Regional Health Care Initiative

Findings, Conclusions and Recommendations

July 2009
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Introduction

Almost 450,000 people in metropolitan Kansas City are either uninsured or covered by Medicaid. An additional number of residents are underinsured with high co-pays and deductibles. Many of these individuals rely on safety net providers to meet their health care needs. The term “safety net” has come to broadly refer to a loose network of care that includes public hospitals, federally qualified health centers, public health departments, faith-based clinics, free clinics and other independent clinics which, either by mission or mandate, provide significant amounts of health care to people who are uninsured, underinsured or medically underserved and who cannot easily access care or cover the costs of their own care.

Metropolitan Kansas City has 17 safety net organizations operating 33 clinics that provide primary health care to patients. While this appears to be an abundance of service sites, there are still critical shortages in the amount of health care that is available to the uninsured and Medicaid populations. Additional barriers unique to the bistate Kansas City region — such as the differences in Medicaid eligibility requirements between Kansas and Missouri, a limited regional public transportation system, limited access to the safety net system in suburban portions of the metropolitan area and limited access to services in the evening and on weekends — further reduce access to timely, quality health care.

The Regional Health Care Initiative (RHCI), sponsored by the Mid America Regional Council (MARC), is a regional initiative promoting innovative, collaborative approaches to providing health care to the uninsured and medically underserved. This initiative is funded through the REACH Healthcare Foundation, Health Care Foundation of Greater Kansas City, the Sosland Foundation, Bank of America, H&R Block Foundation, Wyandotte Health Foundation, the Hall Family Foundation, and the Sunflower Foundation. The RHCI works closely with safety net providers in the Kansas City metro area, and this report is a summary of the information gained and conclusions reached from that work. However, the conclusions and recommendations in the report are solely those of the RHCI staff at MARC.

This report is based on data collected through a safety net survey in 2007, additional data provided by safety net clinics as they worked on a variety of initiatives, data on emergency department visits provided by the Missouri and Kansas Hospital Associations, and public health records from the two states and a variety of other sources.

The intent of this report is to identify issues the safety net community must address if it is going to continue to have the capacity to serve the uninsured and medically underserved. The report is also intended to identify needs and strategies for increasing the capacity of the safety net system as the demand for services increases. This report represents a summary of the data collected and assessments made with respect to the safety net primary care health system in the metropolitan area. It should be noted that the RHCI and the Metropolitan Mental Health Stakeholders recently completed a similar assessment for the behavioral health community, which is available on the RHCI Web site, www.marc.org/healthinitiative.
Key Conclusions and Recommendations

Key conclusions of this report, discussed at greater length in the following pages, are:

Conclusion 1:.................There is a substantial and increasing need for safety net services in the region — a need that cannot be met with the existing capacity of the system.

Conclusion 2:.................The safety net physical plant is adequate to serve additional patients, as measured by exam room space, but the capacity is not evenly distributed across the metro area.

Conclusion 3:.................In terms of medical staffing, the system is currently slightly strained in terms of medical staff per patient and clearly cannot add any capacity without adding additional medical, clinical and administrative staff. The needs for and availability of staff are not matched across the region. In addition, clinics have a difficult time in hiring and retaining medical staff.

Conclusion 4:.................Current evening and weekend services for the safety net population are inadequate.

Conclusion 5:.................Safety net clinics and other safety net providers do not currently have the technology capacity to participate in electronic health records and a health information exchange. There is no single health information exchange system in which health providers can reliably participate.

Conclusion 6:.................Standardized, accessible data for the region is inadequate, both on the health of the population and the state of health care.

Conclusion 7:.................Although the Regional Health Care Initiative focuses on primary care, specialty care and chronic disease management are also major issues in providing comprehensive, quality health care to those who are uninsured or medically underserved.

The report that follows includes of a set of findings and supporting documentation that leads to each of these conclusions. The report also contains a set of recommendations to address these issues:

Recommendation 1:........Monitor the demand for safety net services and the capacity of the safety net system to meet that demand. Develop a better understanding of both the nature of the demand and the capacity of the safety net system to meet it.

Recommendation 2:........Expand weekend and evening hours for safety net clinics and generally take every opportunity to use existing facilities to their fullest extent as a strategy to expand the capacity of the safety net system, serve additional patients, and provide improved access to care.

Recommendation 3:........Invest in additional health care professionals for safety net clinics and provide aid and assistance to safety net clinics in recruiting and retaining health care professionals.
Recommendation 4:...... Expand safety net capacity in Johnson County, north of the river, south Kansas City and Cass County.

Recommendation 5:...... Work with the safety net community to enhance the ability to implement and use electronic medical records and participate in a health information exchange.

Recommendation 6:...... Expand the region’s ability to access and analyze public health and disease incident data in order to better understand where the most effective interventions may be.

Recommendation 7:...... Continue to monitor and assess the need for enhanced specialty care in the region and support specialty care and chronic disease management initiatives.
Demand for Safety Net Services

An important element in assessing the capacity of the safety net system is to determine the current and future demand for these services. With respect to safety net services this demand principally comes from those who are uninsured and those on Medicaid*. Following are key findings with regard to current and anticipated demand for services.

**Key Finding — MARC’s current estimate for the uninsured in the eight-county metro area is 245,439. This is considerably higher than the 2000 estimate in the Lewin Uninsured Study, which was 190,863.**

The increase from an estimated 190,863 in the 2000 Lewin Uninsured Study to MARC’s 2008 estimate of 245,439 constitutes an approximate 28 percent increase in the uninsured in the metro area. It is anticipated that the number of uninsured will continue to climb during the economic downturn as more workers are laid off and more businesses cut costs by eliminating health coverage.

