



CALIFORNIA  
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# **Examining Access to Specialty Care for California's Uninsured: Full Report**

*Prepared for*

CALIFORNIA HEALTHCARE FOUNDATION

*by*

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## About the Foundation

The **California HealthCare Foundation**, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. CHCF's work focuses on informing health policy decisions, advancing efficient business practices, improving the quality and efficiency of care delivery, and promoting informed health care and coverage decisions. CHCF commissions research and analysis, publishes and disseminates information, convenes stakeholders, and funds development of programs and models aimed at improving the health care delivery and financing systems.

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Major Findings

Access Problems Extend Across a Wide Range of Specialties and are Worse for Adults than for Children

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# Executive Summary

MORE THAN 6.5 MILLION CHILDREN AND NON-elderly adults in California, or just over 20 percent of the state's population, were uninsured in 2002.<sup>1</sup> In the absence of a universal system of care, these individuals as well as the underinsured population depend on safety-net providers to deliver health services.<sup>2</sup> While many studies have described and discussed the safety net for primary care, few have explored the safety net for specialty care services. These services are vital to avoid preventable deterioration in chronic conditions and complex cases. The study documented in this report focused on the accessibility of specialty care services for California's uninsured population.

Mathematica Policy Research, Inc. (MPR), under a grant from the California HealthCare Foundation, conducted this study in order to identify the major barriers to access faced by the uninsured; determine whether access is becoming easier or more difficult; and ascertain how access varies from one community to the next. While other studies have generally identified access to specialty care for the uninsured as a problem, these findings in a sense lift the lid on a "Pandora's box" of problems related to specialty care access for the uninsured population.

## Methodology

Both quantitative and qualitative methods were used to collect data on specialty care services for the uninsured. Two statewide surveys of key safety-net providers were conducted. The first surveyed the medical directors of all 101 federally qualified health centers (FQHCs) in California from November 2002 through April 2003. The medical directors were asked about the specialty care access problems faced by their centers' uninsured patients. The second surveyed directors of 64 hospital outpatient departments that serve the uninsured. They were asked about the factors that affect hospitals' willingness and capacity to provide care for the uninsured, and how they accommodate the needs of uninsured patients. The hospital survey was mailed to the facilities named by the FQHC medical directors as places where they commonly refer patients for specialty care. The response rate for the FQHC medical directors survey was 76 percent; for the hospital

outpatient department directors survey, it was 48 percent.

In addition to the surveys, case studies of the safety net for specialty care were conducted in four communities—two in which medical directors reported relatively good access and two in which medical directors reported relatively poor access. (Because the respondents were assured that their identities would be kept confidential, the names of the four communities are not disclosed.) The case studies complement the surveys by providing insight into how services are sought, including differences in service delivery across communities. The case studies are based on site visits to the communities in the summer of 2003. They include interviews with diverse providers and other knowledgeable informants as well as focus groups of uninsured individuals who said they needed specialty care in the past year.

## Major Findings

### Access Problems Extend Across a Wide Range of Specialties and Are Worse for Adults than Children

Access to specialty care for the uninsured population is a widespread problem in California. Fully 85 percent of the FQHC medical directors reported that their patients “often” or “almost always” have problems in obtaining care.

FQHC medical directors characterized access as “often” or “almost always” problematic for 16 of the 24 specialties listed on the survey for adults. Neurology, allergy/immunology, and orthopedics were among the specialties most frequently cited

as problematic. Although children fared better, their access was still reported to be “often” or “almost always” problematic for several specialties. The most problematic specialties for adults and children are listed below. At least one-half of the surveyed medical directors reported their uninsured patients “often” or “almost always” experienced problems obtaining these services (Table 1).

**Table 1. Most Problematic Specialties for Uninsured Adults and Children\***

Adults		
Allergy/Immunology	Neurology	Specialty Care for
Dermatology	Orthopedics	Diabetes
Endocrinology	Otolaryngology	Substance Abuse
Gastroenterology	Physical and	Surgery (other than
Nephrology	Occupational Therapy	vascular)
	Psychiatric	Urology
	Pulmonology	Vascular Surgery
Children		
	Allergy/Immunology	
	Dermatology	
	Neurology	
	Psychiatry	

### Problems Have Grown over the Past Two Years

One-half of the FQHC medical directors said access to specialty care is worse today than it was two years ago, while only 15 percent said it had improved. In the case study communities, respondents reported access had worsened because of an increase in the demand for such care due to population growth, more uninsured people, and/or increased health needs within this population.

The case studies point to the difficulty patients or FQHCs have in finding a specialist willing to accept patients and their inability to obtain a timely appointment. Formal referral agreements between FQHC primary care providers and specialists that would cover patients across the board

appear rare; typically, FQHC physicians and staff work hard to secure specialty care for their uninsured patients on a case-by-case basis. Waiting times for the most problematic specialties are often months long, as the case studies and the hospital outpatient department survey show.

The medical conditions of the uninsured patients in the four focus groups did not appear to be well-managed or treated on a timely basis. Many participants said they delayed seeking specialty care because of its high cost; the lack of an appropriate referral or follow-up; or because they were not given critical information about self-managing their condition.

### **Hospitals Are a Vital Source of Specialty Care for the Uninsured**

Hospitals are the major source of specialty care for the uninsured who use FQHCs, accounting for 73 percent of the organizations listed by FQHC medical directors as common specialty referral destinations for their patients.

Government-owned hospitals represent only about 20 percent of California community hospitals, but account for about one-half of the hospitals named as major specialty referral destinations for FQHC patients.<sup>3</sup> Similarly, major teaching hospitals represent only about 5 percent of California hospitals, but account for over one-fourth of the major specialty referral destinations.<sup>4</sup> Almost all the major specialty referral destination hospitals are urban hospitals. The institutions named as major specialty referral destinations are not, however, limited to those traditionally thought of as safety-net providers. Medical directors reported that 46 percent of the hospitals named are not primarily focused on providing services to low-income populations.

Public hospitals and major teaching hospitals are widely known for their critical role in many communities' safety nets. This study points to a large number of other hospitals that collectively make a substantial contribution to the safety net

for specialty care, although their role has not gained widespread acknowledgment. The findings suggest that policies and research studies that focus *only* on supporting or studying hospitals that primarily serve low-income populations will miss a substantial number of other hospitals that also provide critical support to uninsured patients for specialty care.

While hospitals responding to the survey cited many factors as important to their capacity or willingness to provide specialty care for the uninsured, at least one-half of the responding hospitals reported the following as *very* important: nonprofit status/mission; the hospital board's views on charity care; receipt of Medicaid disproportionate share funding; overall shortage of specialists in the community; and negative financial margin.

### **Private Physicians Play an Important Role**

While only 16 percent of the FQHC medical directors listed a physician practice as one of the top three referral destinations for specialty care, the collective contribution of private physicians to the safety net could still be large if many specialists took a few uninsured patients into their practice. MPR did not have data on private specialty care delivered to the uninsured; however, respondents in three of the four case study sites indicated that private specialists provide a significant level of charity care on an ad hoc basis, although accessing the specialists is a difficult, case-by-case effort. Organized efforts in two communities encourage volunteerism among private specialists, although each effort is limited in scale or requires substantial cost-sharing by the patient.

### **Community Characteristics Affect Access**

Survey and census data show that FQHC communities where the population is at least 40 percent Hispanic had significantly more access problems than other communities for

ophthalmology, orthopedic surgery, laboratory services for adults, and allergy/immunology services for children.<sup>5</sup> Because laboratory and allergy/immunology services are vital for appropriate management of asthma and other conditions, impaired access is likely to negatively affect care management and outcomes. Other specialties in the largely Hispanic communities were in short supply as well, although these differences were not statistically significant. There were no significant differences in reported access problems for urban versus rural FQHC communities.<sup>6</sup>

Site visits to the four case study communities suggested the following factors are important in determining access to specialty care:

***Strong relationships between FQHCs and hospitals.*** The ability of uninsured people to obtain specialty care depends heavily on their doctor's or clinic's relationships with other physicians and hospitals. Informal relationships are as important as formal ones. Current relationships between primary care safety-net providers and hospitals are often not particularly strong, and although some collaborative coalitions work to address health needs in three communities, hospitals have been active in only one of them.

***Community support.*** Evidence of community support for the uninsured is indicated by private funding to support the safety net, advocacy groups, coalitions such as those mentioned above, and local programs designed to facilitate access. The case study community with the strongest community support clearly provides the most favorable access environment for uninsured people to obtain specialty care. In two communities with moderate support, specialty care access was elevated, but there were still substantial problems.

***Size of the uninsured population and its composition.*** When only a small share of the population lacks coverage, providers in the community are less fearful of becoming

“flooded” with uninsured individuals if they agree to accept a few patients. In addition, when uninsured residents are a relatively homogeneous group—recent immigrants of the same ethnicity concentrated in one geographic area, for example—providers and advocates have an easier time reaching out to and targeting programs for them.

***Supply of specialist physicians.*** Numerous respondents reported specialist shortages and difficulty in attracting specialists because of the cost of starting up a practice in communities where the cost of living is high. Further, it is difficult for FQHCs and hospitals to pay physicians a livable wage in such areas. The result is longer waits for appointments for both insured and uninsured residents.

### **Local Efforts to Improve Access to Specialty Care Have Limitations**

Efforts now underway in three of the four case study communities have the potential to improve access to specialty care for the uninsured. However, substantial gaps remain. Two of the four communities are working to cover more uninsured children through county health insurance programs. If successful, this approach should greatly reduce problems for children, but the more severe problem of adult access will remain unaddressed.

Several of the FQHCs are beginning to offer some specialist services in-house. This strategy appears promising if the FQHCs can increase supply where shortages are the primary problem and the volume of low-income patients in need of services is large. On the other hand, it seems highly unlikely that FQHCs could expand to include all the specialty care needed by their patients.

### **Implications and Short-Term Action Steps**

The study findings provide insight into the reasons for the poorer clinical outcomes that have



been well-documented for uninsured and low-income individuals.<sup>7</sup> They suggest a need for attention, both in the short term from local health leaders and in the longer term among state and national policymakers.

A number of steps can be taken by a variety of groups and individuals, including: local health leaders such as hospital executives; FQHCs and other primary care clinics focused on low-income populations; local health department directors; physicians active in communitywide issues (for example, through local medical associations); and executives and staff of local foundations and charitable organizations. Among the actions they can take are the following:

***Assess the severity and nature of specialty care access problems.*** An assessment could consist of interviews with several primary care physicians who serve the uninsured, as well as a representative of the relevant hospital outpatient departments, to identify which specialties are inaccessible or experiencing long waiting times for appointments—and why. Such an assessment would provide a solid foundation for developing a plan to improve identified problems.

***Develop and execute a plan for improvement.*** While it may sometimes be beyond the ability of local health care leaders in underserved and low-income communities to solve specialty care access problems on their own, they should explore the following:

- *Implement or expand local initiatives to provide insurance to low-income residents.* The study found that uninsured populations have significantly more access problems than privately insured and Medicaid patients. And, when the uninsured population is small, physicians seem less fearful of pitching in to fill the gap. Therefore, efforts to expand insurance coverage could have the indirect effect of making it easier for the remaining uninsured to obtain specialty care.

- *Strengthen primary care/hospital relationships.* Look for ways to support easier referrals. For example, perhaps a private hospital would agree to take a limited number of referrals per month.
- *Provide advanced training to primary care providers to reduce need.* Find opportunities for training primary care physicians who serve the uninsured in management of the more common chronic diseases such as asthma and diabetes. This will reduce the need for care from specialists and produce better outcomes. A concerted effort to improve chronic care management by primary care physicians might convince specialists to make time for the most difficult cases as part of a communitywide effort to improve care.<sup>8</sup>
- *Consider bringing specialists to primary care settings.* If the problem is severe and sufficiently focused on a common specialty need, a local FQHC or other clinic for low-income patients should consider seeking funding to recruit an in-house specialist on a part-time or full-time basis.
- *Build on existing efforts and experience.* Consider expanding on or modifying existing efforts to encourage physician volunteerism (such as a free clinic). An earlier effort that was abandoned might provide lessons on which to build a new initiative.

State policymakers should identify specialties with widespread shortages, since these lead to access problems. Shortages in low-income areas could be exacerbated by any additional cuts in Medi-Cal that reduce provider reimbursement. State policymakers could, without cost, advise hospitals receiving disproportionate share hospital funds to ensure that all the specialty services they provide are open upon medical referral to at least some low-income uninsured patients on a timely basis.

## **Longer-Term Implications for State and National Policymakers**

State policymakers should consider the following:

***Assist and motivate communities to make local improvements.*** Support for the uninsured varies, and some communities are unlikely to address access problems for the uninsured—particularly for adults—without outside influence. Matching funds are an often-used tool to motivate local spending. Only money raised from public or private sources that is above any local subsidy for the uninsured in the prior year should count toward a match. Outreach may be needed to encourage the involvement of communities that by definition lack the motivation to improve services. Local coalitions to improve coverage for children, such as those funded by the Robert Wood Johnson Foundation’s Covering Kids and Families Initiative, might provide a target for an outreach strategy.

***Consider policy change to encourage physician volunteerism.*** To the extent that widespread shortages across the state are confirmed, state

policymakers should consider actions that might prevent the uninsured from being shut out completely from those specialties in the shortage areas. A loan repayment program for selected specialists who serve shortage areas is one option. Another is tax breaks for physicians for a portion of the value of the services they provide to the uninsured.

Policymakers at the federal level should determine whether the access problem is in fact national in scope. If it is, they should consider changes similar to those mentioned for state policymakers.

In addition, research should be conducted to: identify reasons for the disparity in access to specialty care in communities with a large Hispanic population; further shape potential policy interventions listed above; document the hidden costs of under use of specialists; and document the cost of inefficiencies in the current system for referring uninsured individuals to specialists.

