Sponsored by Kaiser Permanente

2010 Colorado Safety Net Specialty Care Assessment

Final Report

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Executive Summary

Kaiser Permanente Colorado partnered with the Colorado Health Institute (CHI) in 2010 to develop the *Colorado Safety Net Specialty Care Assessment,* a needs assessment with both quantitative and qualitative elements to help document the specialty care access gap faced by the safety net. The assessment included examining the availability of specialty care in the health care safety net through a statewide survey, reviewing the data through a regional lens, and researching best practices for specialty care referrals.

The survey was designed to determine whether Colorado's safety net clinics experienced similar challenges as those documented nationally in securing specialty care services for their patients.[1] In Colorado, anecdotal evidence suggested that specialty care was especially difficult to obtain for the hundreds of thousands of low-income, uninsured, underinsured, and other vulnerable individuals who rely on safety net services for needed health care. However, no known statewide evaluation of the availability of specialty care services in the safety net had ever been conducted in Colorado.

The survey was disseminated in partnership with ClinicNET, the Colorado Community Health Network, and Colorado Rural Health Center. CHI administered the survey on-line between October and December 2010 to medical/clinical directors and administrators of rural health clinics, federally qualified health centers, and community-funded clinics throughout the state. In addition to clinic characteristics, the survey included questions about availability of specialty services on site, the ability to secure referrals, specific barriers to securing referrals, potential solutions, and strategies used by clinics to obtain referrals. A little more than half the survey respondents were from federally qualified health centers, with community-funded and rural health clinics roughly making up the other half.

CHI also developed profiles detailing regional differences in the ability to secure access to specialty care. To provide context to the survey data, the regional profiles included supplemental data from a variety of data sources, including demographic, socioeconomic, health, and health care utilization measures. The state was divided into five regions comprising the eastern plains, western mountain areas, and three metropolitan areas along the Front Range.

Finally, key informant interviews were conducted with local and national specialty care referral networks to identify innovative strategies being used to secure specialty care services for safety net patients.

Any questions about the data or analyses should be directed to Jeff Bontrager, program manager for the Center for the Study of the Safety Net, at BontragerJ@ColoradoHealthInstitute.org.

[1] Cook, NL, et al. (2007). "Access to specialty care and medical services in community health centers." *Health Affairs* 26(5): 1459-1468.

DEFINITIONS USED IN THE ASSESSMENT

What is the health care safety net?

In 2000, the Institute of Medicine (IOM) released a study, *America's Health Care Safety Net: Intact but Endangered*, that describes the nation's safety net as a highly localized and fragile patchwork of health care providers serving vulnerable populations. Specifically, the IOM study defined "core safety net providers" as those that share two distinguishing characteristics: 1) care is provided to patients regardless of their ability to pay, either by legal mandate or an explicit mission, and 2) a substantial share of providers' patient mix is comprised of uninsured, Medicaid or other vulnerable patients.[2]

While a wide array of types of safety net providers exists, survey respondents were limited to community-funded clinics, federally qualified health centers, and rural health clinics.

Community-funded clinics include nonprofit clinics and programs, free clinics, faith-based clinics, rural health clinics, clinics staffed by volunteer clinicians and family practice residency program clinics. These clinics provide free or low-cost primary care services to low-income uninsured and underinsured families and individuals.

Federally qualified health centers (FQHCs), also known as community health centers, provide comprehensive primary care to low-income populations of all ages. FQHCs are located in communities that have been designated as federal medically underserved areas (MUAs) or medically underserved populations (MUPs). CHCs provide primary physical, oral and some behavioral health care in the community; if they do not provide a primary care service directly, they are required to arrange for needed care in the community.

Rural health clinics (RHCs) are located in non-urbanized areas of Colorado that have been federally designated as having a shortage of health care providers or a medically underserved population. RHCs are certified with one of two designations: provider-based or independent, free-standing. While the breadth of services may differ based on a clinic's designation type, both provider-based and independent RHCs provide outpatient services to rural communities. Although RHCs are considered under the umbrella of community-funded clinics, this report discusses them separately because of their federal designations and unique financial and organizational models.

What is specialty care?

For the purposes of the survey, specialty care was identified as medical care provided by a board-certified specialist with advanced training and specialized clinical expertise in such specialty areas as surgery, neurology and oncology, to name a few. Acknowledging that there is no consensus about whether obstetrics/gynecology is a medical specialty, this survey considered obstetrics and gynecology to be specialty care. Behavioral health and oral health care also are included among the list of specialty care services. Specialty care did not include urgent and trauma care, family practice, internal medicine or general pediatrics.

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[2] Institute of Medicine. (2000). *America's Health Care Safety Net: Intact but endangered*. Washington, DC: National Academy Press.

SURVEY FINDINGS

Overall, the survey results revealed that securing specialty care referrals for patients within Colorado's health care safety net system is difficult, inconsistent and often futile.

Most safety net clinics offer specialty services on site but may be limited to just a few types

Two-thirds of responding clinics indicated that they provide specialty services on site, but the data suggest they offer only a few types of care. Most primary care clinics are likely not equipped or staffed to offer services such as vascular surgery or audiology. This fact is reflected in the numbers of clinics responding that they don't offer most specialty services at their facility. Most clinics indicated they provide on-site mental health and dental services, which is beneficial; these services are not always easy to secure when clinics must refer patients, especially those who lack insurance coverage, to outside providers.

The importance of health insurance

Safety net clinics indicated major barriers and greater difficulty in securing specialty referrals for their uninsured patients than for patients covered by public or private insurance. Moreover, the *type* of health insurance influences the difficulty safety net providers have in referring for specialty care. Findings suggest that the challenges in securing referrals for specialty care *decrease* as one moves down the following list of insurance types (from hardest to easiest):

- Uninsured
- Medicaid
- Medicare
- Privately insured

Why? The top three barriers given for problems in securing specialty care for uninsured patients are:

1. Patient cannot afford to pay for all or part of specialist's charges;
2. Specialists available in the community, but not willing to see uninsured patients; and,
3. Requirements that patients pay in full at time of specialist appointment.

There may be multiple reasons why specialists are not willing to see uninsured patients, but the most likely is that the provider will receive little, if any, reimbursement for services. The financial responsibility falls on patients, and most low-income patients are unable to afford expensive specialty services. In addition, the amount of financial reimbursement tends to follow the order list above; that is, uninsured reimbursement is generally the lowest, followed by Medicaid, Medicare and private insurance.

However, having private insurance is not a guarantee of access to specialty care. Roughly 10 percent of respondents identified major challenges in obtaining referrals even for privately insured patients. This result suggests there are additional factors than just those associated with financial reimbursement. Travel distance, transportation, long wait times and lack of specialists in a community are also major barriers for patients covered by Medicare and private insurance.

Barriers to specialty care vary by type of insurance

A thorough understanding of barriers to specialty care is necessary to develop strategies to address them. As mentioned above, the most frequently cited barriers for uninsured patients tend to be financial in nature. For Medicaid patients, the first three barriers point to network adequacy and supply issues:

1. Long wait times to secure appointment with specialist;
2. No specialty providers in community willing to see Medicaid patients;
3. Lack of adequate referral network for specialty care providers;
4. Travel distance to specialists; and,
5. Lack of patient transportation.

The fourth and fifth most frequently cited barriers relate to transportation and travel distance. These barriers may be related to network and supply issues. For example, the patient's town may lack a provider willing to take Medicaid, forcing the patient to drive a long distance to obtain care.

Barriers inherent to the population of patients also may exist. Many individuals covered by Medicaid may not have the financial resources to own a car, may have a disability that prohibits them from driving or may not have access to affordable public transportation.

Similarly, Medicare beneficiaries face transportation constraints. Respondents indicated travel distance and lack of transportation are the top two major barriers to obtaining specialty care for Medicare recipients.

Certain specialty services are less available than others

Referrals for pain management services are particularly difficult to secure. This field frequently topped the list of services that clinics are never or rarely able to secure for their patients. Endocrinology, reproductive endocrinology, physiatry and elective surgery were also identified by clinics as challenging in regard to referrals for their patients.

Clinics most frequently indicated they had success finding referrals for cardiology patients. Diagnostics, ear/nose/throat, gynecology, obstetrics and oncology also are available most of the time or always.

The ability of clinics to secure specialty care in these fields varies somewhat depending on the patient's insurance source and the type of clinic.

Differences exist but safety net clinics of different types cite similar challenges and solutions

Analysis of the survey data reveals some notable differences between community-funded clinics, FQHCs and RHCs. For example, community-funded clinics more frequently have difficulty securing referrals for Medicaid patients than do FQHCs or RHCs. And, community-funded clinics generally reported a slightly greater ability to refer uninsured patients than FQHCs.

Why? This question deserves further exploration, but a comparison of the methods by which safety net clinics secure specialty care services suggests that community-funded clinics utilize a broader array of approaches to secure these services than FQHCs.

The majority of community-funded clinics (95%) indicated they rely on a relationship with an established referral network, compared with 65 percent of FQHCs. Because many community-funded clinics are staffed by volunteer physicians who practice primarily in other venues, these clinicians may bring a host of relationships (and possibly their own formal provider networks) to their volunteer position. The different models used by these clinics, the nature of their referral networks and the nuances between other types of safety net clinics are areas for further exploration.

Although the data reveal many differences between community-funded clinics, FQHCs and RHCs, the three types of clinics also reported some similar patterns. Commonalities between all three types of clinics include:

- Clinics experience greater difficulty in securing specialist referrals for uninsured patients than Medicaid patients.
- Most clinics are never or rarely able to secure services such as pain management, reproductive endocrinology and transplants for Medicaid or uninsured patients.
- Most clinics are most of the time or always able to secure services such as cardiology/interventional cardiology, OB/GYN and radiology.
- Most clinics report collegial relationships with specialty care providers as a method for securing referrals; most also cite partnership with a hospital.
- The most often suggested option for improving access to specialty care is for surgeons to provide surgical services to the clinics' patients. At least 60 percent of clinics (regardless of type) indicated this would be very useful.

<u>Clinic and patient experiences assist in interpreting the story behind the numbers</u>

To further understand the barriers that safety net patients face in securing needed specialty care, clinics were asked to share relevant stories of patients they had served. These qualitative data were compiled and used to understand the findings of the quantitative data. CHI gained permission to publish two stories that serve as examples of the many accounts shared in the survey.

Twenty-three year old male with stage 4 lymphoma who presents as uninsured; sent to emergency room (ER) four times in hopes of securing chemotherapy and sent home without referral and diagnosis as clinically stable. Patient speaks little English.

Woman with football-size uterine tumor. Could not sit down. No one would see her. Drove her to another city and went through the ER. Spent 12 hours there. Surgery done next day.

The stories illustrate the variety of barriers many safety net patients face in securing needed services, including lack of health insurance, advanced and complex medical conditions, cultural and language issues, and lack of available providers in the community.

Chartpack: Introduction

The following chartpack combines graphical or tabular representation of the survey data from the *2010 Colorado Safety Net Specialty Care Assessment* and narrative interpretation.

Of note, this survey did not assess *demand* for specialty care services; that is, a particular type of service may be very difficult for a clinic to secure, but may be needed by only a few patients.

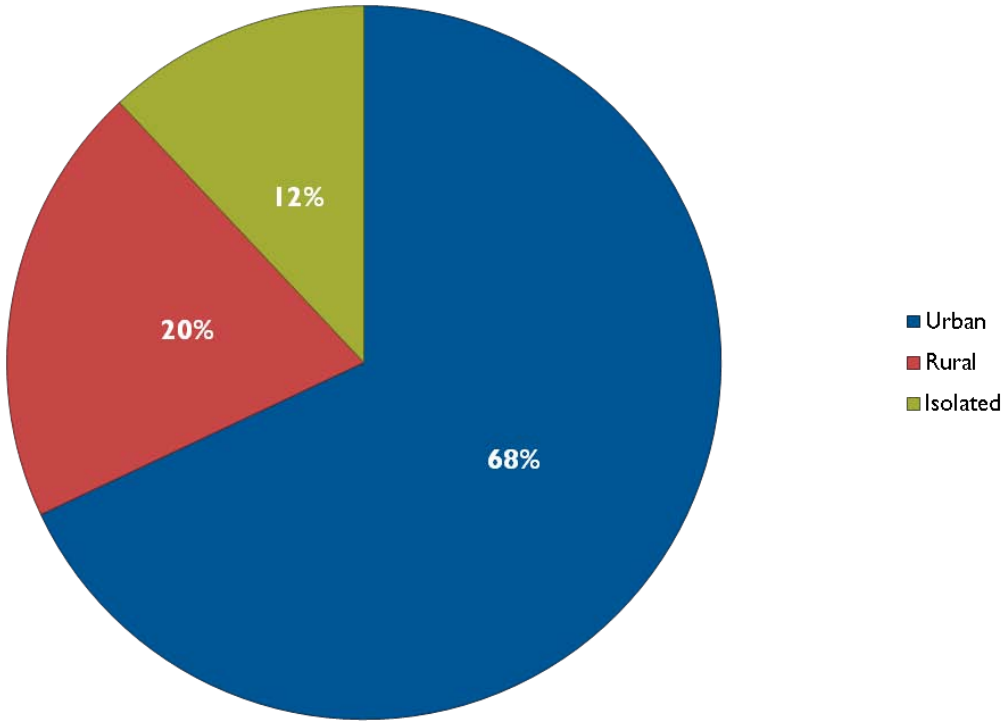
Notes about the chartpack

- All analyses and sample sizes presented in the chartpack reflect the weighted number of respondents. For more information, see the description of the methods.
- CHI would be happy to provide any chartpack graphs in Powerpoint format upon request.
- The graphs included in the chartpack represent a starting place for analyzing the data from the 2010 Colorado Safety Net Specialty Care Assessment. The survey represents a rich data source from which many more analyses can be conducted. For example, a number of cross-tabulations of the data in the chartpack and the regional profiles are focused on uninsured and Medicaid patients, though the same analyses can be conducted for Medicare and privately insured safety net patients as well, should time and resources allow.

Section A

Characteristics of survey respondents

Chart A-1. Distribution of safety net clinics responding to survey by rural/urban designation, Colorado, 2010

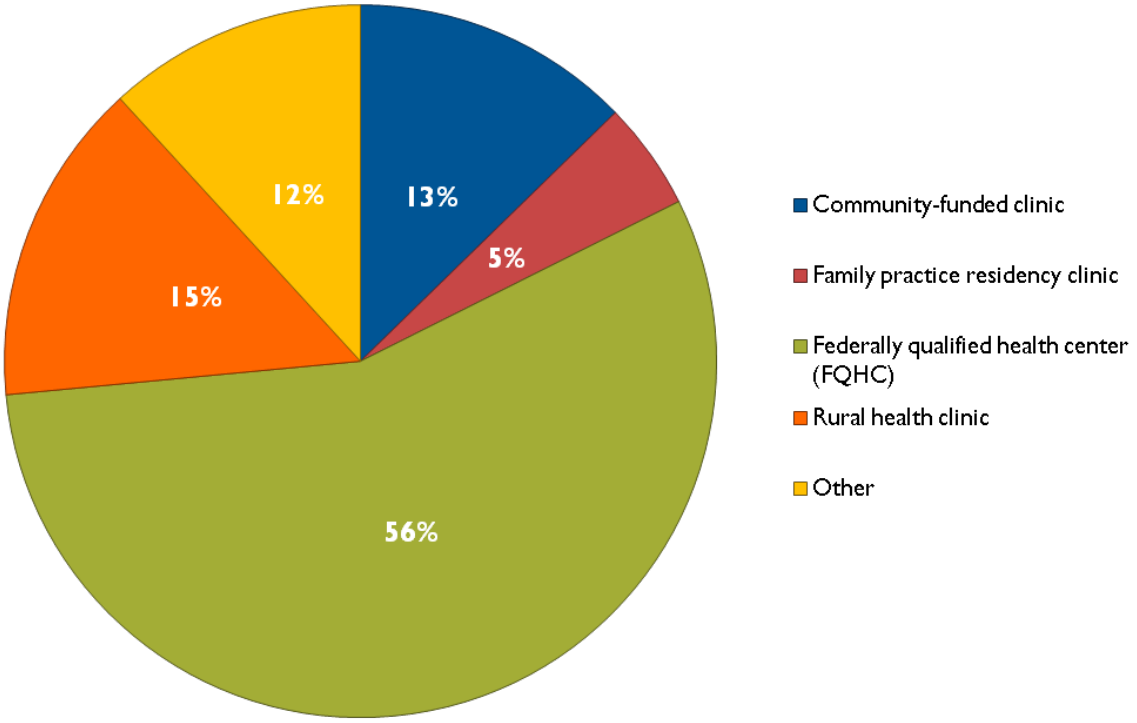


Two-thirds of the safety net clinics responding to this survey represented urban areas, while the other third represented the state's less densely populated rural and isolated regions. Isolated frontier regions of Colorado made up 12% of respondents, and other rural areas made up 20% of respondents. This breakdown is more heavily rural than the state's population, which is approximately 79 percent urban and 16 percent rural in 2010.

NOTE: Rural, urban and isolated areas of Colorado were determined by using Rural-urban commuting area (RUCA) codes. RUCA codes are a sub-county measure of urban/rural status based on 2000 Census data and 2004 ZIP Codes; they are more specific than county-based definitions of rural and therefore more accurately classify intra-county rural and urban areas. For more information on RUCA codes, see http://depts.washington.edu/uwruca/index.html.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Chart A-2. Distribution of safety net clinics responding to survey by type of clinic, Colorado, 2010



FQHCs made up more than half of the 102 safety net clinics responding to this survey. Twenty percent (20%) represented rural health and family practice residency clinics, and 13% (13 clinics) were from community-funded clinics. The latter include nonprofit clinics and programs, free clinics, faith-based clinics and others staffed by volunteer clinicians to provide free or low-cost primary care services to low-income uninsured and underinsured families and individuals. Respondents indicating some other type of clinic composed 12% (see Section F, Question 3 of the chart pack for how these clinics described themselves).

NOTE: In subsequent analyses, family practice residency clinics and "other" clinics have been grouped with community-funded clinics.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Table A-3. Distribution of survey respondents by profession, Colorado, 2010

Profession	Percent
Medical doctor	62%
Doctor of osteopathy	9%
Physician assistant	2%
Nurse practitioner	4%
Certified nurse midwife	0%
Other	24%
Total	**100%**

The majority of responses from health care professionals in safety net clinics came from physicians, generally medical doctors but also some doctors of osteopathy. Only a few respondents were non-physician providers such as a nurse practitioner or physician assistant. The 24% of respondents who indicated "Other" were primarily clinic administrators (see Section F, Question 2 of the chartpack for how these respondents described their profession).

NOTE: These data represent 102 safety net clinics that responded to Question 2. All clinics responded to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Table A-4.1. Percent (%) of clinics reporting affiliation with medical school, teaching hospital or other type of academic program for the training of health professions, Colorado, 2010

	Percent
Yes	66%
No	34%

Table A-4. 2. Type of health professional training program provided by academically affiliated clinics, Colorado, 2010

Type	Percent
Medical or osteopathic students	75%
Medical or osteopathic residents	59%
Clinical specialty fellows	3%
Registered nurses	54%
Advanced practice providers	96%
Social workers	10%
Other health professionals	0%

Safety net clinics tend to provide a place where health care professionals can further their training, as 66% of clinics responded that they have an affiliation with an academic program. Of those with an academic affiliation, most of the training that occurs involves advanced practice providers such as nurse practitioners or physician assistants. In addition, medical and osteopathic students or residents often receive training in safety net clinics, as do registered nurses.

NOTE: Table A-4.1 represents 102 safety net clinics that responded to Question 4. Table A-4.2 is limited to 67 clinics that reported an academic affiliation. Clinics could indicate training more than one type of health professional. All clinics responded to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Section B

Current availability of specialty care in Colorado's health care safety net

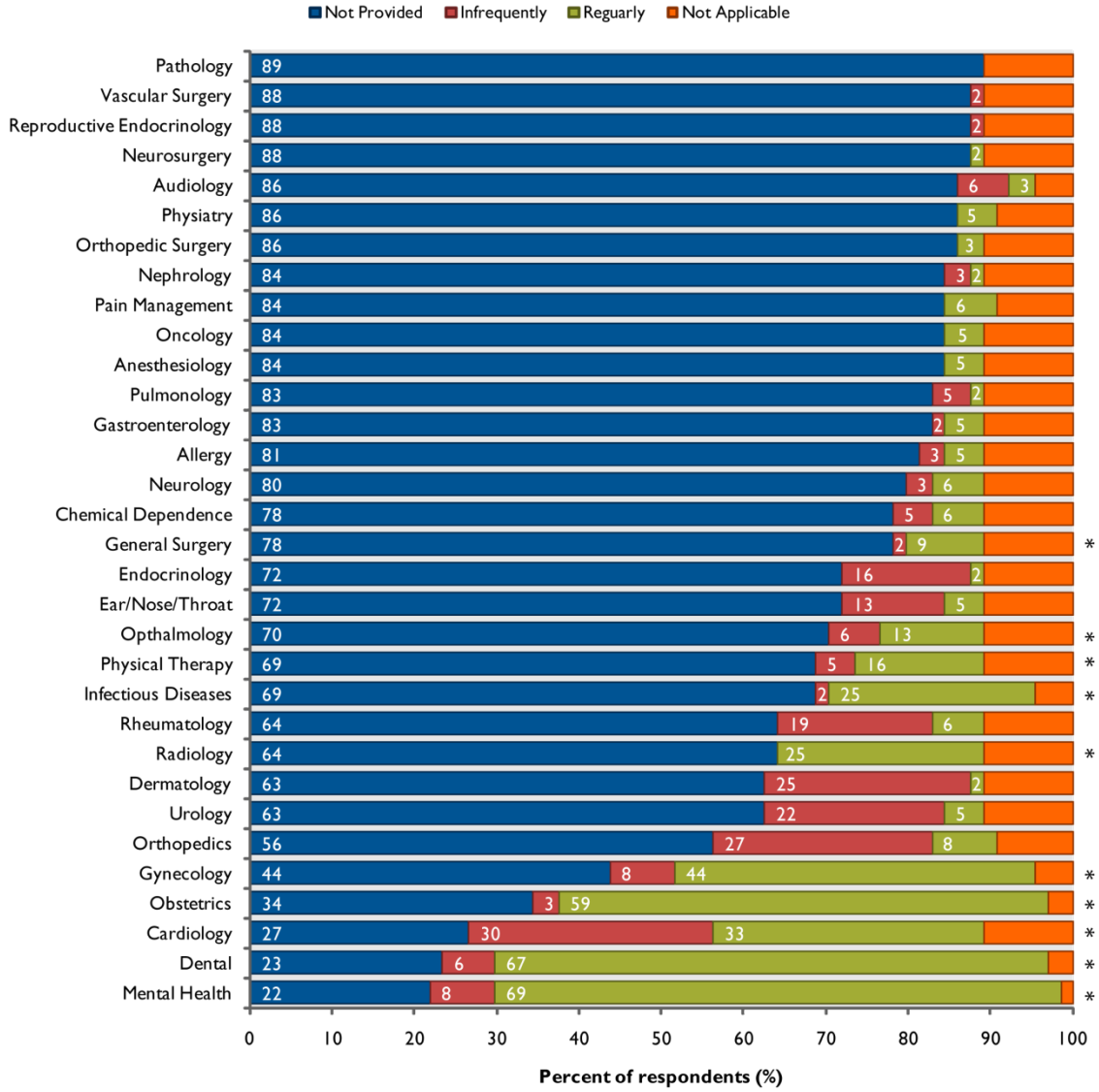
Table B-1.1. Percent (%) of clinics that provide on-site specialty care services, Colorado, 2010

	Percent
Yes	64%
No	36%

More than six in 10 safety net clinics provide some type of specialty care service in their clinics (Table B-1.1), with mental and dental health services most frequently offered. Except for these specialties and OB/GYN, only one in three or fewer respondents has any specialty care service available on site, as displayed by the green bars in Graph B-1.2.

The most specialized services—pathology, vascular surgery, reproductive endocrinology and neurosurgery—are those least frequently provided, unavailable in almost 90% of clinics. Of these four services, only one (neurosurgery) is offered regularly in any clinic.

Graph B-1.2. Types of specialty care services that are provided on site at safety net clinics, Colorado, 2010



* Asterisks represent the 10 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

NOTE: These data represent 100 safety net clinics that responded to Question 8. Two clinics did not respond to the question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Section C

Clinics' ability to secure specialist services

Table C-1. Distribution of survey respondents by the percent of patient visits that result in a referral to an outside specialist, Colorado, 2010

Response (% of patient visits)	Uninsured	Medicaid	Medicare	Private insurance
0-15%	52%	32%	19%	38%
16-25%	21%	35%	34%	41%
26-50%	11%	11%	21%	3%
51-75%	12%	21%	26%	19%
76-100%	4%	1%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**

Most visits to safety net clinics do not result in referrals to specialists. The majority of clinics that responded to the survey indicated that less than one-fourth of their overall patient visits result in a referral to an outside provider. For example, in more than half of the clinics, outside referrals are given in only 0-15% of uninsured patient visits. In an additional 21% of clinics, the proportion of uninsured patient visits that results in an outside referral ranges from 16-25%.

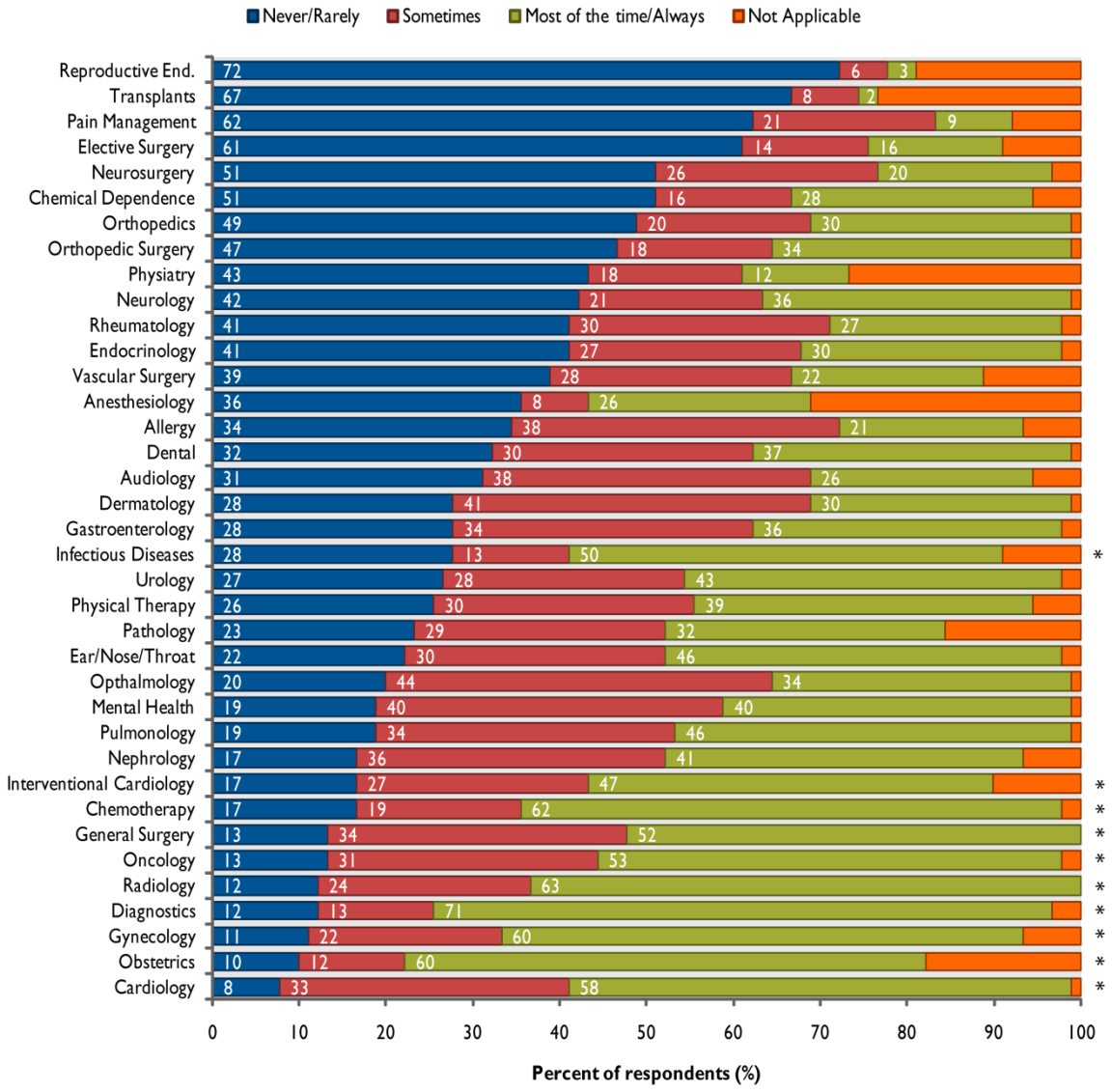
NOTE: These data represent the 100 clinics that responded to Q10 (uninsured), the 82 that responded to Q14 (Medicaid), the 73 that responded to Q20 (Medicare) and the 69 that responded to Q24 (private insurance).

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-2. Frequency (%) with which safety net clinics are able to refer *uninsured* patients to specialty care, by specialty type, Colorado, 2010

More than two-thirds of respondents indicated they are never or rarely able to secure reproductive endocrinology and transplant service referrals for their uninsured patients. Referrals for pain management, elective surgery, chemical dependence services and neurosurgery are also never or rarely available for more than half the clinics.

The green bars indicate that at least 60 percent of respondents are most of the time or always able to secure referrals for diagnostic, chemotherapy, radiology and obstetrics and gynecological services for their uninsured patients.



* Asterisks represent the 10 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

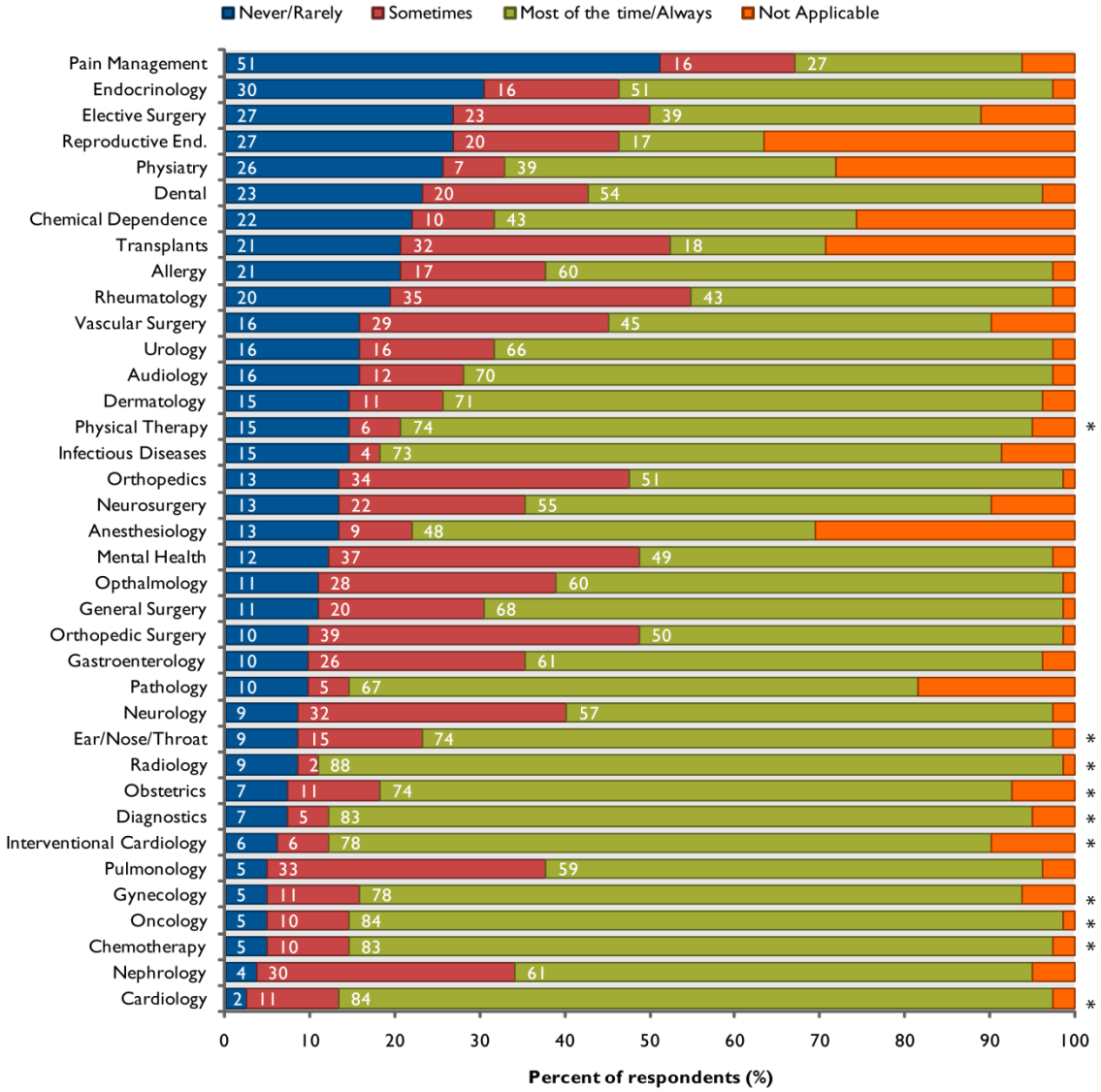
NOTE: These data represent 90 safety net clinics that responded to Question 11. Twelve clinics did not respond to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-3. Frequency (%) with which safety net clinics are able to refer *Medicaid* patients to specialty care, by specialty type, Colorado, 2010

As expected, clinics reported a greater ability to refer insured patients to specialist services than uninsured patients (see Graph C-2). This graph (C-3) reflects clinics that serve Medicaid patients. Only pain management was indicated by more than half of the respondents as a service for which they are never or rarely able to secure specialist referrals. For most specialist services, fewer than 20% of respondents indicated they are never or rarely able to secure a referral for Medicaid patients.

Radiology service referrals are available *most* often (88%) for Medicaid patients, followed by cardiology and oncology and then chemotherapy. More than 80% of clinics also reported being able to secure referrals to cardiology and diagnostic services most of the time or always for individuals covered by Medicaid.



