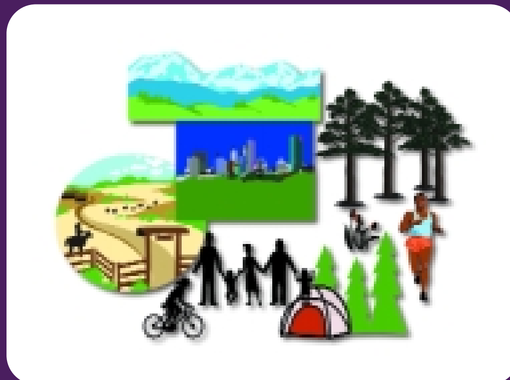
STRATEGIC PLANNING PHASE:

RECOMMENDATIONS FOR ASSURING ACCESS TO QUALITY HEALTH CARE

TURNING POINT INITIATIVE



Colorado's

Public Health

Improvement Plan

Colorado Public Health Improvement Plan
Colorado Turning Point Initiative
August 2001

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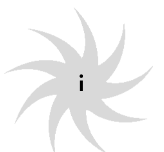
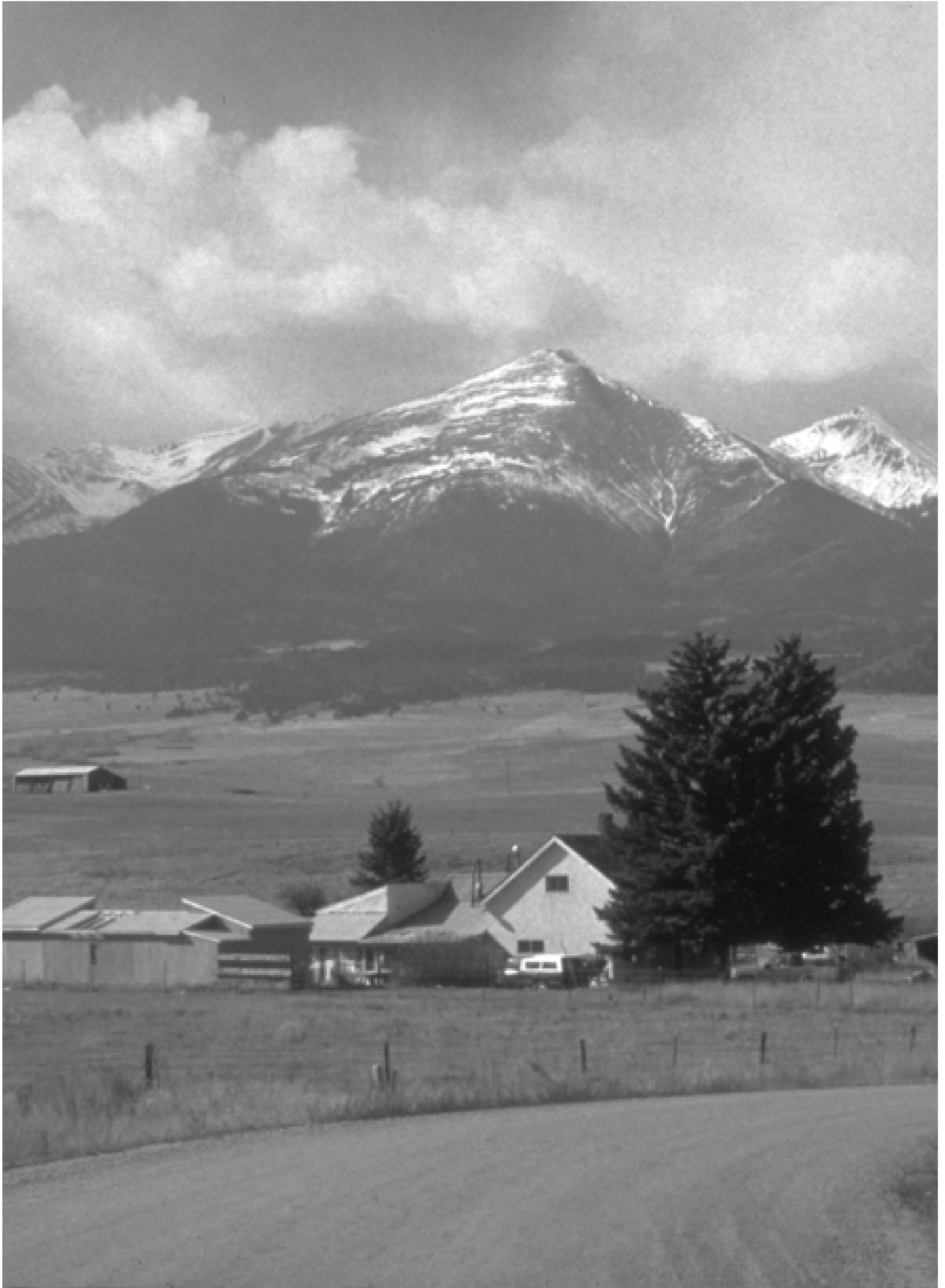




Background

ALMOST 14 YEARS AFTER THE PUBLICATION of the breakthrough report *The Future of Public Health* by the Institute of Medicine (IOM), some would contend that the U.S. public health system today is not much closer to realizing the goals of the IOM study than it was in 1988. While there have been public health achievements since then, new and more complex challenges have presented themselves. Among these new challenges are an increasingly diverse political constituency, the resurgence and spread of drug-resistant strains of disease-causing microbes, global transmission of new and emerging diseases, the threat of bioterrorism, decreased funding for public health programs and infrastructure, reduced health insurance coverage and overall access to health care, and health disparities. All of these issues present overwhelming challenges to safeguarding the future health of the public.

In the summer of 1999, the Colorado Department of Public Health and Environment (CDPHE) received a Turning Point strategic planning grant from the Robert Wood Johnson Foundation. The purpose of the grant was to facilitate a collaborative process to assess the health of Colorado residents, examine public health systems in Colorado, and then create a state public health improvement plan. This document is one product of that work. Colorado is one of 21 states participating in the National Turning Point Initiative and is guided by the overriding mission to transform and strengthen the public health system to make the system more effective, more community-based, and more collaborative.

A steering committee carried out the strategic planning process with input from workgroups. In examining health status and health systems within Colorado, it became clear that while Colorado is a relatively healthy state, there are still barriers that prevent optimal health for the general population, and there are specific population groups that are disproportionately impacted by disease, disability, and death, especially minority communities. In looking toward the future, public health is likely to face challenges never before seen, where a strong public health infrastructure and visionary leaders will be critical to maintaining the health of Colorado residents. Through its assessment, the Turning Point Steering Committee determined that many groups in Colorado have a difficult time accessing health care. This is due in part to a lack of insurance coverage and the fact that many rural areas in Colorado have been federally designated as Health Professional Shortage Areas. In terms of public health infrastructure, funding constraints currently prevent expanding the workforce, increasing information and data systems capacity, and enhancing organizational capacity, especially in local agencies.

