Washington's Primary Care Safety Net: Structure and Availability

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Introduction

Washington's health care infrastructure faces pressures from growing demand, rising costs, increasing numbers of the uninsured and emergency room visits, and a widening gap between costs and revenue. Private providers, who are responsible for the largest share of primary care capacity, are less able or willing to accept new patients whose health care financing comes from public sources such as Medicare and Medicaid. This trend, in turn, places greater pressure on "safety net" providers. The issue raises three questions 1) What is the capacity of Washington's health care safety net? 2) Where is the safety net most vulnerable? and 3) Will the capacity of the safety net increase at a rate that can keep up with increasing demand?

Summary

The primary care safety net's capacity captures more than the community and free clinics that have either a legal mandate or expressly adopted mission to serve all patients, regardless of ability to pay. An accurate definition includes both the *core safety net* and what we refer to as the *auxiliary safety net*, a class of providers and clinics that plays an essential supporting role. Although auxiliary safety net providers are not subject to explicit mandates and missions, they may receive some direct or indirect public support and are more likely to serve enrollees in Medicare and Medicaid and the uninsured population than are most private practices.

Inventories and estimates conducted by the Washington State Department of Health Office of Community and Rural Health (OCRH) reveal the following conclusions concerning core and auxiliary safety net capacity in Washington (excluding King and Pierce counties):

- Less than 10% of primary care physician capacity in the 37 counties studied provide care at core safety net locations—Community and Migrant Health Centers (CMHCs) and charity care clinics.
- And additional 20% of primary care physician capacity in these counties is located at clinics in the auxiliary safety net. These include Rural Health Clinics (RHCs) (16%), tribal clinics (2%), and residency programs (2%).
- Most providers (71% of capacity) do not receive any directed public funds to meet safety net functions or provide care to publicly insured patients.

If the primary care capacity in King and Pierce counties—for which we do not yet have detailed data—were included, we estimate the percentage of capacity in the core safety net would increase to 12-15% because such systems are larger in these communities. But the percentage of capacity in the auxiliary safety net would drop, largely because RHC capacity share would drop by 5-6 percentage points to about 10%, as King and Pierce counties are predominantly urban.

Although core safety net capacity in urban counties is similar to safety net capacity in rural counties (about 10% of physician capacity), the auxiliary safety net is much stronger in rural counties (48%) than urban counties (6%). This is of particular concern because more than two-thirds, and in some counties up to 90%, of non-safety net providers are

closed or impose severe restrictions on taking new public patients. Statewide figures mask considerable county-to-county variation.

The auxiliary safety net in rural Washington is projected to grow over the next three to five years by more than 100 full-time equivalent positions (FTEs), from 44% to more than 70% of total rural physician capacity, largely due to conversions of existing private practices to RHC status. These conversions are crucial in stabilizing clinic finances and maintaining and improving access to health care for Medicare and Medicaid patients. But overall growth in new capacity, particularly for serving the uninsured, has been much more modest. In contrast to the RHCs, the capacity of Washington's residency program—an essential component of the safety net—has not grown, and it may even contract during the next three years. Some future growth in tribal clinic capacity is expected in the coming years. But increasing needs of tribal members and potential changes in Medicaid reimbursement policies may cause some of the clinics to discontinue the practice of serving non-tribal members.

The core safety net has been growing much more slowly. The federal Community Health Center Initiative, which has been supported by the Bush Administration, has funded an increase of from 20 and 25 providers in Washington community health centers since 2001. The program has had significant local impacts but a negligible effect on total core safety net capacity in Washington, which has increased by less than 1 percentage point over the past three years (from about 9% to slightly under 10% of total primary care capacity).

The Washington Association of Community and Migrant Health Centers predicts that the state's growth rate for CMHCs may slow and perhaps capacity could even contract over the next two to three years. The Community Health Center Initiative is expected to support only a handful of new clinic start-ups in Washington in the near future. Meanwhile, CMHC base funding (less than 10% of the typical CMHC budget) for serving the uninsured has increased by less than 5% during the past three years. Despite significant increases in the number of uninsured patients in the state, CMHCs can anticipate little or no increase in this base funding over the next few years, given pressures on the federal budget. State spending is also unlikely to keep up with costs and enrollment growth for Medicaid and the Basic Health Plan (BHP). Tighter eligibility standards and fewer covered services limit resources not only for expansion but also to serve existing patients.

OCRH has documented dramatic declines during the past three years in the percentage of primary care physicians willing to accept new Medicare, Medicaid, and BHP patients in Washington's urban counties. This analysis suggests that expansions of safety net capacity have not been meeting increasing demand in most parts of the state—and if this trend persists, access to health care for some of Washington's most economically vulnerable populations would certainly worsen.

The primary care safety net defined

The federal Institute of Medicine's 2000 report on *America's Health Care Safety Net: Intact but Endangered* defines *core safety net providers* as having two distinguishing characteristics:

1. They offer health care to patients regardless of their ability to pay by either legal mandate or expressly adopted mission, and
2. A substantial share of their patients are covered by Medicaid or Medicare, are uninsured, or are otherwise economically vulnerable.

This definition does not capture all safety net capacity. A second class of providers and clinics, which we refer to as the *auxiliary safety net,* plays an essential supporting role. Although auxiliary safety net providers are not subject to explicit mandates and missions, they may receive some direct or indirect tax support and are more likely to serve the Medicare, Medicaid, and uninsured population than are most private practices.

As the IOM report notes, the safety net is a patchwork of different types of institutions with different capabilities. It is difficult to capture this patchwork with simple definitions and classification schemes. To help sort this out, we would add the following three core characteristics to the IOM definition:

1. Safety net providers receive local, state, or federal resources to serve the un- and underinsured. This support may be in the form of direct grants such as those received by CMHCs, local tax levies to subsidize operations and compensate for losses, or more indirect types of support, such as graduate medical education payments that partially underwrite residency programs.

