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Primary Care's Code Blue: Can basic patient care be revitalized?

Who are ambulatory-care-sensitive utilizers, why do they use emergency care in place of primary care, and what are morally responsible solutions to such utilization?

Introduction

By 2020 health care spending will be twenty percent of the United States' gross domestic product— making health care an unstable fifth of the economy. With the passage and signing of the Patient Protection and Affordable Care Act in 2010 under President Obama, the first of hopefully many economic-based reforms are on their way to changing how America perceives its care. Beyond pure economic reform that works to lower future costs, health care now more than ever vitally needs systematic reform to its most basic and necessary element: patient-focused primary care.

In 1986 congress passed the Federal Medical Treatment and Active Labor Act which requires hospitals to treat all patients with medical emergencies, regardless of their ability to pay (Miller 2012). This mandate fails to do two things: 1) define what exactly a “medical emergency” is and 2) extend its jurisdiction to private primary care offices, accidentally creating an incentive for those without the means to pay for other care options to utilize the emergency room (ER) for care that *could* be provided elsewhere. Today, emergency departments serve patients as a primary, or ambulatory, care facility might, providing basic medical care for ailments or conditions that do not require admission (over-night admission) to the hospital. This poor stream-lining of ambulatory care cases to primary care offices and of acute emergencies to the ER has created a system of

redundancies, built on unnecessary ER visits, ballooning health care costs, and little to no improvement in the health of those who access such care.

The US Healthcare system at its most basic and necessary existence is primary care: caring for patients from the start and preventing diseases before they start. Healthcare needs more than a shock to the entire system to keep it barely floating, more than changes to insurance laws or new scientific advancements—it requires massive changes to support and bolster the basic and life-preserving functions: primary care. The most effective, relevant, and essential method to providing quality care to all and doing so effectively is to alter how every single person acquires basic primary care.

Part One of this paper will identify what it means exactly to access primary care in the ER, the people who access such care, and why they access primary care in the ER. I argue that those who access primary/ambulatory care in the ER do so due to myriad social, structural, economic barriers to be further discussed in this paper. The current healthcare system hurts patients and fails to provide equal access to preventive- and treatment-based primary care. In part two, I state that we have a responsibility to provide solutions to the unequal and superfluous “primary” care that is commonly accessed in ERs due to such barriers, supported by the Rawlsian claims of Norman Daniels. Lastly, I identify the most relevant and feasible current and possible solutions for eliminating primary care-based ER visits.

PART ONE

Terminology and its Utilization in Research and Policy

Discussing relevant terminology and its current role in healthcare is vital in understanding how patient care can be improved for millions across the country. Having

relevant and nationally accepted terminology in healthcare conversation is not only helpful in comparing different areas of policy implementation, but shows that research and policy have a shared responsibility and the know-how to effect change. Research on hospital visits that *could* be avoided or treated elsewhere (for this paper, in a primary care or ambulatory care office) is limited before the 1990s. Terminology for wide-spread research was not developed until John Billings et al published a paper in 1993 analyzing the impact of socioeconomic status on hospital use in New York City. In this paper, Billings coined the term “ambulatory care sensitive conditions” (ACSCs), which are “those conditions for which hospital admission could be prevented by interventions in primary care” and such “timely and effective outpatient care can help to reduce the risks of hospitalization by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease or condition” (1993:163). In all academic setting and policy initiatives surrounding access to primary care in ERs, “ambulatory” is to be understood at its Latin root—“to walk in,” and there serves as a synonym for primary in reference specifically to primary, non-emergency, care.

In the past two decades, the term ACSC has taken on a different meaning for both policy makers and researchers. The United States, in comparison to other countries, has a large body of research on ACSCs as “markers of primary care effectiveness,” allowing researchers to utilize hospital based data to see who accesses ACSC care in an emergency room and why (Purdy et al 2008:169). Billings, upon the development of an applicable research algorithm, showed that ambulatory care-sensitive visits fall into one of two categories: “primary care treatable,” meaning the condition or problem could be safely

handled in a primary care doctor's office and "primary care preventable," meaning the ER visit could have been avoided if care had been provided sooner (Billings et al 2004). Even with the pertinent research that has been performed to provide data on ACSCs, the majority of policy implementations have taken place in the UK, Germany, and Brazil (albeit on a smaller, city wide scale). The data Billings et al used in 2004 is even based on English hospitalization numbers. The US Health Department does not officially recognize the term ambulatory care-sensitive anywhere in its online literature, while the UK widely uses the term. Beyond its initial and intended purpose, the research Billings et al performed was used by other researchers in 2006 to look at individual decision making for reasons to visit the ER- an intention Billings never had for the algorithm (Kellerman and Weinick 2012).

Properly applicable usage of ACSC data and research was done in Northern Baden-Wuerttemberg, Germany to show how physicians identified certain conditions (whether as ACSCs that were avoidable or acute emergency visits) and how the determined list of ACSCs was not consistent for physicians in different states or areas (Freund et al 2013). Purdy et al showed similar results in their research that calculated 35 ACSCs, only 19 of which matched the English National Health Service's list, with the 17 additional ACSCs accounting for the majority 65 percent of the visits (2008), with some NHS recognized ACSC's listed here:

- Angina
- Convulsions and epilepsy
- Chronic obstructive pulmonary disease
- ENT infections
- Nutritional deficiency
- Perforated/bleeding ulcer

One policy stab at ACSCs occurred in 2011 in Washington state when the Health Care Authority stated its intention to stop “paying for emergency department visits [of] beneficiaries when those visits are not necessary for that place of service” (Kellermann and Weinick 2012:2041). This original proposal faced a suspended implementation from Governor Gregoire at the time, and was softened down to aim at reducing just “medical assistance expenditures through the reduction of unnecessary emergency department visits” (2041). The task is still underway, but it is an extreme challenge to cut services that legally must be supplied to the increasing number of asking individuals, especially in a time where almost ten million Americans have lost employer-based insurance and Medicaid enrollment is skyrocketing. While data shows an inconsistent measure of ACSCs in policy-based analysis, it reiterates that public or government based programs do not always reflect ACSC research and its suggestions. Some of the inconsistencies between research analysis and policy implementation can be attributed to the generally marginalized and disadvantaged populations with which ACSCs are associated.