Through its public health systems assessment, the steering committee determined that the key strategies for improving health status in Colorado include:

- Increasing the capacity of public health and environmental agencies
- Increasing the capacity to conduct population-based health status assessment
- Assuring access to quality health care
- Assuring access to insurance coverage
- Eliminating health disparities
- Promoting leadership development within the public health field and community partners

Beyond the steering committee and workgroups, the Turning Point Initiative used key informants, a review of the literature, and national and state data to examine each key strategy area. In this document, a national perspective will be included, as these key strategy areas are not unique to Colorado. This planning process was conducted by a diverse set of partners, many of whom are not from governmental public health agencies. The Colorado Turning Point Initiative believes that maintaining and improving the public's health requires partnerships with many different sectors and communities. This plan is meant to be carried out in collaboration and should be used as a guide. We believe that any person, community, or entity can take a leadership role in mobilizing partners around the recommendations in this plan, and we invite this participation in maintaining the health of our state.

Data Issues

This document attempts to provide the latest data available; however, data availability varies by year depending on the data source. In most cases, 1999 is the most recent year for available data. When 1999 data is not yet available, earlier data will be presented.

In preparing this plan, guidance was sought from the *Healthy People 2010* document, which will be referenced often. *Healthy People 2010* is a set of national health objectives to be achieved over the first decade of the 21st century. The objectives were developed by a consortium of partners, led by the U.S Department of Health and Human Services.

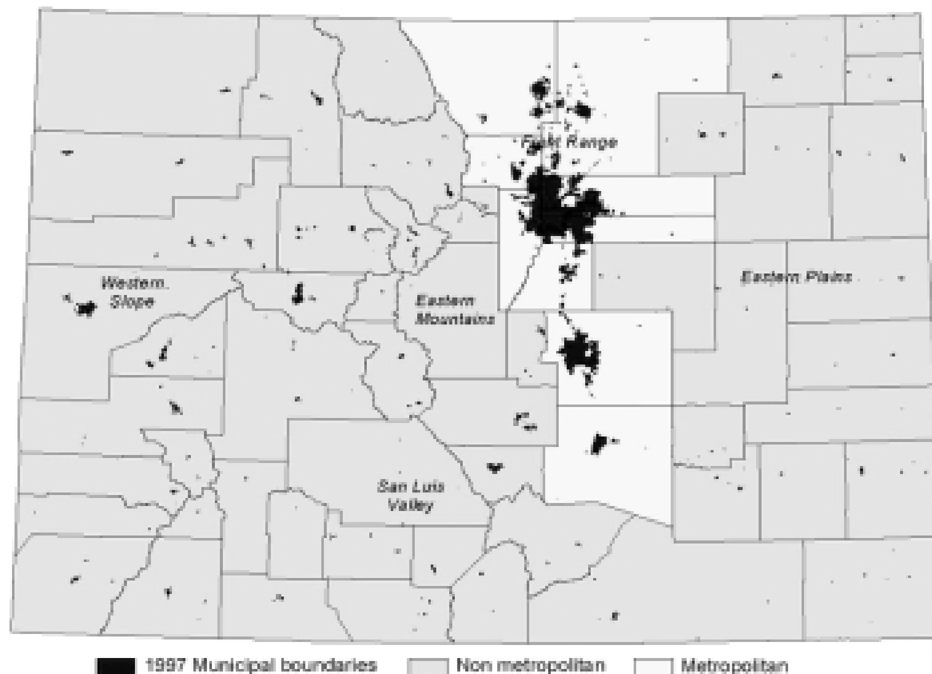
Colorado Turning Point also wishes to recognize the difficult issue of using labels when discussing race and ethnicity. It is hard to gain a consensus on the preference of categories such as "people of color/minority," "American Indian/Native American," "African American/black," "Hispanic/Latino(a)," and "Caucasian/white." We acknowledge that not everyone identifies himself or herself with these categories, and we very much respect the importance of cultural differences in how communities prefer to be defined.

Finally, in accordance with the Centers for Disease Control and Prevention, Colorado Turning Point also recognizes that race and ethnicity are social constructs representing distinct histories and cultures of groups within the United States and that they are not valid biological or genetic categories.

Profile of Colorado

Colorado's population is young, healthy, rapidly growing, and increasingly wealthy, relative to national averages. With a population of approximately 4.3 million, Colorado is home to only 1.5 percent of the United State's population. Colorado's population density is 39.2 persons per square mile compared to the rest of the nation at 77.1.[1] Colorado is a geographically large state with 80 percent of its residents living in 10 metropolitan counties on the east side of the Rocky Mountains. This region is known as the Front Range. The remaining 20 percent of residents are scattered throughout the mountains, eastern plains, and western plains of the state (Figure 1). Colorado consists of 63 counties, 29 of which are considered rural and 23 are considered frontier (less than 6 people per square mile).[2,3] In November of 2001, Broomfield will become Colorado's sixty-fourth county.

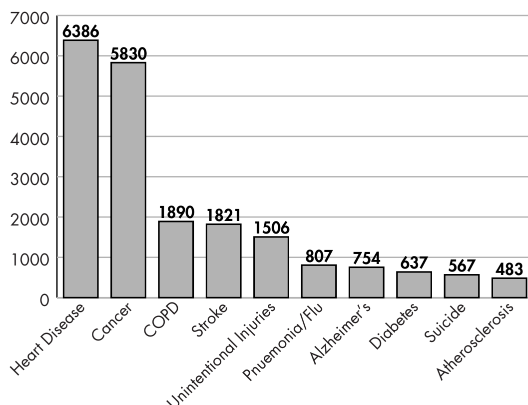
Figure 1: Metropolitan and Rural Regions of Colorado



Health Status

Colorado, by any number of measures, is a healthy state. In 1999, Colorado's age-adjusted death rate for all causes was 801.2 per 100,000 persons, well below the national rate of 881.9.[4] Colorado's death rate has remained lower than the U.S. rate for the past 16 years.[5] The fact that this rate has been adjusted for age indicates that the difference between Colorado and U.S. death rates is not due to Colorado's relatively younger population. Many of Colorado's health indicators are better than national health indicators, including leading causes of death. Colorado's death rates are lower than national death rates for chronic disease such as heart disease, cancer, stroke, and diabetes.[6] Leading causes of death in Colorado are displayed in Figure 2.

Figure 2: Leading Causes of Death, Colorado 1999



Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics,1999.* Denver, CO: June 2001.

