DISTRICT OF COLUMBIA

PRIMARY CARE NEEDS ASSESSMENT

2018

DC | HEALTH

JSI

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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Acknowledgements

The District of Columbia's (DC) 2018 Primary Care Needs Assessment (PCNA) was conducted jointly by the Health Care Access Bureau (HCAB) of the DC Department of Health's (DC Health) Community Health Administration (CHA) and John Snow, Inc. (JSI), in coordination with the State Health Planning and Development Agency (SHPDA) and the Statewide Health Coordinating Council (SHCC).

During the PCNA, SHPDA, HCAB, and its consultants met with over 100 individuals who participated in interviews and community forums. These participants included representatives from health and social service organizations, DC Health, other DC government agencies, community advocacy groups and businesses, as well as individuals from the community at-large. Very special thanks go to the more than 20 senior representatives from DC's leading primary care practice organizations who participated in a primary care survey effort as part of the PCNA. The information gathered through these interviews, community forums, and the survey were integral to the development of the PCNA. DC Health would also like to express its deep appreciation to staff at the DC Department of Health Care Finance (DHCF) and at the DC Hospital Association (DCHA) for their considerable efforts to compile and conduct preliminary analyses of DC Medicaid and DC Hospital Discharge data, which was critical to the development of the PCNA. Finally, special thanks and appreciation goes to staff within HCAB who provided substantial technical guidance and material support in analyzing and synthesizing data and producing the final report.

DC Health would like to thank everyone who was involved in the development of the PCNA for their time, effort, and expertise. Care was taken to ensure that a representative sample of key stakeholders were engaged through the interviews and community forums. Those involved showed a real commitment to strengthening the District's primary care system, particularly for segments of the population that are most at-risk. The PCNA would not have been possible or nearly as comprehensive without the support of all the individuals who were involved.

Finally, DC Health is grateful to the consultants at JSI for playing a leading role in producing the PCNA, including analyzing data, interviewing stakeholders, and drafting the report.

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Executive Summary

Introduction and Background

The **Primary Care Needs Assessment (PCNA)** was executed to answer four key questions to guide the District's efforts to assure access to primary care for DC residents. DC Health contracted with JSI to conduct the PCNA in tandem with the District's Health Systems Plan (released in 2017). The following report is the culmination of DC Health and JSI's research into these questions.

DC Primary Care Needs Assessment
Core Questions

QUESTION A: Is there an unmet need for primary care services among DC residents? If so, where in the city (geographic areas) and/or among what population(s) does the unmet need exist?

QUESTION B: What are the factors that inhibit or facilitate District residents' access to primary care services?

QUESTION C: How should the District improve access to primary care for its residents?

QUESTION D: How should the District continue to monitor access to primary care?

Prior to the PCNA, the last comprehensive assessment of access to primary care commissioned by DC Health was completed by the RAND Corporation in 2008. The findings were published in two reports: *Assessing Health and Health Care in the District of Columbia – Phase 1* and *Assessing Health and Health Care in the District of Columbia – Phase* 2. The RAND findings were instrumental in guiding the District's use of proceeds from the sale of the District's Tobacco Settlement Asset-Backed Bonds. Between 2006 and 2015, the Department of Health invested a total of over $90,000,000 of its Tobacco Settlement and other local funds to construct or renovate 16 community-based facilities. Given these investments in the District's health care infrastructure, DC Health determined it to be a critical time to conduct another comprehensive assessment of access to primary care in DC.

Approach

The PCNA research involved four distinct areas of work: 1) quantitative data analysis, 2) key informant interviews, 3) a provider survey, and 4) the synthesis of quantitative/qualitative data in the following report.

DC Health and JSI partnered with several agencies to obtain data for the quantitative components of the assessment. Key local data sources included DC Health's Capital Health Projects data, the Health Regulation and Licensing Administration's Board of Medicine, Board of Nursing, and Board of Dentistry licensure data; the Center for Policy, Planning, and Epidemiology's Behavioral Risk Factor Surveillance System (BRFSS) data; the Department of Health Care Finance's Medicaid & DC Alliance

(Medicaid) enrollment and claims data; and hospital discharge data from the DC Hospital Association. National data sources included: the U.S. Census Bureau's American Community Survey (ACS), the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey (MEPS), and the Health Resources and Services Administration's Uniform Data System (UDS).