MARC’s estimate was prepared using the 2008 Current Population Survey and the 2005–2008 American Community Survey, both produced by the U.S. Census Bureau. This estimate covers Johnson, Leavenworth and Wyandotte counties in Kansas, and Cass, Clay, Jackson, Lafayette and Platte counties in Missouri. The Lewin Uninsured Study, cited in the Health Management Associates 2006 study, *Kansas City Metropolitan Health Access Policy Assessment*, covered the same counties with two exceptions: it included Ray County, Mo., but did not include Lafayette County.

**Key Finding — As of March 2008, there were 203,989 individuals receiving Medicaid benefits in the eight-county metro area.**

The Medicaid* figures were provided by the respective states. The eight counties include Johnson, Leavenworth and Wyandotte in Kansas, and Cass, Clay, Jackson, Lafayette and Platte in Missouri.

**Key Finding — The safety net population totals 449,428 for the eight-county metro area, almost 25 percent of the total population.**

The safety net population, which combines the uninsured and those on Medicaid, comprises almost 25 percent of the total eight-county metropolitan population. This is the population that is the principal clientele of the safety net clinics.

The total metropolitan population for the eight counties, based on estimates from the 2005–2008 American Community Survey, is 1,792,769.

*Medicaid is a jointly funded, Federal/State health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled and other people who are eligible to receive federally assisted income maintenance payments.
Key Finding — There is a significant health disparity for people living in low-income and minority areas, with increased risk of low-birth-weight babies, a higher-than-expected incidence of death, and a higher incidence of diseases such as asthma.

These maps clearly demonstrate a high degree of correlation between locations with high poverty rates and locations with a higher incidence of low-birth-weight babies, actual vs. expected deaths, and asthma. The maps are based on census data, state and local public health data and data from a study of emergency department visits.
Key Finding — All parts of the metropolitan area have a significant population of residents who are uninsured or on Medicaid.

The table below illustrates that every county in the metropolitan area has a significant portion of population that is uninsured or receives Medicaid. However, there is considerable variation across counties. Over 40 percent of Lafayette County’s population is uninsured or on Medicaid, compared to a third of the population in Wyandotte and Jackson counties. On the other hand, only 13 percent of Platte County residents are uninsured or on Medicaid and less than 16 percent in Johnson County.

Johnson and Wyandotte Counties provide an interesting contrast. In percentage terms, Johnson County’s rate of uninsured and Medicaid is half that of Wyandotte County, but in terms of absolute numbers, Johnson County has almost 30,000 more people in these categories than Wyandotte County. However, Johnson County’s story is even more complicated, since a large portion of its uninsured are residents with incomes greater than 200 percent of poverty. Despite this, Johnson County and Wyandotte County have roughly the same number of residents — just over 40,000 each — who are uninsured with incomes less than 200 percent of the poverty rate or are on Medicaid. This indicates the migration of those in poverty to the wealthier suburbs, which presents challenges in providing services since safety net clinics and other services are often concentrated in traditional low-income areas. See the next section for a further discussion of this issue.

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Below 200% Poverty</th>
<th>Above 200% Poverty</th>
<th>Medicaid</th>
<th>Uninsured &amp; Medicaid</th>
<th>% of Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass</td>
<td>93,607</td>
<td>7,244</td>
<td>5,299</td>
<td>9,992</td>
<td>22,535</td>
<td>24.1</td>
</tr>
<tr>
<td>Clay</td>
<td>203,289</td>
<td>15,040</td>
<td>11,860</td>
<td>18,841</td>
<td>45,741</td>
<td>22.5</td>
</tr>
<tr>
<td>Jackson</td>
<td>653,556</td>
<td>73,337</td>
<td>32,023</td>
<td>108,295</td>
<td>213,656</td>
<td>32.7</td>
</tr>
<tr>
<td>Lafayette</td>
<td>31,585</td>
<td>3,791</td>
<td>5,189</td>
<td>4,669</td>
<td>13,649</td>
<td>43.2</td>
</tr>
<tr>
<td>Platte</td>
<td>82,364</td>
<td>4,476</td>
<td>1,558</td>
<td>4,913</td>
<td>10,946</td>
<td>13.3</td>
</tr>
<tr>
<td>Missouri Total</td>
<td>1,064,401</td>
<td>103,888</td>
<td>55,930</td>
<td>146,710</td>
<td>306,527</td>
<td>28.8</td>
</tr>
<tr>
<td>Johnson</td>
<td>509,862</td>
<td>16,749</td>
<td>38,511</td>
<td>24,031</td>
<td>79,291</td>
<td>15.6</td>
</tr>
<tr>
<td>Leavenworth</td>
<td>66,982</td>
<td>3,243</td>
<td>4,637</td>
<td>5,214</td>
<td>13,094</td>
<td>19.5</td>
</tr>
<tr>
<td>Wyandotte</td>
<td>151,524</td>
<td>14,885</td>
<td>7,597</td>
<td>28,034</td>
<td>50,516</td>
<td>33.3</td>
</tr>
<tr>
<td>Kansas Total</td>
<td>728,368</td>
<td>34,877</td>
<td>50,745</td>
<td>57,279</td>
<td>142,901</td>
<td>19.6</td>
</tr>
<tr>
<td>Metropolitan Total</td>
<td>1,792,769</td>
<td>138,765</td>
<td>106,674</td>
<td>203,989</td>
<td>449,428</td>
<td>25.1</td>
</tr>
</tbody>
</table>

Key Finding — The current safety net system of clinics is at capacity and is unable to serve a significant number of the safety net population not already being served.