# I. Introduction

OVER 6.5 MILLION CHILDREN AND NON-ELDERLY adults, or just over 20 percent of the population in California, were uninsured in 2002.<sup>9</sup> In the absence of a universal system of care, these individuals as well as those who are underinsured depend on safety-net providers to deliver health services. Over the past several years, safety-net providers have become more recognized for filling a critical gap in the country's health care system, and numerous studies have advanced our understanding of the structure, capacity, and funding of the safety net.<sup>10</sup>

However, because these studies focused on primary care or ambulatory care in general, there is still a limited understanding of whether and how the most vulnerable populations obtain vital specialty care services.

In September 2002, the California HealthCare Foundation (CHCF) contracted with Mathematica Policy Research, Inc. (MPR) to conduct the study *Accessibility of Specialty Care Services for California's Uninsured*. It is one of the first to examine the accessibility of specialty care for uninsured patients. The study complements work by CHCF that monitors access to physician services under Medi-Cal and Healthy Families. The following research questions formed the framework for data collection and analysis in the study:

- Are uninsured patients able to obtain specialty care services they seek? Does the availability of specialty care vary by the type of care needed?
- What are the major barriers to specialty care services for the uninsured, and what do these barriers imply with regard to effective policy interventions?
- Has access to specialty care for the uninsured become easier or more difficult in recent years? If so, why?
- Who are the major providers of specialty care for uninsured California residents?
- How does access to specialty care for the uninsured vary across communities in California?

This introductory chapter contains a brief review of recent literature on the accessibility of specialty care for the uninsured and a discussion of the study methods and analysis. A more thorough discussion of the literature and methods is found in Appendix A. Chapter II discusses the problems the uninsured

experience when seeking specialty care services across different specialties, and over time. Chapter III contains information on the providers of specialty care to the uninsured, differences in access across communities, and local initiatives to improve access. In Chapter IV the authors draw conclusions and discuss implications for policy-makers and priorities for future research.

## Background

Numerous studies have explored the problems associated with a lack of insurance. The Institute of Medicine's Committee on the Consequences of Uninsurance has found that insurance is a key influence on whether an individual obtains health care. The uninsured, both children and adults, are much more likely than insured patients to forgo needed medical care even if they have serious or morbid symptoms.<sup>11</sup> This reduced access often leads to less appropriate care and poorer health outcomes. For example, uninsured individuals with diabetes are less likely to receive recommended services, such as regular foot or dilated-eye exams, and are at greater risk for additional chronic disease and disability.<sup>12</sup> These findings are particularly troublesome, given the importance of access to specialty services. Denial of needed specialty care can lead to hospitalization or adverse long-term health consequences.<sup>13</sup>

Few studies have focused specifically on access to specialty care services by the uninsured. In a study just published, Kuhlthau et al.<sup>14</sup> found that specialist visit rates are much lower for uninsured children relative to insured children, and the finding holds for uninsured children with chronic illnesses. The study does not examine the dynamics of access problems as they relate to specialists. There are several reasons to speculate that the uninsured have a more difficult time seeing specialists than primary care physicians.<sup>15</sup> First, many uninsured patients rely on care from FQHCs even though these facilities do not have the expertise or the capacity to provide specialty

care. Although FQHCs are required to have links to specialists for patients needing specialty care, there is evidence of weaknesses in the referral process.<sup>16</sup> There is no federally funded system similar to the FQHC model that focuses on the delivery of specialty care.

Second, the uninsured may have more trouble obtaining specialty care than primary care because private specialists may be less willing to provide free or reduced-cost care. This is because specialty care often involves expensive treatments such as medication and resource-intensive procedures that could require hospital services.<sup>17</sup> Indeed, a study of Medi-Cal and Healthy Families found that the plans had more difficulty securing and sustaining specialist participation than primary care participation.<sup>18</sup> However, a recent study funded by the Medi-Cal Policy Institute found that 48 percent of medical specialists in California were currently accepting new uninsured patients, a higher share than primary care physicians.<sup>19</sup>

Finally, a short supply of specialists in some areas may affect access for both paying and nonpaying patients. One study showed that academic medical centers eliminated specialty care services for which reimbursement rates were relatively low (e.g., burn units, trauma care, pediatrics, and neonatal intensive care) in response to cost pressures.<sup>20</sup> Such cutbacks included communities with large uninsured populations. In some cases, specialists may leave areas where hospitals require them to fulfill on-call obligations of affiliated specialists. There is some evidence that many rural areas have shortages of specialty care physicians in part because the lower population density makes it more difficult to maintain a profitable practice.

Despite these reasons to suspect that the uninsured often lack adequate access to specialty care, research has not provided information about the extent or nature of this problem. Access is a particularly salient issue in California,

where the proportion of the uninsured is higher than the national average. The absence of good information on this issue is a particular problem for policymakers and others concerned with supporting the safety net.

It is important to clarify a few terms used throughout the report. First, the safety net for specialty care is defined broadly as the set of providers that serve a significant volume of uninsured patients. Second, specialty care is defined as services provided by practicing physicians who are residency trained but are *not* family physicians, general internists, obstetricians, or pediatricians. And third, this report includes among the insured people who are covered by county programs that provide temporary insurance for some Californians with very low incomes and a medical need. These programs, called County Medical Services (CMS) coverage or Medically Indigent Adult (MIA) coverage, were developed pursuant to the California requirement that counties provide state-mandated medical and dental services to eligible persons. Counties receive state realignment funds to provide residents with insurance coverage for three to six months.<sup>21</sup>

## Methods

Several approaches were used in this study to address the research questions. First, all FQHC medical directors in California were surveyed in late 2002 and early 2003 about the availability of specialty care for their center's patients; they were asked to identify up to three local specialty care providers to which they most commonly refer patients.<sup>22</sup> Out of the 101 FQHCs in the state, 77 completed surveys were received, for a response rate of 76 percent. The communities represented by respondents and non-respondents did not differ substantially in their population density, percent of the population that was nonwhite, or percent of the population that was Hispanic. However, a slightly higher percentage

of communities with responding FQHC medical directors were rural relative to that with non-responding FQHCs. The survey instrument is available upon request.

Second, the directors of the outpatient departments of all the hospitals identified by the FQHC medical directors were surveyed regarding their policies for providing specialty care for the uninsured. Of the 64 hospitals that were named by the FQHC medical directors, 31 completed the survey, for a response rate of 48 percent. The hospitals represented by respondents and non-respondents were similar in terms of their rural/urban status, average number of beds, average occupancy rate, and average percent of Medicare and Medicaid discharges. However, a higher percentage of responding hospitals were public hospitals and the responding hospitals were slightly less profitable than those that did not respond. The survey instrument is available upon request.

Third, using results of the FQHC medical director survey, four California communities—two whose medical directors reported relatively good access and two with relatively poor access—were selected for case studies in order to gain additional insight into barriers to specialty care and to examine why some communities are better able than others to meet the demand for free or low-cost specialty services (see Table 2).

A community was defined to include the major catchment area of the surveyed FQHC, along with the medical facilities to which people in that area go for specialty care (even if located outside the area). The identities of the case study communities and whether they were reported by medical directors to have good or poor access are not included for two reasons. First, the medical directors were assured that their individual responses would not be publicly reported, and there is only one FQHC in each of the visited communities. Second, the case studies revealed that while one of the communities reported to

**Table 2. Characteristics of Case Study Communities**

CHARACTERISTICS	COMMUNITY 1	COMMUNITY 2	COMMUNITY 3	COMMUNITY 4
<b>Economic status</b>	Affordable area in the Inland Empire	Low-income beach community near the Mexican border	Wealthy San Francisco suburb	Largely Hispanic migrant farm worker community
<b>Medicaid managed care</b>	Two-plan Model	Geographic Managed Care	Prepaid Health Plans (voluntary)	County-organized Health System
<b>Percent below poverty in county, 1999</b>	15.8	12.4	6.6	11.9
<b>Percent white in county, 2000*</b>	44.0	55.0	78.6	65.5
<b>Percent black in county, 2000</b>	9.1	5.7	2.9	1.0
<b>Percent of Hispanic origin in county, 2000</b>	39.2	26.7	11.1	26.8
<b>Percent of births with no or late (3rd trimester) prenatal care, 1999</b>	4.5	4.5	1.5	2.6

Source: Medicaid managed care information from the Medi-Cal Policy Institute; data on race and ethnicity from the United States Census; percent of births with late or no prenatal care from 1999 Vital Statistics.

\*Does not include those of Hispanic origin.

have good access *did* have relatively good access, the other three had substantial access problems. Thus, rather than comparing characteristics of the communities originally selected for good and poor access, the authors identified community characteristics that facilitate or impede access based on all four communities' experiences. And finally, the authors conducted a focus group of uninsured individuals who said they had recently been in need of specialty care in each of the four case study communities.<sup>23</sup>

The FQHCs are used as a major point of reference for this study because: (1) as major providers of care to uninsured patients, they have a good perspective on the demand for and access to specialty care services; (2) their federal designation requires them to strive to provide their patients with access to specialty care in some way; and (3) the size of their catchment area is typically conducive to examination within the study's budgeted resources. Hospitals, and in particular, their outpatient departments, were selected as the point of reference for the second survey because hospitals provide specialty care for

the uninsured in most communities and their policies and capacity would likely be important determinants of access.<sup>24</sup>

In order to obtain a more complete picture of specialty access, three health conditions were selected for more in-depth focus. In addition to obtaining survey information on these conditions, the authors probed about them during the case studies, asking respondents for specific examples of what it is like for the uninsured to try to obtain these specialty services. The three conditions—childhood asthma, diabetes, and cancer—were selected in consultation with CHCF. Asthma and diabetes were selected because of their high prevalence and because both are controllable with proper treatment. Asthma is one of the most common chronic conditions in children, and it is the leading cause of hospitalizations in young children in California.<sup>25</sup> A 2001 statewide survey found that nearly 136,000 children under age 18 (11.4 percent of children with asthma) reported an emergency department visit for asthma in the past year.<sup>26</sup> Similarly, diabetes is very common in

adults. The same 2001 statewide survey found that more than 1.4 million California adults (5.9 percent) were diagnosed with diabetes; an additional 1.8 million adults not diagnosed with diabetes (8.2 percent) were at significant risk for developing diabetes because they were sedentary as well as overweight or obese.<sup>27</sup> Cancer was selected as the third condition because it is a life-threatening disease that typically requires expensive procedures and treatment, such as biopsies or chemotherapy, which uninsured individuals might have trouble obtaining. In addition, treatment requires not only the services of a specialist but also hospital services on occasion.

## Analysis

The qualitative and quantitative results of this study are integrated in each chapter, since both parts of the study were designed to address the same research questions in order to develop a rich set of results. Quantitative analysis consisted of descriptive statistics, with t-tests used to determine statistical significance of two-way comparisons of point estimates, and chi-square tests used to determine whether there was a significant relationship between two categorical variables. Significance levels of comparative data are noted throughout the report; because of the relatively small sample size the authors also report differences between groups or apparent relationships between variables that appeared large but did not reach the threshold of statistical significance.

All of the reported figures are estimates. Because the medical directors survey did not achieve a 100 percent response rate, the survey results are estimates relative to the total population of FQHCs in California. The standard errors or confidence intervals for each percentage are not reported; however, a rule of thumb is to consider

the reported percentages for the medical directors survey as estimates plus or minus 5.5 percentage points.

The results of the outpatient department survey were intended to represent the group of hospitals that serve as common referral destinations for uninsured patients of California FQHCs. Since 64 unique hospitals were identified by medical director respondents, it can be estimated that there are about 80 hospitals that play this role in California (including those that were not named because the associated FQHC medical director did not respond to the survey).

The 31 hospitals that responded can be viewed as a sample of these approximately 80 hospitals. Applying the rule of thumb means that the reported percentages can be considered as estimates plus or minus 15 percentage points.<sup>28</sup> Because the precision is so low, it cannot be said that the respondents are representative of all the California hospitals that serve as major referral destinations for the uninsured. However, the data are useful in providing a sense for what many such hospitals do.

Qualitative analysis consisted of identifying themes across the four case study sites based on the detailed notes from the site visit interviews, the site summaries prepared after each site visit, and the focus group summaries prepared after each focus group. The consistency of qualitative comparisons across sites is assured in this study because the same analyst visited all of the sites and was responsible for developing the site visit-related findings.

Where access problems were found that proved different or more severe for any of the three focus conditions (childhood asthma, diabetes, and cancer), these findings are highlighted in boxes next to the report text.

## II. Problems with Access to Specialty Care Services

THE STUDY FINDINGS CONFIRM THAT IT IS VERY difficult for uninsured individuals to obtain a wide range of specialty care services. Uninsured adults have more difficulty than children, and access appears to have worsened for many FQHC patients over the past two years. FQHC medical directors attributed the diminished access to a general shortage of specialists and the unwillingness of some specialists to take these patients. In the case study communities, insured patients had difficulty obtaining prescription medications and medical devices, as well as physician services.