2. Safety net providers may receive reimbursement enhancements for patients enrolled in Medicare and Medicaid. For example, certified federal RHCs receive additional reimbursement for seeing public patients who are—by income or residence—determined to be "hard to serve." These extra payments may be linked to requirements to serve these patients.

3. Safety met providers tend to serve specific population and payer groups. Most safety net clinics are designed to serve very specific populations. For example, most tribal clinics are not open to non-members. The free clinic system focuses on the uninsured. King County's public health clinic system is oriented toward preventive services, the immigrant population, and the homeless. Although most CMHCs are open to all patients regardless of ability to pay, some sites serve specific populations, and most of the centers are staffed to serve the uninsured and enrollees in the BHP and Medicaid program but not Medicare (though this is changing).

The following chart shows the many “shades of gray” in characterizing different types of safety net and non-safety net providers.

Figure 1
Distinguishing Characteristics of the Core and Auxiliary Safety Net

Clinic Type	Mission or mandate for serving the uninsured	Receives tax support for serving the uninsured	Receives enhanced reimbursement for Medicare and Medicaid patients	Open to all populations and payers	Serves mostly vulnerable and/or low-income patients
Core Safety Net					
Community and Migrant Health Centers (CMHCs)					
Public health clinics					
Free/charity clinics					
Auxiliary Safety Net					
Rural Health Clinics (RHCs)					
Residency programs					
Public hospitals					
Tribal clinics					
Non-safety Net					
Campus health clinics					
Private clinics					

	All or most clinics		A few or indirect role
	Some clinics or specific focus		Very few or none

Public and non-profit hospitals are often a default option for the primary care safety net, but most do not provide full-scope primary care on site. With the advent of primary care hospitalists,[1] the boundary is becoming less distinct. And many hospitals, especially rural public hospital districts, operate primary care clinics with RHC status. Since most of the hospital primary care function is captured in other clinic classifications, we do not include public hospitals in subsequent analyses.

The following section discusses the core, auxiliary, and non-safety net environments.

[1] The hospitalist is a rapidly emerging physician specialist employed by hospitals to coordinate and/or provide in-hospital care for patients of non-hospital based physicians. For example, primary care hospitalists provide and coordinate in-hospital care for primary care physicians in the community, decreasing the need for call coverage or inpatient visits. Most large urban hospitals and many mid-sized hospitals now employ them.

The core safety net

Community and Migrant Health Centers (CMHCs) are required to take all patients regardless of ability to pay and to provide a comprehensive array of primary health care services, including oral health. The CMHCs are second only to emergency rooms as the primary source for health care for the uninsured in most communities. But unlike emergency rooms, some are not open during evenings and many are not open on weekends. CMHCs tend to focus on serving patients without insurance or those enrolled in Medicaid and the state BHP. Some of the CMHCs qualify for additional federal funding streams (Section 330 grants) and are referred to as Federally Qualified Health Centers, or FQHCs. Many CMHCs receive grants to provide dental and medical services to the uninsured through the Washington State Health Care Authority's Community Health Services Program.

CMHCs are non-profit organizations whose community-based boards must have 51% consumer representation. They receive Medicaid and Medicare reimbursement enhancements and some federal support for development. Federal grant support to serve the uninsured typically accounts for less than 10% of the CMHC operating budget. The Bush Administration initiative to expand community health centers offers a one-time grant to increase planning and construction capacity, and it does not cover ongoing costs of providing care. Direct funding to cover care for the uninsured has been growing very slowly or not at all, while the numbers and needs of the uninsured have been rapidly increasing. Statewide, about 100 clinic sites offer medical care, 80 offer dental care, and 30 provide other services such as mental health or wellness services. Locations are mapped at http://ww4.doh.wa.gov/gis/standard_maps.htm

Free or Charity Care Clinics are typically operated by churches or other community service organizations using donated materials and labor. Some receive Community Health Services grants. Most charity care clinics limit operation to a few hours or days per week. In the past year, Washington's free clinics provided more than 40,000 visits. Although the number and capacity of charity clinics is growing along with access concerns, in most areas, charity clinics represent far less than 1% of physician capacity. Consequently, charity clinic capacity is counted in the CHMC category in subsequent analyses.

Public Health Clinics operated by local health jurisdictions were at one time a cornerstone of the safety net. Over the past two decades, most of Washington's local public health jurisdictions have stepped out of roles involving direct patient care to focus efforts on prevention and assurance. Public Health—Seattle & King County is the exception, providing primary medical care at four clinics and dental care at five clinic locations, focusing on preventive services and care for the homeless. Health departments may return to a greater role in direct patient care. As a possible harbinger of things to come, the Wahkiakum County Department of Health and Human Services will take over operation of the Cathlamet Clinic from PeaceHealth Saint John's Hospital in January 2005. Regardless of involvement in direct patient care, local health jurisdictions can perform an essential safety net support role by providing preventive services and

leadership and coordinating efforts to expand or maintain access to primary care for the entire community.

The auxiliary safety net

Rural Health Clinic (RHC) status represents federal certification for profit or non-profit clinics located outside an urbanized area (as defined by the U.S. Census) and in a Health Professional Shortage Area. The RHCs receive enhanced reimbursement for Medicare and Medicaid patients, and this amount is greater for provider-based clinics (those associated with hospitals with fewer than 50 beds) than for free-standing clinics. The additional reimbursement is intended to encourage Medicare and Medicaid access. RHCs are not required to provide care to uninsured or publicly insured patients, but the OCRH-sponsored *Rural Health Clinics of Washington Study* found that Medicare shares for the typical Washington RHC were 20% higher than the typical non-RHC practice in the United States (25% vs. 19%), and Medicaid shares were four times higher (20% vs. 5%). Additionally, 55% of the RHCs reported they used some form of a sliding fee schedule. (See http://www.doh.wa.gov/hsqa/ocrh/RHC/kennpres.pdf) As of March 2004, there were 106 Federally Certified Rural Health Clinics operating in Washington State (map).

