2014 National Healthcare Quality and Disparities Report

CHARTBOOK ON ACCESS TO HEALTH CARE

Agency for Healthcare Research and Quality

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National Healthcare Quality and Disparities Report

Chartbook on Access to Health Care

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ACCESS TO HEALTH CARE

National Healthcare Quality and Disparities Report

This Access to Health Care chartbook is part of a family of documents and tools that support the National Healthcare Quality and Disparities Report (QDR). The QDR includes annual reports to Congress mandated in the Healthcare Research and Quality Act of 1999 (P.L. 106-129). These reports provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups. The purpose of the reports is to assess the performance of our health system and to identify areas of strengths and weaknesses in the health care system along three main axes: access to health care, quality of health care, and priorities of the National Quality Strategy.

The reports are based on more than 250 measures of quality and disparities covering a broad array of health care services and settings. Data are generally available through 2012, although rates of uninsurance have been tracked through the first half of 2014. The reports are produced with the help of an Interagency Work Group led by the Agency for Healthcare Research and Quality (AHRQ) and submitted on behalf of the Secretary of Health and Human Services (HHS).

Changes for 2014

Beginning with this 2014 report, findings on health care quality and health care disparities are integrated into a single document. This new National Healthcare Quality and Disparities Report highlights the importance of examining quality and disparities together to gain a complete picture of health care. This document is also shorter and focuses on summarizing information over the many measures that are tracked; information on individual measures will still be available through chartbooks posted on the Web (http://www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/).

The new QDR and supporting chartbooks are further integrated with the National Quality Strategy (NQS). The NQS has three overarching aims that build on the Institute for Healthcare Improvement's Triple Aim® and that support HHS's delivery system reform initiatives to achieve better care, smarter spending, and healthier people through incentives, information, and the way care is delivered. These aims are used to guide and assess local, State, and national efforts to improve health and the quality of health care.

To advance these aims, the NQS focuses on six priorities that address the most common health concerns that Americans face. Quality measures tracked in the QDR have been reorganized around these priorities and a chartbook will be released marking progress for each NQS priority. Access to health care cuts across all the NQS priorities and is the topic of this chartbook.

Key Findings of the 2014 QDR

The report demonstrates that the Nation has made clear progress in improving the health care delivery system to achieve the three aims of better care, smarter spending, and healthier people, but there is still more work to do, specifically to address disparities in care.

- Access improved.
  - After years without improvement, the rate of uninsurance among adults ages 18-64 decreased substantially during the first half of 2014.
  - Through 2012, improvement was observed across a broad spectrum of access measures among children.
- Quality improved for most NQS priorities.
  - *Patient Safety* improved, led by a 17% reduction in rates of hospital-acquired conditions between 2010 and 2013, with 1.3 million fewer harms to patients, an estimated 50,000 lives saved, and $12 billion in cost savings.
  - *Person-Centered Care* improved, with large gains in patient-provider communication.
  - Many *Effective Treatment* measures, including several measures of pneumonia care in hospitals publicly reported by the Centers for Medicare & Medicaid Services (CMS), achieved such high levels of performance that continued reporting is unnecessary.
  - *Healthy Living* improved, led by doubling of selected adolescent immunization rates from 2008 to 2012.
- Few disparities were eliminated.
  - People in poor households generally experienced less access and poorer quality.
  - Parallel gains in access and quality across groups led to persistence of most disparities.
  - At the same time, several racial and ethnic disparities in rates of childhood immunization and rates of adverse events associated with procedures were eliminated, showing that elimination is possible.
- Many challenges in improving quality and reducing disparities remain.
  - Performance on many measures of quality remains far from optimal. For example, only half of people with high blood pressure have it controlled. On average, across a broad range of measures, recommended care is delivered only 70% of the time.
  - As noted above, disparities in quality and outcomes by income and race and ethnicity are large and persistent, and were not, through 2012, improving substantially.
  - Some disparities related to hospice care and chronic disease management grew larger.
  - Data and measures need to be improved to provide more complete assessments of two NQS priorities, *Care Coordination* and *Care Affordability*, and of disparities among smaller groups, such as Native Hawaiians, people of multiple races, and people who are lesbian, gay, bisexual, or transgender.

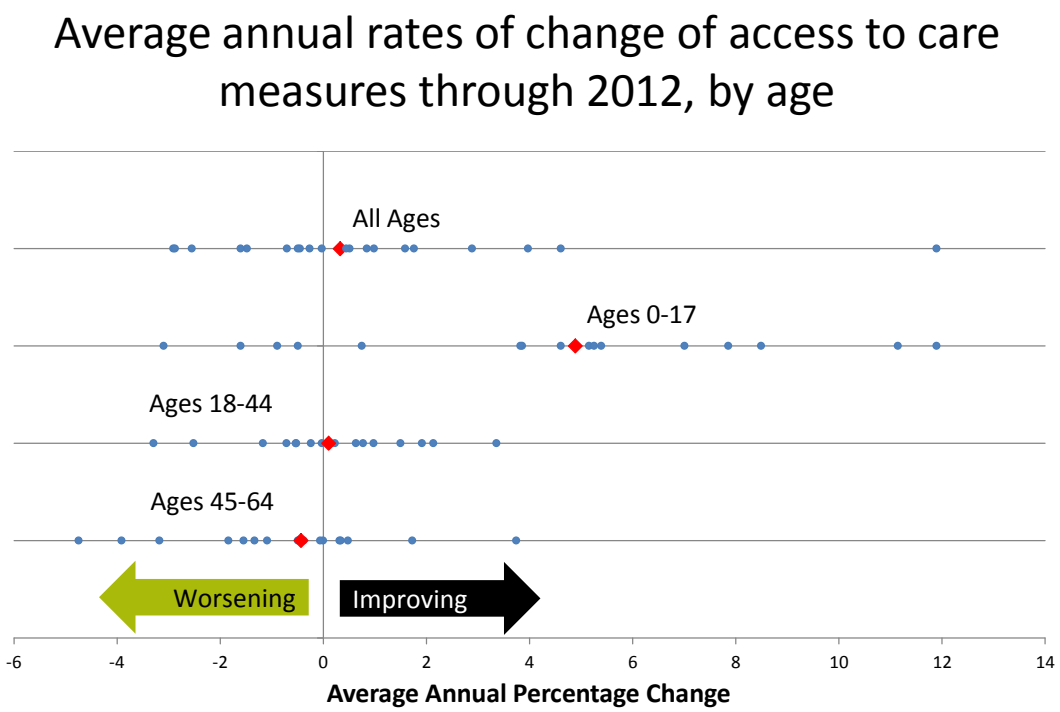
Access to Health Care

- Access to health care means having "the timely use of personal health services to achieve the best health outcomes" (IOM, 1993).
- Access to health care consists of four components (Healthy People 2020):
  - Health insurance: facilitates entry into the health care system. Uninsured people are less likely to receive medical care and more likely to have poor health status.
  - Services: having a usual source of care is associated with adults receiving recommended screening and prevention services.
  - Timeliness: ability to provide health care when the need is recognized.
  - Infrastructure: capable and qualified workforce; updated health information technology.

Chartbook on Access to Health Care

- This chartbook includes:
  - Summary of trends across measures of access to health care from the QDR.
  - Figures illustrating select measures of access.
- Introduction and Methods contains information about methods used in the chartbook.
- Appendixes include information about measures and data.
- A Data Query tool (http://nhqrnet.ahrq.gov/inhqrdr/data/query) provides access to all data tables.