JSI conducted original data collection through key informant interviews, provider surveys, and community forums. The key informant interviews and provider surveys were conducted with senior officials and staff of DC's federally qualified health centers (FQHC's), hospital-affiliated primary care practices, and other major providers of primary care in DC. The interviews and surveys assisted in gathering information related to service utilization, patient characteristics, and provider capacity. The community forums gathered information from residents of Wards 4, 5, 7 and 8 on their perspectives on health care needs, service gaps, and barriers to care.

To answer the PCNA's key question regarding unmet need for care, JSI developed and calculated visit-based estimates of the District's primary care need, demand, and supply based on a range of local and national data. These estimates were based on quantifying the extent of common barriers faced in the health system such as culture, language, economics, education, and insurance status. The analyses also incorporated utilization numbers when claims data were available. (See the inset box for the definition for each of the measures.) Using these visit-based calculations allowed for a more precise measurement of the primary care system's capacity than what commonly-used methods such as population–to-provider ratios are able to yield.

Measure Definitions:

Need: the number of annual primary care visits an individual would have based on their age, sex, and health status assuming there are no barriers

Demand: the number of annual primary care visits an individual is expected to seek accounting for barriers

Utilization: the number of annual primary care visits an individual actually receives

Supply: the number of primary care visits available based on aggregated provider full-time equivalents (FTE)

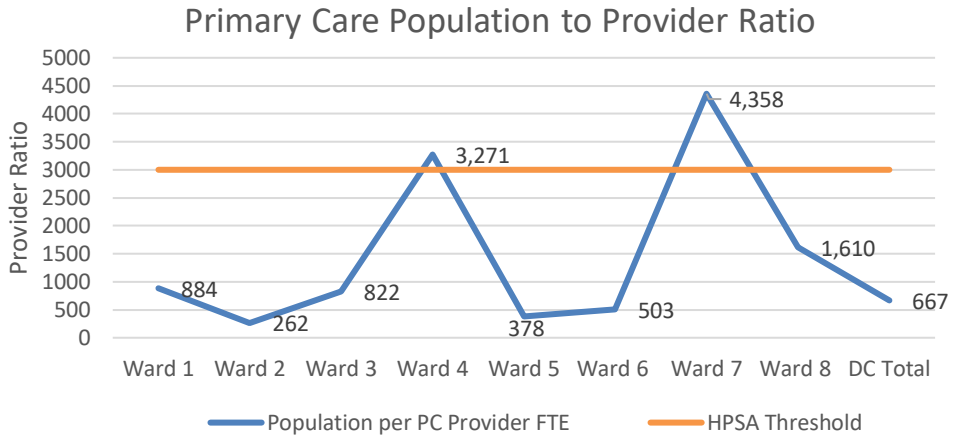
Key Findings

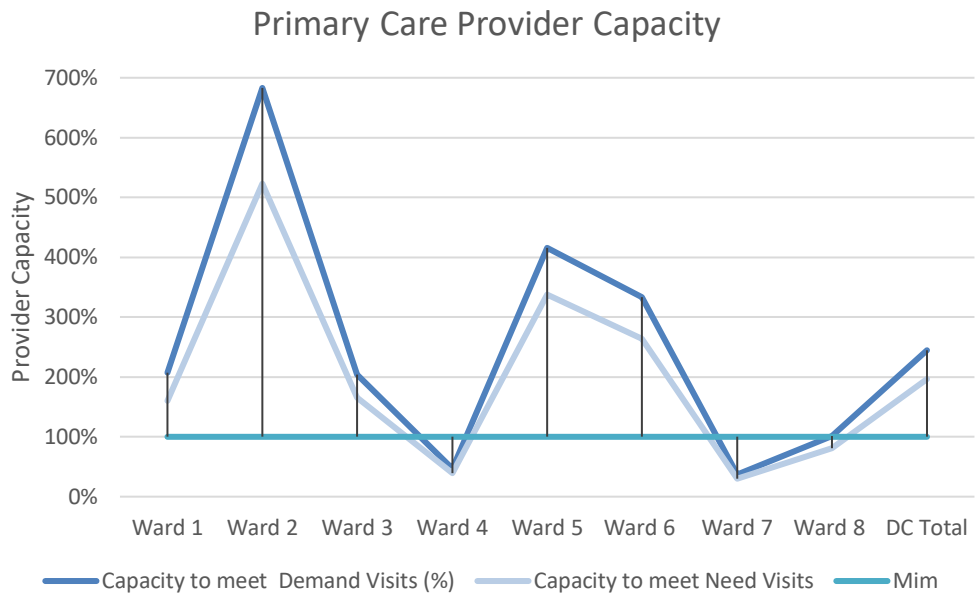
The PCNA makes clear that while there are gains to be made towards ensuring access to primary care in the District, achieving those gains will require strategic, data-driven approaches. At the surface, the PCNA confirms that the District has an ample provider supply overall to meet the primary care needs of its residents, and that there are inequities in the distribution of providers geographically across the District. In particular, two of the District's eight wards, Wards 4 and 7, have provider capacity that is below half of the primary care capacity needed to serve the resident population while other wards have capacity six times the level of estimated need for the wards' populations. However, the PCNA's

