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Safety Net Primer 2016

Practice Transformation

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Safety Net Clinics Leading the Charge for Practice Transformation

Over the past five years, Colorado has witnessed many innovative efforts to transform the practice of primary care in order to improve quality, enhance patient health, and reduce costs.

Colorado's safety net clinics are no stranger to the wave of primary care transformation underway across the state and nation, but they face unique challenges. Many have tight budgets and must find extra funding just to keep the lights on, let alone undertake structural changes or buy new equipment. Implementing change while treating patients can make clinicians feel they are building the plane while flying it. And practice transformation takes time, a precious commodity in a busy clinic.

Despite all this and more, safety net clinics are exploring and implementing promising ways to improve care for their patients, who are among the most vulnerable in the state, and get the best value at the same time.

This issue brief by the Colorado Health Institute (CHI) offers a primer on practice transformation among Colorado's safety net clinics. It contains an overview of initiatives, discusses the challenges and benefits of change, and includes a snapshot of Colorado's health care safety net, who it serves and how it's funded.

Transforming Practices: Different Methods, Similar Goals

Practice transformation is not a new concept, but was greatly accelerated by the Affordable Care Act (ACA). In 2010, the ACA created a new "Innovation Center" within the Centers for Medicare & Medicaid Services with a 10 year, $10 billion budget. The Innovation Center and ACA have since funded federal practice transformation initiatives such as the State Innovation Model (SIM), EvidenceNOW Southwest, and the Transforming Clinical Practices Initiative (TCPi).

At the state level, Colorado launched the Medicaid Accountable Care Collaborative, which is designed to improve health outcomes and quality of care by connecting Medicaid enrollees to a regular source of primary care. There are also a number of philanthropic efforts aimed at practice transformation. For more information on some of these programs, see our break-out box on Page 3.

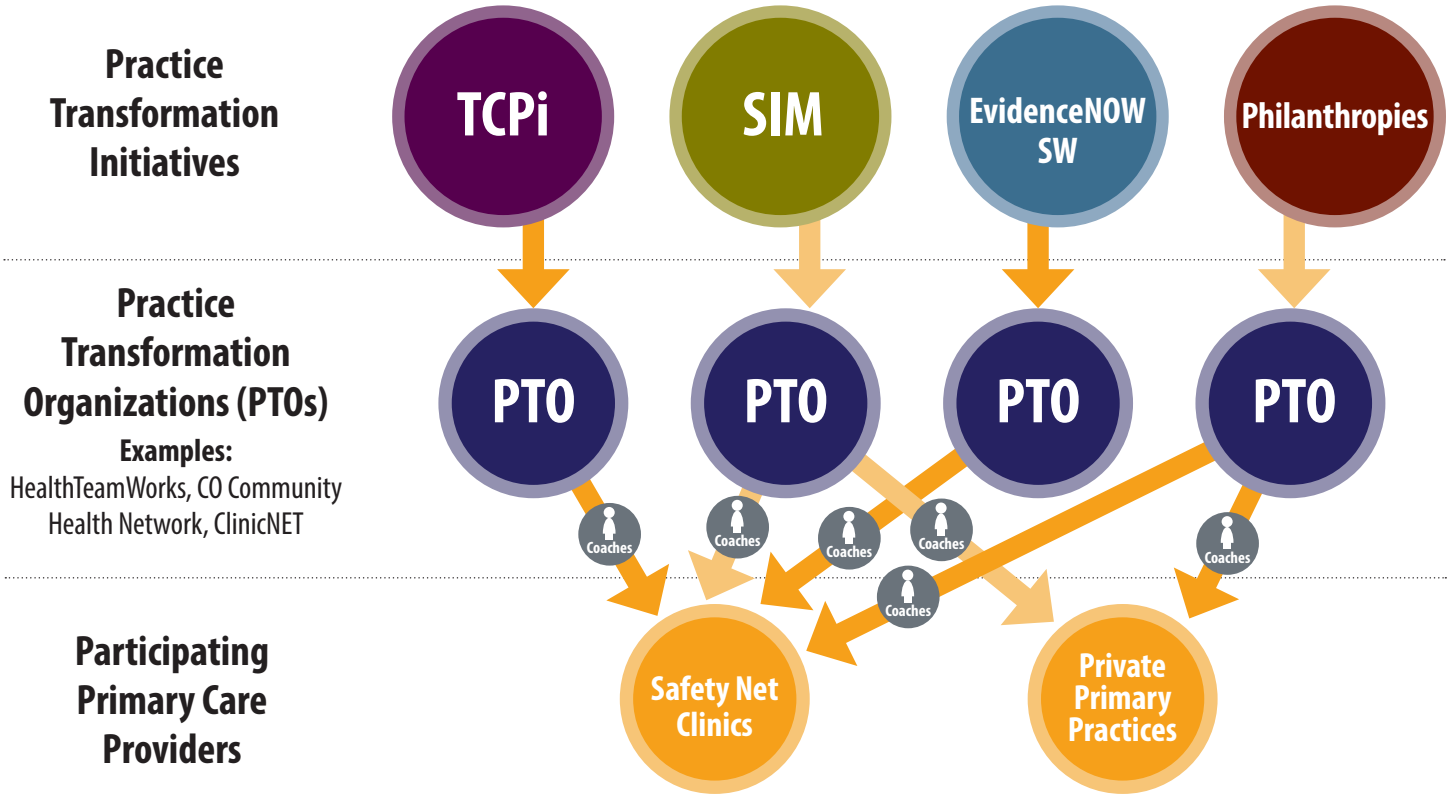
Practice transformation comes in many shapes and sizes, but the goals are largely the same: to improve the quality of health care while reducing system costs.