Based on survey data, the safety net clinics served 101,592 patients in 2007, which is 22 percent of the safety net population. The remaining 350,000 members of the safety net population are either getting care from hospital-related primary care clinics, particularly Truman Medical Center clinics, from private providers that accept Medicaid or from hospital emergency rooms; or they do not need or are going without care. MARC was unable to collect data on hospital-related safety net primary care (although this might be significant) and private providers. A subsequent section provides information on emergency room visits and the uninsured. Individuals who do not receive regular primary care are more likely to need emergency room services and need more extensive care for conditions that have gone untreated.

The capacity of the safety net clinics will be discussed further in subsequent sections. Suffice it to say that based on current staffing and acceptable ratios of doctors and nurse practitioners to patients, clinic staffs currently see more patients than would be expected. Resource restrictions and safety net clinic needs, such as the need for bilingual staff, make it very difficult to add capacity.

Conclusion 1: There is a substantial and increasing need for safety net services in the region — a need that cannot be met with the existing capacity of the system.

Those who are uninsured or medically underserved constitute nearly 25 percent of the Kansas City metropolitan area’s population. This number is growing, and is anticipated to continue to increase, at least during the current economic downturn. Those who are uninsured or medically underserved tend to be poorer and are more likely to suffer from medical conditions and need medical services than the general population. The safety net system currently serves almost a quarter of the medically underserved and uninsured population, leaving a significant proportion of metro residents either served by other means or not served at all.

The safety net system is currently operating at capacity and is not in a position to adequately serve additional patients without increased capacity. This is already a problem with a large proportion of the uninsured and medically underserved who are unable or unwilling to access safety net care. The issue of capacity will increase as more people become uninsured.
Safety Net Facility Capacity

A key element in assessing safety net capacity is the availability of facilities and their distribution with respect to the safety net population. Following are key findings regarding safety net facility availability.

**Key Finding — Safety net clinics have exam room capacity that could accommodate an additional 210,614 daytime and 251,160 evening and weekend visits.**

According to a 2007 survey of 31 safety net clinics, 230 exam rooms are available. Conservatively assuming each patient visit takes one hour and that a clinic is open five days a week, eight hours a day, a single exam room can accommodate 40 visits each week. Assuming clinics are open 52 weeks per year, each exam room can accommodate 2,080 visits annually, meaning the 230 available exam rooms could accommodate a total of 478,400 visits a year. Survey results indicated that safety net clinics accommodated 267,786 visits in 2007. In terms of exam room capacity, these clinics could theoretically have accommodated another 210,614 daytime visits that year.

Using a similar analysis, assuming that clinics were open three hours each evening and six hours on Saturdays — an additional 21 hours or 21 patient visits each week for each exam room— multiplied by 52 weeks in a year and 230 exam rooms, existing exam rooms could theoretically accommodate 251,160 evening and weekend visits.

Again, it is important to mention the caveats: this calculation is in terms of exam room space only and does not account for the need for additional equipment, support space, staffing and other supports, such as utilities and disposable supplies.

**Key Finding — Safety net clinics and exam rooms are not distributed across the metropolitan area in the same pattern that the uninsured and medically underserved are distributed. This means that in some areas the uninsured and medically underserved have a more difficult time accessing safety net services.**

<table>
<thead>
<tr>
<th>County</th>
<th>Exam Rooms</th>
<th># Uninsured below 200% &amp; Medicaid</th>
<th>Potential Patients/Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass County</td>
<td>0</td>
<td>17,236</td>
<td></td>
</tr>
<tr>
<td>Clay County</td>
<td>11</td>
<td>33,881</td>
<td>3,080</td>
</tr>
<tr>
<td>Jackson County</td>
<td>138</td>
<td>181,632</td>
<td>1,316</td>
</tr>
<tr>
<td>Lafayette County</td>
<td>5</td>
<td>8,460</td>
<td>1,692</td>
</tr>
<tr>
<td>Platte County</td>
<td>5</td>
<td>9,389</td>
<td>1,878</td>
</tr>
<tr>
<td>Johnson County</td>
<td>10</td>
<td>40,780</td>
<td>4,078</td>
</tr>
<tr>
<td>Leavenworth County</td>
<td>4</td>
<td>8,457</td>
<td>2,114</td>
</tr>
<tr>
<td>Wyandotte County</td>
<td>68</td>
<td>42,919</td>
<td>631</td>
</tr>
<tr>
<td><strong>Metro Total</strong></td>
<td>241</td>
<td>342,754</td>
<td>1,422</td>
</tr>
</tbody>
</table>

Exam rooms from 2007 clinic survey
Uninsured and Medicaid from 2005-2008 ACS & CPS estimates and state data
The table on the preceding page illustrates the distribution of safety net exam rooms and people in need of safety net services. Some counties have a much higher number of exam rooms for the safety net population they serve than other counties. In particular, Johnson, Platte and Clay counties have the fewest number of exam rooms and clinic locations in comparison to their safety net populations. Also, although not fully evident from the table, southern Jackson County and Cass County lack facilities. The map on the last page of this section illustrates the distribution of clinics and people in need of safety net services.

Some caution needs to be exercised in drawing conclusions from this data. First, although most of the clinics and exam rooms are concentrated in the urban core of Kansas City, Mo., and Kansas City, Kan., there is a valid reason for this — these areas are still where two-thirds of the uninsured and medically underserved are located. Second, there is some evidence that those who are uninsured or medically underserved can and do cross county lines to find services. Finally, all areas of the region appear underserved in terms of adequate safety net services; but some are relatively more underserved than others.

