Colorado State Health Profile: An Overview of the Health Status of Colorado Residents and the Availability of Primary Care Resources

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COLORADO STATE HEALTH PROFILE

Funded with a grant from the Health Resources and Services Administration, the Colorado Primary Care Office collaborates with and helps organizations and providers improve, increase and deliver comprehensive primary care services in geographic areas or for populations that have difficulty gaining access to primary care. To better understand the role of and the challenges facing the Primary Care Office, the following state health profile describes the state's demographics, health status and access to care issues. The report concludes with a description of the solutions and successes associated with the office's ongoing mission of improving the health of Colorado residents through increased availability of health care services. While the Primary Care Office strives to improve access to primary care, oral and mental health services for underserved and vulnerable populations, the focus of this report is on the status of primary care health and resources/availability of services in Colorado.

DEMOGRAPHICS OF COLORADO

Colorado's health profile is influenced by its demography and relatively rapid population growth. To illustrate the state's demographic diversity, Table A1 (see appendix) compares three characteristics (age distribution, race and ethnic composition, and poverty) for each of the state's 14 planning and management regions (PMRs)[1], the entire state and the United States. To understand how these characteristics relate to Colorado's geography, Map A1 delineates the boundaries of each PMR. The data reveal that the state has sparsely settled rural areas, often with stable or declining populations, as well as rapidly growing resort communities and medium and large metropolitan areas. In addition, Colorado is the home to two Native American tribes: the Ute Mountain Utes and the Southern Utes located in the southwest corner of the state. While Colorado is relatively affluent and young, it has geographic pockets with high concentrations of low-income, minority and aging populations.

Age distribution:

On average, Coloradans are younger than U.S. residents, with a median age of nearly 33 in 2000 compared with 35 years for the nation as a whole. Not surprisingly, nearly 10 percent of Coloradans are 65 and over compared with over 12 percent of the U.S. population. Yet half of the state's PMRs (all but one are rural) have higher proportions of residents 65 years and over compared with the U.S. average. Not coincidentally, many of the counties with relatively large elderly populations are also medically underserved areas.

Racial/ethnic composition:

A relatively high proportion of Colorado's population is non-minority (white, non-Hispanic) – about 72 percent compared to 67 percent for the nation. While Colorado is more heavily Hispanic than the United States as a whole (19% vs. 14%), the state has smaller portions of other major minority groups, most notably non-Hispanic blacks (4% vs. 12%). There is great variation, however, in the level of racial and ethnic diversity. In

[1] Planning and Management Regions, which consist of one or more adjacent counties, were established by executive order in the 1970s and are a convenient way of summarizing demographic and health information available for Colorado's 64 counties.

three southern Colorado regions (7, 8 and 14), Hispanics constitute more than one-third of the population, and in six other regions (5, 9, 10, 11, 12 and 13) non-Hispanic whites account for at least 80 percent of the population. While cultural competency is a challenge for providers across the state, it is especially relevant in regions with relatively large minority populations, especially those best served in a language other than English.

Poverty levels:

In 2000, the percentage of Coloradans with incomes below the federal poverty level (FPL) was substantially lower than the percentage of all individuals in the United States (9% vs. 12%). Similarly, the percentage of Coloradans living below 200% of the FPL was around 24 percent compared with almost 30 percent in the United States. Poverty rates in Colorado, however, are highly variable based on geography. For example in PMRs 6, 8 and 14, over 45 percent of the population was below 200% of the FPL. Conversely, in PMRs 3, 4, 5 and 12, less than 25 percent of the population was below 200% of the FPL.

HEALTH STATUS OF COLORADANS

The Colorado Department of Public Health and Environment (CDPHE) maintains a variety of data collection systems that provide timely, accurate and relatively comprehensive information to evaluate Coloradans' health status. This information is useful for assessing primary health care indicators and comparing health disparities across the state.

Key primary care health indicators:

Table A2 (see appendix) summarizes a variety of health indicators across a spectrum of age groups, the commensurate Healthy People 2010 (HP 2010) target values, Colorado's rank relative to the rest of the country and the trend (whether the indicator shows improvement, stabilization or deterioration over time).

The selected indicators provide a mixed assessment of the health status of adults in Colorado.