Summary of Rates of Change of Access Measures

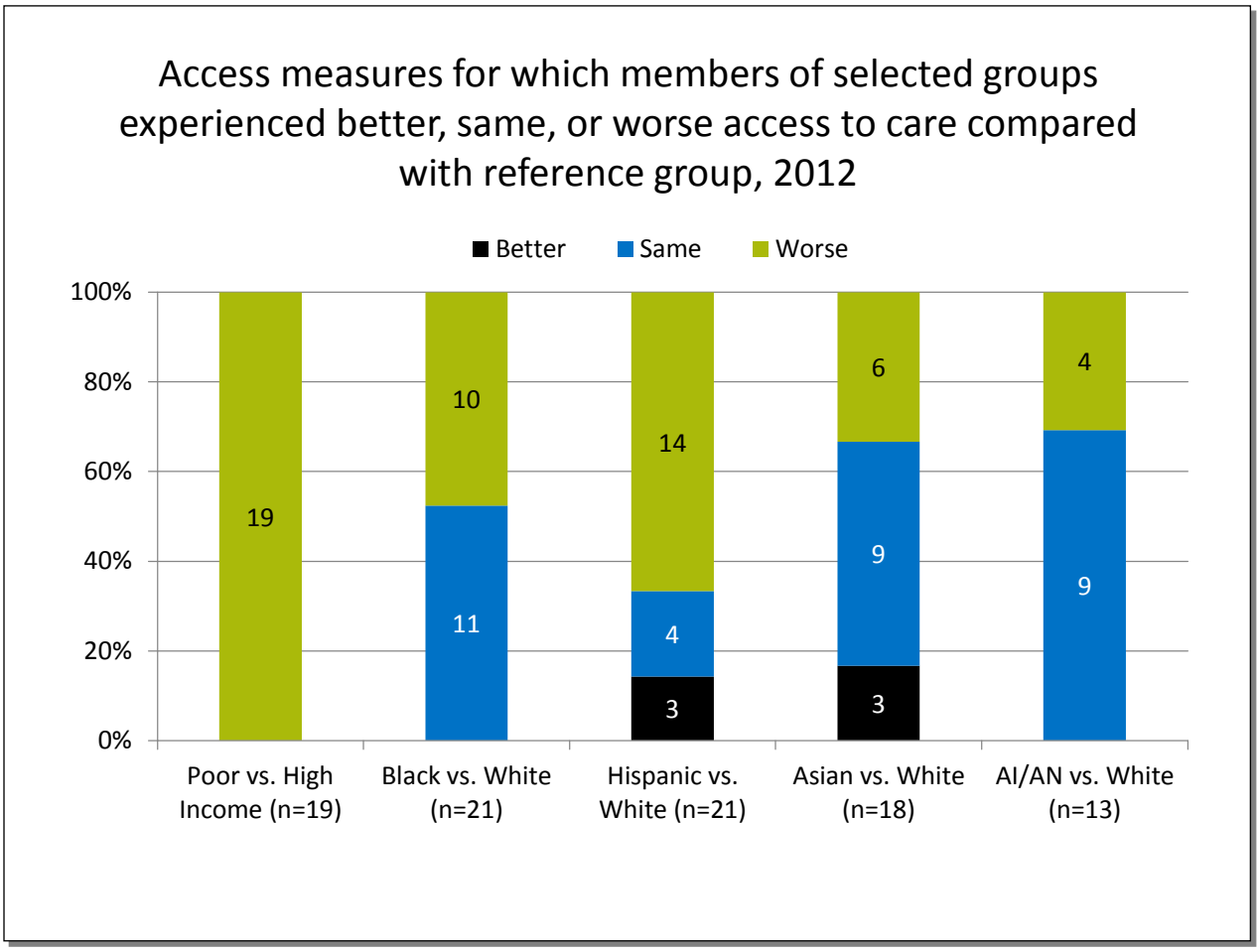


Note: Each point represents one measure. Large red diamonds indicate median values. Access measures include insurance, usual provider, barriers to care, and timeliness of care. For most measures, trend data are available from 2001-2002 to 2012. For each measure with at least four estimates over time, weighted log-linear regression is used to calculate average annual percentage change. Measures are aligned so that positive change indicates improved access to care.

Trends

- Through 2012, most access measures improved for children. The median change was 5% per year.
- Few access measures improved substantially among adults. The median change was zero.

Summary of Access Disparities



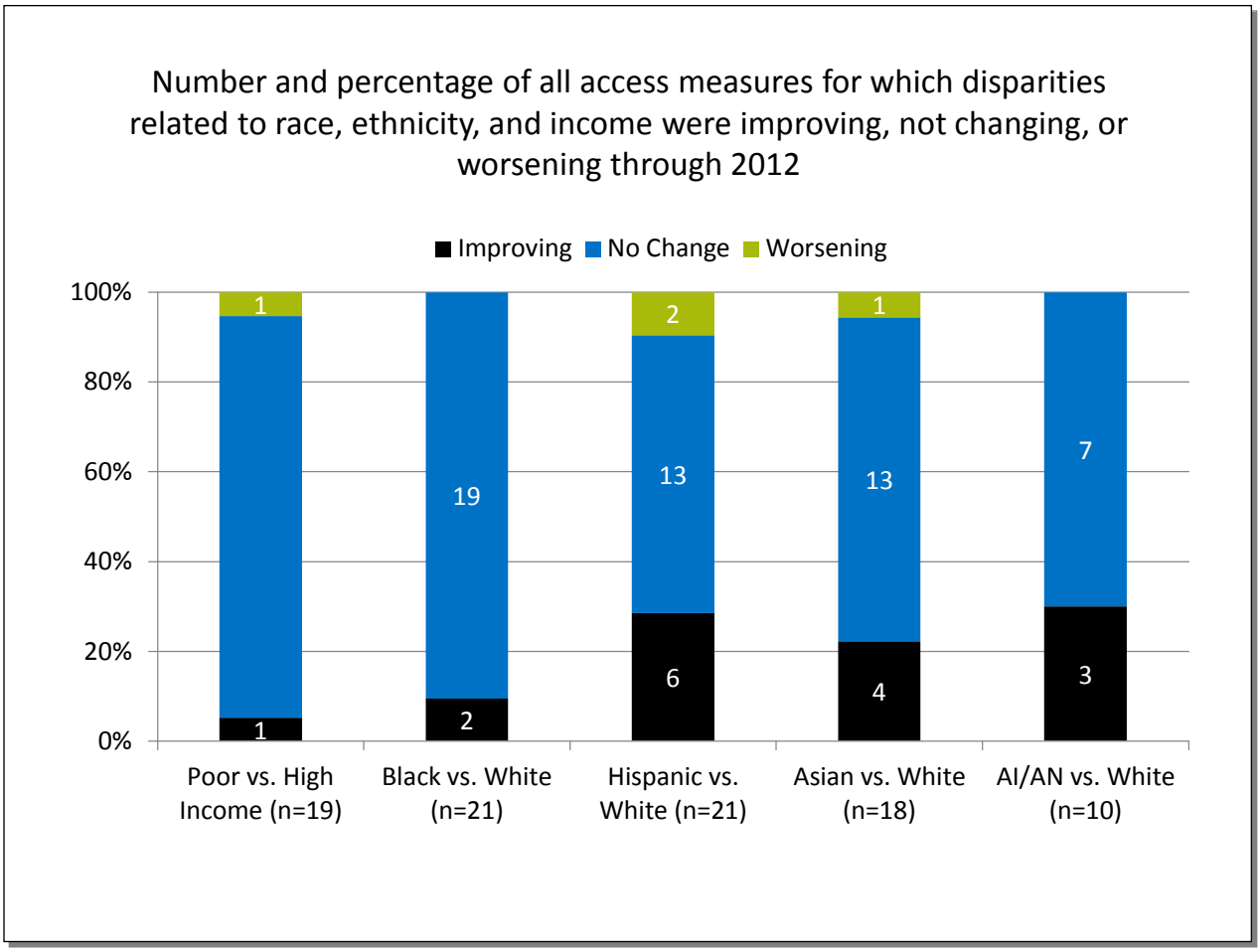
Key: AI/AN = American Indian or Alaska Native; n = number of measures.
Note: Poor indicates family income less than the Federal poverty level; High Income indicates family income four times the Federal poverty level or greater. Numbers of measures differ across groups because of sample size limitations. The relative difference between a selected group and its reference group is used to assess disparities.