**Conclusion 2: The safety net physical plant is adequate to serve additional patients, as measured by exam room space, but the capacity is not evenly distributed across the metro area.**

Based on the number of safety net clinic exam rooms that currently exist and the number of patients the safety net clinics currently serve, these clinics have the exam room capacity to see 65 percent more patients. This is a potential resource that could be employed to help meet the increased demand for safety net services.

However, there are serious caveats to this conclusion. First, the availability of physical space does not necessarily lead to availability of support equipment, such as imaging equipment; support space, such as lab space; or adequate medical staff, which will be discussed in the next section.

Second, the space that is available is not necessarily in the locations that meet the needs of the uninsured and the medically underserved. Clinics are concentrated in the areas of greatest need, but as the low-income population has dispersed, physical clinic space has not necessarily followed.

Finally, as will be demonstrated in the next section, the availability of medical and support staff is the most important determinant of capacity.
Safety Net Clinic Staffing

The key element in assessing safety net capacity is the availability of medical staff to provide quality service to those who are uninsured or on Medicaid. Following are several key findings with regard to safety net medical staffing.

Key Finding — Current medical staffs in the safety net clinics are fully utilized and are working at slightly above capacity.

Calculating the current capacity of the safety net systems is a complicated matter because there are not hard and fast standards against which to measure the system. However, by developing several comparisons it is possible to get some idea of the capacity of the current system and the extent to which it is able to meet the needs of patients and the larger medically underserved population.

Based on standards provided by Cathy Harding, executive director of the Kansas Association for the Medically Underserved, safety net clinics should have at least one doctor for every 1,500 patients and can add at least an additional 750 patients for each mid-level nurse. Based on these standards, the safety net doctors and mid-level practitioners reported in the 2007 safety net survey could be expected to care for at most 97,013 patients. This is the maximum healthy capacity of the safety net system. However, survey results indicated that the safety net system was actually caring for 101,592 patients in 2007.

Key Finding — Wait times at safety net clinics are long, indicating that clinics are at capacity and it is impairing access to care.

Although a formal survey of wait times has not been done, anecdotal reports from clinics indicate that wait times are often substantial, making access to care difficult, especially for non-emergency care. Some clinics are unable to take new patients because they have no more capacity.

One local clinic reported gathering data on the number of callers to the clinic who requested care and were turned away because all of the general medicine appointments had been filled. Over a five-week period, the average number of calls that exceeded available appointments was 242 per week. This number is estimated to be underreported by 10 to 20 percent, as many people simply hang up and do not wait to talk to someone on the phone.

Key Finding — The ratio of safety net primary care doctors to safety net patients is much lower than the ratio of all primary care doctors to the overall population.

One measure of disparity in care for those who are uninsured or medically underserved is the ratio of primary care doctors for this population compared to the ratio of primary care doctors for the general population. Based on data from Care and Trust and the state of Kansas there are 761 persons in the eight-county region for every primary care doctor. However, just for the safety net population that actually uses safety net clinics each year — 101,592 patients — there are 2,331 patients for every primary care safety net doctor. If we consider the entire population of the uninsured and those on Medicaid as the safety net population, there are 10,314 persons for every primary care doctor in the safety net system. Again, some of the safety net population may find primary care through hospital
clinics or through private charity care, but these numbers illustrate the disparity in primary care physicians for the overall safety net population.

**Key Finding — Safety net services are not sufficient in any part of the metro area to meet demand, but some areas are more underserved than others.**

Safety net clinics in all parts of the metro area are operating at capacity and all parts of the region have substantial unmet need in terms of access to health care for the uninsured and those on Medicaid. Using a very conservative estimate of 1.97 primary care visits per year for each person in the population, from the National Center for Health Statistics *National Ambulatory Medical Care Survey, 2005*, the number of expected primary care visits can be estimated, based on the safety net population, and compared to the actual number of safety net visits that clinics are experiencing.

### Expected Safety Net Visits vs. Actual Safety Net Visits

<table>
<thead>
<tr>
<th>County</th>
<th>Safety Net Pop</th>
<th>Expected Visits</th>
<th>Actual Visits</th>
<th>% Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass County</td>
<td>22,535</td>
<td>44,394</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clay County</td>
<td>45,741</td>
<td>90,109</td>
<td>2,046</td>
<td>2.27%</td>
</tr>
<tr>
<td>Jackson County</td>
<td>213,656</td>
<td>420,902</td>
<td>188,716</td>
<td>44.84%</td>
</tr>
<tr>
<td>Lafayette County</td>
<td>13,649</td>
<td>26,889</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Platte County</td>
<td>10,946</td>
<td>21,564</td>
<td>3,130</td>
<td>14.51%</td>
</tr>
<tr>
<td><strong>Missouri Total</strong></td>
<td><strong>306,527</strong></td>
<td><strong>603,858</strong></td>
<td><strong>193,892</strong></td>
<td><strong>32.11%</strong></td>
</tr>
<tr>
<td>Johnson County</td>
<td>79,291</td>
<td>156,203</td>
<td>10,204</td>
<td>6.53%</td>
</tr>
<tr>
<td>Leavenworth County</td>
<td>13,094</td>
<td>25,796</td>
<td>2,014</td>
<td>7.81%</td>
</tr>
<tr>
<td>Wyandotte County</td>
<td>50,516</td>
<td>99,517</td>
<td>61,676</td>
<td>61.98%</td>
</tr>
<tr>
<td><strong>Kansas Total</strong></td>
<td><strong>142,901</strong></td>
<td><strong>281,515</strong></td>
<td><strong>73,894</strong></td>
<td><strong>26.25%</strong></td>
</tr>
</tbody>
</table>

| Metropolitan Total| 449,428 | 885,373 | 267,786 | 30.25% |


Expected visits = 1.97 primary care visits per person, National Center for Health Statistics, National Ambulatory Medical Care Survey, 2005.