For example, some programs work with primary care providers to integrate physical and behavioral health care. That way, patients who need both types of services can receive them in the same visit. Other initiatives are aiming to improve population health by tracking health trends and providing evidence-based interventions. This could mean addressing the prevalence of heart disease by prescribing an aspirin regimen for at-risk patients. Or prescribing a weight-loss program for patients at risk for diabetes.

Many of these federal and state programs contract with Practice Transformation Organizations (PTOs), local organizations that help clinics implement new ways of providing care. PTOs are often Colorado-based organizations that specialize in improving clinical quality and efficiency. Some examples include HealthTeamWorks, ClinicNET and the Colorado Community Health Network.

Many safety net clinics in Colorado participate in more than one practice transformation initiative. That means that they may be working with multiple PTOs. Figure 1 illustrates the relationships between the initiatives, PTOs and safety net clinics.

Figure 1. General Structure of Practice Transformation Efforts



Each PTO hires or contracts with coaches to guide clinic staff through the process of practice transformation. Coaches meet with clinics regularly to monitor progress and help them with everything from electronic health records (EHR) to tracking heart disease in a population. One practice transformation coach we spoke with even developed an electronic patient empanelment program for Clinica Tepeyac, a safety net clinic in Denver. This software program pairs each patient with a team of clinicians who can provide consistent care and address a wide array of health needs.

Leading the Charge

In many ways, safety net clinics are well-positioned to engage in practice transformation. They often serve high-need patients who rely on Medicaid or have no health insurance coverage or not enough of it. As a result, their budgets are stretched, so the prospect of greater efficiency through practice transformation is appealing.

In addition, safety net clinics are often not associated with large hospital systems. Therefore, they can carry out practice transformations like team-based care, integration of services and data tracking without having to wade through red tape.

In Colorado, most safety net clinics are engaged in some type of practice transformation. Many have set up EHR systems that can track population health and coordinate interventions and preventive care. Some systems allow patients to go online to pay bills, access resources, see their health records and schedule appointments.

The Rocky Ford Family Health Center has been successful using EvidenceNOW Southwest programs to educate their patients about cardiovascular health. Owner and clinician Doug Miller told us, "We are forceful about trying to treat cholesterol. With evidence, we can show [patients] that they should."

Team-based care, a hallmark of practice transformation, brings together physicians, physician assistants, nurses, and community health professionals to optimize patient care. In safety net clinics that care for minority patients, this approach can overcome language barriers by pairing patients with teams whose members speak their patients' preferred language. Plus, it allows patients to become comfortable with the same providers over multiple visits and supports continuity of care.

