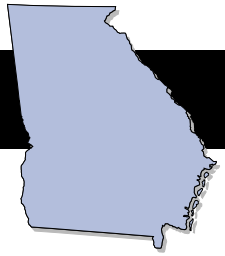
9-30-2003

Assessment of Georgia's primary care safety net

Georgia Health Policy Center



GEORGIA HEALTHCARE COVERAGE PROJECT

Assessment of Georgia's Primary Care Safety Net

Between September 2002 and February 2003, the National Center for Primary Care at Morehouse School of Medicine assessed the availability of low-cost or sliding-fee primary care services for the uninsured throughout Georgia. This assessment identified affordable primary care services available to patients with a broad range of presenting conditions. To ensure that all aspects of the primary care safety net were taken into consideration, a wide variety of sources of information were used. Sources included a survey of district health officers, an information request made to Georgia's Division of Public Health, the Health Resources and Services Administration (HRSA) Uniform Data Set and the HRSA Health Professional Shortage Areas database, the Georgia Association of Primary Healthcare, the State of Georgia's Office of Rural Health, the American Medical Association Master File database, the Georgia Hospital Association, and the Grady Health System. This report summarizes key findings.

"Primary care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Institute of Medicine, 1996[1]

What is a primary care safety net?

To be counted as part of the primary healthcare safety net, a health center or healthcare professional must provide the full range of services typically provided in a family physician's office. In other words, the provider must offer services that meet 85-90% of the healthcare needs of patients in all age groups. Services must be:

Available – involving sufficient numbers of primary healthcare physicians, nurse practitioners, and physician assistants to serve the population in the surrounding area, in practices that are accepting new patients.

Affordable – services offered on a "sliding-fee scale."

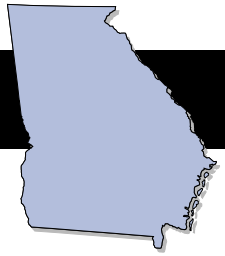
Accessible – within close physical proximity and deliverable within a reasonable number of days during normal weekday business hours (and, ideally, on some evenings and weekends).

Acceptable – having bilingual staff and health professionals or, at a minimum, a mechanism for language translation and a workforce who understands use of language and behaviors and treats patients with respect and dignity.

Comprehensive – offering healthcare for 80-90% of the health needs of patients from all age groups, from newborn to end-of-life. This includes preventive services (such as immunizations and cancer

Common Characteristics of Safety Net Providers

Available
Affordable
Accessible
Acceptable
Comprehensive
Connected



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Currently Uninsured
1.01 million Georgians
144,496 children

Uninsured At Any Time In the Past Year
1,347,580 Georgians

Continuously Uninsured For the Past Year
664,707 Georgians

screening), acute care (earaches, flu, back pain, etc.), and care for chronic diseases (arthritis, asthma, diabetes, hypertension, and heart disease) available during any hours that the practice is open.

Connected – being able to link and refer patients to higher levels of secondary and tertiary care, both within and beyond their own communities.

Who in Georgia needs a primary care safety net?

Over 1 million Georgians, including 144,496 children, currently have no health insurance coverage. An estimated 1.35 million persons experienced some period of being uninsured during the previous 12 months, and 664,707 persons were uninsured continuously for the entire year. Many other individuals feel trapped in their current jobs, because leaving those jobs might mean losing their health insurance coverage. Still other Georgians have health insurance but live in underserved rural or inner city neighborhoods, or may face cultural or language barriers when they seek needed healthcare.

Georgia has no cohesive primary care safety net. Rather, there is a scattered number of small dip nets, straining under the weight of their current loads and unable to catch patients who fall between them.

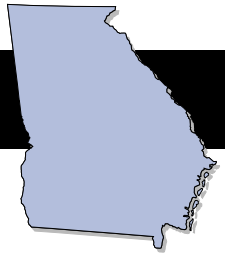
What is Georgia's safety net?