Actual visits from 2007 safety net survey.

The information in the table above indicates that all areas of the region see fewer safety net visits than would be expected given the population. Overall, they are only seeing about 30 percent of the visits that would be expected. Some of these expected visits may be taking place at hospital clinics, emergency departments or private providers. Many in the safety net community may simply be going without care.

Although all areas of the region are underserved, the capacity and need are not evenly distributed across the region. Some areas of the region experience greater need compared to the safety net resources that are available. This can be seen in the table above in the variance of actual visits to expected visits.
The table below compares the distribution of the safety net population to the distribution of safety net practitioners, both doctors and mid-level practitioners.

<table>
<thead>
<tr>
<th>County</th>
<th>Safety Net Pop.</th>
<th>% of Total</th>
<th>Safety Net Practitioners</th>
<th>Mid-Level</th>
<th>Total</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cass County</td>
<td>22,535</td>
<td>5.0%</td>
<td>Docs: 1</td>
<td>1</td>
<td>1</td>
<td>1.17%</td>
</tr>
<tr>
<td>Clay County</td>
<td>45,741</td>
<td>10.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jackson County</td>
<td>213,656</td>
<td>47.5%</td>
<td>28.05</td>
<td>27</td>
<td>55.05</td>
<td>64.18%</td>
</tr>
<tr>
<td>Lafayette County</td>
<td>13,649</td>
<td>3.0%</td>
<td>0.5</td>
<td>1</td>
<td>1.5</td>
<td>1.75%</td>
</tr>
<tr>
<td>Platte County</td>
<td>10,946</td>
<td>2.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missouri Total</td>
<td>306,527</td>
<td>68.2%</td>
<td>28.55</td>
<td>29</td>
<td>57.55</td>
<td></td>
</tr>
<tr>
<td>Johnson County</td>
<td>79,291</td>
<td>17.6%</td>
<td>1.075</td>
<td>1.5</td>
<td>2.575</td>
<td>3.00%</td>
</tr>
<tr>
<td>Leavenworth County</td>
<td>13,094</td>
<td>2.9%</td>
<td>0.9</td>
<td>1.75</td>
<td>2.65</td>
<td>3.09%</td>
</tr>
<tr>
<td>Wyandotte County</td>
<td>50,516</td>
<td>11.2%</td>
<td>13.05</td>
<td>9.95</td>
<td>23</td>
<td>26.81%</td>
</tr>
<tr>
<td>Kansas Total</td>
<td>142,901</td>
<td>31.8%</td>
<td>15.025</td>
<td>13.2</td>
<td>28.225</td>
<td></td>
</tr>
<tr>
<td>Metropolitan Total</td>
<td>449,428</td>
<td></td>
<td>43.575</td>
<td>42.2</td>
<td>85.775</td>
<td></td>
</tr>
</tbody>
</table>


Both tables illustrate that Johnson County and areas north of the river (Clay and Platte counties) are considerably underserved in terms of the number of expected visits and the number of safety net medical staff compared to the safety net population. (This also is reflected in the distribution of exam rooms from Conclusion 2.) The lack of clinic capacity versus safety net population is also apparent in south Kansas City and Cass County. Access to health care in these communities is further exacerbated by the fact that the uninsured and Medicaid population are more dispersed and thus have more difficulty learning about safety net services and traveling to them.

It is important to reiterate that this unequal distribution in resources is a reflection of where those in need were and still are concentrated. However, many poor people have now moved to the suburbs and many middle class families now find themselves without health insurance. An added caution needs to be mentioned with respect to Wyandotte County. Although it appears to be relatively better served, the county also sees a number of Johnson County patients who do not have access to nearby public hospital primary care clinics.

Key Finding — Data indicates that a significant number of the uninsured are receiving primary care through emergency room visits.

One important measure of safety net capacity is the extent to which the uninsured seek primary care through emergency room visits. Based on 2006 emergency room data for the metropolitan area (less one hospital) from the Missouri and Kansas Hospital Associations, there were 123,800 emergency room visits.
visits by the uninsured. This represents 22 percent of all emergency room visits — a higher-than-expected percentage when compared to the uninsured as a percentage of the general metro population (13.7 percent).

The review of 2006 emergency room visits in the Kansas City metro area included a sampling of the top 20 primary and secondary diagnosis codes for each visit. This sampling was about 19 percent of all emergency room visits. Doctors associated with the Regional Health Care Initiative identified five primary codes which they felt represented primary care visits (visits that appear to be of a non-emergency nature). These codes are: 462–acute pharyngitis (sore throat); 4659–acute upper respiratory infections; 5990–urinary tract infection; 7242–lumbago; and 78703–vomiting alone. Based on this data, 26 percent of uninsured visits to the emergency room, or approximately 32,188 visits, were for primary care. These are people who should be going to the safety net clinics, thus freeing up emergency room capacity and providing the patient more appropriate care.

**Conclusion 3:** In terms of medical staffing, the system is currently slightly strained in terms of medical staff per patient and clearly cannot add any capacity without adding additional medical, clinical and administrative staff. The needs for and availability of staff are not matched across the region. In addition, clinics have a difficult time in hiring and retaining medical staff.