*Asterisks represent the 10 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

NOTE: Ninety (90) clinics responded to Question 13, and 12 did not. Of the 90 that did, 82 indicated they accept Medicaid patients (and are displayed in Graph C-3) and 8 did not.

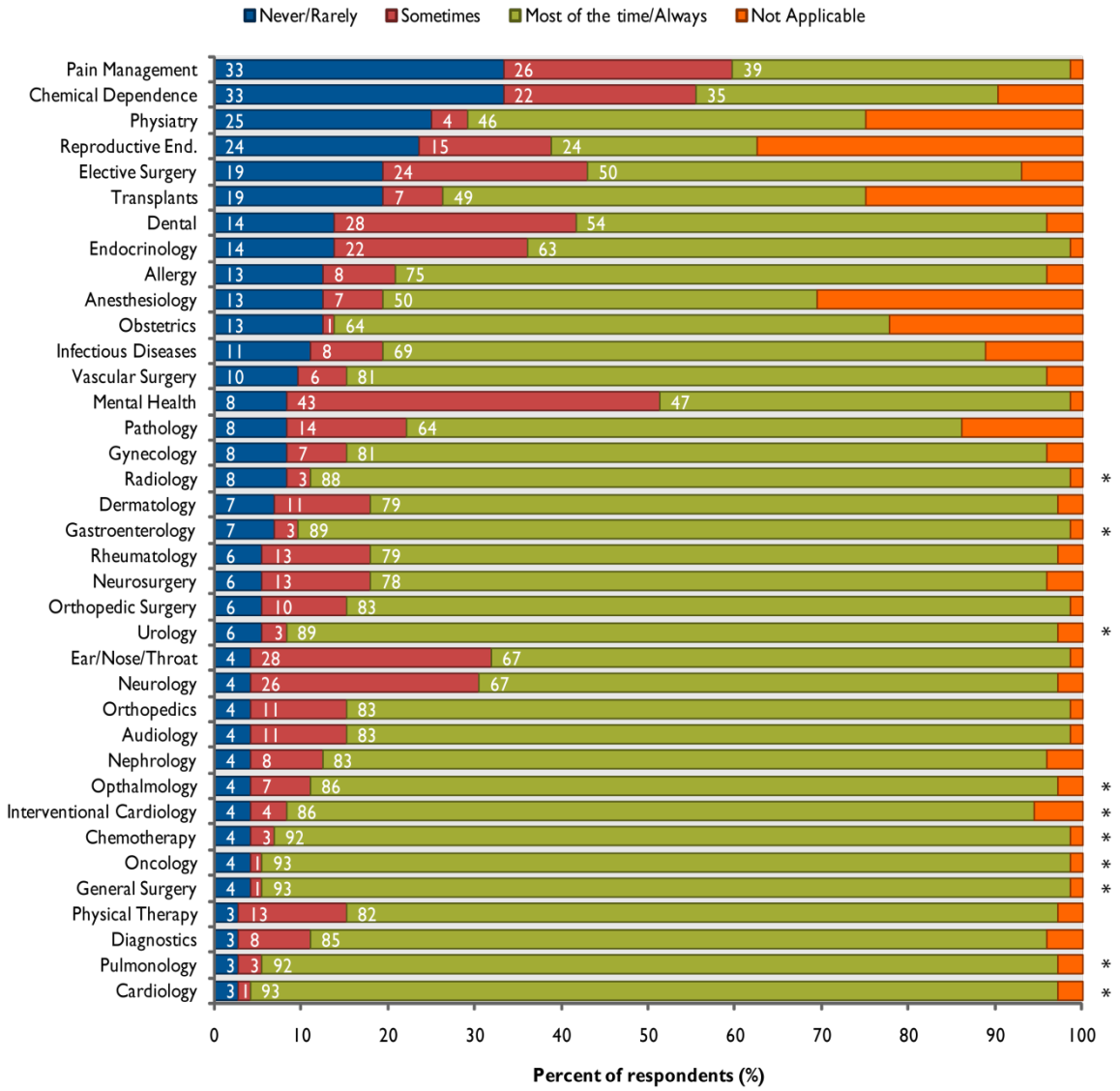
SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-4. Frequency (%) with which safety net clinics are able to refer *Medicare* patients to specialty care, by specialty type, Colorado, 2010

Similar to Medicaid (see Graph C-3), pain management (along with chemical dependence) topped the list of referrals that clinics are never or rarely able to secure for their Medicare patients. Physiatry and reproductive endocrinology referrals are also quite difficult to obtain, though a high proportion of respondents reported these as not applicable (represented by the orange bars).

Cardiology, pulmonology, general surgery, oncology and chemotherapy ranked among those services for which clinics are most of the time or always able to refer their Medicare patients.

Almost half of respondents (43%) indicated that they were able to secure mental health referrals "sometimes" for Medicare patients, perhaps deserving further investigation as to why these referrals are inconsistently available, particularly for Medicare patients.



*Asterisks represent the 10 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

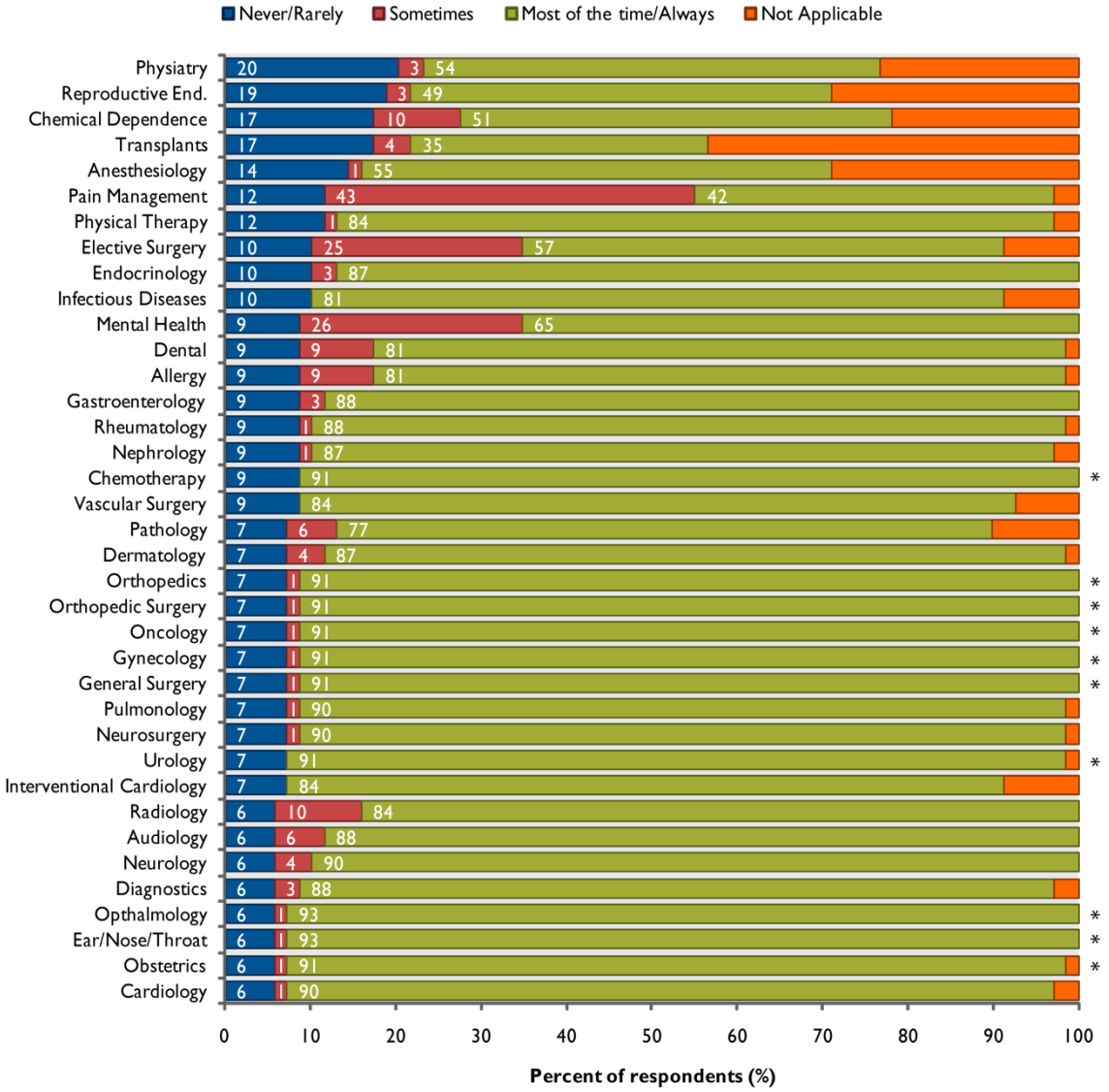
NOTE: Ninety (90) clinics responded to Question 19, and 12 clinics did not. Of the 90 that did, 72 indicated they accept Medicare patients (and are displayed in Graph C-4), and 18 did not.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-5. Frequency (%) with which safety net clinics are able to refer *privately insured* patients to specialty care, by specialty type, Colorado, 2010

The data from the survey suggest that privately insured safety net patients have greater access to a wider array of specialist service referrals than their peers who are uninsured or covered by Medicaid or Medicare (as indicated by the length of the blues bars compared to earlier graphs).

The shorter blue bars, however, also indicate that private insurance does not guarantee access to specialist services for all patients. Referrals for services such as physiatry, reproductive endocrinology, transplants and pain management were among those least available to privately insured safety net patients. These referrals tend to be the same as those least available to uninsured patients or those covered by Medicaid or Medicare.



* Asterisks represent the 10 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

NOTE: A total of 89 clinics responded to Question 23, and 13 did not. Of the 89 that did, 69 indicated that they accept privately insured patients (and are displayed in Graph C-4) and 20 did not.

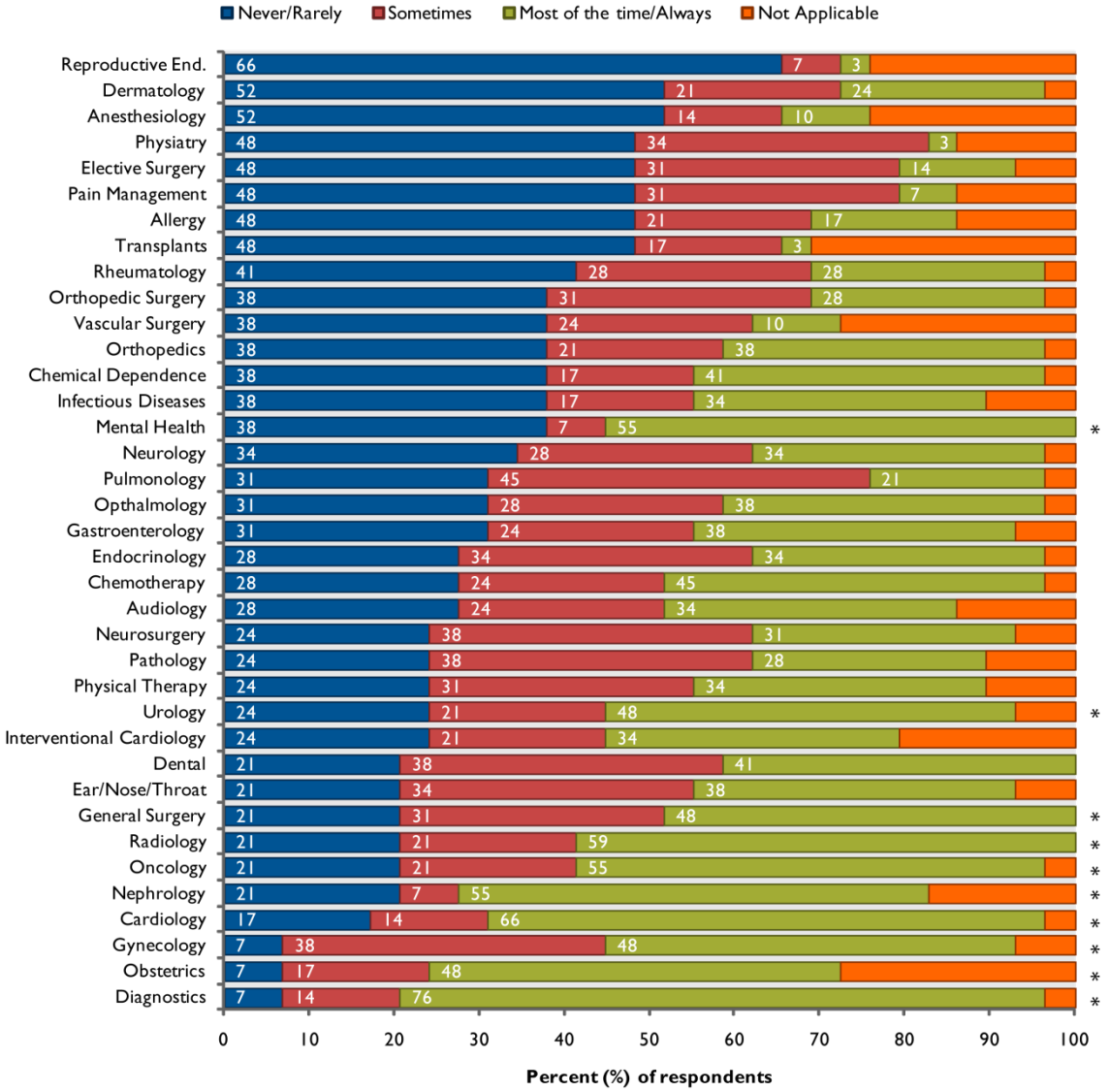
SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-6.1. Frequency (%) in which *community-funded clinics* are able to refer *uninsured* patients to specialty care, by specialty type, Colorado, 2010

Graphs C-6.1, 6.2 and 6.3 examine the ability of three different types of clinics (community-funded, federally qualified and rural health clinics) to refer uninsured patients to specialists.

More than half of community-funded safety net clinics reported reproductive endocrinology, dermatology and anesthesiology as referrals they are never or rarely able to secure for their uninsured patients.

Most clinics reported being able sometimes to most of the time/always to secure diagnostic, cardiology, gynecology and radiology service referrals for their uninsured patients.



*Asterisks represent the 10 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

NOTE: Includes the 29 respondents who answered Q11 and who indicated that their clinic was community-funded, a family practice residency or some other type of clinic.

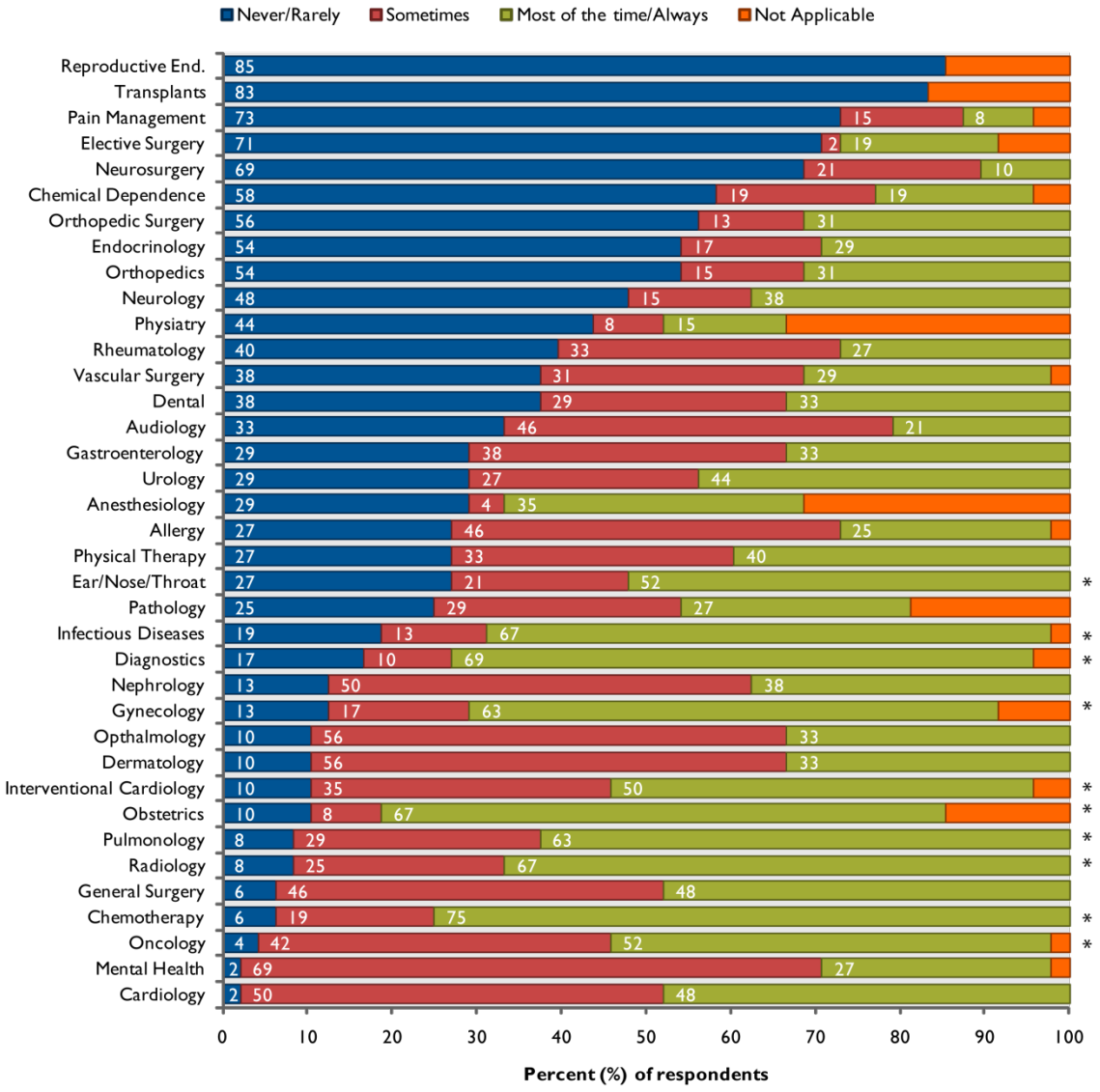
SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-6.2. Frequency (%) in which *federally qualified health centers* (FQHCs) are able to refer *uninsured* patients to specialty care, by specialty type, Colorado, 2010

The aggregate results of the FQHC surveys tend to mirror the general findings across all safety net clinics displayed earlier in Graph C-2.

Reproductive endocrinology, transplants and pain management service referrals are the least available for FQHC uninsured patients. Higher proportions of FQHCs reported difficulty referring for these services than community-funded safety net clinics (Graph C-6.1) or rural health clinics (Graph C-6.3).

Less than 5% of FQHCs reported they are never or rarely able to refer uninsured patients for oncology, mental health and cardiology services.



* Asterisks represent the 10 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

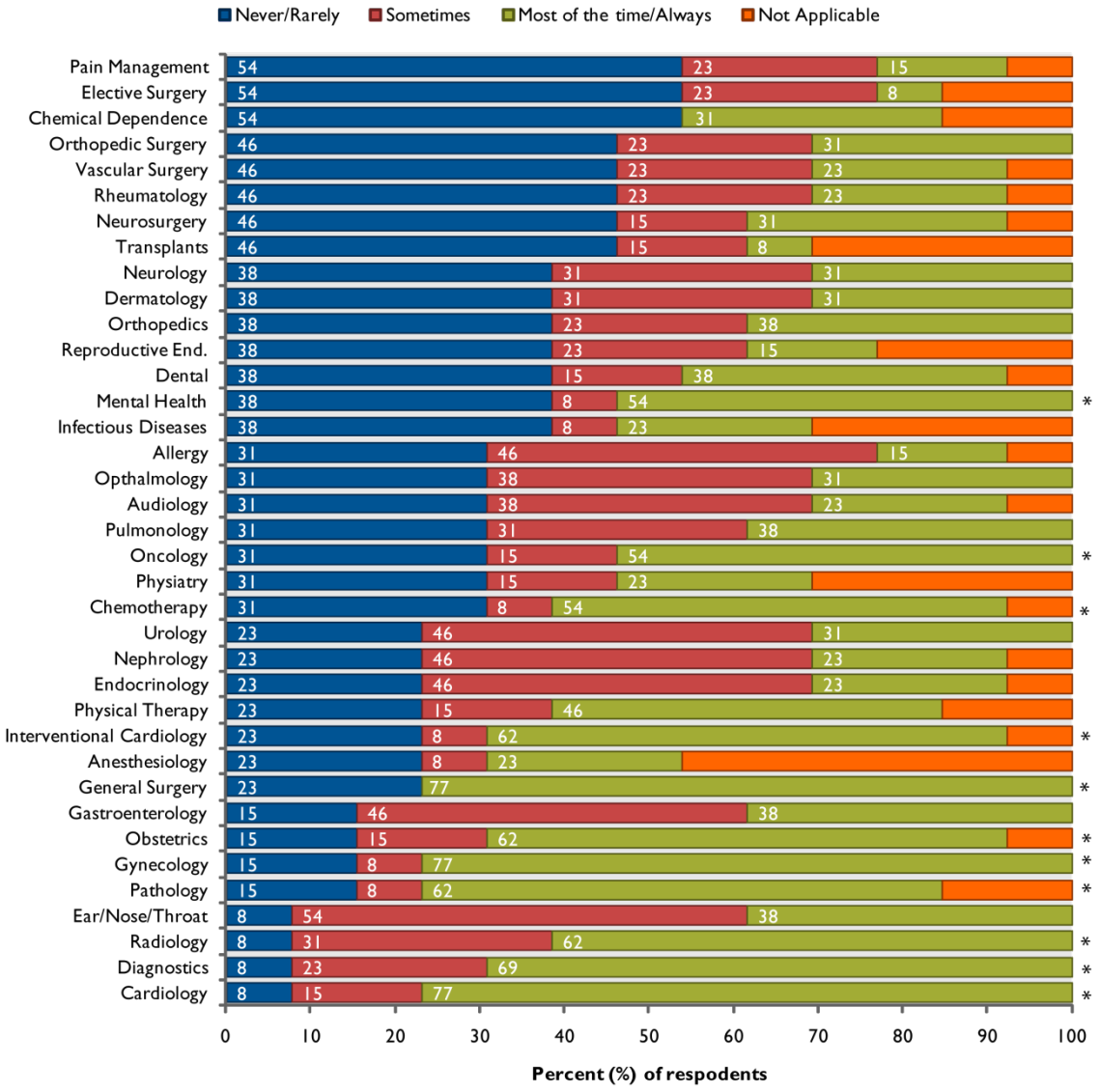
NOTE: Includes the 48 respondents who answered Q11 and indicated that their clinic was a federally qualified health center.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-6.3. Frequency (%) with which *rural health clinics* are able to refer *uninsured* patients to specialty care, by specialty type, Colorado, 2010

More than half of rural health clinics reported that referrals for pain management, elective surgery and chemical dependence services are never or rarely available for their uninsured patients.

Similar to other types of clinics, rural health clinics tend to be more able to provide diagnostic and cardiology referrals for uninsured patients than other types of services.



* Asterisks represent the 11 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

NOTE: Includes the 13 respondents who answered Q11 and who indicated that their clinic was a rural health clinic.

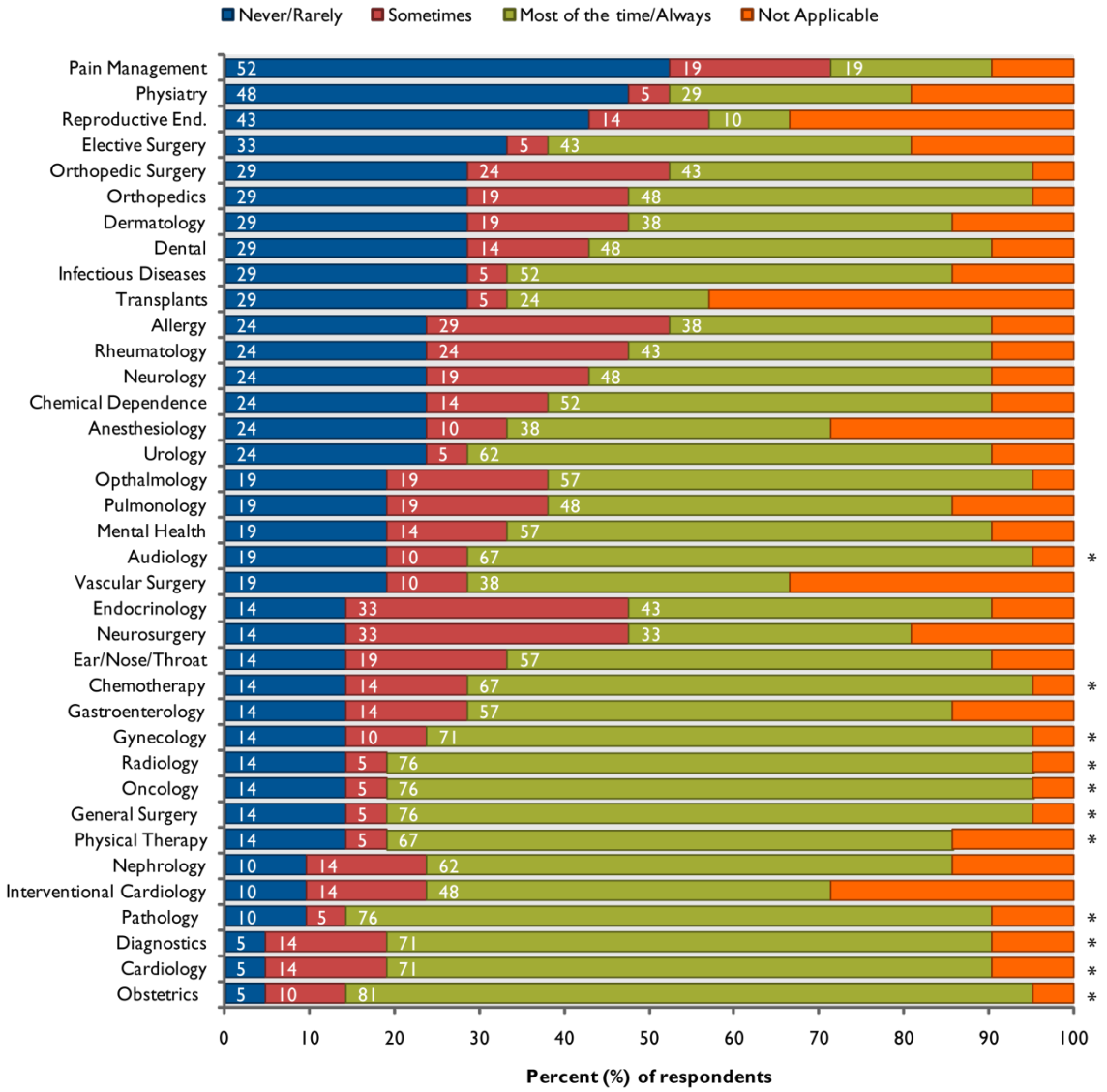
SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-7.1. Frequency (%) with which *community-funded clinics* are able to refer *Medicaid* patients to specialty care, by specialty type, Colorado, 2010

Graphs C-7.1, 7.2 and 7.3 examine the ability of the three different types of clinics (community-funded, federally qualified and rural health clinics) to refer Medicaid patients to specialists.

Similar to the trend observed across all safety net clinics, Medicaid patients at community-funded clinics tend to have better access to many services than uninsured patients. Approximately one-half of these clinics indicated difficulty referring Medicaid patients for pain management (52%) and physiatry (48%).

Referrals for obstetrics, pathology, radiology, oncology and general surgery services are most frequently available for Medicaid patients at community-funded clinics.



* Asterisks represent the 11 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

NOTE: Includes the 21 respondents who answered Q15 and who indicated that their clinic was community-funded, a family practice residency or some other type of clinic.

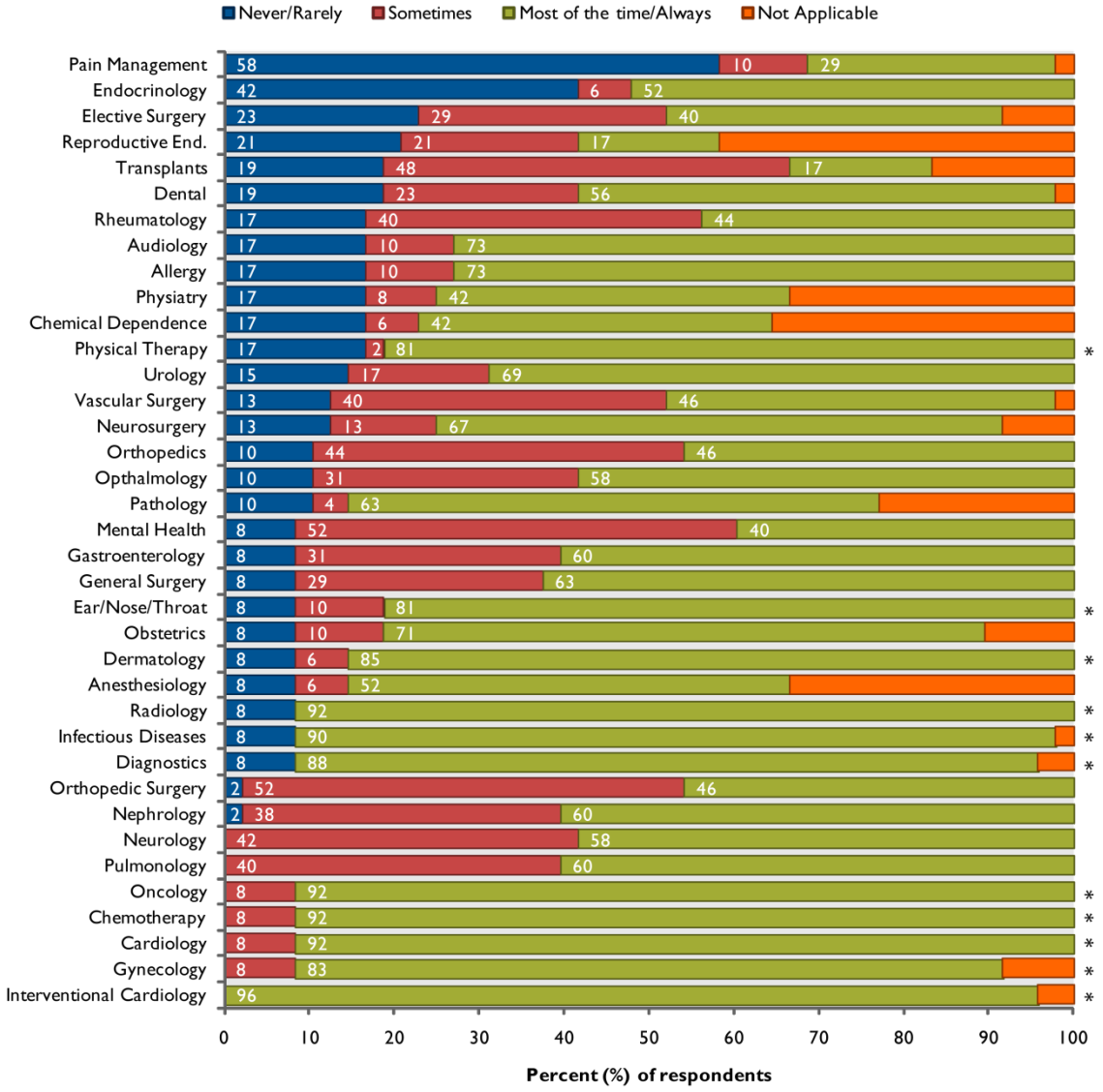
SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-7.2. Frequency (%) in which *federally qualified health centers* (FQHCs) are able to refer *Medicaid* patients to specialty care, by specialty type, Colorado, 2010

Referrals for pain management and endocrinology services are those that FQHCs report having the greatest difficulty securing for Medicaid patients.

Virtually all FQHCs, however, reported being able to secure cardiology/interventional cardiology, chemotherapy and oncology services, pulmonology and neurology referrals at least sometimes for their Medicaid patients.

Radiology, diagnostics and infectious diseases are other services to which FQHCs are able to refer most or all of the time.



* Asterisks represent the 11 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

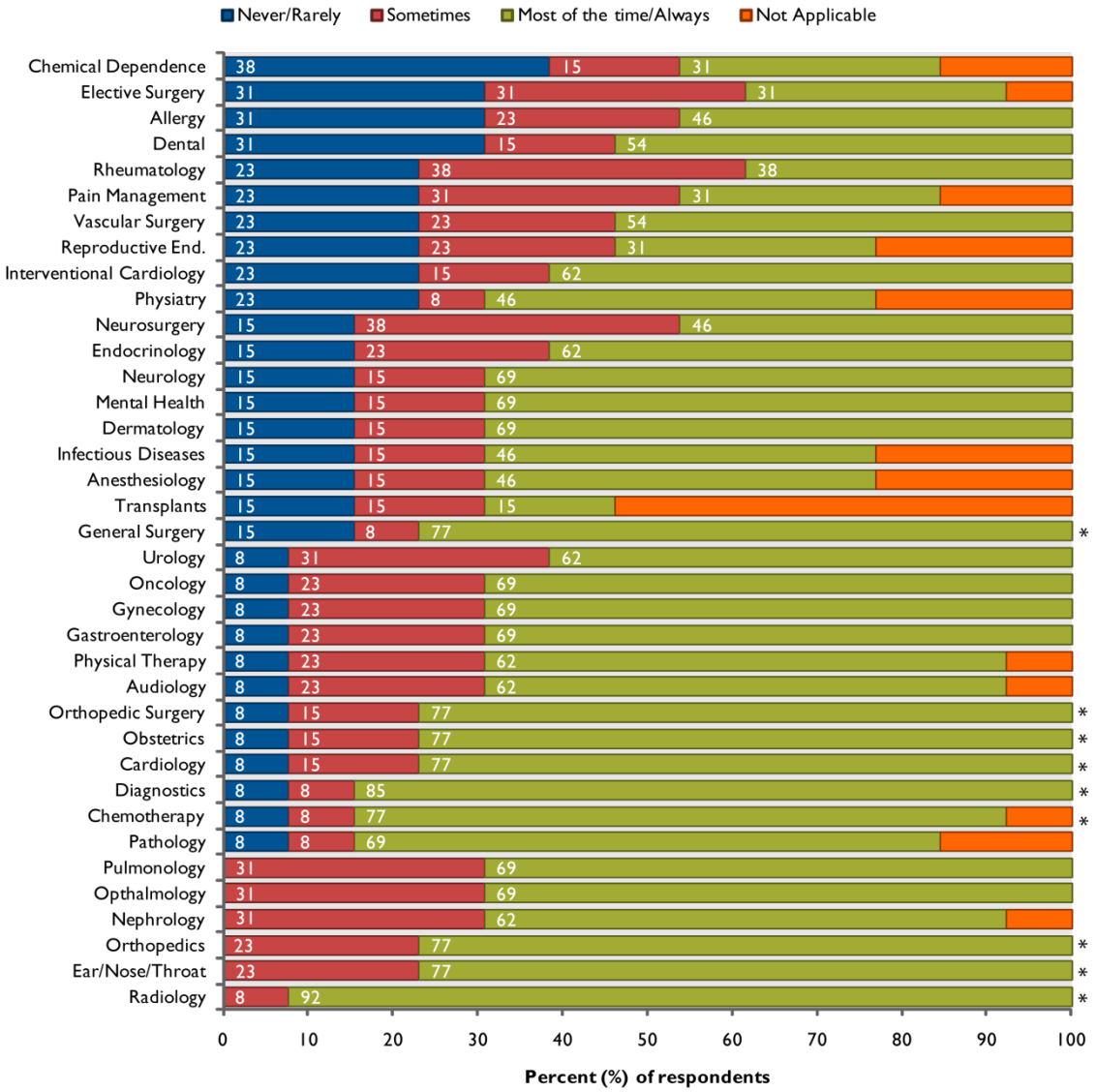
NOTE: Includes the 48 respondents who answered Q15 and indicated that their clinic was a federally-qualified health center.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph C-7.3. Frequency (%) with which *rural health clinics* (RHCs) are able to refer *Medicaid* patients to specialty care, by specialty type, Colorado, 2010

Similar to other types of clinics, the data suggest that Medicaid patients at RHCs have somewhat better access to specialist services than uninsured patients. RHCs reported chemical dependence, elective surgery, allergy and dental services as those for which they have the most difficulty making referrals for individuals covered by Medicaid.