There is no organized, cohesive approach to assuring a primary healthcare safety net for all Georgia communities or citizens. Instead, Georgia's safety net has many layers, with different government agencies and healthcare organizations and individual providers each offering some primary care services in certain geographic areas to some segments of the population in need. Georgia has a scattered collection of safety net providers consisting of community health centers (CHC), county public health clinics, federally-qualified health centers (FQHC), community mental health centers, and hospital-based healthcare (public sector and private not-for-profit).

Community Health Centers. The Health Resources and Services Administration's Bureau of Primary Healthcare (HRSA/BPHC) funds 19 Community Health Center organizations in Georgia, whose clinics and satellites comprise a total of 81 primary care delivery sites.

County Health Department Facilities. Georgia's state and county health departments offer many categorical services (family planning, immunizations, etc.) to uninsured and other underserved Georgians, but may also offer more comprehensive primary care services as well.

Hospital-sponsored Outpatient Clinics or Networks. Public hospitals, such as Grady Health System in Atlanta, offer primary care in outpatient clinics and neighborhood satellites. Georgia's



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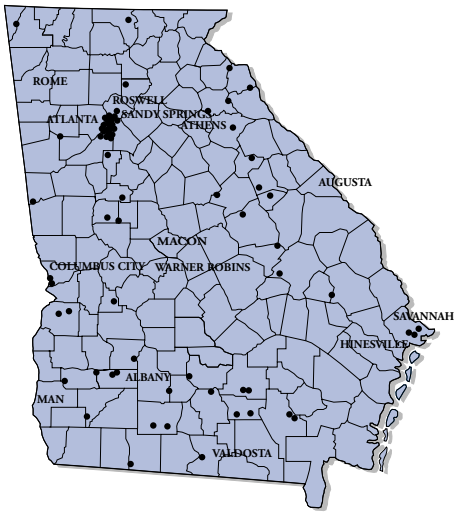
Community Health Center Primary Care Clinic Sites



3-C's for Completing the Primary Care Safety Net

Clinic Sites

Capacity

Coordination

hospitals also provide some outpatient indigent or charity care and report spending roughly $1 billion dollars in unreimbursed costs for hospitalization of uninsured patients.

Indigent Care Trust Fund/Disproportionate Share Hospital Programs. Hospitals that treat a "disproportionate" number of Medicaid and other indigent patients qualify to receive federal Disproportionate Share Hospital (DSH) payments through the Medicaid program. The Indigent Care Trust Fund represents the largest component of DSH payments. Fifteen percent of the state's Indigent Care Trust Fund dollars are explicitly awarded to Georgia hospitals specifically for "primary care" programs. Roughly one-fourth (27%) of these support programs provide comprehensive primary care services to low-income or uninsured clients.

Private-sector Religious and Charitable Organizations. Some charitable organizations operate full or part-time clinics, often with volunteer physicians and nurses. These clinics are essential in providing services to specific immigrant groups or other underserved populations.

Private Practice Physician Offices. Georgia physicians and other healthcare professionals workin g in private practice often care for uninsured and other underserved patients, but typically cannot offer up-front discounted charges or sliding fees for the services they provide.

Community Coalitions and Rural Health Networks. In several Georgia counties, coalitions of community-based organizations and/or healthcare providers have banded together to provide more structured mechanisms for providing primary healthcare to the uninsured. Since 1999, the Georgia Health Policy Center and the Office of Rural Health Services, with funding from Georgia's Department of Community Health, has provided technical support for the development of rural health networks. These networks have demonstrated tremendous success in bringing together key stakeholders to achieve *coordination* of services for patients in need. Through the inclusion of private practitioners they may expand *clinical delivery sites*. However, they have also demonstrated that their impact will be limited if they do not have the ability to expand *capacity* in terms of high volume patient care for low-income and uninsured patients.

Emergency Rooms. Individuals who lack access to primary health-care are significantly more likely to seek care in hospital emergency rooms, even for non-emergency conditions.[2] When they do experience medical emergencies, they are less likely than insured patients to be

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admitted to the hospital for the same level of severity of illness.[3] Even patients who obtain primary healthcare may have care that is less than optimal.

Where are the holes?