synthesis of multiple sources of data reveals that the District's primary care system and how residents engage with it is more complex. Key findings from the synthesis of the data include the following:

Sufficient primary care capacity to serve the District's residents

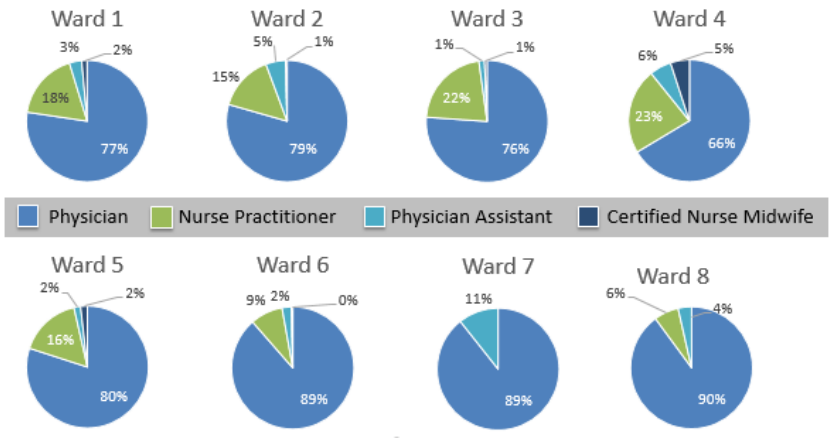
There is an abundant overall supply of primary care providers practicing in the District relative to the resident population; provider capacity, however, is not evenly distributed throughout the city. Visit-based estimates of need, demand, and capacity indicated that Wards 4 and 7 have provider capacity that is below half of what is needed to serve their resident population.



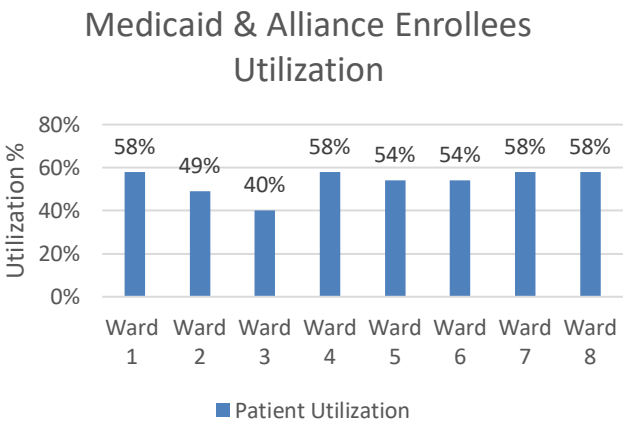


High representation of physicians in the District's primary care workforce

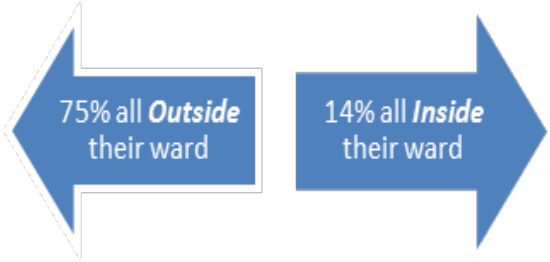
The District's primary care supply is substantially reliant on physicians compared to other provider types. Compared to the national average of 71%, physicians represented over 81% of the provider visit capacity in DC, and in Wards 7 and 8, physicians represented over 90% of primary care capacity.