For the purpose of this paper, ambulatory care-sensitive conditions will be known as ACSCs, and those requiring such services are known as ambulatory care-sensitive utilizer, ACSUs. As previously stated, beyond this paper, a wider acceptance of these terms would lead to better transparency between research and policy methods, as well as a nationally understood term that gives agency to those who are commonly identified as ACSUs. Access to medical care is complex, and we will view it as Andersen and Davidson do: in two parts. Potential access is measured by the enabling variables, or possible outcomes, of the behavioral model at both the contextual (health policy, financing) and individual (regular source of care, health insurance, income) levels.

Realized access is the actual use of service, which includes utilization of physician, hospital, dental and other health services.

Who are Ambulatory Care-Sensitive Utilizers?

In this section, I will provide evidence to highlight certain populations that access the ER for ambulatory care-sensitive conditions. ACSUs accrue emergency medical services for ambulatory care-sensitive conditions is an extremely challenging phenomenon to track and understand. The term ACSU, while extremely practical, is not widely used and no amount of research can fully pinpoint all individuals who are considered ACSUs. Employing such identification measures forces researchers to use data post-diagnoses (or admission into the hospital) to determine the type of visit to the hospital. Without proper medical history of the patients in question, it is also challenging to know if the ACSU was preventable or treatable outside of the ER, especially for conditions like diabetes. Beyond that, comparison studies are nearly impossible as “hospital-based studies can examine issues related to appropriateness of care and other clinical matters, but lack the ability to contrast characteristics of ER users with individuals who did not visit an ER (Zuckerman and Shen 2004:176). For these reasons, analysis of ACSUs, with the help Billing et al’s algorithm, is based primarily on observational studies. More important to furthering the study of ACSUs, the language surrounding such individuals is rarely, if ever, consistent of fully encompassing.

In the past decade, hospitals have been greatly aware of the increased cost of emergency and ambulatory readmissions due to “hot-spotting” research and new financial penalties linked indirectly to the readmissions. In identifying ACSUs, “hot-spotting” is a data mining process that researchers perform to identify patients that meet certain

qualifications, like ER patients, many of whom “were seeking care for symptoms [doctors] and other primary care providers normally treated in their offices,” and were being seen in the ER for treatable and preventable ACSCs (Ward 2011:24).

Hot-spotting led to the identification of publicly insured individuals as the most likely to acquire care in the ER for ACSCs. While being identified as qualifying for Medicaid assistance normally implies other disadvantageous determinants to health and other aspects of life (to qualify, one must earn less than the federal poverty level, unless the level is set higher by the specific state), being insured through public institutions presents myriad challenges of its own. In comparison to privately insured and uninsured frequent users of the ER, publicly insured patients are 29 percent of the frequent user population, even though they only represent five percent of nonelderly health-care seeking adults (Zuckerman and Shen 2004). Overall, Zuckerman and Shen reported that publicly insured adults are 2.08 times more likely to be frequent users in the ER, while uninsured and privately insured adults are equally likely to be frequent ED users. Patients with low socioeconomic status use more acute hospital care and less primary care than patients with high SES (Kangovi et al 2013). In the Billing et al’s study on socioeconomic status and hospital admission rates, patients with incomes of less than 15,000 dollars (in 1993) had substantially higher admission rates than patients in higher income brackets. There is a large negative correlation between socioeconomic status and ACSC hospitalizations—admission rates for asthma, a common ACSC, were 6.4 times higher in low-income areas of New York City than higher-income areas, with income accounting for at least 70 percent of the variance (1993:165).

Blacks, after controlling for demographic, socioeconomic, and geographic factors, have significantly higher rates of ACSC hospitalizations than whites for over half of the researched conditions in O’Neil’s et al study in 2010. The study, which took great care to control for social factors, reported race as a “key predictor” of preventable hospitalizations, especially among the elderly for congestive heart failure, hypertension, diabetes, and adult asthma—all of which are ACSCs (2010:385). Similar results were also seen with Hispanic and Latino populations of all ages, especially in statistical reporting on patient levels of dissatisfaction with physicians and hospitals, which will further discussed later in this paper.

Why do ACSUs go to the ER for ACSCs?

In having identified the majority of ACSUs as publicly insured, of lower SES status, racially in the minority, and/or elderly, the next step in fully understanding ambulatory care-sensitive conditions in the American healthcare system is to determine *why* such populations utilize this care. It is expected from and the goal of primary care offices to provide certain care to patients including “routine physical examinations and screening procedures, such as prenatal care, immunizations, mammograms, and colonoscopies (Wright and Perry 2010:S108)—all services that can be identified as treatable. With the existence of multiple ACSUs, the proper flow of care first to primary care offices and *then* to hospitals is substantially interrupted and disjointed. Therefore, the disorganized handling of care between primary care offices, hospitals, and patients can be described as the degree of “fit” between patients and the health system at large. Health researchers Penchansky and Thomas created dimensions of “fit” in 1984 to test a taxonomic definition of “access” in a health system in which they found “access” to be

poorly and non-uniformly defined. They coined five dimensions of access, all of which can be understood as a way to measure how certain services or processes of access are potential or realized, as Andersen and Davidson describe.

