SHADAC State Reform Survey Workgroup Report

June 2011

shadac
State Health Access Data Assistance Center

Introduction:

The State Health Access Data Assistance Center (SHADAC) assembled a State Survey Reform Workgroup in the fall of 2010 to share information between states that are considering how state health surveys can best capture progress on national and state health reform efforts. Analysts from states that have conducted household surveys in the past few years, or plan to in the future, were invited to participate. The goal of the workgroup is to provide information on key content areas/domains that can be included in state surveys to help monitor progress on the Patient Protection and Affordable Care Act (ACA). That is, the workgroup specifically focused on reform-relevant domains beyond what is typically collected in health insurance surveys such as insurance coverage, health care access and utilization.

Workgroup Membership:

The workgroup consisted of 44 members across 18 states and 1 territory: Alaska, California, Colorado, Connecticut, Florida, Louisiana, Massachusetts, Minnesota, New Jersey, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Utah, Vermont, U.S. Virgin Islands, Washington, and Wisconsin.

Workgroup Activities:

December 2010: Conference call held to review the question domains SHADAC generated to begin a conversation concerning items important to measure and monitor as health reform unfolds throughout the nation. A list of potential question domains and survey items was circulated in advance of the call, which then provided an opportunity to refine the list based on participants' experience and opinions. The initial list of domains included: affordability of care, provider supply/barriers to care, emergency room use, and usual source of care/medical home. The list of reform domains expanded to include navigability/experiences with health insurance as a result of workgroup member feedback.

SHADAC compiled and analyzed notes from the December call, along with emails received from workgroup members before and after the call. We updated the list of domains, providing potential questionnaire items within each domain. The goal is to coordinate the sharing of information across states to facilitate states' data collection activities in the period before and during implementation of the ACA.

March 2011: SHADAC requested the assistance of workgroup members to determine health reform priority domains and items within each of the priority domains that were currently being used or considered for use by the states. This request was in the form of a short questionnaire. What follows is a brief description of the survey methods and results.

Survey of State Survey Priorities:

Methods: All workgroup members were sent a survey by email early in March, with a reminder email and second mailing at the end of March. We continued to request and receive responses through May.

Representatives from 13 states responded to the survey. We were fortunate to collect information from many of states with the most active and ongoing general population health insurance and access surveys: California, Colorado, Louisiana, Massachusetts, Minnesota, New Jersey, Ohio, Oregon, Pennsylvania, Utah, Vermont, Washington, and Wisconsin. Data are missing for 5 states and 1 territory: Alaska, Connecticut, Florida, Oklahoma, South Carolina, and the U.S. Virgin Islands. (See http://www.shadac.org/content/state-survey-research-activity for a listing of state survey research activity.)

States are the unit of analysis in this summary of the survey results. Therefore, in states with multiple workgroup participants, we present only one state response. In most cases, we received only one response per state, either because someone took responsibility for completing the survey independently or one state representative compiled participants' responses in order to provide a unified response. SHADAC compiled information across several participants from one state; this task was made easy by the consistency of data across respondents.

Given the small number of workgroup states, we provide simple counts of responses within the questionnaire grid in Table 1. Questions 1 and 3 are only answered if applicable, so the number of responses per domain varies as does the number of responses to follow-up questions 2 and 4. Table 2 provides state specific comments provided as part of the survey.

Results: As shown in Table 1, affordability is an important domain that states viewed as useful in past surveys and as a priority in monitoring health reform. Within this domain, measuring out-of-pocket costs received mixed assessments in terms of usefulness in past surveys. Although viewed as a priority, half of the states indicated they were not likely to include questions about out-of-pocket expenses in their survey. Other items, such as forgone care due to costs, were judged to be more useful and easier to measure accurately and, thus, more likely to be included in future survey activity.

Although fewer states have included navigability items in their surveys, they report this information was somewhat useful. Furthermore, many indicated this was a priority for future data collection and most said they were somewhat or very likely to include items to tap consumer experiences with health insurance coverage.

Provider supply items were included in past surveys by six workgroup states, but ratings of the usefulness of these data were mixed. Eight states indicated this is a priority area that they are somewhat or very likely to measure in the future.