### **Overview of Access to Specialty Care for the Uninsured**

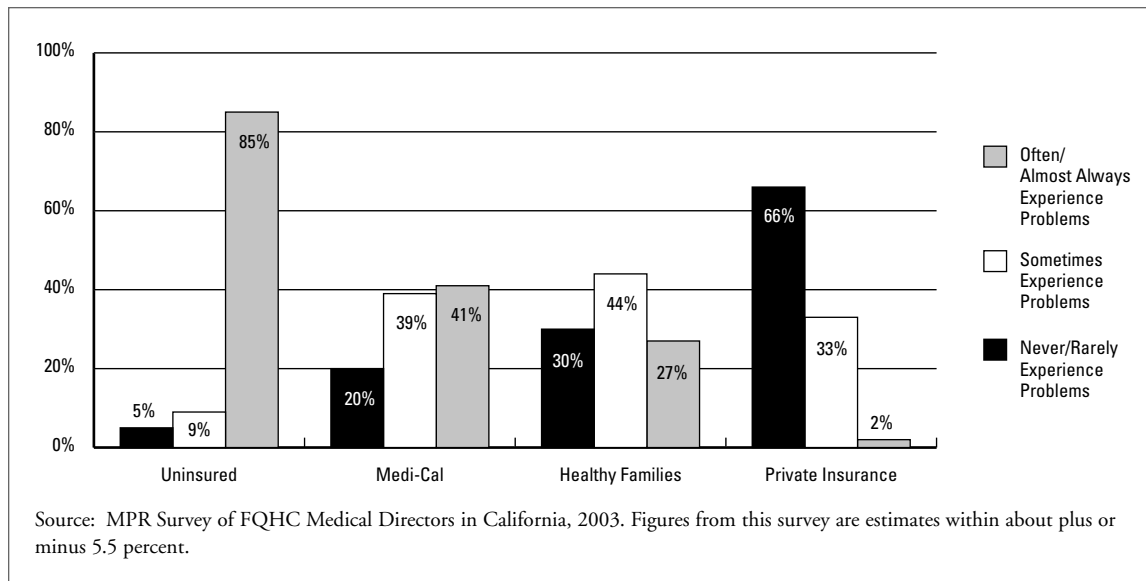
*Access for insured versus uninsured.* Eighty-five percent of responding medical directors said that FQHC uninsured patients in California “often” or “almost always” have problems obtaining specialty care (see Figure 1). These patients experience this difficulty more often than Medi-Cal, Healthy Families, and privately insured persons ( $p < .05$ ). Medi-Cal and Healthy Families patients have problems getting specialty care less frequently than do the uninsured, but they encounter problems more frequently than do commercially insured patients. A significantly larger percent of respondents said that Medi-Cal and Health Families patients experience difficulty finding care “often” or “almost always” compared to privately insured patients ( $p < .05$ ).

*Access for adults versus children.* Adult FQHC patients are more likely than children to experience difficulty accessing specialty care services. At least one-half of the responding medical directors reported that adult patients had trouble with access “often” or “almost always” for 17 of the 24 specialties that were examined (see Table 3). For child patients, this was true of only 4 of 17 specialties examined. A significantly larger percent of medical directors indicated that adult patients experience difficulty accessing care more often than children for 12 of the 17 specialties for which there are data for children and adults.

Almost all respondents in the four case study communities confirmed that uninsured children have better access than adults to specialty care, offering several explanations for this



**Figure 1. Percent of FQHC Medical Directors Reporting That Patients Experience Problems Obtaining Specialty Care**



situation. First, there are relatively few uninsured children because of the reach of Medi-Cal, Healthy Families, and county-sponsored insurance programs for children. As one respondent explained, it is easier for pediatric specialists to financially “absorb” the care for uninsured children due to their smaller numbers. Second, some respondents believe that there is a greater sympathy and willingness on the part of some physicians to provide charity care to uninsured children. There is a feeling that “it’s not their fault” if children lack health insurance. And finally, in some areas, children’s hospitals are a major provider of specialty care for uninsured children. At least one study of children’s hospitals has shown that they tend to provide more low-income care than other local hospitals,<sup>29</sup> perhaps because of their extensive philanthropic support and fundraising activities. Although children have better access to specialty care than adults, it is by no means good; over one-third of the FQHC medical directors reported that uninsured children “often” or “almost always” have trouble obtaining care for at least half of the specialties examined in the survey.

### Allergy/Immunology Services

Obtaining allergy/immunology care—important for asthma sufferers—is a problem for uninsured children. Over half of medical director respondents said access was “often” or “almost always” difficult. Communities with large Hispanic populations reported especially difficult access for children.

**Access across specialties.** The medical directors revealed difficult access across a large number of specialties for uninsured children and adults (see Table 3). From these findings, the FQHCs were classified as having adequate, mixed, or inadequate access for their uninsured patients based on the percent of specialties that medical directors said were “often” or “almost always” problematic. Fully 73 percent of the FQHCs reported inadequate access for adults, and 63 percent reported inadequate access for children (see Table 4).

Because not all specialties are equally difficult to obtain, the medical directors were asked to identify the three specialties that present the most difficulty for their uninsured patients and reasons

**Table 3. Percent of FQHC Medical Directors Saying Uninsured Patients Have Difficulty Obtaining Specialty Care “Often” or “Almost Always”**

<b>SPECIALTY</b>	<b>ADULTS</b>	<b>CHILDREN</b>
Neurology†	69%	52%
Endocrinology*	68%	47%
Allergy/immunology‡	67%	51%
Dermatology†	64%	55%
Orthopedics‡	64%	41%
Urology	63%	NA
Gastroenterology	62%	NA
Otolaryngology‡	62%	37%
Nephrology	62%	NA
Vascular surgery	60%	NA
Psychiatric	56%	57%
Physical and occupational therapy	55%	49%
Other surgery‡	54%	37%
Specialty care for diabetes* <sup>a</sup>	52%	38%
Pulmonary disease†	50%	39%
Substance abuse	50%	NA
Cardiology	47%	36%
Dental services‡	44%	32%
Ophthalmology‡	44%	31%
Optometry	38%	23%
Podiatry	36%	NA
Infectious disease	33%	36%
Oncology†	32%	17%
High-risk obstetrics	19%	NA

Source: MPR Survey of FQHC Medical Directors. NA indicates that the question was not asked regarding children. Figures from this survey are estimates within about plus or minus 5.5 percent.

\*Respondents were asked globally about specialty care for diabetes to better understand the overall level of problems with obtaining this care. The survey then asked about access to other endocrinology services.

†T-test comparing percentages from adults and children for a given specialty was significant,  $p < .10$ .

‡T-test, significant,  $p < .05$ .

for the difficulty. As expected, their answers were fairly consistent with results shown in Figure 1. Collectively, medical directors said that their uninsured patients have the most trouble obtaining orthopedics, dermatology, neurology, and psychiatric services (see Table 5).

Medical directors consistently attributed difficulty in access to three factors. First, some

respondents noted a general unwillingness of the types of specialists they named to take uninsured patients without payment. The survey did not show what economic or other forces make these types of specialists less willing than others to accept uninsured patients.

Second, in some areas, there is a shortage of specialists. For example, in one of the case study communities, there is only one orthopedist in the community and no endocrinologist in the whole county, which has a population of approximately 250,000.

Third, some respondents cited long wait times for appointments as a barrier to access. These three factors are probably often related, but the survey did not provide enough information to fully sort out the relationship. For example, long wait times could reflect both a shortage of physicians in a particular specialty and an unwillingness to take uninsured patients because the shortage allows specialists to “pick and choose” which patients to serve. Transportation and language barriers, though not frequently reported by medical directors as barriers to access, were mentioned by some case study and focus group respondents.

For some cases, the reasons for access problems may be specialty-specific.

Notably, the difficult access to psychiatric services in some communities may ultimately stem from recent public budget cuts, although the medical directors did not make this connection in their survey responses. FQHCs and other health centers have traditionally referred low-income uninsured patients in need of mental health services to county mental health

agencies rather than private physicians or local hospitals. The site visits revealed that budget cuts have forced mental health agencies to scale back on staffing and services. As a result, in two case study communities, county agencies are providing services only to the most severely mentally ill.

**4. Two-year change in access.** One-half of responding medical directors said that access to specialty care for the uninsured is more difficult or much more difficult than in the two years previous (Figure 2). Some 35 percent said access remained the same, while only 15 percent said that it had

**Table 4. Percentage of FQHC Communities Reporting Adequate, Mixed, or Inadequate Access for Adults and Children Across Specialties**

	LEVEL OF ACCESS*		
	Adequate†	Mixed Adequate and Inadequate	Inadequate‡
<b>Adults</b>	7%	20%	73%
<b>Children</b>	15%	22%	63%

Source: Analysis of MPR Survey of FQHC Medical Directors in California, 2003. Figures from this survey are estimates within about plus or minus 5.5 percent.

\*The survey question asked, for each of a long list of specialties, whether it is overall never, rarely, sometimes, often, or almost always a problem for uninsured patients to obtain specialty care. “Never” and “rarely” responses were considered “adequate access” for a specialty, and “often” and “almost always” responses were considered “inadequate” access.

†At least 75% of specialties were adequate.

‡At least 75% of specialties were inadequate.

**Table 5. Most Difficult Specialties for Uninsured Patients to Obtain, According to FQHC Medical Directors**

Specialty	Percent of medical directors reporting the condition is among the 3 most difficult to access	NUMBER OF TIMES EACH REASON WAS GIVEN BY MEDICAL DIRECTORS		
		General unwillingness of specialists	Shortage of specialists	Long wait times
<b>Orthopedics</b>	49%	15	9	6
<b>Dermatology</b>	46%	18	6	1
<b>Neurology</b>	44%	14	9	2
<b>Psychiatry</b>	32%	3	9	2
<b>Cardiology</b>	19%	6	5	1
<b>Endocrinology</b>	19%	3	5	1

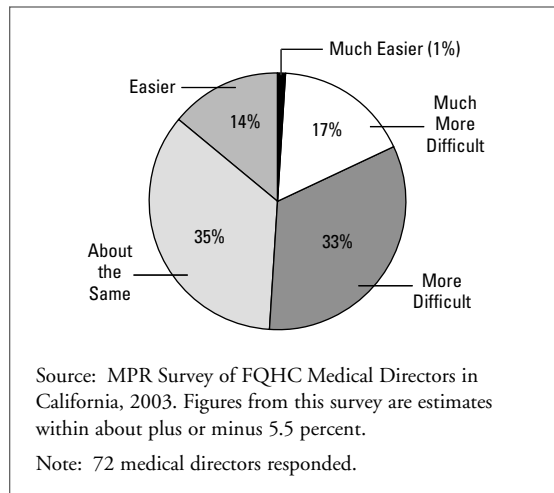
Source: MPR Survey of FQHC Medical Directors in California, 2003. Figures from this survey are estimates within about plus or minus 5.5 percent.

Note: Other specialties named by at least 5 of the 57 respondents to this question include: otolaryngology (18%), gastroenterology (16%), urology (12%), nephrology (9%), rheumatology (9%), and dental services (9%). Respondents were asked to name the three most difficult specialties for uninsured patients to obtain and reasons for the difficulty. In some cases, respondents named more than one reason; all are included here.

gotten easier or much easier. In the four case study communities, respondents reported that access had worsened because of an increase in the demand for such care. Providers interviewed during the site visits were almost unanimous in their opinion that the demand for specialty care had grown during the previous two years, primarily because of increases in the population, the number of uninsured, or morbidity. One

medical director attributed the rise in demand for specialty services to greater physician understanding about when specialty care is needed; as a result, more physicians want to refer to specialists. However, as one medical director put it, “We use up our credits faster,” meaning that it is difficult to secure specialty care for patients through favors from specialists, hospitals, or other resources.

**Figure 2. Accessibility of Specialty Care Services Compared to Two Years Ago, According to FQHC Medical Directors**



Many respondents said the supply of specialists willing to treat uninsured patients has not kept pace with the demand, with many attributing this to declining reimbursement from Medicaid and private insurance. However, in one of the study communities, some respondents said access had become easier because they have built stronger relationships with referral organizations and developed a better understanding of local resources that can help uninsured patients get specialty care.

***Additional insights on access from case studies.***

As applied to access, the meaning of the word “difficult” is subject to interpretation, and the nature and severity of access problems vary across and within communities. Site visit interviews allowed researchers to clarify meanings. In some communities, “difficult” access meant that it took a lot of effort to arrange for particular specialty care for patients, including “begging and pleading” with various providers to accept the uninsured patient for free or at a discount. The appointment might not be timely, but the patient would eventually be seen. In other communities, “difficult” access meant that the patient was not likely to receive the service at all.

Site visit interviews with FQHC and other health center staff lent support to the survey finding that the uninsured typically experience difficulty obtaining specialty care. Linking uninsured patients to specialty care services is a major problem for the health centers—one that physicians and case managers spend a great deal of time trying to address.

At several health centers researchers were told, “there is no easy referral,” meaning that there is not one organization that will offer all uninsured patients a timely appointment. Instead, each patient needing specialty care requires individual attention, typically involving case managers or physicians calling specialists or local hospitals trying to get the patient an appointment. In some cases these efforts are successful—particularly when a physician calls a colleague to ask him or her to see the uninsured patient as a favor. The FQHC in one case study community was able to link about 95 percent of its uninsured patients to specialists, but the process, conducted by five case managers, is very labor-intensive. In contrast, other health centers had less success linking patients to specialists; in several cases patients had to wait until their condition became an emergency before being able to access specialty care via the emergency room.

Because health centers have had such difficulty linking patients to specialty care services, one physician mentioned a unique way to ensure that sick patients receive the care they need. The physician explained, “It benefits us to create an emergency.” For example, a borderline cardiac

**Noncompliance and Asthma**

Providers cited noncompliance as an important problem in treatment of uninsured children with severe asthma. Some site visit respondents said that educating parents of children with severe asthma and getting them to follow through with treatment was difficult and frustrating.

patient could “get hustled” to the emergency room; by the time the patient gets there, he or she will be in a state of emergency, and the hospital is required under the law to treat the patient.<sup>30</sup>

***Additional insights from focus groups.*** The focus group participants had a range of conditions requiring specialty care services and reported varied experiences with the health care system. A common theme across the four focus groups was that their chronic symptoms or conditions did not appear well-managed or treated on a timely basis. Many participants said that they did not initially seek specialty care or purchase prescriptions because the costs were prohibitive. For example, one participant suffered from what she described as a pinched nerve resulting from a fractured vertebra, but had not sought care due to the cost. Another was able to visit a specialist for carpal tunnel syndrome but is unable to afford the cost of surgery to rectify her condition. At the time of the focus group, her hands were swollen and she was unable to pick up small items, such as a cup.