- **Better** = Population had better access to care than reference group. Differences are statistically significant, are equal to or larger than 10%, and favor the selected group.
- **Same** = Population and reference group had about the same access to care. Differences are not statistically significant or are smaller than 10%.
- **Worse** = Population had worse access to care than reference group. Differences are statistically significant, are equal to or larger than 10%, and favor the reference group.

Disparities

- In 2012, people in poor households had worse access to care than people in high-income households on all access measures (green).
- Blacks had worse access to care than Whites for about half of access measures.
- Hispanics had worse access to care than Whites for two-thirds of access measures.
- Asians and American Indians and Alaska Natives had worse access to care than Whites for about one-third of access measures.

Summary of Trends in Access Disparities



Key: AI/AN = American Indian or Alaska Native; n = number of measures.
Note: Poor indicates family income less than the Federal poverty level; High Income indicates family income four times the Federal poverty level or greater. Numbers of measures differ across groups because of sample size limitations. For most measures, trend data are available from 2001-2002 to 2012.
For each measure, average annual percentage changes were calculated for select populations and reference groups. Measures are aligned so that positive rates indicate improvement in access to care. Differences in rates between groups were used to assess trends in disparities.

- **Worsening** = Disparities are getting larger. Differences in rates between groups are statistically significant and reference group rates exceed population rates by at least 1% per year.
- **No Change** = Disparities are not changing. Differences in rates between groups are not statistically significant or differ by less than 1% per year.
- **Improving** = Disparities are getting smaller. Differences in rates between groups are statistically significant and population rates exceed reference group rates by at least 1% per year.

Disparity Trends

- Through 2012, most disparities in access to care related to race, ethnicity, or income showed no significant change (blue), neither getting smaller nor larger.
- In four of the five comparisons shown, the number of disparities that were improving (black) exceeded the number of disparities that were getting worse (green).

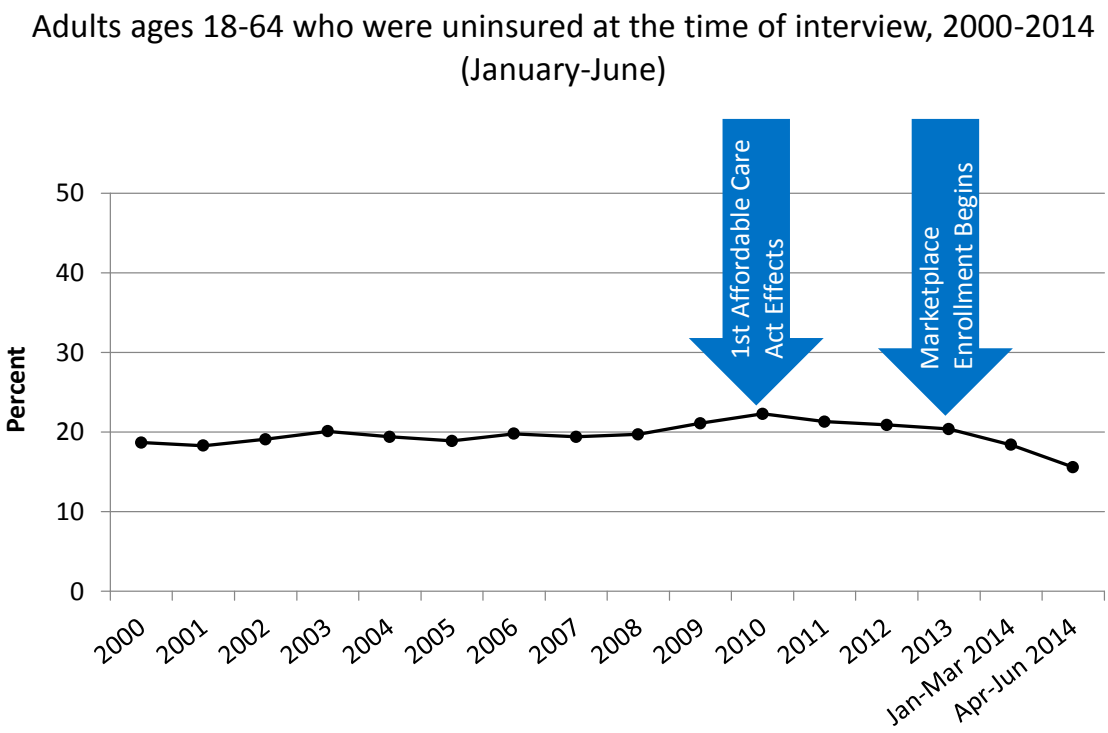
Health Insurance

- Health insurance facilitates entry into the health care system. Uninsured people are less likely to receive medical care and more likely to have poor health status (Healthy People 2020).
- Public health insurance—includes Medicaid, Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored health plans, Medicare, and military plans.
- A small number of people were covered by both public and private plans and were included in both categories.

Health Insurance Measures

- Adults ages 18-64 who were uninsured at the time of interview, 2000-2014 (January-June)
- People without health insurance coverage at the time of interview, by age, 2010-2014 (January-June)
- Adults ages 18-64 who were uninsured at the time of interview, by race/ethnicity, January 2010-June 2014
- Adults ages 18-64 without health insurance at the time of interview, by region, January-June 2014
- Adults ages 18-64 with private health insurance coverage, by age, January 2010-June 2014

Trends in Percentage of Uninsured Adults

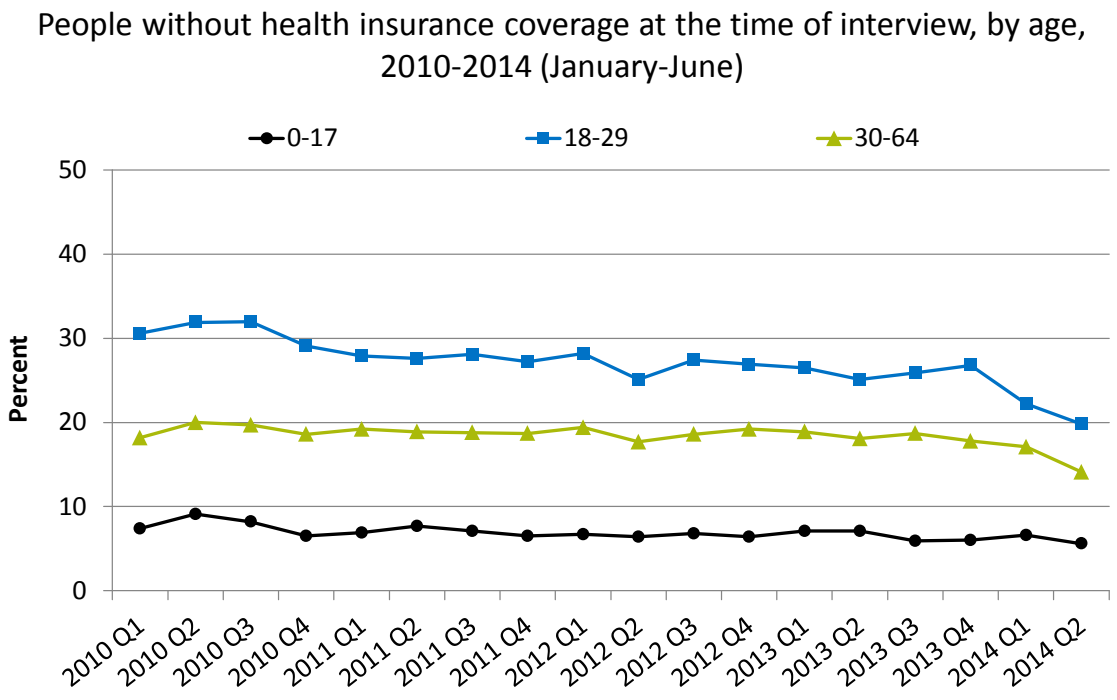


Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2000-2014, Family Core Component.
Note: For this measure, lower rates are better. Data only available for 2014 quarters 1 and 2.

Trends

- From 2000 to 2010, the percentage of adults ages 18-64 who reported they were without health insurance coverage at the time of interview increased from 18.7% to 22.3%.
- From 2010 to 2013, the percentage without health insurance decreased from 22.3% to 20.4%.
- During the first half of 2014, the percentage without health insurance decreased to 15.6%.