Radiology, ear/nose/throat, orthopedics, nephrology, opthalmology and pulmonology are services for which RHCs are able to refer Medicaid patients at least sometimes.



* Asterisks represent the 9 categories with the highest proportion of survey respondents indicating "Most of the time/Always."

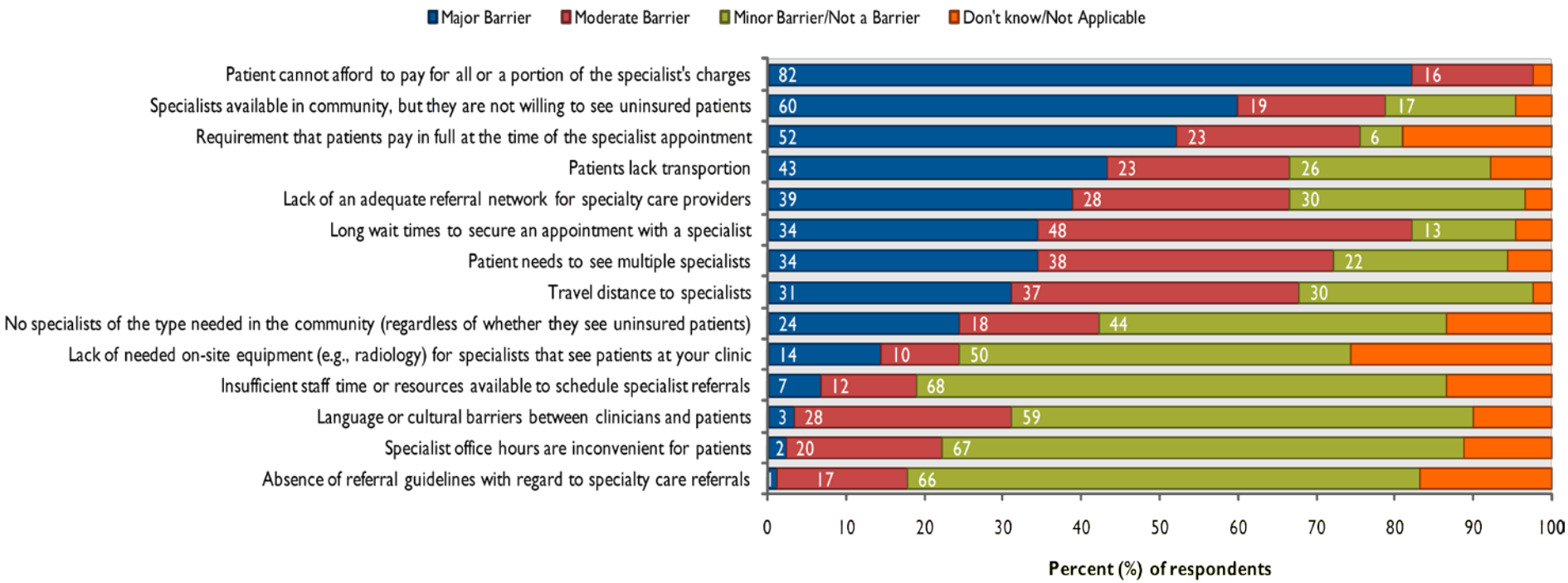
NOTE: Includes the 13 respondents who answered Q11 and who indicated that their clinic was a rural health clinic.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Section D

Barriers to securing specialist services

Graph D-1. Barriers to securing specialty services for *uninsured* patients, Colorado, 2010

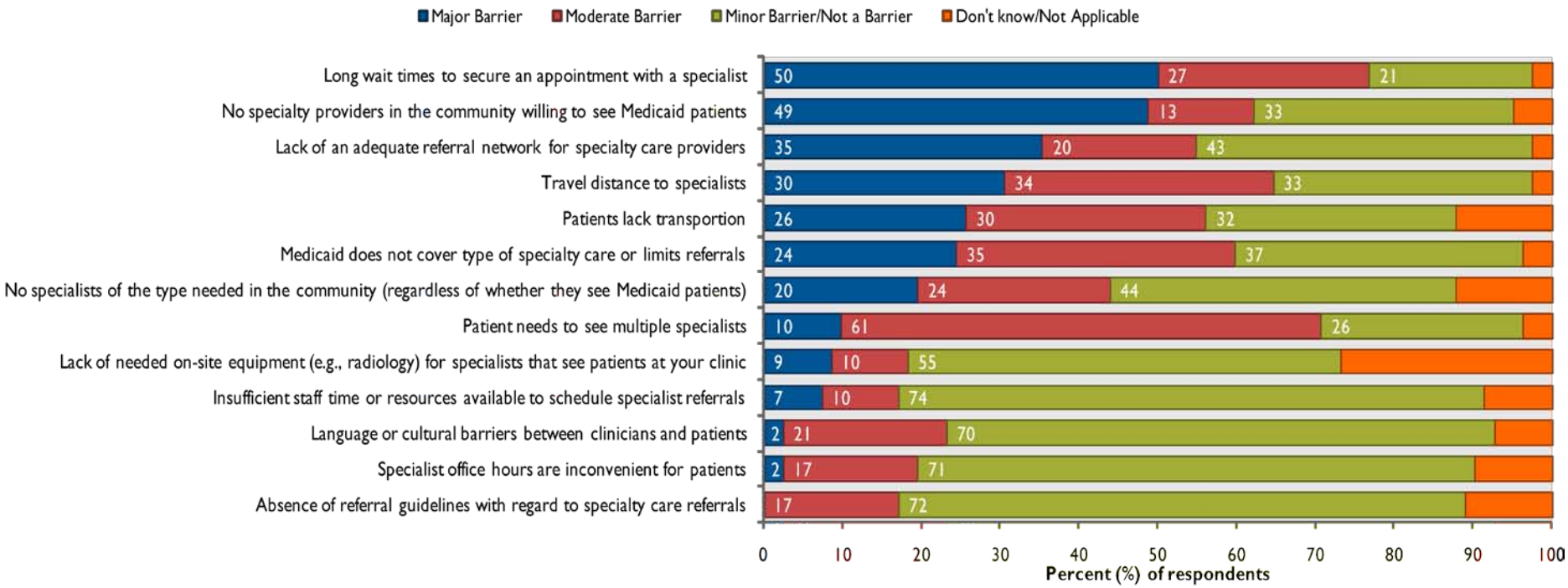


For uninsured patients in safety net clinics, their inability to pay for services is the greatest barrier to receiving their specialty care, according to more than 80% of the 90 clinics responding to this question. Specialists' unwillingness to see uninsured patients also represents a major barrier to specialty care for uninsured patients in over half of responding clinics. Organizationally, many clinics have sufficient personnel, convenient office hours and adequate referral guidelines in place for specialty care; these issues are a minor barrier or not a barrier in two-thirds of responding clinics.

NOTE: These data represent 90 safety net clinics that responded to Question 12. Twelve clinics did not respond to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph D-2. Barriers to securing specialty services for *Medicaid* patients, Colorado, 2010

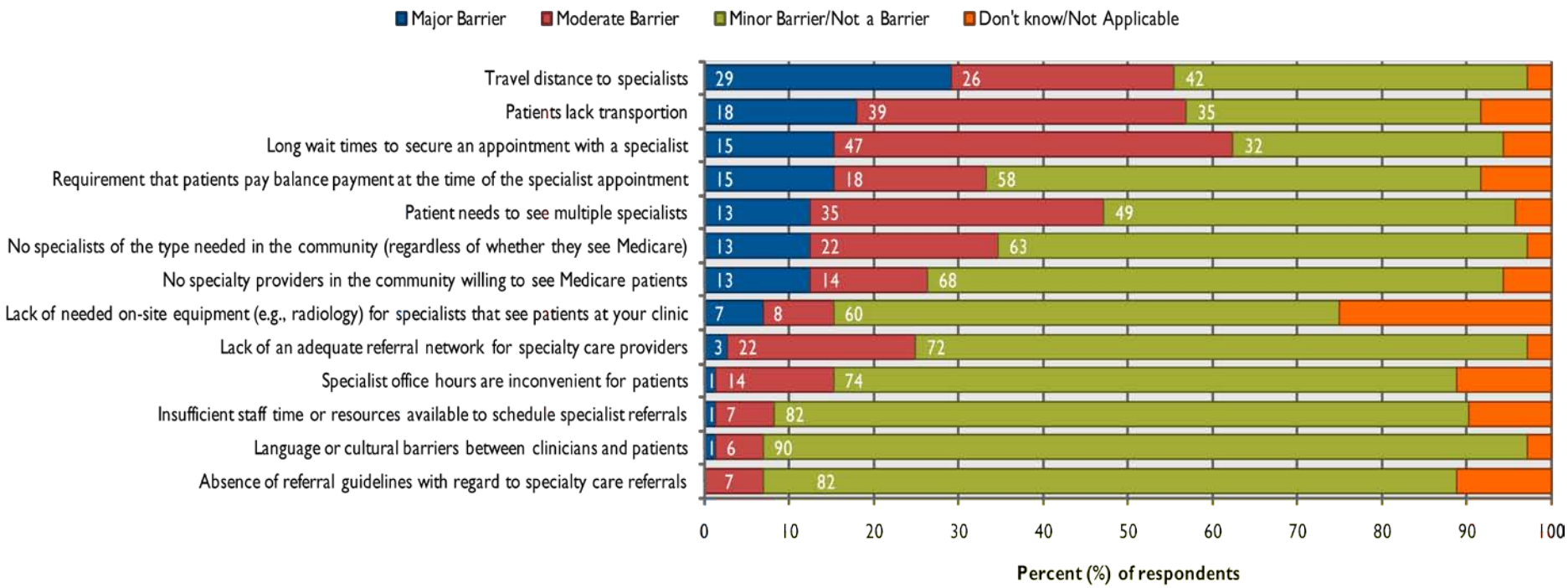


Long wait times were indicated by half the respondents as a major barrier to Medicaid patients' receiving specialty services. Clinics pointed to this as a big barrier for Medicaid patients more frequently than they did for uninsured patients (34% in Graph D-1). An almost equal number of respondents indicated a lack of specialists willing to see Medicaid patients as a major barrier. An inadequate referral network for specialty care providers was the third most common barrier to specialty care for Medicaid patients, though it was most often cited as a minor barrier or not a barrier at all (43%).

NOTE: These data represent 82 clinics responding to Question 16. Twenty clinics did not respond to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph D-3. Barriers to securing specialty services for *Medicare* patients, Colorado, 2010

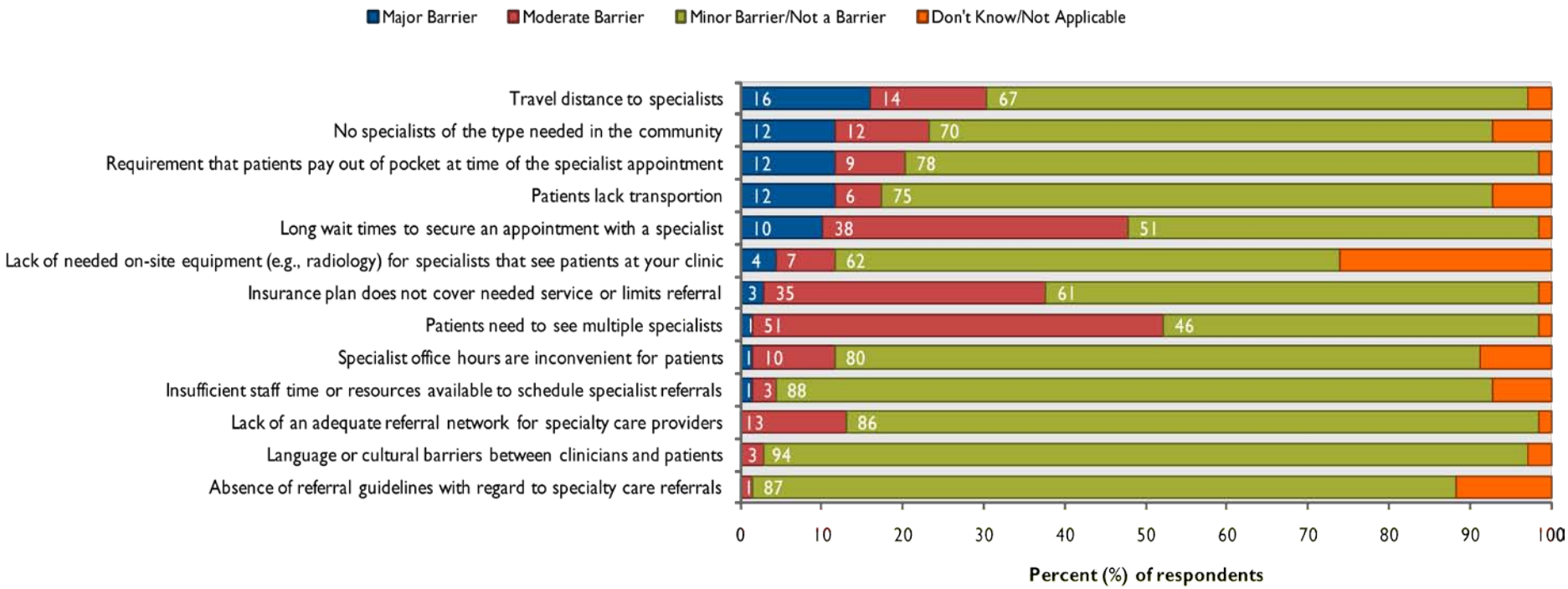


Major barriers to specialty care for Medicare patients are less frequent compared to uninsured and Medicaid patients at safety net clinics. Issues cited as barriers to specialty care are more frequently cited as a minor barrier or not a barrier in clinics serving Medicare patients. Travel distance to specialists represents the greatest barrier for Medicare patients in almost one-third of the 72 clinics that responded to this question. A lack of transportation is the second-most frequent barrier, though cited as a major barrier in less than 20% of clinics.

NOTE: These data represent 72 clinics responding to Question 22. Thirty clinics did not respond to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph D-4. Barriers to securing specialty services for *privately insured* patients, Colorado, 2010



Major barriers to specialty care are infrequent for privately insured patients when compared to uninsured, Medicaid and Medicare patients. Travel distance and a lack of transportation are among the most frequent barriers to specialty care, but cited as a major barrier in only 16% and 12% (respectively) by the 69 clinics that responded to this question.

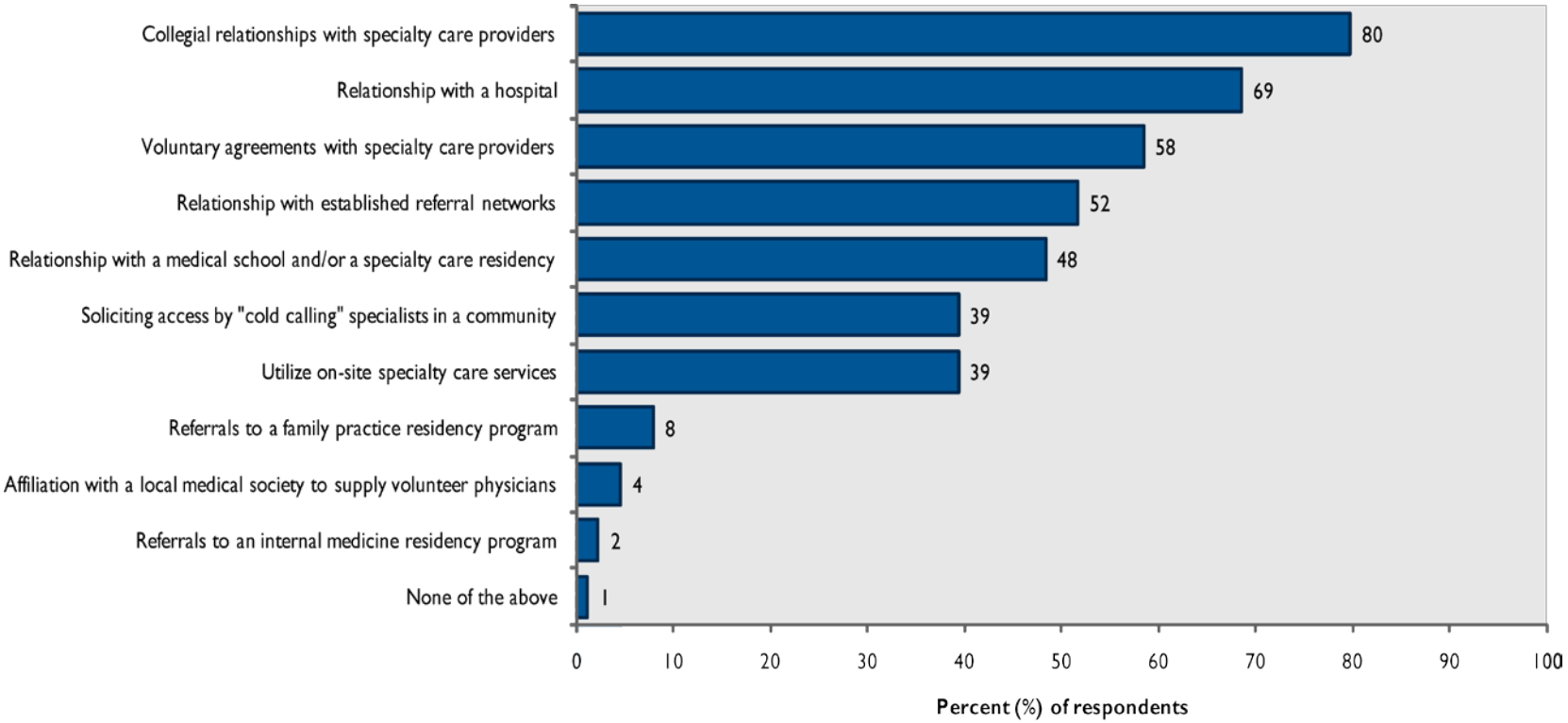
NOTE: These data represent 69 clinics responding to Question 26. Thirty three clinics did not respond to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Section E

Strategies for improving access to specialist services in the safety net

Graph E-1. Methods by which safety net clinics secure specialty care referrals for all patients, Colorado, 2010



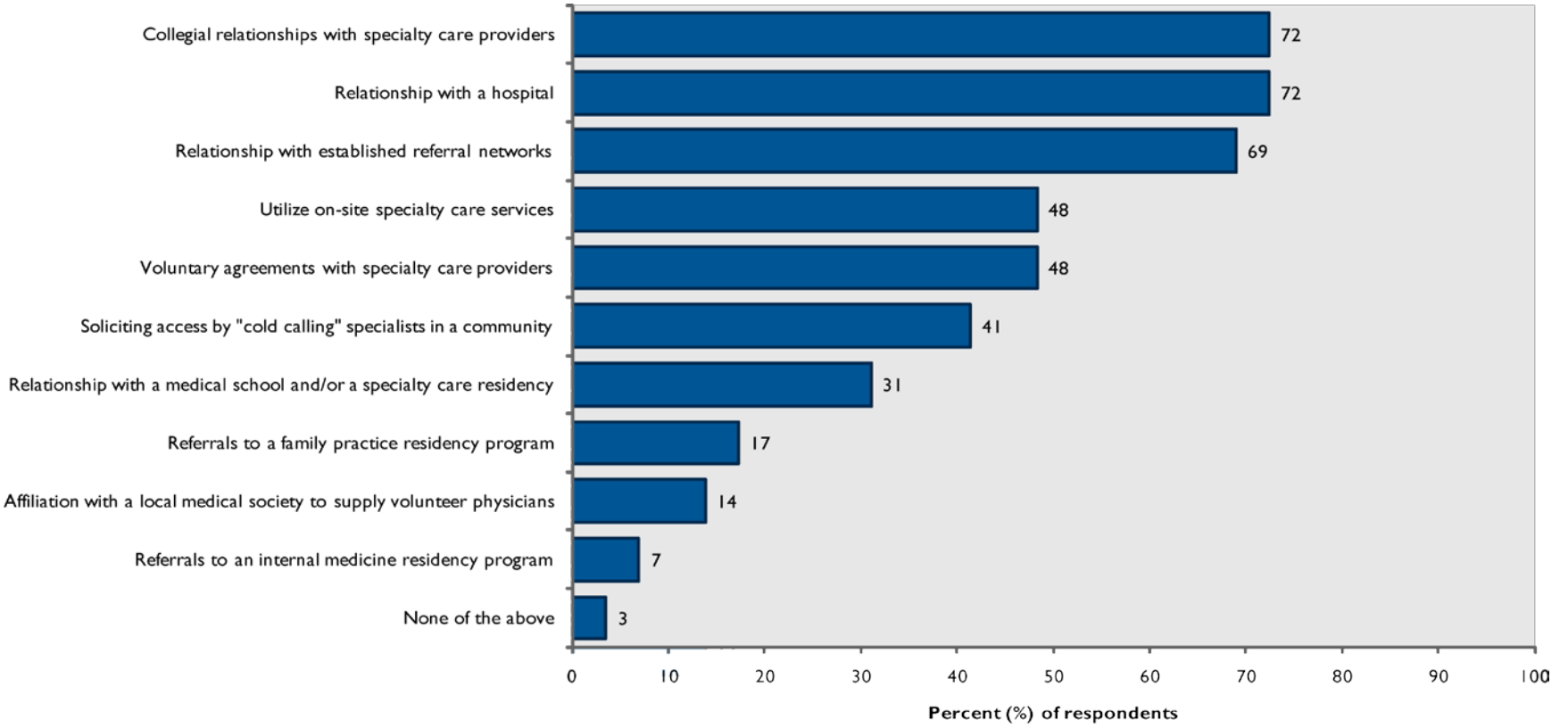
Graphs E-1.1 through E-1.3 examine how different types of clinics (community-funded, federally qualified and rural health clinics) secure specialty care referrals.

The great majority of clinics that responded rely on relationships, informal and formal, to secure specialty care, with eight in 10 securing referrals through collegial relationships with specialty care providers. The second most common method to secure specialty care is through a relationship with a hospital. Fewer than four in 10 clinics obtain referrals from "cold calling" a specialist in their community.

NOTE: These data represent 71 safety net clinics that responded to Question 27. Thirty-one clinics did not respond to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph E-1.1. Methods by which *community-funded clinics* secure specialty care referrals for all patients, Colorado, 2010

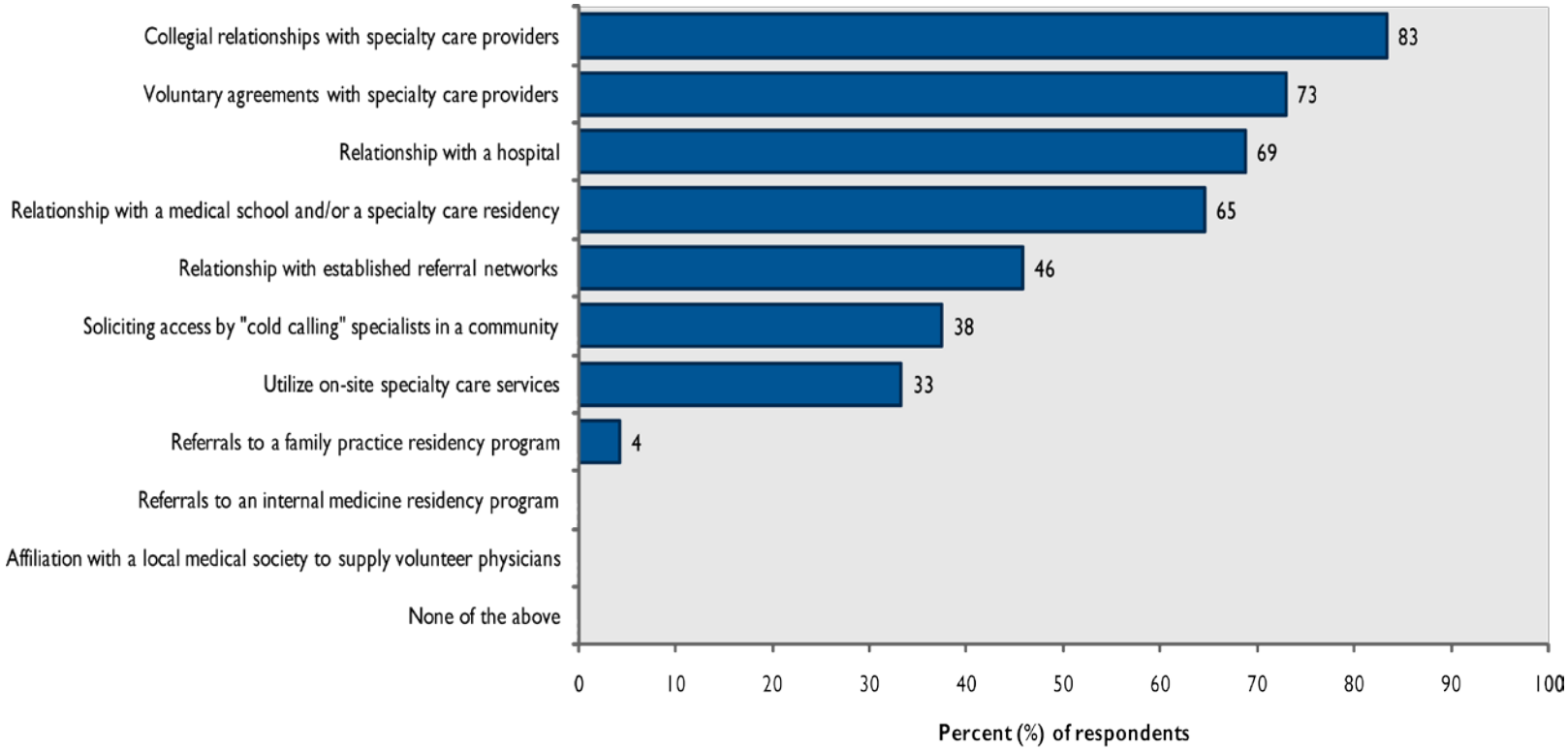


Community-funded clinics rely on a broad variety of sources to secure specialty care referrals. Nearly three-fourths of the clinics that responded use collegial relationships and relationships with hospitals to secure specialty care for their patients. Less than half of the respondents "cold call" specialists in the community. Unlike the other types of safety net clinics, community-funded clinics rely somewhat on family practice and internal medicine residency programs as well as the local medical society to obtain access to specialty care for their patients. It should be noted, however, that residency clinics themselves are included in this analysis as community-funded clinics.

NOTE: Includes the 21 respondents who answered Q27 and indicated that their clinic was community-funded, a family practice residency or some other type of clinic.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph E-1.2. Methods by which *federally qualified health centers (FQHCs)* secure specialty care referrals for all patients, by method type, Colorado, 2010

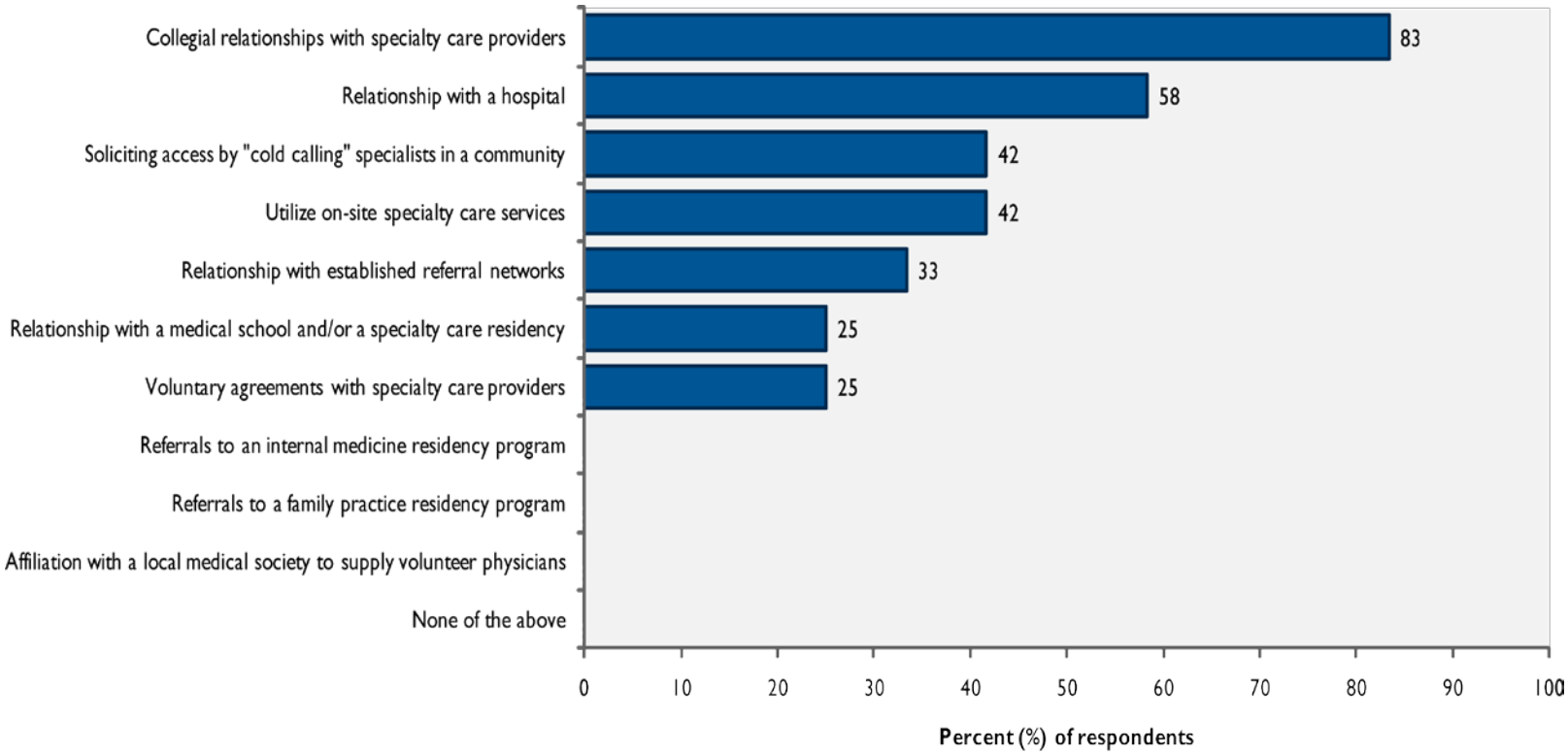


The majority of respondents from FQHCs secure specialty care referrals primarily through collegial relationships or agreements with specialty care providers, hospitals or medical school residency programs. Of all the safety net clinics, FQHCs are less likely to obtain specialty care referrals from on-site specialty care providers. Very few FQHCs secure referrals to family practice programs, and none do so through internal medicine residency programs or volunteer physicians affiliated with a local medical society.

