

Access to Primary Healthcare Services

Definition: Access to primary healthcare supports diagnosis and management of acute health problems and chronic conditions and enables disease prevention. Having health insurance and having a personal healthcare provider (HCP) enable access. This chapter uses two primary measures: self-reports of having health insurance from the American Community Survey and having a personal HCP. For adults, we use self-reports of having a personal HCP from the Washington Behavioral Risk Factor Surveillance System. For children, we use parental report from the National Survey of Children's Health.

Summary

Access to primary healthcare requires two main factors: affordable health insurance and access to a personal healthcare provider (HCP).^{1,2} Health insurance makes healthcare more affordable. A personal HCP facilitates the availability of primary care services. Without an adequate supply and distribution of HCPs, access to care can be compromised.

Children ages 0–17 and adults ages 65 and older have high rates of insurance coverage. The 2012 American Community Survey (ACS)^a indicated that 95% of children and 99% of adults ages 65 and older in Washington have health insurance. Adults ages 18–64 reported lower rates of insurance coverage: 81% in 2012. Based on these figures, more than 950,000 of Washington residents were uninsured in 2012.

Personal HCPs are responsible for assessing, diagnosing and monitoring a patient's health needs. According to the 2011–2012 National Survey of Children's Health, 91% ($\pm 2\%$) of Washington's children under the age of 18 had a personal HCP. The 2010–2012 Behavioral Risk Factor Surveillance System showed that 75% of Washington adults ages 18 and older had a personal HCP. For adults, the likelihood of an individual having a personal HCP increased with age. This patient-provider relationship was also highest among whites.

In addition to Washington's efforts to expand health insurance coverage under the Affordable Care Act, Washington State Department of Health works with local, state and federal

partners to improve availability of and access to personal HCPs. The department designates health professional shortage areas; engages in programs for provider recruitment, retention, loan repayment, scholarships and reimbursement; and provides subsidies for safety net clinics.

Introduction

Access to primary healthcare services is possible only when multiple elements of the healthcare system are in place. Shortages of healthcare providers, facilities or inadequate health insurance coverage can prevent communities or groups of individuals, such as low-income residents, from accessing care.

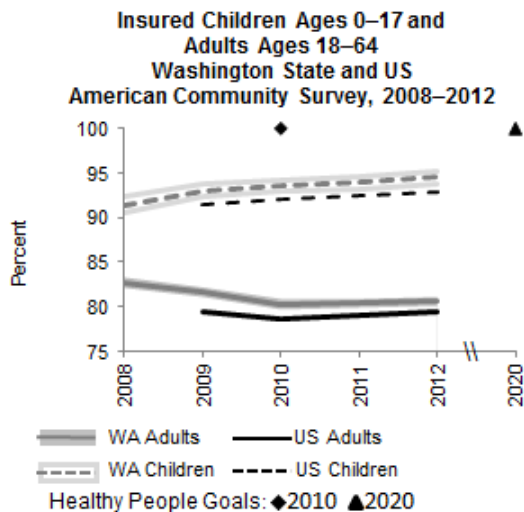
For individuals, having a personal healthcare provider (HCP) is the key connection with the healthcare system.^{1,2} A personal HCP supports consistency and continuity in patient care. Without insurance, access to a personal HCP can be difficult and in some cases impossible. For example, the 2010–2012 [Behavioral Risk Factor Surveillance System](#) (BRFSS) showed that 82% (± 1) of Washington residents who reported having health insurance also reported having a personal HCP compared to only 44% (± 2) of uninsured residents.

When measuring health insurance, this chapter focuses on Washington residents ages 64 or younger, since most people acquire health coverage through Medicare starting at age 65. In the case of having a personal HCP, the focus is all Washington residents. People of all ages, including those on Medicare, can have difficulties accessing a personal HCP.

^a Margins of error for the American Community Survey and the Behavioral Risk Factor Surveillance System are less than or equal to 1% unless otherwise noted.

Time Trends

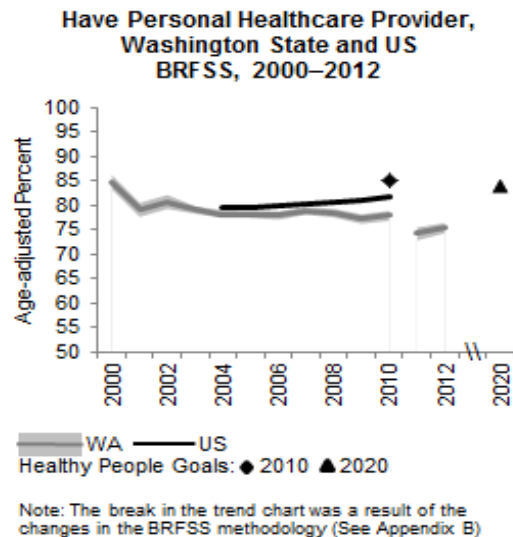
Health insurance. Changes in health insurance coverage in Washington during 2008–2012 reflect national trends both for children and for adults.³ ACS^a data show coverage rates for children under age 18 in Washington growing from 91% in 2008 to 95% in 2012. Conversely, coverage rates from all payer sources for adults ages 18–64 dropped from 83% in 2008 to 81% in 2012. This downward trend for adults ages 18–64 is mostly due to employers cutting back on health coverage for employees and their families and due to higher unemployment during the recent recession.^{4,5}



The implementation of the Affordable Care Act and the expansion of Medicaid in Washington are expected to improve the levels of insurance coverage among adults ages 18–64.

