Access to Specialty Care for Children
(You can’t fix what you don’t measure)

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No Conflicts: Many Acknowledgments

- The state of Illinois provided funding and support
  - Provision of detailed physician licensure data
  - Medicaid and state employee health insurance claims data
  - Dummy Medicaid identification numbers
- Heath & Disability Advocates, the Sargent Shriver National Center on Poverty Law, Goldberg & Kohn, Fredrick Cohen J.D.
- Members of our expert review panel:
  - Diana Becker-Cutts, MD, HCMC
  - Genevieve Kenny, PhD – The Urban Institute
  - Daniel Polsky PhD, LDI, UPenn
  - The University of Chicago Survey Lab
  - Joanna Bisgaier, MSW PhD, Project Director
Overview

- Measuring Access to Specialty Care
  - Experimental design (Simulated patients)
- Results (Pre-ACA):
  - Disparities exist by insurance status
  - Varied by practice characteristics
- The ACA quality and cost goals
  - Implications for Specialty Care?
Why Study Access to Care?

Access is a prerequisite to quality!
“Is there a doctor who accepts Medicaid in the house?”
Auditing Access to Specialty Care for Children with Public Insurance

Joanna Bisgaier, M.S.W., and Karin V. Rhodes, M.D.
Simulated Patient Methodology

- Trained research assistants (simulated mothers) called randomly selected subspecialty clinics -> earliest appointment

- Computer-assisted telephone interview
  - Scripts iteratively developed/reviewed by experts in each field and piloted
  - Standardized responses to questions

- Paired calls at least 4 weeks apart
  - Randomized order of reported insurance type

- Did not volunteer their insurance status
  - If given appointment without being asked, confirmed insurance accepted

- Outcome variables:
  - Ability to schedule appointment
  - Wait-time for appointments

ALL APPOINTMENTS CANCELLED IMMEDIATELY

“All Kids”

“BC/BS”

Clinic
<table>
<thead>
<tr>
<th>Specialty Type</th>
<th>Health Condition</th>
<th>Age</th>
<th>Referred By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>Severe atopic dermatitis</td>
<td>9 mos</td>
<td>PCP</td>
</tr>
<tr>
<td>ENT</td>
<td>Obstructive sleep apnea and chronic bilateral otitis media</td>
<td>5 yrs</td>
<td>PCP</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Type 1 diabetes</td>
<td>7 yrs</td>
<td>PCP</td>
</tr>
<tr>
<td>Neurology</td>
<td>New onset afebrile seizures</td>
<td>8 yrs</td>
<td>ED and PCP</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>Fractured forearm, through growth plate</td>
<td>12 yrs</td>
<td>ED and PCP</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Acute, severe depression</td>
<td>13 yrs</td>
<td>PCP</td>
</tr>
<tr>
<td>Allergy-Immunology/ Pulmonary Diseases</td>
<td>Persistent and uncontrolled asthma</td>
<td>14 yrs</td>
<td>ED and PCP</td>
</tr>
<tr>
<td>Dentistry</td>
<td>Fractured front tooth with pain</td>
<td>10 yrs</td>
<td>ED</td>
</tr>
</tbody>
</table>
Medical Specialty Appointments

Disparities in Access

2/3rds of Children with Medicaid/CHIP denied care
**Medical Specialty Wait Times**

<table>
<thead>
<tr>
<th>Number of Clinics Where Both Insurance Types Accepted</th>
<th>All Kids Wait-time (days) M+SD</th>
<th>BC/BS Wait-time (days) M+SD</th>
<th>Mean Difference (days) M+SD</th>
<th>Paired t-test Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medical Specialties</td>
<td>42.0±75.1</td>
<td>19.9±34.0</td>
<td>22.1±72.9</td>
<td>6.8 to 37.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.862 (0.005)</td>
</tr>
</tbody>
</table>

Disparities in Wait-times
Children with Medicaid/CHIP had to wait 22 days longer

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"The doctor isn't coming in today after all. Do you want to wait?"
Why and how does this happen?
Open-ended semi-structured interviews

- Specialists=30 & PCPs=14 who treat children
- Low, slow, no payments, admin hassle factors
- Institutional Pressures