NOTE: Includes the 40 respondents who answered Q27 and indicated that their clinic was a federally qualified health center.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph E-1.3 Methods by which *rural health clinics* secure specialty care referrals for all patients, Colorado, 2010

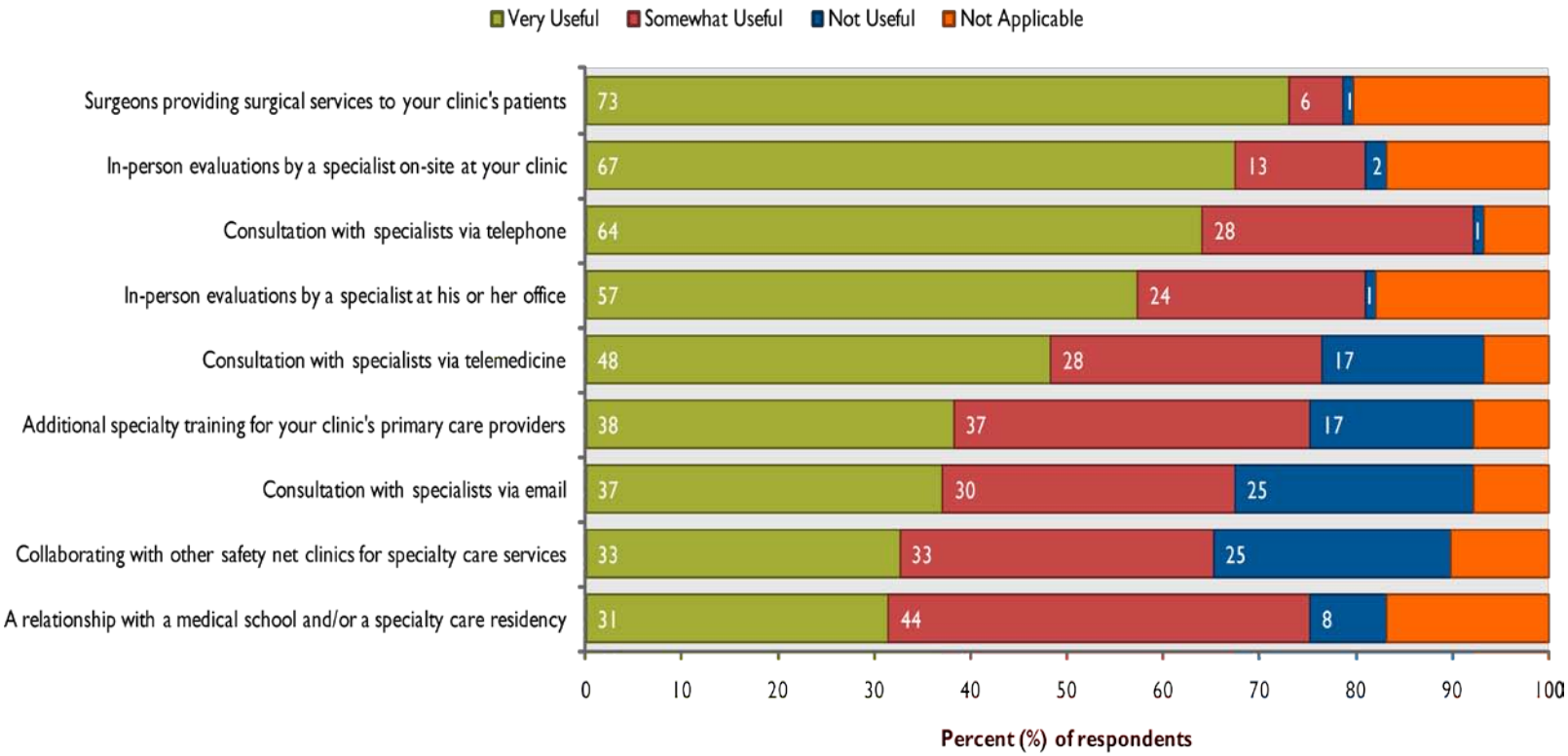


Like the majority of safety net clinics, the most common methods by which rural health clinics obtain specialty care referrals are through collegial relationships and relationships with hospitals. More than 40% also rely on "cold calling" specialists in the community and on-site specialty care services.

NOTE: Includes the 10 respondents who answered Q27 and indicated that their clinic was a rural health center.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph E-2. Frequency (%) by which suggested options for securing specialty care for patients in safety net clinics would be very useful or not useful, Colorado, 2010



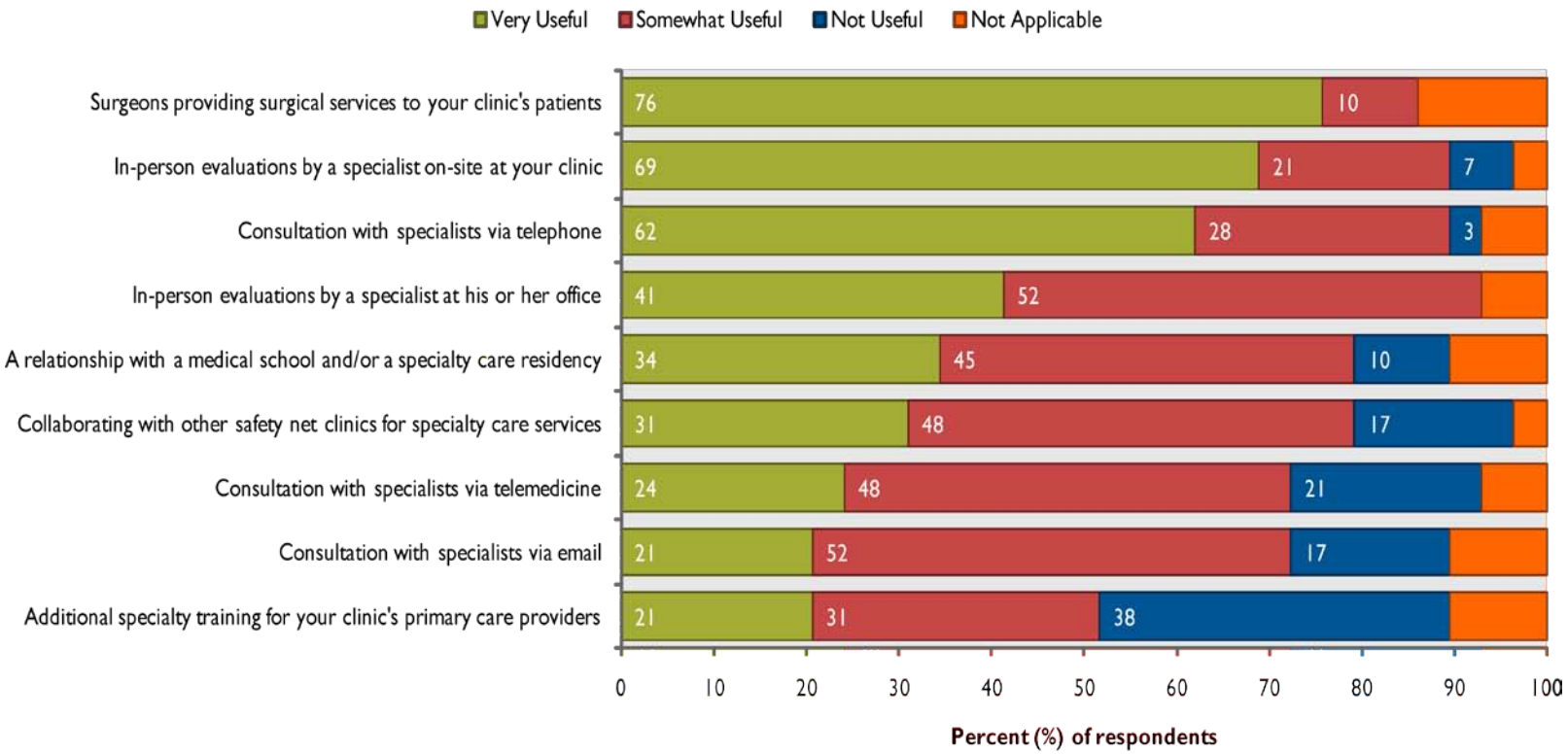
Graphs E-2.1 through E-2.3 display the safety net clinic (community-funded, federally qualified and rural health clinics) rankings of how useful each option would be in securing specialty care for their patients.

For most safety net clinics, the most frequently cited option for securing specialty care for patients is to have surgeons available to provide services. All of the clinics rate in-person evaluations by a specialist as very useful, although some clinics prefer on-site specialist visits and other clinics like the option of visits at the specialist's office. Similarly, consultations with specialists via telephone or telemedicine are consistently rated as very and somewhat useful, though some clinics prefer consultations by one means or the other.

NOTE: These data represent 89 safety net clinics that responded to Question 28. Thirteen clinics did not respond to this question.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph E-2.1. Frequency (%) by which suggested options for securing specialty care for patients in *community-funded health clinics* would be very useful or not useful, Colorado, 2010

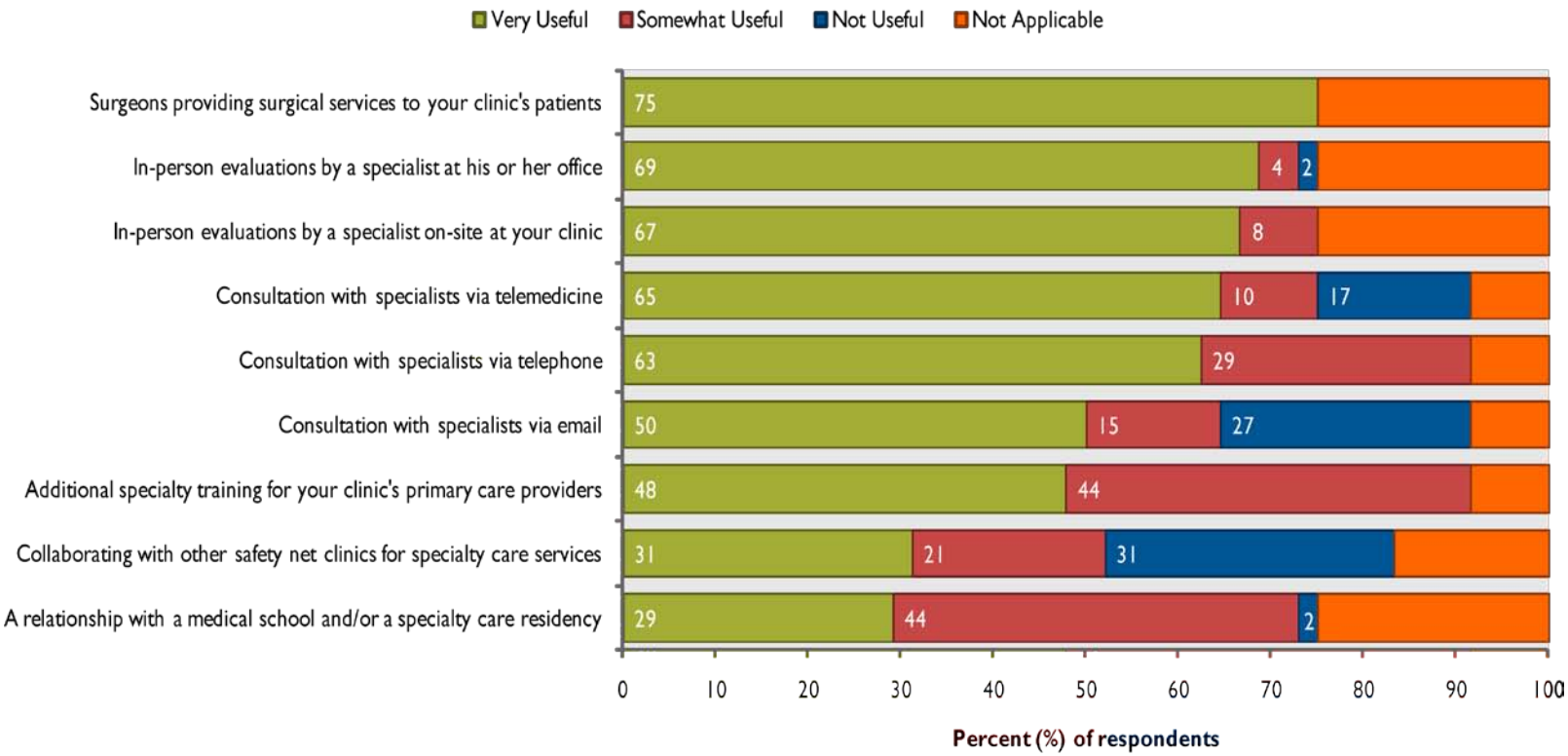


Like safety net clinics as a whole, community-funded health clinics rate surgical services as the most useful option for securing needed specialty care for their patients. The second most useful option would be to have in-person evaluations by a specialist on site. Community-funded clinics also prefer consultations with specialists via the telephone in lieu of telemedicine and e-mail.

NOTE: Includes the 29 respondents who answered Q28 and indicated that their clinic was community-funded, a family practice residency or some other type of clinic.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph E-2.2. Frequency (%) by which suggested options for securing specialty care for patients in *federally qualified health centers (FQHCs)* would be very useful or not useful, Colorado, 2010

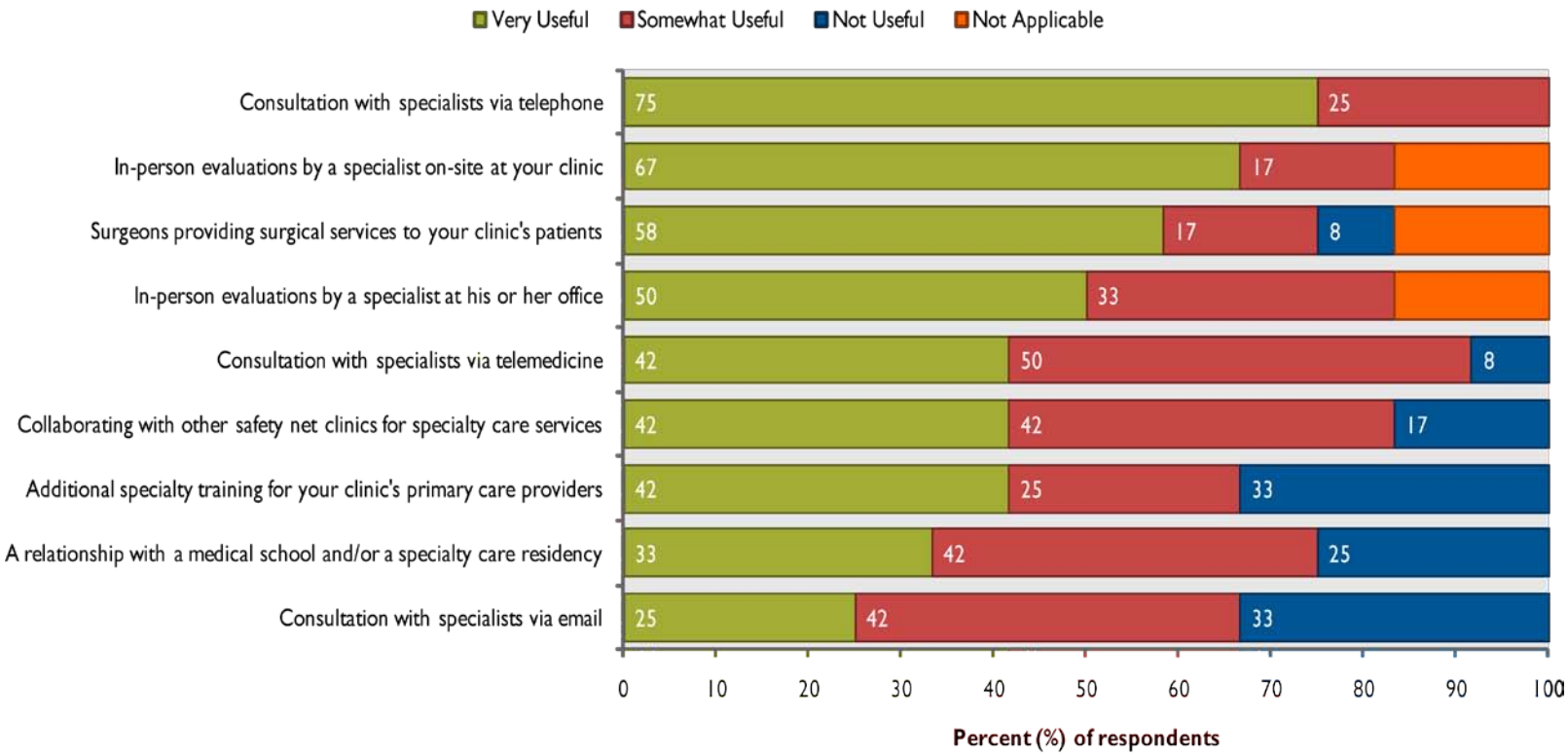


Three-fourths of respondents from FQHCs consider the availability of surgeons and surgical services the most useful option for securing specialty care access for their patients. In-person evaluations by a specialist in his or her office is considered slightly more useful than in-person specialist evaluations on site at the clinic. This slight difference may reflect clinics' available office space or equipment. Similarly, 65% of FQHCs reported that consultations with specialists via telemedicine would be very useful, slightly more useful than consultation via telephone. Again, this ranking may reflect the availability of telemedicine technology at the clinics.

NOTE: Includes the 48 respondents who answered Q28 and indicated that their clinic was a federally qualified health center.

SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Graph E-2.3. Frequency (%) by which suggested options for securing specialty care for patients in *rural health clinics* would be very useful or not useful, by suggestion, Colorado, 2010



All of the rural health clinics reported consultations with specialists via telephone would be most useful or somewhat useful in securing specialty care for their patients. For most other types of clinics, this was the third- or fourth-rated option. In-person evaluations by a specialist on site was also highly rated. The high preference for phone consultations and on-site evaluations may reflect the unique needs of remote rural health clinics. Three-fourths of these clinics also suggested the availability of surgical services would be very or somewhat useful.

NOTE: Includes the 12 respondents who answered Q28 and indicated that their clinic was a rural health center.

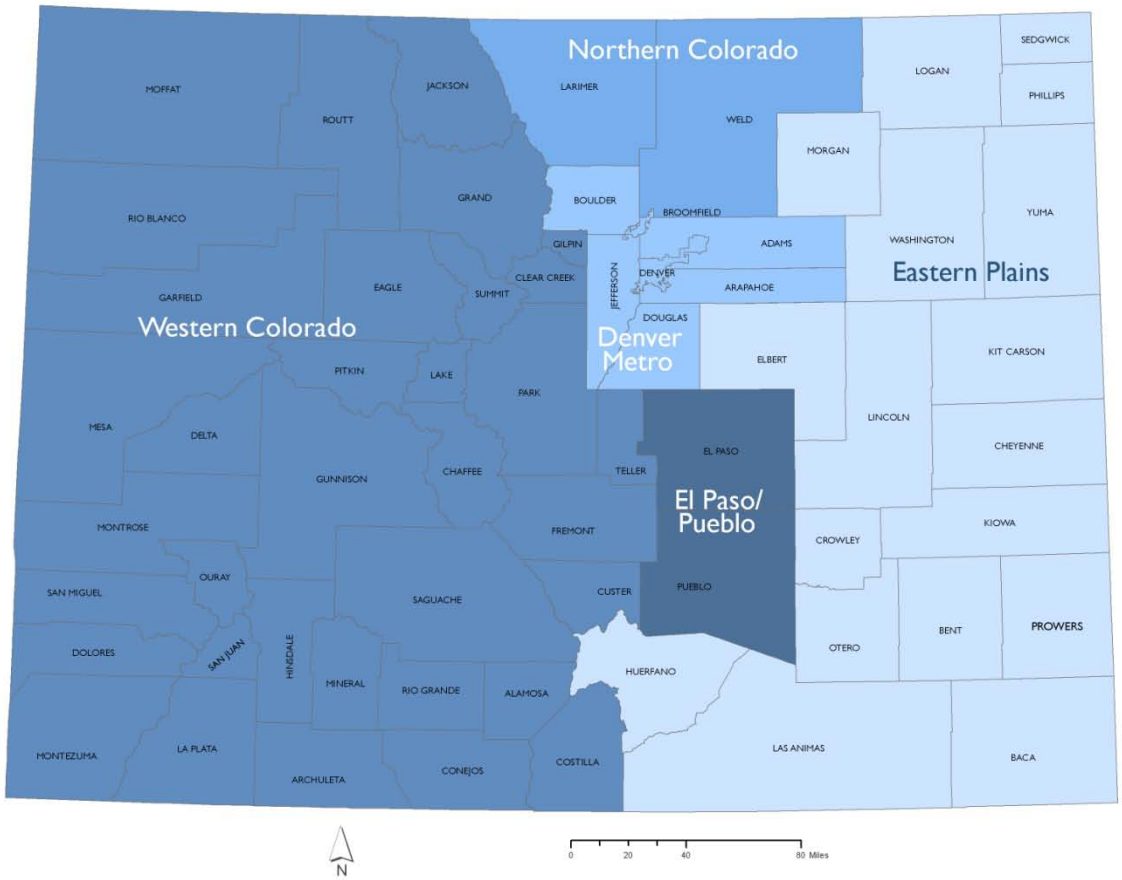
SOURCE: Colorado Health Institute analysis of data from the 2010 Colorado Safety Net Specialty Care Assessment

Regional Profiles: Introduction

For the *Colorado Safety Net Specialty Care Assessment*, the Colorado Health Institute (CHI) divided Colorado into five geographic areas to examine regional differences in safety net clinics' access to specialty care services (see Map 1). Because of the broad geographic distribution of survey respondents, and to protect the anonymity of responses, the regions are relatively large aggregations of the 21 county-based Health Statistics Regions, developed by the Colorado Department of Public Health and Environment (CDPHE). Five regions comprise the eastern plains, western mountain areas and three metropolitan areas along the Front Range.

CHI compiled a series of regional data elements from a wide variety of publicly available sources, including the 2008-09 Colorado Household Survey. These elements include demographic, socioeconomic, employment, health insurance coverage, health indicators and health care utilization measures available at the regional level. These data as well as cross-tabulations of data from the specialty care survey are organized into regional profiles. CHI has included narrative observations about the data throughout the profiles.

Map 1. Colorado regions used for the 2010 *Safety Net Specialty Care Assessment*



REGIONAL DATA PROFILE: DENVER METRO

The demographic profile of a population, community or legislative district matters.

DENVER METRO

As displayed in Table 1, the most notable population growth in the Denver Metro area between 2010 and 2020 will be in the 65+ population (80%), higher than the expected growth in the state as a whole (71%). The slowest population growth in Denver Metro will be among working-age adults (19-64 years) at 7 percent. It is the case in every region of the state that the 65+ age group is the fastest-growing segment of the population by a comfortable margin, while the lowest growth rate typically is found among working-age adults. This finding has policy implications for the allocation of state resources. This trend is especially important in the Medicaid program that funds acute care for chronic disease management and a significant portion of long-term care expenses for low-income older adults.

Table 1. Population by age and population growth rates, Denver Metro and Colorado, 2010 and 2020

	Population		Change 2010-20	
	2010	2020	Percent change	Average annual growth rate
Denver Metro				
Age 0-18 years	757,314	868,884	14.7%	1.4%
Age 19-64 years	1,834,568	1,970,492	7.4%	0.7%
Age 65 years and older	276,530	496,934	79.7%	6.0%
All ages	2,868,412	3,336,311	16.3%	1.5%
Colorado				
Age 0-18 years	1,334,222	1,587,802	19.0%	1.8%
Age 19-64 years	3,284,581	3,656,924	11.3%	1.1%
Age 65 years and older	541,386	927,003	71.2%	5.5%
All ages	5,160,189	6,171,730	19.6%	1.8%

SOURCE: Colorado Health Institute using data from the Colorado Demography Office

Unemployment rates can affect who has access to private health insurance as private health insurance in Colorado and the United States is primarily an employer-based system. The data in Table 2 reveal that the unemployment rate for both the Denver Metro area and the rest of the state was slightly below 9 percent.

Table 2. Unemployment rates, Denver Metro and Colorado, November 2010

	Unemployment rate
Denver Metro	8.5%
Colorado	8.7%

SOURCE: Colorado Health Institute using data from the Colorado Department of Labor & Employment, Labor Market Information Division, November 2010

Annual household income is used to categorize families according to how their income ranks relative to the federal poverty level (FPL). This federal classification is used to determine eligibility for many federal and state programs, including Medicaid and the Child Health Plan Plus (CHP+) and the federal subsidies offered to low- to moderate-income individuals (134% to 400% of FPL) authorized by the Patient Protection and Affordable Care

Act (ACA). Subsidies will be available to purchase health insurance through the state's insurance exchange when it is operational in 2014.

As displayed in Table 3, individuals at the poverty level or 200 percent of the poverty level are slightly less prevalent in the Denver Metro area than in the state as a whole. Nearly half of all children in the Denver Metro area, however, live in a family at or below 200 percent of the poverty level. This group of vulnerable children is a prime target for the Medicaid and CHP+ expansions resulting from the Colorado Healthcare Affordability Act (HB 09-1293) and the ACA.

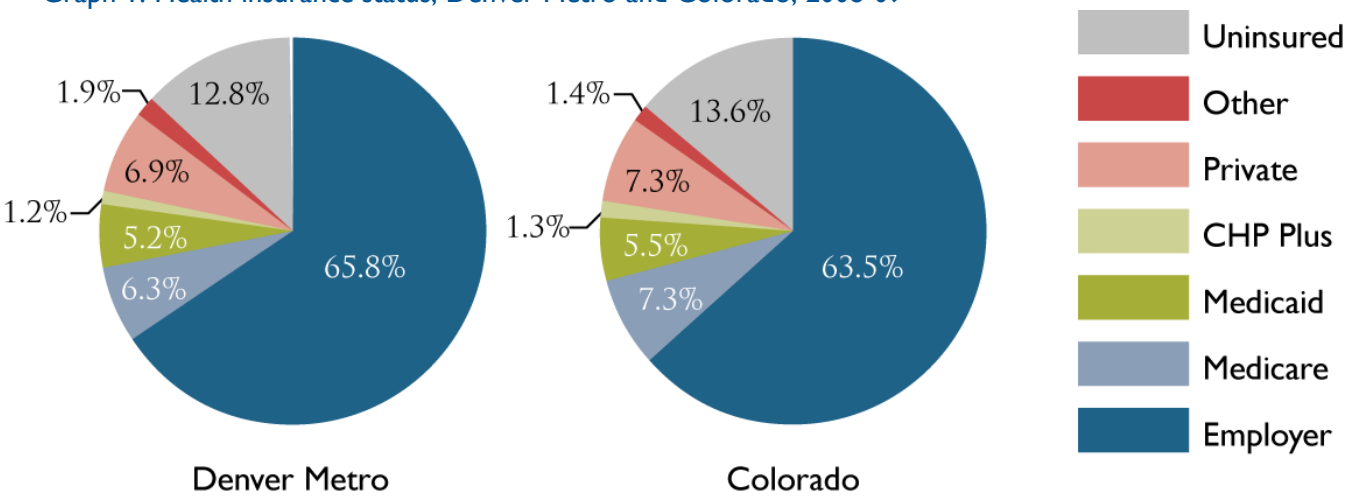
Table 3. Median household income and percent of population at or below 100% and 200% of the federal poverty level (FPL), Denver Metro and Colorado, 2008-09

	Median household income	% of population at or below 100% of FPL, all ages	% of population at or below 200% of FPL, ages 0-18	% of population at or below 200% of FPL, ages 19-64
Denver Metro	$41,494	17.9%	44.4%	35.5%
Colorado	$38,400	18.6%	45.5%	36.9%

NOTE: In 2008, 100% of the FPL for a family of 4 was $21,200.
SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

The relationship between having health insurance coverage, the type of that coverage and health outcomes has been demonstrated by a growing body of research. The Colorado Household Survey (COHS), administered by CHI, provides a better understanding of Coloradans' insurance status.

Graph 1. Health insurance status, Denver Metro and Colorado, 2008-09



SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

In light of the passage of HB 09-1293 that expands CHP+ eligibility to 250 percent of the federal poverty level for children and pregnant women and Medicaid eligibility to 100 percent of the FPL for adults, monitoring eligible but not enrolled individuals in these programs is essential for policy impact and program planning purposes.

Table 4. Number and percentage of persons who are eligible *and enrolled* and eligible *but not enrolled* in Medicaid and Child Health Plan Plus (CHP+) and estimates of expansion groups based on state and federal health reforms, Denver Metro and Colorado, 2008

	Denver Metro		Colorado	
	Number	Percent of population	Number	Percent of population
CHP+ children (age 0-18)				
Currently eligible and enrolled	30,470	50.3%	59,603	52.3%
Currently eligible but not enrolled	30,064	49.7%	54,326	47.7%
HB 09-1293: Expansion group	5,260		11,953	
Medicaid children (age 0-18)				
Currently eligible and enrolled	116,124	75.9%	216,678	78.1%
Currently eligible but not enrolled	36,897	24.1%	60,839	21.9%
Medicaid parents of dependent children (age 19-64)				
Currently eligible and enrolled	27,486	67.6%	56,187	68.7%
Currently eligible but not enrolled	13,148	32.4%	25,544	31.3%
HB 09-1293: Expansion group	12,958		27,618	
National health reform: Expansion group	10,427		23,743	
Medicaid adults without dependent children (age 19-64)				
HB 09-1293: Expansion group	66,887		119,104	
National health reform: Expansion group	15,762		28,933	

* The federal Patient Protection and Affordable Care Act passed in March 2010 expands eligibility for Medicaid for all working-age adults up to 133% of the federal poverty level (FPL). CHI's analyses estimate the number of uninsured parents of dependent children between 100% and 133% of FPL, and the number of adults without dependent children between 0-133% of FPL.
SOURCE: Colorado Health Institute analysis of the 2008 American Community Survey and Medicaid and CHP+ enrollment data from the Colorado Department of Health Care Policy and Financing

Risk factors that affect the health of individuals and populations are a matter of both personal and public responsibility. In the case of obesity, it is clear that neither Colorado as a state nor the Denver Metro area as a region of the state is doing well—approximately 15 percent of children are obese. Like uninsurance rates, obesity rates have a public dimension that is amenable to policy interventions.

Table 5. Health risk factors by age group, Denver Metro and Colorado, 2008-09

	Denver Metro	Colorado
Children (ages 2-14 years)		
Percent who are obese	15.7%	14.7%
Adults (ages 19-64 years)		
Percent with diabetes[1]	5.2%	5.3%
Percent reporting fair or poor health[2]	15.4%	15.1%
Percent who are obese[3]	18.3%	18.7%

NOTES:
[1] Includes those adults who have been told by a doctor that they have diabetes, excluding gestational diabetes.
[2] Fair/poor health data are self-reported.
[3] Adults reporting a Body Mass Index (BMI) of less than 25.0 are considered normal weight; adults reporting a BMI between 25.0 and 29.9 are considered overweight; and adults reporting a BMI of 30.0 or higher are considered obese. BMI is a measure of height relative to weight.
SOURCE: 2009 Colorado Child Health Survey, 2009 Behavioral Risk Factor Surveillance System (BRFSS) Survey, and 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

Table 6. Age-adjusted incidence rate of cancer and mortality rate due to heart disease, Denver Metro and Colorado, all ages, 2007-2009

	Denver Metro	Colorado
Age-adjusted incidence rate of all cancers per 100,000 population	434.7	447.6
Age-adjusted rate of mortality due to heart disease per 100,000 population	139.2	142.1

NOTE: Rates are per 100,000 population and are adjusted to the 2000 U.S. population. SOURCE: Colorado Central Cancer Registry, Colorado Department of Public Health and Environment, 2007; Health Statistics Section, Colorado Department of Public Health and Environment, 2009.

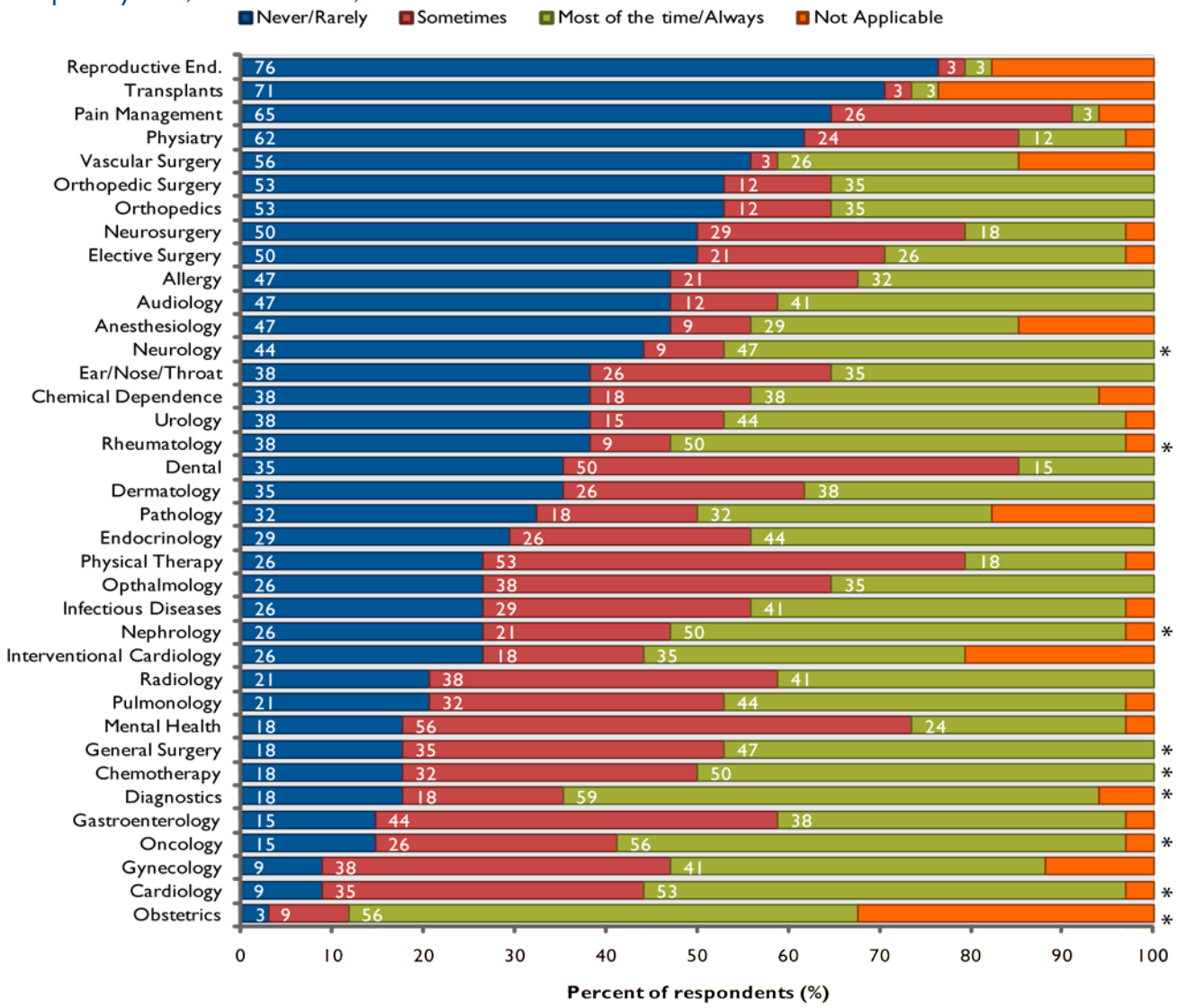
Using the Colorado Household Survey, Coloradans' utilization of health care services can be analyzed. As can be seen in Table 7, individuals in the Denver Metro area are most likely to report a doctor's office or private clinic as their usual source of care, consistent with the rest of the state. Utilization data from the COHS can be examined relative to insurance status and household income to provide policymakers with the impact of having insurance on health care access.