In this section of the paper, the health system and patients in the United States will be viewed under the dimensions of access (which are listed below) to express 1) why a patient would have an ACSC hospitalization and 2) what, if any, barriers are causing the patient to access such care. By using the dimensions of access as a viewing platform into ACSC hospitalizations, each subsequent subsection of the paper will be able to directly point out examples of system failures or gaps that encompass all definitions and meanings of access in the healthcare field.

The Five Dimensions of Access (Penchansky and Thomas)

1. *Availability*: the relationship between the volume and type of existing services (and resources) and the clients' volume and types of needs. It refers to the adequacy of the supply of physicians, dentists, and other providers or facilities, such as clinics and hospitals, and of specialized programs and services, such as mental health and emergency care.
2. *Accessibility*: the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance, and cost.
3. *Accommodation*: the relationship between the manner in which the supply resources are organized to accept clients (including appointment systems, hours of operation, walk-in facilities, telephone services) and the clients' ability to accommodate these factors.
4. *Affordability*: the relationship between prices of services and providers' insurance or deposit requirements and the clients income, ability to pay, and existing health insurance. Client perception of worth relative to total cost may be a concern, as may [be] clients' knowledge of prices, total cost, and possible credit arrangements.
5. *Acceptability*: the relationship between clients' attitudes about personal and practice characteristics of existing providers including age, sex, location and type of facility or religious affiliation of provider or facility, as well as provider attitudes about acceptable personal characteristics of clients, including ethnicity and patient payment source. (1984:554-555)

Barriers to Availability and Accessibility

Outside of taxonomic research on access, separating availability and accessibility is extremely challenging. The low supply of primary care physicians is an important component of barriers access. Individuals in areas with a low supply of physicians may have more difficulty accessing primary care than do individuals in areas with greater supply, as evidenced by longer waiting times for appointments, longer travel times to obtain care, shorter visits with the physician, and reduced follow-up care (Laditka 2005).

A lack of physicians, in both primary care and specialty care, is an issue in rural and urban areas. In the 1970s, congress created the Health Professional Shortage Area (HPSA) designation, stating that for an area to be so labeled, it had to have a population to fulltime-equivalent (FTE) primary care physician ratio of at least 3,500 to 1 (Laditka et al 2005). In 2004, the Bureau of Health Professions reported 1,347 designated primary care HPSAs in U.S. metropolitan areas, and 2,672 in nonmetropolitan areas, translating into twenty percent of the US population living in a HPSA. Of that twenty percent, the majority live in rural areas that also lack consistent and accessible emergency care. For patients who access ambulatory through the ER, in many areas (rural and urban) it may be the only access point. The ER in this case does not necessarily serve as a safety net for the poor or uninsured, or a place to purely triage acute emergencies, but as the first open door for accessible care in a community.

Availability also begs the question of specialized programs, like those aimed at limited English proficiency (LEP) patients. In California there exists a patient Spanish-speaking physician ratio around 700:1, only 26 percent of the primary care physicians in urban counties spoke Spanish, showing a huge lack physician availability to LEP patients (there a total of 18.4 thousand physicians accounted for in the study). For every 100,000

Spanish speaking LEP residents, there were 146 primary care and 66 specialty care physicians. Only 48 primary care and 29 specialty care physicians were reported for every 100,000 Spanish speaking LEP residents on Medicaid (Yoon et al 2003).

A common accompaniment to a limited supply of physicians in an area is the limited supply of provider offices, facilities, and equipment. Patients who have access to a primary care practice are still more likely to use the ER if the practice lacks equipment for immediate care of asthma or there is a high presence of nurse practitioners and physician assistants (Lowe et al 2005). More commonly, primary care offices are struggling to keep up with patient demands because 1) their operating hours or open clinic hours (if applicable) may not be compatible with that of the patient and 2) the location of primary care offices that are compatible with the needs of a patient may not be within a reasonable distance for transportation needs, and considering both reasons, the patient may then be forced to seek care in an ER. For Medicaid patients, whose access to primary care physicians is already limited (doctors who do not wish to serve Medicaid or publicly insured patients are not required to do so by law), the availability and accessibility to care is extremely limited, more so than for privately insured patients. In comparison, uninsured patients also experience the same, if not greater, challenges of seeking primary care as publicly insured individuals.

Barriers to Accommodation

Accommodation is a complicated dimension of access because its strong ties to technology and the changes in patient protection and technology laws. Most primary care offices maintain a different system for booking appointments, some of which allow the doctor to see only so many patients a day, or an hour. The systems through which offices

book appointments are prone to double-booking and “triage” methods (Murray et al 2003) that bump other patients off the list, forcing bumped patients and urgent-care patients to seek care elsewhere because there are no quickly available appointments. Notably, non-Hispanics blacks are 4 times more likely than whites to use the ER for “after-hours” care if primary care is not currently available (DeLia et al 2011).

In Lowe et al’s study of Delaware primary care offices in 2005, only seventy-four percent of practices had weekday office hours after 5 PM, while 56% lacked weekend hours. Simulated patients, who were researchers posing as patients, were unable to make appointments for urgent problems at 21% of practices (2005:796). Regardless of the reason for visit, patients of a primary care office that had 12 or more evening or weekend hours per week saw a 20 percent reduction in ER visits from the same patients that year. The positive statistics seen with evening or weekend hours is likely to be less pronounced at other primary care offices, as this research was performed with four HMOs (health maintenance organizations) that assigned their patients to specific primary care offices—millions of individuals across the nation do not have access to an insurance/healthcare management system that assigns a primary care office.