Use of primary care is not defined by geography nor travel time for Medicaid patients



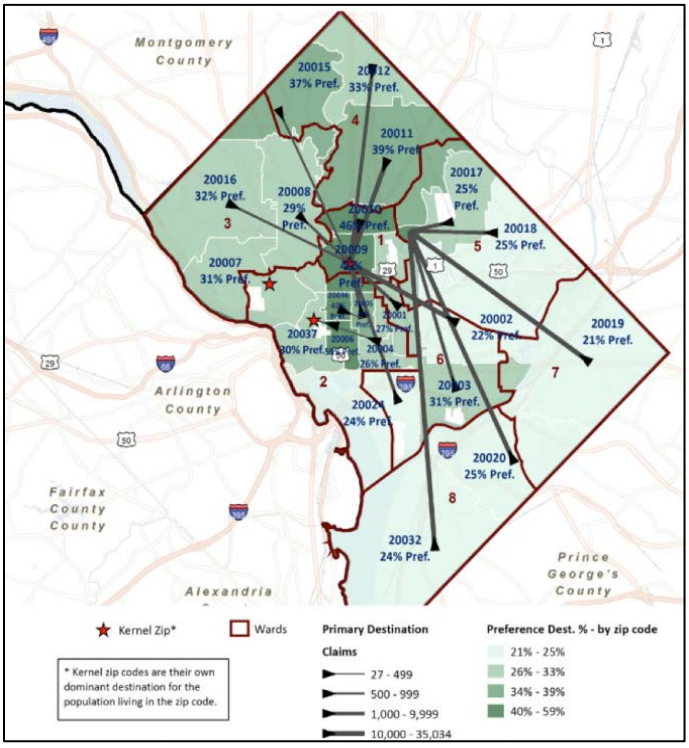
PCNA analyses of Medicaid claims data suggest that engagement in and utilization of care is not clearly associated with available care near a patient's area of residence. Medicaid patients – regardless of ward of residence - generally travel for their care, often bypassing closer care sources.



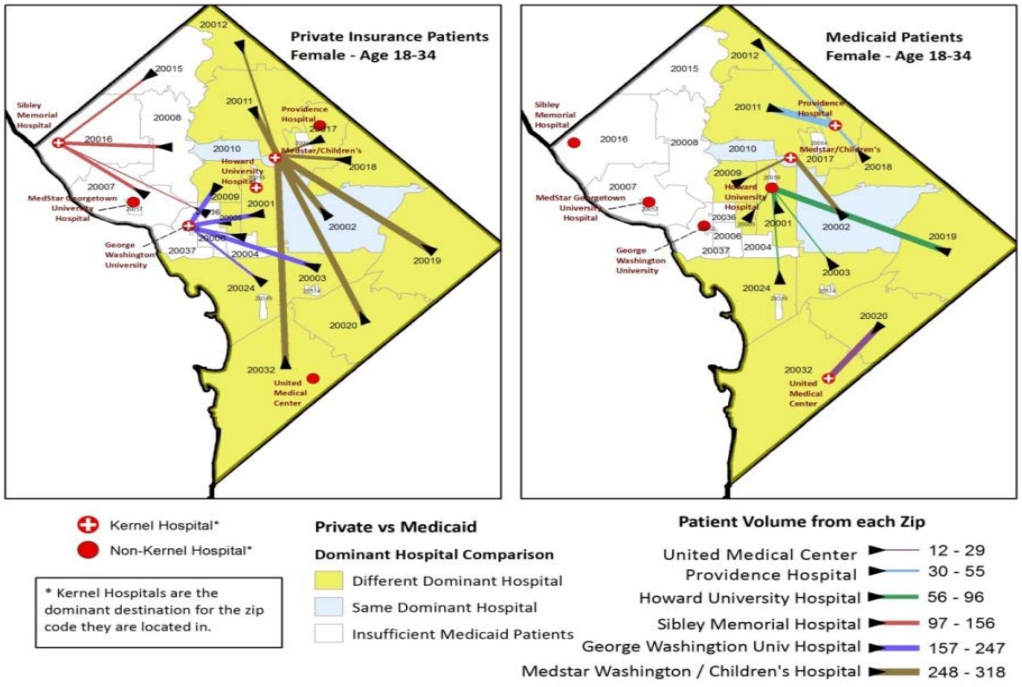
Low community-level preference for local health care resources

At the zip code and ward level, Medicaid analyses revealed that community travel patterns were diffuse. The most frequent destination zip codes generally accounted for less than a quarter of the originating zip codes' primary care claims. Analysis of hospital discharge data indicated that insurance type, private insurance vs Medicaid, rather than the patient's zip code of residence predicted the hospital where the patient received inpatient care.