The safety net system, according to a 2007 survey of safety net clinics, employs 44 doctors and 42 mid-level practitioners (such as nurse practitioners), either as paid staff or volunteers, to serve over 100,000 patients with over 265,000 visits. Based on industry standards, the current staff is serving more patients than would be customary for this size of medical staff. This indicates that the safety net system cannot increase capacity without adding medical and support staff.

The issue of staffing is not just an issue of having adequate financial resources. The safety net clinics face a daunting task of finding and recruiting medical staff, even if they have resources. Sometimes this is a matter of competing in terms of salary and benefits with the private sector. Safety net clinics also face additional issues such as finding bilingual medical staff.

The safety net clinics not only need additional medical and support staff if they are to increase their capacity to serve the uninsured and medically underserved, but also face a critical issue of keeping and replacing existing staff just to maintain services to their current patients.
Weekend and Evening Safety Net Services

Another key issue with regard to the capacity of the safety net system is the ability of the system to serve patients on evenings and weekends. Because of work obligations, this is often the only time when the uninsured can access care. In addition, urgent care situations often occur during these time periods. Following are several key findings which address this issue.

Key Finding — Little safety net primary care is available on weekends or in the evenings.

MARC conducted two surveys with safety net providers about their hours of operation. The first survey was an e-mail survey in December 2007, followed by a telephone survey to update the data in September 2008. The surveys gathered information about the hours that safety net services are available during regular business hours, weekday evenings and weekends (total hours = 982.25 hours). The results indicate limited availability of care in the evenings (35.5 hours or 3.6 percent of total hours) and a significant lack of available care on weekends (19.5 hours or 2 percent of total hours). It is interesting to note that between 2007 and 2008 the number of evening/weekend hours was reduced by 5.5 hours from the time the initial survey was conducted.

Key Finding — Emergency Room data indicates that there is a need for weekend and evening primary care services.

The hospital emergency room data discussed in the previous section indicates that for 2006 26 percent of all uninsured visits to the emergency room were for primary care and of those, 27 percent occurred during evening hours or daytime on Saturdays. This indicates that in 2006 there were 8,578 uninsured persons who sought primary care services in the emergency either on weekday evenings or on Saturdays during the day.

Key Finding — Per Conclusion 3, there is a lack of safety net capacity due to lack of available staffing.

Conclusion 3 indicated that there was a lack of safety net capacity because of a lack of medical staff. The lack of medical staff extends to weekend and evening hours and contributes to the lack of system capacity.

Conclusion 4: Current evening and weekend services for the safety net population are inadequate.

Safety net clinics are primarily open during weekday daytime hours. However, the need for safety net primary care services does not always occur during these hours. Sometimes there is a need for acute care, but there are few options for those who are uninsured, except for the emergency room. Others are unable to visit a clinic during the day because they are employed but have no insurance. This lack of evening and weekend services is compounded by the increasing number of those who are uninsured or on Medicaid.
Health Information Technology

The RHCI devoted a considerable amount of time to investigating health information technology and how it impacts safety net providers. This is a complicated issue for all health care providers, not just the safety net community, and the parameters of the discussion are constantly changing. The use of health information technology holds out the hope of increasing the quality of care for patients while at the same time making health care more efficient. But implementing such systems is complicated, uncertain, and expensive.

Key Finding — Most of the safety net providers do not have sophisticated health information systems or staff capable of managing such systems.

This finding is probably true of most health care providers, not just safety net providers. If safety net clinics are going to take advantage of electronic medical records and other health information technology, they will need to enhance their capacity to understand, assess, implement, use and maintain such systems. Safety net clinics do not have the financial resources to develop such capacity since most resources go into keeping the doors open and providing basic care.

Key Finding — There is considerable uncertainty within the safety net community about where exactly health information technology is headed and what the appropriate strategy is for clinics and the safety net system.

There are a number of initiatives, policies and mandates with respect to health information technology emanating out of the federal and state governments and from private health system players such as insurance companies and hospitals. It is difficult for individual clinics and the safety net system to identify appropriate strategies to maximize the benefits to their patients and their operations while being compatible with the direction of the rest of the industry. It is also difficult to know which vendors are promoting the right strategy and will be around to see that strategy through. Given the high level of uncertainty, it is very difficult for clinics to devote financial and staff resources to this issue when there are so many other needs.

Key Finding — The ability to exchange information between clinics and other members of the safety net system is important, but the health information exchange landscape in the metro area is currently confused and fragmented.

An important element of health information technology is the ability to exchange information with other health care providers and other parts of the system. Such an exchange can facilitate care by making sure that a patient’s record is always with him no matter where he is in the system. It can also help to facilitate referrals that benefit both the patient and clinic operations and can provide clinics and the system with information that facilitates decision making.

However, it is very difficult to establish a sustainable health information exchange. First of all, many of the clinics do not have the technology or staff capacity to effectively use or enter such a system. Also there are currently a number of such systems or proposed systems in the metro area, each serving a different need for different constituencies. To some extent, safety net clinics have not had much of a voice in the discussions about what a health information exchange system should do and how it should
be set up. Until there is agreement on these points and adoption of a regional platform it will be difficult for clinics and other health providers to exchange data and fully benefit from health information technology.

**Conclusion 5:** Safety net clinics and other safety net providers do not currently have the technology capacity to participate in electronic health records and a health information exchange. There is no single health information exchange system in which health providers can reliably participate.

In order to have an effective electronic health records system and an efficient exchange of those records to benefit patient health care, there are two basic requirements:

- Individual health care providers and other elements of the health care system need adequate technology capacity in terms of equipment, software and trained staff to implement, use and maintain electronic medical records and other elements of health care information technology.

- A uniform system for exchange of health information must be in place across the many providers and servicers of health care.