Measures of emergency room (ER) use have been included in prior surveys. Collecting data about the number of ER visits and use of the ER for non-emergency care were viewed a very useful, and were also endorsed as priority areas likely to be included in futures surveys. Measures of reasons for ER use were reported to be less useful and of lower priority.

Usual source of care, a common measure of access (and, perhaps a crude measure of medical home) has been included in many state surveys and evaluated as very useful. Moreover, it is considered a priority domain that is very likely to be included in future surveys. The other items under the medical home domain were less likely to have been included in past surveys.

States have had less experience with the other topic areas listed. Only two states have included multi-dimensional medical home series in their surveys, whereas five states indicated this is a priority area that they are likely to include in their surveys to evaluate health reform. This would be aided by the development of a concise set of measures to assess the presence of medical homes. The CAHPS Consortium is currently working in coordination with the National Committee for Quality Assurance to develop and test Patient-Centered Medical Home Survey instruments.

Conclusions and Implications:

Workgroup members identified a set of reform domains viewed as important to track as health care reform unfolds. There was less consistency in the questions that would be used to measure those domains, highlighting the challenges of developing recommendations to guide states' data collection activities in this era of reform. None of the questions within the five domains were endorsed by all 13 participating workgroup states. Further, in the domain of affordability, while 9 states indicated that out-of-pocket costs were important to monitor, nearly half are unlikely to include this question due to concerns about the validity and reliability of these measures.

There is some consistency in terms of priority areas for future data collection efforts. For example, nine states indicated assessing availability of a usual source of care is a priority and reported they are very likely to include this domain in their survey. Similarly, nine states indicate it is important to track reports of difficulties people face in purchasing insurance in the private market, and most states are very or somewhat likely to include such measures in their survey.

Next Steps:

Many workgroup members commented on the difficulties they face accommodating all of the pressing data needs within their surveys. Many are still in the process of deciding what additions they can make to their instrument. Further, several states are unsure of the funding for their surveys generally (see Table 2). Therefore, we will continue to check in to see how this unfolds as states begin to field their surveys. With the help and participation of workgroup members, SHADAC will continue to compile state health reform questions, circulating these items to workgroup members and posting them on our website.

Join the Workgroup:

We welcome broader participation in the workgroup. If you are interested in participating, please contact Kathleen Call (callx001@umn.edu or 612-624-4802).

About SHADAC:

The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is funded by The Robert Wood Johnson Foundation to help states monitor rates of health insurance coverage, understand factors associated with access to care, and to utilize data for implementation of health reform. Information is available at www.shadac.org.

Table 1. Results from the SHADAC State Reform Survey Workgroup Topic Questionnaire

Reform Domains: (See Appendix at the bottom of this document for detailed survey items, sources and context)	**Q1.** Check box if this domain is included in a past or current survey for your state	**Q2.** **If included** in a past or current state survey, rate the usefulness of this information			**Q3.** Check box if this domain is a priority area for monitoring reform in your state	**Q4.** **If this is a priority,** how likely is it that this domain will be included in your state survey?		
A. Affordability of Care		**Very useful**	**Somewhat useful**	**Not useful**		**Very likely**	**Somewhat likely**	**Not likely**
Out-of-pocket costs	**7**	**2**	**3**	**2**	**9**	**1**	**3**	**4**
Financial problems caused by health care costs	**6**	**4**	**1**	**1**	**7**	**2**	**3**	**0**
Forgone care due to costs	**10**	**6**	**3**	**1**	**8**	**4**	**2**	**1**
Problems paying medical bills	**9**	**6**	**1**	**2**	**7**	**2**	**3**	**1**
B. Navigability/Experiences with Health Insurance								
Problems experienced with coverage	**5**	**1**	**4**	**0**	**7**	**2**	**4**	**0**
Difficulty purchasing insurance directly	**3**	**1**	**2**	**0**	**9**	**4**	**4**	**0**
Difficulty enrolling in a public program	**5**	**1**	**4**	**0**	**6**	**4**	**2**	**0**
C. Provider Supply/Barriers to Care								
Problems finding a provider	**6**	**2**	**2**	**1**	**8**	**3**	**4**	**1**
D. Emergency Room (ER) Use								
Number of ER visits in past 12 months	**9**	**5**	**4**	**0**	**5**	**4**	**0**	**1**
Use of ER for non-emergency care	**6**	**5**	**1**	**0**	**7**	**3**	**2**	**1**
Reason for ER care	**5**	**1**	**5**	**0**	**3**	**2**	**1**	**0**
E. Usual Source of Care/Medical Home								
Usual source of care and type	**10**	**8**	**2**	**0**	**9**	**6**	**2**	**1**
Reason no usual source of care	**5**	**2**	**2**	**1**	**3**	**2**	**1**	**1**
Care coordination	**3**	**1**	**1**	**1**	**4**	**0**	**4**	**0**
Multi-dimensional medical home series	**2**	**1**	**1**	**0**	**5**	**1**	**4**	**0**

