers offer care during nonstandard hours, while 43 percent of children under 18 have parents that work nonstandard hours."*

How is Colorado Addressing Issues of Accessibility?

Recently, Colorado has taken important steps to increase the accessibility of care across the state, as outlined in the table below.

Initiative	Description	Impact
HB20-1002 Emerging and Expanding Child Care Grant Program	Grant created in 2020, helps providers start or expand their child care business, with a priority for providers in areas considered child care deserts.	In its first two years of implementation, 6,000 new child care slots have been or will be created (some are in construction or licensure process). 1,600 of the slots are for infants and toddlers.
Colorado's Universal Preschool Program	In addition to provider reimbursement rates provided by CDEC, one-time provider bonuses will be distributed by tiers, and are stackable. The one time bonuses are prioritized for providers of infant and toddler care and providers in areas with low preschool capacity.	These bonuses will help providers either maintain or expand infant and toddler capacity. Given the strained supply of infant and toddler care, these bonuses will help increase access to infant and toddler care slots. Additionally, they should increase accessibility in areas with low capacity with additional funds to maintain or expand their preschool child care slots.
2021, American Rescue Plan Act (ARPA) funds	ARPA funds were used to set a temporary $15 base wage for direct care workers along with other workforce initiatives.	Workforce initiatives and increased wages will aid in recruitment and retainment of direct care workers. With a more robust direct care workforce, there will be increased accessibility due to a reduced workforce shortage.
HB22-1267 Culturally Relevant Training Health Professionals	In 2022, $900,000 in grant funding was distributed to nonprofits and statewide provider associations to develop and train on culturally responsive care.	Development and increased training on culturally responsive care will increase the number of providers and direct care workers who are able to provide culturally relevant and responsive care.

Conclusion

Accessible care across the lifespan is essential for the health and well-being of our state. Yet, it remains elusive for many. While the state has made efforts to increase the accessibility of care, many of these efforts have impacts yet to be seen as they are in the early stages. Given the acute gap of accessible care, continued efforts are necessary. In addition to funding initiatives, a greater effort in data collection is needed. With more comprehensive and consistent data collection, policy makers can identify and target where and how to most effectively allocate support and resources to increase the accessibility of care.

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