The Health Care Environment in Colorado

Movement and Opportunities Towards an Improved System

Prepared by the Center for Improving Value in Health Care

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CENTER FOR IMPROVING
VALUE IN HEALTH CARE

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INTRODUCTION

The last few years have brought momentous change to health care. Implementation of the ACA is changing the way health care can be delivered and paid for and what services must be covered. Increased consumer focus on price and transparency, fueled by articles like Stephen Brill's "Bitter Pill", is highlighting the need to examine the costs and reimbursement for health care. There is strong concurrence that the current system is broken and the path to a solution includes improved care coordination, communication, and stronger partnerships with patients. Health care is moving towards integrated models of care supported by outcomes-based, value-driven payment systems with an emphasis on population health and outcomes rather than volume. There is no one right way to deliver or pay for health care, but there is a right direction to move. This overview examines the current state of health care across the state and highlights areas of change, directions of movement, and unresolved issues.

DELIVERY SYSTEM

Trends:

- Integrated primary care and behavioral health is a way of addressing high-cost patients with chronic conditions and co-occurring mental health or substance use issues.
- Hospital systems are expanding, employing physicians and taking out insurance licenses.
- Increased data availability is impacting care delivery and patient-provider interactions. Publicly available data on costs and outcomes are changing the medical decision-making paradigm.
- HIT/HIE adoption is expanding, but not universal. Optimal use of HIT is hampered by the expense of adoption and upkeep, and non-universal compatibility and connectivity.
- Patients want full access to their medical information, cost transparency and engaged doctors.
- Doctors are burning out from increased administrative tasks, insurance complexities and other issues.

Colorado's robust foundation of patient centered medical homes (PCMH) provides primary care services to much of the state. The movement towards a medical home structure for primary care began in 2009 with the multi-payer Primary Care Medical Home initiative and continues today with programs like the Comprehensive Primary Care Initiative (CPCI) and Medicaid's Accountable Care Collaborative (ACC). Many of the initiatives across the state are still at least partially supported by grant funding. The next step in the evolution of primary care in Colorado will increase integration of behavioral health and population level services. Providers practicing in the new care delivery environment will have to be skilled in team-based, collaborative care.

In the past few years there have been dramatic increases in hospitals purchasing stand-alone clinics and practices, and directly employing physicians. Hospitals argue that this trend allows them to compete for contracts using new models of care, provide more comprehensive, integrated care for their patients, and help create accountable care organizations. However, when physicians are employed by hospitals, costs can escalate as office procedures get billed at hospital rates. In December 2013, University of Colorado Hospital went a step further and announced that it will become a third party administrator in 2014. While not a full health plan, this action will let them directly offer their physician network to self-insured entities without working through a third party. There are also rumors that at least one of the larger hospital systems will be launching its own health plan in 2014, essentially uniting payer and provider. These kinds of arrangements could potentially reduce premium costs, integrate care and allow for tailored benefit designs, though critics are concerned that the concentrated power gained by hospitals through these arrangements could potentially restrict patient choices and drive up overall costs.

There has also been some development of coordinated approaches to care that integrate care delivery with community supports. This is reflected in the beginnings of community-based ACOs and the emphasis on care transitions and neighborhoods of care. The use of community health workers (CHW) as part of the care delivery team will become more important given the need for a stronger connection between the community and clinical care delivery. Community level coordination, emphasizing whole-person care, can allow the clinical care team to address social determinants of health, like poverty-related lack of transportation or healthy food, which can contribute to continued poor health among patients.

Medicaid Delivery: Medicaid's ACC program is a modified managed care pilot that currently serves about 50% of Medicaid enrollees across the state. The ACC is designed to improve health outcomes and reduce costs by providing a focal point for care and access to comprehensive primary care. The ACC is administered through seven Regional Care Coordination Organizations (RCCOs) that ensure efficient care delivery through affiliations with local primary care physicians. Those providers receive traditional fee-for-service (FFS) payments with per-member per-month supplements to support care coordination for ACC patients. The RCCOs operate under contract with the state and will be re-bidding those contracts starting in summer 2015. The ACC has had success improving care and reducing costs for beneficiaries and will expand over the next few years to cover the full Medicaid population.