There were several examples of patients delaying care until their condition resulted in an emergency. For example, one participant did not seek care for his diabetes because he was uninsured; he also developed pancreatitis and eventually had to seek care at an emergency room. When patients sought care at ERs, they reported receiving very large bills. One woman had a heart attack and received a hospital bill for \$2,000; another was admitted for urinary tract bleeding and received a \$5,000 bill. At the time of the focus groups, the participants with large bills (the largest was \$100,000) were still paying off these debts, some at a rate of \$20 per month. Ultimately the bills deter patients from seeking care again unless they are in dire need, and the cycle begins again.

Many participants believed that care for their condition was delayed because the doctor they

initially saw for their symptoms did not refer them to a specialist or follow up with them about their problem because they were uninsured. For example, a woman with constant vision problems complained that the optometrist she saw diagnosed her problem as “dry eyes” and gave her drops, but did not refer her to an ophthalmologist even when her problem persisted.

A final challenge to accessing care in a timely manner is long wait times for appointments. Participants said they often had to wait a long time, often months, for non-emergent appointments, just as the survey and case study results suggested.

Beyond accessing appointments, many of the participants lacked information about their condition, or had received their information only belatedly through friends and family, for example. More than one individual with diabetes reported being told very little about their condition beyond what medication to take (e.g., handed a couple of pamphlets with a brief overview), although one did report that the FQHC where she was diagnosed sent her to a nutritionist to learn what to eat.

The focus group participants also were often critical of the quality of care that they or uninsured friends and family members had received. They did not believe they had access to the highest quality care, and in several cases attributed deaths or hospitalizations of people they knew to lack of proper care. They were also angered by large bills that they had to pay for services that did not solve their problems. For

#### **Diabetes Education Needed**

A lack of education for diabetes patients is viewed as a problem by providers in the study communities. Focus group respondents also expressed a need for more diabetic education. According to one participant with diabetes, “They never gave me . . . instructions. They just gave me my pills and told me to be on my way.”

example, a man paid several hundred dollars out-of-pocket for a root canal that failed within three months, requiring the tooth to be extracted (incurring another bill). The dentist explained that the tooth was very weak to begin with, so there was always a good chance the root canal would not have worked; the man was angry that he was not told this risk before deciding to pay for the root canal.

Although the majority of participants reported difficulty obtaining care, there were a few positive examples of people being able to get specialty care despite an inability to pay. For example, one participant told of a heart condition that had been left untreated until “it was a matter of life and death.” A local hospital provided her with a pacemaker and surgeons conducted the procedure free of charge. Another participant said that through the local Reach Out program (described in Chapter III), she was able to see an ophthalmologist for only \$30. Local programs and foundations helped some participants obtain medical devices. One participant said she was able to get free eyeglasses through a local program for the homeless, and another said a local foundation paid for a wheelchair that was needed when her boyfriend was paralyzed from a car accident.

### **Access to Complementary Services (Pharmaceuticals, Medical Devices, and Lab Services)**

In addition to physician visits, patients needing specialty care may require pharmaceuticals, medical devices, or lab tests in order for the physician to correctly identify and manage a diagnosis. Problems receiving these services can diminish the efficacy of specialty care treatment.

**Pharmaceuticals.** As noted in the work of Raube and Douglas,<sup>31</sup> the case studies revealed that accessibility of affordable pharmaceuticals is a pressing concern for FQHCs treating uninsured patients. Interviews with medical directors

and administrators at FQHCs and other local health centers revealed that it is very difficult for uninsured patients to obtain pharmaceuticals and that access had become even more difficult in some areas recently. At the FQHC in one of the study communities, a respondent said that most patients are not getting the medications they need. At an FQHC in another community, a respondent reported that 30 percent of patients are going without prescribed medication.

The health centers that were visited routinely make an effort to obtain medication for their uninsured patients in a variety of ways. First, they participate in patient assistance programs offered by pharmaceutical companies. These programs typically provide qualified recipients with a three-month supply of medication, but health centers must bear the burden of completing the paperwork required to enroll patients. For instance, applicants must supply proof of income (e.g., a tax return or pay stub), which is sometimes difficult for homeless or transient patients to provide, and patients must re-apply each time their medication runs out. Also, the programs do not always allow patients to re-apply without a waiting period.

Second, the health centers offer patients samples from pharmaceutical companies. One of the FQHCs, for example, distributes \$300,000 to \$400,000 in samples per year. The drawback to this approach is that the drug choice is limited. As one physician observed, the medication that some patients receive from samples “might not be my first choice, or even my tenth choice.” But while these options have limits, both provide uninsured patients with pharmaceuticals at no cost to them and are important for patients who cannot afford to purchase medications.

FQHCs also make no-cost or low-cost pharmaceuticals available to patients in other ways. Even those without in-house pharmacies access pharmaceuticals at a discounted rate through the federal 340(b) program. One offers medication at

\$8 to \$10 per prescription; another provides patients with a three-month supply of medication for \$15, no matter how many medications are needed. However, according to respondents, despite the nominal cost, medications are still unaffordable for many patients.

Finally, a lawsuit settlement gave FQHCs and other health centers for low-income patients a large quantity and variety of free medications valued at \$160 million.<sup>32</sup> The lawsuit was settled after California, along with many other states, filed a class action lawsuit against several pharmaceutical companies, charging them with price-fixing. Unfortunately, while respondents said the settlement was very helpful in getting medication to low-income uninsured patients, the medications from the settlement ran out early this year. The health centers that relied on the settlement medications are now using the three strategies described above to secure medication for their patients.

**Medical devices.** Respondents in the four case study communities said that medical devices are even more difficult for the uninsured to obtain than pharmaceuticals. Since renting equipment is typically cost-prohibitive, some providers said that they “beg, borrow, or steal” to get medical devices for patients. Generally, the only way that medical devices are available to low-income, uninsured patients is if they are donated. Providers therefore rely heavily on local charitable organizations for help. For example, in one study community, local hospitals look to organizations like the American Cancer Society, Rolling Start (for wheelchairs), or others for donations. As a last resort, the local public hospital may be willing to provide the medical device for a patient. In one community, the FQHC reaches out to a local endowment and charities. “No one is enthusiastic about purchasing hospital beds or hearing aids, and you can forget about getting an insulin pump,” according to one respondent. The Society for the Blind is very generous, according

to local respondents, but obtaining glasses can depend on the type of ocular abnormality. Occasionally, a local hospital receives a used walker as a donation, or case managers go to garage sales looking for inexpensive aids for patients.

**Laboratory services.** Access to laboratory services (general lab services, not MRIs or ultrasounds) does not appear to be a major problem for most uninsured patients who receive care at FQHCs in California. Sixty percent of the medical directors said that uninsured adults and children “never” or “rarely” have difficulty accessing laboratory services. The relative ease of access may be connected to the fact that the FQHCs and other health centers serving uninsured patients tend to be able to provide this service in-house. Still, access to lab services is not universally easy for FQHC patients; 21 percent of FQHC medical directors said that access is “sometimes” a problem, and 19 percent said access was “often” or “almost always” a problem.

## Accessing Specialty Care on an Outpatient Basis at Hospitals

Obtaining access to specialty care at hospitals is often a problem for uninsured patients. FQHC medical directors were asked for the names of three organizations to which they most frequently refer uninsured patients for specialty care. They were also asked if patients experience difficulty receiving care at these organizations and whether the organizations’ focus is on serving low-income populations. The medical directors reported sending patients to hospitals more often than other types of organizations. At 45 percent of the hospitals named, patients “often” or “almost always” experienced difficulty obtaining care, according to respondents. There was little difference in the frequency of reported access problems with hospitals whose primary focus is on the uninsured versus other hospitals (see Table 6).

**Table 6. Reported Access at Hospitals that Serve as Specialty Care Referral Destinations for the Uninsured**

Primary hospital focus is low-income populations	Total number of hospitals	FQHCs REPORT ACCESS TO SPECIALTY CARE IS:		
		Rarely or never a problem	Sometimes a problem	Often or always a problem
Yes	70	19%	37%	44%
No	60	8%	45%	47%
<b>Total</b>	<b>130</b>	<b>14%</b>	<b>41%</b>	<b>45%</b>

Source: MPR Survey of FQHC Medical Directors in California, 2003. Figures from this survey are estimates within about plus or minus 5.5 percent.

Hospital outpatient department directors reported waiting times consistent with the problems reported by the FQHC medical directors, indicating that the extent of the problem varies by specialty (see Table 7). Both groups of respondents named endocrinology, neurology, dermatology, orthopedics, and cardiology as the most difficult specialties to get; the hospital outpatient directors added ophthalmology, rheumatology, and urology. The average wait time for appointments with specialists in these areas range from 28 days for an appointment with a cardiologist to 134 days for an appointment with a dermatologist.

Although it is difficult for the uninsured to obtain appointments at hospital outpatient departments, it is even harder to get access to specialty procedures, according to the site visit respondents in the four communities. Even when primary care physicians and clinic administrators are generally successful in linking their patients to specialist colleagues, it is very difficult, if not impossible, to secure specialty procedures at a hospital if the patient is not in an emergent state. One medical director speaking about a patient with gallstones explained, “I can get the patient a surgical consult and an ultrasound, but I cannot arrange for the gallstone surgery because hospitals and anesthesiologists are not willing to provide it.”

**Table 7. Most Difficult Specialties for Uninsured Patients to Access at Hospital Outpatient Departments**

Specialty	Number of Times Specialty was Identified as among the Top 3 Most Difficult Specialties to Access	WAIT TIMES FOR APPOINTMENTS AT THOSE HOSPITALS (IN DAYS)		
		Minimum	Average	Maximum
Endocrinology	8	14	87	180
Neurology	7	56	92	120
Dermatology	5	56	134	365
Ophthalmology	5	55	126	162
Cardiology	4	14	28	42
Orthopedics	4	14	35	56
Rheumatology	4	90	101	112
Urology	4	25	79	128

Source: MPR Survey of Hospital Outpatient Department Directors in California, 2003.

Note: 14 of the 31 outpatient department directors responded to this question. Therefore these figures should not be assumed to be representative beyond the survey sample. Wait times represent only those hospitals where the specialty was described as one of the most difficult to obtain.



# III. Community Safety Nets for Specialty Care

COMMUNITY SAFETY NETS FOR SPECIALTY CARE vary in their structure, strengths, and weaknesses, but hospitals play a critical role in almost all of them. After an overview of the structure of safety nets, this chapter turns to the role of hospitals and physicians, and then identifies several community characteristics that appear to be associated with differences in access to specialty care. The chapter concludes with a description of the efforts underway in the case study communities to improve access to specialty care.

## Who Provides Specialty Care for the Uninsured?

**Overview.** Hospitals are a major source of specialty care for uninsured patients in most of the FQHCs. Hospitals accounted for 73 percent of the organizations listed by the medical directors as common specialty referral destinations for their patients. Some 90 percent of FQHC medical directors rely on at least one hospital. In contrast, physician practices accounted for only 8 percent of the referral destinations, with free clinics, other community clinics, and miscellaneous organizations accounting for 19 percent.<sup>33</sup> Although respondents were asked to list the three organizations to which they most commonly refer uninsured patients for specialty care, 38 percent named only one or two. This highlights the fact that there are relatively few organizations in each community that commonly provide specialty care to uninsured FQHC patients. Only a few respondents said they would refer patients to a facility other than these common referral destinations if they needed cancer care (14 percent) or cardiology services (18 percent).<sup>34</sup>

The fact that hospitals and other organizations serve as referral destinations for specialty care for the uninsured does not necessarily translate into easy access, as discussed in Chapter II. In fact, the FQHC medical directors said their patients “often” or “almost always” have difficulty obtaining specialty care from 40 percent of those organizations where they most commonly refer their patients for care.

The case studies show that organized volunteer clinics and initiatives to encourage volunteerism exist in some communities and may be considered part of the safety net. The

degree to which they assist uninsured residents in obtaining specialty care varies and appears directly related to their funding, eligibility policies, and outreach.

***Case study examples of the safety net for specialty care.*** Because the structures of community safety nets are known to vary, the four case study communities were selected, in part, to represent a mix of safety-net systems with respect to the extent of concentration of care for the uninsured (see Appendix A). Specialty care services for the uninsured are highly concentrated in one case study community (i.e., most services are provided by one hospital), moderately concentrated in two communities, and highly dispersed in the fourth community.

The community with the concentrated safety net has a large, county-owned public hospital, which provides most specialty care for the uninsured. Other hospitals in the county provide some specialty care to uninsured patients through their emergency rooms, and one provides a relatively small amount through its inpatient and outpatient department. However, the health centers send almost all specialty care referrals to the county hospital. In some ways, this concentration of specialty care services in a single county system has been helpful to uninsured patients, since they are familiar with the county system. However, the county system has traditionally had long wait times for appointments (months for some specialties) and for care in the emergency room (8 to 12 hours) along with an appointment process that is difficult to navigate. The county has recently improved this process and developed a fast-track system in the emergency room, substantially reducing wait times. The lack of private physicians' involvement in serving the uninsured is striking in this community. It could not be determined to what extent the physicians were truly unwilling to participate: because they believe the county system should provide all the care, or because the historical pattern of

channeling patients to the county system meant they did not perceive a need to participate.

The safety net in two other communities is more dispersed; each has three local hospitals, most of which provide limited outpatient services. The primary care physicians and FQHC staff in the two communities play an important role in linking patients to specialists, often relying on private physicians, and in one case, a private, nonprofit hospital with which the FQHC had negotiated a formal referral arrangement. While this form of safety net may "work" from a patient's perspective, it requires substantial effort from the referring organizations to link uninsured patients to specialty care.