Possibly the most substantial change is the transition to integrated care. Patients in integrated care clinics, for example, can get immunizations from their primary care provider, their teeth cleaned by a dental hygienist, and

a behavioral health evaluation from a specialist all in the same visit. This saves the patient and clinicians time and expense.

The benefits of this one-stop-care experience have been especially evident in the safety net population. These patients often have complex health care needs and may face barriers in accessing other types of care. Integrating services allows clinicians to coordinate care, address health care needs in the same location and reduces the chance that a patient may not show up for an off-site referral.

Practice Transformation Challenges

Implementing a transformation initiative can be difficult for any practice. However, safety net clinics face unique challenges – namely with a lack of resources tied to the vulnerable populations they serve. These include Medicaid enrollees and patients who are uninsured and underinsured. Some safety net providers — such as federally-qualified health centers (FQHC) and certified rural health clinics (see Page 5) — receive additional Medicaid reimbursement that helps offset the cost of caring for the uninsured. Other community safety net

Five Practice Transformation Initiatives

This list illustrates the variety of practice transformation efforts in which many Colorado safety net providers participate. It is not an exhaustive list.

Colorado State Innovation Model (SIM)

- **Goal:** 80% of Coloradans have access to integrated behavioral and primary health care.
- **Funded by:** The Center for Medicare and Medicaid Innovation
- **Practices Involved:** 400 practices enrolled over three years – 2016, 2017, 2018
- **Interventions:** Practice transformation support, payment reform, health technology support and population health advancement.

Transforming Clinical Practices Initiative (TCPi)

- **Goals:** Prepare practices for technical changes associated with practice transformations.
- **Funded by:** Center for Medicare and Medicaid Innovation

Practices Involved: 2000 practices

- **Interventions:** Provide facilitation to prepare clinics for payment reform and other practice transformation efforts.

Evidence Now Southwest

- **Goals:** Improve cardiovascular health in at-risk populations.
- **Funded by:** The Agency for Healthcare Research and Quality
- **Practices Involved:** 208 in Colorado and 52 in New Mexico
- **Interventions:** Support cardiovascular disease prevention through evidence-based interventions and monitoring ABCS – aspirin, blood pressure, cholesterol, smoking

Medicaid Accountable Care Collaborative

- **Goals:** Improve the health of Medicaid members
- **Funded by:** Colorado Department of Healthcare Policy and Financing
- **Delivery:** Seven Regional Care Collaborative Organizations provide assistance to clinics in their regions
- **Interventions:** Coordinate resources to provide comprehensive health and wellness care to Medicaid patients.

The Colorado Health Foundation Team-Based Care Initiative

- **Goals:** Give underserved populations access to clinical team-based care.
- **Funded by:** The Colorado Health Foundation
- **Practices Involved:** 30 practices around Colorado that serve significant populations of underserved patients.
- **Interventions:** Provide financial assistance and coaching to help practices achieve team-based care.

clinics receive little or no reimbursement for serving these populations. Or they cite Medicaid reimbursement that is not sufficient to cover their costs. As a result, a number of safety net clinics around Colorado have recently sought a FQHC designation from the federal government. Strapped budgets like these may make it difficult for safety net clinics to transform their practices despite varying levels of financial support from the initiatives.

Practice transformation has brought about a noticeable change in the philanthropic community. Many of the grants that once supported general operations of safety net clinics are now being tied to practice transformation in an effort to improve health outcomes. While many safety net clinics agree with the goals, they find it challenging to find alternate revenue sources to support general operating costs while implementing practice transformation.

Lack of time is another barrier that is cited often. Some clinics find it difficult to take time away from patient care to attend weekly and monthly meetings required by the initiatives. Transformation coaches are assigned to clinics to help implement changes and monitor progress. But occasionally, lack of coordination between the PTOs has made it even harder for clinics to keep up. For instance, several PTOs – each representing a different initiative –might ask a clinic to report hypertension data, but each wants the data in a different format and at a different time. As a result, clinics end up reporting similar data twice. Some initiatives have recognized these challenges and are starting to coordinate their efforts by standardizing some meeting and reporting requirements for clinics.

