CHI SNAC LABS 2014

Food for Thought

Updates from the Safety Net Advisory Committee (SNAC)

The Right Recipe: Examining Workforce and Other Ingredients for Access to Care

FEBRUARY 27, 2014

This year has ushered in many health insurance changes. It remains to be seen how they will affect access to care. Simply having insurance doesn't guarantee a timely and convenient appointment with a provider. What ingredients – workforce capacity, insurance acceptance, the role of technology and more – affect access? How can they be measured? And what does it mean if some measurements suggest access is improving, and others do not?

Participants in the Colorado Health Institute's Safety Net Advisory Committee (SNAC) Learning Lab on Feb. 27, 2014, discussed these questions, focusing in particular on a key element that can impact access – the primary care workforce. Representatives of more than 15 organizations, including safety net providers, consumer advocacy groups, academic institutions, foundations, and state government, attended the meeting.

This report has two sections: Background information provided by the Colorado Health Institute and a summary of the SNAC Lab discussion.

Primary Themes

- Research on what Medicaid enrollees say about their experiences in getting care, together with a new Colorado Health Institute analysis of workforce data, reveals that measuring access is complex and no single data set reveals the whole picture.
- The SNAC Lab research agenda this year will be driven by the latest information to measure different facets of access, such as access to specialty care, how immigrants access care and the use of telemedicine.
- Conversations about health care involve a variety of issues and populations. The SNAC Lab's focus is on access for vulnerable people, an approach that contributes to broader efforts across Colorado to measure the impact of health care reform on consumers.

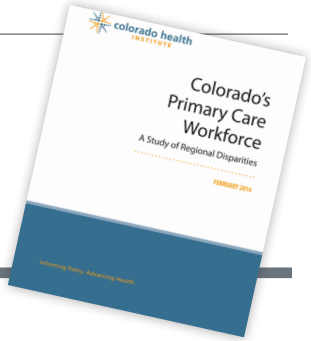
Background: Using Various Data Sources to Understand Medicaid Access to Primary Care

Having insurance is not the same as having access to care, and that is particularly true for Medicaid enrollees. Coloradans with public insurance are more likely than those with private policies to report that a provider would not accept their insurance, according to the 2013 Colorado Health Access Survey.

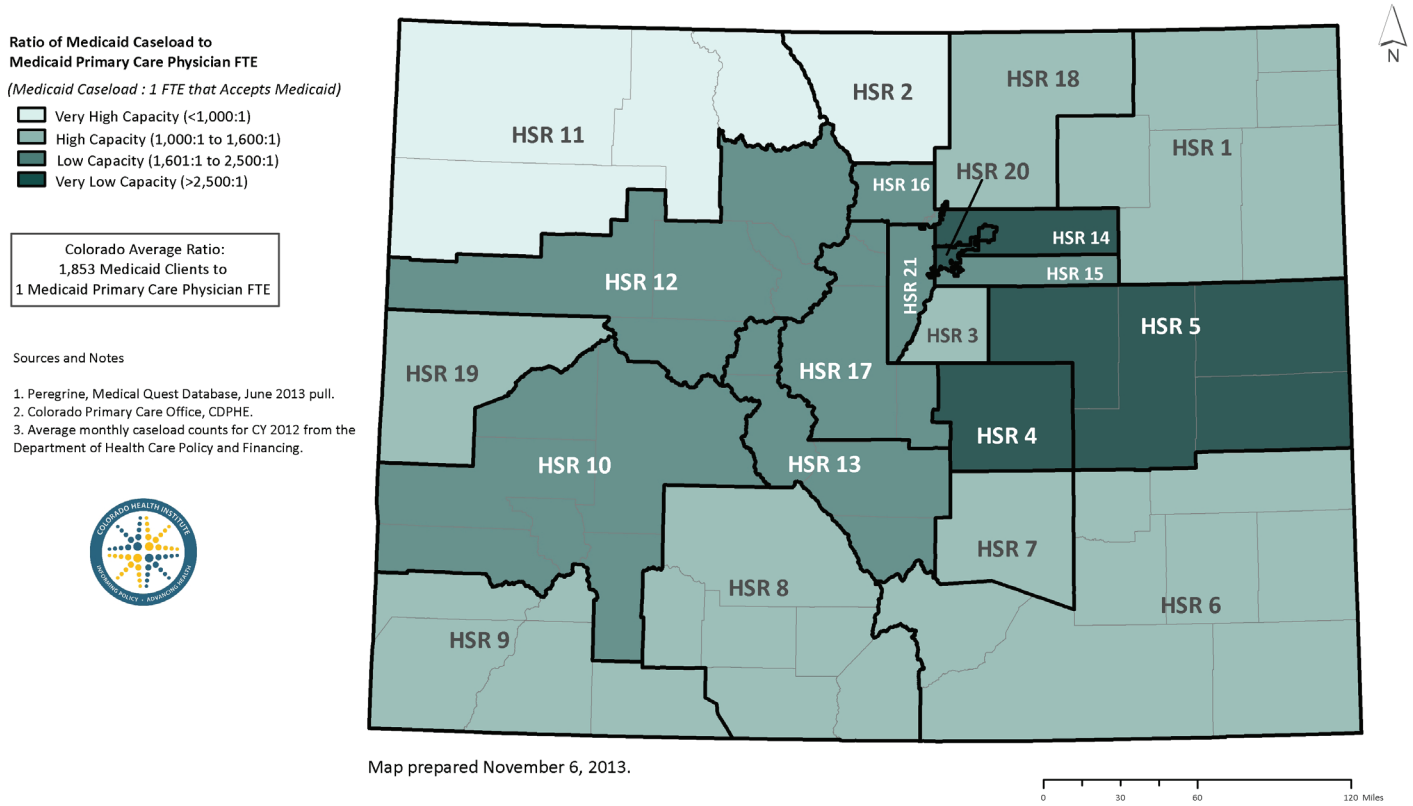
A new Colorado Health Institute study, *Colorado's Primary Care Workforce: A Study in Regional Disparities*, found wide variations in Medicaid primary care capacity across the state, which will become even more pronounced with expanded Medicaid eligibility. Rebecca Alderfer, a senior analyst and lead author of the report, presented the findings and a deeper dive into Medicaid data. Her presentation included the percent of full time equivalent (FTE) primary care physicians who serve Medicaid patients and the estimated number of FTEs that would be needed to reach a relatively adequate number to serve Medicaid enrollees in each health statistics region, based on a benchmark ratio of providers to patients.