The fourth community, on the Mexican border, almost always refers children to a nearby children's hospital, but has a very dispersed safety net for adults without insurance. FQHC respondents reported sending many uninsured adults to private specialists for care. Although there are numerous hospitals nearby, many do not offer outpatient services, and charity care policies are reportedly rather limited. The closest academic medical center receives the largest number of uninsured patients. In addition, residents who can cross the border also have the option of obtaining services and medications in Mexico for about one-third of what they would pay in the United States. Moreover, providers in Mexico are said to have less traditional operating hours (nights and weekends) and reportedly spend more time with each patient. Most respondents are somewhat confident that the care and medication obtained in Mexico is at least adequate. However, one hospital respondent mentioned having to rectify several botched surgeries performed in Mexico.

These examples of community safety nets for specialty care illustrate the variation in how uninsured patients obtain specialty care depending on where they live. No one form of safety net stood out as clearly the best for

specialty care access in this study, since the three case study communities where respondents reported substantial difficulties included one that was highly concentrated, one that was moderately dispersed, and one that was very dispersed.

## The Crucial Role of Hospitals

This section more closely examines the crucial role of hospitals in the specialty care safety net. It discusses the characteristics of hospitals named as referral destinations for the uninsured; how hospitals that serve as referral destinations accommodate the needs of the uninsured; and what

arrangements FQHCs in the case study communities have with hospitals.

**Which types provide specialty care for the uninsured?** Characteristics of hospitals that are the main referral destinations for specialty care are shown in Table 8. Government-owned hospitals represent only about 20 percent of California community hospitals, but account for about one-half of the hospitals named as major specialty referral destinations for FQHC patients.<sup>35</sup> Similarly, major teaching hospitals represent only about 5 percent of California hospitals, but account for over one-fourth of the

**Table 8. Characteristics of Hospitals Serving as Major Specialty Referral Destinations for the Uninsured Versus Those Providing Little Charity Care**

	HOSPITALS LISTED AS:		
	Major referral destinations for FQHC patients needing specialty care	Not providing much care for the uninsured	Both
	(1) (n = 37)	(2) (n=67)	(3)(n = 27)
<b>Ownership type</b>			
Government	49%	9%	26%
Private nonprofit	37	73	70
Investor-owned	14	17	4
<b>Teaching status</b>			
Major teaching	26	4	11
Minor teaching	37	25	44
Non-teaching	37	70	44
<b>Urban/rural</b>			
Urban	91	100	100
Rural	9	0	0
<b>Average number of beds</b>	290	267	342
<b>Average occupancy rate</b>	65	60	60
<b>Average Medicare percent of discharges</b>	21	28	27
<b>Average Medicaid percent of discharges</b>	25	15	23
<b>Average Profitability Index*</b>	6.1	5.2	5.3

Source: MPR Survey of FQHC Medical Directors in California, 2003. Figures from this survey are estimates within about plus or minus 5.5 percent.

Note: FQHC medical directors were asked to list up to three organizations to which they most commonly refer uninsured patients, including but not limited to hospitals. They were also asked to list up to three hospitals that operated in their community but did not provide much charity care. This table compares the characteristics of hospitals named in the first list with hospitals named in the second, using data from Solucient, "Profiles of US Hospitals," 2002.

\*Average Profitability Index: Solucient calculated each hospital's total profit margin (computed as the difference between total revenue and total expense, divided by total revenue). Hospitals were ranked on the basis of the decile that this indicator fell into compared with all U.S. hospitals, and given a number from 1 to 10. An average profitability indicator of "6.1" thus indicates that for the average hospital in that group about 60 percent of U.S. hospitals were more profitable.

major specialty referral destinations.<sup>36</sup> Almost all the major specialty referral destination hospitals are urban hospitals. The hospitals named as major specialty referral destinations are not, however, limited to those traditionally thought of as safety-net providers. Medical directors reported that 46 percent of the hospitals named are not primarily focused on providing services to low-income populations. Hospitals named as specialty referral designations are on average a little less profitable than the average U.S. hospital, and Medicaid accounts for an average of 25 percent of their discharges.

Hospitals that FQHC medical directors listed as not providing much charity care are also likely to be private nonprofit hospitals—but more often non-teaching hospitals—with higher percentages of Medicare discharges and lower percentages of Medicaid discharges (see Table 8).

***What motivates hospitals to provide specialty care to the uninsured?*** Surveyed hospitals identified as providing charity care cited many factors that affect their willingness and capacity to provide specialty care to the uninsured: A majority of the hospitals responding to the survey (20 of 31) reported that ten or more of the 15 factors listed in the survey were important or very important to the decision to offer such care. The factors that were reported as *very* important by at least half of the responding hospitals are shown in Figure 3.

- *Nonprofit status/mission.* It may be more the “mission” than the “nonprofit” status that drives the surveyed hospitals to provide specialty care to the uninsured, since the vast majority of hospitals named as *not* providing much care for the uninsured are also nonprofit hospitals. The mission may include a hospital’s commitment to caring for the uninsured or providing training to residents.
- *Hospital board’s views on charity care.* This factor was viewed as very important by all

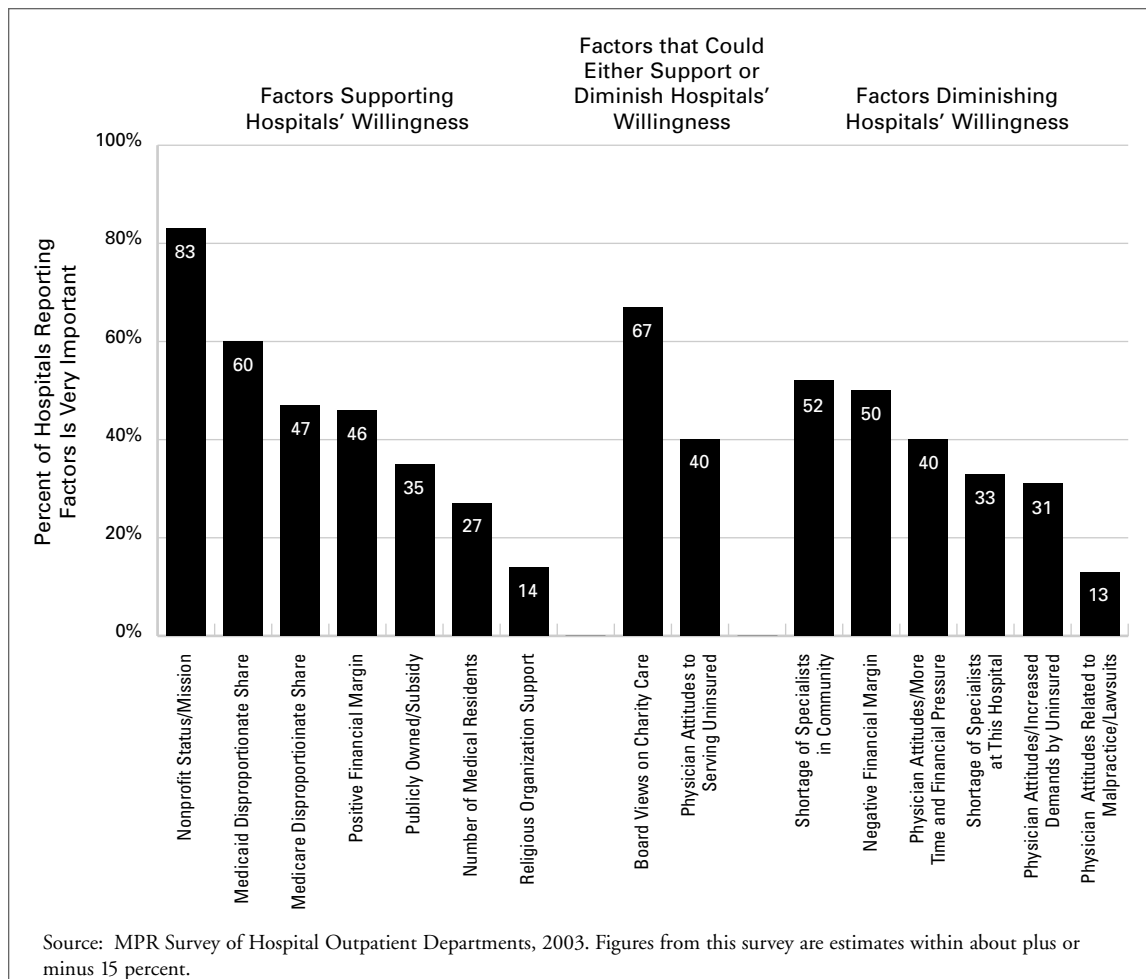
types of hospitals regardless of ownership type.

- *Medicaid disproportionate share funding.* Medicaid disproportionate share funding was cited as very important more often (85 percent versus 50 percent) by government-owned than nongovernment-owned hospitals (chi-square test,  $p < .1$ ).
- *Overall shortage of specialists in the community.* Hospitals see shortages of certain specialists in the community as very important. Few said their hospital had more of a shortage than others, indicating hospital-specific recruiting problems are typically a less important factor than overall shortages.
- *Negative financial margin.* The responding hospitals are a little less profitable than the average U.S. hospital, but the hospitals that view this factor as very important range from the highest to the lowest tiers of profitability relative to the national average. On the other hand, higher-profit hospitals view *positive* financial margin as very important significantly more often than lower-profit hospitals (chi-square  $< .01$ ).<sup>37</sup>

Several factors did not apply to a substantial proportion of hospitals, but were very important for many of those hospitals to which the factor did apply:

- *Publicly owned/subsidized.* Almost 80 percent of the responding hospitals that are publicly owned or subsidized said this is a very important factor in their decision to provide specialty care for the uninsured (11 of 13).
- *Medicare disproportionate share.* More than 60 percent of the hospitals that receive Medicare disproportionate share said this is very important to their willingness or capacity to provide the uninsured with specialty care (14 of 23).
- *Religious organization/support.* One-half of the small number of hospitals affiliated with a

**Figure 3. Factors Very Important to Hospitals' Willingness and Capacity to Serve the Uninsured**



religious organization said this is a very important factor in their decision to provide specialty care to the uninsured (4 of 8).

- *Number of medical residents.* Almost one-half of the teaching hospitals said the number of medical residents is a very important factor for them (8 of 17).

A few hospitals listed other factors, including the community expectation that they are responsible for all uninsured care, new requirements for residents to work fewer than 80 hours, and physical capacity, but none of these factors was listed more than once.

There were only two factors that a substantial number of the hospitals (i.e., more than one-

fourth of those to which the factor applied) cited as not very important: physician attitudes related to fear of lawsuits and malpractice costs; and religious organization support.

***Types of FQHC referral arrangements with hospitals.***

The case studies shed light on the nature of FQHC referral arrangements with hospitals. In the case study communities, the arrangements of FQHCs with hospitals for specialty care referral range from formal agreements to arranging for care on a case-by-case basis. Two of the communities used formal agreements to some extent. In the community with the most formal arrangement, all FQHC patients have received specialty assessment and treatment at a county hospital clinic since 1995. Patients

pay a nominal up-front fee (typically around \$35) to the FQHC in order to schedule an appointment. The FQHC sends the payment to the hospital, and an appointment is made for the patient with a county specialist. The agreement makes it clear that specialists at the hospital send all laboratory tests to the FQHC for completion and that the FQHC is responsible for providing the patient with pharmaceuticals. In addition, the FQHC is responsible for follow-up care if it has the expertise to provide such care. However, at the time of the visit, the future of the arrangement was uncertain, with both sides voicing dissatisfaction with and some allegations of violations of the agreement.<sup>38</sup> The county hospital had just announced that it planned to terminate the agreement with the FQHC because of the cost of the arrangement (the fee had been around \$35 since 1995).

The second community that uses a formal agreement has had better luck in its arrangement with a private, nonprofit hospital. One of the FQHC's board members is the head of the hospital's medical group. He brokered an agreement with the FQHC in which the hospital would take four uninsured patients needing specialty care per month at no charge. However, the actual number of uninsured referrals accepted by the hospital has grown, with approximately 100 appointments for uninsured patients referred from the FQHC in the first four months of 2003. The hospital's physicians help make diagnoses when the clinic is unable to, consult on management plan changes, and treat an episodic or abnormal occurrence caused by an illness or condition. The hospital does not receive all of the FQHC's specialty care referrals for uninsured patients—some are referred to other hospitals and other physicians on a case-by-case basis.

#### ***How hospitals accommodate the uninsured.***

Some 90 percent of the hospitals serving as referral destinations that responded to the

hospital survey had some mechanism to help the uninsured afford outpatient specialty care; 81 percent said *no* services or clinics are closed to patients who cannot fully self-pay. About two-thirds offered free care for those who qualify, and over one-half had a sliding fee scale, with 42 percent using both. A few had other mechanisms in place, including a discount for those who self-pay, and payment plan options that are worked out case by case with the hospital's business office. Hospitals were split on whether they applied a single accommodation mechanism hospital-wide (64 percent), or whether it varied by clinic (36 percent). Most of the hospitals did not have a cap on the dollar value of charity care they would provide; of the three responding hospitals that did, two had reached that cap last year.

While most of the hospitals require some up-front payment (77 percent), most reported that the amounts typically are not collected consistently (71 percent), and patients who do not pay them are seen anyway (58 percent).

### **Role of Specialist Physicians in Private Practice**

While only 16 percent of the FQHC medical directors listed physician practices as one of the top three referral destinations for specialty care, this does not necessarily mean that private physicians play a small role in the safety net for such care. If a large number of specialists each take a few uninsured patients in their practice, they could in theory collectively meet community needs. The case studies suggest that while this is not typical, private physicians may play more of a role in the specialty care safety net than many recognize.