From a public health perspective, Colorado has much in its favor. In 1998, the state was declared the third healthiest in the nation. When considering *Healthy People 2000* national health objectives, Colorado exceeded or was close to meeting objectives on such preventive indicators as mammograms and pap smears for women over age 50, reducing a number of infectious diseases such as HIV and gonorrhea, reducing births among teens, and reducing infant deaths.[7,8]

According to 1998 data, the latest data available nationally, Colorado does have a few health indicators that are poorer than the national average, including the death rates from chronic obstructive pulmonary disease, unintentional injuries, suicide, atherosclerosis, and Alzheimer's disease. Also, Colorado residents failed to meet the *Healthy People 2000* national health objectives for physical inactivity, smoking, and cholesterol screening.[9]

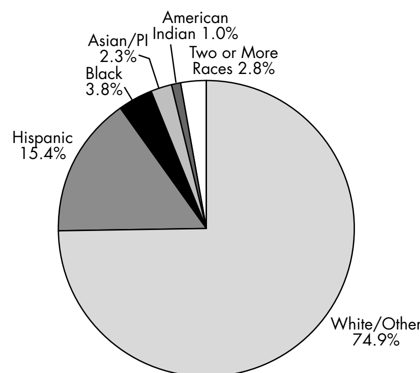
Demographics

In terms of racial and ethnic composition, minority groups account for 25.3 percent of Colorado's general population, and the number is increasing. The percentage of minorities in Colorado has increased over the past decade, mostly due to a nearly 33 percent increase in the number of Hispanics between 1990 and 2000. Population figures are provided in Figure 3. (Percentages do not add to 100 due to rounding.)[10]

Colorado's racial and ethnic composition differs from the national composition in that: the number of Hispanics in Colorado is higher, the number of Asian/Pacific Islanders is lower, and the number of blacks is significantly lower than national numbers. The number of American Indians in Colorado is proportionately similar to the rest of the nation.[11]

In 1999, Colorado's male to female ratio was 49.6 to 50.4. The median age was 35.7. The percentage of the population over age 65 was 10.1 compared to 12.7 percent nationally, and the percentage of the population over age 85 was 1.2 compared to 1.5 percent nationally.[12]

Figure 3: Colorado's Population by Race/Ethnicity, 2000



Source: Colorado Division of Local Government, "Table 3A: Census 2000 Counts of Colorado County Population by Race/Ethnicity and Hispanic Origin," *U.S. Census Bureau: Census 2000 Counts of Colorado Population,* Denver, April 13, 2001.

Poverty

In Colorado, the percentage of people living in poverty has been decreasing since the early 1990s and is below the national rate. In 1999, 8.3 percent of the Colorado population was below the federal poverty level, compared to 11.8 percent nationally. The difference is even more significant for children; 11.2 percent of school-age children in Colorado are below the federal poverty level versus 15.89 percent nationally.[13]

Education

The level of educational attainment for Coloradans is relatively high compared to U.S. average levels. In 1999, 90.4 percent of the population had a high school degree compared to 83.4 percent nationally. Also, 38.7 percent had at least a bachelor's degree, compared to 25.2 percent nationally.[14]

Notes

1. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Colorado 2001, State Health Profile* (Atlanta, Ga.).

2. Colorado Rural Health Center, *Colorado Rural Health Plan: Submitted for Colorado's Participation in the Medicare Rural Hospital Flexibility Program* (Denver, January 1999).

3. Colorado Rural Health Center, *Colorado Rural, Frontier, and Urban Counties, 2000 Census* (Denver, 2001).

4. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics, 1999* (Denver, June 2001).

5. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics, 1998* (Denver, March 1999).

6. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics, 1998* (Denver, March 2000).

7. U.S Department of Health and Human Services, Centers for Disease Control and Prevention, *Colorado 2000 State Health Profile* (Atlanta, Ga.: 2000).

8. U.S. Department of Health and Human Services, Public Health Service, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (Washington, D.C.: U.S Government Printing Office, 1991), No. PHS 91-50212.

9. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado's Progress Toward Year 2000 Objectives,* Brief No. 26 (November 1998).

10. Colorado Division of Local Government, "Table 3A: Census 2000 Counts of Colorado County Population by Race/Ethnicity and Hispanic Origin," *U.S. Census Bureau: Census 2000 Counts of Colorado Population,* (Denver, April 13, 2001).

11. U.S. Department of Health and Human Services, *Colorado 2000 State Health Profile.*

12. U.S. Department of Health and Human Services, *Colorado 2001 State Health Profile.*

13. Ibid.

14. Ibid.

Assure Access to Quality Health Care

Executive Summary

Purpose

Access to quality care is one of several issues being examined by the Colorado Turning Point Initiative. The Initiative's overall mission is to clearly define the factors contributing to health disparities and unfavorable health outcomes. This report provides insight to the integral factors contributing to access of quality care with the ultimate goal of eliminating health disparities and improving the health status of Colorado residents.

Problem

Even in good economic times, large numbers of Americans experience barriers to health care access. This is true for Colorado residents as well. Access to health care is defined as the ability of individuals to use health services, including preventive care, in a timely manner and on an ongoing basis. A lack of insurance coverage, physician shortages, overflow of the safety net system, cultural barriers and other system barriers contribute to the access problem. This is especially true for increasing numbers of uninsured working families with low/moderate incomes who are either not eligible for government-funded insurance programs or who are eligible but not enrolled. Also, young adults (ages 20–25) are less likely to have health insurance coverage from either employer-based or public-based health insurance programs. Minorities are less likely to have health insurance coverage but also experience cultural barriers to accessing care, including language. Many rural communities in Colorado have been designated Health Professional Shortage Areas and rural residents experience unique barriers to health insurance coverage. Finally, access to oral health services and mental health services is also a problem. A lack of access to health care results in poor health outcomes and higher mortality rates, in addition to the financial burden for society.

Findings

Several factors contribute to the lack of access to quality care. As safety net providers face shrinking resources, a growing number of uninsured individuals seek care. More and more physicians feel they can no longer care for indigent patients due to complexities in the financial administration of services. Many physicians have either limited their indigent care efforts or withdrawn altogether. Poverty, which has been shown to lead to a lack of access to insurance coverage, also contributes to a covered individual's ability to obtain and access services. Alarmingly, new studies show that language barriers and differences in treatment modalities contribute to a disproportionate amount of adverse health outcomes experienced by individuals of racial/ethnic backgrounds as compared to Caucasians. Rural health care is experiencing a lack of physicians, financial strains, and a large number of uninsured residents. Quality of health care can be viewed from many different perspectives, but regardless, the result of providing quality care is positive health outcomes. Once financial, systematic, and personal barriers are eliminated, access to quality care becomes a standard.

Colorado Analysis

Colorado is confronted with factors specific to the state. Insurance availability is low for uninsured or underinsured Coloradans, especially in rural Colorado. The number of specialty providers in rural Colorado is considerably low, and even urban specialists are choosing not to accept Medicaid and Medicare patients. Many providers are simply leaving their practices. And in Colorado, oral and mental health care present unique challenges as they emerge to the forefront of needed services.

