



Federally qualified health centers reduce the primary care provider gap in health professional shortage counties

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ABSTRACT

Background: Federally qualified health centers (FQHCs) were designed to provide care in medically underserved areas. Substantial and sustained federal funding has accelerated FQHC growth.

Purpose: To examine temporal trends in primary care provider supply and whether FQHCs have been successful in reducing the gap in provider supply in primary care health professional shortage areas (HPSAs).

Methods: Retrospective cohort study design using national county-level data from 2009 to 2013. Primary care providers included physicians, nurse practitioners, and physician assistants.

Findings: Partial-county HPSAs had the highest average provider supply and the greatest increase, followed by non-HPSA counties and whole-county HPSAs. The provider gap was larger in whole-county HPSAs compared with partial-county HPSAs. Counties with one or more FQHC sites had a smaller provider gap than those without FQHC sites. An increase of one FQHC site was statistically significantly associated with a reduction in the annual provider gap.

Discussion: FQHCs reduced the gap in primary care provider supply in shortage counties and mitigated uneven distribution of the primary care workforce.

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Background

Maldistribution of the primary care workforce has been a persistent barrier in reducing health care disparities and improving the efficiency of the primary care system (Bodenheimer & Pham, 2010; Dwyer-

Lindgren et al., 2017). The most recent data show that county disparities in U.S. life expectancy are large and increased from 1980 to 2014; this differential is in part explained by the number of physicians per 10,000 population along with socioeconomic, behavioral, metabolic, and other health care factors (Dwyer-Lindgren et al., 2017).

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Federally qualified health centers (FQHCs) were designed to provide care for medically underserved populations who otherwise would have difficulty accessing health care services. One of the criteria to be certified as an FQHC is to serve a designated medically underserved area or a medically underserved population (MUA/P) (Center for Medicare & Medicaid Services, 2017), which was defined by Section 330(b)(3) of the Public Health Service Act as “the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services, or a population group designated by the Secretary as having a shortage of such services.” (Negotiated Rulemaking Committee, 2011). The designation has been used by federal programs to allocate resources in underserved areas. The designation criteria for MUA/P overlap with certain criteria for designation as primary care health professional shortage areas (HPSAs) (Health Resources and Services Administration, 2018), which as yet count only primary care physicians as providers, despite a recommendation in 2011 by the Negotiated Rulemaking Committee to include nurse practitioners (NPs) and physician assistants (PAs) (Negotiated Rulemaking Committee, 2011; Ryan, 2017).

Substantial and sustained federal funding, including the investment of \$11 billion through the Health Center Trust Fund, has accelerated FQHC growth (Rosenbaum et al., 2017). As of 2015, there were over 1,300 health centers that delivered comprehensive primary care to 24 million people in the United States (Health Resources and Services Administration, 2015b). As the largest and most essential source of comprehensive primary care for medically underserved populations (Rosenbaum et al., 2017), FQHCs have expanded access to care and improved health outcomes (National Association of Community Health Centers, 2015).

One other benefit of FQHCs has been to increase health care providers to serve in medically underserved areas. Over a 12-year period, employment in FQHCs increased from 25,780 in 2003 to 120,000 in 2015 (National Association of Community Health Centers, 2014, 2016a). This growth includes physicians, NPs, PAs, and other clinicians (National Association of Community Health Centers, 2014). Notably, FQHCs have increased the use of NPs and PAs to reduce barriers in access to primary care (National Association of Community Health Centers, 2013). Widely recognized as primary care providers, NPs and PAs provided similar quality of care to health center patients as primary care physicians (Kurtzman & Barnow, 2017). Accordingly, FQHCs have the potential to reduce the gap in provider supply in shortage areas and to mitigate uneven distribution of primary care providers (primary care physicians, NPs, and PAs) between shortage areas and nonshortage areas. However, empirical evidence is lacking in understanding this important impact of FQHCs on the primary care workforce, especially given worsening primary care physician shortages and growing NP and PA supply.

The NP and PA workforce have been expanding substantially across states and are expected to help fill

primary care physician shortages and to meet the increasing demand for care (U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis, 2016). Yet, little is known about the relative growth of primary care providers in shortage and nonshortage areas. The objectives of this study were to examine the temporal trends in primary care provider supply and assess whether FQHCs have been successful in reducing the gap in provider supply in primary care HPSAs.

Methods

Study Design

We employed a retrospective cohort study design using national county-level data from 2009 to 2013. We used primary care HPSA designation to identify shortage counties, which has extensive overlap with MAU/P and the data on county primary care HPSA status is readily available. We assessed the effect of FQHCs on the primary care provider gap in two ways. First, we compared the provider gap between primary care HPSA counties with and without FQHC sites. We hypothesized that counties with FQHC sites would have smaller provider gaps over time than those without FQHC sites. Second, among counties with FQHC sites, we examined whether counties with a greater number of FQHC sites had a bigger reduction in the provider gap over time. We hypothesized that as the number of FQHC sites increased in shortage areas, the provider gap decreased.

Data Source

The primary source of data was the Area Health Resource File (AHRF) compiled by the Bureau of Health Workforce at the U.S. Health Resources and Services Administration (HRSA). The AHRF contains county-level data on health professional supply, health service volumes, health delivery infrastructure, and demographics. Data for physicians, NPs, and PAs were not available in the AHRF for 2009, so for that year we obtained physician data from the American Medical Association Physician Master File and extracted data on NPs and PAs from the National Provider Identifier registry, which are the same data sources used by the AHRF.

FQHC data were acquired from the HRSA's Data Warehouse (Health Resources and Services Administration, 2015a). The data collected by the HRSA include both FQHCs and “Look-Alike” health centers, which are other community-based organizations that meet the same requirements at FQHCs but do not currently receive Health Center Program funding. These can include public health clinics, migrant health clinics, and other similar non-FQHC organizations. In addition, we obtained data from

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