

Barriers... Access Barriers... Risk Factors for Access Problems: 4.14.11

HISTORY

Access needs to be addressed by this process. Clearly, access is addressed in other ways, but not directly. This is a piece of the puzzle – doesn't have to be part of some big index.

A population subcommittee workgroup came up with a big list of risk factors for access problems (*called "barriers"*) and categorized them into four groups "buckets". The list of was derived from a review of the research/literature from the Commonwealth Fund, the Robert Wood Johnson Foundation, Kaiser Family Foundation, George Washington University Center for Health Policy, Institute of Medicine, UCLA Center for Health Policy Research, Urban Institute, AHRQ. The list also included barriers identified by the Advisory Committee at its second meeting in October 2010.

<p><i>Geographic/ Environmental Barriers:</i> rural isolation, health professional shortages, lack of transportation</p> <ul style="list-style-type: none"> ✓ Lack of availability ✓ Exposure to crime, violence, and social disorder, such as the presence of trash ✓ Social support and social interactions ✓ Exposure to mass media and emerging technologies, such as the Internet or cell phones ✓ Transportation options – both urban, rural, and frontier ✓ Actual travel time ✓ Convenience – location and integration ✓ Public safety ✓ Residential segregation ✓ Natural environment, such as plants, weather, or climate change ✓ Geographical barriers ✓ Built environment, such as buildings or transportation accessibility ✓ Worksites, schools, and recreational settings ✓ Housing, homes, and neighborhoods ✓ Exposure to toxic substances and other physical hazards ✓ Physical barriers, especially for people with disabilities ✓ Aesthetic elements, such as good lighting, trees, or benches ✓ Physical activity (not sure if this is where this belongs) ✓ Seasonal influx of workers (not sure if this is where this belongs) ✓ Frontier and island geographies where populations are sparse ✓ The lack of locally available services 	<p><i>Language and Cultural Barriers:</i> lack of linguistic competence, health beliefs and behaviors, societal stigma</p> <ul style="list-style-type: none"> ✓ Lack of availability ✓ Limited language access ✓ Social norms and attitudes, such as discrimination ✓ Age ✓ Sex ✓ HIV status ✓ Inherited conditions, such as sickle-cell anemia, hemophilia, and cystic fibrosis ✓ Carrying the BRCA1 or BRCA2 gene, which increases risk for breast and ovarian cancer ✓ Family history of heart disease ✓ Diet ✓ Survey bias in English/sometimes Spanish-underreporting health status, access barriers, utilization amongst Linguistically Isolated and Disabled ✓ Literacy ✓ Dominant Culture ✓ Trust ✓ Eligibility Culture: Documentation, ban on new legal immigrants, prison re-entry ✓ Military Traumatic Stress
<p><i>Organizational Barriers:</i> issues related to health facility operation, providers lack of training or experience managing specific patients or inter-related conditions, availability of medical providers, practice decisions affecting ability to meet needs of certain populations</p>	<p><i>Socioeconomic Barriers:</i> such as poverty, lack of health insurance, low educational attainment</p> <p>Insurance-related:</p> <ul style="list-style-type: none"> ✓ lack of insurance,