Trends in Percentage of Uninsured People Ages 0-64

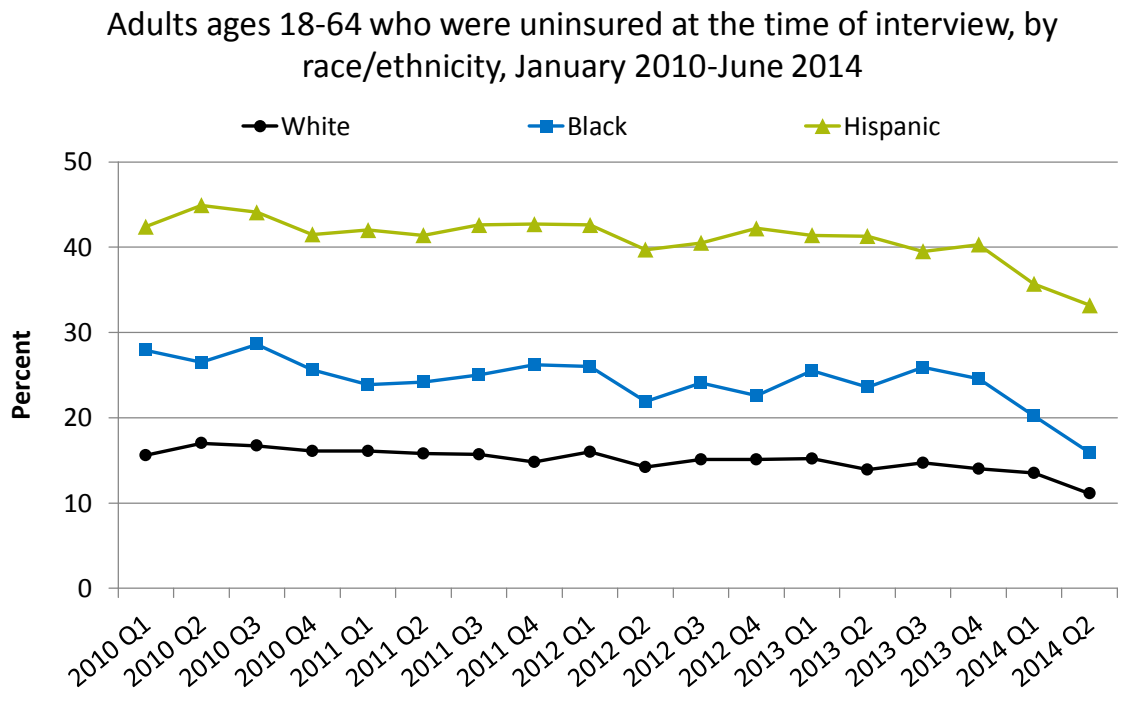


Key: Q = quarter.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2010-2014, Family Core Component.
Note: For this measure, lower rates are better. Data only available for 2014 quarters 1 and 2.

Trends

- For adults ages 18-29, the percentage uninsured at the time of interview decreased from 32% in 2010 Q3 to 19.8% in 2014 Q2.
- For adults ages 30-64, the percentage uninsured at the time of interview decreased from 20% in 2010 Q2 to 18.7% in 2013 Q3, then decreased again to 14.1% in the second quarter of 2014.

Trends in Uninsurance Disparities

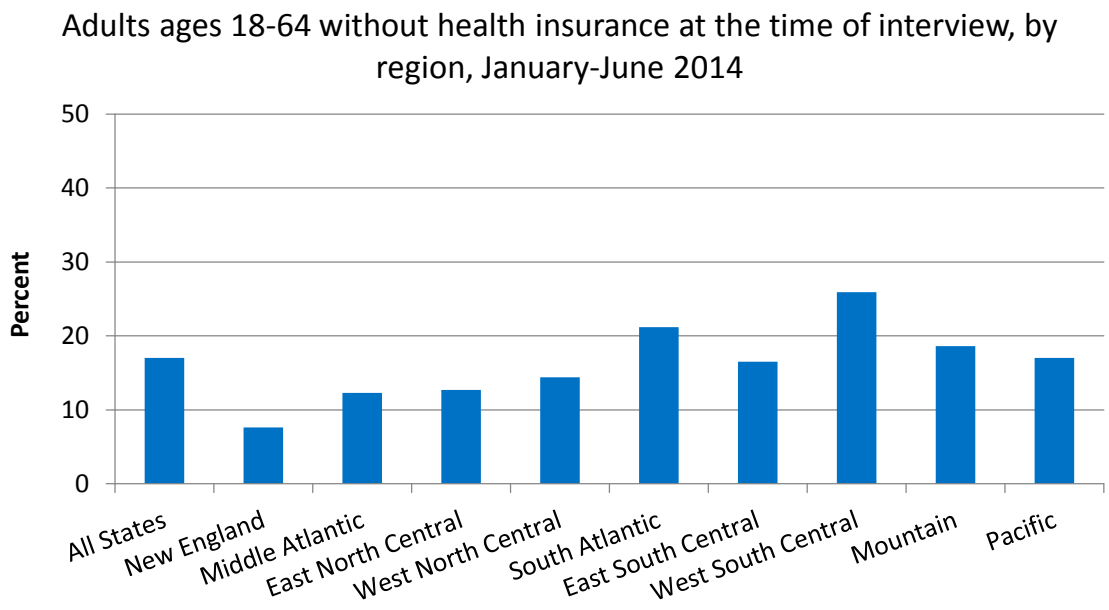


Key: Q = quarter.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2010 -2014, Family Core Component.
Note: For this measure, lower rates are better. Data only available for 2014 quarters 1 and 2 White and Black are non-Hispanic. Hispanic includes all races.

Trends

- Hispanic adults ages 18-64 were significantly more likely to be uninsured from January 2010 to June 2014. The percentage peaked in the second quarter of 2010 at 44.9%, then significantly decreased to 33.2% for the second quarter of 2014.
- All racial/ethnic groups displayed a decrease from 2013 Q4 to 2014 Q2:
  - White: 14.0% to 11.1%
  - Black: 24.6% to 15.9%
  - Hispanic: 40.3% to 33.2%

Adults Without Health Insurance, by Region



Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2014, Family Core Component.
Note: For this measure, lower rates are better. Regions are based on a subdivision of the four census regions (South, West, Northeast, and Midwest) into nine divisions.[i] For this report, the nine census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic Division. Estimates for 2014 are based on data collected from January through June. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

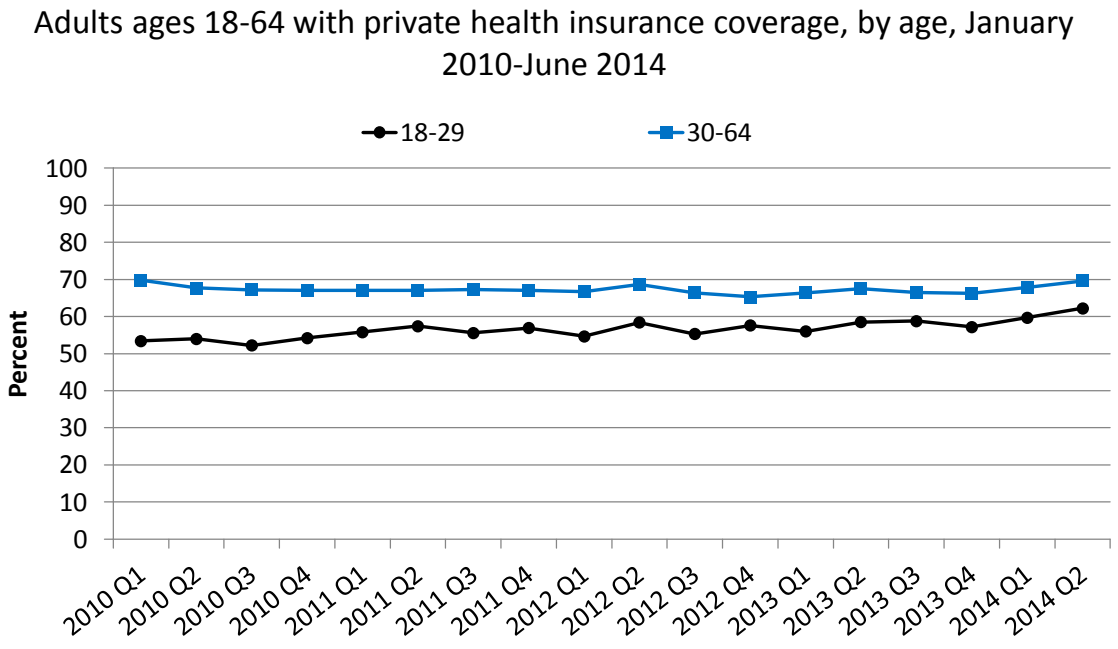
Geographic Variation

- The percentage of uninsured adults ages 18-64 was significantly lower than the national average of 17% in the New England, Middle Atlantic, East North Central, and West North Central regions. The percentage of uninsured adults was significantly higher in the West South Central and South Atlantic regions.