- Colorado leads the nation with the lowest obesity rate (16%). But the proportion of adults who are obese has begun to increase and now exceeds the HP 2010 target of 15 percent.
- Colorado ranks second and fifth in the nation for the lowest death rates from heart disease and lung cancer, respectively.
- The teenage birth rate in Colorado is higher than the rates of 31 other states.

Colorado faces challenges in improving access to and outcomes associated with maternal and child health.

- Colorado ranks 44th in the country for access to prenatal care. Nearly one in five mothers (or twice the HP 2010 target) report that they did not receive adequate prenatal care.
- Colorado ranks in the bottom 10 states for its high rate of low-weight births. Colorado's rate of 9 percent is nearly double the HP 2010 target of 5 percent.
- Only 77 percent of young children receive the entire series of recommended vaccinations by 19 to 35 months of age. In 2004, Colorado ranked 44th in the

country based on this measure, an improvement from 2003 when Colorado ranked 50th.

Health disparities:

While Colorado as a whole is a healthy state, health disparities exist between racial and ethnic groups. The leading causes of death in Colorado among racial and ethnic groups (1998-2002) are shown in Table 1. Testing for statistical differences was performed previously as presented in the Racial and Ethnic Health Disparities Report [2].

Table 1. Causes of death among racial and ethnic populations compared to the state rate. Based on age-adjusted rates per 100,000 population.

Cause of Death	Caucasian	Latino	African American	American Indian	AAPI*
Chronic Disease					
Heart Disease		Lower	Higher	Lower	Lower
Cerebrovascular Disease		Lower	Higher	Lower	
Alzheimer's		Lower			
Diabetes	Lower	Higher	Higher		
Chronic Liver Disease	Lower		Lower		
Chronic Lower Respiratory Diseases	Higher		Lower		Lower
Kidney Disease		Higher	Higher		
Cancer					
All Cancers	Higher	Lower	Higher	Lower	
Colorectal Cancer			Higher		
Lung Cancer	Higher		Higher		
Cervical Cancer		Higher			
Prostate Cancer			Higher		
Maternal Child Health Indicators					
Teen Fertility Rate	Lower		50% decrease in 12 years		
Infant Mortality			Higher		Lower
Perinatal Period Conditions	Lower	Higher	Higher		
Communicable Disease					
HIV/Aids	Higher		Higher		
Influenza and Pneumonia					Lower
Tuberculosis		Higher	Higher		Higher
Injuries					
Motor Vehicle Deaths			Lower	Lower	
Suicide	Higher		Lower		

Source: Colorado Department of Public Health and Environment. 2005. *Racial and Ethnic Health Disparities in Colorado 2005.*
*Asian American/Pacific Islander

[2] Colorado Department of Public Health and Environment. 2005. *Racial and Ethnic Health Disparities in Colorado 2005.*

Key: Higher = statistically higher than state rate
Lower = statistically lower than state rate

Geographic health disparities also emerge when analyzing various regions of the state. Map A2 summarizes the percentage of the population with diabetes in various regions throughout the state. Populations in the eastern and southern parts of the state experience higher rates of diabetes than the state average of 4.6 percent. Similarly, Map A3 shows that populations in these same general areas of the state experience disproportionately higher rates of hypertension.

ACCESS TO CARE

Access to primary health care in Colorado is influenced by a wide spectrum of factors such as the location of health care facilities, the cost of health insurance, the availability of employer-sponsored health insurance and the geographic concentration of health care providers. Access for Coloradans receiving health care via public programs is also affected by providers' willingness to accept clients in these programs and to agree to reimbursement rates provided by the government.

Shortage designations:

In order to mitigate shortages of health care providers and address geographic health disparities, the Primary Care Office applies federal shortage designation criteria to determine if geographic areas or population groups qualify as Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs).

- For a geographic area to receive a HPSA designation it must have no more than one provider to 3,500 people, be a rational area for the delivery of health services, and demonstrate that health care resources in the contiguous areas are over-utilized, excessively distant or inaccessible. A low-income HPSA must have no more than one provider to 3,000 low-income residents.
- For a geographic area to receive a MUA designation or for a population in a particular area to receive a MUP designation, the Primary Care Office determines if the concentration of low-income and elderly individuals, high infant mortality rate and high population to provider ratios meet the designation criteria.