Personal HCPs. The National Survey on Children’s Health (NSCH) showed the percent of children in Washington with a personal HCP increased from 86% (±2%) in 2003 to 91% (±2%) in 2011–2012.

BRFSS^a showed the percent of Washington adults reporting personal HCPs declining from 85% in 2000 to 79% in 2003, and remained at 78% during 2004–2010. The lower estimates in 2011–2012 likely reflect changes in BRFSS methods.



2010 and 2020 Goals

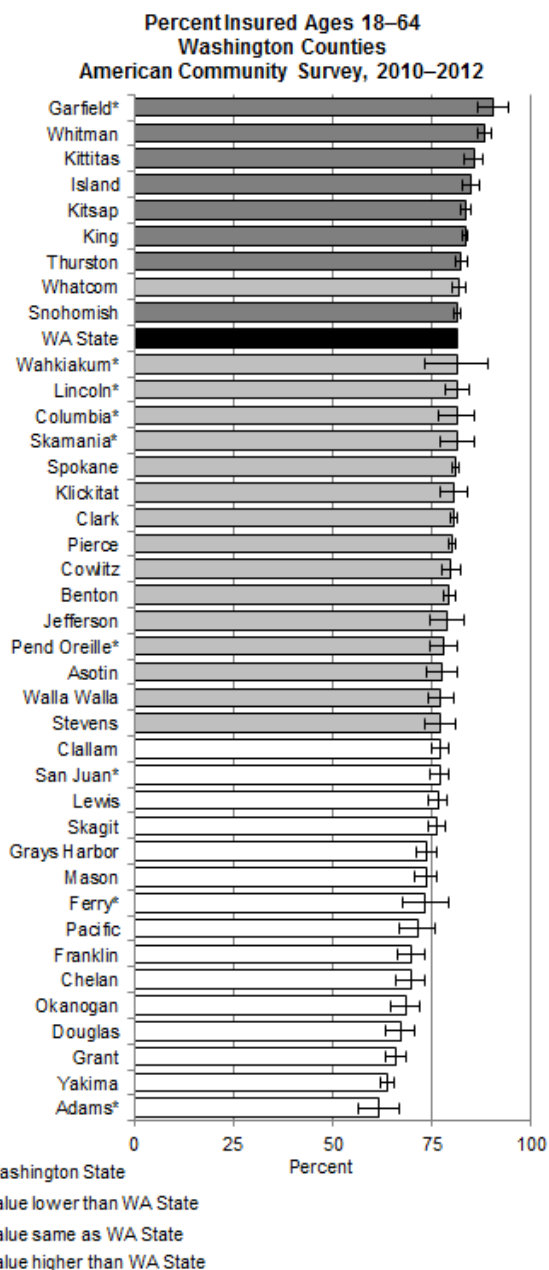
Health insurance. The national Healthy People 2010 and 2020 goals are that 100% of Americans younger than age 65 have health insurance coverage. With the 2010 ACS showing about 94% of children and 80% of adults ages 18–64 with health insurance, Washington did not meet the 2010 goal. Based on current trends, we would not expect Washington to meet the 2020 goal, but this may change with the Affordable Care Act.

Personal HCPs. Healthy People 2010 and 2020 define a “usual” HCP from a set of four questions in the Medical Expenditure Panel Survey (MEPS). While the concepts of a usual HCP and a personal HCP are similar, we do not know whether data from MEPS and BRFSS are comparable. The 2010 national goal for usual HCP was to have at least 85% of Americans having a usual HCP. The nation did not achieve this goal: only about 76% of Americans had a usual HCP in 2007. As a result, the goal for 2020 was reassessed and lowered to 83.9%.

According to BRFSS data, the percent of Washington State adults with a personal HCP remained around 78% during 2004–2010. The BRFSS measurement provides even lower percentages for 2011 and 2012. These lower estimates likely reflect changes in BRFSS methods. (See [Technical Notes](#).) If the MEPS and BRFSS measures are comparable, the low rates in Washington suggest that Washington will not meet the 2020 target goal, but this may change with the Affordable Care Act.

Geographic Variation

Health insurance. During 2010–2012,^b eight Washington counties had larger percentages of residents ages 18–64 with health insurance than the state as a whole; 15 had smaller percentages. Nine of the 15 with smaller percentages had high percentages of individuals living in poverty during the same time period.⁶

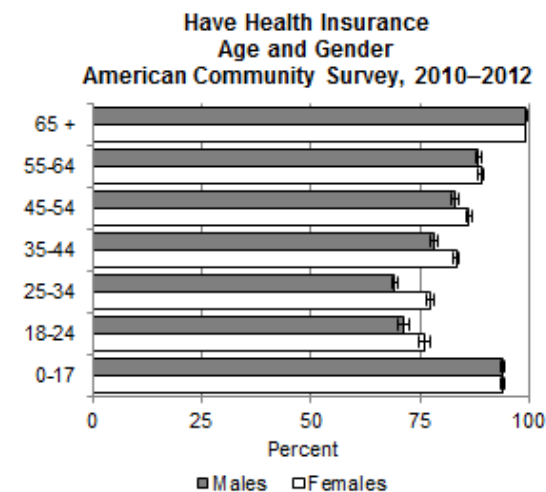


^b American Community Survey data for counties with less than 20,000 people are for 2008–2012

