Executive Summary

Safety net health care providers in Travis County experienced a 5% increase in demand for primary care services in 2001, and are projecting a similar increase in demand for 2002. At a cost of almost $100 per visit, this translates to $1.7 million of additional care in 2001, and nearly $1.8 million more in 2002. Only one-quarter of this care is covered by Medicare, Medicaid, or CHIP, meaning that most of it is paid either through local tax dollars or charitable donations. Most providers are experiencing these increases at a time when they are already providing care at capacity, and when both public and charitable resources are being stretched thin. Without both additional capacity and sources of financing this care, it will be difficult, if not impossible, for them to continue to absorb demand increases.

The Indigent Care Coalition (ICC) recently conducted a survey of Travis County safety net providers who are member agencies of the ICC. The survey reveals that these providers are predominantly serving pediatric and adult patients under age 65, a majority of whom they estimate as non-English speaking patients. Data from these providers indicate:

?? Over 90,000 patients were seen in CY 2001, an increase of nearly 4,000 from CY 2000,
?? Nearly one quarter (23%) of those seeking care were between the ages of 0 and12,
?? 58% of those seeking care at an ICC member agency were between the ages 19 and 64,
?? 54% are non-English speaking, and,
?? 75% have either no third party payment source, or are MAP or Seton Care Plus recipients, or are funded through other sources, such as Title V or Title X, which are not considered insurance.

Furthermore, ICC survey data indicate that member agencies experienced an average of 2.74 visits per patient, which is consistent with national ambulatory survey data.

In 2001, Travis County safety net providers had the following capacity:

?? 20 clinic facilities167 exam rooms,
?? 50 full time equivalent (FTE) providers,
?? 1,001 clinical hours of operation per week,
?? 885 medical appointment slots available daily,
?? 1,007 medical appointments booked daily.

The numbers and figures in this report are intended to reflect the current reality for primary health care safety net providers in Travis County. The demand for primary care services at the local safety net provider level may continue to grow and/or fluctuate due to changes in the economy, changes in population and population demographics, changes in provider mix, or changes in the availability of employer-sponsored health insurance.

Introduction

During the 'boom' years in Austin, when the unemployment rate hovered around 1 – 2%, the number of uninsured and under insured individuals in Travis, Williamson and Hays Counties was estimated by members of the health care community to be approximately 200,000. Over the past year, the declining national economy, the number of layoffs in the local high tech community, and the aftermath of the events of September 11th have all led to an increase in the demand for services at local area health and human service providers. Many of these local agencies were already operating at or full or nearly full capacity prior to the events of the past year, and were concerned about the trend they have been seeing in the demand for services.

The Indigent Care Coalition, or ICC, is a coalition of many of the local health care safety net providers in Travis, Williamson and Hays counties. The events and changes over the past year that have affected the majority of local health and human service providers have also affected the ICC member agencies.

In this report, we set out to describe the current use and capacity of major safety net primary care providers in Travis County, based on actual visit data as reported to us by these providers in a recent survey completed in January 2002. Collectively, these data paint a compelling picture of the stress that is currently placed on this safety net, and hint at the growing gap between demand and capacity.

Nevertheless, the data reflect only a part of the overall demand for care in the County. Others, including other community clinics, hospital emergency departments, and private physicians, also work to meet this demand. Further work should be done to describe fully overall community capacity to serve uninsured or underinsured people, and their total current and projected use of the system of caregivers. As one piece of this effort, the ICC is currently evaluating emergency department data.

Many local health and human service agencies have seen their annual charitable contributions decline as a result of the weakening economy and the outpouring of support to the September 11 funds. A November 2001 survey of Social Service and Faith Based Providers by the Community Action Network Community Council in Austin found that 68% of social service agency respondents said they were not able to meet the current demand for their services. The number was even higher (73%) for faith-based providers. The same survey indicates that 33% of social service agencies and 45% of faith-based agencies experienced a decrease in their budgets during the past 6 to 12 months[1].

Health care professionals and administrators of safety net providers in the region have dedicated years of service to keeping the uninsured and under insured as healthy as possible. Recent trends in the numbers and types of individuals seeking services at the safety net provider facilities, however, have these health care veterans concerned. Providers are seeing their waiting lists fill up, forcing them to turn away clients and/or refer them elsewhere for services. With many other local health care providers at capacity as well, this often forces individuals either to forgo care altogether, or to use inappropriately the already strapped local hospital emergency departments for their primary care service needs. However, local hospital emergency departments have also seen an average annual increase in visits of over 6% from 1998 to 2000, raising questions about their capacity to handle a new influx of non-emergency patients while still providing emergency services without unreasonable delays.[2] As a result of these trends and observations from our member agencies, the ICC recently surveyed the Travis County primary care providers in an attempt to document the current realities of the demand for versus the capacity for services among our providers.