Recommendations

Considering all the factors contributing to the access to quality of care, the State Improvement Plan recommends: (1) expanding the state's Medicaid and State Child Health Insurance Plans; (2) promoting innovative physician practice management; (3) implementing physician recruitment

programs; (4) implementing a state tax credit law for medical professionals; 5) assuring culturally competent care; and (6) building community partnerships to help assess and develop solutions to their community health care needs.

If the goal of providing appropriate and effective health care to all Coloradans is to be achieved, the Colorado Turning Point Initiative's Steering Committee sees a need to address the more in-depth intricacies of providing access to quality care. For instance, research needs to be conducted to investigate barriers to enrollment and then the enrollment process should be streamlined. A comprehensive and integrative delivery system should be coordinated, one in which there is smooth transition and communication between private and public programs and includes preventive services and practices. Regulatory reform, balanced with strong accountability standards should be advocated. Action needs to be taken to provide incentives to utilize preventive services. Trainings and technical assistance must be offered in partnership with communities to share best practices.

Access to Quality Health Care

Access to health care is defined as "the timely use of personal health services to achieve the best possible outcomes including preventive care and ongoing care for health problems or emergencies."[1] Strong predictors of access to quality health care include having health insurance, a higher income level, and a regular primary care provider.[2] Achieving quality health care for low-income populations, however, has come to represent a serious and continual problem for the United States.[3]

The access problem directly affects large numbers of uninsured working families with low or moderate incomes, involving both children and adults who are eligible for government-funded insurance programs but are not enrolled. Another segment of the uninsured population that is a concern consists of single adults who are not getting health coverage from either employer-based or public-based health insurance systems. People ages 18 to 24 years are most likely to lack a usual source of primary care as well.

These three segments of the population also face a plethora of noninsurance barriers.[4]

Issues such as inadequate housing, poor nutrition, poverty resulting from joblessness or low wages, poor air quality, and other social determinants also have an adverse effect on the health and well-being of low-income individuals and families.[5]

Even in good economic times, a growing number of Americans lack basic access to care. Between 1993 and 1996, the economy produced 7 million new jobs, but the percentage of Americans without insurance increased from 15.3 to 15.6 percent.[6] Over 44 million people remain uninsured—despite the fact that efforts have been made to expand coverage at both the state and federal level. More than 40 million people do not have an ongoing source of care. They do not have a particular doctor's office, clinic, or health center where they usually go to seek health care or health-related advice.

Yet having health insurance coverage does not guarantee access to quality care. A significant number of privately insured persons lack a usual source of care and report difficulty accessing needed care due to financial constraints or insurance problems. There are many other barriers to accessing quality health care in addition to financial barriers. A host of linguistic, cultural, racial, geographic, and organizational factors present roadblocks that interfere with the health of a large portion of the population.[7]

Issues Affecting Access to Health Care

Access to health care is top a priority in our society today, especially as it influences health disparities. Most Americans say that the health care system needs to fundamentally change; they worry about the uninsured, and more than half believe there should be a system to provide health insurance to those who cannot afford it.[8] Access to primary and basic preventive care is the key to health and wellness for all populations. Largely preventable health problems cause a strain, both financial and social, on the entire health care system. To change the health care system, one must first understand all of the issues. The following factors contribute to the lack of access to quality care.

Safety Net Providers

In the past, the safety net hospitals and clinics provided care to those who needed it. However, today the system is experiencing many difficulties. Part of the problem is pure mathematics; the numbers of uninsured are already high and keep growing at a rate of more than 1 million persons each year. Safety net providers offer a "medical home," or a regular source of comprehensive and coordinated primary care services. According to a Kaiser Family Foundation report, some areas of the country have been feeling a major financial strain on their systems. Managed care has diverted paying patients away from safety net providers, leaving those providers with the higher levels of the uninsured.[9] Indigent care programs and safety net providers are trying to do more with shrinking resources.[10]

The threat of lost Medicaid revenues has encouraged the safety net provider networks to make the needed changes to participate in managed care. Moreover, state and federal policies that promote and/or require Medicaid managed care organizations to include safety net providers in their network have subsequently improved the involvement of the safety nets in managed care.[11]

Physicians

During most of the 1990s, experts predicted there would be an abundance of physicians that would far exceed the demand. These predictions were based on the assumption that managed care would reduce the use of hospitals and physicians. In reality, managed care did reduce the use of hospitals, but physician visits actually increased.[12] In addition to the utilization of physician services, managed care was also thought to place pressures on physicians to be more productive. In essence, that would mean seeing more patients and spending less time with each patient. However, this turned out not to be true either. According to one study that examined the length of office visits with physicians from 1989 to 1998, the time a physician spent with a patient increased by one to two minutes. This upward trend was noted for primary care, specialty care, and for both new and established patients. The number of office visits increased significantly as well over the same period of time.[13]

Physicians have experienced a number of changes in the way they practice medicine over the past decade. A variety of reasons exist, including increased competition, patient satisfaction, and payer and regulatory mandates. Fewer and fewer physicians are willing to volunteer their time to care for the uninsured. As a result, the most vulnerable patients are without care. Some physicians feel it is because of shrinking reimbursements due to federal budget cuts and managed care; others say the reason is they just do not have the time.

There are a growing number of physicians who feel that they can no longer care for indigent patients and that they have either limited their indigent care efforts or withdrawn altogether. Three major causes for not seeing these patients include low payments from Medicaid and the State Children's Health Insurance Plan; administrative hassles; and patient issues such as a high rate of missed appointments. Missed appointments cause both practice management and financial problems for the physician. The likelihood of patients keeping their appointments is improved when a case management system is in place to address logistical, cultural, and behavior barriers.[14]

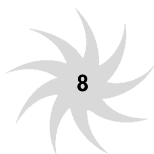
Poverty and Lack of Insurance

Several public and private initiatives address the rising numbers of uninsured. Two public programs, Medicaid and the State Child Health Insurance Plan, have been reaching out vigorously to the uninsured. Yet the people who need the coverage the most are the ones who are unaware of their eligibility or choose not to enroll. Although Medicaid covers nearly half of all poor people, it is not enough. Moreover, enrollment has actually dropped since welfare reform legislation was passed in 1996. One out of every five children in the United States is eligible to enroll in Medicaid but has not done so.[15]

Concerns about access to quality health care for low-income children covered by Medicaid have long been a concern, even though medical benefits for children are comprehensive and include services for dental care and mental health. Historically, low reimbursement rates, administrative hassles, and lack of neighborhood providers have contributed to the lack of access for Medicaid children.[13] However, one study compared Medicaid children with other low-income children covered by private insurance. The results showed that Medicaid and privately insured low-income children had comparable access to health care but that Medicaid children were more likely to receive routine and preventive care.[16]