Personal HCPs. The percentage of adults with personal HCPs is relatively consistent across counties. BRFSS data for 2010–2012 showed only Columbia County as having a higher percentage of adults with personal HCPs than the state. Only three counties—Franklin, Grant and Okanogan— had lower rates. The three counties with low HCP rates also have large populations of Hispanic origin, a group that reports low rates of having personal HCPs.⁷

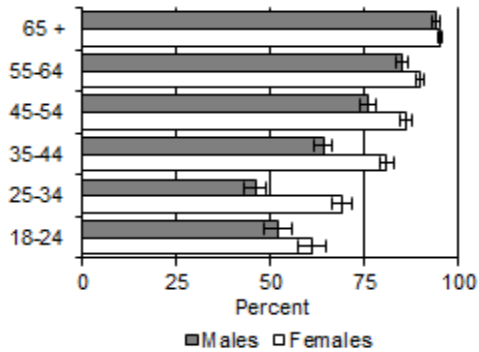
Age and Gender

Health insurance. ACS^a data for 2010–2012 show 94% of children ages 0–17 and 99% of adults ages 65 and older having health insurance. In contrast, only 80% of adults ages 18–64 had insurance during the same time period. The availability of public insurance is a key factor in explaining differences in rates of insurance coverage among age groups.⁸ Most adults are Medicare eligible at the age of 65. Similarly, most children who need health insurance are eligible for Medicaid under the State Children’s Health Insurance Program. Among residents ages 18–54 women are more likely to have health insurance than men, and rates for both men and women increase with age after age 34.



Personal HCPs. The 2010–2012 BRFSS showed that women ages 18–64 were more likely to have a personal HCP than men of the same ages. Having a personal HCP also increased with age.

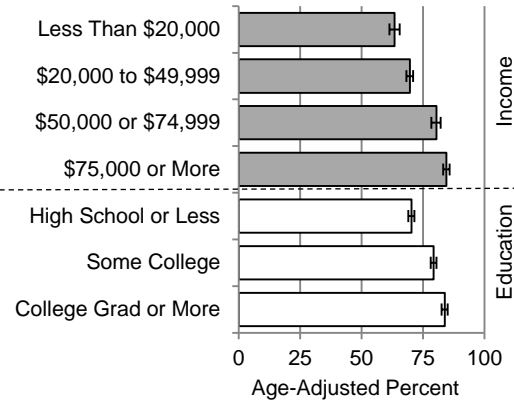
**Have Personal Healthcare Provider
Age and Gender
BRFSS, 2010–2012**



Economic Factors and Education

Health insurance. ACS^a data for 2010–2012 showed about 60% of Washington residents ages 18–64 with incomes at or below the federal poverty level having health insurance compared to about 91% of residents with incomes at least three times higher than the poverty level. ACS data also showed the percent of those with health insurance increased as household income increased. Among adults ages 25 and older, the likelihood of having health insurance also increased from 75% for those with a high school education or less to 94% for those who graduated from college.

**Have Personal Healthcare Provider
Annual Household Income
and Education
BRFSS, 2010–2012**



Personal HCPs. Similar to relationships of income and education with health insurance, people with higher incomes and higher levels of formal education are more likely than others to have personal HCPs. On the 2010–2012 BRFSS,^a 84% (±2%) of Washington residents ages 18 and older with annual household incomes greater than \$75,000 reported personal HCPs compared to 63%

(±2%) of residents with annual household incomes less than \$20,000. Among college graduates ages 25 and older, 84% reported having personal HCPs compared to 70% of those with high school educations.

Race and Hispanic Origin

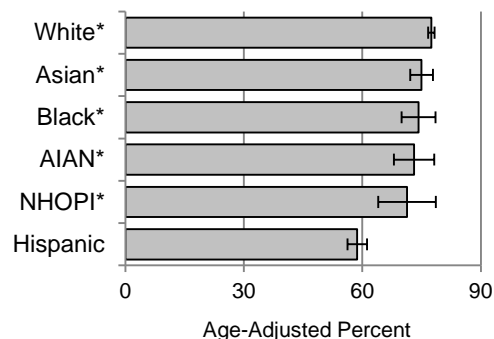
Health insurance. ACS data for 2010–2012 showed American Indian and Alaska Natives having the lowest insurance coverage rates for children ages 0–17 (82% ±3%). Rates for other groups ranged from 96% (±3%) for Native Hawaiian and Pacific Islanders to 93% (±2%) for Asians.

For adults ages 18–64, the 2010–2012 ACS showed 81–82% (±<1–2%) of Washington’s white, Asian and Hispanic residents having health insurance. Rates for American Indian and Alaska Native, Native Hawaiian and other Pacific Islander, and black residents ranged from 75–76% (±1–6%). Among adults ages 65 and older, health insurance coverage rates are similar for all racial groups and for those of Hispanic origin as a result of near universal coverage by Medicare.

Personal HCPs. Among adults 18 and older, BRFSS^a data for 2010–2012 showed access to a personal HCP was greatest among whites (78%) and lowest among individuals of Hispanic origin (59% ±3%). Similarly, NSCH data for 2011–2012 showed white non-Hispanic children ages 0–17 with the highest access to a HCP.