The analysis was done using health statistics regions (HSRs). The Colorado Department of Public Health and

Download the new report, *Colorado's Primary Care Workforce: A Study of Regional Disparities*, at **coloradohealthinstitute.org**



Map 1: Ratio of Medicaid Caseload to Medicaid Primary Care Physician Full-Time Equivalents (FTE), by Colorado Health Statistics Region, 2012



Environment has established these 21 geographic areas for public health planning purposes. Some more populous counties are designated as an HSR, while less populous counties are aggregated into one HSR.

Nine Colorado regions have a relatively low Medicaid capacity, meaning they have less than one FTE Medicaid primary care physician for every 1,500 enrollees. Four of these regions are urban and five are rural. (See Map 1). With an estimated 440,000 more Medicaid enrollees by 2016, the workforce will need to increase in some regions, including some that currently have relatively high Medicaid capacity.

While workforce data provides one angle on Medicaid access to care, the 2013 Colorado Health Access Survey reveals the consumer perspective. It asked people several questions to measure their access to care, including:

- Do you have a usual source of care?
- In the prior 12 months, could you not get an appointment because the doctor's office was not accepting patients with your type of insurance?
- In the past 12 months, could you not get an appointment as soon as you thought one was needed?

These data at a regional level, alongside the Medicaid workforce data, tell a complicated story. Four regions were discussed during the meeting to highlight this point. Consider, for example, the situation in El Paso County.

• See insert for detailed data for El Paso County

It has relatively low primary care capacity overall and low Medicaid primary care capacity. To reach a benchmark of relatively adequate primary care capacity for all residents in this region requires an additional 120 FTE primary care physicians, a 53.5 percent increase. The number of FTE physicians caring for Medicaid patients full time would need to increase by 22 physicians, a 122 percent increase.

But a relative shortage of primary care providers for both Medicaid enrollees and those with commercial insurance in our example is just part of the access equation. Another part is the ability to get an appointment with a primary care provider. Taken together, the workforce data and information from the Colorado Health Access Survey about the consumer experience provides a fuller picture.

AN EXAMPLE: EL PASO COUNTY

Workforce data show that El Paso County has relatively low primary care capacity overall and low Medicaid primary care capacity.

- Practicing Primary Care Physicians: **270**
- Average Weekly Patient Care Hours per Physician: **33.2**
- Practicing Primary Care Physician FTEs: **224.4**
- Population: **654,406**
- Residents per Physician FTE: **2,917**
- Physician FTEs Needed to Reach 1,900:1 Ratio: **120.1**
- Percentage Change Needed: **53.5%**
- Medicaid Patients to Physicians FTEs Ratio: **3,333**
- FTE to Meet 1500:1 Benchmark: **22**
- Percent Increase: **122.2%**
- Percent of Total FTE Serving Medicaid: **8.0%**
- Percent of Population on Medicaid 2014: **9.0%**
- High, Average, or Low Use of NP/PA: **High**

The benchmark used to assess relatively more or less abundant primary care capacity is one full time equivalent (FTE) primary care physician for every 1,900 residents. Since Medicaid patients often require more services, a benchmark of one Medicaid FTE primary care physician for every 1,500 Medicaid enrollees was used to estimate the adequacy of the Medicaid primary care workforce.

El Paso County residents with public insurance said they have more trouble getting an appointment because their insurance isn't accepted than their counterparts statewide, but these residents are not more or less likely than all Coloradans with public insurance to have a usual source of care or see a provider when necessary.