Earlier this year, Colorado was awarded a contract to develop a new approach to care for the almost 60,000 Medicare-Medicaid dual-eligible residents. If the plan is fully funded, the program will coordinate health care, services, and supports through greater integration between the ACC Program, other Medicaid programs and Medicare. The effort also aims to improve transitions around long-term services and supports, improve the integration of physical and behavioral health, simplify access to care, and reduce costs.

Table 1: Selected Delivery Innovations (current and under development)

Project	Description	Results
Advancing Care Together	The University of CO is leading an initiative to integrate physical/behavioral health for patients with chronic physical and mental health conditions. 11 clinical sites in urban and rural areas, including FQHCs, community mental health centers, various primary care practices.	Pending.
Community Care Transitions Program (CMMI)	DRCOG received a CCTP grant to pilot community approach to care transitions. Medicaid patients at risk for readmission are provided non-medical supports (i.e., transportation, nutrition services etc.) to reduce readmissions.	Pending – trends look positive, no results until end of 2015. Some challenge getting adequate #'s enrolled.
Bridges to Care Project (CMMI)	Multi-entity project to get patients out of emergency rooms and into quality primary care. Teams visit patients in high-need neighborhoods to improve access to health care and manage chronic conditions (Metro Community Provider Network, Aurora Mental Health and others)	Appears positive. No quantitative results yet.
Salud Family Health Centers	Salud uses a unique system to address behavioral health provider shortages by stratified providers according to their training. Providers with different levels of training (PhD, MA, Case Manager, etc) provide varying services. Aim is to have staff work to the top of their ability and license.	Highly successful, but still new – increases productivity and effectiveness of a limited BH staff in an integrated delivery environment.
State Innovation Model (CMMI)	A state-wide plan to transform Colorado health care starting by integrating behavioral health care into primary care. Includes outcomes-driven payment model for primary care.	Planning stages – funding announcement anticipated early 2014

Data and Transparency: Data collected by state departments, insurers, public health, practices and others have the potential to transform health care by allowing providers to gain a large-scale picture of their patient panel and the health of their communities and the state. Unfortunately, little of this information is aggregated and returned to physicians. Physicians must have access to aggregated claims data across all their payers in order to get a comprehensive and objective picture of costs and performance. That level of data access is essential for tracking and managing costs and outcomes to succeed in new payment models. The CPCI is developing this kind of data functionality for their 74 practices and nine payers. Outside of the advanced PCMH practices, many practices and physicians are unable to afford the infrastructure to track and manage claims and clinical data.

The Colorado All Payer Claims Database (APCD), launched in 2012, now holds commercial and Medicaid claims for about 45% of insured Coloradans, with Medicare and additional commercial lives coming in this year. As the data in the APCD is collected and becomes more complete, more data will be made public – eventually including information on costs and quality by procedure (limited), by facility and by provider group. CIVHC is working closely with CHA, CASCA and CMS to validate the quality and type of data that will be provided. Physicians will be able to order custom reports for benchmarking, cost tracking and performance improvement. The APCD consumer website has the potential to become a powerful transparency tool, providing objective information to offset physician ratings sites such as HealthGrades. This kind of data transparency is being supported and duplicated by public and private efforts across the country and will continue to expand. It's unclear what kind of impact this data is going to have on patient care choices, cost trends or care provision, but certainly providers will have to take steps to ensure they are at least as informed as their patients about the quality and quantity of data available.