Hospital-sponsored **primary care residency programs** play an important auxiliary role in Bremerton, Olympia, Seattle, Spokane, Tacoma, Vancouver, and Yakima, and in Colville and Goldendale in eastern Washington. (See map.) The primary purpose of residency programs is to provide training and experience for resident physicians as part of their post-graduate medical education. Accreditation requirements for residency programs are designed to ensure an appropriate clinical mix for a model family practice, covering as broad a scope of conditions as possible. Although these rules don't specify payer mix, residency programs may take on an important safety net support role as a way of providing adequate clinical experience to the residents in training. Residency programs often pick up patients who would normally be seen by private practices, and they provide back-up for local physicians (patients receive 24-hour coverage if accepted to teaching programs). Residents are more likely than private providers to accept publicly insured or uninsured patients since many residents receive subsidies from their sponsoring institutions or federal teaching grants, and they draw lower salaries. Residency programs have experienced a tension between safety net roles, requirements for financial viability and the need to expose residents to a broad and representative mix of patients. Roles and functions vary from residency program to program (map).

Of Washington's 29 federally recognized tribes, 23 operate **tribal health clinics.** Four of these clinics are operated by the Indian Health Service and are open only to tribal members. Tribes operate the remaining clinics under federal Indian Self-Determination and Education Act (P.L. 93-638) contracts or compacts. The U.S. Commission on Civil Rights reports that the federal government spends less per capita on Indian health care than on any other federal health program (about 60% of average annual per capita health expenditures nationwide) despite significant health disparities. Tribes increasingly are relying on Medicare, Medicaid, other third-party revenue sources, and revenue from tribal enterprises to fill the gap. Some Section 638 clinics are open to non-members, in part to improve access to third-party reimbursement. In some rural areas, tribal clinics

have stepped-up to provide care because of a lack of providers willing to see Medicaid patients. The decision on how or whether to open tribal clinics to non-members is made locally and is subject to changes in reimbursement policy.

Contributions from outside the safety net

Because of their numbers, physicians in **private practice** provide most Medicaid, BHP, and Medicare capacity in Washington State. Primary care surveys conducted by OCRH show that with a few exceptions, private providers limit the combined share of Medicaid and Medicare patients to less than 50% and often less than 25% of their patient mix to maintain financial viability or for other concerns. Private practices provide very limited amounts of charity care in their practice settings or through volunteering in other safety net settings. A very small number accept up-front sliding fee scale payment, and when it is offered, it is used by well under 5% of patients. A larger number offer some type of cash discounts. Private practices report in OCRH surveys that they have no more capacity to see Medicaid, Medicare, and BHP patients. Between 65% and 95% of private providers in urban counties report their clinics are closed-to or significantly restrict new public patients. In contrast, 20% to 60% of private practices (depending on location and payer) with RHC certification report that they are closed-to or are restricting new patients.

Most of Washington's public higher education institutions operate **campus health clinics,** which are open to faculty and students. These clinics provide basic primary care and preventive services regardless of insurance status, and as such, have some features of the auxiliary safety net. They play an important role in university communities where they serve a low-income student population that is less likely to be insured. The OCRH is inventorying capacity at these clinics and developing a clearer picture of the role they play. Capacity at these clinics has not been included in this assessment—an omission that may understate safety net capacity in counties with a strong university presence (such as Whitman County).

Physician capacity by clinic type and safety net role

During the past two years, OCRH has inventoried or estimated physician capacity in 37 of 39 Washington counties. Using the methods described in Appendix A, we estimate that approximately 1,800 FTEs of primary care physician capacity was available in these counties during 2002 and 2003 (1 FTE = 40 hours of direct patient care). Over the next year, OCRH will conduct inventories of the remaining two counties, King and Pierce, the most populous Washington counties. Based on population, these counties would be expected to account for an additional 1,100 to 1,200 FTEs, or about 40% of state capacity.