[i] States in each region follow:

- New England region: CT, ME, MA, NH, RI, and VT.
- Middle Atlantic region: DE, DC, MD, NJ, NY, and PA.
- East North Central region: IL, IN, MI, OH, and WI.
- West North Central region: IA, KS, MN, MO, NE, ND, and SD.
- South Atlantic region: FL, GA, NC, SC, VA, and WV.
- East South Central region: AL, KY, MS, and TN.
- West South Central region: AR, LA, OK, and TX.
- Mountain region: AZ, CO, ID, MT, NV, NM, UT, and WY.
- Pacific region: AK, CA, HI, OR, and WA.

Trends in Private Insurance Among Adults



Key: Q = quarter.
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 2010-2014, Family Core Component.

Trends

- The percentage of adults ages 18-29 with private health insurance was lowest in 2010 Q3 (52.2%) and highest in 2014 Q2 (62.2%).

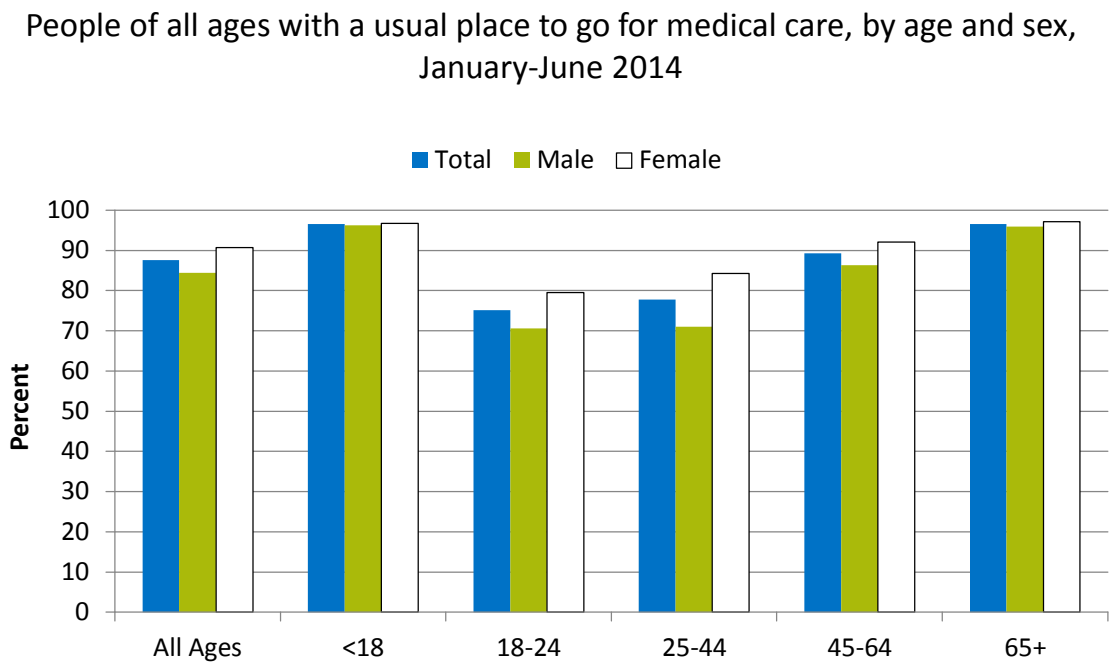
Services

- People with a usual source of care have better health outcomes and fewer disparities and costs (Healthy People 2020).
- Having a usual place of care and a usual provider are associated with an increased likelihood of receiving preventive services and recommended screenings compared with having no usual source of care (Blewett, et al., 2008).

Services Measures

- People with a usual place to go for medical care, by age and sex, January-June 2014
- Age-sex adjusted percentage of people with a usual place to go for medical care, by race/ethnicity, 2013 and January-June 2014
- People who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines in the last 12 months, by insurance (under age 65) and age, 2002-2012
- People who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines in the last 12 months, by perceived health status and ethnicity, 2003-2012

People With a Usual Source of Care

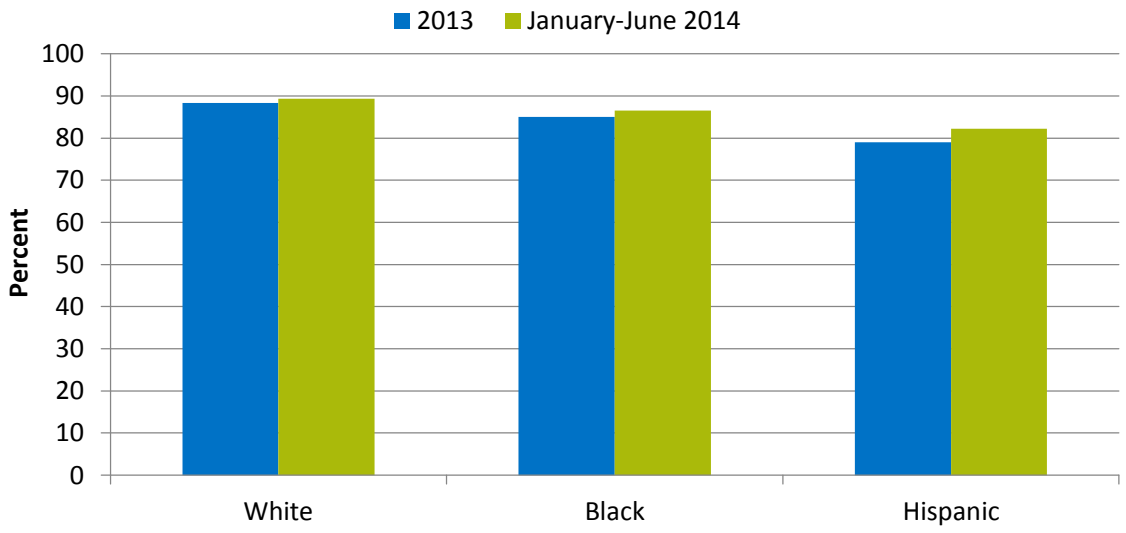


Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, January-June 2014, combined Sample Adult and Sample Child Core.
Note: Data only available for 2014 quarters 1 and 2.

Groups With Disparities

- From January to June 2014, adults ages 18-24 were the least likely to have a usual place to go for medical care. Children under age 18 were more likely than adults ages 18-24, 25-44, and 45-64 to have a usual place to go for medical care.
- For all ages combined, as well as age groups 18-24, 25-44, and 45-64, females were more likely than males to have a usual place to go for medical care.
- Among those age 18 and over, the percentage of people with a usual place to go for medical care increased (data not shown).