Recent Trends In Use

The demand for primary health care services depends on the local population demographics and health status as well as local utilization patterns. A provider can generally see and treat a child in less time and for less money than they would need for an adult or elderly patient with chronic or complex health care needs. On the other hand, a provider treating a patient with limited English proficiency may need a little additional time and resources (assistance from bilingual staff if necessary) unless the provider is bilingual, or multilingual. In the past year, several local agencies have noted an increase in the number of requests for services from recently laid off individuals and others have noted an increase in the number of seniors (people over age 65) seeking services.

The demographic profile for Travis County from the 2000 census is summarized in Table 1. As demonstrated below, the demographics for the county parallel those for the state very closely in many of the age and race/ethnic categories.

In 1999, (the latest year for which data are available from the Texas Health and Human Services Commission, or HHSC), Travis County was estimated to have 152,709 persons without insurance. The poverty rate in Travis County the year 2000 was also projected by HHSC to be between 10 and 15%.

The data presented from the Travis County health care safety net providers indicate that these agencies see patients who are both 'insured' through public sources (but not private commercial insurance) such as Medicaid and Medicare, as well as those who are uninsured or under insured. These providers also tend to see patients who are at or below the federal poverty income limits, as well as those who are 'low income' or sliding fee scale. In general, the safety net providers may experience demand for services from a wide range of individuals.

Table 1
Demographic Profile of Travis County
Compared to the State of Texas[3]

Category	Travis County	State of Texas
2000 Population	812,280	20,851,820
Percent Population Under 5 years	7.2%	7.8%
Percent Population Under 18 years	23.8%	28.2%
Percent Population 65 years and older	6.7%	9.9%
Percent Anglo Population	58%	55%
Percent Black Population	11%	11%
Percent Hispanic Population	26%	31%
Percent Other Population	5%	3%
Persons below poverty, percent, (1997 estimate)	11.7%	16.7%
Children below poverty, percent, (1997 estimate)	17.0%	23.6%
Per capita Personal Income (1997)	$27,610	$23,707
Homeownership rate (2000)	51.4%	63.8%

A recent ICC survey revealed that our providers are predominantly serving pediatric and adult patients, a majority of whom they estimate to be non-English speaking patients. These data are provided in Table 2, along with data reflecting the increasing demand for services at primary care clinics.

From the table, it can be seen that over 80% of those obtaining primary care services are either age 19-64 or 0-12, 54% are non-English speaking, and 75% have either no third party payment source, are MAP or Seton Care Plus recipients, or are funded through other sources, such as Title V, Title X, Title XX, that are not considered insurance. These data are consistent with the "Demographic profile of the Texas Population without Health Insurance in 2000" from the Texas Health and Human Services Commission (HHSC). According to HHSC estimates, 58% of all Texans without insurance in 2000 were Hispanic, and 70% were between the ages of 18 and 64.

The visit data are also consistent with a 1999 National Ambulatory Medical Care Survey, which indicate that physician office utilization rates average approximately 2.82 visits per person per year.[4]

Table 2
Summary of Travis County
Safety Net Provider Population Data

Category	Number/Percent of Population
Breakdown of patients by age:	
0-12 years (pediatric)	23%
13-18 years (adolescent)	8%
19-64 years (adult)	58%
65+ years (geriatric)	5%

Other/Unknown	6%
Breakdown of patients by payor: Medicaid/CHIP Medical Assistance Program (MAP) Seton Care Plus Private Insurance No Insurance Medicare Other (Title V, X, XX)	 22% 12% 7% 0% 39% 4% 17%
Estimate of non-English speaking patients:	54%
Average number of visits per patient in CY 00:	2.67
Average number of visits per patient in CY 01:	2.74
Average cost per patient in CY 01:	$265.17
Average cost per visit in CY 01:	$96.83

Figure 1 also summarizes the recent increase in use, or demand for services from these primary care providers. Over 90,000 patients were seen in 2001, an increase of almost 4,000 from 2000. These patients accounted for almost 250,000 encounters in 2001, an increase of 7% over 2000. Providers estimate that they will treat 5,000 additional patients in 2002, with an average cost per visit of over $96 currently. While the overall value of care given in 2001 was over $24 million, the increase *alone* in visits between 2000 and 2001 cost providers the equivalent of $1.7 million; a comparable increase in 2002 will lead to the equivalent of an estimated $1.8 million in additional cost in 2002 – only one-quarter of which is likely to be covered by either Medicare, Medicaid, or CHIP.