[Developmental pediatrician, academic hospital] “Yeah, we are cutting down. In the last budget revision, we were called, you know, ‘You are losing money, so you need to improve your patient mix’…So what we’re doing is just trying to restrict the number of Medicaid patients… we have a number of slots for Medicaid, a limited number of slots actually.”
Providers identified strategies used to allocate scarce specialty care appointment slots

1. Severity of patient’s health condition
2. Taking responsibility for patients who lack alternatives
3. Geographic proximity of patient’s home address or location of the referring PCP
4. Hospital affiliation of PCP
5. Personal connection or professional courtesy with PCP
6. Informal exchange arrangements with PCP
7. Send them to the Emergency Department
The ED as Access Provider

- [Otolaryngologist] “So some patients who can’t get an appointment will go to the ER and get sent that way….and once they are in the system…I am obligated to see them.”

- [Pediatrician] “The idea is that if I send them to the emergency room and they need to be referred to a specialist, they get a specialist. So I’m bypassing a number of problems. I’m fully aware that I’m crowding the emergency room.”
Implications for spending scarce resources

- Target providers already caring for publicly-insured
- Incentives to increase the presence of specialty practices in low income communities
- Resource allocation to AMC/ACOs contingent on equity across both dimensions of access
Large National Experiment!

BIG Problems with US healthcare

The Affordable Care Act, HR 3590

- Insure ~32 million by 2019
  - Primary Care Medical homes
  - Population-based health
  - Health IT
  - Prevention and wellness
- P4P \(\rightarrow\) Individual & community outcomes
- Incentives for system redesign ACOs
- Disincentives for over-utilization
- Control costs \(\rightarrow\) bundling payments/alternative payment models
- Increase care coordination
- DECREASE FRAGMENTATION OF CARE
Fragmentation of Care

COSTS

Time/# health problems/# providers/# sites of care/#transitions/#EHRs, etc.
Change in Specialty Care Delivery?

The current visit-dependent paradigm for the delivery of specialty care in the United States contributes to inefficient and ineffective health care.
Next Step: Affordability!

*Affordable Care Act*
Conclusions

- **Pre-ACA**, we found **significant disparities** in access to outpatient specialty care for children, attributable to provider non-acceptance of public insurance.

- **Post-ACA** there remain **many** challenges but also opportunities for improving care delivery

- **Need for on-going monitoring**
  - Access/Equity
  - Quality
  - Affordability
  - Patient experience
  - Health outcomes
EXTRA SLIDES
Background: 42 Million U.S. Children Are Publicly Insured

- Medicaid/CHIP Entitlement programs
  (poor economy => more eligible)
- Federal Law*
  “Medicaid must provide the same access to services that is available to privately insured children living in the same geographic area”
- Yet in 2010, the Office of Inspector General of DHHS found most children in nine states did not receive Medicaid-required preventive screenings (DHHS, OEI-05-08-00520)

* Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, Sec. 6402

Kaiser Family Foundation, statehealthfacts.org
AMC-affiliation = 45% decrease in discriminatory denials

<table>
<thead>
<tr>
<th></th>
<th>OR</th>
<th>95% CI</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic is affiliated with an academic medical center</td>
<td>0.55</td>
<td>0.31 to 0.99</td>
<td>0.045</td>
</tr>
<tr>
<td>Neighborhood poverty level of clinic location</td>
<td>0.95</td>
<td>0.92 to 0.98</td>
<td>0.000</td>
</tr>
<tr>
<td>Practice size (number of specialists) of clinic</td>
<td>0.91</td>
<td>0.77 to 1.08</td>
<td>0.285</td>
</tr>
<tr>
<td>Average years of experience of all clinic specialists</td>
<td>1.00</td>
<td>0.98 to 1.03</td>
<td>0.920</td>
</tr>
<tr>
<td>Clinic employs any foreign medical graduates</td>
<td>0.72</td>
<td>0.39 to 1.32</td>
<td>0.281</td>
</tr>
<tr>
<td>Clinic employs any board certified specialists</td>
<td>1.65</td>
<td>0.68 to 4.03</td>
<td>0.271</td>
</tr>
<tr>
<td>Clinic employs any pediatric board certified specialists</td>
<td>0.44</td>
<td>0.22 to 0.88</td>
<td>0.021</td>
</tr>
<tr>
<td>Specialty type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy-immunology/Pulmonary diseases</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>1.41</td>
<td>0.53 to 3.76</td>
<td>0.494</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>0.70</td>
<td>0.23 to 2.14</td>
<td>0.527</td>
</tr>
<tr>
<td>Neurology</td>
<td>0.87</td>
<td>0.33 to 2.26</td>
<td>0.770</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>2.45</td>
<td>0.75 to 7.98</td>
<td>0.137</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>1.06</td>
<td>0.40 to 2.77</td>
<td>0.912</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0.55</td>
<td>0.21 to 1.40</td>
<td>0.209</td>
</tr>
</tbody>
</table>
## Wait time 41 days longer if Child has Medicaid