Adjusted Percentage of People With a Usual Source of Care



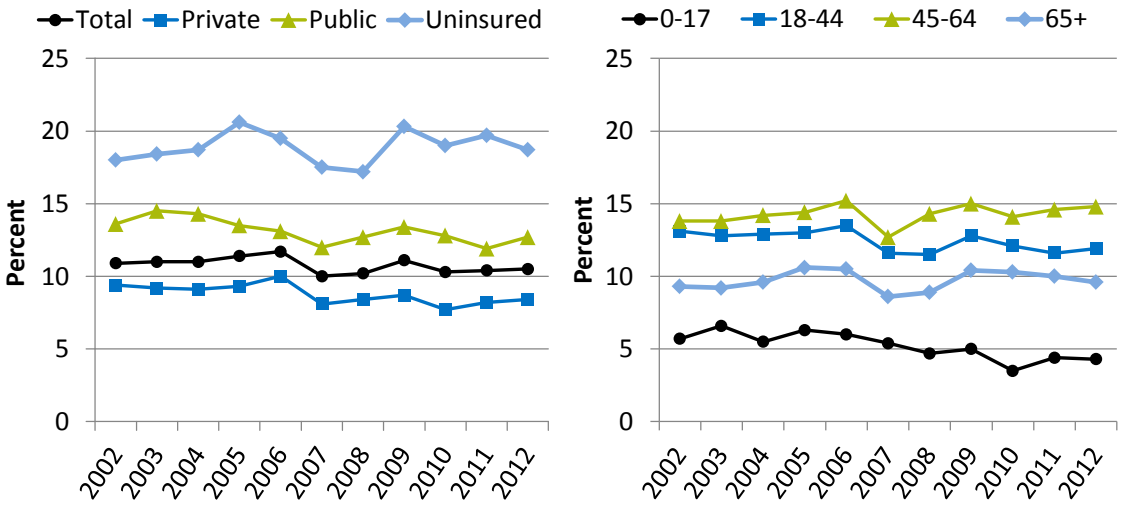
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey, 1997-2013 and January-June 2014, Combined Sample Adult and Sample Child Core Component.
Note: White and Black are non-Hispanic. Hispanic includes all races. Data only available for 2014 quarters 1 and 2.

Groups With Disparities

- For January to June 2014, after adjustment for age and sex, the percentage of people with a usual place to go for medical care was 82.2% for Hispanics, 89.3% for Whites, and 86.5% for Blacks.

Trends in Problems or Delays in Getting Needed Care

People who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines in the last 12 months, by insurance (under age 65) and age, 2002-2012



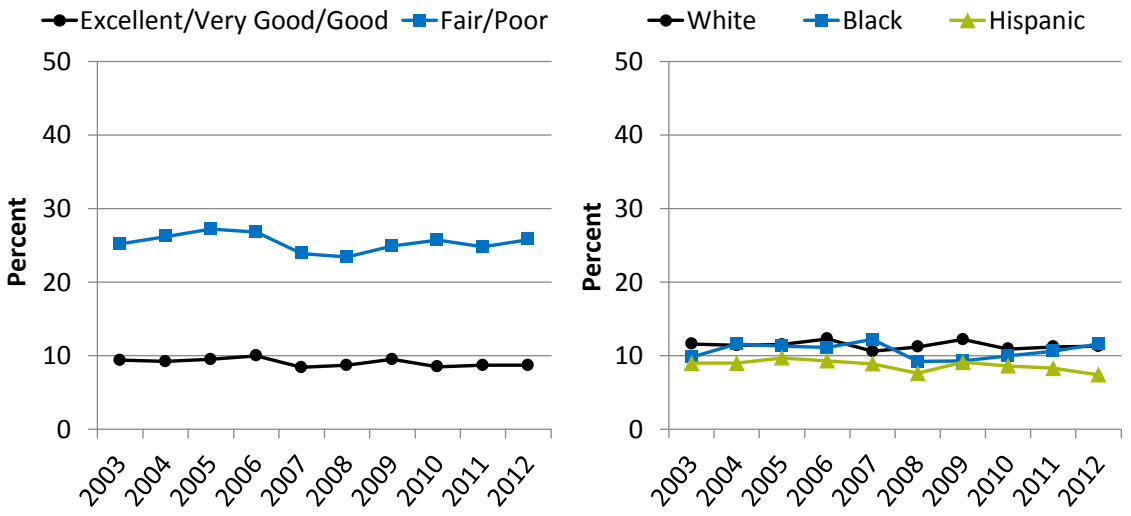
Data Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2012.
Note: For this measure, lower rates are better.

Groups With Disparities

- In all years, for people under age 65, uninsured people and people with public insurance were significantly more likely than people with private insurance to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines.
- In 2012, the percentage of people who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines was significantly higher for people with no health insurance (18.7%) than for people with private insurance (8.4%).
- In all years, adults ages 45-64 were more likely than adults age 65 and over, adults ages 18-44, and children ages 0-17 to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines.

Trends in Disparities in Getting Needed Care

People who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines in the last 12 months, by perceived health status and ethnicity, 2003-2012



Data Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2003-2012.
Note: White and Black are non-Hispanic. Hispanic includes all races.

Groups With Disparities

- From 2003 to 2012, people whose perceived health status was fair or poor were significantly more likely to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines.
- From 2008 to 2012, Blacks had an increase (from 9.2% to 11.6%) in the percentage of people who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines.
- From 2003 to 2012, Hispanics were less likely than Whites to be unable to get or delayed in getting needed medical care, dental care, or prescription medicines.

Timeliness

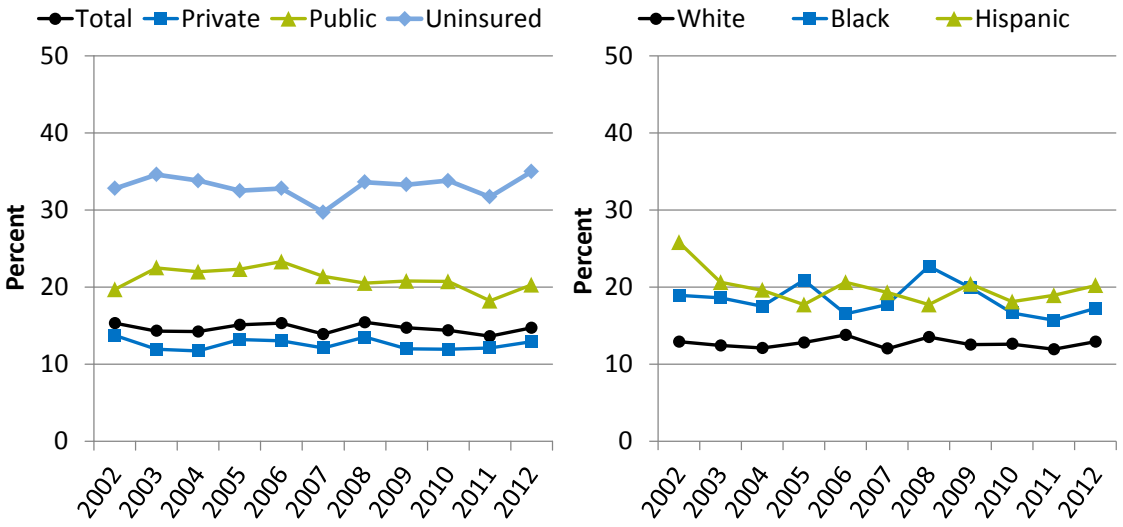
- Timeliness in health care is the system's capacity to provide care quickly after a need is recognized (Healthy People 2020).
- Timely delivery of appropriate care can help reduce mortality and morbidity for chronic conditions, such as kidney disease (Smart & Titus, 2011).