In three of the case study communities, private specialists provide a considerable amount of charity care on an ad hoc basis. Obtaining this type of access is often difficult, however, for both

patients and providers. To gain access, primary care physicians or clinic staff contact private specialists directly, asking them to take an uninsured patient as a favor. The success of this arrangement depends on the relationships that referring physicians or organizations have with the specialists. In most cases, the primary care physicians or health center staff contact specialists who are friends or acquaintances. If the two reach an agreement, the specialist will either waive charges or work out a payment plan with the patient. One FQHC tries to refer uninsured patients to the same specialists as its Medicaid patients, hoping that they will be more receptive to taking uninsured patients. Referring physicians and staff also make an effort to “spread out” the uninsured patients among different specialists so that no single one is overwhelmed by uninsured patients. In the community with a county hospital, care provided by private specialists was reported to be very limited, with all referrals sent to the hospital.

Access to specialist physicians for the uninsured appears to be markedly better in one site than in the others, for several reasons. In that community, according to respondents: there is strong public will, or motivation, to provide enough care (most people in the community support universal health care); since there are relatively few uninsured in the county, the “burden” is manageable; and organizations in the area make it easier for physicians to participate because the organizations “take the hassle” out of volunteering. For example, one arranges for elective surgeries for a limited number of uninsured patients.

More specifically, two efforts in this same community encourage volunteerism among private physicians. Physicians waive all fees for patients who are selected for a limited number of free outpatient and elective surgeries and surgical consultation. The program is supported in-kind by the contributions of local hospitals and physi-

cians, but the organization is based outside the county and operates in other areas of the region as well. Also, the local FQHC hosts a committed group of volunteer specialists. A gastroenterologist, pediatric orthopedist, neurologist, dermatologist, and urologist volunteer at the health center at least once per month. All FQHC patients needing those services are given an appointment to see the specialist when he or she will be at the center next. Most of these volunteers have been coming to the clinic for six to ten years. Representatives from the center believe it is more convenient for the physicians to see patients at the FQHC than in their private practices, and the FQHC case managers work to keep relationships strong.

In a second community, two organized efforts to encourage volunteerism among private physicians were also helpful. First, a university runs free clinics that offer a variety of specialty services in three locations, where medical students recruit specialists to volunteer. The clinics offer cardiology, diabetes, dermatology, ophthalmology, psychiatry, and dental services approximately once a month to patients. Unfortunately, these clinics are overwhelmed by referrals and often have to turn patients away. In the same community, a program called Reach Out links uninsured patients with providers willing to take a reduced fee for service. The program covers all specialties except orthopedics (there are currently no orthopedists involved in the program). Patients in the program must pay cash up front. The discount for uninsured patients is typically at least 50 percent of the usual charge.

### **What Community Characteristics Lead to Better Specialty Care Access?**

Understanding how community characteristics affect specialty care access could help policymakers and others target assistance to communities that are more vulnerable, and assist

local health care leaders in understanding why their communities may be faring well or poorly relative to others. To address this question, researchers classified communities using census data on community characteristics.<sup>39</sup> Information from the case studies was also examined. The analysis using census data compared the reported access experience in urban versus rural areas,<sup>40</sup> areas with larger versus smaller nonwhite populations, and areas with larger versus smaller Hispanic populations.

**Analysis of census and survey data.** Reported levels of problems accessing specialty care providers in FQHC communities were similar for urban versus rural communities, communities with larger versus smaller nonwhite populations, and those with larger Hispanic populations (see Table 9). However, these overall results appear to mask some important differences by specialty.

FQHC medical directors in communities whose populations are at least 40 percent Hispanic reported significantly more access problems than other communities for ophthalmology and orthopedic surgery, as well as lab services for adults and allergy/immunology for children. There was a similar pattern for several more specialties; however, the results for those other than the above are not statistically significant (see Table 10).

Nonetheless, the responses suggest high-risk obstetrical services may be more problematic in rural areas. Some 28 percent of rural respondents reported poor access to high-risk obstetrical services compared with 15 percent of urban residents. Also, many fewer rural respondents reported adequate access to those services (44 versus 70 percent). On the

other hand, the share of urban respondents reporting poor access to orthopedic surgery for their uninsured patients is greater than that for rural respondents (72 percent versus 45 percent).

**Insights from the case studies.** Although access to specialty care in only one of the four communities appeared relatively adequate, there were some features in the other three that had helped with access (see Table 11). The following are features that seemed to facilitate access considering the experience in all four communities.

- **Strong relationships between FQHCs and hospitals.** In the current health care environment, the ability for uninsured people to get specialty care depends heavily upon the relationships their doctor or clinic has with other specialist physicians and hospitals. Formal relationships between FQHCs and hospitals promoted access in two of the case

**Table 9. Percent of FQHC Communities Reporting Adequate, Sometimes Adequate, and Inadequate Access to Specialty Care, by Selected Community Characteristics**

	level of access*		
	Adequate†	Sometimes Adequate	Inadequate‡
<b>Population density</b>			
<100 per sq mi (rural)	0%	14	86
100 >500 per sq mi	0%	0	100
500 or more per sq mi	9%	9	82
<b>Percent nonwhite</b>			
<30%	9%	5	87
30 >60%	6%	12	82
60% or more	3%	11	86
<b>Percent Hispanic</b>			
<20%	9%	9	82
20 >50%	0%	14	86
50% or more	5%	5	90

Source: Analysis of FQHC Medical Directors Survey (level of access) and census data. Figures from this survey are estimates within about plus or minus 5.5 percent.

\*The survey question asked for each of a long list of specialties whether it is never, rarely, sometimes, often, or almost always a problem for uninsured patients to obtain specialty care. “Never” and “rarely” responses were considered “adequate access” for a specialty, and “often” and “almost always” responses were considered “inadequate” access.

†At least 75% of specialties were adequate.

‡At least 75% of specialties were inadequate.



**Table 10. Substantial Differences Between Reported Access by the Uninsured for FQHCs in Communities with Hispanic Populations**

	POOR ACCESS		MODERATE ACCESS		ADEQUATE ACCESS	
	Higher Hispanic* Population (1)	Lower Hispanic* Population (2)	Higher Hispanic Population (3)	Lower Hispanic Population (4)	Higher Hispanic Population (5)	Lower Hispanic Population (6)
<b>Adults</b>						
Cardiology	60%	40	28	31	12	29
Gastroenterology	72%	57	24	24	4	20
Neurology	84%	62	8	19	8	19
Ophthalmology‡	48%	41	40	20	12	39
Orthopedic surgery†	81%	54	15	28	4	17
Other types of surgery	70%	45	17	39	13	16
Lab services‡	35%	11	13	26	52	64
<b>Children</b>						
Allergy/immunology‡	52%	50	40	18	8	32
Orthopedics	56%	33	28	30	16	37
Psychiatric	48%	61	16	20	36	18
Pulmonary	52%	31	22	38	26	31
Lab services	30%	14	13	23	57	64

Source: Analysis of FQHC Medical Directors Survey (level of access by specialty) and census data (percent of community's population of Hispanic origin). Figures from this survey are estimates within about plus or minus 5.5 percent.

\*Higher Hispanic population communities were defined as those where the Hispanic population in the ZIP code of the responding FQHC was 40 percent or more of the total population. Lower Hispanic population communities were all others.

† chi-square significant  $p < .05$ . Chi-square tested relationship between columns 1, 3, and 5 and columns 2, 4, and 6 for each specialty.

‡ chi-square significant  $p < .10$

study communities. Informal relationships appear as important as formal ones. For example, in one community, a formal agreement between the FQHC and a hospital that seems to assure only limited access is being used informally on a larger scale in the context of good informal relationships (also discussed above). Relationships between FQHCs and hospitals were relatively weak in two communities. There were no formal referral arrangements, and hospitals were not active participants in collaborative efforts among FQHCs and others in the area to improve access to care for low-income populations. In the one community where hospitals were active in a collaborative effort to address community access needs, such collaboration seemed a good forum for diverse providers to get to know one another,

forming the basis for the relationships that can promote access.

- *Community support.* Community support for the uninsured varies across the case study communities and is manifested by the presence of private funding to support the safety net, advocacy groups, active coalitions like those mentioned above, and local funding and programs designed to facilitate access. The case study community with the strongest community support is the one that provides the most favorable access environment of the four communities for uninsured people to obtain specialty care. In two communities with moderate support, access is somewhat elevated, but substantial problems remain. The types of initiatives in the community with the strongest support include:

**Table 11. Profiles of the Safety Net for Specialty Care in the Case Study Communities**

	COMMUNITY 1	COMMUNITY 2	COMMUNITY 3	COMMUNITY 4
<b>SAFETY NET STRUCTURE</b>				
Concentrated/dispersed system	Concentrated	Dispersed	Neither extreme	Neither extreme
Most common specialty care referral destinations for uninsured patients listed by FHQC medical directors	One public hospital (minor teaching)	None listed	One public, major teaching hospital and two nonprofit hospitals (non-teaching)	One public major teaching hospital, one public minor teaching hospital, one major teaching nonprofit hospital
Private physician care	Limited	Some	Considerable	Some
Free clinics providing specialty care	None	Yes	None	None
Medicaid managed care	Two-plan model	Geographic managed care	Voluntary (pre-paid health plans)	County-organized health system
<b>FACTORS LEADING TO BETTER ACCESS TO SPECIALTY CARE</b>				
<b>Strong relationships between FQHCs and hospitals</b>				
Strong informal relationships			X	
Formal referral arrangements	X		X	
<b>Community support</b>				
Private funding to help support safety-net services			X	X
Coalitions to address access problems		X	X	X
Community is said to value helping the uninsured			X	
Organized effort to encourage physician volunteerism		X	X	
<b>Level of demand by the uninsured and composition of that population</b>				
Relatively low number of uninsured			X	
Uninsured are relatively concentrated in a single ethnicity			X	X
<b>Supply of specialists</b>				
Supply perceived to be adequate	X			

Source: MPR case studies in four California communities, 2003.

\*There is no routine local public funding that supports the safety net in these communities.

1. *Active coalition to address access problems.*  
An active local Health Access Committee consists of all the major safety-net organizations, including local hospitals and two local foundations that have historically supported uninsured individuals and safety-net facilities.

2. *Private funding.* Two local foundations support the Health Access Committee's efforts. Funds from one of these foundations historically provided support for uninsured patients to see specialists. However, because of the downturn in the stock market, this funding stream was

eliminated, although the foundation hopes to restore funding in the future if economic conditions permit.

3. *Organized effort to facilitate access* Many specialists volunteer through Operation Access, a nonprofit organization that arranges for free outpatient elective surgeries and surgical consultation for uninsured individuals in the county. Since 2000, one local nonprofit hospital has provided five procedures per month, and another has provided three per month. The participating hospitals waive all fees for the operating room, supplies, pharmaceuticals, and lab work. Volunteer physicians waive all fees. The average cost of a procedure under the program was about \$6,000 at the time of the visit, including hospital and physicians' fees.

4. *Community said to value helping the uninsured.* Respondents described an overall community attitude that values helping the uninsured. Providers appear to be among those who share this value—Operation Access, noted above, is based outside the county and only operates where it can get enough support from local providers—which is the case in this community. Also, a representative from the program said that it is relatively easy to recruit physicians.

- *Size of the Uninsured Population and Its Composition.* The case study community with the best access environment for specialty care for the uninsured not only enjoys a high level of community support, but also has a relatively small uninsured population. The relatively small number of uninsured residents prevents providers from being as fearful as they are in other communities that their offices could become inundated with uninsured individuals if they agree to accept a few.

Also in that community, uninsured residents are a relatively homogeneous group. Recent Latino immigrants are concentrated in one geographic area, so they are easier to reach than residents in a second community where the uninsured population is more racially and ethnically mixed and is dispersed throughout a very large county.

- *Supply of Specialist Physicians.* Numerous respondents in three of the four communities reported specialist shortages and difficulty attracting specialists to the area. Several respondents in each of these communities said that the high cost of living in the area makes it difficult for physicians to start up a practice. Also, it is difficult for FQHCs and hospitals to pay physicians a livable wage in these areas.<sup>41</sup>

## Efforts to Improve Access in the Case Study Communities

*Expanding services at FQHCs.* Three of the four FQHCs visited are making efforts to offer common specialties in-house. As discussed earlier, an FQHC in one of the study communities is able to offer a broader range of specialties through a committed group of specialists who have been volunteering at the health center for years. The FQHCs in two other communities are trying to expand staff in order to offer a greater range of services. Since referrals are often difficult to secure for uninsured patients, “We grow our own,” according to one FQHC administrator. For example, in response to long wait times for appointments at the county hospital, one of the FQHCs recently added two internists (one with a pediatric specialty), an optometrist, and a pediatric dentist (part-time). An obstetrician will begin seeing high-risk obstetrics patients onsite as well. Similarly, the FQHC in the other community recently hired an Ob/Gyn and will likely hire another. It also hired a specialist in internal medicine and will look for another

physician who specializes in diabetes. Having added these physicians, the clinic can offer more comprehensive services under one roof and manage patients more efficiently.

***Covering uninsured children.*** At the time of the site visits, local foundations and advocacy groups in two communities were planning countywide programs that would provide universal health coverage for children (including undocumented children). In one case, a quasi-governmental organization that receives tobacco tax funds earmarked for children's benefit has committed \$0.5 million over the next ten years to the project, and a local foundation will pay for strategic planning. It is estimated that 1,100 children in the county lack health insurance and, depending on how comprehensive the coverage will be, the cost of the program in FY 2003-04 will range from \$480,000 to \$1 million.<sup>42</sup> As of this writing, the county had not decided whether to contribute funding to the program.