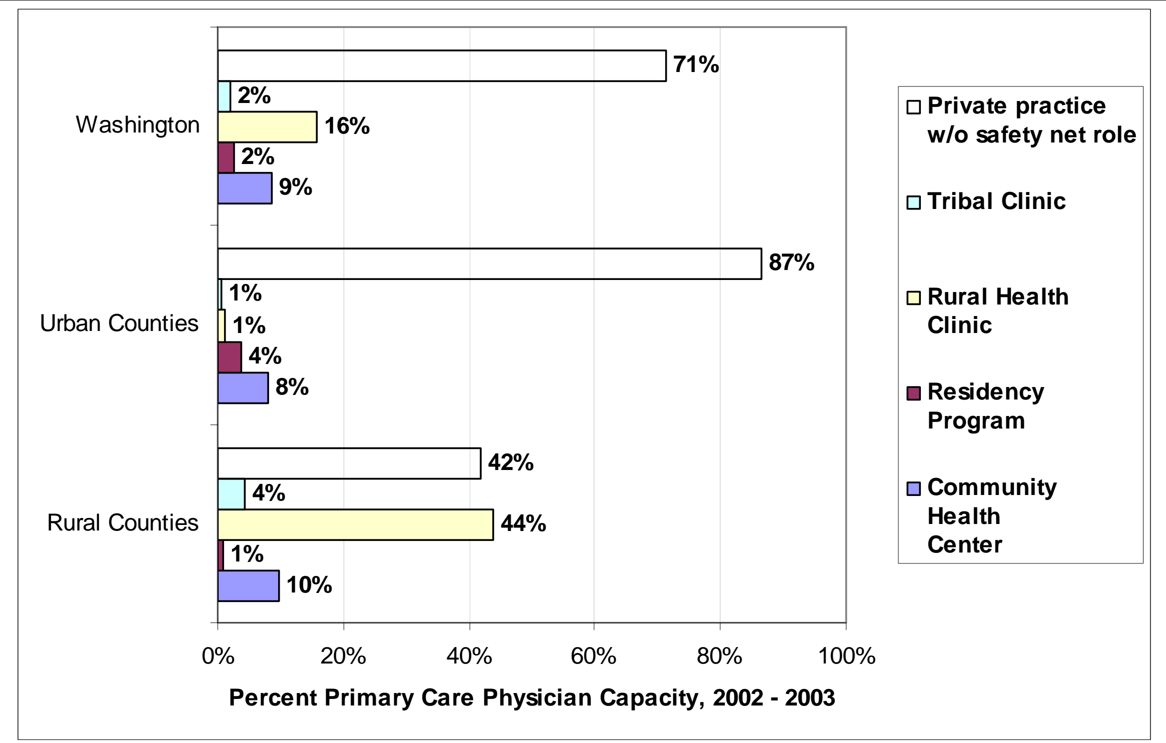
The OCRH inventories and estimates reveal the following conclusions concerning core and auxiliary safety net capacity in Washington (excluding King and Pierce counties):

- Less than 10% of primary care physician capacity in the 37 counties studied provide care at core safety net locations—CHMCs and charity care clinics.

- And additional 20% of primary care physician capacity in these counties is located at clinics in the auxiliary safety net. These include RHCs (16%), tribal clinics (2%), and residency programs (2%).
- Most providers (71% of capacity) do not receive any directed tax support to meet safety net functions or provide care to publicly insured patients.

If the primary care capacity in King and Pierce counties were included, the percentage of capacity in the core safety net would increase by 3 to 6 percentage points to 12-15% because core safety net systems are larger in these communities. But the percentage of capacity in the auxiliary safety net would drop, largely because RHC capacity share would drop by 5-6 percentage points to about 10%, as King and Pierce counties are predominantly urban. These proportions are shown in the following chart.

Figure 2: Primary Care Physician Capacity by Clinic Type for Washington's Rural and Urban Counties (excluding Pierce and King counties)



- Nearly 60% of the primary care capacity in rural Washington counties receives some reimbursement enhancement to support safety net roles, compared to about 15% in urban counties. Residency programs play a more significant role in urban counties (4% vs. <1%), and tribal clinics have more significant roles in rural counties (4% vs. 1%). The percentage of capacity in CMHCs is fairly similar between urban and rural counties. This does not necessarily mean that all rural health care systems are financially stable. Reimbursement rates differ by as much as 100% across RHCs. While some RHCs are financially stable, others, especially free-standing RHCs, face greater financial difficulty.

- RHC certifications in Washington are growing rapidly, a trend that is strengthening the auxiliary safety net in these communities and resulting in better access for Medicare and Medicaid enrollees than they experience in urban areas. RHC certification and reimbursement has reversed the payment and reimbursement disparities between urban and rural areas. With enhanced RHC reimbursement, private primary care physicians with large Medicare and Medicaid patient loads practicing in rural areas of the state receive *greater* reimbursement than urban providers with large Medicare and Medicaid patient loads. In the absence of RHC payments, reimbursement rates for Medicaid and BHP patients in urban and rural counties are fairly similar, though larger private practices in urban areas may be able to negotiate slightly higher rates with insurers for managed care patients. Medicare managed care reimbursement rates are higher in urban counties, but Congress has reduced these disparities. King County physicians have higher Medicare fee-for-service reimbursement rates, but rates for other urban counties and rural areas are fairly similar.