These findings are consistent with the findings of national studies indicating that individuals of Hispanic origin are less likely to have a usual source of care.⁹

**Have Personal Healthcare Provider
Race and Hispanic Origin
BRFSS, 2010–2012**



* Non-Hispanic, single race only
AIAN: American Indian/Alaska Native
NHOPI: Native Hawaiian/Other Pacific Islander

Health Effects

While access to healthcare is not the only determinant of health, those with a reliable and consistent source of healthcare and health insurance are more likely to benefit from preventive healthcare.¹⁰ Other benefits of primary care include improved self-reported health status, reduced mortality, and lower medical care costs.¹¹ The uninsured and those with no personal HCP are more likely to use emergency departments, be hospitalized for potentially avoidable health conditions, or to die from cancer.^{12,13,14,15,16}

Barriers

Poverty and unemployment. A major barrier to receipt of primary healthcare is limited financial means. Health insurance is often tied to employment; individuals with no employment or part-time employment are less likely to have health coverage. In turn, this group of unemployed or underemployed individuals is more likely to delay medical treatment because of cost. High deductibles, co-payments and out-of-pocket expenses can also act as deterrents. Based on the 2010–2012 BRFSS, 16% ($\pm 1\%$) of adults in Washington State did not see a doctor in the past year due to cost. These barriers likely affect some racial and ethnic groups in Washington more than others. For example, black and Hispanic residents have higher rates of unemployment¹⁷ than white residents. These groups also have higher percentages of individuals living in poverty than white and Asian groups.⁶

Research indicates there is a current shortage of healthcare providers serving low-income communities. These communities are commonly associated with low rates of insurance coverage and high rates of Medicaid enrollment.^{18,19,20} According to the Office of Financial Management, the rural parts of western and southwest Washington have the highest percent of providers not accepting Medicaid patients.²¹

Health workforce shortages. The need for primary care services is expected to increase due to the aging of the substantial number of “baby boomers,” the ACA’s expansion of health insurance coverage and the influx of adults eligible for Medicaid.²² As a result, Washington faces a growing shortage of many healthcare providers, including physicians, nurses, physician’s assistants, nurse’s assistants and other providers.

The Washington State Health Care Personnel Task Force recently projected an annual gap, from 2015

through 2020, of 372 physicians and surgeons, 177 registered nurses, and 45 physician’s assistants.²³ About 75% of all family physicians in the state are recruited from outside of the state.²⁴ The shortage of family physicians is especially worrisome considering that residency positions for family physicians declined nationally.²⁵

In Washington, nearly half of the state’s nurse practitioners are family practice certified and play a lead role in primary care service delivery. Demographic data suggest that more than half of practicing nurse practitioners are 50 years of age or older.²⁶ They will soon retire or age out of the workforce, causing further stress to primary care service delivery across the state and especially in rural areas, where a large proportion of nurse practitioners are functioning as primary care providers.²⁷

Geographic access and transport. In 2011, an estimated 14% of the state’s population lived in areas without any form of public transportation, making access to care difficult for many seniors, disabled persons, and those without reliable transportation.²⁸ In addition, weather-related road closures and long distances to the nearest healthcare facilities can further isolate rural populations.

Limited English proficiency. Language barriers compromise access to consistent high quality care. Language barriers can lead to misunderstanding of diagnosis, treatment, self-care choices and follow-up care plans; inappropriate use of medications; lack of informed consent for procedures; longer hospital stays; and poor patient satisfaction.^{29,30}

The 2010–2012 ACS showed that about 4% of households in Washington were linguistically isolated. Isolation is defined as no one in the household older than 14 years speaks English “very well.” (See [Technical Notes](#).) The same survey showed 23% ($\pm 2\%$) of Spanish-speaking households, 15% ($\pm 2\%$) of households speaking other Indo-European languages, 25% ($\pm 2\%$) of households speaking Asian and Pacific Island languages, and 24% ($\pm 5\%$) of households speaking other languages in Washington are considered “isolated.”

Other Measures of Impact and Burden

In addition to negative health outcomes, a lack of access to health services has lasting

economic implications. The annual cost of uncompensated care in Washington was projected at one billion dollars annually for 2011–2013.³¹ Costs associated with uncompensated care are partially absorbed by those with insurance through higher medical fees and treatment costs.

Risk and Protective Factors

Medical spending increases and cost containment responses. In the United States, healthcare cost inflation consistently outpaces growth in gross domestic product. Employers who provide health insurance must decide how to handle rising health insurance costs. The cost of health insurance remains the primary reason cited by employers for not offering health benefits.³² Nationally the percent of all businesses offering health benefits was about 61% in 2011 and about 60% in 2012. In Washington State, the percent of adults younger than 65 who receive employer-based health insurance declined from about 71% in 1993 to about 67% in 2006 and to about 52% in 2011.³³ The ACA will eventually require businesses with 50 or more employees to provide affordable health insurance to employees who are legal citizens.³⁴ This is, however, one of the few provisions that will be implemented after 2016.

Migrant and seasonal farm workers. In 2011, about 620,000 migrant and seasonal farm workers and dependents lived in Washington.³⁵ It is uncommon for migrant workers and their families to have a personal HCP or insurance coverage. Common barriers to care and coverage include low family income, language barriers, lack of permanent housing, frequent moves, legal issues and limited transportation options.

