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Title

Exploring the Relationship between Primary Care Physician Rates and Usual Source of Care

Priority 1 (Research Category)

Health Care Disparities

Presenters

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Abstract

Context: The NASEM Primary Care Report and PC scorecard highlighted the importance of primary care physician (PCP) capacity and having a usual source of care. However, research has found that PCP capacity and usual source of care do not always correlate. Objective: To compare the characteristics of counties with similar rates of primary care capacity but varying rates of usual source of care (USC). Study Design and Analysis: Cross sectional approach. Conditional mapping to stratify US counties by primary care physician (PCP) capacity and usual source of care terciles, allowing us to identify four types of counties: (1) high PCP capacity, low USC; (2) high PCP capacity, high USC; (3) low PCP capacity, high USC; (4) low PCP capacity, low USC. We also use t-tests to compare (1) with (2) and (3) with (4) to explore differences in counties with similar primary care capacity. Setting/Dataset: Robert Graham Center, Behavioral Risk Factor Surveillance System (BRFSS) estimates, RWJ County Health Rankings (CHR). US Counties (n=3,141). Outcome Measures: Primary care physician rates per 100,000; Percentage of adults with no usual source of care. Results: The results show clear geographic patterns – counties with high PCP capacity, high USC are located primarily in northern and northeastern US; counties with high capacity, low USC are more scattered throughout western and southern US. Low PCP capacity and high USC counties are concentrated in Appalachia and the Great Lakes regions; low PCP capacity and low USC counties are concentrated in southeastern US and Texas. Descriptive results for these four types of counties reveal that race/ethnicity, uninsurance, and social deprivation are highest in counties with low rates of USC for both high PCP and low PCP areas. Conclusions: Recognizing PCP shortages and improving rates of USC are key strategies for increasing access to high-quality, primary care. Targeting strategies by geographic region will allow local tailoring; specifically, increased training and continued practice in Texas will be essential to improve health outcomes as seen in PC settings. Alternatively, Appalachia may benefit from collaborative models with public health and emergency medicine to ensure that patients seen at USC sites other than primary care can be funneled back to PCPs - which necessitates a growth of PCPs in the region. Tailored models to improve access and continuity will improve equitable health outcomes despite geographical differences.