In rural primary care offices it is common to see doctor’s panels swell to over 1,500, forcing staff to book appointments well in advanced, without notice or knowledge of future “demand” (possible urgent care need by patients in the panel). Two weeks prior to any open day, many systems only leave 30 to 50 percent of the average 28 appointment slots open in the morning, booking the elderly (who most commonly have chronic conditions) and then double booking them in favor of more urgent patients or at times closer to the holidays, resulting in shorter patient-doctor interaction time (Murray et

al 2003:1043). Many appointment systems, in rural and urban areas, do not account for this possible urgent care need, forcing patients to access care for ACSCs in the emergency as a same day appointment or next day appointment were not available. Similarly, these appointment systems do not normally account for walk-in patients, creating a similar issue of not being able to receive care before a medical issue becomes acute or the ER becomes a more viable option for care.

Barriers to Affordability

Affordability is an extremely delicate dimension of access to health care because it so easily connects patients, hospitals, and primary care offices through the complicated maze of money and payment methods. Except for those located in California, hospitals are not forced to report their “chargemaster”, a list of the hospital’s price for every procedure performed in the hospital and every single item used during those procedures (Reinhardt 2006:58). A chargemaster allows a hospital to charge Medicare, Medicaid, private insurance companies, and uninsured or self-insured individuals different prices for the same services based on multiple counts of deliberation and behind-the-door dealings.

The Health Insurance Portability and Accountability Act (HIPAA) in 1996 stated that Medicaid and Medicare must have a standard national format for all hospitals’ chargemasters, which is why it is so challenging to change the already low amount or paid by public insurance to hospitals to reflect market prices or equal that of private insurance. Partnerships with hospitals by primary care offices, health maintenance organizations (HMOs), and accountable care organizations (ACOs) result in similar low payments for outpatient, or non-hospital partnered, care, another reason why physicians

may choose to not service Medicaid/Medicare patients because the low payment rate at the hospital with which the primary care office or HMO is partnered. In contrast to Medicare payment methods, private insurers strike deals with certain hospitals and outpatient centers to pay either “steeply discounted prices (with discounts in excess of 50 percent)” (2006:61). This system results in uninsured or self-insured patients paying the full chargemaster price, is the full, inflated cost of service- a service for which the “real” price is never revealed.

Having to pay the entire cost of the chargemaster price is what puts the uninsured or self-insured at risk of debt declaration or extreme financial burden. More commonly, ACSC treatment in primary care offices is charged the same way as hospitals with a chargemaster, resulting in highly inflated costs for even a band aid or cotton swab, further discouraging action for care in primary care offices prior to a serious emergency. For already low SES Medicaid insured or low-SES patients, if they have knowledge of a possible copayment, or upfront fee, due at the time of a primary care visit, they may choose to go directly to the ER for immediate care and deal with the bill later, despite the price inflations in hospitals (Shaw et al 2013). Most challenging of all, as only a percentage of primary offices serve publicly insured patients or uninsured patients, the Affordable Care Act states that “health plans, including Medicaid managed-care organizations, can no longer deny payment of a claim if the patient or the parent of the pediatric patient reasonably believed that the problem required treatment in an emergency department” (Kellerman and Weinick 2012:2143). This provision, especially for Medicaid patients, means that when primary care is unavailable or challenging to receive,

it is not only lawful and reasonable to go to the ER for ACSC care, but perhaps the *only* viable option.

Barriers to Acceptability

A patient's attitude about the characteristics of primary care offices and emergency rooms is key in understanding why a patient is more prone to ACSC hospitalizations. Un- or underinsurance may drive the preferential use of the ER for care, the "low-value use" of primary care offices has negative consequences on overall health (2013:1196). It is the decision-making process the patient may have regarding places or opportunities to access medical care that may directly influence where they eventually seek help (Kangovi et al 2013). A patient who consistently accesses ambulatory care through the ER will gain few health benefits of primary care, further exacerbating health disparities as primary care encompasses preventive medical care. The panel Kangovi et al surveyed was comprised of 90 percent black/African-American individuals, but data from DeLia et al with a patient panel of 64 percent white individuals shows similar results: at least one-third of patients surveyed went to the ER for "non-urgent" care and fifteen percent of them did so because lack of hours at primary care office or felt "diverted" to other possibilities of care (2011).

Lack of knowledge of possible care options is a common reason behind eventual ACSC hospitalizations. Kangovi et al reported that for patients with five or fewer acute care episodes in the past six months, those patients found accessing ambulatory care to be the most difficult task. For patients who accessed the ER more than five times in the last six months, they reported more social dysfunction (in their personal lives) and disability (2013).

Even less understood by sociological and economic analysis is that the racial disparities in ACSC hospitalization rates are not explained completely by demographic and socioeconomic factors. Blacks, in the Sasigant et al study, had statistically significant higher rates than whites did for hospitalizations for five of eight ACSC conditions, controlling for demographic, socioeconomic, and geographic factors (including diabetes, adult asthma, CHF, and hypertension) which leads researchers to look at possible “variations in primary care, quality of care, and physician practice experienced by [different races]” (2010:386). Such possible variations suggest there is primary care physician preference regarding “acceptable personal characteristics of clients” (Penchansky and Thomas 1981) affecting ACSC hospitalization rates more than previously expected by researchers.