HIE/HIT: The expansion and development of health information technology (HIT) and health information exchange (HIE) are critical to support the changes in delivery and payment. Currently, Colorado is doing well compared to the rest of the country. By the end of 2013, 44% of eligible Colorado providers had achieved meaningful use of electronic health records (EHR) compared to 36% nationwide. Colorado also has the third highest acute care hospital EHR adoption rate at 68.3% compared to the national average of 44.4%.[4]

Table 2: Statewide HIE/HIT Uptake

	CORHIO	QHN
Licensed Providers	1282	816
EHR Practices	76	49
Labs	3	5
Hospitals/systems	31	11
Behavioral health	21 facilities	5 facilities
Long Term Care	42 facilities	30 facilities
Payers	n/a	RMHP
Patients	2,976,180	489,472

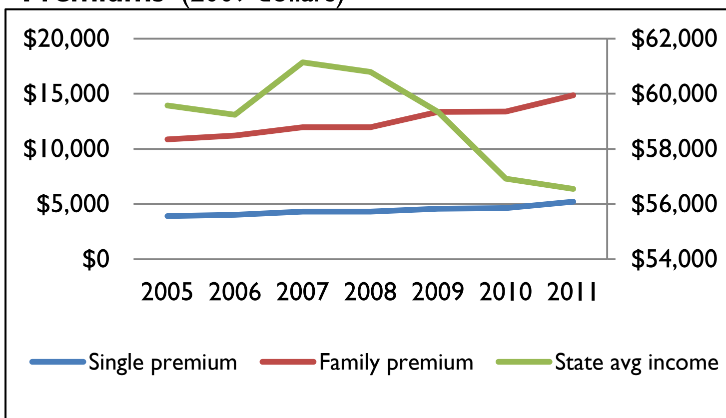
Despite the high adoption rate, Colorado still faces serious problems with EHR compatibility and two-way communications between hospitals and practices. CORHIO and QHN are actively working with the state and other stakeholders to explore options for enhancing two-way communications and affordable connectivity with the HIE. There are also dedicated efforts underway to integrate HIT/HIE with the behavioral and public health systems. This extended interconnectivity to ancillary services is key to achieving the larger, population-focused health goals that are coming into the spotlight.

At the provider level, success within new models of care and payment requires improved data feedback and the ability to combine registry and claims data with the practice EHR. Universal EHR compatibility, consolidated data reporting and streamlined measure sets will all be part of efficient utilization of HIT data. However, the costs of HIT/HIE participation and achieving meaningful use are outside the reach of many small or rural physicians. Until we can support the financial commitment needed for current technology, rural and under resourced areas of the state will continue to lag behind.

Patient Satisfaction: According to the most recent Colorado Health Access survey, close to half of Coloradans feel that the current health system is not meeting the needs of the population. During the recent State Innovation Model development process, patients were asked to discuss their experiences with the health care system. Specific issues identified by participants included: a desire for patient access to medical records, increased availability of appointments, the need for a personal relationship with their provider, more respect in the patient/provider relationship, increased awareness of co-occurring mental health issues, and concern that the system is not focused on the patient.

The most frequent concern raised by patients was the cost of health care. Last year, more than 12% of Coloradans didn't get needed care because of cost and 18% had problems paying their medical bills; over 400,000 Coloradans went without basic necessities like food or heat because of their medical bills and another 104,000 declared medical bankruptcy.[5] The rate of increase for medical care has been outpacing inflation for years. While there are signs that the rate of increase is slowing, the high cost of health care is preventing Coloradans from accessing needed care.

Figure 1: Single and Family Health Insurance Premiums (2009 dollars)[1]



With increasing data transparency and continued use of high deductible health plans, patients will demand more information about costs and quality prior to receiving services. Physicians can expect that their costs will be scrutinized by patients, and they will field more patient questions about ways to reduce costs during the course of treatment. The increase in hospital-owned practices and hospital-employed physicians has brought an increase in the prevalence of hospital-level facility charges. These charges can vary dramatically between facilities and can be challenging to explain to patients. In 2011, the facility fee for a knee replacement in Colorado ranged from $15,000 to over $60,000. Physicians will have to be able to lead discussions about these fees and be prepared to advocate for both their patient and the facility they represent. Increased transparency about costs and quality may impact the way health care is delivered by allowing patients to demand high value (high-quality, low-cost) care and supplying data to back up their demands.