	All Insurance Types	Commercial Insurance	Public Insurance	Uninsured
Has a Usual Source of Care	–	↑	–	↓
In the Prior 12 Months, Could Not Get Appointment Because the Doctor's Office Was Not Accepting Patients with Your Type of Insurance	↓	–	↓	↓
In the Prior 12 Months, Could Not Get Appointment As Soon As You Thought One Was Needed	–	–	–	–

↓ Significantly worse than Colorado average ↑ Significantly better than Colorado average – Not significantly different than Colorado average

Sources: (Top) Colorado's Primary Care Workforce: A Study in Regional Disparities; (Bottom) 2013 Colorado Health Access Survey

For example, El Paso County residents with public insurance said they have more trouble getting an appointment because their insurance isn't accepted than their counterparts statewide. That makes sense, given what the workforce data show about the need for more primary care physicians who see Medicaid patients. But at the same time, these residents are not more or less likely than all Coloradans with public insurance to have a usual source of care or see a provider when necessary.

The SNAC Lab Discussion

The SNAC Lab participants came up with some possible explanations for these access issues.

People routinely cross geographic boundaries that are used for data collection

Data is collected for particular geographic areas, such as counties, health statistics regions or the state. But people flow across these boundaries every day; commuting is part of their routine. They may travel to a neighboring county to work or to take their children to school. So it's not unexpected that they would see a doctor in county other than the one where they live. Geographic boundaries may be artificial when looking at access to care. Safety net providers often see patients who are willing to travel to services they need and providers they trust.

Mid-level providers must be considered to get a full picture of the primary care workforce

A community-level assessment of the role of mid-level providers could help explain access to care patterns. Nurse practitioners and physicians assistants, often referred to as mid-level providers, play an important and growing role in Colorado's primary care workforce. Practices use these providers in different ways, based on the culture and preferences of the practice as well as the needs of the population they serve. Safety net clinics are developing their own models for using mid-level providers. School-based health centers in particular rely heavily on nurse practitioners. At Colorado's federally qualified health centers there is at least one mid-level provider for each FTE primary care physician, and they are sometimes assigned their own panel of patients.

Conclusion

All data sources have strengths and limitations. Workforce data allow for comparison across the state and can provide high-level insights into access and related issues. It allows researchers to identify hot spots and develop plans and policies to strengthen the workforce. But a more detailed picture of access can only be seen on a local level. Patients may get care from different kinds of providers, or may travel to the next county for services. While each data source offers insight into access to care, a more thorough understanding of this important issue requires detailed community-level context.

Prioritization for 2014 SNAC Lab Access to Care Meetings

Access to care encompasses a variety of perspectives and challenges. The group discussed elements that should be considered when evaluating these topics and prioritized areas of interest. These elements will guide SNAC Labs for the year, although agendas will remain flexible to respond to changing health policy developments.

- What care is offered and when: culturally and linguistically appropriate care, all kinds of care (including specialty care), evening and weekend hours, minimal wait times;
- How patients are connected to care: patient navigation, care coordination, adequate transportation, affordability of care;
- Patient responsibilities: patient compliance, patient education;
- Cultural context: stigma around public insurance or accessing certain kinds of care; perceived need for care.

Topics prioritized for future SNAC Lab discussions include access to specialty care, use of telemedicine, and how immigrants access care.

Reporting from the Field

Inner City Health Center has been providing medical, dental and counseling services for 30 years. People come from across the Denver metro area and beyond to receive care at the clinic, which is in the heart of Denver's inner city. About 80 percent of its patients are uninsured.

Kraig Burleson

Kraig Burleson, CEO of Inner City Health Center, expects the demand for services to increase as health reform evolves and newly insured people, as well as those who remain uninsured, seek care. Inner City Health Center has started to accept private insurance for the first time, along with public insurance, so patients can get treatment there regardless of insurance status.

Burleson says that the clinic has a sufficient workforce, but its model is a bit unusual. About 70 percent of the medical providers are volunteers who give a specific time commitment and are assigned a panel based on how many patients the provider can see in a day. This number depends on the medical specialty and who is being served. For example, children usually have fewer complex health needs than adults, so a pediatric provider can see more patients in a day than one serving adults. Uninsured adults in particular tend to have accumulated a list of health concerns and complex chronic conditions that take time to discuss with a medical provider.

While the current model is working well for Inner City Health Center, Burleson thinks it may look different in a few years. Assuming the Affordable Care Act continues to be implemented more or less as it is now, he expects pent-up demand for care and the volume of treatment for chronic conditions at the clinic will eventually level out. At that point, Inner City Health Center may employ a more conventional approach to designing a patient panel.

Organizations Represented at the February 27, 2014, SNAC Lab

- Caring for Colorado Foundation
- Colorado Access
- Colorado Association for School-Based Health Care
- Colorado Coalition for the Medically Underserved
- Colorado Community Health Network
- Colorado Department of Health Care Policy and Financing
- Colorado Hospital Association
- Colorado Rural Health Center
- ClinicNET
- Inner City Health Center
- Jefferson Center for Mental Health
- Kaiser Permanente Colorado Community Benefit
- Oral Health Colorado
- Quality Health Network
- University of Colorado – Anschutz Medical Campus
- University of Denver

Colorado Health Institute is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. Colorado Health Institute is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

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