Perhaps the greatest challenge facing the long-term sustainability of practice transformation is payment reform. Currently, Medicaid pays most clinics on a "fee for service" basis, meaning that each service provided is reimbursed according to a set amount. However, some integrated services are not currently reimbursable. This presents a problem for clinics attempting to integrate behavioral health or dental care because they cannot bill for these services.

A few practice transformation initiatives are attempting to address this issue. For example, the ACC started a pilot program on Colorado's Western Slope called Medicaid Prime. Participating providers receive a single payment to cover both physical and behavioral health services. This "global" payment allows greater flexibility for providers to integrate services, while incentivizing them to improve coordination of care and health outcomes for their members.

Staff and Patient Responses

Patients and staff have generally responded well to practice transformation efforts. Patients like that they can save time by making one appointment to get primary, behavioral, and dental care. Without integration, many patients would not have access to these services – let alone at the same location. In the safety net community, this is not something they're used to. Bebe Kleinman, CEO of Doctors Care clinic in metro Denver, told us, "At Doctors Care, Medicaid patients are treated as well as patients seen in private practice – and they are sometimes surprised by that. We strive to provide a completely different experience. We want to make it feel like a private practice."

Clinicians have also been receptive to the change, but say that it has been a challenge keeping up. A number of clinics expressed that, after months of participation, they were experiencing change fatigue. As Jessica Dunbar from Rocky Mountain Youth Clinics put it, "With all the change that's happening, even when you believe in it, it's a lot to handle."

Conclusion

As the primary health care providers for Colorado's most vulnerable populations, safety net clinics continually strive to find innovative ways to improve patient health on tight budgets. From integrating practices to tracking population health, limited resources have not stopped them from taking part in practice transformation initiatives. These initiatives are changing the way Colorado's safety net clinics practice medicine.

However, safety net clinics will continue to face challenges. With limited resources, implementing any new program may be difficult for safety net clinics. After launching the program, the next step for clinics — and evaluators of these initiatives — is figuring out the return on investment. In what way did their efforts make a difference? Doug Miller at Rocky Ford Family Health Center, simply noted that "In ten years, if my patients are still functioning where they need to be, then I'll know we did a good job with these programs." It may be that only time will tell how effective they are. The Colorado Health Institute will continue to monitor how these initiatives are playing out with an eye towards the future.

PRIMER

Colorado's Health Care Safety Net

What is the Safety Net?

Providers and clinics offering 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. Some communities may have a number of safety net providers, while others may have only one or two.[1]

Safety Net Providers

- **Community Health Centers (CHCs)**, also known as Federally Qualified Health Centers (FQHCs): Primary care, including preventive physical, dental and behavioral health services. Located in medically underserved areas and among medically underserved populations.
- **Community Mental Health Centers:** Outpatient, emergency, day treatment and partial hospitalization mental health and substance use disorder services for low-income residents of designated geographic service areas.
- **Community-Funded Safety Net Clinics (CSNCs):** Free, low-cost or sliding-fee primary care services for low-income and uninsured families and individuals. Can include faith-based clinics, those staffed by volunteer clinicians and family practice residency clinics.
- **Community-Based Dental Clinics:** Dental services for low-income uninsured Coloradans.
- **Critical Access Hospitals:** Rural hospitals with no more than 25 beds located 35 miles or more, or 15-plus miles of mountainous terrain, from another hospital.
- **Emergency Departments of Community and Public Hospitals:** Emergency medical care regardless of ability to pay or insurance status.[2]
- **Local Public Health Departments and Public Nursing Services**: Limited primary care services, varying by community. May include health assessments and screenings for Medicaid children,[3] immunizations, family planning, oral health, cancer screenings and testing for sexually transmitted diseases and HIV.
- **Rural Health Clinics (RHCs):** Primary care services, differing by clinic. Located in non-urbanized areas with documented shortages of health care providers and/or medically underserved populations.
- **School-Based Health Centers (SBHCs):** Primary health care services in schools with many low-income children, including immunizations, well-child checks, sports physicals, chronic care management for conditions such as asthma and diabetes and acute medical care. May also include mental and dental care, substance use disorder services and violence prevention.

Who Uses the Safety Net?