Neither of these conditions exists within the safety net community or, to a large extent, throughout the health care system. Although some clinics are on the path to developing the technology capacity to participate in electronic medical records, others are not. This stems from several causes, including lack of resources and the fact that a number of the clinics are small.

An efficient exchange of medical information is very important as the health care system becomes more complex and interdependent. Unfortunately, there is currently not a single health information exchange that can affordably and effectively meet all of the needs of the safety net health care system. There are currently several systems, each serving a different population and need, with no one system the clear vehicle for health information exchange among safety net providers.
Health and Safety Net Data

One premise of the RHCI is that decisions about health care and about the health care system should be based on sound data. Data is critical in order to make informed decisions on what interventions will have the greatest, most effective impact, both on the health of individuals and populations and on the health of the system. The availability of data and the analysis of data becomes a critical component in an effective health care strategy.

Key Finding — There is not adequate, uniform public health data available for the metropolitan area, especially at sufficiently localized geographies.

Through investigations with local health departments and state and federal agencies, we have determined that there is not a consistent set of public health data across the region. This is especially true at geography levels that would allow the community to investigate the distribution of disease and compare it to demographic and environmental factors.

MARC pieced together some health data from health departments, state agencies and through the use of emergency room data. However, the information was generally not readily accessible; in many cases, was not comparable across the region; and was not easily related. The emergency room data, while extensive, is not fully representative of disease occurrence in the metro area; however, it does give an interesting picture of where disease is occurring, at least as it impacts the emergency room.

Key Finding — There is not adequate, comparable data about safety net operations.

Data on the operations of the safety net system in terms of staffing, patients and visits, types of visits, and location of patients is not routinely collected. There is not an agreed-upon set of data and definitions for data that should be collected or an agreement on how that data would be used. A number of clinics do not have systems to easily collect and produce data on operations.

| Conclusion 6: Standardized, accessible data for the region is inadequate, both on the health of the population and the state of health care. |

There is inadequate data or convenient access to data on the health of the safety net population and the operations of the safety net system. This lack of access to current public health data hinders the ability of the health care system and the community to identify and address key health issues. Lack of consistent data on the safety net system’s operation makes it difficult to assess how well the system is addressing the needs of the safety net community, where investments would be most beneficial for the health of this population, and how system capacity and access is — or is not— keeping pace with rising demand for services.
Specialty Care and Chronic Disease Management

Although the RHCI focuses on primary care, it is evident that the provision of specialty care remains an issue for the safety net health care system. When patients of safety net primary care clinics need specialty care such as diagnoses, treatment, or surgery, they must be referred to specialists for this care. Such specialists are not a part of the normal safety net system. How this care is provided and how patients find their way to this care is an important element of the capacity of the safety net system.

The identification, treatment and management of chronic disease within the safety net population is an important issue. Chronic disease treatment can comprise a significant portion of safety net clinic and emergency room visits. Chronic disease can have a disproportionate impact on the health and well being of the uninsured and their families.

Key Finding — Specialty care for the uninsured and medically underserved is in a situation where demand exceeds capacity.

Currently, specialty care is provided in different ways in different parts of the region. In Jackson County and Kansas City, Mo., a significant amount of specialty care is provided through Truman Medical Centers, the region’s only hospital whose primary mission is serving the safety net population. However, Truman often has difficulty providing specialty care in a timely fashion because of patient loads and backups for certain specialties.

Several years ago, recognizing the need for specialty care for the uninsured, the Medical Society of Johnson and Wyandotte Counties, and later the Metropolitan Medical Society of Greater Kansas City and Northland Health Access, established Access programs. These programs solicit specialty doctors and hospitals to donate care for a certain number of patients each year. The program matches patients in need with specialists and makes sure that all of the information the doctor needs is available at the visit. The program also arranges transportation and follow-up care. The programs have been successful, but are limited in the number of patients they can serve and some of their specialties are booked up.

This indicates that demand continues to exceed capacity for safety net specialty care.

Key Finding — Chronic Disease diagnosis and management is a major issue for those who are uninsured or medically underserved, and there is not a systematic approach for identifying these individuals and helping them manage their care.

Chronic diseases such as diabetes and asthma are a major health issue for those who are uninsured or medically underserved. There are several reasons for this. First, those who are low-income or uninsured are less likely to have their disease diagnosed than those in the general population, because they are less likely to receive routine primary care. Once diagnosed, because of issues of income or access, they are less likely to manage their disease on a consistent basis. Left untreated, those with a chronic disease are more likely to have severe episodes that require a visit to the emergency room, accounting in part for the high rate of emergency room use by the uninsured. Also, once left untreated, not only does the disease degrade the person’s life, but it also becomes much more difficult and costly to treat.
Most safety net clinics provide some chronic disease management services. A few specialize in certain diseases, such as HIV/AIDS or diabetes. However, there is not a systematic approach in the metro area for identifying individuals with chronic disease and getting them sustained managed care. Also, since the safety net clinics are at capacity, it is difficult to provide additional chronic disease management services without additional medical staff and resources.

**Conclusion 7:** Although the Regional Health Care Initiative focuses on primary care, specialty care and chronic disease management are also major issues in providing comprehensive, quality health care to those who are uninsured or medically underserved.

Despite the presence of a major public hospital in the metro area and two Access programs, there is still a substantial need for specialty services for those who are uninsured. Access to specialty doctors is limited and is not provided on the same basis that primary care is provided.

Chronic disease management is a major issue throughout the health care system and the safety net system is no exception. However, those who are uninsured or medically underserved are more likely to go undiagnosed or have their care poorly managed, making this a more challenging issue for the safety net community. In addition, that community is at capacity and it is difficult to provide additional chronic disease management without additional dedicated resources.
Recommendations

Based on the key findings and conclusions in this report, the RHCI makes the following recommendations to the regional community.

