Capacity & Access

Care in Colorado during Health Reform

Health reform presents an exciting opportunity to provide access to healthcare for Coloradans. Much of the focus so far has been on increasing insurance coverage and potential problems. It is clear that reform may pose some challenges, but Colorado can improve its healthcare system to provide access to quality healthcare. Evidence shows that the current healthcare system can become more effective and efficient to meet the needs of the currently insured and the newly insured. Now is the time for everyone to commit to making the changes necessary to provide access to quality healthcare.

Current Colorado Healthcare System

About one third of Medicaid enrollees report their usual source of care as a community health center or public clinic as opposed to about 5% of the commercially insured.[27]

Utilization

- 37.8% of Medicaid enrollees visited an ED in the year before the survey compared to only 20.5% of uninsured and 19.2% of commercially insured.[27]
- 51% of Medicaid enrollees who visited an ED said their visit was for a condition that could have been treated by a primary care provider had one been available (compared to 39% of commercially insured).[27]

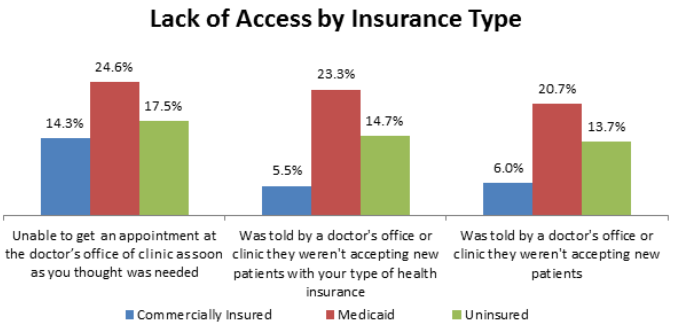

Chart 1: Lack of Access by Insurance Type. Source: The Colorado Trust.[27]

Newly Insured

- 510,000 CO residents expected to be newly insured by 2016 (130,000 new to Medicaid and 380,000 newly privately insured) [1]
- Other estimates performed in 2013, suggest there will be a total of about 211,000 Colorado residents who will be newly enrolled in Medicaid in 2016 with around 65,000 being previously insured through the individual or employer-sponsored markets and 146,000 previously uninsured.[29]

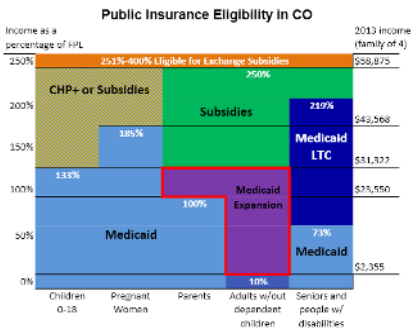

Chart 2: Public Insurance Eligibility in Colorado. Source: Colorado Health Institute[1]

- Those newly eligible for Medicaid include Parents 101-133% FPL and Adults without dependent children 0-133% FPL. This group has the following characteristics:
  - Worse self-reported health status than the Colorado population;[7] better self-reported health status than current Medicaid enrollees.[6]
  - Uninsured low-income (<133% FPL) adults are also less likely than Medicaid enrollees to have diabetes, high blood pressure, or high cholesterol, but if they have one of these diseases, the disease is more likely to be uncontrolled or undiagnosed.[6]
  - Approximately 32,000 adults in Colorado that will be newly eligible for Medicaid may have diabetes, high blood pressure, or high cholesterol uncontrolled.[31]

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Practice-Level Recommendations

Theoretical Modeling

• The predicted primary care physician shortage can be eliminated through the optimum and widespread use of team-based care, mid-level providers, and electronic communication along with moderate or advanced access scheduling.[41]

• Interdisciplinary team in which all team members perform at the top of their skill level can increase panel size[11]

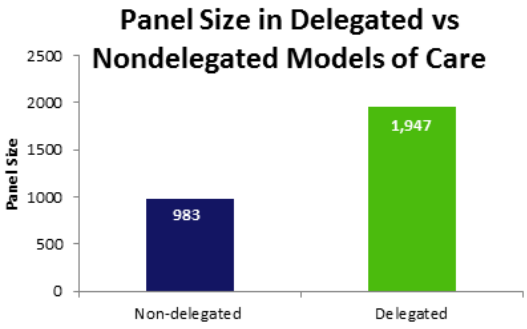

Chart 3: Panel Size in Delegated vs. Nondelegated Models of Care. Source: Altschuler, 2012.[11]