Despite the number of agencies and organizations providing healthcare to the uninsured and other underserved populations, the current level of statewide or even regional planning and coordination of services is not sufficient to assure coverage for all Georgians. Five gaping holes preclude Georgia from having one cohesive safety net for the delivery of primary care.

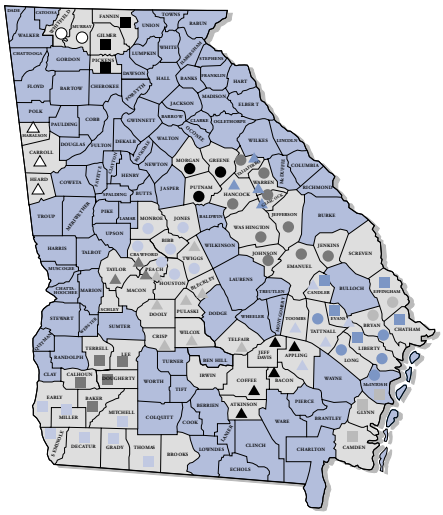
Rural Areas. Many rural counties have inadequate numbers of primary care physicians, large proportions of the population with no health insurance, struggling hospitals, and no safety net clinic. Thirty-nine counties have been designated as high priority primary care access areas, based on their shortages of health professionals, poverty rates, and excess mortality.[4] As of 1996, there were 101 counties that needed more family physicians, including eight counties with not even one family practitioner.[5] Rural hospitals which provide supporting infrastructure for primary care are also in jeopardy. Seven general hospitals closed between 1990 and 1997; five were in rural areas. Since that time, significant nursing shortages as well as increasing malpractice insurance costs have created additional threats to the survival of rural hospitals.

Urban Areas. A plethora of healthcare safety net agencies overlap each other's coverage areas, provide high-volume services, and still have inadequate capacity to serve all the low-income and uninsured patients in need. In part, this may be due to the lack of coordination between agencies for allocation of resources and integration of services.

Suburban Areas. Rapid growth in outer suburbs has brought the healthcare needs of an urban population to communities that did not traditionally require a large safety net infrastructure. The growth of jobs in small businesses and industries that do not offer health benefits to their workers has led to the need for new primary care safety net services.

Immigrant Populations. Georgia's rapidly growing immigrant populations may face significant language and cultural barriers to care in a system that historically has viewed cultural diversity in black and white. The Hispanic and Latino population has grown by 300% in the past decade and has the highest rates of being uninsured among all ethnic groups in Georgia.

Rural Networks



Counties participating in networks funded by the Philanthropic Collaborative for a Healthy Georgia and/or Georgia's Office of Rural Health Services

- Albany Area Primary healthcare
- Appalachian Health Aliance
- Archbold Memorial Hosp.
- Coastal Medical Access Project
- Coastal Rural Health Corp.
- East Georgia Health Cooperative
- Greene Morgan Putnam Health Net
- healthcare Central Georgia
- HIP Community Network
- Liberty Regional Network
- NW Ga. healthcare Partnership
- Peach Care Rural Health Network
- Perinatal Health Partners
- South Georgia Access Network
- Taylor Regional Health
- Tri-Cnty Plus Rural Health Net
- W Ga Chronic Disease Institute

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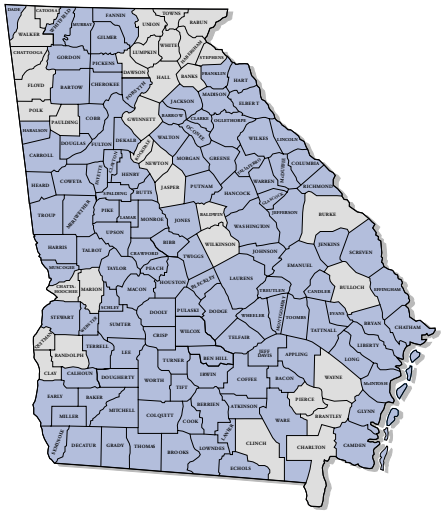
Georgia Counties with No Federal or State/County Primary Care Clinic Sites