While some patients are driven to the ER because a perceived lack of accessible ambulatory care, basic social understandings of preference and perception play a huge role in seeking out care. In some cases, patients may completely bypass the option of primary care due to past interactions they perceived as problematic. More perplexing, patients at federally qualified health centers, regardless of their own race, are extremely affected by 1) the racial/ethnic composition of their care center and 2) perceived racial bias in the quality of health care delivery there (Shaw et al 2012:1298). These perceptions were reported by a quarter of the survey panel, regardless of race. Such sensitivities can lead to a less than optimal consumption of health care if patients’ actions are driven by possible precarious perceptions of primary care facilities.

Access and Answers

It is through defining and painting a clear picture of the barriers of healthcare access that researchers, analysts, and politicians can together find ways to decrease and eventually eliminate ACSC hospitalizations. Each dimension of access is important in solving this problem, and highlights the myriad and vital sections of the American healthcare system it compasses. By understanding the current gaps in each dimension of access, it becomes clear where the healthcare system does not “fit” the needs of patients, how it does not meet the needs of each dimension of access, and how the basic barriers to access have persisted. Solutions for eliminating ACSC hospitalizations are constructed in the same way, by using the dimensions of access as a lens to view and analyze the healthcare system to better fit the needs of patients (and the system as a whole) to end ACSC hospitalizations.

PART TWO

In part two of this paper, I argue why we have a moral responsibility, using the Rawlsian thought of Norman Daniels, to eliminate gaps in access and breakdown barrier to healthcare. I then present possible solutions for eliminating ACSC hospitalizations, in part through the current efforts of the Camden Coalition of HealthCare Providers to highlight examples for possible national solutions through their localized work.

A Rawlsian-based Argument: Why is the elimination of ER-treated ACSCs important?

As analysis of the dimensions of access show, emergency care utilization for ambulatory care-sensitive conditions is neither an equal substitute nor an adequate replacement for primary care. ACSUs are not seeing preventive care services and their less productive care is extremely costly. Emergency care is not a substitute for more

consistent, better-managed care and cannot replace or be counted as a sustainable source of care. While many patients can receive quality care in ERs, their care is not without extra expenses imposed on themselves, the hospitals, and other insurance buyers or its system participants. Most importantly, ambulatory care-sensitive utilization in emergency rooms is a sign that the dimensions of access do not fit the needs or qualities of the communities or population in question. For each case of ACSC hospitalizations, there is a greater, hidden problem lurking behind the patient's health concern that provides a glance into a system that is lacking proper and just access to health care. It is through an analysis of the responsibility to just health Americans should have, supported by the Rawlsian-based writings of Norman Daniels, that a solution for ACSC hospitalizations will be deemed not only necessary, but warranted by a commitment to just health. Daniels, drawing on Rawls, provides moral arguments for why a commitment to just health is important: it gets every player safely to starting line of life so they can pursue other opportunities (education, jobs, etc.). It is the basic concept that having good health means a chance at success in life and everyone deserves that chance. That chance is best found with the elimination of ACSC hospitalizations.

In the particular case of patients entering the ER, their need for health care is part of a greater system with many players—other patients, insurance holders, hospitals, physicians, laws, and issues of payment, reimbursement, and overall health cost structures. Each player, or entity, has a role in determining how care is distributed, managed, provided, and accepted in the health care world. Care, at its most basic level, is the fulfillment of health needs, or “things we need in order to maintain, restore, or provide functional equivalents (where possible) to normal species functioning” (Daniels

2008:42). Health, in all its forms, has a huge effect on economic, social, and educational outcomes, and in turn, those outcomes as social determinants have a mirror-like effect on one's health, normal functioning, and the overall distribution of health care. Therefore healthcare is not just the fulfillment of the basic health needs like medication, but ensuring that social determinants that affect health outcomes are fully considered as well. "Social conditions- including class, gender, race, and ethnic inequalities in obtaining various goods-contribute significantly to the distribution of disease and disability... [they] are not simply a product of the natural lottery but [are] influenced by the social lottery as well" (2008:58). By working to fulfill the health needs for all, the health care system is giving each involved individual the fair equality of opportunity so that one can obtain and achieve future successes with a starting point of normal health functionings.

Since the health care system, with all its players, is the societal structure that will work fulfill such health needs, it is the first system that can and must be altered to "keep people functioning normally and thus to assure them the range of opportunities they would have in the absence of disease of disability" 2008:58). Even with these efforts to get individuals to the closest state of normal health functionings, not all treatment methods are "cures," so institutions and services in the health care system must be provided to keep them as "close as possible to the idealization that all function normally," a goal attained most productively through preventive care (2008:62). But with each additional service or health concept added to the growing list of interventions, we step away from the perfect concept of Rawlsian thought on normally functioning people (because we are creating solutions for a problem that implies that normal functioning is not occurring). While moving away from Rawls, Daniels provides us with the important

that “it is better to prevent than to cure and better to cure than to compensate for lost functioning... All these institutions and services are needed if fair equality of opportunity is to be guaranteed” (2008:63). Equal access to quality healthcare is the most important step in ensuring the fair equality of opportunity—it is what most adequately and fairly gets everyone to the starting line, rather than leaving some in the dust and stuck on the benches.