<p>Facility</p> <ul style="list-style-type: none"> ✓ Hours facilities are open ✓ Appointment waiting times ✓ Physical barriers, especially for people with disabilities ✓ Practice decisions driven by provider versus client/patient needs, e.g., location, hours, services, federal program and third-party contracting ✓ Medical provider productivity requirements, i.e., amount of time allotted to spend with patients per medical visit ✓ Physical, structural, environmental barriers, e.g., facilities ✓ Lack of availability Information systems not connected with Tribal [information] systems ✓ Linguistic and language capabilities Does not accept Medicaid and/or Medicaid <p>Medical Provider/Clinical Expertise</p> <ul style="list-style-type: none"> ✓ Unawareness of [population] service [needs] ✓ Lack of experience and training in conditions affecting underserved population, e.g., tuberculosis, sexually transmitted diseases, obesity ✓ Lack of providers with HIV expertise or unwillingness to treat HIV disease Providers untrained or resistant to caring for people with disabilities ✓ Provider ill-equipped to meet needs of local population ✓ Medical staff turnover and staff vacancies ✓ Lack of [certain] provider types <p>Service Delivery</p> <ul style="list-style-type: none"> ✓ [Not a] medical home care ✓ Lack of interdisciplinary medical professional team approach to primary care (reworded) ✓ Emphasis on Allopathic medicine ✓ Does not provide comprehensive care, e.g., mental health care, management of multiple chronic conditions, no specialty expertise, inter-professional teams with primary care ✓ [Poor medical management] leads to preventable hospital admissions <p>Other</p> <ul style="list-style-type: none"> ✓ Medicaid and Medicare reimbursement levels (This might belong under socioeconomic too) ✓ Lack of reimbursement for non-physician professionals, e.g., midwives ✓ [High or] increased malpractice insurance premiums ✓ State laws or regulations restrict role of providers, e.g., nurse practitioners and physician assistants ✓ Stockpiling illness (not familiar with this item) 	<ul style="list-style-type: none"> ✓ underinsurance, ✓ limitations of coverage. <p>Financial:</p> <ul style="list-style-type: none"> ✓ inability to pay for care, ✓ out-of-pocket expenses, ✓ variability in cost of living, ✓ population segments excluded from coverage, ✓ IHS underfunding. <p>Social status:</p> <ul style="list-style-type: none"> ✓ social determinates, ✓ factors related to social support networks, ✓ ability to function in medical environment (e.g., follow instructions, complete paperwork). <p>Age-related:</p> <ul style="list-style-type: none"> ✓ children in care of non-biological parents, ✓ elderly living alone, ✓ youth with disabilities transitioning to adulthood. <p>Education-related:</p> <ul style="list-style-type: none"> ✓ low education levels, ✓ poor quality schools. <p>Danger:</p> <ul style="list-style-type: none"> ✓ providers in unsafe environment when offering care, ✓ population fear for personal safety when seeking care. <p>Personal decisions affecting health:</p> <ul style="list-style-type: none"> ✓ diet, ✓ physical activity, ✓ use of alcohol, cigarettes and other drugs. <p>Fragmentation of care: requiring lack of cohesion for family members seeking assistance.</p> <p>Interrelationships: between the necessities of daily living and medical well-being.</p>
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LATER... the list of risk factors (“barriers”) was refined and the workgroup split from the population subcommittee to increase cross-fertilization with folks from the original “data” committee. Final factors were chosen based on group consensus – including discussion of relevance and data availability.

ACCESS BARRIERS (risk factors)
Geographic/Environmental
Geographical/Seasonal Barriers
Public Safety
Neighborhoods
Physical
Language/Cultural
Discrimination and Disparity of Care
Linguistic Isolation/Limited English Proficiency
Immigration Status
Race/Ethnicity
Literacy
Organizational
Provider Capacity
Physical Barriers
Linguistic Competency
Cultural Competency
Quality/Medical Home
Socio-Economic
Coverage
Ability-to-Pay
Educational Attainment



FINAL-ish RISK FACTORS
1. Linguistic isolation/LEP
2. Race/ethnicity
3. Travel time
4. % Uninsured
5. Population density
<i>Others Considered/Suggested</i>
• <i>RUCA</i>
• <i>Childhood Poverty</i>
• <i>Heating/Cooling Days</i>

THEN... we asked JSI to look at the data

- Data run #1 – looked at the prevalence of these 5 factors by county and population. Some mapped as expected, others were surprising. For example, LEP not limited to “expected” geographic areas.
- Data run #2 – looked at how these factors correlate to usual source of care (as measure of access) at county level. Can only run on 2/3 of county (due to lack of data). Found a low correlation for most factors (0.22-0.27).
- Data run #3 – created new maps that show weighting possibilities (if we want to weight factors). *HOLD THIS THOUGHT*
- Data run #4 (pending) – look at correlation with ambulatory care sensitive (ACS) hospitalizations (instead of usual source of care). First look at area (ecologic – census/American Community Survey) and then at individual (population – surveys like MEPS) if area doesn’t work. Hypothesis is that the identified risk factors will correlate with access problems. *BOB TO EXPLAIN MORE WHEN I AM DONE!*

ISSUE SUMMARY

- “Top up” idea - community could get points by identifying an access problem that wasn’t identified in another part of the process.
- Dependent/outcome variables – usual source of care, avoidable hospitalizations or preventable ER visits – data may not always available. Could model for some states. Want to look at population, not just area.
- Index vs. menu method – this was intended to be a menu from the start, but as we heard this am, the term “index” is clearly a more general term than some of us imagined. The general feeling (but NOT a consensus) is that we want to avoid an SDI like index. The next question is what the menu (or simple index) would look like - not just a yes or no, some kind of threshold, choice of factors (1,2... 5), etc.
- To weight or not to weight? Some members of the committee feel strongly that factors should be equally weighted. Hard to decide until we see data – how factors measure against outcomes.
- Need to consider problem of arbitrary decision-making. Model we choose needs to be defensible. [menu approach does not = arbitrary]
- There needs to be both validity and choice. Unique areas and pops are not accounted for in other parts of the rule. What about things that don’t have data? Still important.

Next steps:

- 1) Define leadership and membership. Sherry agreed to be chair. Who is on the committee? Need a good mix that remains somewhat constant. David seems to be free ☺!
- 2) JSI to run data, committee to review results (phone meeting).

- 3) Results will help direct next steps – are these the right factors (do they correlate with access)? What about missing factors/data? How do we create a menu/“index”? How does it fit into the bigger process?