Provider Satisfaction: Ongoing concerns about burnout and quality of life, and increased risks of suicide all point to the burden that increased bureaucracy and less patient time have had on the field. A Rand report released in October 2013 found that the biggest driver of provider satisfaction is the ability to provide high-quality care to their patients. When that ability is frustrated by administrative requirements, insurance limitations and mandates, insufficient reimbursement and other complications, physicians end up with decreased job satisfaction, anger and ultimately burn out. High rates of exhaustion and depersonalization are driving many to consider leaving practice, which could accelerate the physician shortage and ultimately negatively affect patient care.

Takeaways:

- To efficiently use the new data, we need universal adoption of HIT/HIE, more efficient data collection, knowledge to use population-level data, and more robust assurances of data security.
- The cost of adopting new technologies and delivery models is holding many practices back and may have a significant impact on the sustainability and effectiveness of these new approaches to care.
- The high cost of care impacts both patient and provider decisions and may be affecting outcomes.
- Will these new delivery models be sustainable beyond grant funding? If not, what other options exist?
- How will increased transparency impact patient choice? What will that mean for physician practices?
- How will delivery and payment models change with these newly empowered patients? How will that change the relationship between physician and patient?

WORKFORCE

Trends:

- Increased rates of hospital-employed physicians are significantly changing the medical landscape.
- Recent expansions to Medicaid and growing Medicare enrollment will increase demand for care as supply is decreased through the impending retirement of much of the health care workforce.
- Increased demands require rethinking the care team and developing new roles and partners, such as community health workers, to help optimize the work that physicians are able to do.
- Developing technological solutions to workforce shortages has potential to ease demands.

The health care workforce in Colorado has been changing dramatically over the past years. Many physicians are selling their practices to hospitals and health systems or have entered into direct employment contracts with hospitals. Estimates of the number of hospital-employed physicians in Colorado vary from close to 30% (Colorado Medical Society) to more than 50% (Colorado Hospital Association), compared to over 60% nationally.[6] Kaiser is the largest physician employer in the state, but that could soon change. In 2010, Centura didn't have any employed physicians and now has almost 500, many of them specialists. At this point, certain specialist groups, such as cardiologists, are almost completely employed by hospitals. Some physicians would prefer to remain independent, but cannot accept the risk-bearing contracts that are becoming a required part of new payment methods. In order to pursue these contracts, they are forced to either seek employment with a larger entity or join an independent physician association (IPA) or management service organization (MSO) in order to gain access to the financial resources, sophisticated systems and infrastructure needed to accept risk. Solo practitioners without associations with IPAs or hospital systems are becoming increasingly scarce and may disappear if current trends continue.

Increased demands coupled with a decreasing professional workforce will create a severe imbalance in supply versus demand in the very near future. As of 2011, Colorado had 3,262 primary care physicians (PCP) – over 35% of whom are over age 55 and plan to retire in the next 7-10 years; a trend that is reflected across the full health care workforce. At the same time, the number of insured Coloradans is increasing due to Medicaid expansion and subsidized private insurance through the ACA, likely increasing the demand for care. Despite increasing enrollments in medical schools, there are shortages of physicians in a number of specialties, including primary care, pediatrics and geriatrics. There are a number of reasons for the shortage of PCPs, including stagnated growth in funded residencies and preferences for high-end specialties driven by FFS reimbursement. While the incentive programs for rotations in rural areas have helped increase the number of students gaining experience in rural areas, many small communities still see rapid turnover and overall scarcity of PCPs.

As in the rest of the country, Medicaid patients in Colorado have problems accessing specialists, especially in endocrinology, pain management and elective surgery.[7] The recent expansion of Medicaid swelled the program to over 753,000 enrollees, without a commensurate expansion of Medicaid providers, placing further pressure on providers and patients. Specialists do not receive the ACA Medicare parity reimbursement or the per-member, per-month payment that PCPs receive under the ACC, giving most specialists less financial incentive to participate in Medicaid.