Baldwin	Dawson	Polk
Banks	Floyd	Quitman
Brantley	Gwinett	Rabun
Bulloch	Habersham	Randolph
Burke	Hall	Rockdale
Catoosa	Jasper	Stephens
Chattahoochee	Lumpkin	Union
Chattooga	Marion	Walker
Charlton	Newton	Wayne
Clay	Paulding	White
Clinch	Pierce	Wilkinson

Georgians With Chronic Illness or Disabilities. Individuals with chronic illnesses or disabilities as well as mental health problems often have "primary care" needs that go beyond the scope of services provided by public health or primary care safety net clinics. Their needs may include sub-specialist care and sophisticated ancillary services, as well as special transportation or home healthcare and coordination of care between various fragmented service programs.

What is the cost of an insufficient safety net?

An estimated 772,947 outpatient primary care safety net visits are being provided to uninsured Georgians each year. This number compares to a projected need of almost 3 million outpatient visits. Thus, Georgia's current safety net is meeting only 25% of the need for adequate primary healthcare.

Similarly, roughly 266,533 uninsured persons, or one-quarter of Georgia's currently uninsured population and one-third of Georgia's chronically uninsured, are being served by existing safety net providers.

Georgia pays a substantial price for an insufficient primary care safety net, in terms of both human suffering and economic costs. While the total cost is difficult to calculate precisely, a proxy measure is the cost of uncompensated hospital care for the uninsured. In 2000, Georgia hospitals spent nearly $1 billion for indigent care and unreimbursed services to the uninsured.

How can a safety net be assured for all Georgians?

To complete Georgia's safety net, services must be expanded until they cover all geographic areas of the state, creating a seamless web of healthcare providers in each community, county, and region. At the same time, the capacity of existing centers must be expanded to serve the growing number of patients in need.

Six essential steps are recommended for creating a secure primary healthcare safety net for all Georgians.

1. Assess the status, location, services, and capacity of each safety net provider and private sector source of care for the uninsured in each county or district.

2. Build capacity by investing in existing safety net health centers until they are able to meet our growing needs. Build new safety net health centers in communities where existing healthcare practitioners and hospitals are unable to add capacity to serve the uninsured.

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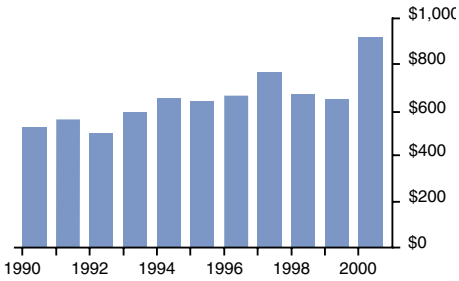
Uncompensated Hospital Care for the Uninsured, in Millions



3. Coordinate services between county and district health departments, HRSA-funded health centers, private practice physicians, and community hospitals to develop provider networks or integrated service delivery networks to coordinate the care of uninsured patients in the most cost-effective manner across all levels of care in each district.

4. Direct medical education funds toward training programs that produce the health professionals Georgia needs most, notably primary care (generalist) physicians, and health professionals that will serve Georgia's low-income, rural, and inner-city underserved.

5. Engage all potential providers from both public and private sectors in district-wide planning and coordination of care for the indigent and the uninsured. Contract with willing providers to make primary care and preventive services available to all patients through a subsidized sliding fee scale based on family income.

6. Follow-up initial efforts with a continuous and proactive process of planning, coordinating, building, investing, and monitoring to create and maintain a secure primary healthcare safety net for all Georgians.

[1] Primary Care: America's Health in a New Era. Report from the Institute of Medicine, 1996, p. 31.

[2] Bond TK, Stearns S, Peters M. Analysis of chronic emergency department use. Nursing Economics, 1999; 17(4):207-13.

[3] Sox CM, Burstin HR, Edwards RA, O'Neil AC, Brennan TA. Hospital admissions through the emergency department: does insurance status matter? Am J Med, 1998; 105:506-12.

[4] Georgia Office of Rural Health and Primary Care. Rural healthcare Plan. May 1998.

[5] Dever A. Physician Workforce 1996. Georgia Joint Board of Family Practice, 1996.

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