The program being planned in the other county would be administered by the Medi-Cal managed care organization. The county's Health Services Agency and a nonprofit advocacy organization committed a total of \$1.5 million to the program. The estimated annual cost is approximately \$2.7 million, which would cover 2,500 uninsured children up to 300 percent of the federal poverty level. At the time of the site visit, the organizers had raised about 65 percent of the funds for the first year of operation. The program was expected to roll out in January 2004, but it has been delayed to July 2004 because of some questions regarding funding.

***Encouraging or leveraging volunteer service.*** Officials in one county were able to obtain a commitment from a local hospital to provide

charity care as part of a land-use agreement between the two parties. Under the agreement, the hospital will provide some free care to uninsured patients. Local clinics refer female patients who cannot qualify for any public insurance program to the hospital. In another study community, a local hospital began requiring all new contracting primary care physicians to donate four hours per month to the community. Much of this time involves providing charity care at the local FQHC.

None of the four communities had plans to expand efforts to encourage physician volunteerism. In fact, respondents seemed skeptical when asked about the potential for increased volunteerism through the creation of an organized volunteer network. Their general sense is that physicians in these areas who are willing to volunteer already do so; others are unwilling to volunteer for a variety of reasons, the most critical being financial. Respondents reported that reduced reimbursements under public and private insurance and the high cost of running a practice make charity care challenging.

***Creating access in other ways.*** Safety-net organizations and policymakers are also reacting to challenges and opportunities as they arise, at least in one community. When Medicaid managed care was introduced in one of the counties, the local orthopedists banded together and decided not to participate; most also refused to accept uninsured patients. Access to orthopedists was so difficult for the uninsured that the county contracted with tertiary specialists from a neighboring county to staff a free orthopedic clinic. Orthopedics is now one of the easiest specialties for uninsured residents to access.

# IV. Key Findings and Implications

ALTHOUGH ACCESS TO SPECIALTY CARE FOR THE uninsured has generally been identified in other studies as a problem, this study in a sense lifts the lid on the “Pandora’s box” of problems related to specialty care access for this population. Although the researchers focused on the problems described by FQHC medical directors, access may well be worse for uninsured people who do not use FQHCs as their medical home, since FQHCs, unlike other providers, are required to have at least some link to specialty services for their patients.

## Major Findings

### **Access Problems Extend Across a Wide Range of Specialties and Are Worse for Adults Than for Children.**

Access to specialty care for the uninsured population is a widespread problem in California. Fully 85 percent of the FQHC medical directors reported that their patients “often” or “almost always” have problems in obtaining care. Further, they characterized access as “often” or “almost always” problematic for 17 of the 24 specialties listed on the survey for adults. Children were reported to fare better, but access is still “often” or “almost always” problematic for several specialties. One-half of the FQHC medical directors said access to specialty care is worse today than it was two years ago, while only 15 percent reported that it had improved.

The case studies showed that major problems involve the difficulty patients or FQHCs have in finding a specialist willing to accept patients and the inability to obtain a timely appointment. Formal referral agreements between FQHC primary care providers and specialists that would cover patients across the board appear rare; typically, FQHC physicians and staff work hard to secure specialty care for their uninsured patients on a case-by-case basis. Waiting times for the most problematic specialties are often months long, as shown by the case studies and the hospital outpatient department survey.

The medical conditions of the uninsured patients in the four focus groups did not appear to be well-managed or treated on a timely basis. Many participants said that they delayed seeking specialty care because of its high cost, because they felt that

they were not appropriately referred or followed up, and because they lacked critical information about self-managing their condition.

### **Hospitals Are a Critical Source of Specialty Care for the Uninsured, Including Many Not Specifically Focused on Low-Income Populations.**

Hospitals are the major source of specialty care for the uninsured who use FQHCs, accounting for 73 percent of the organizations listed by FQHC medical directors as common specialty referral destinations for their patients.

Government-owned hospitals represent only about 20 percent of California community hospitals, but account for about half the hospitals named as major specialty referral destinations for FQHC patients. Similarly, major teaching hospitals represent only about 5 percent of California hospitals, but account for over one-fourth of the major specialty referral destinations. Almost all the major specialty referral destination hospitals are urban hospitals. The hospitals named as major specialty referral destinations are not, however, limited to only those traditionally thought of as safety-net providers. Medical directors reported that 46 percent of the hospitals named are not primarily focused on providing services to low-income populations.

Public hospitals and major teaching hospitals are widely known for their crucial role in many communities' safety nets. This study points to a large number of other hospitals that also contribute substantially to the safety net for specialty care, although their role as such has not gained widespread acknowledgment. The findings suggest that policies and research studies that focus *only* on supporting or studying hospitals that primarily serve low-income populations will miss a substantial number of other hospitals that also provide vital support to uninsured patients for specialty care.

While hospitals responding to the survey cited many factors as important to their capacity or

willingness to provide specialty care for the uninsured, at least half reported the following as *very* important: nonprofit status/mission, the hospital board's views on charity care, receipt of Medicaid disproportionate share funding, overall shortage of specialists in the community, and negative financial margin.

### **Private Physicians Also Play an Important Role in the Safety Net for Specialty Care, but Their Contribution Is Harder to Determine.**

While only 16 percent of the FQHC medical directors listed a physician practice as one of the top three referral destinations for specialty care, the collective contribution of private physicians to the safety net could still be large if many specialists took a few uninsured patients into their practice. While the authors had no data on private specialty care delivered to the uninsured, site visit respondents in three of the four case study sites indicated that private specialists provide a significant level of charity care on an ad hoc basis, although obtaining this access is a difficult, case-by-case effort. Organized efforts in two communities work to encourage volunteerism among private specialists, although each effort is limited in scale or requires substantial cost-sharing by the patient.

### **Community Characteristics Affect Access to Specialty Care for the Uninsured.**

Survey and census data show that FQHC communities whose populations are at least 40 percent Hispanic reported access problems significantly more frequently than other communities for ophthalmology, orthopedic surgery, and laboratory services for adults and for allergy/immunology services for children. Because laboratory and allergy/immunology services are essential for appropriate management of certain conditions such as asthma, impaired access is likely to negatively affect care management and outcomes. More access

problems were reported by FQHC communities with larger Hispanic populations for other specialties as well, although the results for those other specialties are not statistically significant. There were no significant differences in reported access problems for urban versus rural FQHC communities. Visits to the four case study communities suggest that the following factors are important in determining access to specialty care:

***Strong relationships between FQHCs and hospitals.*** The ability of uninsured people to obtain specialty care depends heavily on their doctor's or clinic's relationships with other physicians and hospitals. Informal relationships appear as important as formal ones. Current relationships between primary care safety-net providers and hospitals are often not particularly strong, and although some collaborative coalitions work to address health needs in three communities, hospitals have been active in only one of them.

***Community support.*** Community support for the uninsured is evident in private funding to support the safety net, advocacy groups, coalitions like those mentioned above, and local programs designed to facilitate access. The case study community with the strongest community support is the one that clearly provides the most favorable access environment for uninsured people to obtain specialty care. In two communities with moderate support, specialty care access is elevated, but problems were still substantial.

***Size of the uninsured population and its composition.*** When only a small share of the population lacks coverage, providers in the community are less fearful of becoming “flooded” with uninsured individuals if they agree to accept a few patients. In addition, when uninsured residents are a relatively homogeneous group—recent immigrants of the same ethnicity concentrated in one geographic area, for example—providers and advocates have an easier time reaching out to and targeting programs for them.

***Supply of specialist physicians.*** Numerous respondents reported specialist shortages and difficulty in attracting specialists because of the high cost of starting up a practice in communities where the cost of living is high. Further, it is difficult for FQHCs and hospitals to pay physicians a livable wage in such areas. The result is longer waits for appointments for both insured and uninsured residents.

### **Local Efforts to Improve Access to Specialty Care Exist but Have Limitations.**

Efforts now underway in three of the four case study communities have the potential to improve access to specialty care for the uninsured. However, while such efforts appear poised to “chip away” at the problems, substantial gaps remain. Two of the four communities are working to cover more uninsured children through county health insurance programs. If successful, this approach should greatly reduce problems for children, but the more severe problem of adult access will remain unaddressed.

Several of the FQHCs are beginning to offer some specialist services in-house. This strategy appears promising if the FQHCs can increase supply where shortages are the primary problem and the volume of low-income patients in need of services is large. On the other hand, it seems highly unlikely that FQHCs could expand to include all the specialty care needed by their patients.

### **Implications**

The findings about the nature of specialty care access problems provide insight into the reasons for the worse clinical outcomes that have been well-documented for uninsured and low-income individuals.<sup>43</sup> They suggest a need for attention, both in the short term from local health leaders and in the longer term among state and national policymakers.

### Short-Term Action Steps.

The following initiatives could be taken by local health leaders, including medical and administrative leaders of hospitals, FQHCs, and other primary care clinics focused on low-income populations; local health department directors; physicians active in communitywide issues (for example, through local medical associations); and executives and staff of local foundations and charitable organizations:

***Assess the severity and nature of specialty care access problems.*** An assessment could consist of interviews with several primary care physicians who serve the uninsured, as well as a representative of the relevant hospital outpatient departments, to identify which specialties are inaccessible or experiencing long waiting times for appointments, and why. Such an assessment will provide a solid foundation for developing a plan to improve identified problems.

***Develop and execute a plan for improvement.*** Although it may sometimes be beyond the ability of local health care leaders in underserved and low-income communities to solve specialty care access problems on their own, they should explore the following:

- *Implement or expand local initiatives to provide insurance.* Could insurance be expanded? This study finds significantly fewer problems with access to specialty care for both privately insured and Medicaid patients relative to uninsured populations. Further, it identifies a potential spillover benefit from increasing the number of insured adults. When the uninsured population is small, physicians seem less fearful of pitching in to fill the remaining gap; they perceive less chance that their practices will become inundated by uninsured patients. In other words, efforts to expand insurance coverage could have the indirect effect of making it easier for the remaining uninsured to obtain specialty care.

- *Strengthen primary care/hospital relationships.* How could relationships between area hospitals and FQHCs and other primary care clinics that serve the uninsured be strengthened to support easier referrals? Would a private hospital agree to take a limited number of referrals per month?
- *Provide advanced training to primary care providers to reduce need.* Are there opportunities for training primary care physicians who serve the uninsured in management of the more common chronic diseases such as asthma and diabetes, thereby reducing the need for care from specialists and producing better outcomes? A concerted effort to improve chronic care management by primary care physicians might convince specialists to make time for the remaining most difficult cases as part of a communitywide effort to improve care.<sup>44</sup>
- *Consider bringing specialists to primary care settings.* Is the problem severe enough and sufficiently focused on a common specialty need that a local FQHC or other clinic for low-income patients should consider seeking out funding to recruit an in-house specialist on a part- or full-time basis?
- *Build on existing efforts and experience.* Is there an existing effort to encourage physician volunteerism (such as a free clinic) that could be expanded or modified? Is there a historical volunteer effort that was abandoned but provided lessons learned that might fuel a new effort?

State policymakers should identify specialties with widespread shortages, since communitywide physician shortages for certain specialties contribute to the access problems in many communities. Shortages in low-income areas could be exacerbated by any additional cuts in Medi-Cal that reduce provider reimbursement. State policymakers could, without cost, advise hospitals receiving disproportionate share



hospital funds to ensure that all the specialty services they provide are open upon medical referral to at least some low-income uninsured patients on a timely basis.

### **Longer-Term Implications for State and National Policymakers.**

State policymakers should consider the following:

***Assist and motivate communities to make local improvements.*** Because community support for the uninsured varies across communities, some are unlikely to address access problems for the uninsured—particularly for uninsured adults—without outside influence. Matching funds are an often-used tool to motivate local spending. (Only money raised from public or private sources that is above any local subsidy for the uninsured in the prior year should count toward a match.)

***Consider policy change to encourage physician volunteerism.*** To the extent that widespread shortages across the state are confirmed, state policymakers should consider actions that might prevent the uninsured from being shut out completely from those specialties in the shortage areas. A loan repayment program for selected specialists who serve shortage areas could be considered. Tax breaks for physicians who provide volunteer services in shortage areas could also be considered, for a portion of the value of the services they provide to the uninsured.

In addition, national policymakers should examine how rare or common the specialty care access problems are among the states. If the problem is national in scope, policymakers should consider changes similar to those mentioned for state policymakers.

### **Priorities for Further Research**

Additional research appears warranted in the following areas:

### **Reasons for Access Disparity in Communities in Which Hispanic Residents Make up 40 Percent or More of the Population.**

Analysis of census data, along with the FQHC medical directors survey, suggests that future research should explore the reasons for greater access problems to several specialties in communities with large Hispanic populations. The disparity in access could be attributable to: a more rapid increase in demand—for example if these communities' populations grew faster than others; greater problems in supply—for example if more providers are leaving or failing to set up practices in these communities compared to others; ethnic bias—for example if the Hispanic population is concentrated in the area around the FQHC and the existing providers in the broader area do not want to treat them. Other factors could also be at play.

### **Further Shaping Potential Policy Interventions.**

State policy options for addressing issues of specialist provider shortages and motivating change should be further explored in terms of stakeholder reaction, specifically how they could best be implemented, and what they might cost.

### **Research to Document the Hidden Costs of Under Use of Specialists.**

Logically, under use of specialists carries hidden costs that include greater hospital and emergency room use, economic costs such as lower productivity, more sick days, and possibly spillover effects to the next generation for adults whose conditions are not being addressed in a timely way. Even incarceration costs may be higher, if, for example, psychiatrists cannot be provided to evaluate and treat detainees with mental illness in a timely way. Further research could help identify these costs and thus help clarify why access to specialists for non-emergent care is

important for those who do not view expanding such access as a priority.