The need for access to specialty care in rural and under-resourced areas has spurred the development of telehealth programs like the University of New Mexico's Project ECHO. ECHO is a video telehealth system that virtually brings specialists to rural areas of the state to consult with local providers. The model has improved a number of outcomes by eliminating the need to travel hours for care. CU is developing a similar program to help meet the needs of rural Coloradans. Some programs are already happening in Colorado, like the Colorado Neurological Institute's rehab telemedicine program and the Colorado Telehealth Network's work to bring video capability to health facilities across the state. These models provide a way to address the needs of rural patients, but may change the dynamic of the doctor-patient relationship.

There is a movement towards the development of a new tier in the health care workforce. Community health workers (CHW) and patient navigators can act as a bridge between care facilities and the community, increasing social support systems and allowing highly skilled professionals to spend more time in direct patient care and less time coordinating community resources. Two community colleges are already offering CHW training courses, though currently no payers regularly reimburse for the use of CHW in patient care. Rocky Mountain Health Plans will be implementing a trial of CHW in the health care workforce in January 2014.

Takeaways:

- Increased and unsustainable costs of care are motivating many of the structural shifts in delivery and payment. These shifts are in turn driving changes in the health care workforce structure and function.
- The trend toward physician employment continues and its ultimate impact on the system is still unknown.
- Technological advances allow for new care models, but may alter the doctor-patient relationship.
- New models of care will require a new care team and new roles for existing team members.
- How can physicians support needed changes and become leaders in this new landscape?
- Are there enough alternatives to hospital employment (IPAs, MSOs) to make non-hospital based practices viable in the future?

INSURANCE COVERAGE

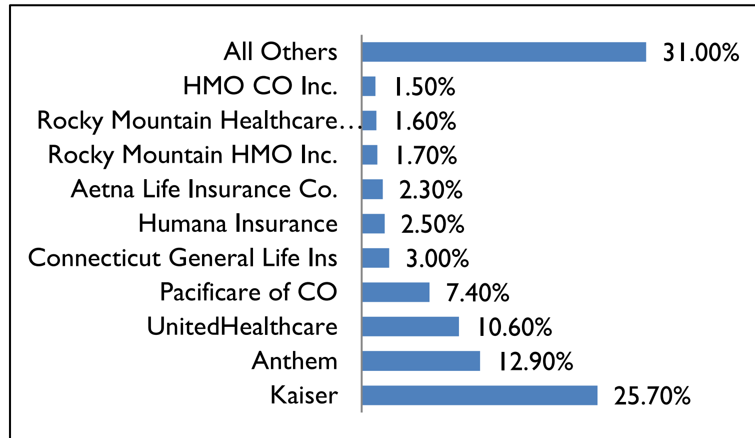
Trends:

- Insurance premiums have increased rapidly and high-deductible plans are becoming more common.
- The CO Exchange has had significant impact on Medicaid enrollment and plan configurations, though the impact on costs is still unknown.
- New plan offerings on the exchange include narrow networks and alternative payment models.
- The legislature has recently passed another patch to the sustainable growth rate formula into 2014.

Commercial Insurers: Colorado has an intensely competitive insurance market-place with more than 400 active health care insurers in the state, though the top ten insurers account for almost 70% of the commercial marketplace (based on written premiums).[3] As in the rest of the nation, premiums in Colorado have increased faster than inflation for decades. From 2010-2011, individual premiums increased 12.5% to $5212 per year and family premiums increased by almost 11% to $14,850 (see figure 1).[3] At the same time, the average income in

Colorado was actually decreasing due to the impact of the recession. Over 53% of Colorado's employers are moving to plans with deductibles of $1,000 or more per person compared to a national average of 34%.[1]