FIGURE 1

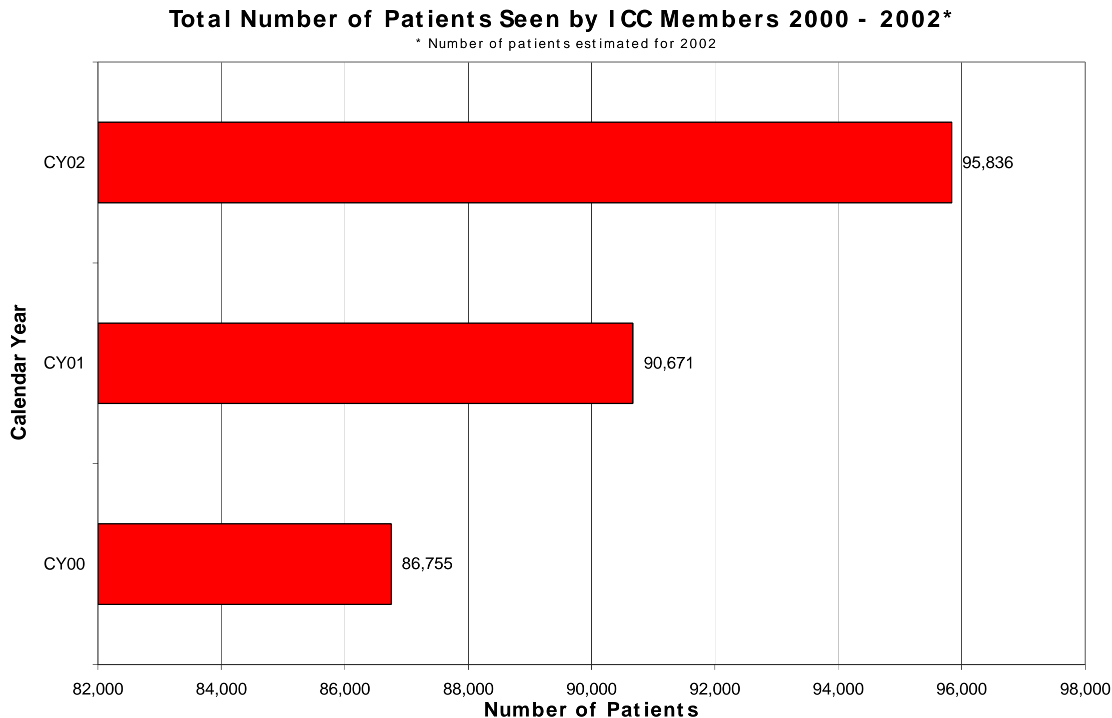
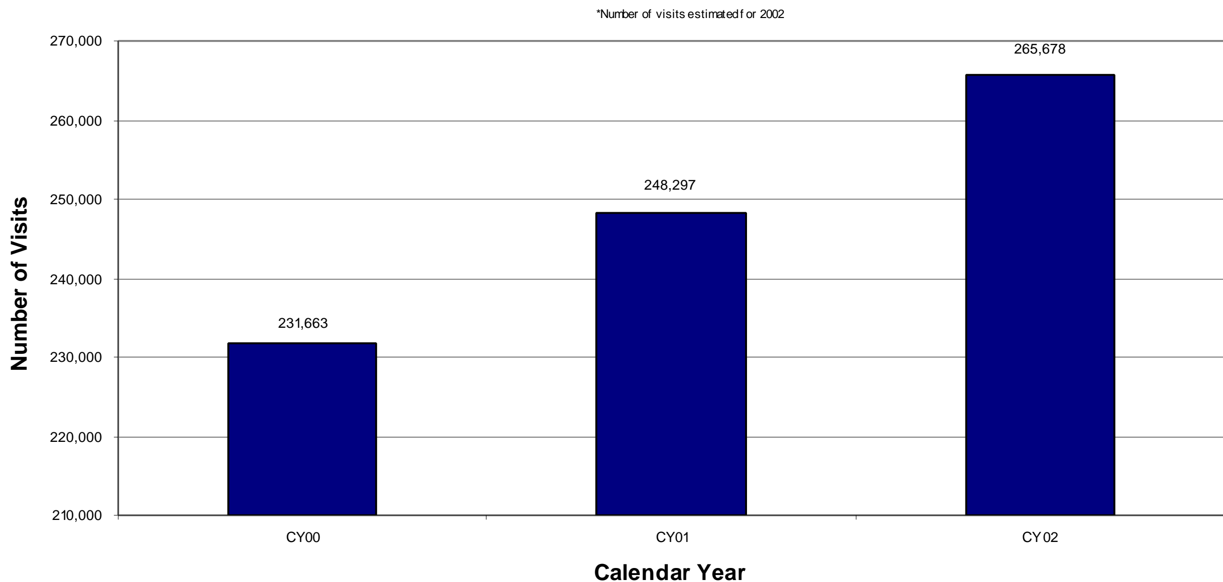