Table 7. Health care utilization profile, Denver Metro and Colorado, 2008-09

	Denver Metro	Colorado
Health care utilization during past year *		
Percent of population that visited an emergency room	23.1%	24.4%
Percent of population that visited a primary care physician	90.6%	90.9%
Percent of population that visited a specialist physician	47.3%	45.5%
Deferred medical care and/or did not fill a prescription due to cost during past year		
Percent of insured individuals who deferred care/did not fill a prescription	17.2%	16.9%
Percent of uninsured individuals who deferred care/did not fill a prescription	41.6%	43.7%
Usual source of care		
A doctor's office or private clinic	77.6%	76.0%
A community health center or other public clinic	10.5%	11.8%
A retail clinic like Wal-Mart	0.4%	0.2%
A hospital emergency room	5.2%	4.7%
An urgent care center	2.6%	3.2%
Some other place	3.4%	3.5%
Does not go to one place most often	0.4%	0.4%

* These items limited to respondents who indicated they has visited a health care professional or health care facility in past 12 months.
SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

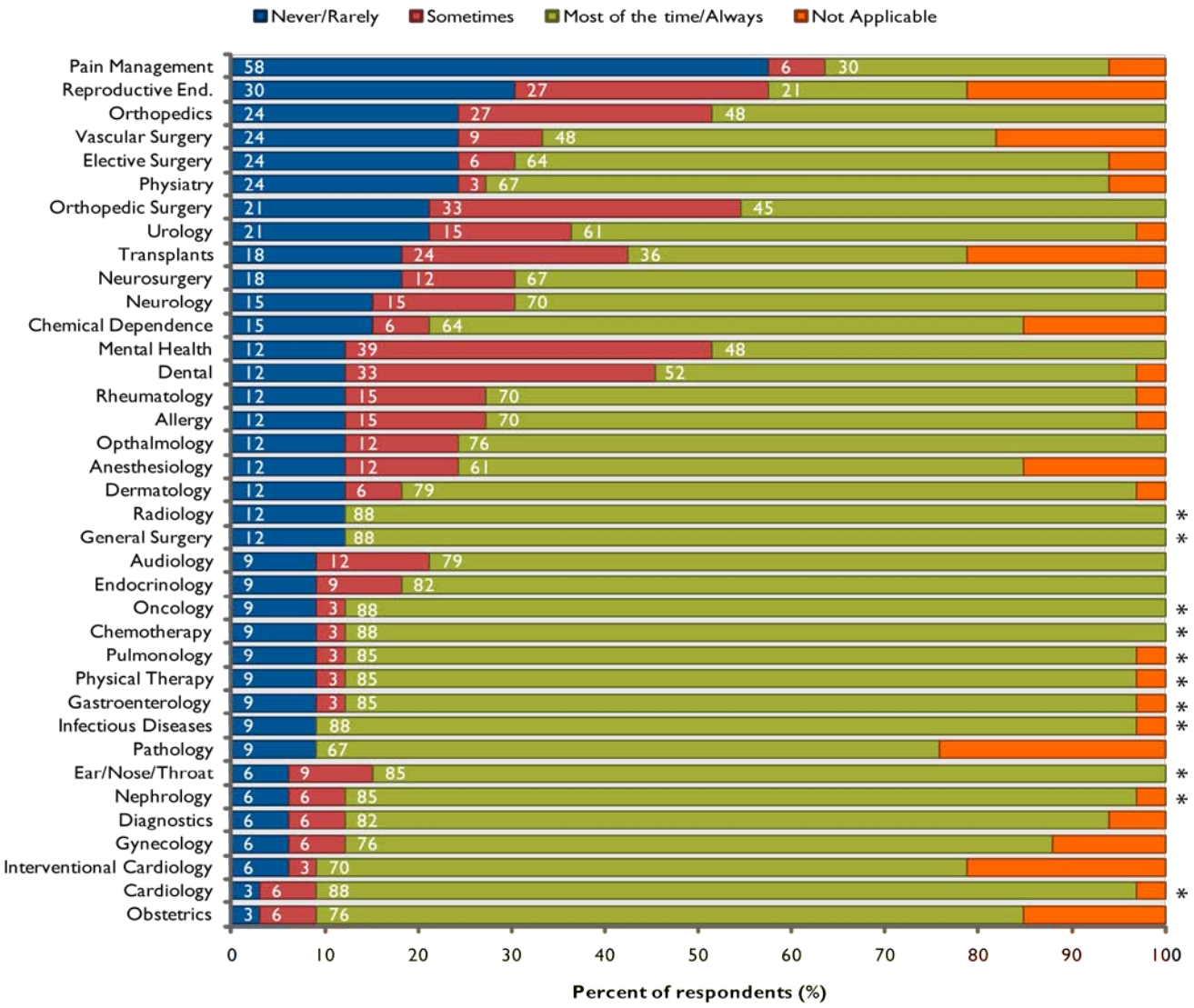
Graph 2. Frequency with which safety net respondents are able to refer *uninsured* patients to specialty care, Denver Metro, 2010



* Asterisks represent the nine categories with the highest proportion of survey respondents indicating "most of the time/always."
NOTE: These data represent 34 clinics within the Denver Metro region that responded to Question 11.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

Cardiology and oncology are the most frequently available specialty referrals for uninsured patients, present in over 80 percent of clinics in the Denver Metro area. Two common specialties, dentistry and physical therapy, have surprisingly low availability for referral for uninsured patients in Denver Metro area clinics. Only 15 percent of clinics report being able to refer their uninsured patients to a dentist most of the time or always, and only 18 percent are regularly able to refer these patients to physical therapy.

Graph 3. Frequency with which safety net respondents are able to refer *Medicaid* patients to specialty care, Denver Metro, 2010



* Asterisks represent the 11 categories with the highest proportion of survey respondents indicating "most of the time/always."
NOTE: These data represent 33 clinics within the Denver Metro region that responded to Question 15.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

Only one specialty care service, pain management, is unavailable or rarely available by referral for Medicaid patients in over half the safety net clinics in the Denver Metro area. Other services, including oncology, chemotherapy and radiology, are most of the time or always available for referral for Medicaid patients in almost 90 percent of safety net clinics. Nearly all (97%) of surveyed clinics accept Medicaid patients.

REGIONAL DATA PROFILE: EASTERN PLAINS

The demographic profile of a population, community or legislative district matters.

EASTERN PLAINS

As displayed in Table 1, the most notable population growth in the Eastern Plains between 2010 and 2020 will be in the 65+ population (37%), although it is substantially lower than the expected growth in the state as a whole (71%). The slowest population growth in the Eastern Plains will be among working-age adults (19-64 years) at 17 percent. It is the case in every region of the state that the 65+ age group is the fastest-growing segment of the population by a comfortable margin, while the lowest growth rate typically is found among working-age adults. This finding has policy implications for the allocation of state resources. This trend is especially important in the Medicaid program that funds acute care for chronic disease management and a significant portion of long-term care expenses for low-income older adults.

Table 1. Population by age and population growth rates, Eastern Plains and Colorado, 2010 and 2020

	Population		Change 2010-20	
	2010	2020	Percent change	Average annual growth rate
Eastern Plains				
Age 0-18 years	46,203	55,645	20.4%	1.9%
Age 19-64 years	111,816	130,638	16.8%	1.6%
Age 65 years and older	28,455	39,072	37.3%	3.2%
All ages	186,474	225,355	20.9%	1.9%
Colorado				
Age 0-18 years	1,334,222	1,587,802	19.0%	1.8%
Age 19-64 years	3,284,581	3,656,924	11.3%	1.1%
Age 65 years and older	541,386	927,003	71.2%	5.5%
All ages	5,160,189	6,171,730	19.6%	1.8%

SOURCE: Colorado Health Institute using data from the Colorado Demography Office

Unemployment rates can affect who has access to private health insurance as private health insurance in Colorado and the United States is primarily an employer-based system. The data in Table 2 reveal that the unemployment rate for the Eastern Plains (7%) was lower than that of the rest of the state (9%).

Table 2. Unemployment rates, Eastern Plains and Colorado, November 2010

	Unemployment rate
Eastern Plains	7.0%
Colorado	8.7%

SOURCE: Colorado Health Institute using data from the Colorado Department of Labor & Employment, Labor Market Information Division, November 2010

Annual household income is used to categorize families according to how their income ranks relative to the federal poverty level (FPL). This federal classification is used to determine eligibility for many federal and state

programs including Medicaid and the Child Health Plan Plus (CHP+) and the federal subsidies offered to low- to moderate-income individuals (134% to 400% of FPL) authorized by the Patient Protection and Affordable Care Act (ACA). Subsidies will be available to purchase health insurance through the state's insurance exchange when it is operational in 2014.

As displayed in Table 3, individuals at the poverty level or 200 percent of the poverty level are more prevalent in the Eastern Plains than in the state as a whole, especially among children. This group of vulnerable children is a prime target for the Medicaid and CHP+) expansions resulting from the Colorado Healthcare Affordability Act (HB 09-1293) and the ACA.

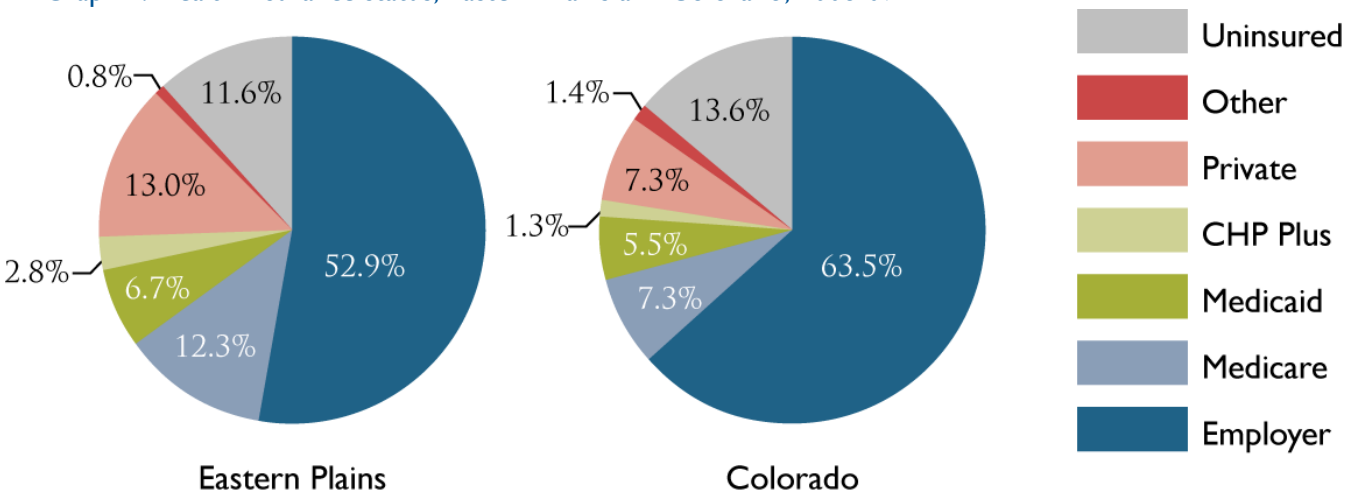
Table 3. Median household income and percent of population at or below 100% and 200% of the federal poverty level (FPL), Eastern Plains and Colorado, 2008-09

	Median household income	% of population at or below 100% of FPL, all ages	% of population at or below 200% of FPL, ages 0-18	% of population at or below 200% of FPL, ages 19-64
Eastern Plains	$32,412	24.7%	58.4%	45.8%
Colorado	$38,400	18.6%	45.5%	36.9%

NOTE: In 2008, 100% of the FPL for a family of 4 was $21,200.
SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

The relationship between having health insurance coverage, the type of that coverage and health outcomes has been demonstrated by a growing body of research. The Colorado Household Survey (COHS), administered by CHI, provides a better understanding of Coloradans' insurance status.

Graph 1. Health insurance status, Eastern Plains and Colorado, 2008-09



SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

In light of the passage of HB 09-1293 that expands CHP+ eligibility to 250 percent of the federal poverty level for children and pregnant women and Medicaid eligibility to 100 percent of the FPL for adults, monitoring eligible but not enrolled individuals in these programs is essential for policy impact and program planning purposes.

Table 4. Number and percentage of persons who are eligible and enrolled and eligible but not enrolled in Medicaid and Child Health Plan Plus (CHP+) and estimates of expansion groups based on state and federal health reforms, Eastern Plains and Colorado, 2008

	Eastern Plains		Colorado	
	Number	Percent of population	Number	Percent of population
CHP+ children (age 0-18)				
Currently eligible and enrolled	3,176	55.1%	59,603	52.3%
Currently eligible but not enrolled	2,584	44.9%	54,326	47.7%
HB 09-1293: Expansion group	472		11,953	
Medicaid children (age 0-18)				
Currently eligible and enrolled	10,486	86.0%	216,678	78.1%
Currently eligible but not enrolled	1,711	14.0%	60,839	21.9%
Medicaid parents of dependent children (age 19-64)				
Currently eligible and enrolled	2,682	69.6%	56,187	68.7%
Currently eligible but not enrolled	1,173	30.4%	25,544	31.3%
HB 09-1293: Expansion group	139		27,618	
National health reform: Expansion group	1,819		23,743	
Medicaid adults without dependent children (age 19-64)				
HB 09-1293: Expansion group	5,796		119,104	
National health reform: Expansion group	908		28,933	

* The federal Patient Protection and Affordable Care Act passed in March 2010 expands eligibility for Medicaid for all working-age adults up to 133% of the federal poverty level (FPL). CHI's analyses estimate the number of uninsured parents of dependent children between 100% and 133% of FPL, and the number of adults without dependent children between 0-133% of FPL.
SOURCE: Colorado Health Institute analysis of the 2008 American Community Survey and Medicaid and CHP+ enrollment data from the Colorado Department of Health Care Policy and Financing

Risk factors that affect the health of individuals and populations are a matter of both personal and public responsibility. In the case of obesity, it is clear that neither Colorado as a state nor the Eastern Plains as a region of the state is doing well—21 percent of children in the Eastern Plains and 15 percent of children across the state are obese. Like uninsurance rates, obesity rates have a public dimension that is amenable to policy interventions.

Table 5. Health risk factors by age group, Eastern Plains and Colorado, 2008-09

	Eastern Plains	Colorado
Children (ages 2-14 years)		
Percent who are obese	21.0%	14.7%
Adults (ages 19-64 years)		
Percent with diabetes[1]	6.9%	5.3%
Percent reporting fair or poor health[2]	18.5%	15.1%
Percent who are obese[3]	27.1%	18.7%

NOTES:
[1] Includes those adults who have been told by a doctor that they have diabetes, excluding gestational diabetes.
[2] Fair/poor health data are self-reported.
[3] Adults reporting a Body Mass Index (BMI) of less than 25.0 are considered normal weight; adults reporting a BMI between 25.0 and 29.9 are considered overweight; and adults reporting a BMI of 30.0 or higher are considered obese. BMI is a measure of height relative to weight.
SOURCE: 2009 Colorado Child Health Survey, 2009 Behavioral Risk Factor Surveillance System (BRFSS) Survey, and 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

Table 6. Age-adjusted incidence rate of cancer and mortality rate due to heart disease, Eastern Plains and Colorado, all ages, 2007-2009

	Eastern Plains	Colorado
Age-adjusted incidence rate of all cancers per 100,000 population	402.1	447.6
Age-adjusted rate of mortality due to heart disease per 100,000 population	173.4	142.1

NOTE: Rates are per 100,000 population and are adjusted to the 2000 U.S. population. SOURCE: Colorado Central Cancer Registry, Colorado Department of Public Health and Environment, 2007; Health Statistics Section, Colorado Department of Public Health and Environment, 2009.

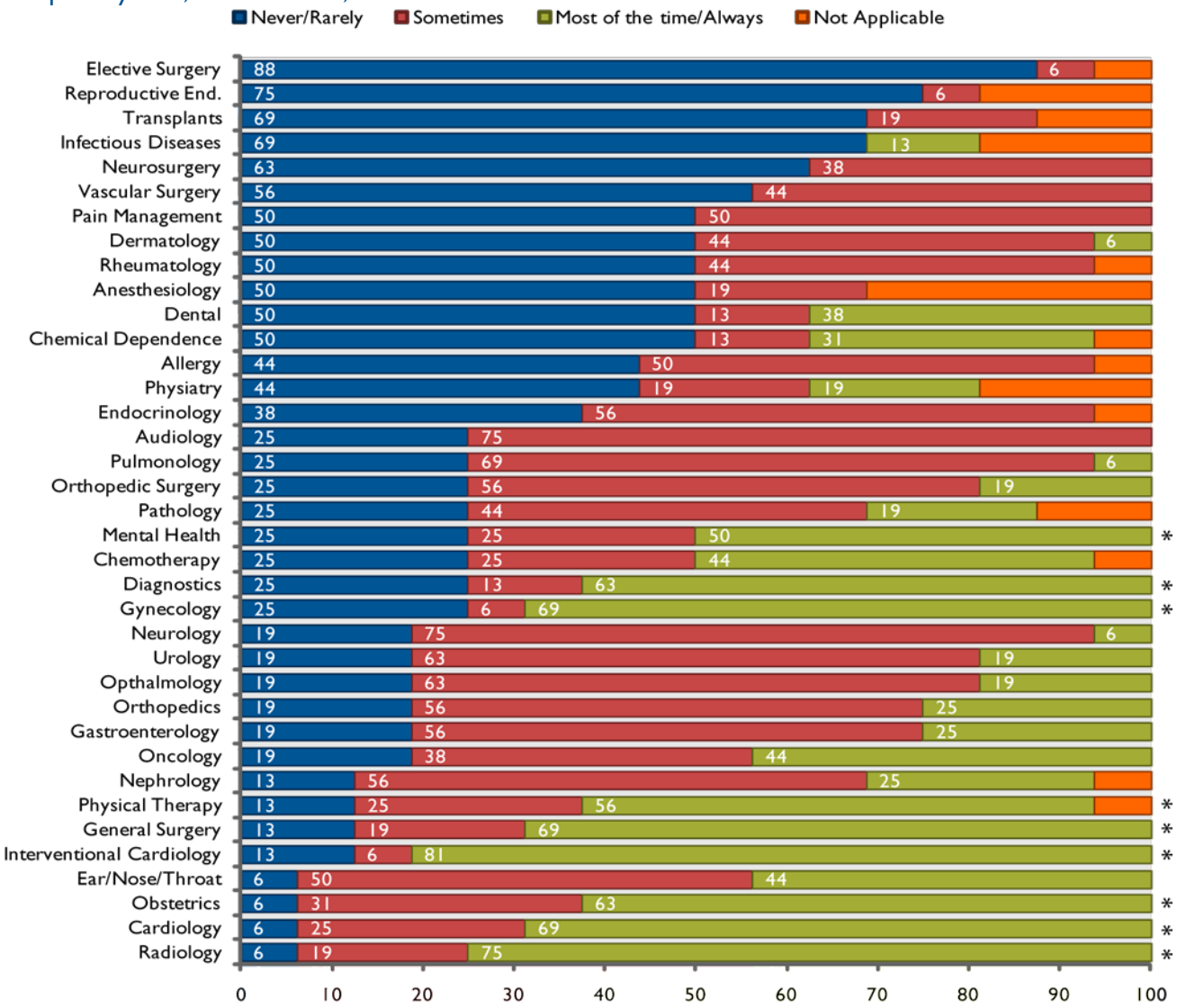
Using the Colorado Household Survey, Coloradans' utilization of health care services can be analyzed. As can be seen in Table 7, individuals in the Eastern Plains utilized safety net clinics, such as community health centers, as their usual source of care at almost twice the rate of Coloradans as a whole. Utilization data from the COHS can be examined relative to insurance status and household income to provide policymakers with the impact of having insurance on health care access.

Table 7. Health care utilization profile, Eastern Plains and Colorado, 2008-09

	Eastern Plains	Colorado
Health care utilization during past year		
Percent of population that visited an emergency room	28.6%	24.4%
Percent of population that visited primary care physician	93.8%	90.9%
Percent of population that visited specialist physician	36.3%	45.5%
Deferred medical care and/or did not fill a prescription due to cost during past year		
Percent of insured individuals who deferred care/did not fill a prescription	18.4%	16.9%
Percent of uninsured individuals who deferred care/did not fill a prescription	53.0%	43.7%
Usual source of care		
Percent reporting no usual source of care	4.9%	10.4%
Of those indicating they had a usual source of care, percent reporting…		
A doctor's office or private clinic	70.2%	76.0%
A community health center or other public clinic	23.4%	11.8%
A retail clinic like Wal-Mart	0.0%	0.2%
A hospital emergency room	3.2%	4.7%
An urgent care center	0.8%	3.2%
Some other place	2.2%	3.5%
Does not go to one place most often	0.2%	0.4%

SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

Graph 2. Frequency with which safety net respondents are able to refer *uninsured* patients to specialty care, Eastern Plains, 2010

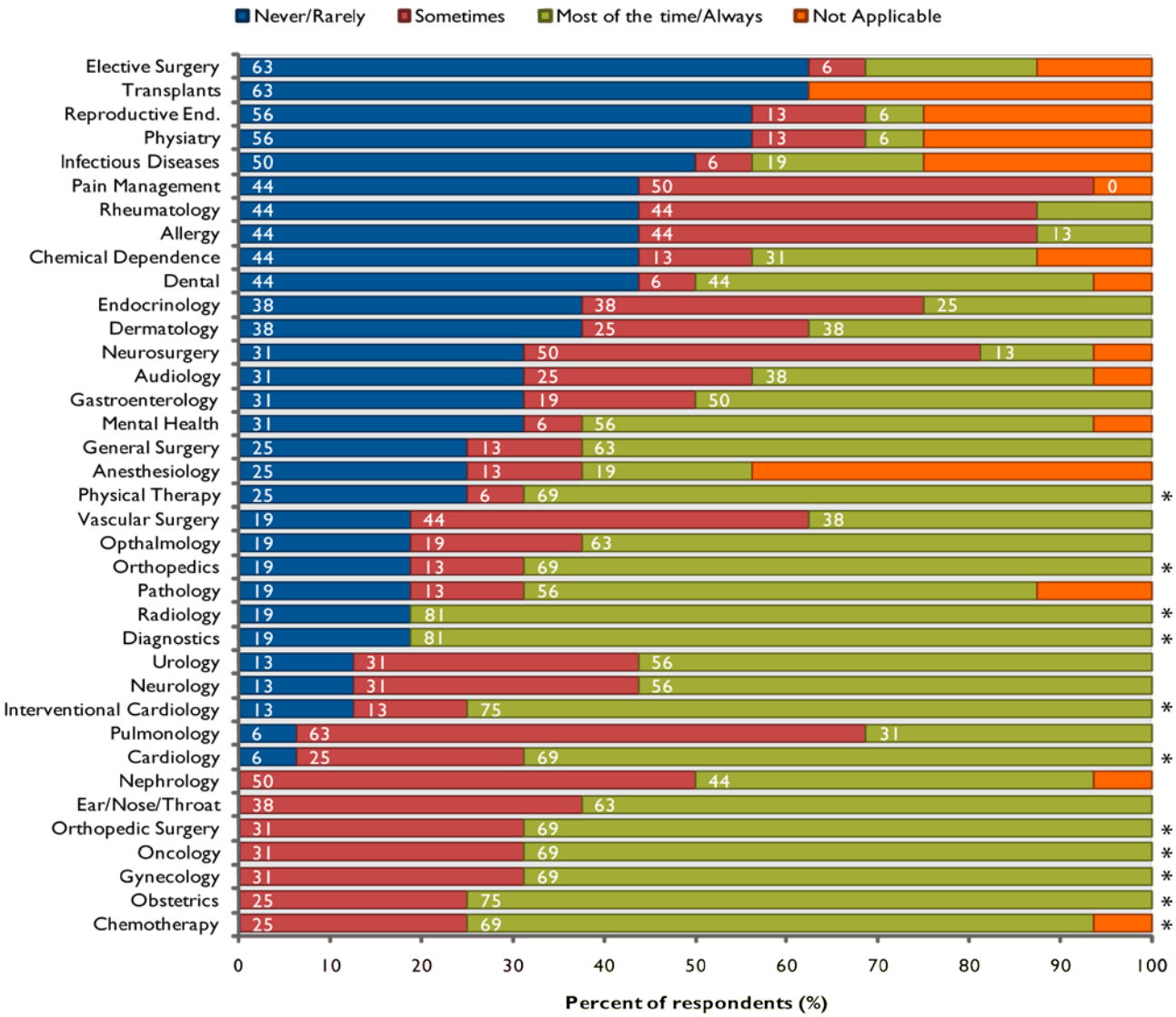


* Asterisks represent the nine categories with the highest proportion of survey respondents indicating "most of the time/always."
NOTE: These data represent 16 clinics within the Eastern Plains region that responded to Question 11.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

Coloradans living on the Eastern Plains are more likely to have certain chronic conditions, such as obesity or diabetes, which puts them at higher risk for needing referrals to specialists such as cardiologists. Although the majority of clinics are usually able to refer to cardiologists, 31 percent are able to refer patients to cardiologists only sometimes or never.

Other services, such as allergy care, neurosurgery and anesthesiology are infrequently or never available in any safety net clinic in Eastern Colorado.

Graph 3. Frequency with which safety net respondents are able to refer *Medicaid* patients to specialty care, Eastern Plains, 2010



* Asterisks represent the 11 categories with the highest proportion of survey respondents indicating "most of the time/always."
NOTE: These data represent 16 clinics within the Eastern Plains region that responded to Question 15.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

Residents of the Eastern Plains are more likely than other Coloradans to rely on safety net clinics as their usual source of care. In addition, poverty levels and Medicaid enrollment levels are higher on the Eastern Plains than in other regions of Colorado, making Graph 3 especially important for clinics in this region.

All of the clinics within the Eastern Plains reported accepting Medicaid patients. Of these, all were able to refer at least some of the time to seven specialties, including oncology, gynecology, and ear/nose/throat. As is the case with other regions in Colorado, very few clinics reported being able to routinely refer Medicaid patients to elective surgery, transplants and pain management.

REGIONAL DATA PROFILE: EL PASO/PUEBLO

The demographic profile of a population, community or legislative district matters.

EL PASO/PUEBLO

As displayed in Table 1, the most notable population growth in El Paso/Pueblo between 2010 and 2020 will be in the 65+ population (63%), although it is still lower than the expected growth in the state as a whole (71%). The slowest population growth in El Paso/Pueblo will be among working-age adults (19-64 years) at 10 percent. It is the case in every region of the state that the 65+ age group is the fastest-growing segment of the population by a comfortable margin, while the lowest growth rate typically is found among working-age adults. This finding has policy implications for the allocation of state resources. This trend is especially important in the Medicaid program that funds acute care for chronic disease management and a significant portion of long-term care expenses for low-income older adults.

Table 1. Population by age and population growth rates, El Paso/Pueblo and Colorado, 2010 and 2020

	Population		Change 2010-20	
	2010	2020	Percent change	Average annual growth rate
El Paso/Pueblo				
Age 0-18 years	204,383	238,588	16.7%	1.6%
Age 19-64 years	493,367	543,985	10.3%	1.0%
Age 65 years and older	85,767	140,033	63.3%	5.0%
All ages	783,517	922,606	17.8%	1.6%
Colorado				
Age 0-18 years	1,334,222	1,587,802	19.0%	1.8%
Age 19-64 years	3,284,581	3,656,924	11.3%	1.1%
Age 65 years and older	541,386	927,003	71.2%	5.5%
All ages	5,160,189	6,171,730	19.6%	1.8%

SOURCE: Colorado Health Institute using data from the Colorado Demography Office

Unemployment rates can affect who has access to private health insurance as private health insurance in Colorado, and the United States is primarily an employer-based system. The data in Table 2 reveal that the unemployment rate for El Paso/Pueblo was slightly higher than the state average.

Table 2. Unemployment rates, El Paso/Pueblo and Colorado, November 2010

	Unemployment rate
El Paso/Pueblo	9.5%
Colorado	8.7%

SOURCE: Colorado Health Institute using data from the Colorado Department of Labor & Employment, Labor Market Information Division, November 2010

Annual household income is used to categorize families according to how their income ranks relative to the federal poverty level (FPL). This federal classification is used to determine eligibility for many federal and state programs including Medicaid and the Child Health Plan Plus (CHP+) and the federal subsidies offered to low- to moderate-income individuals (134% to 400% of FPL) authorized by the Patient Protection and Affordable Care Act (ACA). Subsidies will be available to purchase health insurance through the state's insurance exchange when it is operational in 2014.

As displayed in Table 3, individuals at the poverty level or 200 percent of the poverty level are slightly more prevalent in El Paso/Pueblo than in the state as a whole, especially among children. This group of vulnerable children is a prime target for the Medicaid and CHP+ expansions resulting from the Colorado Healthcare Affordability Act (HB 09-1293) and the ACA.

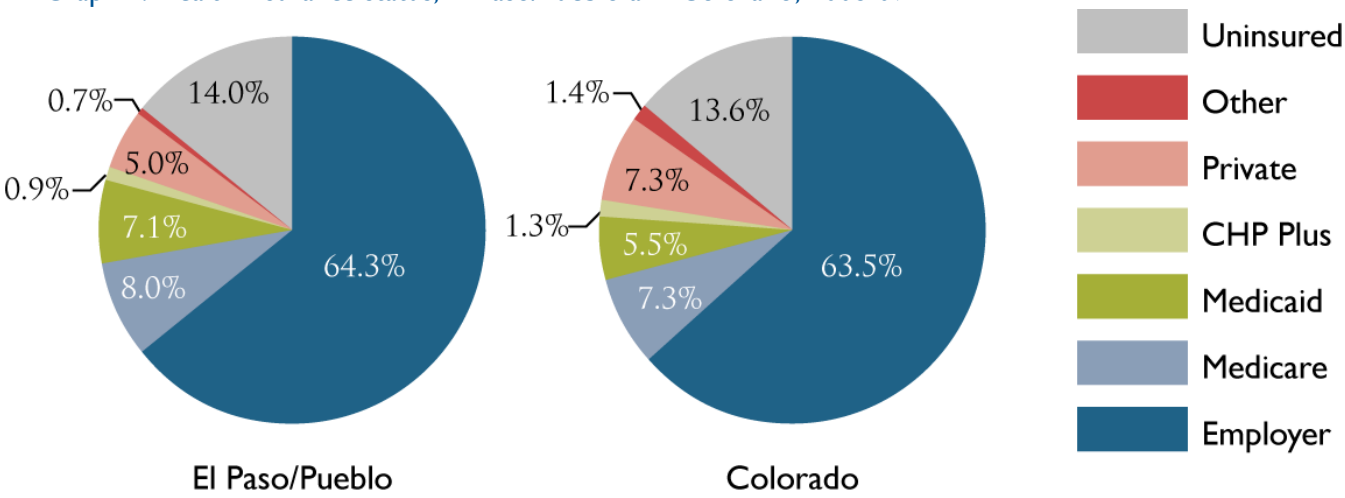
Table 3. Median household income and percent of population at or below 100% and 200% of the federal poverty level (FPL), El Paso/Pueblo and Colorado, 2008-09

	Median household income	% of population at or below 100% of FPL, all ages	% of population at or below 200% of FPL, ages 0-18	% of population at or below 200% of FPL, ages 19-64
El Paso/ Pueblo	$ 35,996	21.5%	48.9%	40.9%
Colorado	$ 38,400	18.6%	45.5%	36.9%

NOTE: In 2008, 100% of the FPL for a family of 4 was $21,200.
SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

The relationship between having health insurance coverage, the type of that coverage and health outcomes has been demonstrated by a growing body of research. The Colorado Household Survey (COHS), administered by CHI, provides a better understanding of Coloradans' insurance status.

Graph 1. Health insurance status, El Paso/Pueblo and Colorado, 2008-09



SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

In light of the passage of HB 09-1293 that expands CHP+ eligibility to 250 percent of the federal poverty level for children and pregnant women and Medicaid eligibility to 100 percent of the FPL for adults, monitoring eligible but not enrolled individuals in these programs is essential for policy impact and program planning purposes.

Table 4. Number and percentage of persons who are eligible *and enrolled* and eligible *but not enrolled* in Medicaid and Child Health Plan Plus (CHP+) and estimates of expansion groups based on state and federal health reforms, El Paso/Pueblo and Colorado, 2008

	El Paso/Pueblo		Colorado	
	Number	Percent of population	Number	Percent of population
CHP+ children (age 0-18)				
Currently eligible and enrolled	7,178	64.1%	59,603	52.3%
Currently eligible but not enrolled	4,029	35.9%	54,326	47.7%
HB 09-1293: Expansion group	2,002		11,953	
Medicaid children (age 0-18)				
Currently eligible and enrolled	8,649	83.1%	216,678	78.1%
Currently eligible but not enrolled	7,835	16.9%	60,839	21.9%
Medicaid parents of dependent children (age 19-64)				
Currently eligible and enrolled	12,382	75.6%	56,187	68.7%
Currently eligible but not enrolled	4,002	24.4%	25,544	31.3%
HB 09-1293: Expansion group	6,544		27,618	
National health reform: Expansion group	3,052		23,743	
Medicaid adults without dependent children (age 19-64)				
HB 09-1293: Expansion group	17,478		119,104	
National health reform: Expansion group	2,576		28,933	

* The federal Patient Protection and Affordable Care Act passed in March 2010 expands eligibility for Medicaid for all working-age adults up to 133% of the federal poverty level (FPL). CHI's analyses estimate the number of uninsured parents of dependent children between 100% and 133% of FPL, and the number of adults without dependent children between 0-133% of FPL.
SOURCE: Colorado Health Institute analysis of the 2008 American Community Survey and Medicaid and CHP+ enrollment data from the Colorado Department of Health Care Policy and Financing

Risk factors that affect the health of individuals and populations are a matter of both personal and public responsibility. In the case of obesity, it is clear that neither Colorado as a state nor El Paso/Pueblo as a region of the state is doing well—11 percent of children in El Paso/Pueblo and 15 percent of children across the state are obese. Like uninsurance rates, obesity rates have a public dimension that is amenable to policy interventions.