Medicaid Primary Care Visits, Volume and Preference by Zip Code (2015 - 2016)

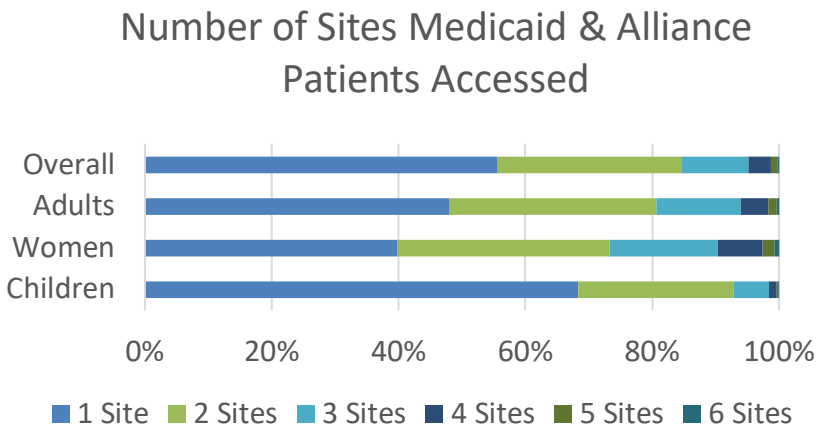


Hospital Patient Discharge: Zip Code Origin-Destination and Preference for Medicaid vs Private Insurance (2014)



Low engagement with a medical home for primary care

At least two out of five Medicaid enrollees received primary care services at multiple locations. Children were the most likely to receive primary care at one location while women aged 18 to 34 were least likely to receive their primary care at one location.

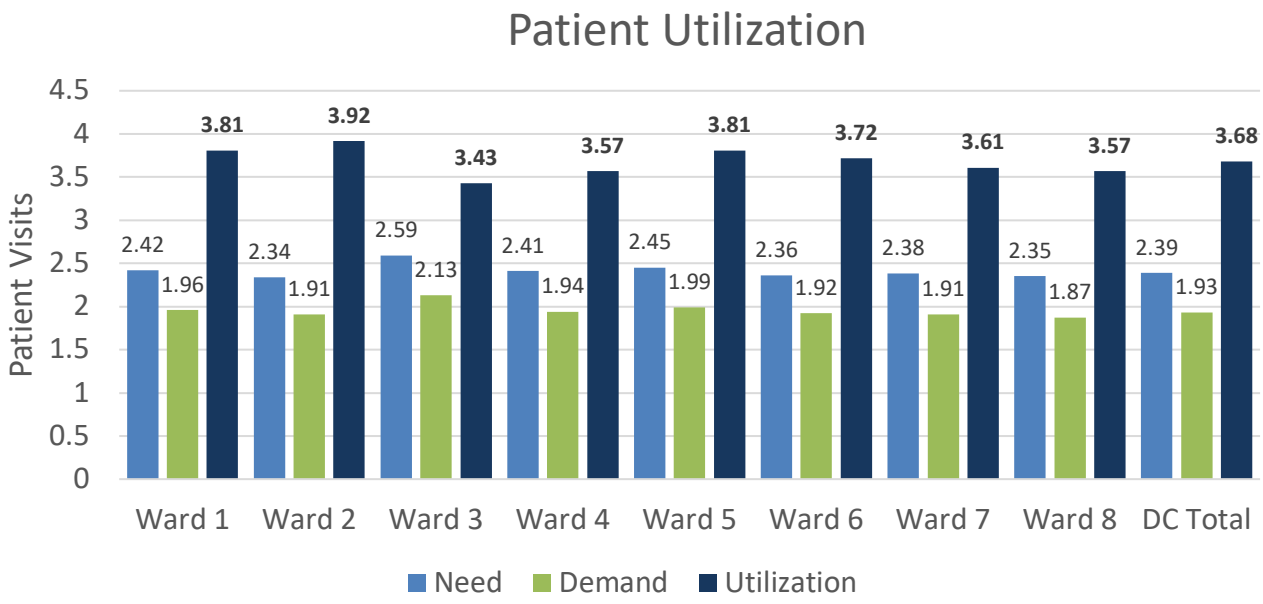


Low utilization of primary care amongst all Medicaid enrollees

Approximately four out of ten DC Medicaid enrollees did not have any primary care visits in the 12-month period reviewed. Women aged 18 to 34 were the least likely among the population groups to have had a primary care visit. Data also showed that almost 70 percent of these women were not engaged in care.