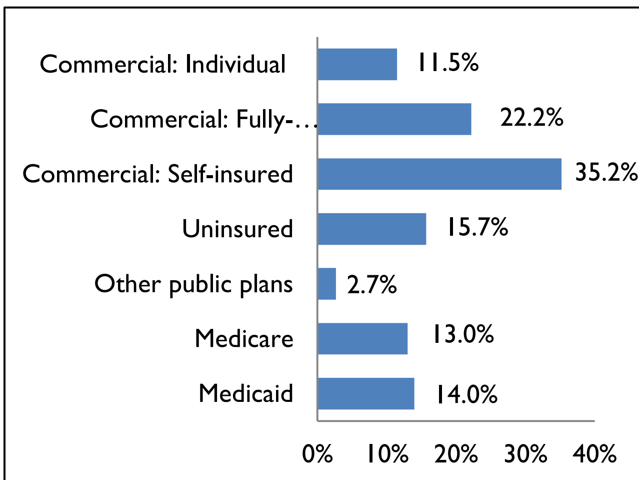
Figure 2: Top 10 Insurers by market share based on written premiums, 2011(most recent available)[1]



On October 1, 2013, Colorado launched Connect for Health Colorado (C4HCO), the state's health insurance exchange. As of January 1, 2014, just over 52,000 Coloradans had signed up for private health insurance through the exchange and over 138,000 Coloradans qualified for Medicaid through the site – a substantial increase to the program. Eleven carriers are offering 242 different plans on C4HCO.

Insurers across the state including Cigna, United, RMHP, the Co-op, and Anthem have introduced narrow-network plan offerings in an effort to bring down plan prices and compete with other plans like Kaiser Permanente. These narrow networks are contractual arrangements with local health systems and offer comprehensive coverage at limited sites. RMHP's narrow network is a partnership with New West Physician Groups and includes a risk bearing contract. There have been rumors that insurers have negotiated lower prices for some of these plans, but there is no confirmation. It will be interesting to see if narrow networks will receive pushback from consumers who want access to a wider variety of providers in order to find the highest value care for their health care dollar.

Figure 3: CO Insurance Coverage[2,3]

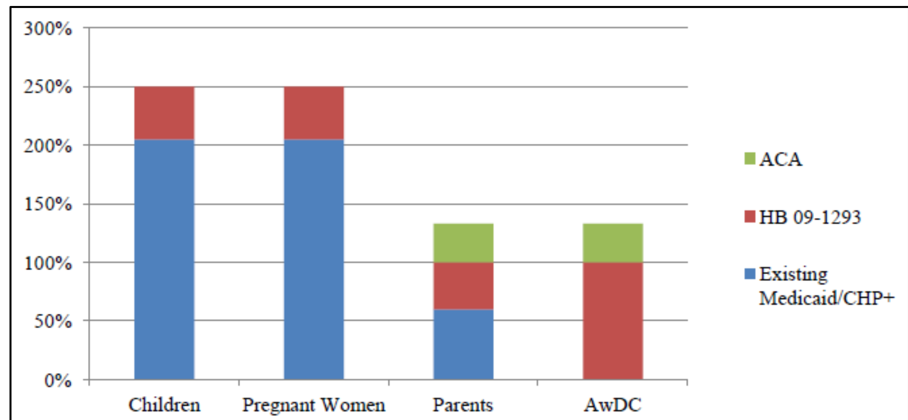


Medicaid: Over the last several years, Colorado has been successfully working on decreasing the total cost of care for Medicaid through the use of the ACC, capitated payment for behavioral health and other non-traditional approaches. While the total cost of care has decreased, increasing Medicaid rolls have swelled the annual budget despite the per capita cost decrease and it's unclear how the expansion will actually impact health care provision and costs over time. As part of the ACA, PCPs (family medicine, general internal medicine, or pediatric medicine) are reimbursed for covered Medicaid primary care services at 100% of the Medicare rates for those services from January 1, 2013 to December 31, 2014. On January 1, 2015, federal financial support to supplement those Medicaid payments will stop.

The bump was initially intended to support Medicaid PCPs, encourage physicians to participate in Medicaid, and ensure access to primary care for Medicaid populations. Given the rate of the expansion and the increased Medicaid rolls due to the recession, access to primary care is still a significant concern. It is unclear what will happen after the reimbursement subsidy stops at the end of 2014. There are fears that PCPs will stop accepting Medicaid patients, making an already challenging access situation even worse. While specialists were not given a

payment bump, low reimbursement rates and high patient volume may prompt specialists to stop accepting Medicaid patients as well.

