WORK GROUP ON IDENTIFYING AREAS OF GREATEST UNMET NEED

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The goal of the work group is to identify areas of the state with greatest unmet need for safety net services. We will analyze data collected on the provision of primary care services by safety net providers to determine which areas/ counties have uninsured individuals that do not have adequate access to primary care services.

The goal of data collection was to identify the number of uninsured receiving primary care services by different safety-net organizations, in order to identify areas of greatest unmet needs. The definition of primary care services was based on the Institute of Medicine's definition.

Primary Care essential elements:

- Accessible (e.g. available 24 hours per day, 7 days per week)
- Comprehensive (e.g. covers preventive, primary and acute care services)
- Coordinated (e.g. does provider work with and follow-up on patient's care with referral sources?)
- Continuous (e.g. can patient make subsequent appointments with same providers?)
- Accountable (e.g. regular review of quality, assessing outcomes)

Comment: This is an issue of definition. Hospital emergency rooms can be a person's primary care provider. Teaching hospitals and residencies provide high risk care and primary care providers rely on them as the safety net. These are part of the safety net but do not meet the clean definition.

Comment: An area of the state may have adequate primary care but these practitioners may hit a wall when it comes to referrals to specialists.

Comment: Our goal here is to first provide adequate primary care capacity and then work on specialty referrals and other levels of the safety net.

Question: Isn't the goal of this group to identify the uninsured and sell this data to policy makers, not necessarily the accuracy of the data?

Answer: The goal of the group is to identify the areas of greatest unmet need. We need to decide whether these data are useful in doing this.

Data Sources and Limitations:

County level uninsurance data (Column A through F): Estimates of the uninsured in each county are based on a model developed by the Sheps Center for Health Services Research. They are based on statewide CPS data. County level estimates were

developed using: age, gender, race/ ethnicity, employment status, industry, income, and education of the county population as predictors of uninsured status. The limitations are that these are only estimates. They are not based on county level survey data.

Federally Qualified Health Centers (Column K): Data on uninsured users were provided by NC Association of Community Health Centers. Health centers provided total numbers of uninsured users in UDS reports from 2003. Health centers also report the percentage of users in each county in the service area. County level estimates of uninsured seen in FQHCs were obtained by multiplying the total of uninsured by the percentage of total users from a county.

State Funded Rural Health Clinics (Column L): Data on uninsured were provided by ORDRHD (2003 estimates). Numbers of uninsured users only include MAP eligible individuals e.g. individuals who are uninsured with incomes below 200% FPL. State funded rural health centers also see other uninsured individuals that do not apply for or qualify for MAP.

Free Clinics (Column M): Data was provided by the NC Association of Free Clinics from 2003. The total number of uninsured seen by free clinics (69,320) was lower than originally estimated (125,000) because some centers initially counted visits instead of users. There was not data on county of residence of all free clinic users. Users were assigned to the county where their free clinic was located.

Hospital primary care clinics (Column O) and AHEC Clinics (Column P): Data on uninsured seen in hospital primary care clinics are still being collected. We are still missing data from UNC, Duke, and Pitt. Tom Bacon provided data on uninsured seen in AHEC clinics. The information was provided by visit. The number of visits was divided by 3.2 to estimate the number of uninsured users. We have data from six AHEC teaching sites and are still missing data from Cabarrus, Union, and Henderson.

Other safety-net organizations (Column R): We are still trying to collect data from Project Access and HCAP grants. One of the limitations of these data is that some of the uninsured individuals may be going to other safety net providers.   The data does not capture individuals seen in private physicians offices and some individuals seen by rural health clinics that do not receive state funds.

Public Health (Column S through MM): Data on uninsured users provided by the Division of Public Health is from the HSIS system. User information was provided by service area (e.g. adult health, child health, maternal health, etc…). Not all of these service areas provide comprehensive primary care. For example a child health clinic may provide well child checks and immunizations but not “sick” care. The Division of Public Health does not currently collect data for primary care visits. The Division of Public Health has provided a list of health departments that have self identified themselves as providing primary care services (designated for adults, children, or both). We also have data from Medicaid that identify health departments that are enrolled as providers for

Carolina Access I or CCNC. These practices are required to provide comprehensive primary care services.

With these data limitations, to estimate the number of uninsured individuals seen by local health departments, data was used for LHDs that identified themselves as primary care providers and were designated as Medicaid PCPs. We included all the uninsured users of adult health, child heath and maternity health clinics for the counties that self-reported that they provided primary care services to children and adults. We included all the uninsured users of child health clinics for those counties that self-reported that they provided primary care to children only. We included all the uninsured users of adult health and maternity clinics for the one county that reported that it provided primary care to adults only.

Limitations of the Public Health data: These data are the most speculative and are subject to both an overestimate and an underestimate of the uninsured seen. Including all the uninsured who used the adult health, child health, or maternal health clinics may be an *overestimate* of the number of people who receive primary care. However, because health departments are not required to report on primary care visits, the data may be an *underestimate* of the number of people who receive primary care.

Question: How many counties are providing Healthy Carolinian programs and can we use them to help us gather data on where the uninsured receive their care?