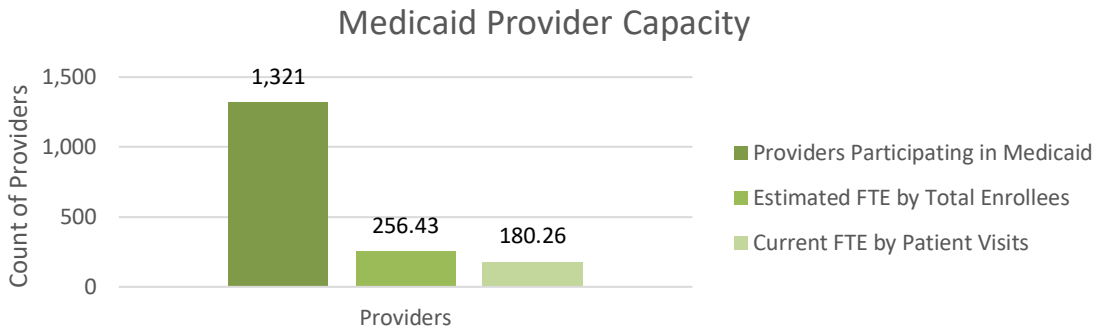
Higher-than-expected utilization amongst Medicaid enrollees who accessed care

DC Medicaid enrollees are expected to demand 1.9 visits per enrollee (given existing barriers) and to need 2.4 visits (after overcoming barriers.) However, Medicaid enrollees who had at least one primary care visit over a 12-month period (i.e. patients) utilized more primary care than predicted, accessing 3.7 visits per enrollee.



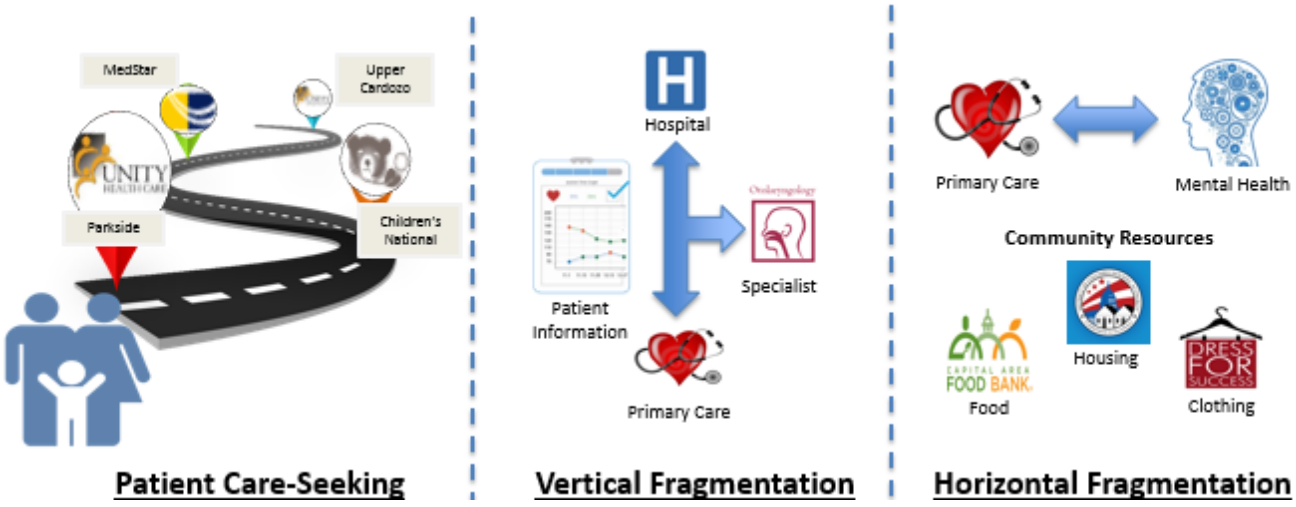
Untapped Medicaid provider capacity

Review of the Medicaid claims showed that there is a substantial proportion of providers who are actively participating in Medicaid - but at a fraction of their total potential capacity (at an average of 15% of their total capacity). It is therefore likely that the existing pool of actively participating Medicaid providers could absorb additional Medicaid patient demand.