Figure 4: Source of Medicaid Expansion[2]



Medicare: According to a 2013 report from the Medicare Hospital Insurance trustees, the Medicare Hospital Trust will not be facing insolvency until 2026, not 2016, as some sources reported. The 2026 date only applies to Part A (hospitals). It does not apply to coverage for physician and outpatient services or to the Medicare prescription drug benefit; these parts of Medicare do not face insolvency and cannot run short of funds. Despite the extension of Medicare solvency due to recent health reforms, soon the Medicare trust will not be able to cover 100% of the costs charged against it. While Medicare is not currently in financial crisis, it will be without legislative intervention or significant adjustments to delivery and payment strategies.

The Medicare sustainable growth rate (SGR) continues to be a challenge. On December 12, the House passed a three-month patch to avoid the 24% cut in pay that was to take effect in January of 2014 and the Senate passed the bill on December 18. There is strong indication that a permanent fix to the SGR, up to and including repeal, may happen in 2014. Both the houses of Congress have proposals and legislation to replace the SGR formula. Though neither proposal offers a financial offset for the repeal of the SGR, the Congressional Budget Office recently decreased its 10 year projection of the cost of SGR repeal by more than $20 billion.

Takeaways:

- Increasing premiums place financial pressures on individuals and businesses. Continued increases could cause businesses to drop employee insurance coverage and increase the uninsured.
- Increasing Medicaid enrollment and uncertain reimbursement may result in reduced access to care.
- What is the role of physicians in this insurance environment? What is the physician's responsibility to patients, both public and private? How can physicians help find a resolution for these issues?

PAYMENT METHODS

Trends:

- Payment models are moving away from unsustainable FFS and towards outcome-based payment in both public and private payer systems.
- Consumer protection requirements related to risk reserves may prevent unaffiliated or small practices from participating in the new payment models.

Public payers: Colorado's Medicaid program is leading the movement away from FFS and towards outcome-based payment. In the ACC, participating PCPs are given a per-member, per-month payment to support infrastructure development and care coordination. The remaining 50% of Medicaid beneficiaries receive care through a more traditional FFS reimbursement structure. Colorado Medicaid pays for behavioral health services through a capitated payment contract with area behavioral health organizations (BHO). This capitated carve out may be facing significant changes in the coming year as the BHO contracts are up for re-bid, but exactly what

those changes will be is still unclear. Certainly, some changes to the payment structure will have to happen to enable more wide spread behavioral and physical health integration.

More than 34% of Colorado Medicare enrollees are participating in a Medicare Advantage plan -- higher than the national average of 27%.[8] In January 2013, five major Colorado hospitals were chosen to participate in Medicare's Bundled Payments for Care Improvement (BPCI) initiative to use bundled payments to deliver higher quality, more coordinated care at a lower cost. Medicare is testing both retrospective and prospective models and hopes to be able to see a cost savings by Fall of 2014, when the current pilots will either end or be renewed for further development. Colorado also has 3 Medicare Shared Savings Program ACOs

Private payers: Health care in Colorado is still primarily reimbursed on a traditional FFS basis, with Kaiser Permanente and Denver Health's salaried physicians and system-level payment model as the exception. In fact, outside of Kaiser, Denver Health and a few pilots, the vast majority of the health care in Colorado is paid on a FFS basis. However, payers are beginning to move toward outcomes-based payment. Every commercial payer in Colorado offers care coordination payments to PCPs, and most offer shared savings contracts as well. There are some offering primary care capitation to select groups (mostly through Medicare Advantage plans) and Rocky Mountain Health Plans is piloting global payment for both commercial and Medicaid contracts. A couple of plans are developing bundled payments for acute procedures with anticipated introduction to the market in 2014.