Timeliness Measures

- Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted, by insurance (ages 18-64) and ethnicity, 2002-2012
- Children who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted, by preferred language and ethnicity, 2002-2012

Trends in Adults Getting Care As Soon As Wanted

Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted, by insurance (ages 18-64) and ethnicity, 2002-2012



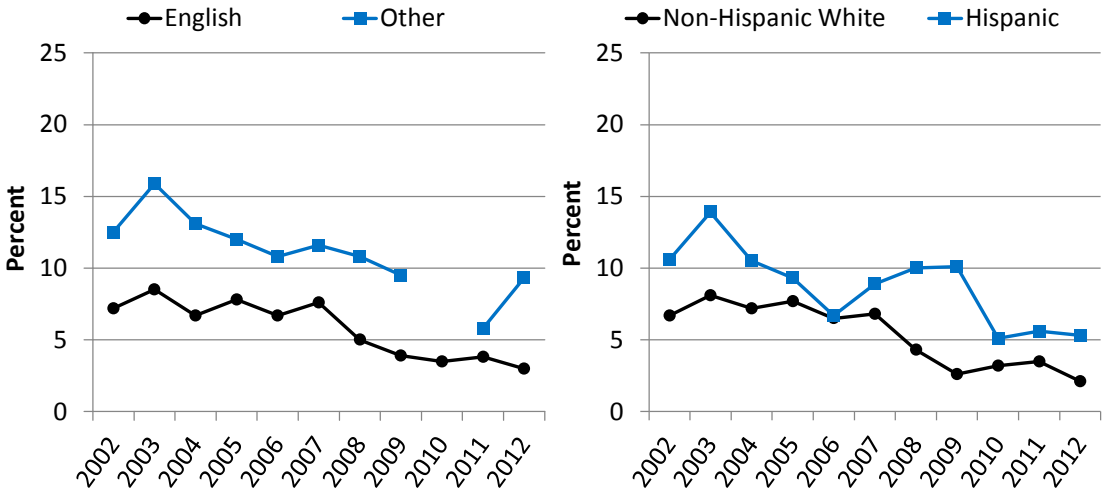
Data Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2012.
Note: White and Black are non-Hispanic. Hispanic includes all races.

Groups With Disparities

- In 2012, the percentage of adults who needed care right away who sometimes or never got care as soon as wanted was 35% for uninsured people, 20.3% for those with public insurance, and 12.9% for those with private insurance.
- In all years, uninsured adults were less likely to receive needed care right away for an illness, injury, or condition in the last 12 months.
- From 2010 to 2012, Hispanics were less likely than Whites to receive care as soon as wanted.

Trends in Children Getting Care As Soon As Wanted

Children who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted, by preferred language and ethnicity, 2002-2012



Data Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2012.
Note: For 2010 in the language chart, the data for Other did not meet the criteria for statistical reliability, data quality, or confidentiality.

Groups With Disparities

- In 2012, the percentage of children who needed care right away who sometimes or never got care as soon as wanted was 9.3% for those who spoke a language other than English and 3% for those who spoke English.
- In all years, English-speaking children were less likely than children speaking other languages to have problems receiving care as soon as wanted.
- From 2007 to 2012, Hispanic children were more likely non-Hispanic White children to sometimes or never get care as soon as wanted.

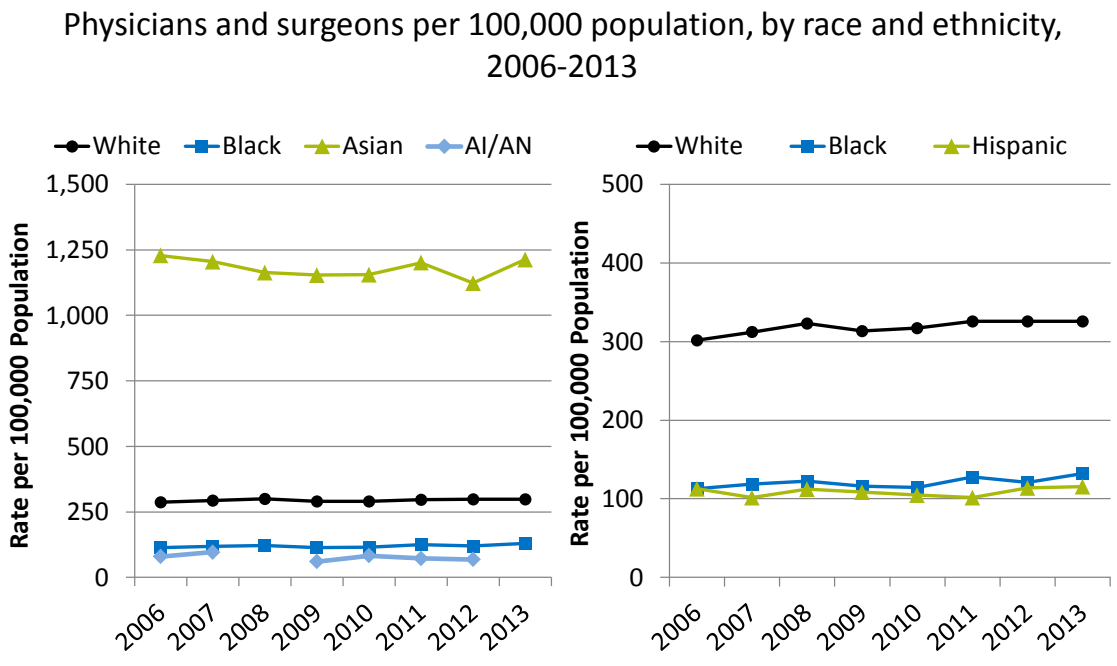
Infrastructure

- Ensuring well-coordinated, high-quality health care requires the establishment of a supportive health system infrastructure (IOM, 2010). Key elements include:
  - Well-distributed capable and qualified workforce
  - Organizational capacity to support culturally competent services and ongoing improvement efforts
  - Health care safety net for hospital admissions of vulnerable populations

Infrastructure Measures

- Physicians and surgeons per 100,000 population, by race and ethnicity, 2006-2013
- Primary care medical residents per 100,000 population, by sex and race/ethnicity, 2012-2013
- Characteristics of HRSA-supported health center population versus U.S. population, 2013
- Medicaid and uninsured discharges in U.S. short-term acute hospitals, by facility characteristics, 2012

Rate of Physicians and Surgeons per 100,000 Population

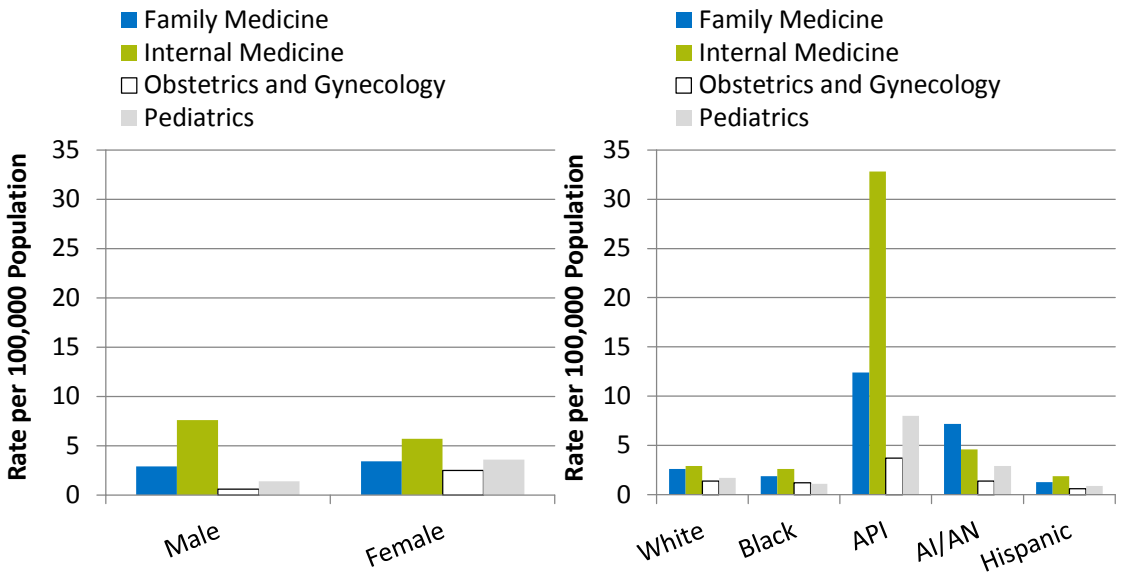


Key: AI/AN = American Indian or Alaska Native.
Data Source: U.S. Census, American Community Survey, 2006-2013.
Note: The 2008 and 2013 data for AI/ANs did not meet the criteria for statistical reliability, data quality, or confidentiality. White and Black are non-Hispanic. Hispanic includes all races.