Colorado continues to face challenges in recruiting primary care providers to serve in the eastern and southern parts of the state. As delineated on Map A4, 51 of Colorado's 64 counties are designated as full or partial primary care HPSAs. Not surprisingly, Colorado's Medically Underserved Areas and Medically Underserved Populations (Map A5) are also concentrated in the eastern and southern counties. Forty-six counties are designated as full or partial MUA/Ps. These areas tend to coincide with the areas of the state with high concentrations of low-income, minority and aging populations as identified earlier in this report. To ameliorate shortages of providers and improve access to care, the Primary Care Office at the Colorado Department of Public Health and Environment, collaborates with a variety of partners and providers, and administers a number of programs as discussed later in this paper.

Ambulatory care sensitive conditions:

Hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs) are often used as a marker for access to primary care and to study disparities across populations and

geographic areas. A recent study completed by the Colorado Area Health Education Center System for the Primary Care Office [3], looked at six pediatric conditions and thirteen adult conditions in twelve rural or frontier counties [4] without a Medically Underserved Area designation. Eleven of the counties were found to have at least one zip code with higher ACSC rates than the rest of the state. The results of the study indicate that these areas have poorer access to primary care services resulting in higher hospitalization rates. Poor access could be due to a variety of factors: lack of providers, lack of providers who see low-income patients, lack of health insurance, cultural or geographic barriers.

The health care workforce:

Colorado ranks 20th in the nation in the number of physicians relative to the state's population. In 2004, Colorado had fewer physicians (292 per 100,000 population) or around 2 percent less than the national average (297 per 100,000 population.)

The Colorado Health Institute recently surveyed physicians for its Colorado Health Professions Database. Of the 16,138 physicians who renewed their 2005 medical license, 7,715 (48%) submitted survey forms. Of the 5,140 survey respondents who indicated a primary practice in Colorado, 90 percent practiced in urban settings, while nine percent practiced in rural locations and less than two percent in frontier locations. Of the almost 5,000 respondents who provided a year of birth, 35 percent indicated they were 55 years of age or older and the mean age was more than 50 years. Based on this statistic, coupled with the aging of the general population, Colorado's challenge in maintaining an adequate physician workforce could intensify.

In 2000 the supply of nurses in Colorado was 26,556 while the demand was 29,735 or a shortage of 3,179 (10.7%).[5] The current Colorado nursing shortage is about twice the national average. Based on current trends, Colorado's shortage is expected to nearly triple by 2020. Part of the state's challenge is to increase its capacity for nursing students in the face of the shortage of qualified nursing faculty, which is three times the national average at Colorado's two-year nursing schools and double the national average at four-year schools. Not surprisingly, in 2003, more than 2,600 applicants were turned away from nursing programs in Colorado due to capacity constraints.[6] As of 2005, Colorado had 31 Licensed Practical Nurse, Associate Degree Nurse, and Bachelors Degree Nursing programs plus six graduate degree nursing programs.[7]

Counties lacking providers and/or services:

A number of counties in Colorado lack access to primary care providers, hospital services and physicians who accept Medicaid and/or CHP+.

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[3] Colorado Area Health Education Center System. 2006. *Hospitalization for Ambulatory Care Sensitive Conditions: Access to Care in Rural Colorado*

[4] Counties include: Baca, Chaffee, Eagle, Garfield, Grand, Gunnison, Huerfano, Lake, Mesa, Moffat, Pitkin, and Routt

[5] National Center for Health Workforce Analysis, Health Resources and Services Administration, http://ww.ahca.org/research/rnsupply_demand.pdf, p. 14

[6] Colorado Health Institute (CHI) on behalf of the Colorado Center for Nursing Excellence. February 2005. *The 2004 Colorado Nursing Faculty Supply and Demand Study.*

[7] http://www.coloradonursingcenter.org/downloads/swf/schoolcontactinfo.swf

- In Colorado, three rural and frontier counties and one urban county do not have a primary care physician[8] and seven additional counties do not have a physician who accepts new Medicaid clients.[9] In addition, five counties, which do have physicians, lack any physicians who will accept new CHP+ clients.[10] Nine counties have only one primary care physician[11], and four of those physicians do not accept new Medicaid patients.[12]

- Twenty of Colorado's 64 counties lack a hospital. Of these counties, three are rural,[13] 11 are frontier,[14] and six are urban.[15]

Insurance coverage:

A recent Colorado Health Institute (CHI) analysis concluded that, commensurate with national trends, between 1999-2000 and 2003-04, the number of uninsured Coloradans increased from 14.9 percent to 17.1 percent.[16]