Finances and Risk: In the wake of the financial failures of HMOs in the 1990's, the Colorado Department of Insurance instituted financial requirements for any health care provider entering into a risk-bearing contract. The financial threshold was designed to protect companies and consumers from unexpected expenses in a capitated or episodic payment arrangement. Practices must be able to create a withhold or risk pool to cover services that exceed the designated payment. As a result, small practices and independent physicians that do not have the financial resources to create this kind reserve are effectively barred participating in prospective, risk-based payment models unless they join an IPA or other network. It's possible that truly independent practices may soon be unable to participate in the market.

Table 4: Selected Payment Innovations

Project	Description	Results
Rocky Mountain Health Plan SHAPE demo	Population-based reimbursement including accountability for total cost of care including behavioral health through partial and global capitation. Bonus opportunity for quality independent of global budget targets. SHAPE evaluates RMHPs behavioral health global payment pilot HB 1280.	Pending – trends look positive, no results until end of 2014.
Physician Health Partners Pioneer ACO (CMMI)	PHP started the first year of the Pioneer ACO program to achieve increased shared savings by hitting high quality benchmarks. Program would have added downside risk and global payments after first few years.	PHP left the Pioneer program after the first year and is now one of 3 Medicare Shared Savings ACOs in the state.
Comprehensive Primary Care Initiative (CMMI)	Primary Care Medical Home initiative combines Medicare care coordination payments with those from private payers for 74 primary care practices. Includes potential for shared savings. Four-year pilot, launched mid-2012.	Positive feedback, but little data so far. Actively developing data aggregation and analysis for participating practices.
Prometheus (Colorado Business Group on Health)	Develop bundled payments for six chronic diseases in commercial populations: asthma, COPD, coronary artery disease, diabetes, gastro-esophageal reflux disease and hypertension. Currently in Colorado Springs and Alamosa.	There have been significant challenges getting the bundles established. Results not yet available.

Takeaways:

- Payment models are changing, but there is little consensus on what models may have long-term success. Results from pilot programs over the next few years will help highlight potential solutions.
- Financial regulations put in place to protect practices may be having unintended consequences on the make-up of the field. Are there alternatives that would promote practice independence?
- Can physicians anticipate changes and become leaders going into these new structures?

REMAINING QUESTIONS AND CONCERNS

Colorado continues to be a health care leader in many areas, but there are concerning trends that could threaten our position as one of the healthiest states in the nation. Increasing obesity and diabetes rates, poor care for children and mental illness, and persistent racial and economic inequalities all spotlight opportunities to improve the overall health of Colorado. These issues also highlight the hot topic areas that will likely come to the forefront in the next few years. New models of payment and delivery will emphasize population level health, including chronic care management, the integration of mental health care and a focus on the social determinants of health. Practitioners will need to develop closer ties with public health and ancillary care providers as new models of care emerge. Some local public health agencies are taking on more active roles in direct care delivery, such as chronic disease education, nutrition, and immunizations. As the health care environment changes, there are many questions left to be answered:

- How can physicians contribute to reducing the overall cost of care while improving health?
- How will the movement towards ACO's affect care delivery and the care team?
- Will these new integrated care delivery approaches be sustainable beyond grant funding?
- How will the expansion of Medicaid affect costs and patient access?
- How can administrative burdens be decreased while increasing access to high-quality, useable data?
- What kind of impact will data transparency have on care quality and the patient-provider relationship?
- Who will lead the culture change within the medical field that is necessary to support integrated care and outcomes-based payment?

While the future of health care is still uncertain, there are signs that indicate the direction of change and the interdependence of health care delivery and payment is central to innovation. Physicians must help lead the movement towards integrated care and outcomes-driven payment. Visible leadership will be a key component to the success of this evolution of care. New models may look different depending on location and practice area – but there are certain commonalities that will be needed across all practices. Access to and effective use of data, EHR adoption and HIE participation, and streamlined administrative work flow will be required of every health care provider. Ultimately, there are tough questions that must be asked and answered about traditional roles and the coming culture change. The way physicians' work is changing and the profession needs to change with it in order to continue to prosper.

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