Gaps in systems of care

Qualitative data indicates there is a high degree of care fragmentation and lack of structural avenues for care coordination in the District. This fragmentation exists within the continuum of care, regarding integrated health care services, thus preventing patients from comprehensively addressing their health care needs.



From Assessment to Action

In response to the key findings and recommendations from JSI, DC Health has identified the following priorities that will be woven into its diverse efforts to strengthen the District's primary care system and maximize the system's role in improving the health of District residents. While DC Health will use

the PCNA to guide the development of new programs, its approach will reflect a recurring theme from the PCNA: first, leverage existing resources and partnerships where possible to address priorities.

Address patient perception of brand, quality, and convenience: The Health Care Access Bureau (HCAB) through its Primary Care Office (PCO) will target resources to support initiatives to improve care quality and customer service, with an emphasis on initiatives to increase cultural competency of the primary care workforce, increase patient satisfaction, and increase care accessibility. DC Health will also work to increase the public's awareness of where residents can access primary care and the benefits of doing so (i.e. primary care literacy). The PCO will also conduct "deep dives" of available data to identify trends and significant determinants of patients' selection and utilization of a medical home.

Promote use and accessibility of the medical home, especially among women: Beginning in Fiscal Year 2019, the PCO will provide funding through the Care Transformation (CaT) grants to support team-based care coordination, patient engagement and satisfaction, and clinical-community linkages to improve continuous engagement and health outcomes for women.

Engage residents who are not accessing care: DC Health will target bringing residents into care by adding to its work with community partners an explicit focus on populations that have not utilized primary care in two or more years. Two grant programs developed for FY19 include this focus. Innovative outreach methods that DC Health will use or support to reach these residents include but are not limited to, city-wide marketing campaigns, targeted educational interventions, care coordination, patient navigation, and other health literacy initiatives.

Promote the development of systems of care that emphasize community-clinical linkages and care transitions, and ensure that residents across the District can access these systems locally: DC Health, in partnership with District sister-agencies, is also increasing its focus on ensuring greater vertical and horizontal integration among local sources of care. Strengthening connections across sources of care will be a central facet of its direct work with medical and social service providers.

Ensure a workforce that supports team-based care delivery: HCAB will leverage its existing workforce programs, such as the Health Professional Loan Repayment Program (HPLRP), to promote team-based models of care delivery as well as encourage team-based care models and diversification of the primary care workforce through the CaT grants and various Oral Health Workforce grant initiatives. HCAB's PCO and Oral Health Programs will also continue to gather data and conduct analyses on the composition of the workforce through its partnerships with the Boards of Medicine, Nursing, and Dentistry and will engage with DC's health professional schools and associations, and employers to implement policies and programs that respond to identified workforce trends and gaps.

Encourage maximizing and strategically leveraging existing provider resources to address identified and perceived gaps: HCAB will provide guidance to agency and community partners, such as the SHPDA, to identify and implement solutions to District-wide needs that emphasize adapting existing resources and building new partnerships - before recommending new health care access points.

Strengthen partnerships and systems to routinely collect, analyze, and disseminate data on access to care: DC Health is actively establishing, evaluating and enhancing data-sharing partnerships among agency and community partners to facilitate sharing of critical data for assessment and evaluation purposes. Examples of key data partners include DHCF, the DC Hospital Association, and within DC Health: Vital Records; Center for Policy, Planning and Epidemiology; and HRLA. Both the PCO and the Oral Health Program are in the process of establishing key indicators for continuously assessing primary care access and are exploring the best mechanisms for disseminating the data and findings. These mechanisms include both technology platforms for sharing data, such as Tableau, and written materials such as fact sheets, reports, and policy documents.

Identify and explore emerging issues through targeted quantitative and qualitative data collection and analyses: HCAB programs will conduct targeted explorations of key findings from the PCNA. These in-depth explorations will involve collecting and analyzing existing and new datasets to address key questions identified through routine monitoring activities. Recognizing that many questions cannot be answered quantitatively, the programs will collect qualitative data from consumers and providers, through focus groups and key informant interviews, to understand key populations' experiences and decision-making processes related to accessing and providing care.

Collectively, these activities will help DC Health and stakeholders in appropriately targeting and directing resources to strengthen the capacity of the primary care system to ensure that every resident has access to quality primary care at the right place and right time.