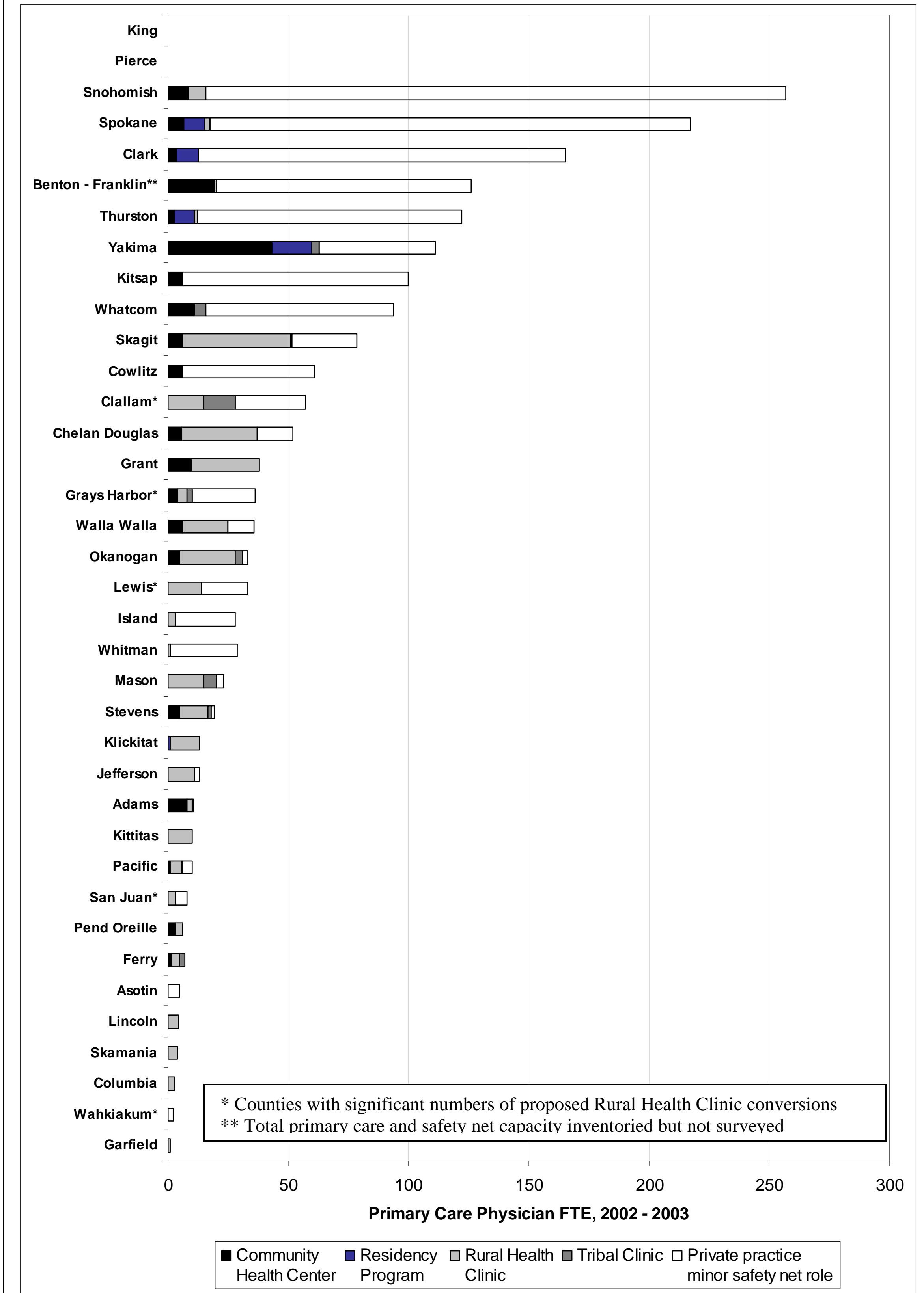
Significant county-to-county differences

Unlike most urban counties, where the safety net providers account for less than 10% of capacity, more than 50% of physician capacity in Yakima County is located at a CHMC or residency program. One contributing factor to Yakima County's strong safety net is the community's high poverty rates and large migrant population, which are consistent with federal criteria for investing in CHMC starts and expansion. An April 2004 study from The Center for Studying Health Systems Change, **Federal Aid Strengthens the Safety Net: The Strong Get Stronger**, has also noted that CMHC expansion policies are "risk adverse," that is, they favor expansions of existing CHMC systems with a strong track record over independent starts.

There are also significant differences in the distribution of clinic capacity among the rural counties. Rural counties in Figure 3 are discussed in more detail in Appendix A. Some of this variation is disappearing. Clinics in Clallam, Grays Harbor, Lewis, San Juan, and Wahkiakum counties are expected to achieve RHC certification in the coming year. Private practice clinic capacity in those counties is expected to drop below 25%, in line with other rural counties. Whitman County's unique health care delivery system is influenced by Washington State University, which results in a high proportion of "employer-insured" patients. While there is a large low-income population, many of these are students who receive care at the university's campus health clinics. The community of Clarkston in Asotin County is now part of the Lewiston-Clarkston urbanized area; most of the area's physician capacity is located in Idaho, which has higher private insurance reimbursement rates than rural Washington. Other newly urbanized counties, according to the 2000 Census, are Skagit, Chelan, and Douglas. Much of the RHC capacity in these communities may be decertified in the next 2-5 years.

Figure 4, on the following page, highlights significant exceptions to the rural-urban patterns noted above.