While many families at 200 percent of the FPL cannot afford health insurance, most children in Colorado with family incomes at or below 200 percent of the FPL are now eligible for government-sponsored health insurance programs, Medicaid or the Child Health Plan Plus (CHP+).[17] In addition, parents with incomes at or below 60 percent of the FPL, now qualify for Medicaid.[18] [19]

In 2003-04, the rate of uninsured children in Colorado (14.4%) was lower than the rate for working-age adults (20.0%), but was greater than the national average. One factor contributing to the higher insured rate of children is the increasing enrollment of children in Medicaid and CHP+. In 2004-05, the average monthly enrollment for children in the Medicaid and CHP+ programs was more than 277,000 children, compared to just over 145,000 in 1999-2000, or an increase of 91 percent. However, there is still a ways to go to assure that all children have access to health care. Based on family incomes, the CHI estimated that between 2002-2004, there were 204,200 children eligible for Medicaid and 93,700 eligible for CHP+. Of the Medicaid eligible children, 138,800 (68%) were insured. Of the CHP+ eligible children 36,500 (39%) were insured.[20]

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[8] Counties include: Bent, Crowley, Park, and San Juan

[9] Counties include: Cheyenne, Clear Creek, Conejos, Hinsdale, Jackson, Saguache, and Washington.

[10] Counties include: Clear Creek, Hinsdale, Jackson, Pitkin, and Washington.

[11] Counties include: Cheyenne, Costilla, Custer, Dolores, Hinsdale, Hackson, Kiowa, Mineral, and Washington

[12] CDPHE analysis of the Peregrine database, March 2006

[13] Rural counties include: Archuleta, Crowley, and Ouray

[14] Frontier counties include, Bent, Costilla, Custer, Dolores, Hinsdale, Jackson, Mineral, Saguache, San Juan, San Miguel, and Washington.

[15] Urban counties include: Broomfield, Clear Creek, Elbert, Gilpin, Park and Teller.

[16] CHI. January 2006. *Profile of the Uninsured in Colorado, 2004*, p.2.

[17] The Child Health Plan Plus or CHP+, is the State Children's Health Insurance Program (SCHIP) in Colorado.

[18] An exception is pregnant women. If they have incomes at or below 130 percent of the FPL, they qualify for Medicaid. Pregnant women with incomes at or below 200 percent of the FPL, who do not meet the criteria for Medicaid, qualify for CHP+.

[19] Beginning on July 1, 2006, parents in low-income families with incomes at or below 60 percent of the FPL are eligible for Medicaid.

[20] CHI. October 2006. *Colorado Children's Health Insurance Status.*

Table 1 summarizes the insurance status for Colorado working-age adults between 1999 and 2004. The percentage of working-age adults receiving health insurance via employer/individual insurance coverage decreased during the study period while the percentage without insurance increased.

Table 1. Insurance status for Colorado working-age adults (18-64), 1999-2004

Insurance Category	1999-00	2000-01	2001-02	2002-03	2003-04
Employer/Individual	72.8%	73.6%	71.7%	69.9%	70.0%
Uninsured	17.0%	17.6%	19.0%	20.0%	20.4%
Military	5.7%	4.9%	5.1%	5.4%	5.0%
Medicare	2.1%	1.9%	2.2%	2.1%	1.8%
Medicaid	2.5%	2.0%	2.1%	2.6%	2.9%