Patient-Centered Medical Home

• Patients in PCMHs used more email, phone, and specialist visits but less emergency visits and inpatient ambulatory care services with no significant difference in costs.[48]

• Improvements in patient satisfaction and access have also been seen. Children with medical homes had significantly lower rates of unmet medical needs.[44] Patients also reported enhanced care coordination, access, and patient activation and involvement.[45]

• Emotional exhaustion of staff at PCMH clinics was 10% after one year compared to 30% at control clinics.[45]

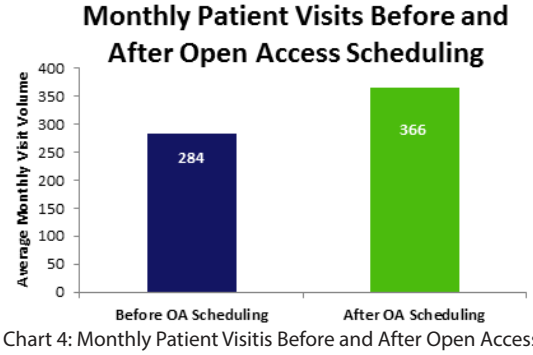

Chart 4: Monthly Patient Visitis Before and After Open Access Scheduling, at one practice. Source: Heptulla, 2013.[53]

Enhanced Scheduling Methods

• Open Access (OA) scheduling (also called Advanced Access or Same-Day Scheduling) has been shown to decrease wait times and patient no-shows while increasing patient volume.[12,52,53]

• One clinic that implemented OA scheduling decreased wait times for new appointments from 11.0 to 1.7 weeks while simultaneously increasing the mean monthly visit volume by 28.9%.[53]

Extended hours

• Extended office hours at primary care practices are associated with increased access, decreased ED usage, and lower health expenditures.[54-55]

Telemedicine

• Telemedicine can increase efficiency, reduce in-person office visits, and enable rural clinics and patients to easily consult specialists, increasing access for patients.[56-64]

Group Medical Visits

• Group medical visits can reduce overall the number of visits while achieving at least similar outcomes as traditional visits.[14]

Staff Mix Changes

• Use of MAs and RNs as EMR scribes during visits can increase the number of patients seen daily.[13]

"Whether Colorado is ready for the change or not, it is going to happen. One of the most important things that can be done to prepare for healthcare reform is learn to manage change. Embracing new models of care will help Colorado lead the country in providing access to quality healthcare."

- Anita Rich,
Colorado Children's
Healthcare Access Program[40]

System-Level Recommendations

Payment Reform

• Payment reform needs to support the changes Colorado hopes to see in order to increase access and quality in healthcare in a consistent way. Payments must align with current access and quality efforts to incentivize and reward those improving the healthcare system.

• There is a correlation between the rate of Medicaid payments and the number of physicians accepting Medicaid patients.[92-93]

Medicaid Provider Recruitment and Education

• Provider education is critical to increasing the number of providers who accept Medicaid.

Better HIT usage

• Better interoperability of EMRs and CORHIO's HIE can improve the speed and effectiveness of referrals, reduce duplicated care, and provide one place for patients to access their records.[22]

Increase Access to Specialty Care

• Increasing the availability of specialty care (through telehealth, using PAs to deliver specialty services, and having specialist travel to remote primary care sites);[75]

• Expanding the role of primary care providers through training and electronic consultations so they are able to handle more specialized health issues themselves;[75] and

• Enhancing care coordination with access coordinators dedicated to arranging specialty care.[75]

Scope of Practice

• States with the least restrictive regulations had the most growth in licensed NPs and the highest proportion of Medicare patients with an NP as their primary care provider.[21]

• Regrettably, Colorado has the strictest regulations in the country for new graduate PAs, which discourage new graduate PAs from seeking jobs in rural areas and physicians from hiring new graduate PAs.[80]

For 2013-2014, Medicaid will reimburse primary care claims at Medicare rates[81]

Providers contracted with the ACC will receive a $3 PMPM incentive for patients enrolled in Medicaid that are attributed to their practice. Additional benefits of up to $1 PMPM can be received based on quality outcomes.[73]

Source: [81]Kaiser Family Foundation, [73]Colorado Department of Health Care Policy

Care Coordination and PCMH Neighbors

• A typical primary care physician coordinates care with 229 other physicians working in 117 practices.[76] An average Medicare beneficiary sees 7 different physicians each year in 4 different practices[76] which can result in greatly fragmented care.