NOTE: Results represent simple counts of responses for the 13 states included in the survey.

Table 2. Comments from the SHADAC State Reform Survey Workgroup Topic Questionnaire

- [Our] instrument would be improved by including all of these domains, but the constraints (both in terms of funding and in terms of length of the survey) make it impossible to include all questions in every iteration of the survey. For example, the "problems paying medical bills" domain was highly policy-relevant data from [our previous surveys], but was not included in the [current survey].
- In [our state] we may be in a unique situation in that we have both a state sponsored household survey on health insurance as well as [a health reform survey]. Due to continuing budget constraints at the state level, it is very difficult at this time to say what changes may happen with the survey (right now we are primarily focused on keeping the survey going). The [other survey] fills in many areas that the state survey does not cover at this time.
- We are interested in the affordability questions, but are not convinced that the measures will be sufficiently reliable. Because of that and limited real estate [in the survey], we'll likely not include too many of the measures of self-observed affordability. We may include some of the measures that observe behavior related to affordability problems.
- My responses to the first page question reflect domains that we've covered, but the actual questions we've used differ to varying degrees from the work group draft questions. If we move ahead with a new survey (depending on funding), we'd take a close look at the draft questions, particularly for domains that we have not covered or are not happy with our prior question wording.
- At this point in time, it looks like our 2010 [survey] will be our last survey due to funding issues and coverage concerns. There are a number of areas indicated above, however, for which we would like to have better data.
- Out-of-pocket costs are important but we haven't found a reliable way to measure in household telephone surveys. Care coordination and medical home are very high priorities for us, but we haven't found concise and understandable ways to measure them. We also are very interested in ways to effectively measure the use of the ER for non-emergency care and reasons for using ER care. We also think a phone call with the states would be very useful in sharing experiences, particular from those who have had success in the priority areas.
- [Our next survey] will be concentrating on: 1) economic stressors, 2) enhanced primary care homes, 3) uninsured and underinsured rates, 4) access to care, 5) macro- and intimate social determinants of health, 6) health status, 7) Medicaid and Medicare characteristics, 8) obesity, 9) health status indicators, and 10) behavioral risks.
- [Our survey] is the first iteration of a health access, care, and utilization survey in [our state]. As such, we cannot completely speak to the usefulness of the information we are still in the process of gathering. We constructed the instrument and questions with the intent to track [our state] as it progresses through state and federal directed reform efforts.

- [Our state] is no longer asking about ED Visits.
- For questions about out-of-pocket costs - we have asked these questions but they were asked in order for us to evaluate underinsurance rather than solely examining costs by themselves. Underinsurance seems to be an important topic based on what we've done in the past and all of the work that is now being done on the Health Benefits Exchanges - which about every project I've come across seems to ask for an analysis of the underinsured. For the provider supply/barriers to care - problem finding a provider - when we've asked these questions we've found it important to ask a follow-up to determine what type of care/provider they have difficulties in finding - if nothing else to isolate difficulties in finding a primary care provider from other providers. We find that there are certain groups that have difficulties finding a primary care physician (namely Medicaid or those on other state health insurance programs) but also find many people regardless of the type of coverage are experiencing difficulties finding specialists to provide care.
- Reason for ER care: We ask only whether the ER visit was for "a tooth or dental problem" in the past 12 months.


shadac
State Health Access Data Assistance Center
www.shadac.org