Figure 3: Primary Care Physician Capacity By Clinic Type in Washington Counties

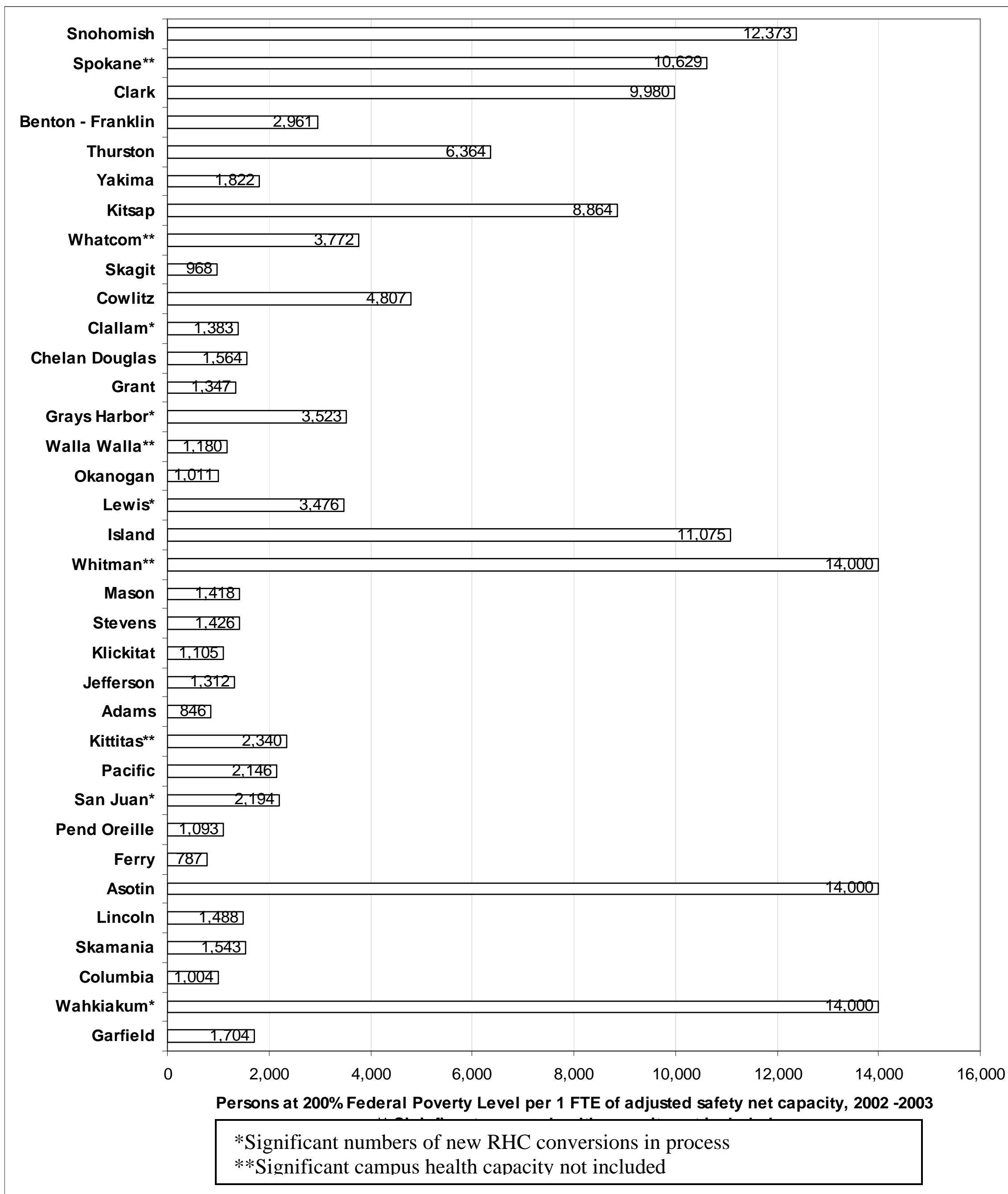


Distribution of safety net capacity relative to county poverty levels

OCRH addressed the question of whether communities with less relative safety net capacity also have smaller proportions of their populations in need. As a rough means of accounting for need, we calculated the ratio of population under 200% of the federal poverty level (FPL) to primary care safety net FTE.

Capacity in the core safety net is counted 1:1, and capacity in the auxiliary safety net is counted at 1.5 to account for differing contributions. The ratios reported in Figure 4 on the following page range from 787:1 to more than 12,000:1. As these ratios don't account for "working uninsured" or for differences in capacity delivered by private practices, it is difficult to establish benchmarks for the point at which a community faces a serious problem accessing care. Another important limitation of this analysis is that in some counties, particularly those with significant auxiliary safety net capacity and little core capacity, availability of care for the uninsured may be overstated.

Figure 4: Adjusted Safety Net Capacity Relative to Potential Need



Safety net capacity growth rates and demand

CMHCs

Neither the Washington Association of Community and Migrant Health Centers nor the federal Bureau of Primary Health Care maintains long-term trend information on CMHC physician capacity or have readily available data. The Bush Administration initiative to increase CMHC capacity has had limited impact in Washington State. Most of the new funding is oriented to developing new sites or expanded services. Since 2001, eight new sites or site expansions have been approved, adding from 20 to 25 FTEs of new capacity. As of spring 2004, about 300 primary care physician FTEs were located at Washington's CHMCs. Therefore, core safety net capacity has been increasing at an annual rate of only about 2-3%. When viewed in the context of total statewide primary care capacity, an increase from 275 to 300 FTEs raised the core safety net share by less than 1 percentage point, from less than 9% to slightly more than 10%.

The Washington Association of Community and Migrant Health Centers predicts that the state's growth rate for CMHCs may slow and perhaps even contract over the next two to three years. The expansion initiative is expected to yield only a handful of new clinic start-ups in Washington in the near future, due to the long and complicated CMHC site development process, the state's fairly high penetration of CMHCs relative to other states, and the fact that federal criteria point to greater levels of need elsewhere. Meanwhile, base funding for Section 330 grants (less than 10% of the typical CMHC budget) for serving the uninsured has increased by less than 5% during the past three years. Despite significant increases in the number of uninsured patients the CMHCs are seeing, little or no increase in this base funding is expected over the next few years, given the pressure on the federal budget. These trends are summarized in a recent report prepared for the Community Health Network of Washington: **Stretching the Safety Net: The Rising Uninsured at Washington's Community Health Centers**

At the same time, Washington State's potential $1.2 billion budget shortfall in the 2005-2007 biennium is also likely to result in decreased eligibility for Medicaid and the BHP, which will further increase the number of uninsured. The possibility of decreases in covered services and less flexibility in using Medicaid reimbursement for non-Medicaid patients would result in fewer resources for ongoing CHMC operations or capacity expansions. See the June 2004, the Kaiser Commission on Medicaid and the Uninsured study **Economic Stress and the Safety Net: A Health Center Update** for a national summary of these trends.