Solutions for Ambulatory Care-Sensitive Condition Hospitalizations

It is through drawing from the moral Rawlsian arguments of Daniels and the evidence of access barriers presented earlier in this paper, that I will formulate possible solutions and policy initiatives for decreasing and eventually eradicating the cases of ACSC hospitalizations. These solutions will be presented through the dimensions of access with specific and macro-level examples in research and personal involvement at the Camden Coalition of HealthCare Providers. The established fact that there are individuals who access ambulatory-sensitive care in hospital emergency rooms intended to serve only those with acute emergencies openly implies that there is need for a solution; simply, primary care should not be sought out in the emergency room. People who do seek such care in ERs (ACSUs), do so because the dimensions of access are not fully realized and do not entirely “fit” the needs of the patients or the healthcare system. Any ACSC hospitalization implies a failure or gap in accessing healthcare properly.

This gap in access not only creates the health disparities mentioned earlier in this paper, but also exacerbates health inequalities while starkly increasing economic and social costs on all involved parties, from the patient to the federal government. Economic costs are evident with a patient’s initial visit, and increase as acute-injury trained

hospitals do not treat ACSC patients with preventive care, raising healthcare costs in the long run. The more Medicaid and Medicare patients that are serviced in hospital ERs the more their care becomes a matter of treating rather than preventing disease, increasing costs further. “Indeed, public emergency room departments have effectively become the safety net for America’s marginally poor [and] compensating for changes in government funding for other social services” (Wright and Perry 2010:S111). The social costs of the current system unfairly land on the shoulders of the disadvantaged, mostly ACSUs. The lack of doctors or facilities to provide care to ACSUs creates a social divide between who has proper care and who does not. The system further marginalizes the poor by presenting the ER as the only viable option for care, and further exacerbates health inequalities because the lack of preventive care found in hospital ERs.

I found such a case of increased social and economic costs due to poor access to healthcare while working in New Jersey this past summer as a Shepherd intern with the Camden Coalition of HealthCare Providers (CCHP). CCHP today is a ten-year-old accountable care organization staffed with social workers, nurses, administrators, community health workers, physicians, and AmeriCorps volunteers. Over a decade ago it was the “side-job” for founder Dr. Jeffrey Brenner, a primary care physician in Camden who served a community of 75 thousand, 95 percent of whom are currently eligible for Medicaid. After acquiring six years of data computation and agreements with the three local hospitals and multiple primary offices, Brenner was able to compile a map of “hot spots,” areas in which residents had a high rate of readmission in the last six months to any hospital. The research showed massive overutilization of the hospital services and the communication was so fragile between the hospital and primary care offices, patients

would be “lost” after discharge, having a huge impact on a patient’s overall health, as primary care offices could not contact them (Ward 2011:25).

Brenner explained that “multiple barriers and stressors such as poverty, mental illness, lack of health insurance, housing and transportation build up over time in people’s lives, and when they need care, they go to the one place that won’t reject them — the ERs and hospitals” (2011:25). The huge data analysis on Camden proved Brenner correct: 50 percent of Camden residents visited the ER annually, and of the 387,000 patients seen in all hospitals, 1,000 patients made up the top 1 percent of those who used emergency room 39,000 times in one year, accounting for 375 million dollars in medical costs (Ward 2011). For Brenner, emergency-room visits and hospital admissions are failures of the healthcare system until “proven otherwise”--failures of prevention and effective, timely care (Gawande 2011:42). The social costs of the flailing healthcare system in Camden was even more evident after Brenner identified two apartment buildings as the “hot-spots” for the most falls, mostly my elderly residents. Upon further investigation, it was found that both buildings lacked proper stairwell safety measures and elevators.

Solutions in healthcare through the dimensions of access

This place-based analysis by Dr. Brenner and the CCHP reflects the same conclusions found in research regarding barriers to accessing primary care. The efforts Dr. Brenner has made with the CCHP to ensure access to healthcare are tremendous, and a prime example of the way organizations can work to better make healthcare access “fit” their communities. In this final section of part two, I present solutions, abstract or

currently implemented by CCHP, to the previously mentioned disparities in access to healthcare and healthcare in general through the lens of the dimensions of access.

Solutions to Access: Availability and Accessibility

There is a great need for physicians throughout urban and rural parts of the United States. Across 20 urban counties in Laditka et al's 2005 study, there was strong negative correlation between the supply of primary care physicians and ACSC hospitalizations. This result was not seen in rural areas because many rural counties lacked a hospital in general, and even primary care offices. Both cases show that there is a need for a higher number of primary care physicians in underserved areas. More physicians need to be targeted for service in these underserved areas through placement programs like the National Health Service Corps, state loan repayment programs, and Title VII training programs (Laditka et al 2005). Laws should also be enacted to allow nurse practitioners to open their own practices separate of physician's offices, allowing for more patient access to care and an increase in qualified health care professionals to treat and manage ACSCs. The addition of new physicians also means hiring and training more culturally specialized physicians, especially for LEP populations. Increasing the number of physicians who see Medicaid patients would be challenging, but through new provisions in the Affordable Care Act, hospitals and primary care offices will be able to be reimbursed more heavily for their services (the ACA will reimburse Medicaid at the same rate as Medicare as of 2013).

Even with the increase in physician and qualified healthcare professionals' numbers, physical access to their offices must be unhindered and available, through inner-city locations and the potential for transportation assistance. For the CCHP today,

they track and service patients once they have been identified as “super-utilizers” of the ER for ACSCs. The patient is matched with a community health worker (a trained community-based employee or Americorps volunteer) and they ensure the patient makes it to appointment by providing taxi services and reminder calls. Improving accessibility means providing care closer to all patients- a challenging task in rural areas due to spread, but one that should be combatted with assisted transportation.