Coloradans most likely to use the safety net are low-income, uninsured or underinsured, as well as those covered by public health insurance. CHI has defined medically vulnerable as having one or more of these characteristics:

- Incomes below 300 percent of the federal poverty level (FPL) - $72,900 for a family of four in 2016;
- No insurance;
- Enrollment in a publicly financed health insurance program or high-deductible health plan;
- A geographically isolated location;
- No regular source of primary care.
- Cultural, language and other social barriers.

Uninsured Coloradans

Colorado's uninsured residents are frequent users of the state's safety net. A CHI analysis, Uneven Progress: Health Insurance by Zip Code in Colorado, found

Figure 2.
Medically Vulnerable Coloradans by Category[4]

Income <300% of FPL	3,249,000
No Insurance	353,000
Average Monthly Medicaid Enrollees	1,297,000
Average Monthly CHP+ Enrollees	51,000
Living in Rural Area[5]	694,000
Speak English Less Than "Very Well"	312,000

NOTE: Values are rounded. People may be included in more than one category. Income and uninsured values are from the 2015 Colorado Health Access Survey (CHAS). Medicaid and CHP+ reflect average monthly enrollment for fiscal year (FY) 2015-16.

six socioeconomic factors are the best predictors of whether a Coloradan living in a particular community will be uninsured:[6]

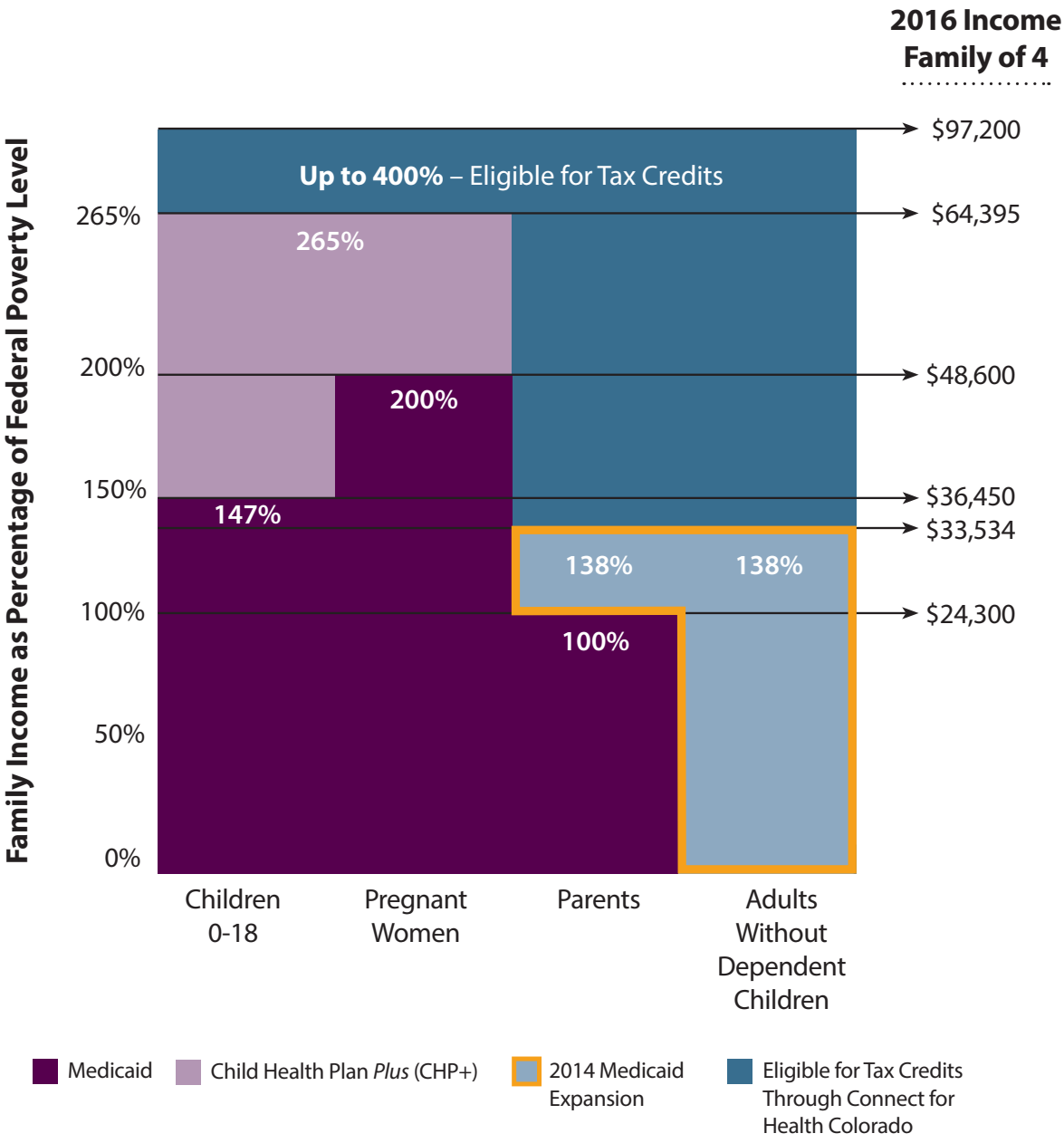
- **Poverty:** In 2015, more than one of ten Coloradans (10.6 percent) with family incomes below 100 percent of the FPL - $24,300 for a family of four in 2016 - were uninsured. Poverty is the most important predictor of being uninsured in Colorado.
- **Spanish spoken at home:** In Colorado about 555,000 residents (10.5 percent), most of whom are Hispanic, speak Spanish at home. Those who speak Spanish at home are disproportionately uninsured.
- **Renting:** Coloradans who rent have a greater chance of being uninsured even after adjusting for age and income. This may reflect the fact that most of their income goes to paying for housing and utilities leaving them with less money to spend on health insurance.
- **Unemployment:** Most Coloradans rely on their employer for health insurance. In 2015, approximately 21 percent of the unemployed who were looking for work did not have health insurance.[7]
- **Age:** Communities with primarily pre-retirees with a median age between 46 and 58 and those with mainly "young invincibles" between 20 and 37 are most likely to be uninsured. Young invincibles have historically had the highest level of uninsurance. The 2014 Medicaid expansion extended eligibility to many low-income adults without dependent children, likely effecting both of these age groups.
- **Household size:** Individuals who live in the smallest households, those with one or two people, are more likely to be uninsured than individuals in larger households. Because Colorado has made great strides toward getting most children covered, members of larger households with children are less likely to be uninsured.