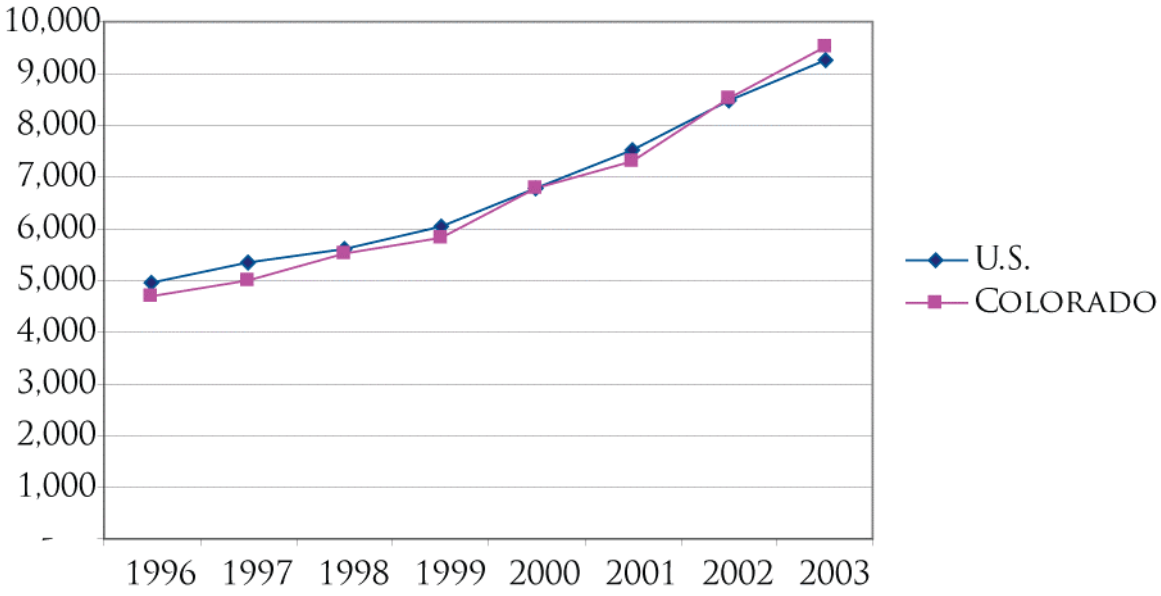
Source: Colorado Health Institute. 2006. *Profile of the Uninsured in Colorado, 2004*, p. 9.

The CHI study also revealed that:

- Uninsured rates differ by race and ethnicity. Hispanics had a significantly lower rate of insurance (34%) than other racial/ethnic groups. Non-Hispanic whites had the lowest uninsured rates (12%).
- More than three-fourths of uninsured working-age adults in Colorado reported working at some point during the previous calendar year.
- Adults who did not complete high school were twice as likely to be uninsured as those with a high school diploma.
- In 2000, counties in the southern portion of the state and on Colorado's Eastern Plains tended to have higher uninsured rates than western and mountain counties. Suburban counties around Denver had among the lowest uninsured rates in the state (see Map A6 in appendix for insurance status by county).

Health care costs:
Similar to national trends, the cost of health insurance in Colorado has increased significantly over the past decade. Graph 3 illustrates that between 1996 and 2003 the average family premium per enrolled employee in private-sector establishments increased 102 percent in Colorado and 87 percent nationally.

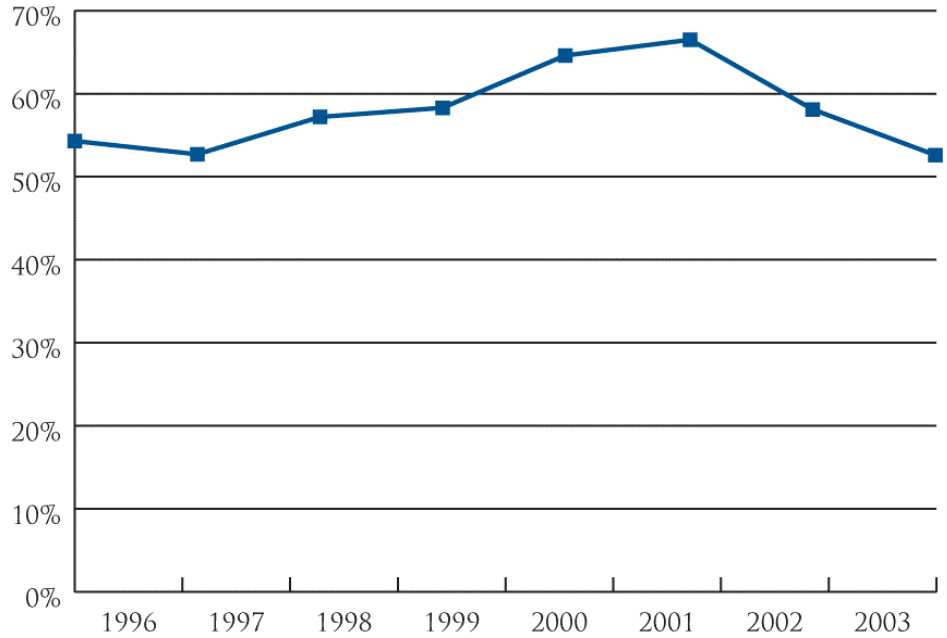
Graph 3: Annual average total family premium per enrolled employee at private-sector establishments that offer health insurance, United States and Colorado



Source: Medical Expenditure Panel Survey, 2003.