Answer: The focus of the Healthy Carolinian program is on promoting prevention and public health and not as much on access to care.

Health status data (Columns NN, OO, PP, QQ): Avoidable hospitalization rates were obtained from AHRQ Monitoring the Health Care Safety-Net (Source 1999 HCUP Data). These data do not distinguish between conditions that are very preventable (e.g., asthma admissions) from those that are not as preventable (e.g., congestive heart failure). Also, it is unclear whether high ACS rates are due to lack of primary care, physician practice patterns, or other factors. Infant mortality rates (Column QQ) are from the State Center for Health Statistics (1998-2002).

Total uninsured primary care clients (Column G): This number represents the total number of uninsured seen in various safety-net organizations totaled across organizations.

Estimate of unduplicated primary care clients (Column H): The number in Column G was reduced by approximately 11% to get an estimate of unduplicated individuals. NC BRFSS data indicate that approximately 11% of uninsured who report a usual source of care report two or more sources of care.

Percentage of uninsured who have primary care home (Column I): Determined by dividing the estimate of unduplicated primary care clients (Column H) by the county estimates of uninsured (Column E).

Number of uninsured who did not receive primary care services from safety net organizations (Column J): Determined by taking the difference of the county level uninsured estimates (Column E) and the estimate of unduplicated primary care clients (Column H).

Comment: If the total [number of uninsured] is approximately correct and you divide by the total capacity of primary care practitioners in the state, the uninsured would account for about 2% of their patient load. This appears to be a reasonable number. If you look at this and begin to allocate cost it also looks reasonable. The uninsured, if they reflect national use rates, would generate about a million visits in a year. One million visits at $100 per visit totals to $100 million. This would be the approximate cost of seeing the uninsured in the safety net of primary care physicians were to take care of their ambulatory care needs.

Comment: Only 20% of the uninsured are being seen by safety net providers. These data do not take private physicians into account.

Comment: The bottom line is that 80 % of people are not cared for by the safety net. Shouldn't we be thinking about what kind of bill you might propose [to address this] and look at the data from that perspective.

Comment: We are looking at the uninsured, maybe we should be looking at the <200% FPL (low income uninsured). Then it would show that 40% of the need is met instead of 20%. [This may have a greater impact when we approach policy makers.]

Comment: It would be helpful to rank the counties by unmet need and see if it makes sense.

Comment: These numbers are not ready for prime time, but we should think about what we would do when they are. State level estimates are helpful, but I wouldn't trust the county level numbers as much. May not be helpful for action at the county level.

Response: My goal was to actually help identify communities or areas where we could focus grant funds.

Comment: It would be helpful to take this data and somehow go back to the county and ask if the data makes sense. How would we do that?

Comment: This data should just give us an idea of where to focus the findings of the other group (dealing with coordination and integration of safety-net services). We are not going to have a data cut where there is a top 10.

Questions: Can we do a survey about what percentage of doctors see the uninsured in NC.

Answer: The medical society did a survey and only got a 10% response [so we are really not certain of this number].

Comment: Wouldn't it make sense to zero in on the number who are not being seen by anybody.

Question: Is there a better local network than the healthy Carolinian group?

Answer: CCNC network would be better because they deal with medical care as opposed to broader public health issues.

Comment: Possibly we could feed this data back to the CCNC networks and see if it matches up with their perceived needs.

Response: Nobody is going to have better data than this. When you have to make decisions about distributing money, decisions will be made [whether the quality of the data is high or low]. If we are going to be distributing money, the counties that are not funded will be pushed to refine the data if they do not agree with it. We should get on with trying to use this data and realize this is a multi year process.

Comment: Thinking about Kate B Reynolds and other grantors: What you always come back to is capacity in the rural counties. The problem is that the northeast and other counties always come out with a lot of need, but there is no local leadership.

Comment: It would be helpful to have the number of low income uninsured because that will lead to different solutions.

Comment: This is what I have heard: To improve the usefulness of this data in identifying unmet needs

1. *Add estimates for low income uninsured (<200% FPL) to spread sheet.*
2. *Follow up with data sources that we have not obtained.*
3. *Attempt to make an estimate of the percentage of uninsured seen by private physicians. (Attempt to weight column J by private physician capacity).*

Comment: From a hospital perspective, these numbers do not reflect their need. Often it is the amount of commercial insurance and not the absolute number of uninsured that is the most important because [commercial insurance allows you to cost shift to cover the costs of the uninsured].

Comment: Just by picking high need counties, you miss some of the most at risk and devastated individuals. For example: there may be extremely high risk individuals in a county with an adequate safety net that would benefit the most from improved services.

Potential recommendation: We need an organization that is responsible for collecting and monitoring the safety-net on an ongoing basis. The NC Office of Research, Demonstrations and Rural Health Development (ORDRHD) would make the most sense,

since they help develop safety-net resources, and also have the responsibility of distributing the new legislative appropriations.

Comment: We should also send the data to local communities to review, for example, through Healthy Carolinian or CCNC networks. Counties could partner with other counties and explore their local situation in greater detail, and then send additional updated data to the ORDRHD.