Table 5. Health risk factors by age group, El Paso/Pueblo and Colorado, 2008-09

	El Paso/Pueblo	Colorado
Children (ages 2-14 years)		
Percent who are obese	10.8%	14.7%
Adults (ages 19-64 years)		
Percent with diabetes[1]	5.7%	5.3%
Percent reporting fair or poor health[2]	15.8%	15.1%
Percent who are obese[3]	20.1%	18.7%

NOTES:
[1] Includes those adults who have been told by a doctor that they have diabetes, excluding gestational diabetes.
[2] Fair/poor health data are self-reported.
[3] Adults reporting a Body Mass Index (BMI) of less than 25.0 are considered normal weight; adults reporting a BMI between 25.0 and 29.9 are considered overweight; and adults reporting a BMI of 30.0 or higher are considered obese. BMI is a measure of height relative to weight.
SOURCE: 2009 Colorado Child Health Survey, 2009 Behavioral Risk Factor Surveillance System (BRFSS) Survey, and 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

Table 6. Age-adjusted incidence rate of cancer and mortality rate due to heart disease, El Paso/Pueblo and Colorado, all ages, 2007-2009

	El Paso/Pueblo	Colorado
Age-adjusted incidence rate of all cancers per 100,000 population	497.7	447.6
Age-adjusted rate of mortality due to heart disease per 100,000 population	144.2	142.1

NOTE: Rates are per 100,000 population and are adjusted to the 2000 U.S. population. SOURCE: Colorado Central Cancer Registry, Colorado Department of Public Health and Environment, 2007; Health Statistics Section, Colorado Department of Public Health and Environment, 2009.

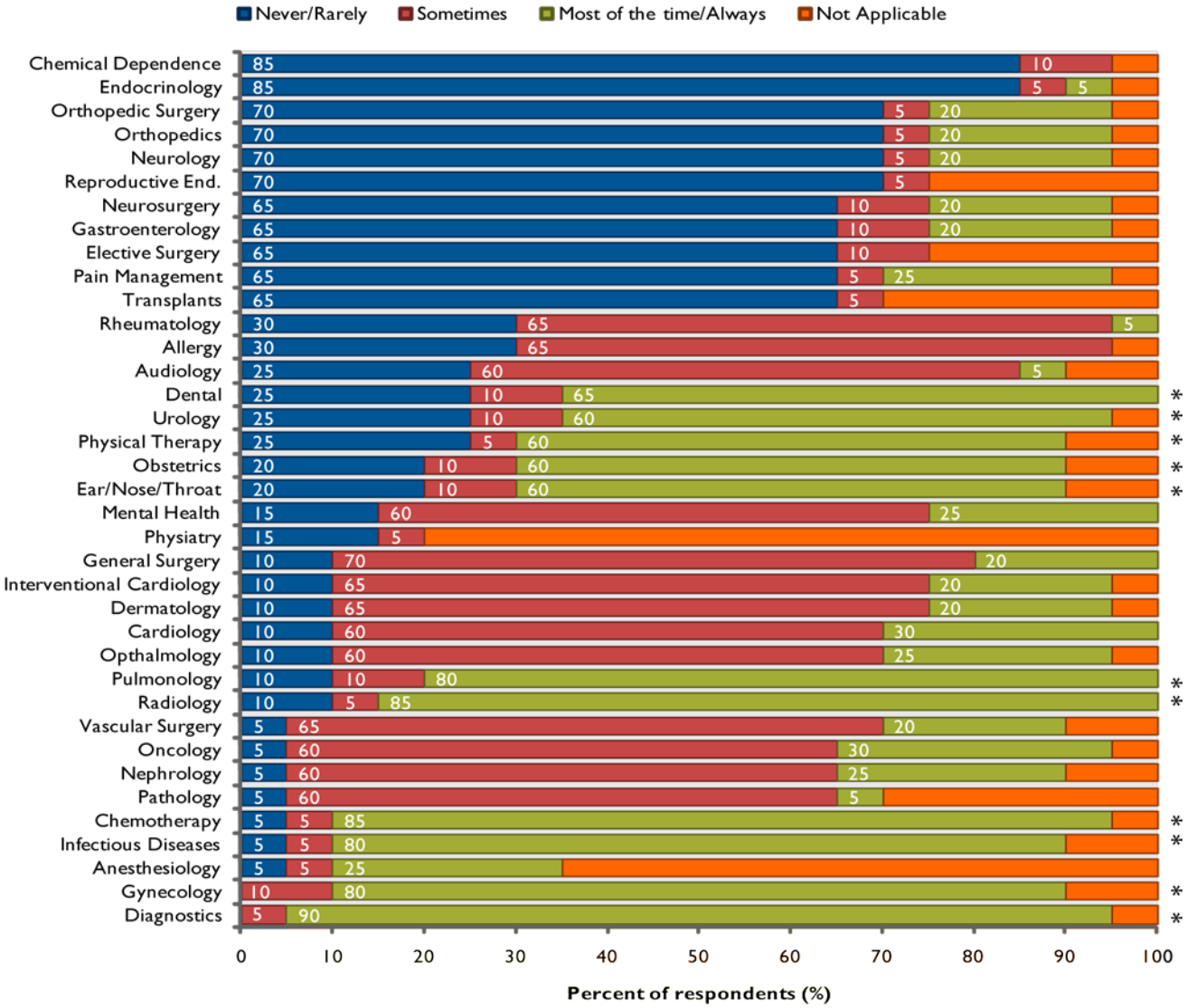
Using the Colorado Household Survey, Coloradans' utilization of health care services can be analyzed. As can be seen in Table 7, individuals in El Paso/Pueblo are most likely to report a doctor's office or private clinic as their usual source of care, consistent with the rest of the state. Utilization data from the COHS can be examined relative to insurance status and household income to provide policymakers with the impact of having insurance on health care access.

Table 7. Health care utilization profile, El Paso/Pueblo and Colorado, 2008-09

	El Paso/Pueblo	Colorado
Health care utilization during past year		
Percent of population that visited an emergency room	28.1%	24.4%
Percent of population that visited a primary care physician	92.4%	90.9%
Percent of population that visited a specialist physician	44.6%	45.5%
Deferred medical care and/or did not fill a prescription due to cost during past year		
Percent of insured individuals who deferred care/did not fill a prescription	16.9%	16.9%
Percent of uninsured individuals who deferred care/did not fill a prescription	46.5%	43.7%
Usual source of care		
Percent reporting no usual source of care	10.5%	10.4%
Of those indicating they had a usual source of care, percent reporting…		
A doctor's office or private clinic	71.9%	76.0%
A community health center or other public clinic	13.2%	11.8%
A retail clinic like Wal-Mart	0.0%	0.2%
A hospital emergency room	5.7%	4.7%
An urgent care center	3.2%	3.2%
Some other place	5.9%	3.5%
Does not go to one place most often	0.1%	0.4%

SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

Graph 2. Frequency with which safety net respondents are able to refer *uninsured patients* to specialty care, El Paso/Pueblo, 2010

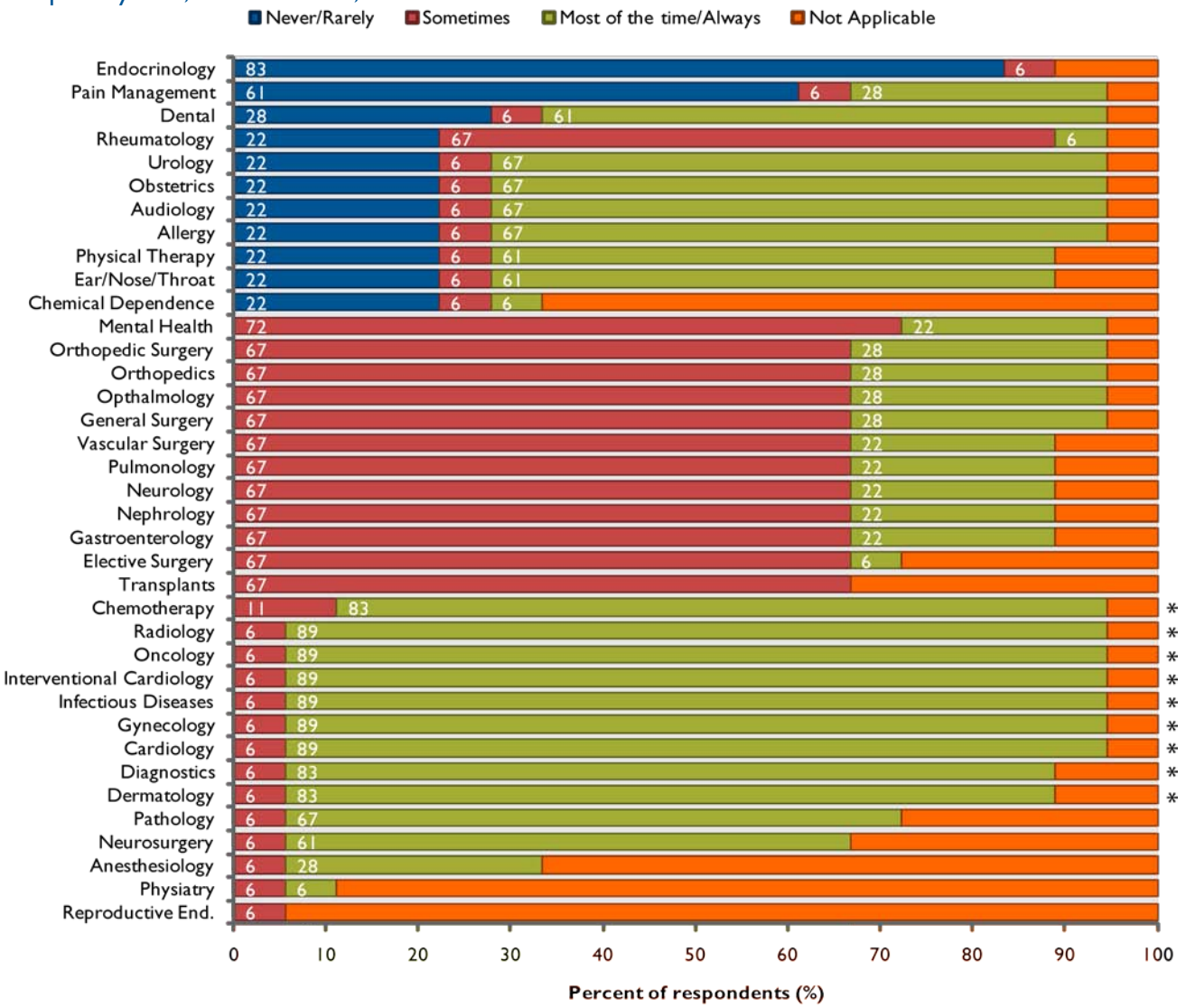


* Asterisks represent the 11 categories with the highest proportion of survey respondents indicating "most of the time/always."
NOTE: These data represent 20 clinics within the El Paso/Pueblo region that responded to Question 11.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

El Paso/Pueblo has an age-adjusted death rate of cancer that is quite a bit higher than the state as a whole (498 deaths per 100,000 population compared to the state average of 448 deaths per 100,000 population.) Yet, only 30 percent of safety net clinics reported being able to refer uninsured patients to oncologists always or most of the time.

Diagnostic medicine is the most widely available specialty in El Paso/Pueblo, with 90 percent of clinics reporting the ability to refer uninsured patients most of the time or always. In contrast, referrals to specialties such as general surgery or mental health are only usually available for uninsured patients in 20 percent or 25 percent of clinics, respectively.

Graph 3. Frequency with which safety net respondents are able to refer Medicaid patients to specialty care, El Paso/Pueblo, 2010



* Asterisks represent the nine categories with the highest proportion of survey respondents indicating "most of the time/always."
NOTE: These data represent 18 clinics within the El Paso/Pueblo region that responded to Question 15.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

Ninety percent of clinics surveyed in the El Paso/Pueblo region reported accepting Medicaid patients. Two-thirds of these clinics reported only being able to "sometimes" refer these patients to general surgery, orthopedics or nephrology. Nearly one-quarter of respondents in El Paso/Pueblo reported never or rarely being able to refer Medicaid patients to obstetrics, physical therapy or dentists.

REGIONAL DATA PROFILE: NORTHERN COLORADO

The demographic profile of a population, community or legislative district matters.

NORTHERN COLORADO

As displayed in Table 1, the most notable population growth in Northern Colorado between 2010 and 2020 will be in the 65+ population (70%), just slightly lower than the expected growth in the state as a whole (71%). The slowest population growth in Northern Colorado will be among working-age adults (19-64 years) at 21 percent. It is the case in every region of the state that the 65+ age group is the fastest-growing segment of the population by a comfortable margin, while the lowest growth rate typically is found among working-age adults. This finding has policy implications for the allocation of state resources. This trend is especially important in the Medicaid program that funds acute care for chronic disease management and a significant portion of long-term care expenses for low-income older adults.

Table 1. Population by age and population growth rates, Northern Colorado and Colorado, 2010 and 2020

	Population		Change 2010-20	
	2010	2020	Percent change	Average annual growth rate
Northern Colorado				
Age 0-18 years	144,319	182,678	26.6%	2.4%
Age 19-64 years	363,259	437,878	20.5%	1.9%
Age 65 years and older	56,741	96,668	70.4%	5.5%
All ages	564,319	717,224	27.1%	2.4%
Colorado				
Age 0-18 years	1,334,222	1,587,802	19.0%	1.8%
Age 19-64 years	3,284,581	3,656,924	11.3%	1.1%
Age 65 years and older	541,386	927,003	71.2%	5.5%
All ages	5,160,189	6,171,730	19.6%	1.8%

SOURCE: Colorado Health Institute using data from the Colorado Demography Office

Unemployment rates can affect who has access to private health insurance as private health insurance in Colorado and the United States is primarily an employer-based system. The data in Table 2 reveal that the unemployment rate for Northern Colorado (8.1%) was slightly below that of the rest of the state (8.7%).

Table 2. Unemployment rates, Northern Colorado and Colorado, November 2010

	Unemployment rate
Northern Colorado	8.1%
Colorado	8.7%

SOURCE: Colorado Health Institute using data from the Colorado Department of Labor & Employment, Labor Market Information Division, November 2010

Annual household income is used to categorize families according to how their income ranks relative to the federal poverty level (FPL). This federal classification is used to determine eligibility for many federal and state programs, including Medicaid and the Child Health Plan Plus (CHP+) and the federal subsidies offered to low- to moderate-income individuals (134% to 400% of FPL) authorized by the Patient Protection and Affordable Care Act (ACA). Subsidies will be available to purchase health insurance through the state's insurance exchange when it is operational in 2014.

As displayed in Table 3, the percent of individuals at the poverty level or 200 percent of the poverty level is very similar to those in the state as a whole, especially among children. This group of vulnerable children is a prime target for the Medicaid and CHP+ expansions resulting from the Colorado Healthcare Affordability Act (HB 09-1293) and the ACA.

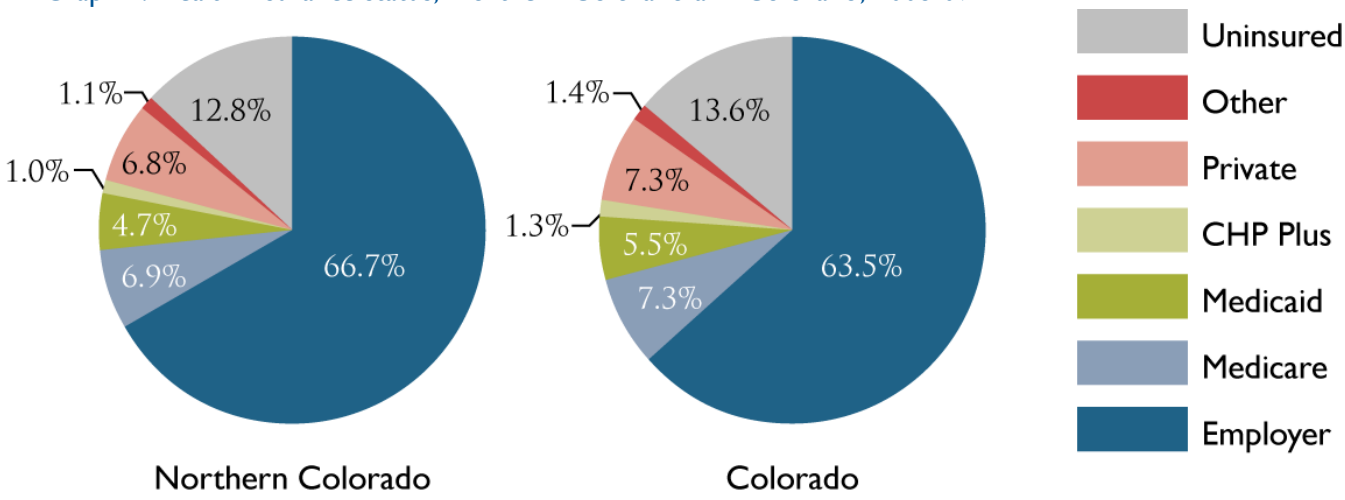
Table 3. Median household income and percent of population at or below 100% and 200% of the federal poverty level (FPL), Northern Colorado and Colorado, 2008-09

	Median household income	% of population at or below 100% of FPL, all ages	% of population at or below 200% of FPL, ages 0-18	% of population at or below 200% of FPL, ages 19-64
Northern Colorado	$ 38,186	18.7%	47.1%	37.0%
Colorado	$ 38,400	18.6%	45.5%	36.9%

NOTE: In 2008, 100% of the FPL for a family of 4 was $21,200.
SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

The relationship between having health insurance coverage, the type of that coverage and health outcomes has been demonstrated by a growing body of research. The Colorado Household Survey (COHS), administered by CHI, provides a better understanding of Coloradans' insurance status.

Graph 1. Health insurance status, Northern Colorado and Colorado, 2008-09



SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

In light of the passage of HB 09-1293 that expands CHP+ eligibility to 250 percent of the federal poverty level for children and pregnant women and Medicaid eligibility to 100 percent of the FPL for adults, monitoring eligible but not enrolled individuals in these programs is essential for policy impact and program planning purposes.

Table 4. Number and percentage of persons who are eligible *and enrolled* and eligible *but not enrolled* in Medicaid and Child Health Plan Plus (CHP+) and estimates of expansion groups based on state and federal health reforms, Northern Colorado and Colorado, 2008

	Northern Colorado		Colorado	
	Number	Percent of population	Number	Percent of population
CHP+ children (age 0-18)				
Currently eligible and enrolled	7231	54.3%	59,603	52.3%
Currently eligible but not enrolled	6096	45.7%	54,326	47.7%
HB 09-1293: Expansion group	595		11,953	
Medicaid children (age 0-18)				
Currently eligible and enrolled	22,169	80.0%	216,678	78.1%
Currently eligible but not enrolled	5,546	20.0%	60,839	21.9%
Medicaid parents of dependent children (age 19-64)				
Currently eligible and enrolled	5,832	65.0%	56,187	68.7%
Currently eligible but not enrolled	3,136	35.0%	25,544	31.3%
HB 09-1293: Expansion group	4,527		27,618	
National health reform: Expansion group	2,276		23,743	
Medicaid adults without dependent children (age 19-64)				
HB 09-1293: Expansion group	10,544		119,104	
National health reform: Expansion group	3,545		28,933	

* The federal Patient Protection and Affordable Care Act passed in March 2010 expands eligibility for Medicaid for all working-age adults up to 133% of the federal poverty level (FPL). CHI's analyses estimate the number of uninsured parents of dependent children between 100% and 133% of FPL, and the number of adults without dependent children between 0-133% of FPL.
SOURCE: Colorado Health Institute analysis of the 2008 American Community Survey and Medicaid and CHP+ enrollment data from the Colorado Department of Health Care Policy and Financing

Risk factors that affect the health of individuals and populations are a matter of both personal and public responsibility. In the case of obesity, it is clear that neither Colorado as a state nor Northern Colorado as a region of the state is doing well—19% of children in Northern Colorado and 15% of children across the state are obese. Likewise, uninsurance rates have a public dimension that is amenable to policy interventions.

Table 5. Health risk factors by age group, Northern Colorado and Colorado, 2008-09

	Northern Colorado	Colorado
Children (ages 2-14 years)		
Percent who are obese	18.5%	14.7%
Adults (ages 19-64 years)		
Percent with diabetes[1]	4.7%	5.3%
Percent reporting fair or poor health[2]	14.3%	15.1%
Percent who are obese[3]	18.6%	18.7%

NOTES:
[1] Includes those adults who have been told by a doctor that they have diabetes, excluding gestational diabetes.
[2] Fair/poor health data are self-reported.
[3] Adults reporting a Body Mass Index (BMI) of less than 25.0 are considered normal weight, adults reporting a BMI between 25.0 and 29.9 are considered overweight and adults reporting a BMI of 30.0 or higher are considered obese. BMI is a measure of height relative to weight.
SOURCE: 2009 Colorado Child Health Survey, 2009 Behavioral Risk Factor Surveillance System (BRFSS) Survey, and 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

Table 6. Age-adjusted incidence rate of cancer and mortality rate due to heart disease, Northern Colorado and Colorado, all ages, 2007-2009

	Northern Colorado	Colorado
Age-adjusted incidence rate of all cancers per 100,000 population	420.9	447.6
Age-adjusted rate of mortality due to heart disease per 100,000 population	132.1	142.1

NOTE: Rates are per 100,000 population and are adjusted to the 2000 U.S. population. SOURCE: Colorado Central Cancer Registry, Colorado Department of Public Health and Environment, 2007; Health Statistics Section, Colorado Department of Public Health and Environment, 2009.

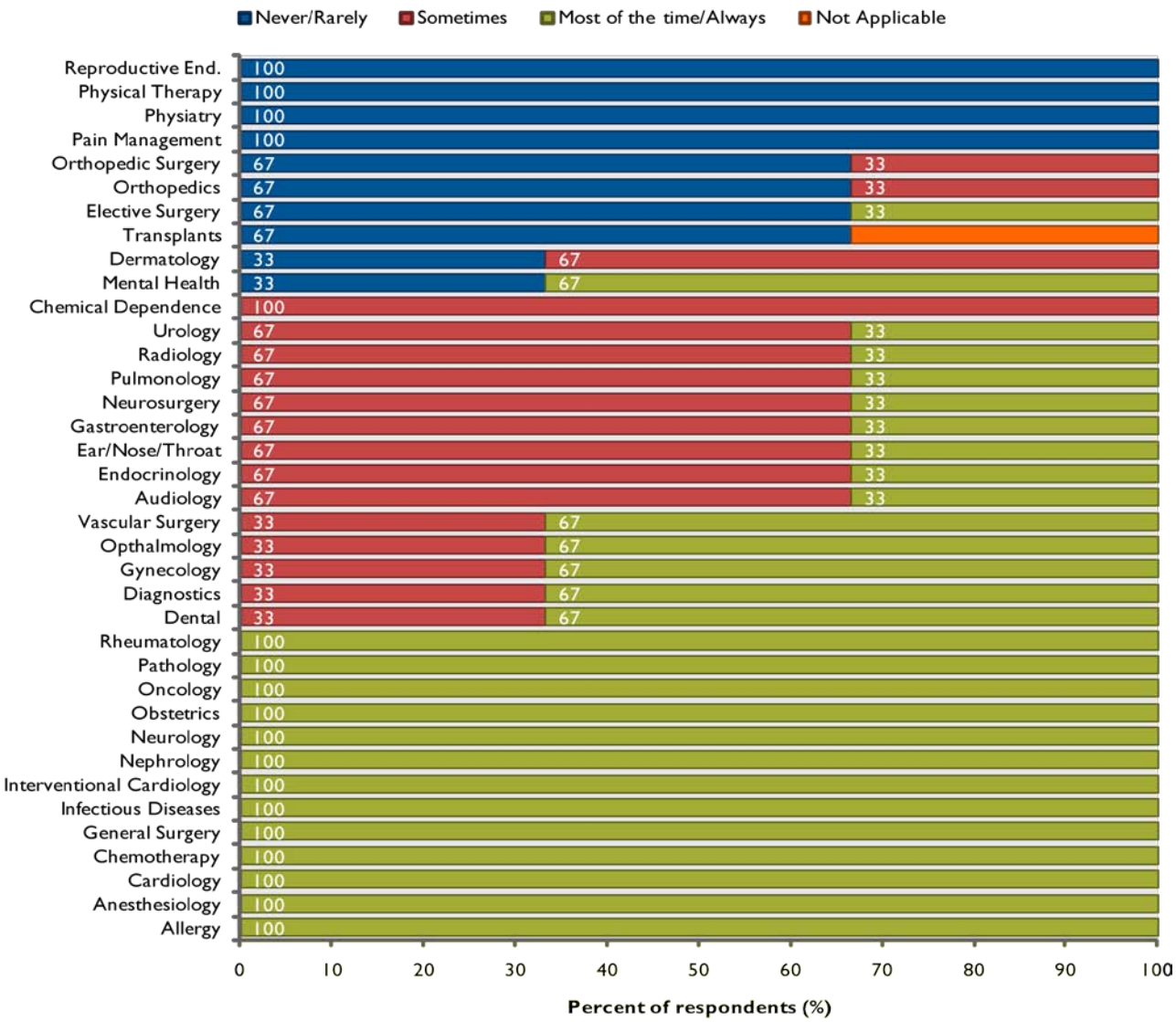
Using the Colorado Household Survey, Coloradans utilization of health care services can be analyzed. As can be seen in Table 7, individuals in Northern Colorado utilized urgent care centers at more than twice the rate of Coloradans as a whole. Utilization data from the COHS can be examined relative to insurance status and household income to provide policymakers with the impact of having insurance on health care access.

Table 7. Health care utilization profile, Northern Colorado and Colorado, 2008-09

	Northern Colorado	Colorado
Health care utilization during past year		
Percent of population that visited an emergency room	20.8%	24.4%
Percent of population that visited a primary care physician	91.1%	90.9%
Percent of population that visited a specialist physician	43.6%	45.5%
Deferred medical care and/or did not fill a prescription due to cost during past year		
Percent of insured individuals who deferred care/did not fill a prescription	16.3%	16.9%
Percent of uninsured individuals who deferred care/did not fill a prescription	45.4%	43.7%
Usual source of care		
Percent reporting no usual source of care	10.1%	10.4%
Of those indicating they had a usual source of care, percent reporting…		
A doctor's office or private clinic	75.5%	76.0%
A community health center or other public clinic	12.6%	11.8%
A retail clinic like Wal-Mart	0.3%	0.2%
A hospital emergency room	1.8%	4.7%
An urgent care center	7.7%	3.2%
Some other place	2.0%	3.5%
Does not go to one place most often	0.2%	0.4%

SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

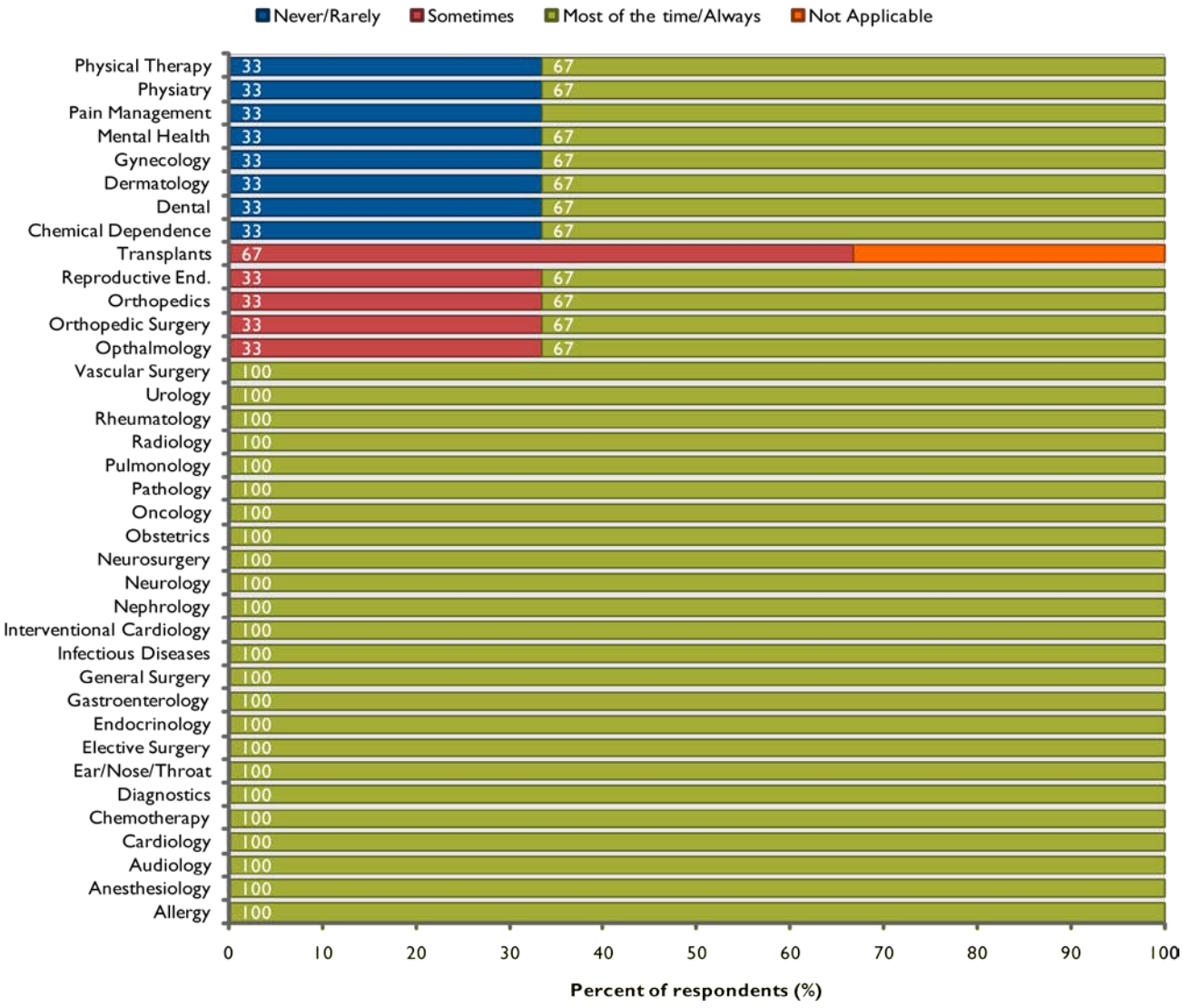
Graph 2. Frequency with which safety net respondents are able to refer *uninsured* patients to specialty care, Northern Colorado, 2010



NOTE: These data represent three clinics within the Northern Colorado region that responded to Question 11.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

Several specialty care services, including physical therapy, physiatry and pain management are never or rarely available for outside referrals for uninsured patients at safety net clinics in Northern Colorado. Dermatology, orthopedic surgery and orthopedics are also not available regularly by referral for uninsured patients in Northern Colorado.

Graph 3. Frequency with which safety net respondents are able to refer *Medicaid* patients to specialty care, Northern Colorado, 2010



NOTE: These data represent three clinics within the Northern Colorado region that responded to Question 15.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

All of the survey respondents in Northern Colorado accept Medicaid patients. Carrying a Medicaid card, however, does not guarantee these patients access to all specialists in Northern Colorado. While referrals to commonly needed specialties such as gynecology and oncology are usually available in Northern Colorado, one-third of clinics responding are not able to make outside referrals for Medicaid patients to other critical providers such as dentists and dermatologists.

REGIONAL DATA PROFILE: WESTERN COLORADO

The demographic profile of a population, community or legislative district matters.

WESTERN COLORADO

As displayed in Table 1, the most notable population growth in Western Colorado between 2010 and 2020 will be in the 65+ population (64%), although it is still lower than the expected growth in the state as a whole (71%). The slowest population growth in Western Colorado will be among working-age adults (19-64 years) at 19 percent. It is the case in every region of the state that the 65+ age group is the fastest-growing segment of the population by a comfortable margin, while the lowest growth rate typically is found among working-age adults. This finding has policy implications for the allocation of state resources. This trend is especially important in the Medicaid program that funds acute care for chronic disease management and a significant portion of long-term care expenses for low-income older adults.

Table 1. Population by age and population growth rates, Western Colorado and Colorado, 2010 and 2020

	Population		Change 2010-20	
	2010	2020	Percent change	Average annual growth rate
Western Colorado				
Age 0-18 years	182,003	242,007	33.0%	2.9%
Age 19-64 years	481,571	573,931	19.2%	1.8%
Age 65 years and older	93,893	154,296	64.3%	5.1%
All ages	757,467	970,234	28.1%	2.5%
Colorado				
Age 0-18 years	1,334,222	1,587,802	19.0%	1.8%
Age 19-64 years	3,284,581	3,656,924	11.3%	1.1%
Age 65 years and older	541,386	927,003	71.2%	5.5%
All ages	5,160,189	6,171,730	19.6%	1.8%

SOURCE: Colorado Health Institute using data from the Colorado Demography Office

Unemployment rates can affect who has access to private health insurance as private health insurance in Colorado, and the United States is primarily an employer-based system. The data in Table 2 reveal that the unemployment rate for both Western Colorado and the rest of the state was approximately 9 percent.

Table 2. Unemployment rates, Western Colorado and Colorado, November 2010

	Unemployment rate
Western Colorado	9.3%
Colorado	8.7%

SOURCE: Colorado Health Institute using data from the Colorado Department of Labor & Employment, Labor Market Information Division, November 2010

Annual household income is used to categorize families according to how their income ranks relative to the federal poverty level (FPL). This federal classification is used to determine eligibility for many federal and state programs, including Medicaid and the Child Health Plan Plus (CHP+) and the federal subsidies offered to low- to moderate-income individuals (134% to 400% of FPL) authorized by the Patient Protection and Affordable Care Act (ACA). Subsidies will be available to purchase health insurance through the state's insurance exchange when it is operational in 2014.

As displayed in Table 3, individuals at the poverty level or 200 percent of the poverty level are slightly less prevalent in Western Colorado than in the state as a whole, especially among children. This group of vulnerable children is a prime target for the Medicaid and CHP+ expansions resulting from the Colorado Healthcare Affordability Act (HB 09-1293) and the ACA.