While premiums for health insurance have increased, the percentage of private-sector establishments that offer health insurance in Colorado has declined since 2001 (Graph 4.) According to the Medical Expenditure Panel Survey, in 2003, 53 percent of private-sector establishments offered health insurance to their employees compared to 67 percent in 2001.

Graph 4: Percent of private-sector establishments that offer health insurance in Colorado, 1996-2003



Source: Medical Expenditure Panel Survey, 2003.

SOLUTIONS AND SUCCESSES

Based on Colorado's demographic trends, health disparities and health care access concerns, the Primary Care Office at the Colorado Department of Public Health and Environment administers a number of programs and collaborates with Community Health Centers, Certified Rural Health Clinics and other provider groups and facilities to address these challenges.

Safety net providers:

To improve access to care, Colorado has a network of safety net providers that supply services in rural areas and metro underserved areas. Map A7 (see appendix) summarizes the location of the following safety net providers by county.

- Community Health Centers (CHCs) also known as Federally Qualified Health Centers, provide comprehensive primary health care services to clients in underserved areas. Colorado has 15 Community Health Centers operating 113 clinic sites. CHCs operate in 34 counties, of which 11 are rural and eight are frontier counties. In 2005, CHCs provided care to more than 396,000 patients, 182,304 were uninsured or underinsured clients and 129,461 were Medicaid clients. CHCs must be located in MUAs or MUPs.

- Certified Rural Health Clinics provide primary care services to Coloradans living in HPSAs and MUAs. Colorado has 45 Certified Rural Health Clinics that serve 30 rural and frontier counties.

- ClinicNet is a loosely affiliated coalition of 22 safety net clinics and programs that are not certified as Federally Qualified Health Centers or Rural Health Clinics. ClinicNet members provide direct or indirect primary care to uninsured and/or low-income Coloradans. Nine ClinicNet members received funds from the Primary Care Grant Fund as established by Amendment 35 (discussed later in this document.) These members saw around 20,500 low-income uninsured patients in 2004.

- Colorado has a variety of primary care residency programs in which a large number of uninsured and indigent patients receive primary care services. There are nine residency programs in family practice. In 2004-05, these residency programs served almost 117,000 patients of whom almost 60 percent were Medicare, Medicaid or uninsured. In addition, the state has two residency programs in internal medicine, one in pediatrics, and two in obstetrics and gynecology.

- Colorado has 34 permanent school-based health centers and one mobile unit that provide access to primary health care services for over 86,000 students.

- The state has 15 organized health departments that provide laboratory services, collect vital statistics, implement disease control measures and provide epidemiological investigation and environmental services. These health departments serve 25 counties, of which 13 are urban, seven are rural and five are frontier.

- Forty Colorado counties, of which five are urban, 17 are rural and 18 are frontier, are served by public health nursing services.

- International Medical Graduates (IMGs) who complete a residency or fellowship program in the United States may work in underserved areas under the auspices of the J-1 Visa Waiver program. In addition, the National Interest Waiver program allows primary care, IMGs to practice in underserved areas. While each state is allowed 30 J-1 Visa Waiver slots per year, Colorado has never used more than thirteen slots per year, indicating that based on community need, Colorado could use more J-1 Visa Waiver physicians. In Colorado, 19 physicians practice under J-1 Visa Waivers and National Interest Waivers. Eleven physicians provide care in rural and frontier counties while eight practice in urban counties. Twelve physicians provide primary care and the remainder provides specialty care. Since 1997, 60 J-1 Visa Waiver and National Interest Waiver physicians have provided more than 359,000 patient visits. Almost 60% of those visits were to Medicaid, Medicare or uninsured patients on a sliding fee scale.

- The National Health Services Corps (NHSC) is a group of highly skilled health care professionals who practice in underserved areas. Colorado currently has 91 NHSC providers of whom 61 provide primary care, 21 provide mental health care services and nine provide oral health services. Fifty-seven providers are in rural and frontier counties, while 34 providers practice in urban counties.

Loan Repayment Programs:

To provide a recruitment and retention incentive, several programs offer loan repayment to health professionals in Colorado.