Solutions to Access: Accommodation

Accommodation may be best realized by the addition of evening/weekend primary care office hours and alterations to appointment scheduling systems. A study of New Jersey hospitals showed that patients from practices with more than 12 evening/weekend hours per week used the ER 20 percent less than patients from practices with without evening/weekend hours (Lowe et al 2005). Increasing the amount of evening/weekend hours allows more low SES patients to access primary care, especially in cases wherein their jobs prevent them from taking time off for health visits or put them at risk of being let go. Overall ER use would decrease by 13 percent if patients in all practices used evening hours (2005:798). Still, this only shows proof for patients that already have affiliations or relationships with primary care offices.

For new or discouraged patients, an accessible and easy appointment scheduling system will help to bring more patients into primary care offices. Electronic Health Records (EHRs) are the first step of this process, and data show that the initial cost of record transitioning (\$32,409) is well spent with the increased revenue from streamlined services and greater flexibility in patient scheduling (Fleming et al 2011). EHRs also now have the capability to allow patients to communicate with their doctors through the

record's program, look at prescription or discharge information, and access answers to frequently asked questions. Through EHRs, the CCHP was able to strike deals and form relationships with primary care offices and hospitals in Camden to not only track super-utilizers, but to help primary care offices utilize an "open-access" model for appointment allotment. Such a system leaves a certain amount of appointments open each day based on past and current demand levels so same-day callers have the chance to come in for an appointment time. This allows patients to be seen by a primary care doctor rather than the ER the same day, tracking them for preventive care one cannot find in hospitals.

Solutions to Access: Affordability

Affordability is the one dimension of access that will see the most benefits under the Patient Protection and Affordable Care Act. The ACA expands Medicaid to 133 percent of the poverty line and creates American Health Benefits Exchanges in each state wherein families and individuals who make 133 to 400 percent of the poverty level can purchase insurance- with possible subsidies (Kaiser Health 2013). The law also increases payments to primary care offices for Medicaid patients in fee-for-service and managed care, up to 100 percent of the poverty line. Increases in doctor payments will give incentives to offices to serve more publicly insured patients, providing more options for ACSUs seeking primary care. The biggest challenge facing further advancement of the law is that states choose to expand the Medicaid benefits and subsequent increased payments to doctors for individuals 100 to 133 percent of the poverty line. Many states (24) are doubtful that the federal government will continue to cover at least 90 percent of the costs after 2020, as stated in the ACA. By not moving forward with Medicaid

expansion, these states are preventing millions of low income individuals for accessing the benefits to which the ACA entitles them.

Still, a system that grants to opportunity of insurance to all is a preferred system as it accounts for income in subsidy distribution for purchasing healthcare, taking into account the needs of low-SES individuals and may even open doors to better care for those seeking LEP services or who require a more specialized style of healthcare. A study in Massachusetts on the effects of health insurance and ER visits found that ER visits were most dramatically reduced anytime primary care offices were open (Miller 2012)—a sign that insurance provides access to primary care and expanded hours can be the key to ensuring primary care usage. Hospitals must also makes their chagemasters easier to navigate and better available to all parties involved. A basic knowledge of the inflated costs of hospital emergency care may deflect many ACSUs from ER usage and further encourage primary care consumption.

Solutions to Access: Acceptability

Acceptability as a dimension of access requires changes in attitudes and actions of patients, primary care offices, hospitals, and all involved parties in community healthcare. Acceptability may be the most important dimension for ACSC policy implications as its solutions seek to connect the myriad branches of the healthcare tree as the “broader U.S. health care system remains a fragmented, uncoordinated patchwork of remarkably independent organizations driven largely by the pursuit of immediate organizational and economic interests, not by the longer-term health care needs of the country” (Wright and Perry 2010:S114).

The CCHP takes the model approach to acceptability solutions by maintaining a collaborative effort with primary care offices and hospitals in Camden to track, encourage, and eventually graduate patients in the program. Their model utilizes “motivational interviewing,” a method of patient interaction that uses “directive, client centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence” (Emmons and Rollnick 2001:69). Along with free transportation, regular (sometimes incessant) telephone calls, home-visits, and frequent medication and attitude reviews, the CCHP program helps patients realize the need for better care on their own while providing the necessary resources along the way. Over time, patients (referred to as “clients” in the program) understand the benefits of primary care and preventive medicine, learning when and how to access such care. This method accounts for the cultural needs of the patients (many CCHP staff members are proficient in Spanish) and the importance of relationship building to establish trust with the care providers, which is extremely relevant in a community with racial divisions and cultural stratification.

Implementing more ACOs like CCHP will be challenging without funding or community healthcare partnerships. This type of access growth is community based, and would require more state and local oversight than that from the federal government. Building trust in communities with programs like CCHP takes years, so benefits from such programs make takes years to be realized. This type of collaborative care is also most challenging in rural areas where basic primary and emergency care are marginal at best.

CONCLUSION

The five dimensions of access are a positive and helpful framing tool to help researchers and policy makers understand the community in which they are invested. Even so, the five dimension of access, like parts of car, require each other equally to work as a viable system- and to make healthcare move in a manageable, efficient, and equal direction. There are myriad policy concepts that can spring from the minds of those who understand the gaps that exist today in the American healthcare system, specifically the gaps that are an incubator for ACSC hospitalizations. The current system fails the most marginalized without providing a quality buffer for the lack of appropriate they receive, if at all. By focusing policy efforts on decreasing the number of ACSC hospitalizations, every single person will have the access to medical treatment he or she deserves and requires to pursue a life full of equal opportunity. With the encouragement of and increased access to primary care and preventive health measures, we may see not only reduced health and social costs in our lifetimes, but better health outcomes for the generations who follow us.