Free clinics

Ongoing capacity at free clinics is not monitored. The OCRH has collected anecdotal information suggesting an increasing interest in free clinics, including a new start in Thurston County and an effort underway to build an informal statewide free clinic network. But reports suggest that growth in capacity during the past three years has generated fewer than 10 FTEs and possibly fewer than 5 FTEs. Even though additional

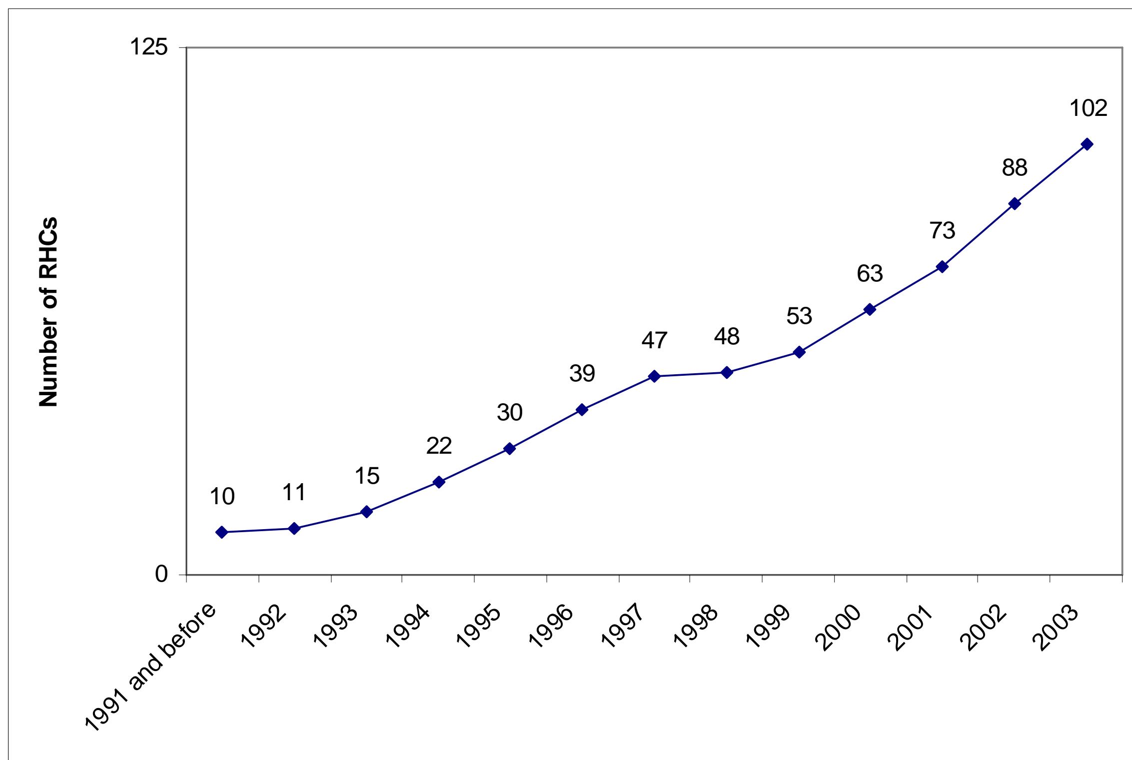
clinics are being developed, the limited number of hours means that the growth in the number of free clinics will not have a significant impact on overall safety-net capacity in Washington.

RHCs

The number of certified RHCs has steadily increased over the past three years. In spring 2004, about 285 primary care FTEs were located in RHCs statewide. The number RHCs will continue to grow over the next three to five years as the remaining eligible RHC sites are certified. The OCRH estimates that from 100 to 125 FTEs of primary care physician capacity are located at RHC-eligible clinics and are likely to convert. This estimate could be offset by a loss of 40 to 60 FTEs if clinics in newly urbanized areas are decertified. But even if RHC decertification occurs, it would take at least two to three years to implement.

RHC certification is most effective as a means of preserving existing access to Medicare and Medicaid. It provides enhanced reimbursement to existing clinics, many which already have combined Medicare and Medicaid shares of more than 50%. RHC conversion does have an indirect effect on capacity in that the higher rates allow for some expansion of capacity, improving Medicaid and Medicare access in some cases. RHCs are also more likely to adopt sliding fee scales and more charity care policies, though most clinics limit such services to less than 5% of patient care. The amount of new capacity RHC conversions create is unknown as the growth in conversions swamps any other effects. In the few counties where the OCRH has compared clinic capacity before and after RHC conversion, the transition did increase capacity by 5% to 10%. Figure 5 on the following page illustrates the growth trends of RHCs in Washington:

Figure 5: Number of Federally Certified Rural Health Clinics in Washington By Year of Certification



Family practice residency programs

The capacity of family residency programs has not been growing. In recent years, the programs have encountered difficulty matching medical graduates to open residency slots; more than 20% of residency positions in Washington were not matched over the past year. Most of the unfilled positions were in the rural residency programs in Goldendale and Colville communities. Residency programs have been hard-hit by malpractice insurance increases, which could affect viability

Trend data compiled by the University of Washington Department of Family Medicine indicate that family medicine residency program capacity could contract over the long haul. Fewer University of Washington medical students are choosing primary care specialties (35% in 1997, compared with 14% in 2004). For more details see:

http://www.fammed.washington.edu/~Roger_Rosenblatt/rural_workforce_04.ppt.

Tribal clinics

Several tribal clinics have added capacity in the past three years. Financing for these expansions has come from enhanced third-party reimbursement, increasing revenue from

tribal enterprises, and in one case (the Wellpinit Clinic serving the Spokane Indian Reservation), a one-time infusion of resources secured by the state's congressional delegation. CMHC expansion grant funding was also used for two CHMC/tribal clinic satellites on the Colville Reservation.

The Lower Elwha, Shoalwater, Jamestown S'Klallam, and other tribes have opened up clinics to non-members in part to provide access for Medicaid patients unable to find other providers who will take them. This is a local option subject to change. Potential changes in Medicaid reimbursement, reducing resources for non-tribal members seen at tribal clinics, could eliminate this option. In the long-term, the continued shortfall in federal appropriations, health cost inflation, and the growing American Indian/Alaska Native population may reverse the trend toward providing care to non-tribal members.