*Interaction Model: Additional Wait-time (days) for Children with Medicaid-CHIP (Versus Private Insurance) By Specialty Clinic Characteristics (n=178 calls to 89 clinics)*

<table>
<thead>
<tr>
<th>Clinic Characteristics Interacting with Insurance Status</th>
<th>β</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic is affiliated with an academic medical center</td>
<td>40.73</td>
<td>0.026</td>
</tr>
<tr>
<td>Neighborhood poverty level of clinic location</td>
<td>-1.34</td>
<td>0.060</td>
</tr>
</tbody>
</table>

**Specialty type**

- Allergy-immunology/Pulmonary diseases: 16.34, 0.279
- Dermatology: 16.34, 0.279
- Endocrinology: 65.08, 0.146
- Neurology: 15.76, 0.403
- Orthopedics: 5.84, 0.672
- Otolaryngology: 51.93, 0.022
- Psychiatry: 14.26, 0.398

*Note.* β = beta coefficient. Interaction terms from linear model of wait-times for appointments. The model also included as control variables clinic practice size and the years of experience, foreign medical graduate status, board certification status, and pediatric board certification status of clinical staff. Standard errors adjusted for clustering by clinic (i.e. two wait-time observations per clinic). R² for the model was 0.307.
Simulated Patient Studies
Standardized Patient/Mystery Shopping/Audit Methodology

Education/feedback
Quality Assurance

Measure discrimination
Participant Observation Factitious Patient
# Audit Research to Inform Public Policy

## STRENGTHS
- Studies real world behavior: what people do, not what they say
  - Persuasive, not subject to selection, response, or recall bias
- Studies the system not individuals
- Protects human subjects (IRB)
- Benefits anticipated to outweigh harms (monitor system capacity and inequity)
- Experimental design
  - Can control for confounders
  - Isolates the impact of the variable you are studying

## WEAKNESSES
- Deceptive design
- Not feasible to get consent, would influence “business as usual”
- Only studies entry into the market place (Access not Quality)
- Does not identify reasons for the observed behavior
- Need comprehensive lists, from which to randomly sample
- Must be able to supply same information a real patient would have, (e.g. insurance numbers)
# Expert Panel Members

## Medical Expert Panel
- Fuad Baroody, MD
- Kelly Carter, MBA
- Janet Currie, PhD
- Diana Cutts, MD
- Matthew M. Davis, MD MAPP
- Paul F. Detjen, MD
- Chris Forrest, MD PhD
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- Rick Hamilton, PhD
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- Daniel Johnson, MD
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- Richard A. Levy, MD, MBA
- Katie Merrell
- Gail Patrick, MD MPP

## Oral Health Expert Panel
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- Robert J. Collins, DMD MPH
- Eileen Crespo, MD
- Diana Cutts, MD
- Burton Edelstein, DDS MPH
- Patrick W. Finnerty, MPA
- Raul Garcia, DMD
- Shelly Gehshan, MPP
- Robert E. Isman, DDS MPH
- Ray J. Jurado, DDS
- Genevieve M. Kenney, PhD
- Lew N. Lampiris, DDS MPH
- Stacey McMorrow, PhD
- Muzaffar Mirza, DDS