Near-poor with health conditions. Individuals in fair or poor health status are more likely to be uninsured compared to those who report being in good or excellent health. This is concerning because those individuals also tend to have greater healthcare needs.¹⁶ Many low-income Washington residents with preexisting conditions and no employer-based health insurance do not qualify for Medicaid. As a result this group's only option for health insurance is through individual health policies. These policies often have high deductibles and expensive monthly premiums. In some situations, preexisting conditions lead to denial of private insurance. The ACA includes provisions, such as prohibiting insurance companies from denying health insurance based on a preexisting health condition, to solve this problem. It is, however, too early to assess the law's impact.

Intervention Strategies

Affordable Care Act (ACA). In March 2010, the ACA was signed into law. The majority of the ACA's provisions became effective on or before January 1, 2014.

A central focus of the law is to transform and strengthen primary healthcare to improve patient outcomes and lower costs.³⁶ Additionally, the ACA implemented reforms designed to improve access to care including, but not limited to: allowing adult children to remain on their parents' insurance plan until the age of 26; expanding Medicaid coverage to low-income adults with household incomes up to 38% higher than the federal poverty limit; establishing "essential health benefits" that must be covered by all health insurance plans; and prohibiting insurance companies from denying coverage based on preexisting health conditions.^{37,38} Washington State is working to fully implement the ACA by expanding Medicaid, implementing a health benefits exchange and supporting patient-centered care, in addition to other reforms. The State Health Care Innovation Plan published in December 2013 outlines these efforts in detail.³⁹

- **Medicaid expansion:** Medicaid is the largest single source of major medical coverage serving low-income residents in Washington State. Currently, Medicaid covers nearly 1.5 million Washingtonians, including children under age six and pregnant women with family incomes up to 38% higher than the federal poverty limit and children ages 6–19 with family incomes up to the federal poverty level.³⁹ In January 2014, Medicaid expanded to include individuals (parents and adults without dependent children) with incomes up to 38% of the federal poverty limit.⁴⁰ During January 1–March 27, 2014, 268,000 newly qualified people in Washington enrolled in Medicaid.⁴¹ This number is expected to reach about 325,000 new Medicaid clients over several years.⁴²
- **Health benefit exchanges:** In October 2013, Washington State rolled out the "Health Benefit Exchange" as a new marketplace for individuals, families and small businesses to find, compare and enroll in qualified health insurance plans. Plans are offered in the "metallic" tier system characterized by descending levels of benefit—platinum, gold, silver and bronze.

Through this marketplace, consumers whose incomes are up to four times of the federal poverty limit can apply for tax credits and financial help for affordable health coverage. Early estimates show that as many as 400,000 Washingtonians may obtain private health insurance through the exchange.⁴³ As of March 31, 2014, more than 146,000 people purchased health insurance through the exchange.⁴¹

• **Medical homes:** The core idea behind the medical home concept is to enhance patient access to a regular source of primary care, create a stable and ongoing relationship with a personal HCP who directs a care team, and provide timely and well-organized healthcare services that emphasize prevention and chronic condition management.³⁶ During the past several years, the Washington State medical home plan has expanded from a focus on improving care for children with special healthcare needs to improving care for people of all ages. To set the stage for this transformation towards the medical home concept, Washington has already implemented several successful demonstration projects led by both public and private initiatives.^{44, 45, 46} The ACA provides an opportunity to strengthen Washington's primary care and to expand the implementation of the medical home concept. The law strengthens primary care by giving patients incentives to obtain annual preventive care free of additional charge, and promotes new payment structures that reward positive patient outcomes rather than fee for service. The law specifically encourages the adoption of medical homes by offering states the option to increase reimbursement to primary care sites designated as "health" homes—a concept similar to medical homes—for Medicaid patients.^{36, 47, 48}

Health professional shortage area (HPSA) designations. The HPSA is a federal designation managed by the Shortage Designation Bureau (SDB), of the U.S. Department of Health and Human Services. The Washington State Department of Health coordinates the designation process for Washington by assessing provider-to-population ratios and service area characteristics. HPSAs identify areas that have shortages of primary care, dental and mental health providers. Nearly 58% of counties in Washington are designated as entirely HPSA, and 42% as partially HPSA for primary care. Several federal and state programs use HPSAs to improve provider availability. A map showing primary care shortage areas is at <http://ww4.doh.wa.gov/gis/pdf/primary.pdf>

State efforts to increase the supply of primary care providers. Several national and state health professional support programs are designed to combat primary care provider shortages.⁴⁹

- **Loan repayment and scholarship programs for health professionals.** Medical training programs are expensive and the demand for scholarships and loan repayment programs is high. The Washington State Department of Health works with the National Health Service Corps and Washington Health Professional Loan Repayment Program to provide students with scholarships and health professionals with loan repayment assistance in return for work in designated shortage areas. In February 2014, there were 238 National Health Service Corps providers working in the state. The state program assisted 212 providers between 2009 and 2013.
- **Provider recruitment and retention programs.** Given the shortages of health professionals, recruitment and retention are two major challenges. The Washington Resources Group, a collaborative effort among several state and nonprofit agencies, focuses on recruitment and retention of primary healthcare practitioners who want to provide healthcare to medically underserved populations. During the past five years, this program placed 147 providers throughout the state.
- **J-1 Visa Waiver program.** The department's J-1 Visa Waiver program helps healthcare facilities in rural and underserved areas recruit foreign physicians. This program sponsors up to 30 physicians each year in an attempt to improve patient access to care. During 2004–2009, 74% of foreign physicians remained in physician shortage areas for at least four years.⁵⁰

Reimbursement and subsidy programs for safety net clinics, such as rural health clinics and community health centers. The Rural Health Clinics program was established to stabilize access to outpatient primary healthcare in medically underserved rural areas and to encourage the use of physician's assistants, nurse practitioners and certified nurse midwives in primary care. Under the program, private and nonprofit clinics can seek certification as a rural health clinic from the U.S. Centers for Medicare

and Medicaid Services. These clinics are eligible for enhanced Medicare and Medicaid reimbursement.