There are differing opinions among health care professionals and political leaders as to how to solve the many problems related to accessing quality health care and health care disparities. Studies have shown a strong association between the lack of insurance, the inability to obtain services, and adverse health outcomes, especially for low-income populations. Dennis P. Andrulis, Ph.D., reviewed many of these studies and feels the literature shows that when actions are taken to successfully decrease the financial barriers across socioeconomic groups, a substantial reduction in health disparities results.[17]

One report noted that children who live in poverty, many of whom are uninsured, have a greater likelihood of receiving lower quality care and of dying in infancy.[18] A 1997 study from the Center for Studying Health Systems Change showed a similar trend;[19] families classified as low income were more likely to report a decrease



in access to health care within the past three years. Forty-three percent of the uninsured reported reduced access compared to 21 percent of those with private insurance. In contrast, the elderly with Medicare coverage were the least likely to report reduced access to care.[20] In addition, people living in poverty, with no health insurance, are less likely to have a "medical home"—a regular source of comprehensive and coordinated primary care. As a result, this population has a high rate of costly emergency room visits and preventable hospitalizations.

Racial/Ethnic Differences

There is a growing interest in studying the differences of health outcomes based on race and ethnicity. The findings are very disturbing. One study revealed that black and Hispanic patients with severe pain are less likely to obtain commonly prescribed pain relievers because pharmacies in predominately non-Caucasian communities do not stock these drugs. The pharmacists gave many reasons as to why they do not stock these common drugs. Some cited fear of crime and theft, but 54 percent cited that there was little demand for these drugs. This could indicate that physicians in minority neighborhoods may be under-treating pain in their communities.[21]

In almost every disease category, there is evidence that non-Caucasian patients were treated differently than Caucasian patients. Studies showed that blacks have an overall higher incidence of cancer—and a higher rate of death from cancer than other racial groups. Two studies showed that Hispanics and blacks were substantially under-treated for pain from bone fractures and that postoperative pain was poorly managed. Blacks with chronic renal failure were less likely to be evaluated for a renal transplant or thoroughly evaluated for coronary artery disease.[22]

Children are not immune to such disparities. Black and Hispanic children are less likely to have a usual source of care. Hispanic children are less likely to have a recent physician visit, less likely to use preventive services, more likely to delay seeking care, and more likely to report that they have not received needed care. Consequently, both of these groups are at increased risk for adverse health outcomes.[23] One study found this was true even after the researchers controlled for insurance status and poverty. However, when the researchers controlled for language, differences between Hispanic and Caucasian children became negligible. Barriers in access to health care were attributable to those whose parents had difficulty communicating about health care in English.[24] Further studies are needed to investigate additional health care system factors that may explain differences in racial and ethnic disparities.

Rural Health Care

The rural health system has changed dramatically in the 1990s due primarily to health care financing, the introduction of new technologies, and the development of health care systems and networks.[19] Rural communities struggle to make sure there are enough providers and services to care for all segments of the population. Many rural communities have a physician shortage. A higher percentage of rural hospitals are under financial stress compared to urban hospitals. Rural America has 20 percent of the population, but less than 11 percent of the all physicians practice in rural communities.[25]

The rural access problems cut across all demographic, racial, and socioeconomic groups, as well as diseases. Rural residents are more often uninsured than urban residents—18.7 versus 16.3 percent, and are more likely to report poor health, having restricted activity, and a lower level of access to a regular primary care provider.[26] However, a study of Medicare beneficiaries did not show a problem with access to care if the rural community had a population of at least 10,000 and was in close proximity to an urban center. The only services that showed a problem for this population were cancer screenings and dental care. Additionally, low-income groups did show a problematic relationship between utilization, self-reported access, and patient satisfaction.[27]

Some rural businesses such as forestry, mining, and agriculture present extraordinary threats to safety and overall health. A recent review of reasons rural residents went to the emergency department found that 12.5 percent of the visits were work-related injuries. In contrast, the national average is only 4.2 percent.[28]

According to another study, children in rural communities have a much higher rate of fatal injuries. Data from this 1992 study showed that rural children ages one to 19 had a 44 percent higher death rate than their urban counterparts. A Colorado study found that rural children had a significantly higher risk of death from motor vehicle crashes and unintentional firearm accidents.[29]

Quality Health Care

Quality health care is important to every community. Measuring quality of care has been shown to be beneficial even if quality is difficult to define.[30] Experts have struggled to formulate a concise definition of quality of health care. In 1984, the American Medical Association (AMA) defined high-quality care as care that "consistently contributes to the improvement or maintenance of quality and/or duration of life." According to the AMA, specific attributes of care should be examined in determining quality, including an emphasis on health promotion and disease prevention, timeliness, the participation of patients, attention to the scientific basis of medicine, and efficient use of resources.[31]

The definition of quality care differs depending on one's perception. Physicians define measures of quality by technical indicators: correct diagnoses and appropriate modalities.[32] In contrast, consumers place an emphasis on convenience as a measure of quality care: access and availability. Health plans tend to place greater emphasis on the health of enrollees and on attributes of care that reflect the functioning of organizational systems.[34] Providers can cut costs and improve quality at the same time by focusing their cost containment efforts on reducing inappropriate use of health services and avoiding adverse effects.[35]

Quality of care also can be defined in financial terms. The type of health plan a person is enrolled in can be a determinant of quality of care. Differences in quality have been attributed to various types of health plan payment and delivery systems such as a traditional indemnity plan, an independent practice association, and a health maintenance organization. One study identified and measured seven core indicators of primary care quality as they related to payment methodology: (1) financial accessibility, (2) organizational accessibility, (3) continuity, (4) comprehensiveness, (5) coordination, (6) interpersonal accountability, and (7) technical accountability. The results showed notable differences in these outcomes measures. Financial accessibility was highest in the prepaid systems. Organizational accessibility (actually obtaining care), continuity, and accountability (both interpersonal and technical accountability) were highest in traditional indemnity plans. Coordination was highest and comprehensiveness lowest in HMOs.[36]

Barriers that Limit Access to Care

Financial, structural, and personal barriers can limit access to care. Financial barriers include the lack of health insurance, inadequate health insurance, or not having the financial capacity to cover nonbenefit services. Structural barriers include the lack of medical providers and health care facilities to meet the needs of the population or those with special needs. Personal barriers may include cultural or spiritual differences, not knowing when to seek care, or concerns about confidentiality or discrimination.[37]

It is important to understand the barriers to accessing quality health care so that strategies can be developed to overcome these obstacles. Numerous studies have identified a strong link between adequate health insurance and poverty with access to care and health outcomes. Insurance coverage, both public and private, does play a major role in whether a person has access to care.