Covered by Public Health Programs

Coloradans covered by public health insurance may have difficulty finding providers who will accept their coverage, so they often use safety nets. The public insurance programs are:

- **Medicaid:** A state/federal partnership that provides health care coverage to low-income Coloradans. Colorado expanded Medicaid eligibility in January 2014, leading to a 72 percent increase in enrollment from December 2013 to June 2016. The expansion primarily affected low income, working age adults without dependent children. Coverage includes certain preventive services, primary and acute care, dental care, behavioral health care and long-term care in a nursing home or in the community. Enrollees: Monthly average of about 1,300,000 in fiscal year (FY) 2015-16.[9]
- **Child Health Plan Plus (CHP+):** A state/federal partnership providing health care coverage to low-income children ages 0-18 with family incomes between 148 percent and 265 percent of the FPL and pregnant women with incomes between 200 percent and 265 percent of the FPL ($64,395 for a family of four in 2016). Coverage includes inpatient and outpatient hospital care, physician services, prescription drugs and a limited dental and mental health benefit for children only. Congress has extended funding for CHP+ until 2017. After that, if the program is not funded again, parents of children enrolled in CHP+ will likely need to look elsewhere for health insurance, such as the online insurance marketplaces. **Enrollees:** Monthly average of about 51,000 in FY 2015-16.[10]
- **Colorado Indigent Care Program (CICP):** A state program that partially reimburses certain high-volume hospitals and clinics for uncompensated care provided to patients who are uninsured or underinsured, have limited assets and have incomes at or below 250 percent of the FPL. Fewer individuals qualify for CICP now that more are eligible for Medicaid. Beneficiaries: Around 186,000 doctor's office visits and admittances were reimbursed by CICP in FY 2014-15, a 60 percent decrease from FY 2013-14.