Washington's community health centers are local, nonprofit, community-owned healthcare facilities that serve low-income and medically underserved communities. In 2012, these centers served 789,707 Washington residents, of whom 43% were on Medicaid, 35% were uninsured, and 37% were children.⁵¹

See Related Chapters: [Hospitalization](#), [Self-reported Health Status](#), [Washington: The State and Its People](#)

Data Sources

National Survey of Children's Health (NSCH), 2011/12. U.S. Centers for Disease Control and Prevention.

American Community Survey (ACS), 2008–2011, 2009–2011 3-years estimates, and 2010–2012 3-years estimates. United States Census Bureau.

Washington State Behavioral Risk Factor Surveillance System (BRFSS): 2000–2010, 2010–2012.

For More Information

Office of Community Health Systems, Research, Analysis, and Data Section, (360) 236-2870

<http://www.doh.wa.gov/hsqa/ochs>

Technical Notes

Personal health care provider. The BRFSS survey has included a question on "personal healthcare provider" since 2001. We combined three years of data (2010, 2011, and 2012) for recent percentages and for demographic estimates. The data source for personal health care provider for children (ages 0–17) is the one-time 2011–2012 National Survey of Children's Health, which asked about the child's "personal doctor or nurse" in Washington State.

Health insurance coverage. The American Community Survey (ACS) included a question on "current health insurance coverage" since 2008. Depending on the size of the population for a geographic area, the ACS releases estimates data on annual, three year and five year basis. The ACS ask about specific insurance coverage of each person within a household, track rapidly changing community trends, provides more accurate and point-in-time measure than the data collected using the decennial long form or from most national surveys. The ACS provides estimates at the state and sub-state levels. The ACS follows different survey structures to provide sub state level data. Data for areas with population of 65,000 or more are reported annually, areas with populations between 20,000 and 64,999 every 3-years, and smaller areas with population less than 20,000 every 5-years.

Limited English proficiency. For households that report speaking a language other than English in the home, the

American Community Survey (ACS) asks about proficiency in English for all household residents ages five and older. Responses include very well, well, not well and not at all. The ACS compiles this information to define linguistic isolation as households in which no member older than 14 years speaks English very well. Respondents can take the ACS in the language of their choosing and so the ACS does not exclude anyone based on limited English proficiency.

Acknowledgments

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Endnotes

¹ Agency for Healthcare Research and Quality. *National Healthcare Quality Report, 2011*. Rockville, MD: Agency for Healthcare Research and Quality; 2012.

<http://www.ahrq.gov/research/findings/nhqrd11/nhqrd11.html>. Accessed October 1, 2013.

² Tillotson CJ, Wallace LS, Lesko SE, Angier H. The effects of health insurance and usual source of care on a child's receipt of health care. *J Pediatr Health Care*. 2012;26(5):e25-e35. doi:10.1016/j.pedhc.2011.01.003.

³ U.S. Census Bureau. *Income, Poverty, and Health Insurance Coverage in the United States: 2012: Current Population Reports*. Washington, DC: U.S. Census Bureau; 2013. www.census.gov/prod/2013pubs/p60-245.pdf. Accessed on March 25, 2014.

⁴ State Health Access Data Assistance Center. *State-Level Trends in Employer-Sponsored Health Insurance – A State-by-State Analysis*. SHADAC Report. Minneapolis, MN: University of Minnesota; April 2013. <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405434>. Accessed April 24, 2014.

⁵ U.S. Department of Labor, Bureau of Labor Statistics. *Labor Force Statistics from the Current Population Survey*. Washington, DC: U.S. Department of Labor; 2014. <http://data.bls.gov/timeseries/LNS14000000>. Accessed on April 24, 2014.

⁶ Washington State Department of Health. *Socioeconomic Position in Washington State. Health of Washington State*. Olympia, WA: Washington State Department of Health; 2014.

⁷ Washington State Office of Financial Management. *Estimates of April 1 population by age, sex, race, and Hispanic origin for the state and counties*. Olympia, WA: Washington State Office of Financial

Management; 2012. <http://www.ofm.wa.gov/pop/asr/default.asp>. Accessed February 5, 2014.

⁸ Clemens-Cope L, Garrett B. *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility and Participation: 2001–2005*. Washington, DC: The Urban Institute, Kaiser Commission on Medicaid and the Uninsured; December 2006. http://www.urban.org/UploadedPDF/411619_health_insurance.pdf. Accessed April 15, 2014.

⁹ U.S. Department of Health and Human Services. *Addressing Racial and Ethnic Disparities in Health Care*. Rockville, MD: Agency for Healthcare Research and Quality; 2013. <http://www.ahrq.gov/research/findings/factsheets/minority/disparit/>. Accessed March 24, 2014.