Appendix: Data Notes

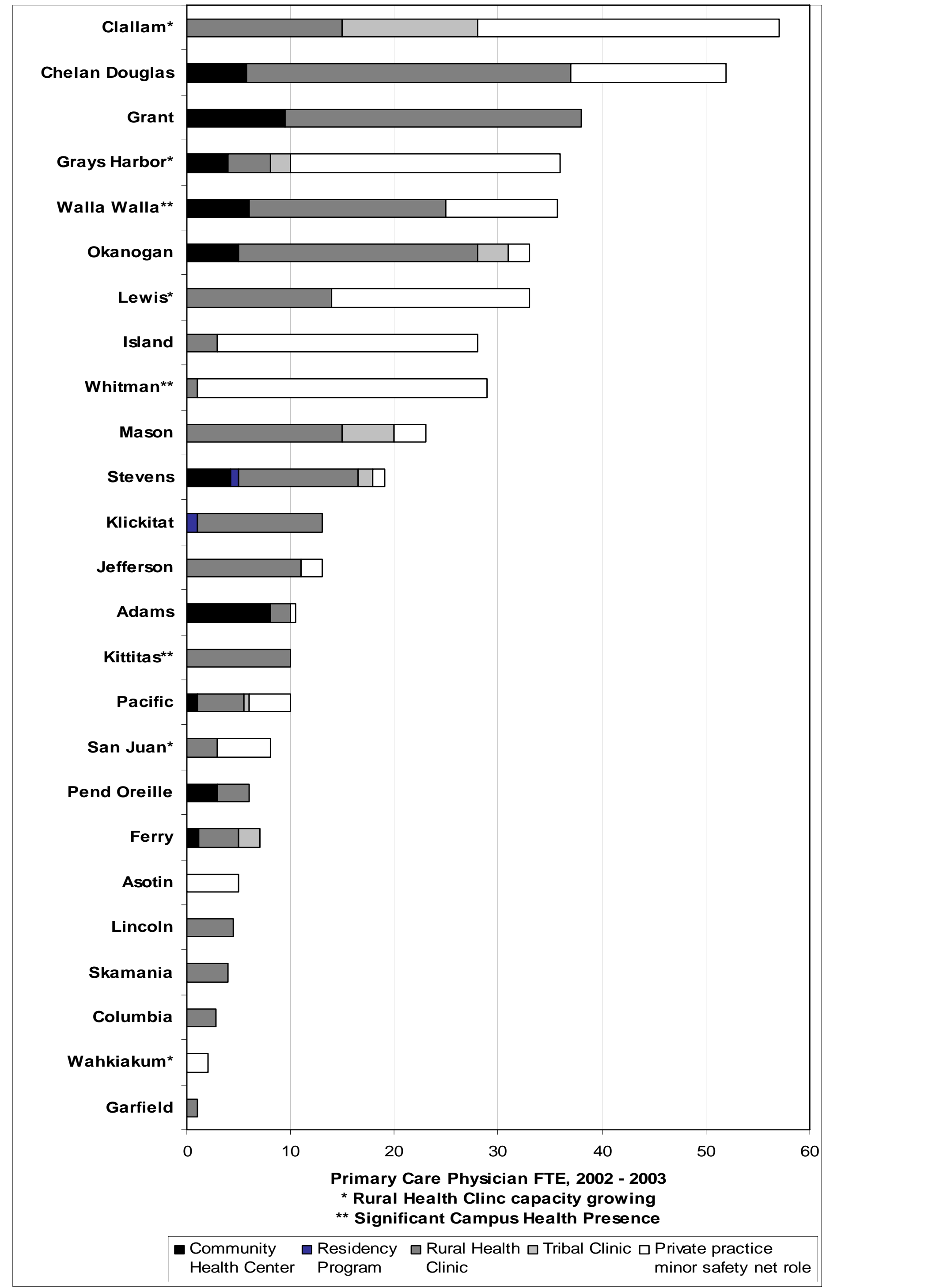
Definition of primary care capacity: For this report, primary care specialties include family and general practice, general pediatrics, general internal medicine, and obstetrics/gynecology.

Data collection methods: Data for this report was derived from Primary Care Capacity/Health Professional Shortage Area surveys conducted within the past two years. These surveys are administered through a collaborative effort involving the OCRH, local health jurisdictions, and other local partners to inventory primary care physician capacity by location and clinic type. OCRH identified all providers in active practice and matched them to specific clinic locations. It surveyed business office staff to obtain information on hours invested in direct patient care and other detailed information. Survey response rates ranged from 80% to 100% of providers, with the highest response rates in rural areas. FTE capacity for non-responding providers was estimated using average values by clinic and specialty. In cases where the data were more than two years old, we reviewed and verified data using yellow pages, insurance directories, and hospital referral lists. Data for four urban counties were not available. Provider data for Benton and Franklin counties were developed by compiling head counts and estimating FTEs. Data for Pierce and King County were not available. Efforts are underway to complete these surveys within the next 12 months. Based on population, we would expect to find about 300 FTEs of physician capacity in Pierce County and 800 to 900 FTEs in King County. We estimated CMHC and Public Health Clinic capacity in King and Pierce counties using FTE data compiled on State Loan Repayment Applications and information available on the web about the core safety net in these counties. This estimate is imprecise and given the large contribution these counties make to primary care physician capacity, statewide estimates should be viewed as approximate.

Urban and rural counties: This generally followed Census definitions. Urban counties are King, Pierce, Snohomish, Spokane, Clark, Benton-Franklin, Thurston, Yakima, Kitsap, Whatcom, Skagit, and Cowlitz. All others are rural.

Figure 6, on the following page, shows clinic capacity specifically for rural counties.

Figure 6: Primary Care Physician Capacity By Clinic Type: Rural Washington Counties



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