Resources

- Andersen, Ronald M. "Revisiting the behavioral model and access to medical care: does it matter?." *Journal of health and social behavior* 36.1 (1995): 1-10.
- Billings, John, Jennifer Dixon, Tod Mijanovich, and David Wennberg. "Case finding for patients at risk of readmission to hospital: development of algorithm to identify high risk patients." *Bmj* 333.7563 (2006): 327.
- Billings, John, Lisa Zeitel, Joanne Lukomnik, Timothy S. Carey, Arthur E. Blank, and Laurie Newman. "Impact of socioeconomic status on hospital use in New York City." *Health Affairs* 12.1 (1993): 162-173.

- DeLia, Derek, Joel C. Cantor, Susan Brownlee, Jose Nova, and Dorothy Gaboda. "Patient Preference for Emergency Care Can and Should It Be Changed?." *Medical Care Research and Review* 69.3 (2012): 277-293.
- Emmons, Karen M., and Stephen Rollnick. "Motivational interviewing in health care settings: opportunities and limitations." *American journal of preventive medicine* 20.1 (2001): 68-74.
- Fleming, Neil S., Steven D. Culler, Russell McCorkle, Edmund R. Becker, and David J. Ballard. "The financial and nonfinancial costs of implementing electronic health records in primary care practices." *Health Affairs* 30.3 (2011): 481-489.
- Freund, Tobias, Stephen M. Campbell, Stefan Geissler, Cornelia U. Kunz, Cornelia Mahler, Frank Peters-Klimm, and Joachim Szecsenyi. "Strategies for reducing potentially avoidable hospitalizations for ambulatory care-sensitive conditions." *The Annals of Family Medicine* 11.4 (2013): 363-370.
- Gawande, Atul. "The hot spotters." *The New Yorker* 24 (2011): 40-51.
- Kangovi, Shreya, Frances K. Barg, Tamala Carter, Judith A. Long, Richard Shannon, and David Grande. "Understanding why patients of low socioeconomic status prefer hospitals over ambulatory care." *Health Affairs* 32.7 (2013): 1196-1203.
- Kellermann, Arthur L., and Robin M. Weinick. "Emergency departments, Medicaid costs, and access to primary care—understanding the link." *New England Journal of Medicine* 366.23 (2012): 2141-2143.
- Laditka, James N., Sarah B. Laditka, and Janice C. Probst. "Health care access in rural areas: evidence that hospitalization for ambulatory care-sensitive conditions in the United States may increase with the level of rurality." *Health & place* 15.3 (2009): 761-770.
- Laditka, James N., Sarah B. Laditka, and Janice C. Probst. "More may be better: evidence of a negative relationship between physician supply and hospitalization for ambulatory care sensitive conditions." *Health services research* 40.4 (2005): 1148-1166.
- Lowe, Robert A., A. Russell Localio, Donald F. Schwarz, Sankey Williams, Lucy Wolf Tuton, Staci Maroney, David Nicklin, Neil Goldfarb, Deneen D. Vojta, and Harold I. Feldman. "Association between primary care practice characteristics and emergency department use in a Medicaid managed care organization." *Medical care* 43.8 (2005): 792-800.
- Miller, Sarah. "The effect of insurance on emergency room visits: An analysis of the 2006 Massachusetts health reform." *Journal of Public Economics* 96.11 (2012): 893-908.

- Murray, Mark, Thomas Bodenheimer, Diane Rittenhouse, and Kevin Grumbach. "Improving timely access to primary care: case studies of the advanced access model." *Jama* 289.8 (2003): 1042-1046.
- O'Neil, Sasigant S., Timothy Lake, Angela Merrill, Ander Wilson, David A. Mann, and Linda M. Bartnyska. "Racial Disparities in Hospitalizations for Ambulatory Care–Sensitive Conditions." *American journal of preventive medicine* 38.4 (2010): 381-388.
- Penchansky, Roy, and J. William Thomas. "The concept of access: definition and relationship to consumer satisfaction." *Medical care* 19.2 (1981): 127-140.
- Purdy, S., T. Griffin, C. Salisbury, and D. Sharp. "Ambulatory care sensitive conditions: terminology and disease coding need to be more specific to aid policy makers and clinicians." *Public health* 123.2 (2009): 169-173.
- Reinhardt, Uwe E. "The pricing of US hospital services: chaos behind a veil of secrecy." *Health Affairs* 25.1 (2006): 57-69.
- Shaw, Eric K., Jenna Howard, Elizabeth C. Clark, Rebecca S. Etz, Rajiv Arya, and Alfred F. Tallia. "Decision-Making Processes of Patients Who Use the Emergency Department for Primary Care Needs." *Journal of health care for the poor and underserved* 24.3 (2013): 1288-1305.
- Ward, Lauren H. "Data Network Transforms Camden Care." *Health Progress-St Louis* 92.6 (2011): 22.
- Wright, Eric R., and Brea L. Perry. "Medical Sociology and Health Services Research Past Accomplishments and Future Policy Challenges." *Journal of health and social behavior* 51.1 suppl (2010): S107-S119.
- Yoon, Jean, Kevin Grumbach, and Andrew B. Bindman. "Access to Spanish-speaking physicians in California: supply, insurance, or both." *The Journal of the American Board of Family Practice* 17.3 (2004): 165-172.
- Zuckerman, Stephen, and Yu-Chu Shen. "Characteristics of occasional and frequent emergency department users: do insurance coverage and access to care matter?." *Medical care* 42.2 (2004): 176-182.