¹⁰ National Commission on Prevention Priorities. *Preventive care: A national profile on use, disparities, and health benefits*. Washington, DC: Partnership for Prevention; August 2007.

¹¹ Sommers BD, Backer K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. *N Engl J Med*. 2012; 367:1025-1034.

¹² Leong D, Roberts E. Social Determinants of Health and the Affordable Care Act. *R I Med J*. 2013;96(7):20-22.

¹³ Niu X, Roche LM, Pawlish KS, Henry KA. Cancer survival disparities by health insurance status. *Cancer Med*. 2013;2(3):403-411.

¹⁴ Chang CF, Pope RA. Potentially Avoidable Hospitalizations in Tennessee: Analysis of Prevalence Disparities Associated with Gender, Race, and Insurance. *Public Health Rep*. 2009;124:127-137.

¹⁵ Kozhimannil KB, Abraham JM, Virnig BA. National Trends in Health Insurance Coverage of Pregnant and Reproductive-Age Women, 2000 to 2009. *Womens Issues*. 2012;22(2):35-131. doi:10.10.16/j.whi.2011.

¹⁶ Wilper AP, Woolhandler S, Lassere KE, McCormick D, Bor DH, Himmelstein DU. Health Insurance and Mortality in US Adults. *Am J Public Health*. 2009;99(12):2289-2295.

¹⁷ Kids Count Data Center. *Unemployment by race and Hispanic or Latino ethnicity, state-level*. Baltimore, MD: Annie E. Casey Foundation; 2012. <http://datacenter.kidscount.org/data/tables/4699-unemployment-by-race-and-hispanic-or-latino-ethnicity-state-level?loc=49#detailed/2/any/false/867,133,38,35,18/1,2,12,13/10997,10998>. Accessed April 7, 2014.

¹⁸ Swartz K. Health care for the poor: For whom, what care, and whose responsibility? *Focus*. 2009;26(2):69-74.

¹⁹ Pharr JR, Moonie S, Bungum TJ. The Impact of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviors. *ISRN Public Health*. Volume 2012 (2012), Article ID 483432, 7pages. <http://dx.doi.org/10.5402/2012/483432>.

²⁰ Institute of Medicine. *Future Directions for the National Healthcare Quality and Disparities Reports*. Washington, DC: The National Academies Press; April 2010. <http://www.iom.edu/-/media/Files/Report%20Files/2010/Future-Directions-for-the-National-Healthcare-Quality-and-Disparities-Reports/Future%20Directions%20AHRQ%20Quality%20Disparities%20Reports%202010%20Report%20Brief.pdf>.

²¹ Washington State Office of Financial Management. June 2012. *Availability of Primary Care Physicians to Serve the Affordable Care Act's Medicaid Expansion Population*. Olympia, WA: Washington State Office of Financial Management; June 2012. <http://www.ofm.wa.gov/researchbriefs/2012/brief065.pdf>. Accessed February 19, 2014.

²² Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. *Primary Care: America's Health in a New Era*. Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine. Washington, DC: National Academy Press; 1996.

²³ *Health Care Personnel Shortage Task Force, 2012 Annual Report*. Olympia, WA: Workforce Training and Education Coordinating Board; December 2012. <http://www.wtb.wa.gov/Documents/HealthCareReport2012.pdf>. Accessed February 17, 2014.

²⁴ Chen FM, Fordyce MA, Hard LG. *WWAMI physician workforce 2005*. Working paper #98 [Electronic version]. Seattle, WA: University of Washington, School of Medicine, Department of Family Medicine, WWAMI Center for Health Workforce Studies; 2005. <http://depts.washington.edu/uwrhrc/uploads/CHWSWP98.pdf>. Accessed December 2, 2006.

²⁵ American Academy of Family Physicians. *Family Practice Management: News and Trends – 2007 Match results: Family medicine stays flat*. Leawood, KS: American Academy of Family Physicians; 2007. <http://www.aafp.org/fpm/2007/0400/p20.html>. Accessed March 24, 2014.

²⁶ Andrilla CHA, Hart LG, Kaplan L, Brown MA. *Practice patterns and characteristics of nurse practitioners in Washington State*. Working Paper #109. Seattle, WA: University of Washington, School of Medicine, Department of Family Medicine, WWAMI Center for Health Workforce Studies; 2007.

²⁷ Grumbach K, Hart LG, Mertz E, Coffman J, Palazzo L. Who is Caring for the Underserved? A Comparison of Primary Care Physicians and Non-physician Clinicians in California and Washington. *Ann Fam Med*. 2003;1(2):97-104.

²⁸ Washington State Department of Transportation. *2011 Summary of Public Transportation*. Olympia, WA: Washington State Department of Transportation; November 2012. <ftp://ftp.wsdot.wa.gov/public/PubTranSummaries/2011%20Summary%20of%20Public%20Transportation.pdf>. Accessed October 28, 2013.

²⁹ Somnath S, Fernandez A. Language Barriers in Health Care. *J Gen Intern Med*. 2007;22(Suppl 2):281-282.

³⁰ Flores G. Language Barriers to Health Care in the United States. *N Eng J Med*. 2006;355:229-231.

³¹ Washington State Office of the Insurance Commissioner. *State of the uninsured: Health coverage in Washington State. Costs, trends and projections, 2008 to 2014*. Olympia, WA: Washington State Office of the Insurance Commissioner; December 2011. <http://www.insurance.wa.gov/about-oic/commissioner-reports/documents/2011-uninsured-report.pdf>. Accessed September 12, 2013.