Comment: The new state appropriation requires ORDRHD to report on the number of new uninsured seen in safety-net organizations. That means that ORDRHD will have to collect baseline information, in order to determine the increase in the numbers of uninsured seen.

Comment: We should use this data as a starting point, and try to use it to get more accurate data. If Kate B. or Duke Endowment asked for the information, we would get a greater response rate.

Comment: We don't want people to focus on the actual numbers in any particular county, because with the problems with the data, the numbers may not be exact. However, as these data get cleaned, we may be able to present these data in a more useful format—for example, a consumer reports type of document, that displays counties that have greater or less safety-net resources.

Comment: In summary, we need to get the outstanding data that we are missing (from hospital outpatient clinics, AHEC family medicine clinics, and other safety-net organizations). We should also try to estimate the number of uninsured patients being seen in private doctors offices. (We have national data, but not NC specific data on this). After we get the outstanding information, we can prepare a list of high-need counties (based both on percentages of uninsured that do not have a medical home, and the numbers of uninsured that don't have a safety-net home). We will make a set of proposed recommendations that include: 1) ORDRHD will be in charge of maintaining and refining these data; 2) we will seek help from foundations to collect the data and to give priorities to communities that appear to have the greatest needs; 3) we will send the data back to local communities through CCNC networks and Healthy Carolinians. The local communities can help us identify other sources of care for underserved populations and can use the data in developing strategies to address outstanding needs. Other data, such as ED visits for uninsured, would be useful, as many uninsured use the ED as their primary source of care. However, given that we are trying to find out if the uninsured have access to comprehensive, continuous primary care (e.g., a medical home), the hospital ED data should not be included in this chart.

Comment: We also need to examine ways to meet other health care needs of the uninsured, such as specialty referrals, prescription drugs, dental, behavioral health, etc. Even in communities that are able to meet the primary care needs of the uninsured, they may not be able to address these other health needs.

Comment: Many low-income uninsured patients don't need access to ongoing specialty care, what they need is a specialty consult—for example, a surgeon to consult on a mammogram or a GI to consult on abdominal bleeding. It's really primary care done by specialists.

Question: Is this a capacity issue or a financial issue—i.e., are there enough specialists to meet the need? Or is it that specialists won't see the uninsured without payment.

Answer: Its both. In many communities, it's a financial issue—but in some urban and rural communities, there are too few specialists or not enough technology to meet the needs of the insured. Transportation is also a problem, if the uninsured need to travel to another community to get care.

Question: In one study that examined the adequacy of the safety-net, the researchers surveyed communities to find out the safety-net capacity, both for primary care and specialty care. Absent a statewide survey in North Carolina, is there any proxy we can use to measure specialty access?
Answer: It will differ by specialty. Oncology, cardiovascular, neurology all might have different degrees of access to the uninsured.

Question: Can we use community examples as a way of describing the problems accessing specialists? This issue also affects the willingness of community doctors to take ER call, as they are concerned about the lack of access to specialty consults. The ED physician doesn't want to be left holding the bag.

Comments: We should try to identify a way to get better data about specialty access—maybe through a survey with community health centers and/or rural health clinics. But we need to make sure we don't just anecdotes about the problems that one physician had getting a specialty referral. We want to know what are the major problem areas—the specialty consults or specialty care that are most problematic. We want evidence of a systemic problem obtaining certain types of referrals, but quantifying the problem may be difficult.

Comment: It may not make sense to do a survey, but we could use isolated case examples for illustration. We will ask the NC Primary Health Care Association to help us gather data about the problems across the state accessing certain types of specialty consults.

Comment: At the next meeting, we'll try to finalize our recommendations for the primary care, and to focus some on specialty problems. One potential solution would be to expand Project Access, or a fair share system so that specialists can be assured that they will not be inundated with uninsured patients.

Comment: Maybe we can develop a modified Project Access model—to work out arrangements with specialists to take a certain number of uninsured and to give them public recognition for their work.

Question: What are we trying to address with the data? Just because a person is uninsured doesn't mean that they have problems getting care when they need it. They may not be sick. How do we know the number of people who aren't getting the care they need?
Answer: We don't have definitive data on this, but know from a NC BRFSS survey (Behavioral Risk Factor Surveillance System) that 45% of the uninsured reported that there was a time in the last 12 months when they needed to see a doctor but didn't because of the cost (compared to 9% of those with insurance).
Comment: So, we are really looking at 45% of 19% (percentage of the state population under 65 that is uninsured).

Comment: That may be too restrictive. Some people get care, but get it too late. Many of the uninsured are seen in the Emergency Department, but it is often too late and costs more. A few don't seek care because of the costs, or because they have outstanding bills that acts as a barrier.

Comment: That is my concern with examining the provision of care to the uninsured by private doctors. Uninsured patients may be seen in private physicians offices, but if the provider doesn't have a system to waive or reduce the fees; then the uninsured patient may not seek additional care because of an outstanding bill. We want to know if the uninsured really have access to providers.

Comment: Ideally, we want numbers of the uninsured who should have sought care but didn't. Just because you are uninsured doesn't mean there is a problem.