The following reasons have been identified as barriers that impact access to care:

1. Changes in welfare policies have contributed to a decline in Medicaid coverage; many people leaving welfare take jobs without health care coverage and are unaware that Medicaid is still available.
2. Changes in demographics, including an increase in minority and immigrant populations, negatively affect access to care.
3. The design of the health care delivery system imposes a variety of obstacles to timely access to health care services. These include: the lack of transportation or childcare, evening or

weekend hours, inadequate staffing, problems with language and cultural differences, lack of respect, and others. Some employers that do not offer sick time or flexible hours have employees who often delay seeking care, which ultimately leads to a higher cost of care and loss of productivity.

4. Adults without dependent children are ineligible for subsidized health coverage and fall through the cracks between government and employer-sponsored coverage.
5. Critical health care needs include oral care and mental health; these are often neglected due to lack of insurance or inadequate coverage.
6. Many areas around the country are experiencing a shortage of primary care physicians and other medical professionals. There are too few minority professionals to meet the needs of vulnerable populations.[38]

Changes in Welfare Policies

During the 1996 welfare reform legislation, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) allowed families and children leaving cash assistance to remain eligible for Medicaid health benefits. States are required to provide Medicaid coverage to all families that meet the income and family structure guidelines.[39] Although many people remain eligible for Medicaid benefits, they have not enrolled.

As people transition from welfare to work under new program rules, some are losing Medicaid coverage that they are still eligible to receive. As a result of not enrolling eligible children, nearly 6 million remain uninsured.[40] A 1997 National Survey of America's Families found that a majority of women who left welfare were working, though not all had insurance coverage. Only 36 percent reported having Medicaid, 23 percent obtained private or employer-sponsored insurance, and only 4 percent were covered under other forms of public health insurance. Consequently, approximately 40 percent of women who were previously covered under welfare are now uninsured.[41]

Several reasons may be to blame for low enrollment levels in this group:

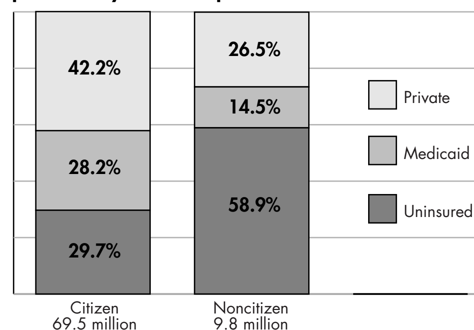
1. The stigma attached to Medicaid could deter some former welfare recipients from applying to Medicaid again.
2. PRWORA has increased the complexity of the Medicaid eligibility rules.
3. State administrative burdens such as complicated application forms and in-person interviews may place an undue hardship on newly working persons.
4. The complexity of new eligibility rules is difficult even for caseworkers to understand, though it is their responsibility to educate eligible families.[42]

Increase in Minority and Immigrant Populations

Immigrants are an integral part of the U.S. economic and social infrastructure, adding to the country's diversity. Despite this important role, immigrants disproportionately lack health coverage and receive fewer services than native-born citizens.[43] Low-income immigrants are twice as likely to be uninsured as low-income citizens. Of the 9.8 million low-income citizens, almost 59 percent had no health insurance in 1999 and only 15 percent received Medicaid.[44]

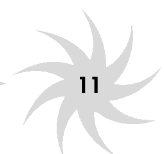
Figure 1 shows the comparison between citizen and noncitizen health insurance coverage. Approximately 30 percent of low-income citizens were uninsured and about 28 percent had Medicaid.

Figure 1: Health Insurance Coverage of the Low-Income Population, by Citizenship Status, 1999



Source: Urban Institute estimates based on March 2000 CPS data prepared for the Kaiser Commission on Medicaid and the Uninsured.

Note: Low-income is less than 200 percent of poverty; low-income population is the nonelderly only.

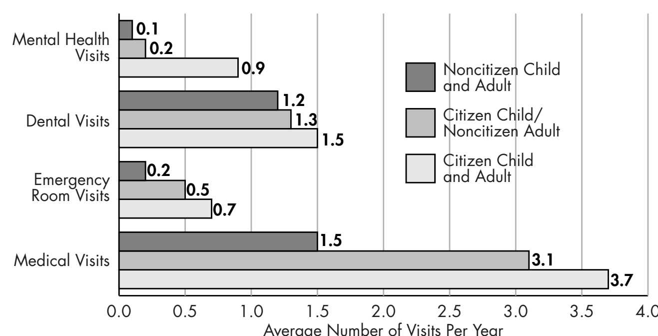


Furthermore, there are wide variations in insurance coverage among foreign born. While Southeast Asian children have low rates of uninsurance due to their refugee status, Latino immigrant children have very high rates of uninsurance. This is of particular concern because Latinos make up 55 percent of all children in the immigrant population.[45]

Immigrants face other barriers to care in addition to lack of insurance coverage, and they experience poorer access to health care services than do citizens. One way to measure access to care is to determine if a child has a usual source of care. This may be a person or place to which a child usually goes for treatment when sick, for health advice, or for routine medical care. A 1997 study showed only 66 percent of low-income children in noncitizen families had a regular source of care compared to 92 percent of children in low-income citizen families.[46] For low-income adults, 37 percent of noncitizens reported not having a usual source of care compared to 19 percent of citizens. In addition, children of immigrants have fewer mental health, dental, and medical visits than children of citizens, as is shown in Figure 2.[47]

Delay in seeking care may also be a problem for children in immigrant families when compared to children in native-born families. A delay of more than one year since seeing a physician was more likely for noncitizens than for uninsured citizen children, regardless of health status.[48]

Figure 2: Health Care Utilization for Low-Income Children, by Citizenship Status, 1997



Health Care Delivery System

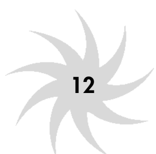
Even when families and children have access to health care coverage, this does not guarantee quality services. There are a number of barriers that affect the quality of care, some of which include:

1. **Language barriers**: These include a lack of interpreters or bilingual staff and insufficient written materials in multiple languages or at appropriate reading levels.
2. **Transportation to primary care services**: There is a lack of neighborhood clinics or clinics along public transportation routes.
3. **Reduction in safety net providers**: Safety net providers cannot remain financially viable in the changing health care market.
4. **Hours of operation**: Clinic and physician offices do not offer extended hours and weekend hours to accommodate working parents who may have difficulty seeing a health care provider during the workday. Also, there may be long delays in getting an appointment and additional delays before seeing the provider once a person arrives for the appointment.
5. **Childcare**: Sick children or siblings face a lack of childcare.
6. **Culturally sensitive care**: There exists a lack of understanding of cultural diversity of population.

These noninsurance barriers are especially problematic for vulnerable populations such as minorities, non-English-speaking immigrants, and those with special health needs.