³² The Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits, 2013 Annual Survey*. Menlo Park, CA: The Kaiser Family Foundation and Health Research & Educational; 2013. <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf>. Accessed October 29, 2013.

³³ Washington State Office of Financial Management. *Washington State Private Employer-Sponsored Health Insurance*. Olympia, WA: Washington State Office of Financial Management Forecasting; March 2013. http://www.ofm.wa.gov/healthcare/healthin/employerbaseins/2013/private_employer-sponsored_health_insurance.pdf.

-
- ³⁴ *Health Care for Small Businesses. Frequently Asked Questions.* Olympia, WA: Maria Cantwell, United States Senator for Washington; 2013.
http://www.cantwell.senate.gov/issues/healthcare_smallbusiness.cfm. Accessed October 29, 2013.
- ³⁵ Doyle S. *2011 Farmworker Population Profile. Northwest Region: Washington, Oregon, Idaho.* Seattle, WA: Northwest Regional Primary Care Association; 2012. http://www.bienestar-or.org/web/resources/2011_regional_profile_northwest_region.pdf. Accessed October 25, 2013.
- ³⁶ Davis K, Abrams M, Stremikis K. How the Affordable Care Act will strengthen the nation's primary care foundation. *J Gen Intern Med.* 2011;26(10):1201-1203.
- ³⁷ *The Affordable Care Act and Trends in Health Care Spending.* Washington, DC: The White House; 2013.
http://www.whitehouse.gov/sites/default/files/docs/fact_sheet_implementing_the_affordable_care_act_from_the_erp_2013_final1.pdf. Accessed September 19, 2013.
- ³⁸ Health Policy Brief: Pre-Existing Condition Insurance Plan. *Health Affairs.* Updated June 13, 2011.
- ³⁹ Washington State Health Care Authority. *Washington State Health Care Innovation Plan.* Olympia, WA: Washington State Health Care Authority; December 2013.
http://www.hca.wa.gov/shcip/Documents/SHCIP_InnovationPlan_121913.pdf. Accessed February 7, 2014.
- ⁴⁰ Washington State Health Care Authority. *The Affordable Care Act: ACA Health Care Improvements.* Olympia, WA: Washington State Health Care Authority; 2014. <http://www.hca.wa.gov/hcr/Pages/default.aspx>. Accessed February 5, 2014.
- ⁴¹ Stiffler L. 146,000 buy health insurance on state exchange. *Seattle Times.* April 1, 2014.
http://seattletimes.com/html/localnews/2023278763_acaenrollmentxml.html. Accessed April 2, 2014.
- ⁴² Washington State Health Care Authority. *Medicaid Expansion 2013–2014.* Olympia, WA: Washington State Health Care Authority; 2013.
http://www.hca.wa.gov/hcr/me/documents/ME2014_Fact_Sheet.pdf. Accessed April 2, 2014.
- ⁴³ Whiteaker C. *Washington State's Health Insurance Exchange Progress.* Olympia, WA: Washington State Hospital Association; 2011.
<http://www.wsha.org/files/149/Summary%20of%20Exchange%20July%202011.pdf>. Accessed February 5, 2014.
- ⁴⁴ Washington State Department of Health. *2009–2011 Washington Patient-Centered Medical Home Collaborative Final Report.* Olympia, WA: Washington State Department of Health; 2012.
<http://www.doh.wa.gov/Portals/1/Documents/Pubs/345-310-PCMHFinalReport.pdf>. Accessed on April 24, 2014.
- ⁴⁵ Washington State Medical Home Partnerships Project. *Clinical Practice Medical Home Initiatives – Patient Centered Medical Home Multipayer Reimbursement Model.* Seattle, WA: Washington State Medical Home Partnerships; 2014.
<http://www.medicalhome.org/about/medhomeplan.cfm#clinical>. Accessed on April 24, 2014.
- ⁴⁶ Reid RJ, Fishman PA, Yu O, et al. Patient Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation. *Am J Managed Care.* 2009;15(9):e71-e87
- ⁴⁷ Washington State Health Care Authority. *What is a Health Home?* Olympia, WA: Washington State Health Care Authority; 2014.

http://www.hca.wa.gov/pages/health_homes.aspx. Accessed February 5, 2014.

⁴⁸ Washington State Department of Health. *Washington Healthcare Improvement Network (WHIN).* Information about the Department of Health's role in medical/health home development. Olympia, WA: Washington State Department of Health; 2014.
www.doh.wa.gov/whin.

⁴⁹ Washington State Department of Health. *Health Systems Support.* Olympia, WA: Washington State Department of Health; 2013.
<http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/RuralHealth.aspx>. Accessed October 14, 2013.

⁵⁰ Kahn TR, Hagopian A, Johnson K. Retention of J-1 visa waiver program physicians in Washington State's health professional shortage areas. *Acad Med.* 2010;85(4):614-621.

⁵¹ Washington Association of Community and Migrant Health Centers. *2011 Snapshot: Washington's Community Health Centers.* Olympia, WA: Washington Association of Community and Migrant Health Centers; 2012.
<http://www.vhcc.org/pdf/WACMHC2011StatewideFactsheet.pdf>. Accessed on December 12, 2013.