- Colorado offers a State Tax Credit for health care professionals working in rural areas. This program is available to physicians, nurse practitioners, physician assistants, certified nurse midwives and dentists as an incentive to work in rural areas. In 2000, 11 health professionals qualified for the credit. In 2001, 37 professionals qualified. The tax credit is given during years when the state's fiscal year ends with a qualified surplus; therefore it has not been available for the past several years. It is unknown when the program will resume.

- The Colorado Area Health Education Center administers a Colorado Health Professions Loan Repayment Program, funded by the Bureau of Health Professions in HRSA. Between 1991-2006, this program funded partial loan repayment for 42 primary care providers.

- The Colorado Medical Society and Foundation implemented the Colorado Rural Outreach Program (CROP) to support the recruitment and retention of health care providers in rural Colorado. Since 1998 approximately 145 grants totaling $1.5 million have been awarded. The Colorado Rural Health Center currently administers the program with support from The Colorado Trust's, Health Professionals Initiative.

State Funding for primary care:

In recent years, Colorado has used nontraditional funding sources to fund primary care programs. For example, via the Comprehensive Primary and Preventive Care (CPPC)

Grant Program, the state uses funding from the settlement with tobacco companies, the Master Settlement Agreement, to provide grants to assist health care providers expand primary and preventive health care services to uninsured, low-income residents. From FY 2000-01 through FY 2003-04, almost $20 million was granted to CPPC providers to offer medical, oral health, mental health and pharmaceutical services, and to construct infrastructure to serve 83,700 low-income Coloradans. [21]

To dedicate more resources for the health care needs of low-income Coloradans, Colorado voters in November 2004 approved Amendment 35 to the Colorado Constitution to raise excise taxes on tobacco products. Revenues from the tax, which are expected to total around $165 million in FY 2005-06, are used to:

- Fund tobacco education, prevention and cessation programs;
- Provide resources for prevention, early detection and treatment of cancer, heart and lung disease via the Primary Care Fund;
- Distribute grants to providers who supply primary care to uninsured or medically indigent patients;
- Implement chronic disease management programs;
- Remove the asset test for Medicaid enrollment for low-income adults and children;
- Increase Medicaid eligibility for low-income adults from 36 percent to a minimum of 60 percent of the federal poverty level;
- Reinstate Medicaid presumptive eligibility for pregnant women;[22]
- Provide Medicaid coverage for legal immigrants;[23]
- Expand enrollment in Children's Extensive Support and the Children's Home and Community-Based Waiver programs;
- Increase eligibility for the CHP+ children's and pregnant women's programs from 185 percent to 200 percent of the FPL; and
- Increase marketing of CHP+.

The Governor's Rural Health Initiative provides funds to increase the public infrastructure capacity and access for primary, oral and mental health care services for rural populations. The funding comes from the state Energy and Mineral Impact Assistance and the federal Small Cities Community Development Block Grant. In 2004, approximately $9.2 million were awarded, and in 2005, $8 million were awarded. At this juncture, it is not known if funding will be available in 2006. Most of the funds have been used for equipment and construction at rural clinics and hospitals.

FUTURE CONSIDERATIONS

Colorado's demographic and health status profile portrays a state with a geographically diverse population. While Colorado has a relatively young and affluent population, the state also has rural geographic areas with high concentrations of elderly, low-income

[21] Colorado Department of Health Care Policy and Financing. November 2004. *Comprehensive Primary and Preventive Care Grant Program, FY 2003-04 Annual Report*, p.5

[22] Until September 2004, pregnant women in Medicaid were considered presumptively eligible. That is, after applying for Medicaid, pregnant women could start receiving services before their self-reported income was verified.

[23] SB 03-176 eliminated most Medicaid services for some legal immigrants. While the legislation was challenged and tied up in the courts, Amendment 35 dollars were dedicated to funding Medicaid services for this population.

and minority residents -- individuals who, in many cases, have relatively acute primary health care needs. Based on demographic projections, the Hispanic and elderly populations in Colorado are anticipated to increase. This trend, coupled with the difficulties in recruiting primary care physicians to rural areas of the state, likely will highlight the health disparities of Coloradans that already exist. Consequently, the Primary Care Office's work in this area will become even more pertinent.

The Primary Care Office collaborates with a variety of safety net providers and programs to direct care to those areas of the state and populations facing access issues. There are a wide range of successes in which underserved areas have gained access to primary health care services. Based on current trends, such as the increasing cost of health insurance, the growing numbers of uninsured and the population's increasing health care needs, these challenges are likely to intensify.