Groups With Disparities

- From 2006 to 2013, the rate of physicians and surgeons per 100,000 population was higher for Asians than for Whites, Blacks, and American Indians and Alaska Natives.
- From 2006 to 2013, the rate of physicians and surgeons per 100,000 population was higher for non-Hispanic Whites than for non-Hispanic Blacks. Lower rates were observed in Hispanic physicians and surgeons from 2007 to 2013.

Rate of Primary Care Residents per 100,000 Population

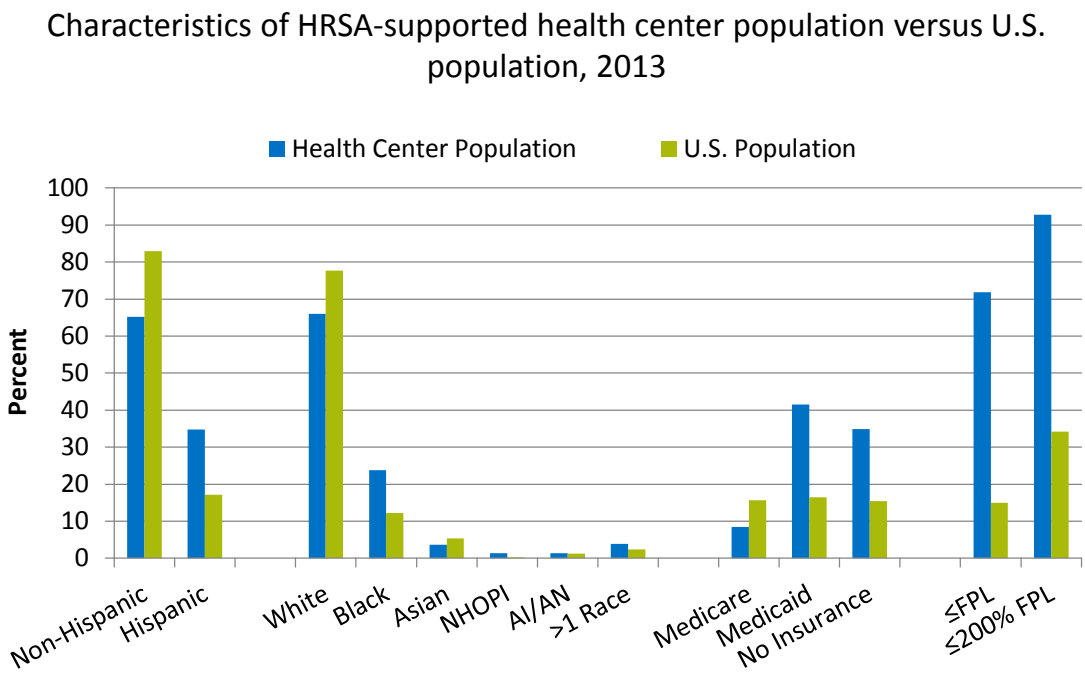


Key: AI/AN = American Indian or Alaska Native; API = Asian or Pacific Islander.
Data Source: Accreditation Council for Graduate Medical Education, Data Resource Book, Academic Year 2012-2013. http://www.acgme.org/acgmeweb/tabid/259/Publications/GraduateMedicalEducationDataResourceBook.aspx
Note: White, Black, API, and AI/AN are non-Hispanic. Hispanic includes all races. Rates are based on American Community Survey 1-year population estimates for 2012.

Groups With Disparities

- From 2012 to 2013, the rate of primary care medical residents was higher for females than for males in family medicine, obstetrics and gynecology, and pediatrics. The rate for males was higher than for females in internal medicine.
- From 2012 to 2013, the rate of primary care medical residents was higher for Asians and Pacific Islanders than for all other racial/ethnic groups, with the highest rate in internal medicine. Lower rates were observed for Hispanic primary care residents.

Characteristics of HRSA-Supported Health Center Population

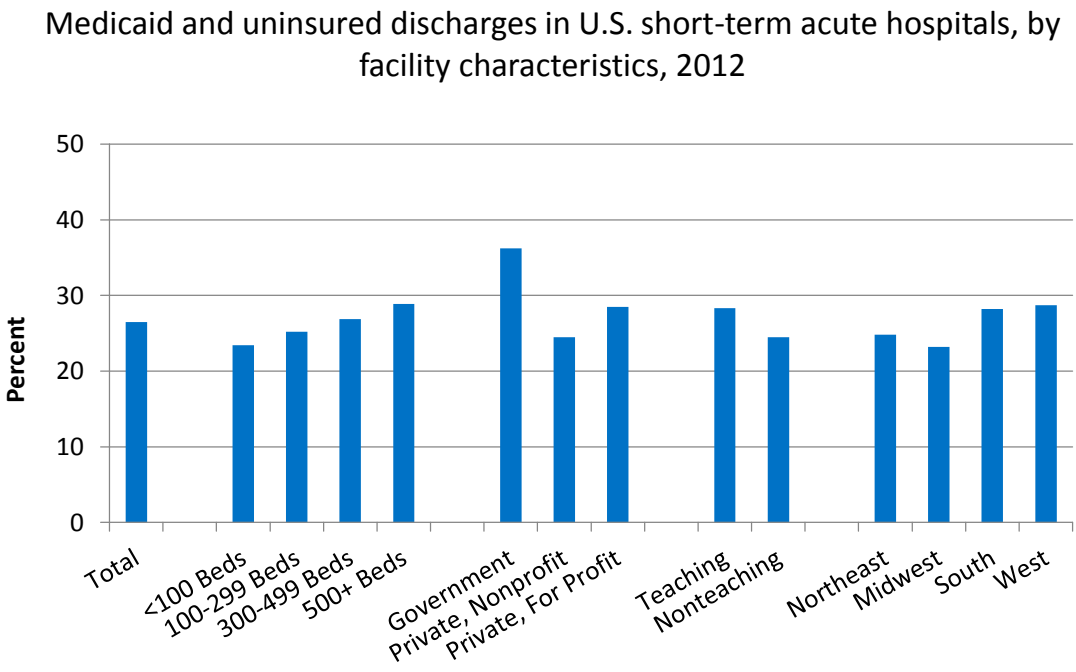


Key: AI/AN = American Indian or Alaska Native; NHOPI = Native Hawaiian or Other Pacific Islander; FPL = Federal poverty level.
Data Source: Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System, 2013. http://bphc.hrsa.gov/uds/datasnapshot.aspx?year=2013
Note: Racial groups include Hispanics and non-Hispanics. Health center population includes 1,202 program grantees data only.

Groups With Disparities

- In 2013, 71.9% of the health center population was at or below the Federal poverty level compared with 15% of the U.S. population. The health center population also had higher percentages of uninsurance (34.9%) and Medicaid enrollment (41.5%) than the U.S. population (15.4% and 16.4%, respectively).
- In 2013, slightly more than one-third (34.8%) of the health center population was Hispanic, which was twice as much as the percentage in the U.S. population (17.1%). The percentage of Blacks at the health centers was nearly one-quarter (23.8%), nearly twice as much as the percentage in the U.S. population (12.2%).

Medicaid and Uninsured Discharges in Short-Term Acute Hospitals



Data Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, HCUPnet, 2012.

Differences by Type of Hospital

- In 2012, 28.5% of discharges from private, for profit hospitals were Medicaid and uninsured patients compared with 36.2% from government hospitals.
- Compared with hospitals with 500 or more beds (28.9%), hospitals with bed sizes under 300 (23.4% for <100 beds and 25.2% for 100-299 beds) had a smaller percentage of Medicaid or uninsured patients.
- The percentage of patients discharged from teaching hospitals who were uninsured or covered by Medicaid was 28.3% compared with 24.5% of patients in nonteaching hospitals.
- Hospitals in the West discharged a greater percentage of Medicaid and uninsured patients (28.7%), while hospitals in the Midwest discharged the lowest percentage of these patients (23.2%).

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