Figure 3. Eligibility Levels for Medicaid, CHP+ and Tax Credits for Private Insurance, Colorado, 2016 [11]



Note: Medicaid and CHP+ eligibility levels reflect new methods of calculating income under the Affordable Care Act and Modified Adjusted Gross Income (MAGI). Does not include elegibility for Medicaid Long-Term Services and Supports.

Where Does the Money Come From?

Safety net providers rely on a variety of public and private funds and patient fees.

Funding Sources

- **Grants from the federal Bureau of Primary Health Care:** The federal government provides grant funding to community health centers, migrant health centers and the Health Care for the Homeless and Public Housing Primary Care Programs. Colorado received nearly $87 million in these grant funds in 2015.[13]
- **Block grants:** Colorado passes some of its federal block grant funding, including the Maternal and Child

Health Services Block Grant, Ryan White CARE Act[14] funds and the Preventive Health and Health Services block grant, to various safety net providers.

- **CHP+ funding:** About $167 million was spent for FY 2015-16 for CHP+ medical, dental, and prenatal premiums. This is a $5 million increase from last year. The state funds approximately one-third of the expenditures, while the federal government funds the remaining two-thirds.[15]
- **Disproportionate share hospital (DSH) payments:** These funds help states partially compensate hospitals providing a disproportionate share of medical care to uninsured indigent patients and Medicaid enrollees. The ACA decreased DSH payments due to the assumed increase in insurance coverage and therefore decreased amount of uncompensated care. Decreased DSH payments could have consequences for hospitals that rely on the DSH revenue for covering the remaining uninsured or underinsured.
- **Fees:** Most safety net providers employ a sliding-fee schedule based on a patient's income, offsetting a portion of the costs.
- **Foundation funding:** Colorado's philanthropic community provides support to safety net providers through grants and contracts. Foundation funding is often directed at specific health care needs of a local community or special population group.
- **Hospital fees:** The Colorado Health Care Affordability Act (CHCAA), passed in 2009, assessed a fee on Colorado hospitals, leveraging federal dollars to increase hospital reimbursement rates of publicly funded programs and funding Medicaid and CHP+ expansions. In the next year, look for continuing discussion regarding how hospital fees will be classified in the state budget.
- **Local public funding:** This funding fills gaps in services. The duration, type and level of financial support vary by community.
- **Medicaid funding:** Medicaid medical services premiums for providers amounted to more than $6.8 billion in FY 2015-16.[16] The state general fund covered about 30 percent of appropriations, while federal funds comprised approximately 60 percent.[17] In addition, behavioral health capitated payments were about $610 million.[18]
- **Tobacco Excise Revenues:** Amendment 35, passed by voters in 2004, increased the excise tax on tobacco products, with some of those revenues earmarked for safety net providers. In FY 2015-16, approximately one third ($29 million) of the Amendment 35 money went to clinics and hospitals offering health care services to the uninsured and medically indigent.[19] This year, Coloradans will vote on a ballot measure that would increase the excise tax by $1.75 per pack and raise approximately $315 million per year. [20]

Additional Resources

For additional resources and more information regarding Colorado's safety net, see:

- ClinicNET: http://www.ClinicNET.org
- Colorado Hospital Association: http://www.cha.com
- Colorado Behavioral Healthcare Council: http://cbhc.org/
- Colorado Coalition for the Medically Underserved: http://www.ccmu.org
- Colorado Consumer Health Initiative: http://www.cohealthinitiative.org/
- Colorado Community Health Network: http://www.cchn.org
- Colorado Association for School-based Health Care: http://www.casbhc.org
- Colorado Rural Health Center: http://www.coruralhealth.org
- Colorado Department of Health Care Policy and Financing
- Medicaid: https://www.colorado.gov/pacific/hcpf/colorado-medicaid
- CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
- CICP: https://www.colorado.gov/pacific/hcpf/colorado-indigent-care-program
- Old Age Pension Program: http://bit.ly/2aGlFf8
- Colorado Department of Public Health and Environment: http://www.cdphe.state.co.us

End Notes

[1] Institute of Medicine. (2000). America's Health Care Safety Net: Intact but Endangered. Washington, DC: National Academies Press. p.10. Retrieved July 22, 2015 from http://iom.nationalacademies.org/Reports/2000/Americas-Health-Care-Safety-Net-Intact-but-Endangered.aspx

[2] As a condition of receiving Medicare funds, hospitals must provide a medical screening examination to all individuals who enter the emergency room seeking treatment as required by the Emergency Medical Treatment and Active Labor Act (EMTALA). If the hospital determines that the individual is suffering from an emergency medical condition, the hospital must provide treatment until the patient is stable or transfer the patient to another hospital. More information available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305897/

[3] Screening and assessments are provided through the Early and Periodic Screening, Diagnosis and Treatment requirements outlined by federal Medicaid regulations.