• A Patient-Centered Medical Home Neighbor is a specialist who ensures effective bidirectional communication and patient care information flow, engages in management of patients, and supports and attempts to embody the goals of the PCMH model. [77]

• PCMH Neighbor initiatives saw improvements in transitions of care from the PCP to the specialist and the specialist to the PCP improved significantly in the first 6-8 months.[20] Access to specialty care also improved.[20]

Traveling Providers and Hub-and-Spoke Model

• Hubs are found in areas with larger populations and include a wide range of higher-level services like specialist, procedural, emergency, mental health, and imaging services that can be provided remotely or by traveling providers. Spokes are service partners in the communities that provide primary healthcare services only to the local population.[78] In Colorado, this model could be used to improve access to specialty services in rural settings.

Shared Resources

• Smaller practices who cannot afford all the resources required to comprehensively treat their patients can share resources to save money and be more efficient. Resources can be technical (such as a shared EMR, billing staff, or QI planning) or clinical (such as shared patient educators for genetic, nutrition, and chronic disease counseling, mental health, social services, home visiting, supply purchasing, and nurse phone lines).[79]

All of the previous recommendations do come at some cost, whether in time, money, or effort. It is important to keep in mind, though, that health reform in Colorado is going to happen. Whether or not providers, policymakers, and patients embrace this change to our healthcare system will influence health reform's success. With that in mind, the following page describes some of the key challenges Colorado may face in the next few years.

Potential Challenges

Provider Shortages

• Estimated that by 2016, an additional 83-141 primary care providers (71-117 physicians and 12-24 nurse practitioners and physician assistants) will be needed throughout Colorado to provide an additional 256,000 – 432,420 primary care visits per year more than they currently do just to cover the extra visits by the newly insured Coloradans.[1]

• CHI projections estimate there will be a shortage of 2,200 primary care providers by 2025.[18]

• Much of Colorado already has healthcare shortages. Of the 64 Colorado counties, 56 counties were either fully or partially designated as primary care health provider shortage areas.[33]

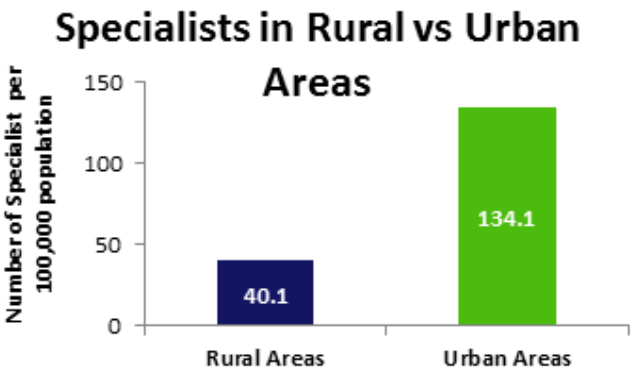

Chart 5: Specialists in Rural vs Urban Areas. Source: Gamm, 2010.[37]

Specialty Care

• Obtaining specialist referrals for patients in Colorado's safety net is difficult and inconsistent.[35]

• Psychiatry and dermatology had the lowest rates of Medicaid acceptance.[36]

Rural Care

• Only 10% of physicians in the U.S. practice in rural areas while 25% of the U.S. population lives there.[37]

• Shortages in rural areas exist for all providers, but these shortages are worst in specialist fields.[37]

"PCMH Neighborhoods can help reclaim the joy of medicine and camaraderie for providers."

- R. Scott Hammond, MD
Westminster Medical Clinic[20]

Physician Perceptions

• Many physicians feel a tension between a personal, ethical responsibility to care for all patients and the need to run a profitable business, thus many physicians cap the percentage of Medicaid patients they can accept.[38]

• In one survey, all physicians noted that low Medicaid payments were a barrier to accepting new Medicaid patients and thought that if payments were increased more providers would consider accepting Medicaid patients or expanding their current Medicaid patient population.[38]

• Primary care providers who currently see the greatest number of Medicaid patients are more likely to take on more Medicaid patient.[39]

For a full report and references,
please visit *www.healthteamworks.org/about/capacityandaccess.html.*

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