Eligibility for Subsidized Coverage

Many low-income adults without dependent children are ineligible for Medicaid. This group includes adults with many chronic illnesses or special health problems. It includes people working at low-wage jobs that do not offer health insurance benefits and people who are unemployed. This group cannot afford to purchase health insurance on their own.



Critical Health Needs

Many people are not receiving dental care, mental health care, and other medical services outside of the traditional medical model. Neglecting these services can have an impact on a person's emotional and physical health. Oral diseases restrict activities in school, work, and home and often diminish the quality of life of those who suffer the worst. Poor oral health affects mortality, general health, nutrition, digestion, speech, social mobility, self-image, self-esteem, and overall well-being.

Mental health is another area that is often neglected and has a tremendous effect on individuals, families, and the economy. Major depression is the leading cause of disability. A variety of barriers prevent people from accessing care for mental health services: (1) lack of insurance for 16 percent of the population; (2) underinsurance for mental health; (3) lack of trust and negative past encounters; and (4) stigma associated with mental health disorders.

Paul Melinkovich, M.D., director of the Denver School-Based Health Centers, has stated that these barriers are especially problematic for adolescents. According to Melinkovich, teenagers with and without insurance coverage have difficulty accessing mental health services due to a limited provider network, especially for inpatient substance abuse treatment. For a variety of reasons including lack of trust, lack of resources, or denial, this age group notoriously delays seeking care.[49]

Labor Shortage

Access barriers are augmented by the fact that there is a critical shortage of health care providers in some communities and an overabundance in others. There is a lack of practitioners in inner-city neighborhoods, rural communities, and other underserved areas. In addition, recruiting minorities into professional training programs is inadequate to meet the needs of vulnerable populations.

Access to Care in Colorado

Colorado has some unique characteristics that impact access. Many aspects of access are related to the state's geography, demographics, and political thinking of the state's legislative bodies. Although 31 of its 64 counties are classified as "frontier," only 15 percent of the state's population lives in non-metropolitan areas.[50] Health policy developments in Colorado have emerged from political debates between conservatives and liberals, as well as between urban and rural groups. Colorado's policymakers have been able to balance the competing requests of these different groups, which have led to incremental changes in health policy.

Insurance

Colorado implemented a Medicaid managed care program in 1974 when it contracted with Rocky Mountain HMO to provide health coverage in rural Colorado. By 1993, there were only 10,000 Medicaid recipients enrolled in Rocky Mountain HMO. It was felt that this low enrollment was due mainly to the lack of mandates or incentives to join. In 1995, several safety net providers formed a Medicaid HMO called Colorado Access. The state initiated a rollover strategy, which meant that the Medicaid enrollees who were being cared for by these safety net providers were automatically enrolled in Colorado Access. In early 1996, Colorado Access had 55 percent of the state's Medicaid HMO enrollees—more than twice as many as the next leader, Rocky Mountain HMO.[51]

Most rural communities do not have a wide range of health insurance options to choose from; most are lucky to have any. Whether it be private, employer-based, or a managed care plan, most carriers have found it difficult to penetrate rural Colorado. In fact, several plans have recently withdrawn coverage from rural areas for three main reasons: (1) the lack of an adequate provider network, (2) high costs/poor reimbursements, and (3) the lack of acceptance of managed care by residents and physicians.[52]

According to Florine Raitano, D.V.M., the executive director of the Colorado Rural Development Council, health insurance coverage is a big

problem in rural Colorado and is getting worse. Insurance carriers are leaving the marketplace despite an increase in population.

State Commissioner of Insurance William Kirven III confirmed that in the past 18 months, 13 companies have withdrawn from the small group market in rural Colorado. The small group market insurance products provide health coverage to businesses with one to 50 employees. In 1998 there were 536,367 individuals covered by small group plans in rural Colorado compared to 478,344 in 1999.

The problem is exacerbated by the fact that, in many cases, there was only one carrier bidding on the contract, and premiums were too expensive for the small business owners and their employees to afford. As a result, the number of small businesses offering health coverage drops as insurance carriers leave the marketplace. Once a carrier leaves a market, state law requires a five-year waiting period before the carrier may return to that market. Current state law does not allow insurance premiums to be based on the health status of the employee. Therefore, a healthy "group of one" can obtain insurance less expensively by switching to the individual market, and a high risk "group of one" basically gets a discounted premium by leaving the individual market. Consequently, Colorado's small group market experiences adverse selection and must leave the market or raise premiums for everyone.

Provider Network

Another major problem facing some communities in Colorado is the lack of providers. Although access to an adequate provider network has improved in rural Colorado over the past 25 years, it still does not meet the needs of many communities. In some rural communities such as Trinidad, there are no specialty physicians providing obstetrical care; no physicians are capable of performing a Cesarean section. Pregnant women must travel 90 miles north to Pueblo or 22 miles south to Raton, New Mexico. However, this is not just a rural issue. In some urban areas there may be enough practitioners, but some specialists are not accepting managed care insurance plans, especially Medicaid and Medicare. Enrollees in these plans may have an added hardship of traveling to another community to access care.

Some practitioners are leaving clinical practice altogether due to changing practice environments. Doctors have cited the difficulties of forming partnerships with their patients as one reason for leaving medicine. Plans and networks change often, which results in a lack of continuity for doctors and their patients. When experienced providers leave private practice, patients are left to find another doctor. When plans change networks, patients often have no other choice but to change doctors.

Health Problems

Access to quality health care remains a big concern for populations with certain health problems. Access to oral health care is one particular issue. Low-income children and adults throughout Colorado suffer from tooth decay and dental disease because they face significant barriers to obtaining dental care. The Colorado Commission on Children's Dental Health was charged with studying key policy issues related to improving children's oral health and to provide recommendations on how to improve the current delivery system. The commission began studying the problem in May 2000 and identified five broad themes:

1. Low-income and at-risk children have severe and urgent oral health care needs.
2. Many children lack access to oral health care services.
3. There are important differences between pediatric and adult dental services.
4. There is a dental workforce shortage in Colorado.
5. Parents, guardians, and other adults play a critical role in the oral health of children insofar as they recognize the importance of oral health, value prevention, and appreciate the provider's time.[53]

Mental health care, especially mental health services for adolescents, is another area of concern in Colorado. This group may experience inadequate health insurance coverage and have difficulty paying for needed services out-of-pocket. School-based health centers have implemented mental health programs to care for this group to try and address its unmet needs.