[4] Sources: Income and uninsured data are based on the 2015 Colorado Health Access Survey. Medicaid and CHP+ data come from FY 2015-16 average monthly caseload figures from the Colorado Department of Health Care Policy and Financing. Language proficiency estimates are based on data from the U.S. Census Bureau's 2013 ACS and includes the population age 5 years and older who report speaking English less than "very well".

[5] U.S. Department of Agriculture. (2016). "State Fact Sheets: Colorado." (Retrieved August 8, 2016, from: http://www.ers.usda.gov/data-products/state-fact-sheets/state-data.aspx?StateFIPS=08&StateName=Colorado).

[6] Uneven Progress: 2015 Health Insurance by Zip Code in Colorado, December 2015 using the Colorado Health Access Survey. 2015. Denver, CO: The Colorado Trust. http://www.coloradohealthinstitute.org/uploads/postfiles/CHAS/CHAS_Zip_Code_2015.pdf

[7] This does not include the unemployed individuals who were not in the labor force

[8] CHI analysis of FY 2014-15 Medical Premiums Expenditure and Caseload Report. Colorado Department of Health Care Policy and Financing. Reference from July 2015. Retrieved July 20, 2015 from https://www.colorado.gov/hcpf/premiums-expenditures-and-caseload-reports

[9] FY 2015-16 Medical Premiums Expenditure and Caseload Report. Colorado Department of Health Care Policy and Financing. Reference from July 2016. Retrieved August 12, 2016 from https://www.colorado.gov/hcpf/premiums-expenditures-and-caseload-reports

[10] FY 2015-16 Medical Premiums Expenditure, July 2016.

[11] 2015 Poverty Guidelines. Office of the Assistant Secretary for Planning and Evaluation. Retrieved July 15, 2015 http://aspe.hhs.gov/poverty/15poverty.cfm

[12] Rural Assistance Center (August 3, 2011). "FQHC frequently asked questions." Retrieved July 22, 2015 from https://www.raconline.org/topics/federally-qualified-health-centers

[13] Health Resources and Services Administration. 2014 Health Center Colorado Data. Retrieved July 22, 2015 from http://bphc.hrsa.gov/uds/datacenter.aspx?year=2015&state=CO . Note: Total funding amount includes capital grants.

[14] These funds are targeted to people with HIV/AIDS.

[15] FY 2015-16 Appropriations Report, Colorado Joint Budget Committee, July 2015. Retrieved August 8, 2016 http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/FY15-16apprept.pdf

[16] FY 2015-16 Medical Premiums Expenditure, July 2015

[17] FY 2015-2016 Supplemental Requests and FY 2016-2017 Budget Amendments, Exhibit A: Calculation of Request, Calculation of Funds Split. Colorado Department of Health Care Policy and Financing. January 2016. Retrieved August 8, 2016 from https://www.colorado.gov/pacific/sites/default/files/PB-Schedule-02%20%28SUMMARY%29.pdf

[18] FY 2015-16 Appropriations Report.

[19] FY 2015-16 Appropriations Report.

[20] Denver Post. (2016). "New Proposed Tobacco Initiative Would Triple Cigarette Taxes In Colorado." (Retrieved August 10, 2016, from: http://www.denverpost.com/2016/07/06/cigarette-tax-colorado-initiative-143/)

CHI staff members contributing to this report:

Ian Pelto
Jeff Bontrager
Ashlie Brown
Maggie Bailey
Brian Clark
Cliff Foster
Deb Goeken
Rebecca Silvernale

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303 E. 17th Ave., Suite 930, Denver, CO 80203 • 303.831.4200
coloradohealthinstitute.org