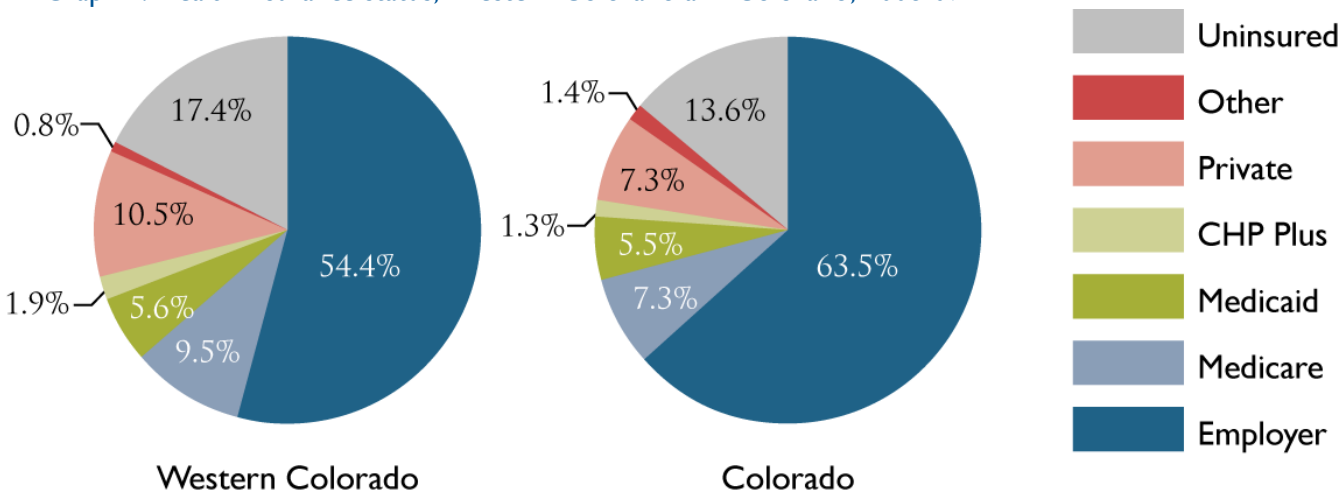
Table 3. Median household income and percent of population at or below 100% and 200% of the federal poverty level (FPL), Western Colorado and Colorado, 2008-09

	Median household income	% of population at or below 100% of FPL, all ages	% of population at or below 200% of FPL, ages 0-18	% of population at or below 200% of FPL, ages 19-64
Western Colorado	$ 38,266	16.8%	41.4%	36.4%
Colorado	$ 38,400	18.6%	45.5%	36.9%

NOTE: In 2008, 100% of the FPL for a family of 4 was $21,200.
SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

The relationship between having health insurance coverage, the type of that coverage and health outcomes has been demonstrated by a growing body of research. The Colorado Household Survey (COHS), administered by CHI, provides a better understanding of Coloradans' insurance status.

Graph 1. Health insurance status, Western Colorado and Colorado, 2008-09



SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute.

In light of the passage of HB 09-1293 that expands CHP+ eligibility to 250 percent of the federal poverty level for children and pregnant women and Medicaid eligibility to 100 percent of the FPL for adults, monitoring eligible but not enrolled individuals in these programs is essential for policy impact and program planning purposes.

Table 4. Number and percentage of persons who are eligible *and enrolled* and eligible *but not enrolled* in Medicaid and Child Health Plan Plus (CHP+) and estimates of expansion groups based on state and federal health reforms, Western Colorado and Colorado, 2008

	Western Colorado		Colorado	
	Number	Percent of population	Number	Percent of population
CHP+ children (age 0-18)				
Currently eligible and enrolled	11423	49.9%	59,603	52.3%
Currently eligible but not enrolled	11452	50.1%	54,326	47.7%
HB 09-1293: Expansion group	3624		11,953	
Medicaid children (age 0-18)				
Currently eligible and enrolled	29193	76.8%	216,678	78.1%
Currently eligible but not enrolled	8820	23.2%	60,839	21.9%
Medicaid parents of dependent children (age 19-64)				
Currently eligible and enrolled	7,520	65.7%	56,187	68.7%
Currently eligible but not enrolled	3,920	34.3%	25,544	31.3%
HB 09-1293: Expansion group	3,450		27,618	
National health reform: Expansion group	6,169		23,743	
Medicaid adults without dependent children (age 19-64)				
HB 09-1293: Expansion group	18,399		119,104	
National health reform: Expansion group	6,142		28,933	

* The federal Patient Protection and Affordable Care Act passed in March 2010 expands eligibility for Medicaid for all working-age adults up to 133% of the federal poverty level (FPL). CHI's analyses estimate the number of uninsured parents of dependent children between 100% and 133% of FPL, and the number of adults without dependent children between 0-133% of FPL.
SOURCE: Colorado Health Institute analysis of the 2008 American Community Survey and Medicaid and CHP+ enrollment data from the Colorado Department of Health Care Policy and Financing

Risk factors that affect the health of individuals and populations are a matter of both personal and public responsibility. In the case of obesity, it is clear that neither Colorado as a state nor Western Colorado as a region of the state is doing well—10 percent of children in Western Colorado and 15 percent of children across the state are obese. Like uninsurance rates, obesity rates have a public dimension that is amenable to policy interventions.

Table 5. Health risk factors by age group, Western Colorado and Colorado, 2008-09

	Western Colorado	Colorado
Children (ages 2-14 years)		
Percent who are obese	10.0%	14.7%
Adults (ages 19-64 years)		
Percent with diabetes[1]	5.4%	5.3%
Percent reporting fair or poor health[2]	13.0%	15.1%
Percent who are obese[3]	16.7%	18.7%

NOTES:
[1] Includes those adults who have been told by a doctor that they have diabetes, excluding gestational diabetes.
[2] Fair/poor health data are self-reported.
[3] Adults reporting a Body Mass Index (BMI) of less than 25.0 are considered normal weight, adults reporting a BMI between 25.0 and 29.9 are considered overweight and adults reporting a BMI of 30.0 or higher are considered obese. BMI is a measure of height relative to weight.
SOURCE: 2009 Colorado Child Health Survey, 2009 Behavioral Risk Factor Surveillance System (BRFSS) Survey, and 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

Table 6. Age-adjusted incidence rate of cancer and mortality rate due to heart disease, Western Colorado and Colorado, all ages, 2007-2009

	Western Colorado	Colorado
Age-adjusted incidence rate of all cancers per 100,000 population	431.8	447.6
Age-adjusted rate of mortality due to heart disease per 100,000 population	147.4	142.1

NOTE: Rates are per 100,000 population and are adjusted to the 2000 U.S. population. SOURCE: Colorado Central Cancer Registry, Colorado Department of Public Health and Environment, 2007; Health Statistics Section, Colorado Department of Public Health and Environment, 2009.

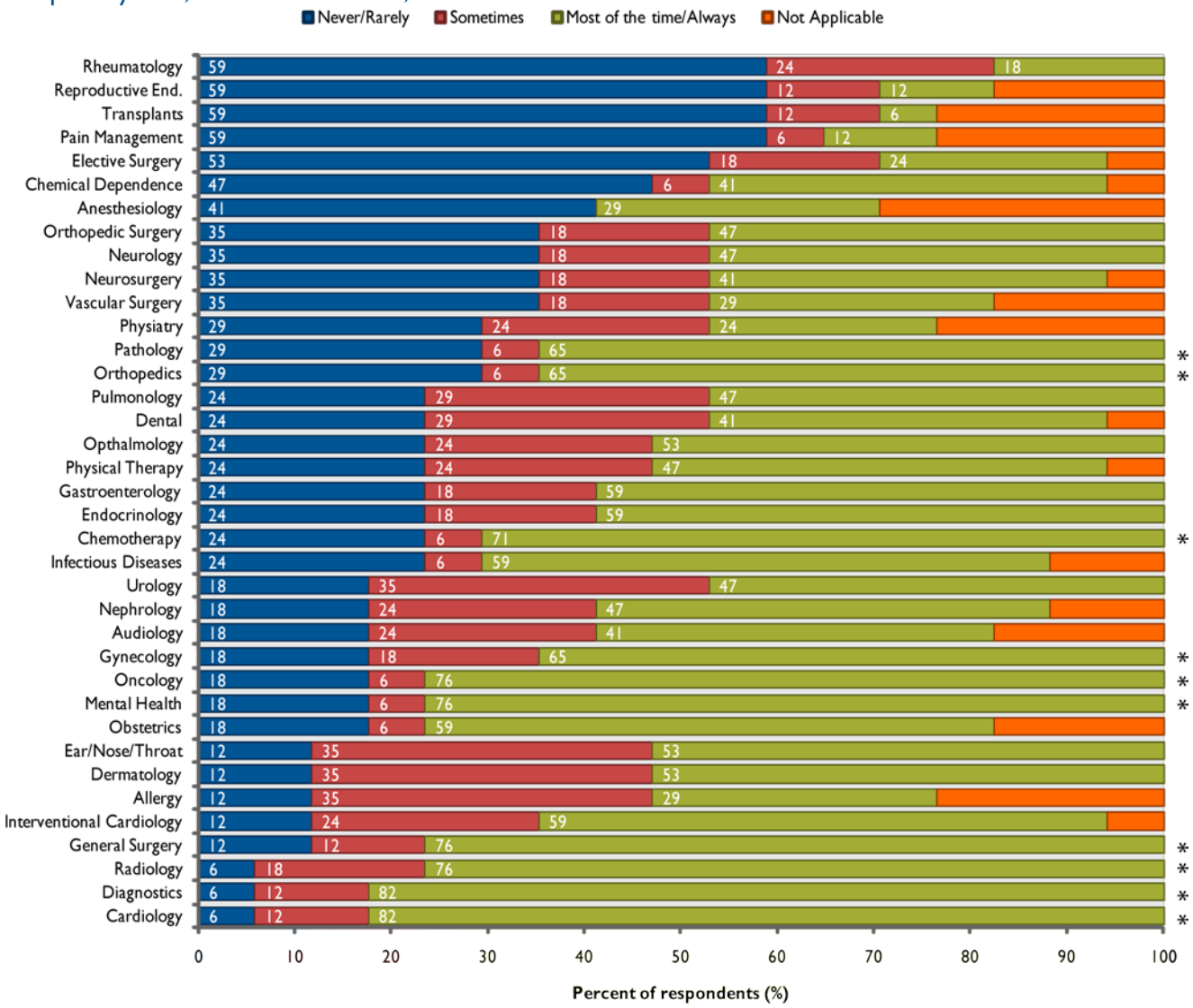
Using the Colorado Household Survey, Coloradans' utilization of health care services can be analyzed. As can be seen in Table 7, individuals in Western Colorado are most likely to report a doctor's office or private clinic as their usual source of care, consistent with the rest of the state. Utilization data from the COHS can be examined relative to insurance status and household income to provide policymakers with the impact of having insurance on health care access.

Table 7. Health care utilization profile, Western Colorado and Colorado, 2008-09

	Western Colorado	Colorado
Health care utilization during past year		
Percent of population that visited an emergency room	26.9%	24.4%
Percent of population that visited a primary care physician	89.7%	90.9%
Percent of population that visited a specialist physician	43.0%	45.5%
Deferred medical care and/or did not fill a prescription due to cost during past year		
Percent of insured individuals who deferred care/did not fill a prescription	16.2%	16.9%
Percent of uninsured individuals who deferred care/did not fill a prescription	44.6%	43.7%
Usual source of care		
Percent reporting no usual source of care	11.2%	10.4%
Of those indicating they had a usual source of care, percent reporting…		
A doctor's office or private clinic	76.4%	76.0%
A community health center or other public clinic	12.0%	11.8%
A retail clinic like Wal-Mart	0.2%	0.2%
A hospital emergency room	4.7%	4.7%
An urgent care center	2.5%	3.2%
Some other place	3.1%	3.5%
Does not go to one place most often	1.1%	0.4%

SOURCE: 2008-09 Colorado Household Survey, Colorado Department of Health Care Policy and Financing, analyzed by the Colorado Health Institute

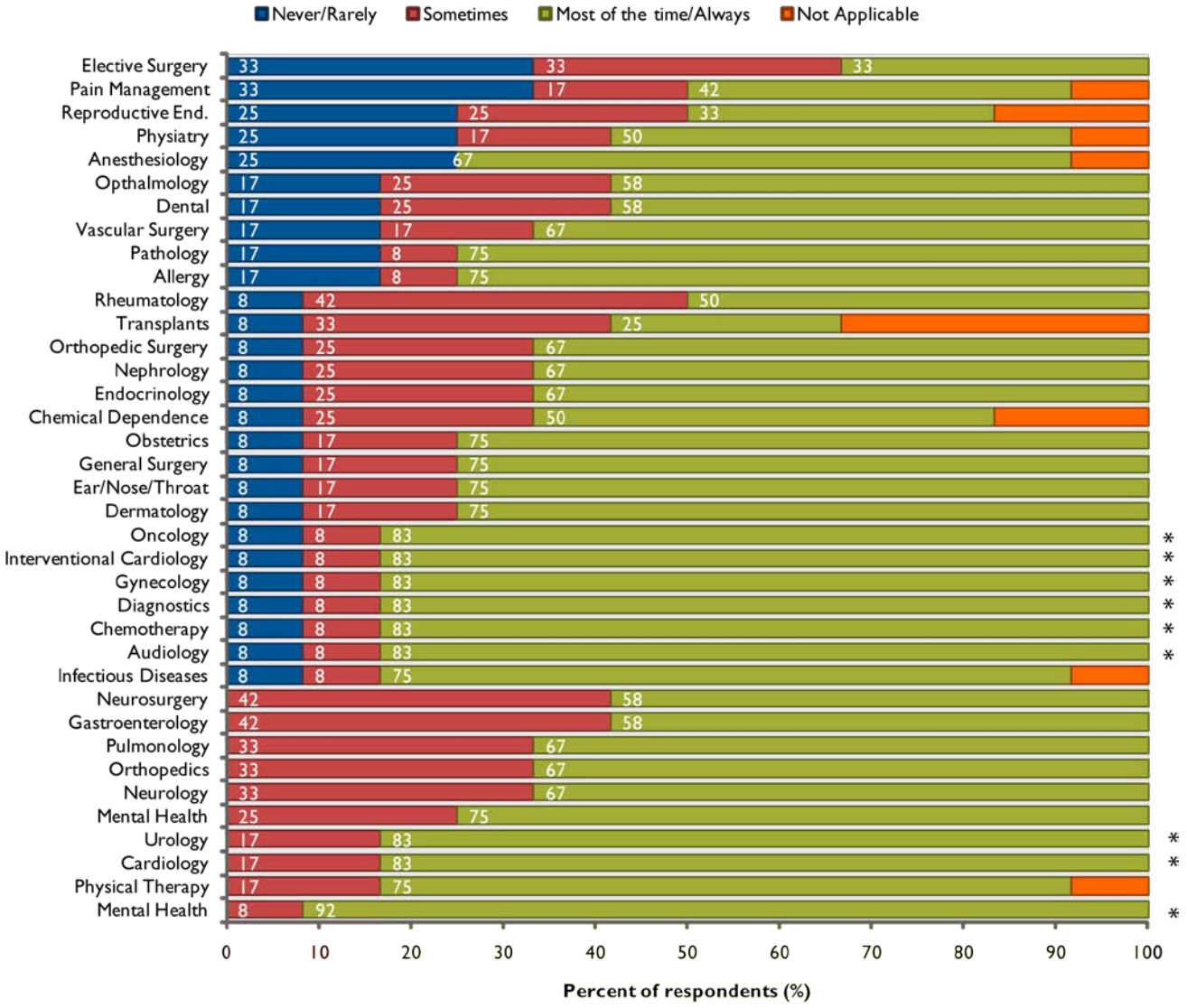
Graph 2. Frequency with which safety net respondents are able to refer *uninsured* patients to specialty care, Western Colorado, 2010



* Asterisks represent the 10 categories with the highest proportion of survey respondents indicating "most of the time/always."
NOTE: These data represent 17 clinics within the Western Colorado region that responded to Question 11.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

Common specialty care needs, such as dental and mental care, are never or rarely available by outside referral for uninsured patients in almost one-quarter (24% and 18% respectively) of safety net clinics in Western Colorado. More acute specialty services, such as rheumatology, reproductive endocrinology and pain management, are never or rarely available by referral for uninsured patients in over half the clinics in Western Colorado.

Graph 3. Frequency with which safety net respondents are able to refer *Medicaid* patients to specialty care, Western Colorado, 2010



* Asterisks represent the nine categories with the highest proportion of survey respondents indicating "most of the time/always."
NOTE: These data represent 12 clinics within the Western Colorado region that responded to Question 15.
SOURCE: Colorado Health Institute analysis of data from the 2010 Safety Net Specialty Care Assessment

Seventy-one percent of clinics surveyed in Western Colorado reported accepting Medicaid patients. In general, specialty care referrals for these patients are widely available. Pain management and elective surgery referrals, however, are never or rarely available for Medicaid patients in one-third of safety net clinics in Western Colorado. Common services, such as cardiology, radiology and oncology, are always available or available most of the time for referral for Medicaid patients in at least three-quarters of clinics surveyed.

Network profiles: Introduction

Unique models for increasing access to care among medically underserved individuals exist both nationally and in Colorado. These programs rely on networks of participating clinicians – sometimes paid, sometimes volunteer – to provide primary and specialty care to vulnerable populations.

This section profiles six organizations – two within Colorado and three outside the state – identified by Kaiser Permanente Colorado staff as employing innovative approaches to establishing their provider networks:

- Access to Healthcare Network
- Doctors Care
- King County Project Access
- Metro Community Provider Network
- Operation Access
- Project Access NOW

To develop the profiles, CHI and Kaiser Permanente staff conducted key informant interviews both in person and over the phone. Although the interviews varied somewhat depending on the organization, the interviews followed a similar structure.

The success of these programs and organizations in securing specialty services for patients is dependent upon establishing robust networks of providers. A variety of approaches are used to build and maintain these networks, and six critical success factors were repeatedly emphasized as central to success:

- Partnerships, particularly with hospitals: The genesis of most of these programs involved hospitals, and all six organizations mentioned the importance of maintaining ongoing hospital partnerships. In particular, hospitals not only provide important resources for the delivery of care, but their leadership and influence within a community also can generate enthusiasm and buy-in for the launch of a program. Other crucial partnerships mentioned throughout the interviews included physician groups, medical societies, diagnostic service providers, foundations, medical liability companies and community organizations such as the United Way.
- Provider leadership: Not only are *partnerships* with physicians important in maintaining success, but from the beginning, many of these programs also had established physician leadership in some capacity. Physician involvement is crucial to establishing credibility among peers, recruitment and the collegial relationships on which many volunteer and referral networks are based. Each of the organizations also mentioned the importance of other types of health care providers, including nurse practitioners, physician assistants, behavioral health and oral health professionals.
- Neutral convener/coordinator: Care for the uninsured and other vulnerable populations is a challenge shared by all providers. Many of the interviewees emphasized the importance of a "neutral convener" or third party that served in some capacity as a coordinator of efforts. In the operational sense, these organizations connect patients with providers by coordinating referrals and maintaining provider networks. Conceptually, they expressed their role as establishing

common ground in addressing the shared challenge of caring for the uninsured, often within a competitive health care environment.

- Shared responsibility with patients: These organizations' strong care coordination involves customer care and making the process more navigable for vulnerable patients who have often faced challenges gaining access to services within the traditional/mainstream provider network. Organizations also emphasize the patient's shared responsibility in accessing health care. Shared responsibility takes many forms, including membership fees, co-pays for appointments, required orientation sessions, strict missed-appointment policies and instruction in how to navigate the health care system. These policies also serve to promote strong physician participation as they assuage many providers' hesitations about serving medically indigent patients in their own practices.
- Sustainability: Perhaps most essential to ongoing success is financial sustainability. These programs incorporate many models and funding sources to continue their mission and grow their networks. For example, because many of these programs rely on a strong network of volunteer physicians, they strategically invest resources in making the experience of volunteering as easy, efficient and hassle-free as possible for the provider.

The six programs profiled in this section are by no means meant to be an exhaustive list. Many other noteworthy models operate in communities around the United States and in Colorado which could perhaps be profiled in a subsequent phase of the study.

ACCESS TO HEALTHCARE NETWORK (AHN)

Service area:	State of Nevada
Year established:	2007
Overview of AHN:	▪ AHN is a program that connects uninsured Nevadans with health care through a wide network of participating providers. ▪ Enrollees pay a monthly membership fee and receive significantly reduced rates for discounted medical services from participating providers. ▪ AHN's model has been successful because of the high participation rate of providers and its sustainable financial model through member fees.
For more information, contact:	Niki King, Northern Nevada Director niki@accesstohealthcare.org
Website:	http://www.accesstohealthcare.org/home.asp

Background

Access to Healthcare Network (AHN) employs a "shared responsibility" model to secure care for uninsured patients. The idea behind this model is to split the financial burden of providing care to uninsured patients between patients and providers. According to staff at AHN, when the program was established, clinics, outpatient facilities and hospital emergency rooms were providing care to uninsured patients in an unstructured system that often left providers with no reimbursement. To give structure to this self-pay system, the creators of AHN developed an accessible network comparable to an insurance product and became the first medical discount plan to be recognized in Nevada. Medical discount plans allow their members to receive a discounted rate for a medical service and pay cash up front instead of being billed for the service.

AHN is a membership organization that coordinates both primary and specialty care for members, but does not provide any clinical services itself. Members pay a flat monthly fee to access the AHN network and then a cash payment to the provider at the time of each service. The network includes both a for-profit arm, the medical discount plan, and a nonprofit Patient Care Fund (PCF) through which it assists members with some of their medical costs.

AHN was first organized in Reno, Nevada, by a coalition of health departments, hospitals and other nonprofit organizations. This coalition applied for a Health Community Access Program grant from the federal government and received $2 million to create an innovative approach to providing care for uninsured individuals. Because AHN's leadership had extensive experience working in the health care system, they had developed valuable relationships that were beneficial in creating the AHN network.

Partnerships

AHN's work began by securing the participation of the two non-profit hospitals in Reno, Renown Health and Saint Mary's Regional Medical Center. The hospitals played a crucial role in setting an

example for other providers to join the network. Once the hospitals agreed to accept the rates set by AHN, the next step was to get large specialty and physician groups to join at the established rate. Because physicians and specialists were already providing care to the uninsured population with little financial return, many were willing to accept lower rates for services in return for reducing administrative costs associated with collecting payment from uninsured individuals.

Each provider in the AHN network must sign a written memorandum of understanding stating that it will provide services to AHN members at the established rate. Providers must participate under AHN's terms—the program does not negotiate or bargain with any provider. Luckily, most providers accept payments that are below market rates for care provided that normally would go unreimbursed. AHN contracts with a variety of providers, including hospitals, physicians, dental and vision, and chiropractors.

Securing specialty services

AHN members have access to specialty care within the network. Referrals come into the AHN office, and a care coordinator then communicates with the member and the doctor or specialist to schedule an appointment. The member then pays cash to the provider at the time of the appointment. The care coordinators are not clinicians and do not offer medical advice of any kind. Transportation services are not provided for members because of difficulties associated with contracting with ambulance organizations. Unfortunately, without a contract with AHN, ambulance companies bill the uninsured patients who often are unable to pay for the ambulance service. Because Nevada has a significant rural population, AHN is working with MedFlight (a flight-for-life organization) to establish a reasonable rate. The network will also be a key player in developing telemedicine options in Nevada.

Provision of primary care services and the development of medical homes have become main areas of focus for AHN for many reasons, one of them being a grant from a local foundation with a special interest in primary care. Members choose a primary care provider at the time of enrollment and then schedule an appointment within the first 90 days. If a member cannot afford this first appointment, AHN will pay for it out of the Patient Care Fund (PCF), discussed below.

Funding

In the beginning, Renown and Saint Mary's hospitals provided in-kind office space and seed money for AHN to start enrolling members. Now, member fees account for most of AHN's revenue, making the model financially sustainable because it is not solely dependent on outside funding sources.

AHN also partners with the State of Nevada for part of its funding. receives sub-grants from the state to administer health care programs, such as the outreach arm for Nevada Check Up, Nevada's State Children's Health Insurance Program, and provides application and outreach assistance for the program. In addition, the state provides money to AHN's Patient Care Fund, which the state uses as an avenue to more efficiently secure access to health care services for extremely vulnerable populations than could by contracting with providers on a fee-for-services basis. For example, the state gives its federal grant dollars from the Ryan White HIV/AIDS Program to the PCF to provide free care for vulnerable individuals with HIV/AIDS. These individuals become members of AHN and access AHN's network of providers, while AHN covers their fees through the PCF. The PCF also receives funding from local

foundations and individuals to help individuals afford care. The PCF is tailored in each county to local contributors' wishes.

Operation and enrollment

To enroll in AHN, members must be residents of Nevada, meet income guidelines and not be currently insured. Members must make between 100-250 percent of the Federal Poverty Level, which AHN uses as its guidelines (in 2009, this was $10,830 to $27,075, respectively, for an individual or $22,050 to $55,125 for a family of four). This program is not intended for the extremely poor. About 80 percent of members work, with 60 percent working full time.

To become a member, individuals must meet with an AHN care coordinator and complete an orientation at which they receive a manual and a member card. Accepted members can begin receiving services immediately. A care coordinator is appointed to manage the care for each member. As noted above, members pay a monthly rate to AHN and then pay providers significantly reduced cash rates at the time of service, depending on their income. Members can be removed from the program for several reasons, including failure to show up for multiple appointments or nonpayment of services.

About 40 percent of members find out about AHN through provider recommendations (each provider is stocked with brochures). The rest come to AHN through a recommendation from other community agencies and nonprofit organizations, and by finding AHN online. AHN does not actively seek members due to capacity concerns. AHN also operates a 1-800 helpline to assist Nevadans in finding the best option for securing health care, whether it be Medicaid, Medicare, SCHIP, private insurance, AHN or any other program available.

In December 2010, AHN was operating in several areas of the state, and by June 2011 the network expects to be in every Nevada county. AHN expands by meeting with the hospitals and large physician groups in each new community to get their participation, and then offers the program to every provider in the community. The process takes about three months from initial provider contact to provision of services to members.

In 2010, AHN employed about 35 staff members statewide, and had a network of 700 providers in Washoe County, the county where the program originated. AHN has served about 8,000 people since inception, with 4,400 enrolled in December 2010. A formal evaluation of AHN's model has yet to be conducted, but the organization has had several meetings about next steps in the evaluation process. The staff recognizes the need to gather clinical data to report health outcomes and have secured a grant to begin building an evaluation program in 2011.

Other

AHN's shared responsibility model is the center of a federal grant program established in Section 10504 of the Patient Protection and Affordable Care Act (ACA). Through this program, 10 states will be awarded $2 million each to establish similar organizations locally. As of now, medical discount plans will not be allowed to participate in the health insurance exchanges set forth by the ACA and will not count as insurance coverage under the individual mandate. AHN hopes that because it has become an intrinsic

part of the health care field in Nevada, it will not be excluded from participating in the future. Further, many uninsured people will remain outside of the exchange who may benefit from AHN's program.

DOCTORS CARE

Service area:	No defined service area, but primarily serving patients who reside in the southern metropolitan areas of Denver, Colorado (Arapahoe, excluding Aurora; Douglas; and Elbert counties)
Year established:	1988
Overview of Doctors Care:	▪ A program to provide primary and specialty health care services to medically underserved children and adults in the south metropolitan Denver area. ▪ Doctors Care relies on a robust network of community hospitals, donated diagnostic and prescription drug services, and 850 volunteer physicians to provide care to enrollees. ▪ The model is based on fostering partnership, buy-in and leadership among providers, emphasizing patient and provider needs and relationships.
For more information, contact:	Bebe Kleinman, Executive Director BKleinman@doctorscare.org Ali Ayres, Deputy Director AAyres@doctorscare.org
Website:	http://doctorscare.org/

Background

Doctors Care provides significantly discounted primary care and specialty care for eligible patients living in and around the Denver metropolitan area, primarily Arapahoe, Douglas and Elbert counties. The organization relies on an extensive network of volunteer physicians who provide services at the Doctors Care Clinic in Littleton or at their own offices. Individuals age 30 and under who are uninsured or covered by Medicaid or the Child Health Plan Plus (CHP+) program can receive care on site at the Littleton clinic five days a week. Uninsured adults over 30 years old who are financially eligible are assigned a participating provider off site. Doctors Care also provides integrated mental health services to patients who receive medical care. Doctors Care began enrolling patients and providing care in 1988 and 700 patients were enrolled that year. By the end of 2009, the Doctors Care program had served 20,000 patients.

Doctors Care was created in an environment in which there was a great need for health care services among Colorado's uninsured, particularly in the outlying suburbs of Denver. The situation in the area at the time was ripe for the creation of Doctors Care, as there was a less competitive environment among hospitals and providers and there was strong physician leadership in the community. Socioeconomically, the community's population was diverse, creating an opportunity for physicians to voluntarily provide their time and expertise to Doctors Care for the underprivileged population in their own backyard.

Partnerships

Doctors Care's success is largely due to a variety of partnerships in the community. The initial partnerships were with the two hospitals in the community at the time, Swedish Medical Center and Porter Memorial Hospital. Soon after, Littleton Hospital was opened and joined the Doctors Care

network. These hospitals were independent and not yet part of a hospital system, which made partnering easier. The hospitals were also led by CEOs who were concerned with providing care to uninsured people and were focused on reducing unnecessary emergency department (ED) visits. The partnerships were made on the basis that the hospitals were already providing care to the uninsured in their EDs, which was expensive and inefficient, and needed a way to both increase the well-being of patients and reduce avoidable ED visits.

Currently, the community's hospitals and Doctors Care continue a robust partnership. Five hospitals have joined the Doctors Care network: Swedish Medical Center, Porter Adventist Hospital, Littleton Adventist Hospital, Sky Ridge Medical Center and Parker Adventist Hospital. Doctors Care's leadership believes this collaboration is due to the challenge shared by all hospitals in caring for the uninsured, thus fostering common ground and shared purpose.

In addition to these hospitals, physicians have continued to be strong and vocal proponents of the Doctors Care model. Doctors Care was founded on the principle that the program should meet the physicians' ability to serve in whatever capacity they are willing, thus providing a flexible and secure way to provide charity care to uninsured patients. This model, which allows doctors to decide when, where and how much care is provided, boosts the number of physicians wanting to participate in the program.

Two early partnerships integral in fostering physician participation in Doctors Care was the Arapahoe Medical Society – now the Arapahoe-Douglas-Elbert Medical Society [ADEMS]) – and COPIC, a company providing liability insurance for physicians and hospitals. ADEMS was instrumental in securing physicians to participate in the Doctors Care network from the beginning and has continually encouraged and recruited community physicians. COPIC provided the "calming voice" to wary physicians who were concerned about liability in providing volunteer care to Doctors Care's patients. Currently, COPIC provides complimentary liability coverage for physicians who volunteer at the Doctors Care Clinic, and physicians are covered by their own insurance when treating patients in their own offices.

Doctors Care also relies on partnerships for labs, diagnostic services and prescription drugs. Radiology Imaging Associates/INVISION has been another of Doctors Care's valuable partnerships, providing comprehensive imaging services at significant discounts. Doctors Care also cites other partners that have proved invaluable to patients by providing largely discounted medical prescriptions. These partners include prescription drug programs from pharmaceutical companies, as well as the willingness of corporate stores such as Wal-Mart and King Soopers to share their $4 prescription drug lists with Doctors Care and thus be a resource for patients to receive needed prescriptions.

Doctors Care's Board of Directors comprises representatives from the hospitals, ADEMS, physician groups, pharmacies and community members, among others, reflecting these continued partnerships.

<u>Securing specialty services</u>

As mentioned earlier, Doctors Care's success in securing and retaining volunteer providers lies in the flexibility and adaptability to meet the needs of volunteers wanting to join the network. Physicians can participate in any capacity, from seeing one patient a year to providing care on a regular basis. Providers

come to Doctors Care mostly by word of mouth. In addition, Doctors Care has dedicated staff time and resources to recruitment efforts. Six years ago Doctors Care had 350 participating physicians, and today it has 850. This jump is due to Doctors Care's dedication to recruiting new providers and the support of hospitals and other physicians.

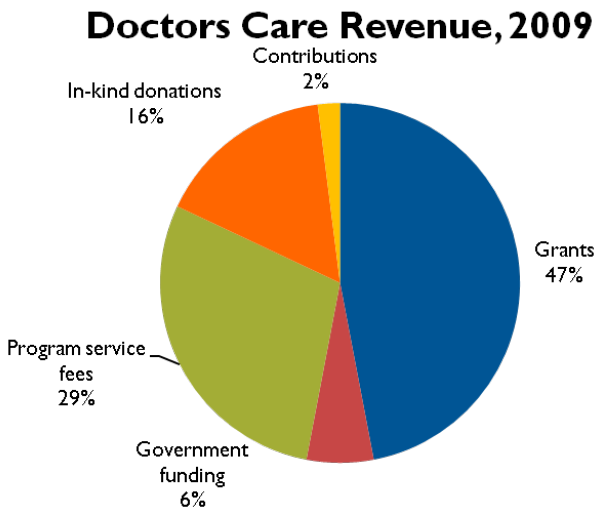
Doctors Care launched a past campaign to recruit providers called "Try Just 1." The campaign targeted providers with the message that a provider could become a part of Doctors Care network, even if she or he only wants to care for one Doctors Care patient, highlighting the relative ease of participating. Another campaign customized for each partner hospital with its hospital name, e.g., "Swedish Medical Center, Doctors Care, and You," helped physicians see how easy it is to participate with Doctors Care. Further, ADEMS now provides Doctors Care with the names of new providers in the community, so outreach efforts can be targeted.

Recruitment of specialists differs slightly from the overall recruitment efforts. While it is often difficult to anticipate demand for many specialties, there are periodically patient waiting lists for certain specialties, and Doctors Care staff educates the surrounding medical community about its waiting lists to quickly secure more specialist providers. Placing "pressure" on providers via collegial physician-to-physician relationships has helped increase volunteer participation, as well as soliciting participation of providers via hospital CEOs. In addition, all specialist referrals must be made through the Doctors Care offices from the patient's primary care provider. This further eases and encourages specialists to volunteer in the program.

Doctors Care also hosts the Kids In Need of Dentistry (KIND) mobile dental van twice a year, integrates in-house mental health services and recognizes the important role of nurse practitioners and physician assistants in providing primary care. These non-physician providers (working within a participating physician's practice) are also included in Doctors Care's recruitment efforts. Recently, Doctors Care has expanded its scope to include alternative medicine providers (acupuncture, chiropractic, massage therapy, yoga therapy) to which interested patients may self-refer.