The financing of mental health services has changed. Medicaid has moved to a capitated payment model to control costs. A fixed amount of money is paid per member per month to a provider regardless of the treatment the member receives. Proponents of mental-health managed care argue that capitation should motivate professionals to pursue secondary and tertiary prevention, which allows for early detection and treatment of mental illness.[32] In a Colorado study, researchers found the cost of service was significantly reduced in counties with capitated services as compared to counties with the more traditional method of paying for care—fee for service. Findings also suggested that the financial incentives might also lead to secondary and tertiary prevention.[54]

Recommendations

Many strategies have been noted in the literature for improving access to care. Some of these reflect the need to increase insurance coverage to the uninsured, but other strategies focus on noninsurance strategies. The following recommendations come from the literature, interviews with key professionals in Colorado, and the Turning Point Steering Committee.

Insurance Strategies

Uninsured Coloradans experience decreased access to care and barriers to preventive care leading to poor health outcomes, and reduced quality of life. This is a significant public health issue. Extending insurance coverage to these citizens is an integral component of a multidimensional strategy to improve access to quality health services. The Colorado Turning Point Initiative Steering Committee believes action needs to be taken immediately to ensure that all Colorado residents have the opportunity to get insurance coverage and maintain their health.

Medicaid and State Child Health Insurance Plan Expansion

One study showed that of the 9.7 million uninsured parents in the United States in 1997, as many as 3.5 million living below the federal poverty level could readily be made eligible for Medicaid under current federal law, but to-date only a few states have expanded coverage to meet federal guidelines.[55] Forty-three percent of these uninsured parents already had a child covered by Medicaid in 1997, which could facilitate the eligibility process.

Some states are expanding eligibility requirements of their State Child Health Insurance Plan (SCHIP) as well as aggressively seeking and implementing new and innovative ways to identify and enroll uninsured children in SCHIP and Medicaid. Some examples include a joint Medicaid and SCHIP application, guaranteed eligibility for 12 months, simple mail-in applications, presumptive eligibility for children that need immediate access to health care, and automatic notification of families when it is time to re-enroll.[56]

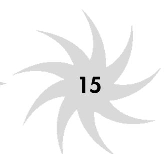
Physician Practice Management

One way to improve access to medical care is to reduce delays in appointment scheduling at primary care and specialist practices. Some innovative management techniques include same-day scheduling, provider teams to manage workload collaboratively, use of e-mails to communicate with patients, and group patient care visits.[57]

Programs to Recruit Physicians to Rural and Underserved Areas

The shortage of physicians in rural areas has been a longstanding problem and has serious implications for access to care. The National Health Service Corp (NHSC) is a program of the Federal Health Resources and Services Administration's Bureau of Primary Health Care, which is the focal point for providing primary health care to underserved and vulnerable populations. Its mission is to increase access to primary care services in health professional shortage areas. NHSC assists communities in recruiting and retaining community-responsive, culturally competent primary care clinicians. NHSC has several programs:

a. Loan Repayment—Several categories of health professionals including primary care physicians, nurse practitioners, physician assistants, nurse-midwives, dentists, dental hygienists,



and mental health professionals are eligible for educational loan repayment programs.

b. Scholarships—Payment of tuition, books, supplies, and a monthly stipend is available for those eligible health professionals willing to work in designated areas that need various health care workers.

According to Richard Krugman, M.D., Dean of the School of Medicine at the University of Colorado, both of these programs offer some relief to communities in need; however, the programs can be made more financially attractive. A recently graduated physician accrues approximately $83,000 in debt and Dr. Krugman believes new physicians would work with uninsured and underserved populations if state and federal assistance helped them with ways to repay their loans.[58]

Colorado Tax Credit Law for Health Professionals

The Colorado Legislature amended the tax credit law in 2001, for health care professionals practicing in rural health care professional shortage areas. This amendment makes a tax credit available for health care professionals to use during the time of their loan repayment period. The amendment provides a financial incentive to encourage health care professionals to locate in medically underserved areas of the state of Colorado.

The Physician Shortage Area Program of Jefferson Medical College in Pennsylvania is another program that has successfully placed family medicine physicians in rural and underserved areas since 1974. This program recruits and admits medical school applicants who have grown up in rural areas and intend to practice family medicine in rural and underserved areas upon graduation. This program has a very high rate of retention—twice that reported by the National Health Service Corps.[59]

Community Partnerships

Both urban and rural communities face enormous challenges in improving access to quality health care. In a recent article in the *Journal of Public Health*, Dr. Dennis P. Andrulis suggested that health care improvement efforts focus on three priorities:[60]

1. Structural changes in the health care system must acknowledge new population dynamics such as cultural diversity, growing numbers of the elderly, those in the welfare-to-workplace transition, and those unable to negotiate the increasingly complex health system.
2. Communities and governments must assess the consequences of health professional shortages, safety net provider closures and conversions, and new marketplace pressures on access to care.
3. Governments at all levels should use their influence through accreditation, standards, tobacco settlements, and other financing streams to educate and guide providers in the directions that respond to their communities' health care needs.

Streamline Documentation Procedures

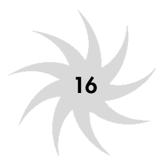
Enrollment procedures need to be streamlined so that enrolling does not become its own entry barrier. When standards for eligibility are met, a family's needs should be determined through one simplified process. Applications need to be processed in a timely fashion; determinations on eligibility need to be made expeditiously.

Coordinate the Delivery System

Public health and its partners should define and coordinate a rational delivery system that may include both private health systems and a substantial role for the "safety net system." The partnerships among provider systems should be strengthened in order to provide effective and efficient care. Health education about preventive services should be offered at the first point of contact in order to increase use of preventive services and practices.

Advocate for Regulatory Reform

Regulatory reform/relief is needed regarding mandated benefits, documentation and the reporting requirements to government agencies. These requirements need to be better balanced with accountability. A system enabling automatic enrollment in Medicaid and SCHIPs based on tax filings would be more efficient than the present system.



Too many resources are spent on monthly eligibility checks. While the objective is to prevent fraud, the current system discourages physicians from taking Medicaid clients for fear they might be deemed ineligible during the month. A system where eligibility is valid for 12 months should be researched.

Provide Incentives

Insurers should provide incentives for those who utilize preventive services. These incentives could include elimination or reduction of co-pays—or discounts on other products and services.

Utilize Research

Research can be used in a variety of capacities. Studies can determine what kinds of outreach and enrollment procedures are effective among certain populations. Research can also help determine what motivates individuals and families to seek improved access to care through insurance programs, and conversely, what barriers exist that prevent individuals from discovering this relevant information and hinders their enrolling.

Offer Training and Technical Assistance

When effective outreach and enrollment strategies are identified, a training and technical assistance program can help other communities replicate the best practices.

Promote the Provision of Culturally Competent Services

Culture is not simply defined by ethnicity and language. In today's society, assuring quality health care for all persons requires that physicians understand how each patient's sociocultural background affects their health beliefs and behaviors. Access to language interpretation and translation services are also an important aspect of cultural competency.

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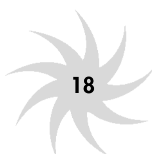

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