**Recommendation 1: Monitor the demand for safety net services and the capacity of the safety net system to meet that demand. Develop a better understanding of both the nature of the demand and the capacity of the safety net system to meet it.**

Understanding the quantity and nature of the demand for safety net services is critical if the community is to make the most effective strategic investments going forward — investments that will have the greatest impact on improving the access to safety net care and the quality of that care.

The first step is to conduct an annual assessment of the number of individuals who are uninsured, on Medicaid, and, if possible, who are uninsured and likely to need safety net services. Not only are the raw numbers needed, but an understanding of who these people are, where they live and what their circumstances are will help us better understand the nature of their health care needs.

Once a clearer understanding of demand has been developed, it is necessary to compare that to the capacity of the safety net system to meet the demand. This includes an annual assessment of services, staffing, patients and visits for the safety net clinics and their distribution across the metro area. It also means extending this understanding of safety net capacity to other providers of care, such as hospital-based primary care clinics.

Such an annual assessment is especially critical as the nature of health care and public support for health care continuously shifts. These changes will affect the nature of the demand for safety net services and possibly the capacity of the system to meet this demand.

**Recommendation 2: Expand weekend and evening hours for safety net clinics and generally take every opportunity to use existing facilities to their fullest extent as a strategy to expand the capacity of the safety net system, serve additional patients, and provide improved access to care.**

Extending weekend and evening services has been identified as an effective way to expand care to the safety net population and make use of existing physical capacity. Weekend and evening care will help serve the working poor who cannot easily access care during business hours. The Safety Net Collaborative and the RHCI have recently received grant funding to support a measured expansion of evening and weekend services and will closely monitor the program.

Beyond weekend and evening services, the safety net community should seek out opportunities to use underutilized clinic space for expanded care, special programs such as chronic disease management, or wellness programs, and funders should be open to funding these initiatives.
Recommendation 3: Invest in additional health care professionals for safety net clinics and provide aid and assistance to safety net clinics in recruiting and retaining health care professionals.

The most direct way to increase capacity of the safety net system is to invest in new medical staff and support staff. It is important to couple this investment in additional medical staff with support services and the development of initiatives to improve clinic efficiency so that the best possible use can be made of new medical staff.

Just as important as investing in new medical staff is providing assistance to clinics in hiring and retaining existing staff. This may be in the form of financial assistance or extended benefits or privileges, such as hospital privileges.

Recommendation 4: Expand safety net capacity in Johnson County, north of the river, south Kansas City and Cass County.

Data indicates that the uninsured and medically underserved are moving outward. The cores of Kansas City, Mo., and Kansas City, Kan., are still the areas of greatest concentration of those in need of safety net care and these areas continue to be underserved. However, the expansion of the safety net population in more suburban areas has not been matched by a commensurate expansion of safety net services. The uninsured and medically underserved in these areas present different issues than those residing in the core because they are more dispersed, making both communication and transportation an issue.

Clinics in these areas want to expand services and these efforts should be supported. Different models have been tried and these should be closely monitored and evaluated to see if these might provide a better approach to providing safety net health care in these communities.

Recommendation 5: Work with the safety net community to enhance the ability to implement and use electronic medical records and participate in a health information exchange.

The safety net clinics, not unlike others in the health care system, have not taken full advantage of electronic medical records and health information exchange. Such systems may help clinics provide more effective and efficient care, extending the quality and quantity of the care they can provide. In addition, there are increasing expectations and requirements that health care providers use and participate in such systems. A concentrated and coordinated effort is needed to assess the best strategy for increasing the technology capacity of safety net clinics and provide assistance in implementing and using these technologies. In addition to the technology capacity of individual clinics, there is a need to develop an effective, coordinated system to exchange medical information.

Recommendation 6: Expand the region’s ability to access and analyze public health and disease incident data in order to better understand where the most effective interventions may be.
More ready access to health data and disease incident data would help the safety net community better assess the needs of the uninsured and medically underserved and design new strategies to prevent health problems or better manage them. The Health Care Foundation of Greater Kansas City is making a start by creating an accessible health database for the region in conjunction with the Kansas Health Institute. However, continued work is needed to develop access to more health and disease data at small geography levels and analyze and use that data to develop intervention strategies. A more strategic approach to health care will result in better outcomes for the uninsured and medically underserved. Such a strategic approach requires reliable data, thorough analysis, and a commitment to use the analyses to develop new strategies.

Special emphasis should be given to developing a picture of chronic disease incidence in the safety net population and the development of interventions to address specific issues that become apparent.

**Recommendation 7:** Continue to monitor and assess the need for enhanced specialty care in the region and support specialty care and chronic disease management initiatives.

Although the RHCI has focused on primary care and the safety net system providing that care, the need for expanded access to specialty care cannot be overstated. On the Missouri side, a considerable amount of specialty care is provided through Truman Medical Centers, the metro area’s only public hospital. Their capacity is continuously strained and they do not serve the entire metro area, which either increases pressure on other parts of the health system or simply means that safety net patients go without specialty care.

The metro area’s two medical societies have established Access programs, which recruit specialty doctors to devote charity time to a set number of patients and recruit hospitals to provide support services. The programs have been very successful, but in some specialties they have no additional capacity.

There is a need for a thorough assessment of the capacity of the specialty care system for the uninsured and medically underserved and the demands for such services. Are patients going without specialty care, and what is the impact on their health and downstream costs to the system?