Funding

The graph below displays Doctors Care's revenues in 2009. Almost half of its operating revenue is generated from grants, another 29 percent are Medicaid and Child Health Plan Plus reimbursements and co-pays patients made by patients in the clinic.



SOURCE: 2009 Doctors Care Annual Report, available at http://www.doctorscare.org/files/ed5e73b3.pdf.

In-kind donations of time, supplies represent 16 percent of operating revenue for Doctors Care. The network, however, estimates that an additional $16 million in inpatient care, outpatient care, diagnostic and prescription drug services were donated in 2009 from its network of participating hospitals, physicians and other partners.

Doctors Care leaders point out that understanding financial pressures of hospitals and providers is critical to the network's success. Originally, Doctors Care patients were children and parents referred from schools and social service organizations, as well as patients whose use of costly hospital ED services could potentially be avoided. Today, Doctors Care serves many adult patients, often with both medical and mental health needs and who cannot find appropriate care. Focus has expanded to reducing hospital re-admissions to ensure community support is available to patients released from hospital care.

Operation and enrollment

Doctors Care has strict guidelines for patients participating in the program. Upon enrollment, patients are expected to attend an orientation session that outlines how the program works, the copayment requirements and policies around missed appointments, scheduling and referrals to specialists. In addition, the orientation serves an educational and navigational role for patients who may have had little exposure to the health care system. Etiquette, respect for providers and education about the donated medical services promote a positive interaction for patients and volunteer providers.

Doctors Care cites patient orientation and education as part of its overall goal to ease the program's impact on participating providers. To accomplish this, it builds on existing partnerships as well as establishing new ones. The program maintains a thorough understanding of both patient and provider needs, as well as of the overall health care landscape and policy implications for its ongoing operations.

In response to expressed interest in Doctors Care, staff members are developing written documentation of the model. The goal of this "replication project" is to provide communities with information about how components of the program could be replicated elsewhere.

KING COUNTY PROJECT ACCESS PROGRAM (KCPA)

Service area:	King and Snohomish County Washington (also includes four hospitals and 50 providers participating in Snohomish County, Washington)
Year established:	2006
Overview of KCPA:	▪ King County Project Access (KCPA) is a community initiative designed to provide access to specialty care for low-income and uninsured individuals through a network of volunteer providers. ▪ All providers in the network offer care free of charge. ▪ The success of KCPA has been due to the partnerships made with, hospitals, safety net clinics and other providers in the community.
For more information, contact:	Sallie Neillie, Executive Director neillies@kcprojectaccess.org
Website:	http://www.kcprojectaccess.org/history.html

Background

The King County Project Access (KCPA) program is modeled after the national Project Access program that serves uninsured individuals. This model recognizes that physicians in many communities want to provide charity care to people who need it, but find it difficult to do so with ease. By participating in the program, these providers can see patients with fewer challenges, which in turn helps reduce hospital admissions and expenditures because people receive timely and appropriate care. Project Access, originally developed in Asheville, North Carolina, has been adopted by communities throughout the United States. In 2007, there were 48 sites around the country.

KCPA is an effort designed to coordinate specialty care for uninsured and underinsured individuals in King and Snohomish Counties, Washington. Discussions originally began in 2002 when the Public Health Department gathered safety net partners to discuss potential solutions to finding specialty care services for uninsured residents. At the time, a program, funded by the Washington Health Foundation, helped uninsured residents gain access to state-sponsored insurance and helped residents find primary care providers. The group decided to try a Project Access-type model to address the need for specialty care services modeled after the program that helped uninsured residents gain access to primary care. In 2006, King County Project Access, an independent nonprofit organization, was established. The program began with financial support and endorsements from many organizations, including the King County Medical Society.

Partnerships

Many organizations were originally involved in developing KCPA, including Community Health Council of King County, hospitals, the King County Medical Society, Pacific Hospital Preservation & Development Authority, county public health offices and the Washington Health Foundation.

The project began with a pilot program with Swedish Hospital for orthopedic care and Pacific Medical Centers for gastroenterology. Since then, many key partners have been added, including hospitals,

multispecialty groups, private practices, and a claims processing organization. More than 850 medical volunteers, including physicians, physical therapists, physician assistants, dentists and other health care providers, currently volunteer with King County Project Access.

Providers are recruited by board members, other providers and word of mouth. Because KCPA case managers ensure that appropriate tests and paperwork are completed before the uninsured patient sees the specialist, most specialists are willing to take KCPA-referred patients. In addition, KPCA staff call patients to remind them of the appointments, help them make transportation arrangements and provide interpreters when necessary. Patients who miss two appointments without providing a day's notice are terminated from the program for six months. KPCA reports a no-show rate of 4.07 percent at year-end 2010.

Securing specialty services

The program connects patients with specialty medical care services provided by a network of volunteer providers. Patients are referred to KCPA through more than 30 safety net clinics, including six federally qualified health centers, five free clinics, two family residency programs, and many family and internal medicine doctors. The County Department of Public Health primary care clinics also refer patients.

A patient must be uninsured or underinsured, and the household income must be at 200 percent of poverty or below. Patients are screened for King and Snohomish County residency, income and insurance eligibility, and medical necessity. All care provided is free for the uninsured. Providers bill Medicaid as normal for the care provided to the underinsured. Providers, including hospitals, primary care doctors and specialists, agree to provide care to KCPA patients because the program reduces many of the challenges associated with providing free care to uninsured people, such as high no-show rates, expensive translator costs for non-English speakers and lab and imaging tests.

Funding

KCPA has a very diverse funding base. All participating hospitals are funders. Two local charity care providers recognize that they can provide more care for the same dollars with the case management provided by KCPA and fund KCPA to do the enrollment/verification and case management for all appointed charity care they provide. In 2009, KCPA received more than $430,000 from private contributions, corporate contributions and grants, and government contributions and grants.

Operation and enrollment

Since 2008, KCPA has served more than 9,500 individuals in King county; in 2010, 2,750 patients were served and KCPA estimated that it will serve 4,500 patients in 2011. To enroll, patients must be referred by a provider based on medical need. After the initial six-month enrollment period is over, the patient may re-enroll if care is still needed and he or she is still eligible.

KPCA has 10 full-time staff members including a new development director, and two part-time staff.

All volunteer providers submit claims data to the claims processing organization which then prices the value of services and provides that information to Project Access. KCPA tracks the care and publicizes the total amount of care provided and the participating physicians.

METRO COMMUNITY PROVIDER NETWORK (MCPN)

Service area:	Jefferson and Arapahoe counties, plus portions of Adams and Park counties, Colorado
Year established:	1989
Overview of MCPN:	▪ A federally qualified health center offering an extensive array of services in the south, east and west suburbs of the Denver metropolitan area. ▪ A strong emphasis on partnerships with hospitals, community organizations, foundations and volunteer providers. ▪ MCPN secures specialty services by focusing on customer care, securing grants for specific services and engagement with the private sector.
For more information, contact:	David Myers, CEO dmyers@mcpn.org
Website:	http://www.mcpn.com/index.htm

Background

In 1989, the Metro Community Provider Network (MCPN) was established in response to an identified shortage of primary care for uninsured and other vulnerable individuals living in the south, east and west suburbs of the Denver metropolitan area. In 1990, the Health Resources and Services Administration (HRSA) designated MCPN a federally qualified health center (FQHC). In its first four months of operation, MCPN served 800 patients. Today, MCPN reports serving approximately 40,000 patients at its 10 clinic locations (including three school-based health centers).

Partnerships

MCPN has established a number of enduring partnerships despite a competitive health care environment in the Denver area. For example, MCPN has fostered a strong partnership with University of Colorado Hospital, as evidenced by robust communication between the two providers. Many patients are referred to University Hospital if they cannot be treated on site at one of MCPN's clinics. The University Hospital (UH) Emergency Department communicates daily with MCPN staff about the services that were provided in the ER, and MCPN has a tracking system to follow its patients as they move through the UH system.

MCPN's extensive portfolio of programs includes many grant-funded and volunteer partnerships that aim to secure primary and specialty care for patients. A few of the grant-funded partnerships that focus on specialty care are described below. While grant-funded programs provide MCPN with additional financial leverage to encourage potential providers to participate, MCPN has also fostered a strong base of volunteer clinicians. According to MCPN, many physicians in the community want to volunteer their services and contribute to the benefit of the community, but they are concerned about time and resource constraints. MCPN makes the process as easy as possible for these providers by providing a flexible volunteer program designed to meet the availability of each volunteer provider willing to donate his or her time.

Securing specialty services

As an FQHC, MCPN works within HRSA's broad framework of primary care, including services that are sometimes considered specialty or auxiliary care: oral health, urgent care, obstetrics/gynecology, etc. Above that, MCPN also provides a great deal of specialty care on site, including cardiology, oncology, physical therapy, acupuncture, radiology, lab tests, ultrasounds, eye care, psychiatry, geriatrics, HIV and infectious disease care, and screenings such as colonoscopies. These specialty services are provided in diverse arrangements, including a volunteer cardiology clinic that is operated out of MCPN clinical space once a month, a cancer program staffed by volunteer oncologists in one of the west metro clinics, and a contractual arrangement with clinicians to provide infectious disease services across MCPN's network. MCPN has found that fragmentation of community health care systems to meet the needs of vulnerable populations has often made bringing specialist care in-house the best and most efficient way to secure needed specialist care for the patients MCPN serves.

MCPN has a three-pronged approach to securing specialty care for its patients:

1) Focus on customer care: MCPN operates an efficient call center that coordinates outside referrals for all of its patients. This center at MCPN tracks referrals from the MCPN primary care provider to the specialist to ensure that the patient does not get lost in the system. The call center coordinates referrals, schedules appointments, follows up with patients and then with providers after the appointment. If a patient fails to receive care from a referral, the referral center likely will know the reason. This central navigation center has been crucial to MCPN's success because it gives volunteer providers reassurance that MCPN patient care is going to be coordinated, and it provides patients much needed help in navigating a complex system. MCPN does not have a specific no-show policy for patients. No-show policies are determined by each participating provider and thus vary for each type of service.

2) Secure grants for specific specialty care services: As mentioned above, MCPN has partnered with a variety of programs, funders and agencies to provide specific services to vulnerable populations. Some of these programs include cancer screening services under the Well Women Care Clinic, a partnership with the State of Colorado, another partnership with the Susan G. Komen Foundation for breast cancer screening, and participation in the Colorado Colorectal Screening Program.

3) Engage the private sector: MCPN has engaged private providers outside of its system to secure specialty care services for its patients. This effort is known as the Partnership for Health Initiative (PHI). PHI was established in 2005 by a grant from The Colorado Trust to create a coordinated patient navigation system. Through the program, MCPN sought to provide the link from the emergency room (ER) to a medical home, ensuring that a patient's primary care doctor coordinates with specialists to avoid ER dependency. To get specialists to agree to see its patients, MCPN offers a variety of options for volunteering their services, ranging from providing space and equipment to establishing strict scheduling guidelines determined by the participating physician.

MCPN also points out that health care solutions are often community-specific. Through PHI, MCPN has established a large network of partnerships with community organizations. Although the initial grant for PHI has concluded, MCPN will continue nurturing relationships with volunteer clinicians participating in

PHI, and will hand off many of the efforts to recruit new volunteers to community organizations such as Aurora Health Access (AHA). Kaiser Permanente's Community Benefit Program has supported AHA, which claims access to specialty care as one of its four primary foci. (It should be noted that an OB/GYN from Kaiser volunteers at one of the MCPN locations.)

Finally, as with any clinic, MCPN faces the challenge that some specialty fields cannot practically be offered on site. MCPN cited neurology/neurosurgery as examples. Though there may be a neurologist who is willing to volunteer his or her time, providing the necessary space, specific equipment and trained support staff is complicated to arrange.

Funding

As an FQHC, MCPN gets 14 percent of its annual funding from the federal Bureau of Primary Health Care Grants for the Uninsured; however, almost half (48%) of its funding comes from non-federal grants and contracts. Another 36 percent of annual funding in 2009 came from patient visits (Medicaid, Medicare, CICP, copayments, private insurance, etc.) and 2 percent from other federal grants.[3]

Operation and enrollment

In 2009, MCPN served 37,454 patients and provided 211,600 services visits (including medical, mental health and substance abuse, dental, pharmacy and enabling services such as case management and financial screenings). MCPN offers a sliding-fee scale for uninsured patients and participates in the Colorado Indigent Care Program. MCPN accepts several types of publicly financed insurance coverage, including the Child Health Plan Plus (CHP+), Emergency Medicaid, Medicaid and Medicare. In addition, MCPN also accepts private insurance, though only two percent of MCPN's patients have private coverage. Over 60 percent of patients in 2009 had no insurance (self-pay, sliding-fee scale or Colorado Indigent Care Program) and 29 percent were Medicaid enrollees. Almost three-quarters of patients were at or below the poverty level. In 2009, MCPN provided almost $12 million in charity care through self-pay sliding fee discounts for the uninsured.

MCPN employed 35 medical providers, eight mental health specialists, 42 enabling personnel (case managers, education specialists, etc.) and six dental providers in 2009.

In 2009, MCPN completed conversion to a fully functional electronic health record system that has increased the efficiency of providing appropriate care to its patients.

[3] Metro Community Provider Network. *2009 Annual Report.* Available at: http://www.mcpn.com/.

OPERATION ACCESS (OA)

Service area:	Operation Access (OA) covers six San Francisco Bay Area counties—San Mateo, Marin, San Francisco, Contra Costa, Alameda and Sonoma. May expand into Solano County.
Year established:	1993
Overview of AHN:	▪ OA leverages community-based medical volunteerism to provide donated elective, outpatient surgeries and procedures to low-income, uninsured individuals in need, thus reducing costly emergency department use. ▪ Having physician and nurse volunteer champions on board has proved essential for OA to secure important partnerships with local hospitals. ▪ OA employs a neutral convener model to ensure effective coordination and cooperation among all volunteer providers, hospitals, and clinics.
For more information, contact:	Jennifer Errante, Director jennifer@operationaccess.org
Website:	http://www.operationaccess.org/

Background

Operation Access (OA) was founded in 1993 by two San Francisco Bay Area surgeons (one was a Kaiser Permanente surgeon) and a hospital executive to help underserved people without health insurance get needed surgeries and specialty care. The OA founders observed that uninsured patients who could not afford care were likely to postpone treatment and experience worsening symptoms until a more costly emergency occurred. They also wanted to give local health providers an opportunity to volunteer in their own community, while at the same time making use of operating rooms that were often empty, especially on the weekend.

OA started with one hospital, seven referring clinics and 15 volunteer physician and nurse providers. Today, the organization is a network of 33 hospitals and medical centers, 18 medical groups, over 80 community clinics and more than 1,000 volunteers. The San Francisco Medical Society was instrumental in conceptualizing OA, though it no longer serves in the role of a vital partner. Kaiser Permanente, the University of California—San Francisco, San Francisco General Hospital, the San Francisco Community Clinic Consortium, the American College of Surgeons, and the Robert Wood Johnson Foundation were other instrumental partners during OA's start-up phase.

Partnerships

OA's main partners now are multiple hospital systems, physician groups, community clinics, volunteers, and local safety net collaboratives. Recognizing the efforts of these partners and volunteers has been a key part of OA's success.

OA established its hospital partnerships primarily through physician champions, who initiated the volunteer process among their peer physicians and recruited a core group of volunteers. OA recognizes the importance of having a core group of volunteers already established and articulating the need for a program like OA before approaching hospital leadership. When OA officials talk with hospital

leadership, they bring a physician champion to the table to represent the commitment of the core group of volunteers and to make the case that offering elective services on a volunteer basis will decrease emergency department use. Further, OA approaches several hospitals at once to show that the program is an equitable partnership with multiple partners.

To address the issue of liability insurance, OA emphasizes to hospital leadership that insurance follows the provider, and that providers will volunteer where they already have privileges. Once hospital leadership agrees to participate, a memorandum of understanding between OA and the hospital is signed for three years. Because many hospitals believe they are already doing their part in terms of charity care, OA believes it is important to clarify criteria for patient eligibility and emphasize protocols for eligibility screening and case management up front and share that with the hospitals. This transparency helps the hospitals see OA as a "gatekeeper", ensuring that only truly needy patients will be receiving donated care at their facilities.

Medical interpreters have also been beneficial to OA. Not all of the interpreters are certified, and some interpretations take place over the phone, but more and more interpretation is being provided to OA in-kind. In addition, partner hospitals and medical centers donate space, equipment and supplies (including medications). Raffle items for recognition events are provided in-kind. Occasionally, marketing for OA is provided free of charge by its partners. Taproot, an organization that links nonprofits with professionals across the country, has developed OA's website, brochures and score cards pro bono.

Securing specialty services

OA secures several types of specialty care and surgeries for its patients: general surgery, ophthalmology, head and neck, gastroenterology, orthopedics, vascular surgery, urology, gynecology, dermatology and plastic surgery. OA doesn't provide colonoscopies and other diagnostic tests unless access to treatment options can be adequately addressed.

Referrals to OA for specialty care or surgery come from a variety of sources, though always from a medical home. Some of these sources include community clinics, county hospitals, and Planned Parenthood. OA staff coordinates patients, volunteer providers and participating hospitals when a referral is received for a patient who meets medical and financial criteria. OA's scope of services is confined to low-risk, elective, outpatient procedures that minimize clinical and complication risks.

Once the referral is accepted, the patient is placed in line for a surgery session consisting of a pre-operative visit to ensure surgery is needed, the surgery itself and routine post-op visits. When the final post-op visit is complete, the patient is referred back to the original referring provider or clinic for ongoing care and case management.

OA's volunteer recruitment is primarily peer-to-peer, using physician and nurse volunteer champions. OA recognizes that many physicians would like to go abroad to provide charity care, but because of family and work commitments are not able to do so. OA recommends seeking out these providers and making the case that there is a huge need in their own communities for charity care, and that working through OA can make it convenient and more efficient. Retaining the volunteer providers who join OA's

network has been a major point of success. Currently, OA has more than 1,000 medical professionals serving an average of 3.2 years each.

The organization employs a neutral convener model because hospitals cannot recruit their own volunteers (violates labor laws) and using hospital administration as the convener could be perceived as coercion in recruiting staff volunteers. This model uses an entity (such as OA) to coordinate referrals, volunteer providers and donated care to maintain a high level of effective coordination. Having a neutral convener is also important in light of union negotiations and perceptions of hospital ownership of a particular pilot program. A neutral convener brings independent entities together. For example, the Access Orange County (Access OC replicated OA's model in 2007) steering committee is quite diverse with each contributing the same amount of money, fostering shared decision-making and accountability.

Funding

Foundations, corporations and private donors from the community support OA's administrative costs and pay for office operations. About 47 percent of OA's operating budget comes from corporate support, including a significant contribution from Kaiser Permanente. Foundation grants made up 23 percent of the 2009 budget, bequests made up 15 percent, and about 10 percent is from individual and family donations. Because OA does not collect any fees from its patients, it relies primarily on the support of grants and donations.

Operation and enrollment

To be eligible for OA, a patient must be uninsured and ineligible for public or job-based health insurance, earn less than 250 percent of the federal poverty level, have less than $5,000 in savings and have a medical home. Patients are referred to OA by community clinics when they need low-risk, outpatient surgery and are fairly healthy with few or no co-morbidities. OA also conducts community outreach to bring in new patients.

Before patients are accepted to participate, they must have a support system in place which will allow them to comply with all appointments and follow-up care. This is especially important for homeless patients, as OA needs a reliable way to communicate with the patient. About 70 percent of OA patients do not speak English as their first language, and 70-80 percent is undocumented immigrants.

In 2009, 1,175 surgeries, specialty care procedures and diagnostic screenings were provided to 952 individuals through OA's network of providers. In 2010, just shy of 1,400 services were provided. To date, over 6,900 specialty care procedures and diagnostic screenings have been provided, valued at over $47 million. Approximately 80 local community clinics refer patients to OA (including federally qualified health centers, non-federally qualified health centers, free clinics and other health care organizations serving uninsured patients). Thirty-three medical centers donate space, supplies, equipment and other services for OA procedures free of charge.

More than 1,000 volunteer medical professionals in OA's network provide surgeries, specialty procedures and diagnostic screenings. A number of administrative volunteers provide interpretive skills and administrative support for the program. OA also receives in-kind support from other medical and

provider groups in the form of ancillary services such as anesthesia, pathology and radiology. OA's staff consists of 14 full-time employees.

OA has a high patient compliance rate. Only about four percent of all patients experience noncompliance (including no shows, appointments cancelled within 24 hours and noncompliance with preparatory procedures such as eating before surgery). The noncompliance rate for operating room surgeries and gastrointestinal procedures is even lower at only two percent.

PROJECT ACCESS NOW (PA NOW)

Service area:	Portland/Vancouver metropolitan area (includes four counties: Clark, Clackamas, Multnomah and Washington)
Year established:	2007
Overview of PA NOW:	▪ Project Access NOW is a community initiative designed to provide access to care for individuals who are low-income and uninsured through a network of volunteer providers. ▪ All providers in the PA NOW network provide care free of charge. ▪ The success of PA NOW has been due to the partnerships made with the United Way, hospitals, safety net clinics and other providers in the community.
For more information, contact:	Linda Nilsen-Solares, Executive Director linda@projectaccessnow.org
Website:	http://www.projectaccessnow.org/

Background

Project Access is a community-based program that serves uninsured individuals. This national model recognizes that physicians in many communities want to provide charity care to people who need it, but find it difficult to do so with ease. By participating in the program, these providers can see patients with fewer challenges, which in turn reduces hospital admissions and expenditures because people receive timely and appropriate care. Project Access is a national model that has been adopted by communities throughout the United States. In 2007, there were 48 sites around the country.

Project Access NOW (PA NOW) is a multi-county, bi-state effort designed to coordinate care for uninsured individuals across county lines in Northwest Oregon and Southwest Washington. PA NOW recognized that some providers had established service areas within their counties, while other providers had no defined service area at all. PA NOW sought to create a coordinated system across county boundaries and a single point of contact for the region's uninsured residents. An existing group of organizations in the area concerned with connecting people to care became the founding partners of PA NOW: United Way of the Columbia-Willamette, medical societies, health departments, hospitals, insurers, safety net clinics and other nonprofit organizations. When the program started, counties were treated as individual programs with some autonomy and PA NOW coordinated efforts that made more sense to address on a regional level. As the program grew, PA NOW shifted to a regional-based program to most effectively utilize resources.

PA NOW was established in April 2007 and began serving patients in March 2008. The program connects patients with health care services through a network of volunteer providers. All of the care provided is free, except for a $4 co-pay on pharmaceutical services which can be waived if needed. Providers, including hospitals, primary care doctors and specialists, agree to provide care to PA NOW patients because the program reduces many of the challenges associated with providing free care to

uninsured people, such as high no-show rates, expensive translator costs for non-English speakers and the difficulty in securing lab tests and specialty care for patients.

Partnerships

As one of the original founders of PA NOW, United Way of the Columbia-Willamette has been instrumental in helping the program get started and become successful. By the time PA NOW was formed, the United Way had already spent a year-and-a-half planning for a program to coordinate safety net providers in the area. United Way and PA NOW formed a strategic partnership to pool each organization's resources for a more successful program. United Way had many contacts in the business community but did not feel adequately connected to the health care industry, whereas PA NOW was in the opposite position. Each organization benefits from the partnership in that PA NOW receives funding from United Way and PA NOW is a key component of the United Way's mission to foster and support community impact.

The importance of partnerships for PA NOW with the hospitals in the area cannot be over stated. Because the hospital market is highly competitive, the board of PA NOW approached the leadership of each hospital and proposed a plan to share the burden of caring for the uninsured. Once the CEOs were in agreement, PA NOW met with the hospitals' chief financial officers to examine discharge data and determine each hospital's market share. The number of PA NOW patients served by each hospital is proportional to the hospitals' market share, so no facility is providing more than its "fair share" of care. Hospitals also provide a substantial amount of in-kind support in the form of physical space and volunteer staff time. Their agreement to allow PA NOW patients to be pre-approved for donated care is a key part of what has made the process so easy to use for provider volunteers.

Along with the hospitals, many other providers volunteer to participate in PA NOW to help alleviate some of the burden associated with providing care to the uninsured. PA NOW recognized that many hospitals, physicians and specialists in the community were already providing charity care to uninsured individuals and wanted to leverage that care to create a coordinated system that works well for both patients and providers. Clinicians and other providers learn about PA NOW by word of mouth from existing PA NOW providers and hospitals, and agree to provide free care to Project Access NOW patients with the benefit of comprehensive care coordination from program staff.

Over and above connecting individuals with needed health care, the program hopes to make the entire social services system more navigable for individuals and families. PA NOW is developing a "Universal Eligibility Screening" based on the premise that about 90 percent of the screening/eligibility criteria for most health and human services programs are the same. Currently, people seeking services must fill out a separate application for each service. The organization is also early in an effort to create a data application for area health and human services that will allow a family to apply for a number of services with only one "intake" appointment. This model has been successful in Yolo County, California.

Securing specialty services

The majority of PA NOW's program is focused on securing specialty care for individuals who need care but do not have the resources to obtain it. The program connects patients to both primary care physicians for needed chronic care management as well as specialists for those who already receive

primary care from a safety net provider but need more specialized care. PA NOW staff cites evidence of success from surveys collected from each patient upon exiting the program. Analysis of the survey data indicated a 53 percent decrease in the number of PA NOW patients who self-reported forgoing specialty care between enrollment and program exit. Further, the number of patients who reported using emergency department services in the past six months declined by 36 percent.

Patient referrals to specialist care usually are made by safety net clinic providers who see the patient in a primary care setting. Of the 1,356 patients who were enrolled in the program at some point from March 2008 to January 2010, about 65 percent received at least one primary or specialty care service within three months of enrollment. To connect patients with appropriate care, PA NOW examines all referrals to determine if the referral is medically necessary, and if it is within the medical scope of PA NOW.

To accomplish this, PA NOW established a panel of three doctors that is responsible for reviewing incoming referrals and patient charts. Each week, the volunteer panel reviews an average of 30-40 charts to determine if PA NOW should follow through with the referral. Generally, PA NOW's medical scope does not include referrals for patients who need transplants, behavioral health counseling, maternity care and deliveries, emergency services or medically unnecessary procedures. As the program has matured, more patients are being connected to primary care and subsequent specialty care.

Funding

PA NOW receives financial support in a variety of ways. Hospitals, health systems and insurers in the region donate care and provide financial and other types of in-kind support. The strategic partnership with the United Way is a key funding source. In addition, the program is supported by foundations, corporate partners and individuals. The support breaks down as follows:

- United Way – 10%
- Health care stakeholder support (hospitals and insurers) – 50%
- Board fundraising (community support) – 20%
- Grant writing – 20%

In 2010, PA NOW implemented a new funding source called "health care stakeholder support." This component of the budget consists of a three-year funding commitment from most of the participating hospitals and insurers, and makes up about half of the organization's budget. Next year, PA NOW will reduce grant-writing efforts and replace that revenue with funding from the organization's referral partners. The referral partners are community clinics that send patients to PA NOW. These partners will be asked to contribute 10 percent of the cost of support that PA NOW provides to their patients.

Operation and enrollment

Since March 2008, PA NOW has had a total enrollment of approximately 6,300 patients in the four-county region served, with an average monthly enrollment of 250 patients and an average active enrollment of 3,000 patients at any given time. The enrollment period for PA NOW is six months for specialty care access and one year for primary care access, at which point the patient must either exit the program or re-enroll if he/she is still eligible. To qualify for PA NOW, patients must have a confirmed medical need, be uninsured and ineligible for publicly funded coverage, have incomes below 200 percent of the federal poverty level and live in the area with intent to stay. To enroll in PA NOW,

patients must be referred by a provider based on medical need. After the enrollment period is over, the patient may re-enroll if care is still needed and he/she is still eligible.

Either PA NOW staff or the referring safety net clinic staff conduct the initial screening to see if the patient is eligible. After eligibility is determined, staff provides comprehensive care coordination throughout the enrollment period, including orientation, appointment scheduling and reminder calls. PA NOW is heavily involved in coordinating the first appointment but often has no information for subsequent appointments because the arrangement is then between the provider and the patient. With better volunteer coordination to follow up with the patients and a higher response rate to requests for information from providers, PA NOW would be able to gather more complete information about subsequent appointments. About 20 community volunteers help with follow-up calls and assist in care coordination, but PA NOW staff would like this number to be increased to better serve its patient load.

PA NOW has a strict, zero-tolerance policy for missed-appointments to ensure that providers don't leave the network because patients don't show up for appointments. Because of this policy, PA NOW has a 95 percent "show" rate. PA NOW also screens for belligerent or excessively rude patients for the same reason. To help maintain a high "show" rate, PA NOW provides transportation such as taxi service or bus passes, but has needed to provide these services only a few times.

Currently, PA NOW's volunteer provider network consists of 2,800 providers, which is about half of the providers in the service area. It also has 11 staff members who work for PA NOW and four full-time equivalent employees who work in safety net clinics in the region. Project Access programs throughout the country have been relatively physician-centric as the program was originally developed by a medical society, but over the years the scope of the program has changed. PA NOW is working on incorporating more physician assistants, nurse practitioners and other non-physician clinicians as part of its provider network, but doesn't track the number of these providers who currently participate under the supervision of volunteer PA NOW physicians. Providers appear to be satisfied with the program, and PA NOW has a 99 percent retention rate among volunteer providers.

Although the organization has had trouble collecting appointment information, PA NOW has a robust evaluation process through which it has gathered claims data from each episode of care from the inception of the program. PA NOW works with Care Oregon and Columbia United Providers (CUP) in Clark County, Washington. Both of these organizations are local Medicaid managed care health plans, who gather claims data on all episodes of care provided to PA NOW patients as an in-kind donation to PA NOW. The program sets itself up to look like an insurer to volunteer providers and uses Care Oregon and CUP's claims infrastructure to collect its own claims data, even though all patients are uninsured. Providers simply submit claims through the same process they would use if they were caring for Care Oregon or CUP patients, but enter a different patient ID number. That ID number is then tracked through Care Oregon and CUP's systems and recorded as a claim for PA NOW, though PA NOW does not pay for care.

Because Care Oregon and CUP work with many of the same providers as PA NOW, the claims system is familiar to most of them, making it easier for volunteer providers to submit claims information to PA NOW. However, not all volunteer providers submit claims data, meaning estimates based on these data

are likely to underestimate services rendered. Participating hospitals are more likely to enter claims data than volunteer providers.

PA NOW also calls patients to participate in a phone survey at the end of their enrollment period in which they are asked about ER use, self-reported health status, the length of time required to connect them with care and other issues. Patients are also queried about access to dental and behavioral health care. Even though it doesn't provide those services, PA NOW hopes to expand to include these services for its patients. The network is also implementing a new database to better track program evaluation.

Survey Methods

Survey development: In April and May 2010, Kaiser Permanente Colorado conducted a pilot study of access to specialty care among clinicians employed at Clinica Family Health Services clinics in Boulder and Longmont, Colorado.

After the pilot study concluded, Kaiser Permanente contracted with the Colorado Health Institute (CHI) to administer the *Colorado Safety Net Specialty Care Assessment*. CHI worked with Kaiser Permanente to revise the pilot project questionnaire. The revised questionnaire incorporated questions from the *Access to Specialty Care and Medical Services Medical Director Survey* developed by the Department of Health Care Policy and Office for Diversity and Community Partnership at Harvard Medical School, in partnership with the National Association of Community Health Centers.[4] The survey focused on access to specialty care and surveyed 814 federally qualified health centers (FQHCs) nationally. Kaiser Permanente staff obtained permission from the Harvard study's authors to use items from the questionnaire.

Following the questionnaire revision process, CHI completed cognitive pretesting of the *Colorado Safety Net Specialty Care Assessment*. Pretesting allows researchers to receive verbal feedback from participants regarding their interpretation of the questions. Researchers use that feedback to refine the survey instrument and address any outstanding issues with language and question structure before the survey is administered. CHI conducted cognitive pretests with safety net clinic medical directors and clinic directors in both rural and urban areas.

The final list of specialty care services included in the survey originated from the specialty care services available at Kaiser Permanente, augmented by the cognitive testing results.

Survey administration: Kaiser Permanente and CHI decided to administer the survey to medical and clinic directors (or, in some cases, administrators), who could reasonably be assumed to possess a broad understanding of access to specialty care and respond on behalf of their clinic(s). The survey was limited to FQHCs (also known as community health centers), community-funded safety net clinics (CSNCs) and federally designated rural health clinics (RHCs). In the future, the survey may be fielded among other types of safety net clinics. CHI worked in partnership with three clinic associations, ClinicNET, the Colorado Community Health Network and the Colorado Rural Health Center, to disseminate and publicize the survey to ensure a robust response from their members and affiliates.

Once Kaiser Permanente and CHI finalized the questionnaire, the survey was fielded online from October 25 to December 6, 2010, using CHI's online survey software, KeySurvey.com. Respondents received an e-mail invitation to participate in the survey. The e-mail included a cover letter explaining the project, a confidentiality statement and a link to the online survey. CHI staff and clinic associations sent multiple follow-up e-mails and made personal phone calls to clinics that did not initially respond. If

[4] Cook, NL, et al. (2007). "Access to specialty care and medical services in community health centers." *Health Affairs* 26(5):1459-68.

respondents started but did not complete the entire survey, CHI contacted them via both e-mail and telephone to encourage them to complete it.

A separate four-question survey was fielded to clinic administrators to gather information from each clinic that completed the medical and clinic director portion of the survey. The administrator survey focused on volume of patients and visits.

Response: The number of safety net clinics in Colorado is constantly changing as clinics open and close. The survey was administered to organizations representing approximately 165 clinics across Colorado. CHI received 57 survey responses, many of which were submitted on behalf of multiple clinics within the same organization. After contacting clinics to confirm the representativeness of responses, CHI weighted the data to represent 102 clinics across Colorado. Therefore, CHI estimates that 102 of the 165 clinics are represented in the survey, for a response rate of 62 percent. For the few respondents who did not complete the entire survey, CHI used what data had been submitted.

Analysis: CHI used SAS software to appropriately weight and to conduct all descriptive analyses.

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