Figure 2 shows the increase in the number of medical visits experienced by providers from 2000 to 2001. Medical visits increased by 7% from 231,663 visits in CY 2000 to 248,297 visits in CY 2001. The same increase has been projected for CY 2002, which would mean providers could expect over 265,600 medical visits this year.

FIGURE 2



Capacity Data

The capacity for services in an area can be determined by a number of factors including the number of providers, number of exam rooms, hours of operation and scheduling policies. A summary of capacity data for Travis County safety net providers is listed below in Table 3.

Many of the Travis County safety net providers already feel that they are operating at capacity, or "capacity-plus". One provider documented over 2,000 patients in a one-month time frame that could not be scheduled for an appointment due to the lack of available appointments. This situation often forces patients to turn to the local hospital emergency departments (ED) for their primary care needs. As mentioned above, local area ED's have documented a recent annual increase of 6% in the number of visits. The use of the ED for primary care services is well documented in the literature as an inappropriate and expensive use of those limited resources. Local hospitals are attempting to find ways to refer their uninsured primary care patients back to the local safety net providers, which only increases access issues for many of these patients.

The Travis county safety net providers all provide a comprehensive mix of primary and preventive health care services. Family planning, pediatrics, prenatal, adult acute and "general medicine", lab, pharmacy and referral services are part of the package of services provided by these agencies. In addition, the agencies have a mix of first-come-first-serve and reserved appointment scheduling systems that generally allow patients to be seen within a day to a week of when they request the appointment. The six Travis county safety net providers schedule an average of 1,007 patient appointments every day, for the 885 existing appointment 'slots'. With the no-show rate varying between 15 and 30%, these agencies have traditionally over-booked all of their appointments to make up for the no-show appointments. However, many agencies are now also beginning to experiment with different forms of appointment scheduling, such as Open-Access that allows them to be more flexible with the number and type of appointments.

Table 3
Summary of Capacity Data for
Travis County Safety Net Providers

Category	Number/Percent
Number of Clinic facilities	20
Number of Exam rooms	167
Total Hours of Operation (week)	1,001
Number of Direct care providers FTEs	50

Clinical Hours (week)	817.5
Number of medical appointments (daily)	885
Number of medical appointments booked (daily)	1,007
No show rate (average)	15-30%
Annual Clinic budgets – Total all clinics	$24,043,173

The Medical Group Management Association (MGMA) completes an annual survey of Physician Compensation and Production. The MGMA 2000 report based on 1999 data found that in a "typical" Family Practice environment (without OB services) a provider will manage an average of 4,662 patient encounters per year. The 50 FTE Travis county safety net providers included in this survey had 248,291 encounters (medical visits) in 2001. These 248,000 plus encounters represent 6% more encounters than the 233,100 total encounters that 50 FTE providers working at capacity would have, according to the MGMA. As a result, these primary care providers, by this measure, could be considered 6% *over* capacity currently. In addition, Travis County primary care providers are fortunate to have the services of approximately 124 volunteer providers to assist with the demand. These providers are not included in the capacity calculation however since they do not provide services on a full-time basis, and many of the volunteers may already be among the 50 FTE providers included in the calculation above.

ICC Responses

One of the goals of the ICC is to help improve the efficiency of the local area safety net providers, thereby having an impact on the provider's capacity to serve the uninsured in Travis County and Central Texas. One way to increase efficiency is to reduce "preparation time" by providers and clinic staff by ensuring that the appropriate information is readily available and easily accessible to providers. Another way of increasing efficiency of providers is to reduce duplication of effort that exists within the regional healthcare system.

The establishment of an Internet based Master Patient Index/Clinical Database Repository (MPI/CDR) will be the foundation of increased efficiency for regional safety net providers. With the implementation of this tool, the ICC will be able to provide the regional safety net providers with realistic unduplicated counts of uninsured patients, which will help the safety net administrators with their budgeting and planning processes. These data will include basic demographics on who these patients are (age, race/ethnicity, etc.), and from where they come (county level data based on zip code). The MPI/CDR will also enable the medical providers to have electronic access to clinical information on patients previously unavailable to them (due to the fact that the patient's clinical information may exist in multiple paper based medical records in numerous provider and clinic offices throughout the region.)

In its earliest generations, the MPI/CDR won't allow providers to see a patient's complete medical record, but it will allow providers to see those key elements that are essential to making a correct diagnosis, or are needed for ordering the correct, non-duplicated, diagnostic tests and procedures for those patients who grant authorization to these data. Patients who have not given the authorization for their data to be viewed by all participating ICC safety net providers will still "participate" in the development of the MPI portion of the ICC database, and will contribute to the overall sizing of the uninsured and under insured in the region.

A Project Access initiative, developed as a collaborative venture between the ICC and one of its key members, the Travis County Medical Society (TCMS), is another response both to building safety net system capacity and to meeting increasing service demands. Scheduled to be launched in the summer of 2002, the ICC and TCMS are staying true to the original Project Access model, developed in Buncombe County, North Carolina, in which both primary and specialty care physician commit to treating a set number of uninsured patients each year, in return for improved access to referral settings, pharmaceutical assistance programs, and case management services. The ICC and TCMS have set a goal of using this volunteer physician model, when fully implemented, to provide care for 3,000 to 5,000 uninsured patients per year, reducing stress on the current system while helping other safety net providers to absorb future increases in demand, and, at maturity, generating millions of dollars in donated care. This project will also expand the safety net capacity by 3 to 5 percent over the 95,000 persons projected to be served this year.

While ICC members are supporting the development and launch of both the MPI/CDR and Project Access in 2002, they recognize that these and other creative initiatives aimed at increasing system efficiency will go only part of the way toward meeting increasing demand and developing additional capacity. Clearly, more comprehensive solutions that organize and coordinate both care and funding, while generating additional sources of revenue for services, will be needed as well.

Conclusion

A recent publication by the Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century" strongly supports the increased use of information technology in the health care delivery environment, especially for chronically ill patients. According to the IOM:

> *"The meticulous collection of personal health information…can be one of the most important inputs to the provision of proper care. Yet for most individuals, that health information is dispersed in a collection of paper records that are poorly organized and often illegible, and frequently cannot be retrieved in a timely fashion, making it nearly impossible to manage many forms of chronic illness that require frequent monitoring and ongoing patient support."*[5]

> In addition,

> *"Automation of clinical data offers the potential to improve coordination of care across clinicians and settings, which is crucial to the effective management of chronic conditions."*[6]

The ICC and the Central Texas safety net providers believe that the implementation of the MPI/CDR will result in cost savings for the providers, in terms of reduced duplication of effort, especially in the area of procedures and diagnostic tests ordered and/or performed. By improving the efficiency and effectiveness of the delivery of care, the ICC and its members also hope to improve the health outcomes of those patients who receive services from these providers.

The MPI/CDR and implementation of an electronic, internet based, coordinated system of care among the regional safety net providers are just the first steps, however, to the long range goal of building a healthy community. Through Project Access, the private practice physicians in the region will be incorporated into the overall safety net system to further increase the effectiveness of the services and the quality of care provided to the uninsured in Central Texas. The originators of the Project Access model in North Carolina have found that "the success of Project Access can be measured not only in monetary terms, but in the value of volunteerism, effective partnerships, and community support."[7]

Historically, while safety net health services have been supported in part through private donations and cost shifting to third-party payors, these strategies have never proven to be sufficient to fund more than a small percentage of safety net care. In Texas, as well as throughout the United States, financing safety net services has fallen heavily on the shoulders of the public.

The residents of central Texas have proven generous in the past in their willingness to fund both safety net and emergency services on an as-needed basis, especially through the use of local tax dollars. Ultimately, though, the residents of Central Texas will decide if the role of the safety net in Central Texas is one considered valuable enough to fund on an on-going basis, through the dedication of increased public revenue. Increased revenue could be obtained through a number of avenues, including Federal Medicaid waivers, increased state appropriations, or creation of a regional or county financing district.

References:

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About the ICC and the Authors

The ICC is a collaboration of twelve safety net health providers in the three county region of central Texas aimed at developing affordable access to effective health care for all residents. The ICC was formed in 1997, and has worked to develop a variety of strategies to improve care delivery in the area since that time. The ICC received a *Communities in Charge* grant from the Robert Wood Johnson Foundation in 2000, which in part supported the development of this report.

The data for this report were provided by a number of ICC members in Travis County. This report was written by Sandra Coe Simmons, M.A., Director of Research and Evaluation for the ICC, and editorial assistance was provided by Paul Gionfriddo, Executive Director of the ICC. Questions about the report may be directed either to Ms. Simmons or to Mr. Gionfriddo at the ICC, at either 512-927-2677 or www.icc-centex.org.