For example, American Medical Association data on physician supply could be used together with hospital discharge data and census data to explore whether and to what extent rates of hospital admissions for conditions that are sensitive to ambulatory care (such as diabetes) are higher for uninsured people in areas with sizable shortages of related specialist physicians. The data could help estimate the excess costs of hospitalizations from the status quo. Beginning in mid- to late 2005, new state data from emergency rooms should be available for use in examining the impact of specialist shortages on emergency room use for the uninsured with diagnoses indicating chronic conditions.

#### **Research to Document the Cost of Inefficiencies in the Current System for Uninsured Referrals.**

The finding that arranging specialty care services typically requires intensive case-by-case effort by

most providers of primary care for the uninsured suggests that this practice could potentially add significant cost to the current health care system, though, to our knowledge, the cost has not been estimated.

Further research could estimate the cost associated with the time and effort spent by FQHCs to link uninsured patients to specialists. For example, a sample of FQHCs could be asked to track personnel and time associated with these activities for a defined period (for example, a month). Greater recognition of this cost could help motivate policymakers, community leaders, and providers to develop a referral system that permits physicians to make referrals with greater ease. It may also help the FQHCs better demonstrate their productivity by taking into account the likely cost of these activities.

## Appendix: Review of the Literature and Methods

### Background

Numerous studies have explored the problems associated with a lack of insurance. The IOM's Committee on the Consequences of Uninsurance, which has been focusing on the scope of the problem in the United States, concluded that insurance is a key influence on whether an individual obtains health care. The uninsured, both children and adults, are much more likely than insured patients to forgo needed medical care even if they have serious or morbid symptoms.<sup>45</sup> This reduced access often leads to less appropriate care and poorer health outcomes. For example, uninsured individuals with diabetes are less likely to receive recommended services, such as regular foot or dilated-eye exams, and are at greater risk for additional chronic disease and disability.<sup>46</sup>

If uninsured patients lack the means to pay for services out of pocket, they must rely on safety-net providers for their health care needs. In this study, safety-net providers are defined as those that offer free or low-cost services to uninsured patients. Such providers typically include: hospitals, especially public or nonprofit hospitals; local health centers, including FQHCs; local health departments; private providers; and free clinics.

A few studies that have examined the safety net in California indicate some weaknesses in the system. For instance, a recent study funded by the California HealthCare Foundation examined charity care policies in 176 hospitals in California. The findings indicate that the majority of hospitals (90 percent) offer at least partial charity care and discounted services depending on a patient's income and resources; however, only 31 percent of hospitals extend charity care to patients with incomes up to 200 percent of the federal poverty level.<sup>47</sup>

Another study found that charity care in California tends to be concentrated in a small

number of hospitals.<sup>48</sup> Although such concentration may provide a clearer path to access for the uninsured, it can also make these hospitals more financially vulnerable, which could limit their ability to enhance access.<sup>49</sup> Another study of health care access in 13 states found that California's safety net is highly vulnerable because of the state's high number of uninsured, considerable commercial managed care penetration, large share of for-profit hospitals, and high percentage of enrollees in Medicaid managed care, but lowest capitation rates in the nation.<sup>50</sup>

National studies have shown that the ability of the uninsured to obtain care from safety-net providers varies considerably according to where the patient lives and what services are needed. One study found that the uninsured in some communities have more difficulty obtaining care than in other communities due to a variety of factors, including difference in the number and capacity of nearby safety-net providers.<sup>51</sup> Several studies have shown that the presence of safety-net hospitals and community health centers (CHCs) are associated with improved access.<sup>52</sup> Other studies have pointed out some of the shortcomings of the safety net. One study of ambulatory care found that safety-net providers are generally good at meeting the demand for maternal and child health services, but adult primary care and specialty care are more difficult to access, involving long wait times.<sup>53</sup> Similarly, a study of safety nets in 12 nationally representative communities concluded that access to specialty care was inadequate across most of the sites.<sup>54</sup>

These findings are particularly troublesome, given the importance of access to specialty services. Denial of needed specialty care can lead to hospitalization or adverse long-term health consequences.<sup>55</sup>

Because few studies of the safety net have focused specifically on access to specialty care services, evidence of the relationship between insurance coverage and access to specialty care is thin.

However, for several reasons, it can be speculated that the uninsured have a more difficult time seeing specialists than primary care physicians.<sup>56</sup> First, many uninsured patients rely on care from FQHCs even though these facilities do not have the expertise or the capacity to provide specialty care services. Although FQHCs are required to have links to specialists for patients needing specialty care, there is evidence of some weaknesses in the referral process.<sup>57</sup> There is no federally funded system similar to the FQHC model that focuses on the delivery of specialty care.

Second, the uninsured may have more trouble accessing specialty than primary care because private specialists may be less willing to provide free or reduced-cost care. This is because specialty care is often expensive, involving medication and resource-intensive procedures that could require hospital services.<sup>58</sup> Indeed, a study of Medi-Cal and Healthy Families health plans found that the plans had more difficulty securing and sustaining specialist participation than primary care participation.<sup>59</sup> However, a recent study funded by the Medi-Cal Policy Institute found that 48 percent of medical specialists in California accept new uninsured patients—a higher share than for primary care physicians.<sup>60</sup>

Finally, access to specialists may be limited in some areas because of short supply for both paying and nonpaying patients. Even in areas without a large uninsured population, one study showed that academic medical centers eliminated specialty care services for which reimbursement rates were relatively low (e.g., burn units, trauma care, pediatrics, and neonatal intensive care) in response to cost pressures.<sup>61</sup> Also, specialists may leave areas where hospitals require them to fulfill on-call obligations of affiliated specialists. Rural areas tend to have shortages of specialty care physicians because it is financially difficult to set up a practice in rural areas.

Despite these reasons to suspect that the uninsured, particularly those in underserved areas, lack adequate access to specialty care services, research has not thus far provided information on the extent or nature of this problem. This is a particularly salient issue in California, where the rate of uninsured is higher than the national average. The absence of good information on this issue is a particular problem for policymakers and others concerned with supporting the safety net.

## Methods

**Survey of FQHC medical directors.** Medical directors at all 101 of the FQHCs in California (both federally funded CHCs and FQHC “look-alikes”) were surveyed. Most of the medical director surveys were administered by telephone, although respondents could request a hard-copy version of the survey by fax or email. The survey consisted of ten questions (closed- and open-ended) and took respondents approximately 15 minutes to complete. Questionnaire items focused on the following three topics: the level of difficulty uninsured child and adult patients experience obtaining care in various specialties; specialties that are most difficult for uninsured patients to get; and differences in access by insurance type. Respondents were also asked to identify the three provider organizations in the community to which they most frequently refer patients for specialty care.

In September 2002, the survey was pre-tested with medical directors outside California who were randomly selected from HRSA’s “Primary Care Programs Directory.” Respondents were asked to complete the questionnaire by telephone and provide comments concerning its relevance and clarity. Feedback from the pre-test resulted in minimal changes to the survey.

In late October 2002, an advance letter was mailed from CHCF to all FQHC medical

directors in California, highlighting the purpose of the study and stating that MPR staff would contact them to complete the questionnaire over the telephone. The letter also provided a toll-free number that medical directors could call to complete the interview at their convenience.

MPR began calling the medical directors in November 2002. The initially strong response rate leveled off at about 45 percent after a few months. The primary problem was that medical directors did not have time at work to complete the survey. Concerned about reaching the target response rate, researchers halted the data-collection process from late January to early February 2003 to discuss ways to increase the response rate.

To boost response, researchers decided to offer respondents \$50 once they had completed the survey.<sup>62</sup> (Those who completed the survey before February 2003 were sent \$50 in recognition of their participation.) The interviewers' script was also revised to more heavily emphasize the study's relevance to medical directors. In addition, researchers began offering to contact the medical directors at home, as this had proved effective in other surveys of medical directors. Efforts to boost the response rate continued with a final mailing to non-respondents in March 2003. The package, sent by priority mail, included a revised cover letter, a hard copy of the survey, a postage-paid envelope, and a \$50 check. As a result of these efforts, the response rate increased quickly, and data collection was closed in April 2003, with a 76 percent response rate (101 eligibles, 24 refusals, and 77 completes). Because a 100 percent response was not achieved, the reported figures are estimates. Although standard errors or confidence intervals are not reported for each estimate, a rule of thumb is to consider each one plus or minus five percentage points.<sup>63</sup>

Only limited information was available for comparing communities represented by

respondents and non-respondents; however, the communities (defined by ZIP code) with FQHCs that responded did not differ substantially from those that did not respond in terms of: population density; percent of the population that was nonwhite; or percent of the population that was Hispanic (see Table 12). A slightly higher percentage of communities with responding FQHC medical directors was rural (having less than 100 persons per square mile) relative to that with non-responding FQHCs (29 versus 17 percent).

**Table 12. Characteristics of Responding and Non-Responding Communities**

	Responding Communities	Non- Responding Communities
<b>Population density</b>		
<100 per sq mi	29	17
100 >500 per sq mi	12	17
500 or more per sq mi	60	67
<b>Percent nonwhite</b>		
<30%	31	29
30 >60%	22	29
60% or more	47	42
<b>Percent Hispanic</b>		
<20%	44	33
20 >50%	30	38
50% or more	26	29

**Survey of hospital outpatient department directors.** The sample for the survey of hospital outpatient departments was derived from responses of FQHC medical directors, who were asked to identify up to three facilities in their community to which they most often refer uninsured patients. In several cases, more than one medical director identified the same hospital, and many respondents identified fewer than three hospitals. As a result, the sample for the hospital outpatient department survey consisted of 64 hospitals.

The survey items included both closed- and open-ended questions that focused on: the factors affecting a hospital's willingness or

capacity to serve the uninsured; the hospital's charity care policies; and what—in the minds of hospital outpatient department directors—were the most difficult specialties for uninsured patients to access. The primary mode of data collection was a hard-copy questionnaire with telephone follow-up.

The survey of outpatient department directors was pre-tested in November and December 2002, with participants from the hospitals identified by pre-test respondents in the survey of medical directors. However, since this selection approach did not yield a large enough sample of hospitals for the pre-test, the sample was supplemented with hospitals outside California identified through the *AHA Hospital Guide*. Four hospital outpatient department directors responded to the pre-test and were given \$50 for their participation. Their feedback indicated that a worksheet in the initial version of the instrument was too time-consuming, required input from several staff members, and requested information that often was not readily available. As a result, the worksheet was eliminated, making the final survey instrument a 12-item questionnaire that took approximately 15 minutes to complete.

Data collection for the survey of medical directors took longer than expected and delayed development of the sample for the survey of outpatient department directors. As a result, it was decided to conduct the survey of outpatient department directors in two waves. The first wave started in January 2003. Hospitals were called to obtain the name and contact information for the director of the outpatient department. If no such position existed, researchers worked with the hospital to identify the person most appropriate to complete the survey.

Each sample member in the first wave was mailed a packet containing a cover letter from CHCF, a hard copy of the survey, and a postage-

paid return envelope. The letter stated the purpose of the study, summarized the content of the questionnaire, and informed respondents that they would receive a \$50 check after completing the survey. Follow-up calls to sample members in the first wave began in February 2003. Response to the survey was slow. Sample members unfamiliar with CHCF were hesitant to participate. Others said they did not have the time to complete the survey, while still others simply seemed unmotivated.

Each of these issues was addressed during the second wave of data collection, which began in May 2003. The mailing included a revised letter, a hard copy of the survey, and a \$50 check. The revised letter provided a brief description of CHCF and its mission, and gave respondents the option of completing the questionnaire by telephone.

Data collection closed in November 2003 with a final response rate of 48 percent (64 eligibles, 33 refusals, and 31 completes). The characteristics of the hospitals represented by respondents and non-respondents were similar in terms of urban/rural status, average number of beds, average occupancy rate, average share of Medicare and Medicaid discharges (see Table 13). However, a higher percentage of responding hospitals were public hospitals (and a higher percentage of non-responding hospitals were investor-owned). The responding hospitals were also slightly less profitable.

**Case studies.** The third phase of the data collection effort involved case studies of four California communities. A community was defined as the major catchment area of an FQHC. The objective of the case studies was to gain practical insight into the barriers to specialty care access for the uninsured and to explore why some communities are better able than others to meet the demand for free or low-cost care than others. Case study communities were selected on the basis of the following criteria:

**Table 13. Characteristics of Hospitals by Response Status**

Hospital Characteristics	Respondents	Non- Respondents
<b>Number</b>	31*	33
<b>Ownership type %</b>		
Government	52	27
Other nonprofit	45	58
Investor-owned	3	15
<b>Teaching status %</b>		
Major teaching	17	21
Minor teaching	48	33
Non-teaching	34	45
<b>Urban/rural %</b>		
Urban	93	96
Rural	7	3
<b>Average number of beds</b>	331	296
<b>Average occupancy rate</b>	63	62
<b>Average Medicare percent of discharges</b>	21	27
<b>Average Medicaid percent of Discharges</b>	28	20
<b>Average Profitability Index<sup>†</sup></b>	6.5	5.2

Source: Solucient, profiles of U.S. hospitals, 2002.

\*Two respondents' characteristics were missing; 29 are included in this table.

<sup>†</sup>The profitability index is a 1 to 10 number representing the decile of the hospital's total profit margin considering all U.S. hospitals. Lower numbers are better.

- *Level of access to specialty care.* Researchers selected two communities with relatively good access and two with relatively poor access, according to results of the medical directors survey. This would allow exploration of possible reasons why some communities are better able than others to provide access, and factors that lend themselves to policy solutions. Medical directors were assured that their individual responses would not be publicly reported, so this report does not indicate which of the case study communities had relatively good or poor access according to survey results. This information is not essential to the report, since the case studies revealed that each community had characteristics that facilitated or impeded access. The objective was not to rank communities but to discern what policies and resources facilitate good access.
- *Presence of a responding FQHC.* The communities eligible for the study were those with an FQHC that responded to the survey by April 1, 2003, the cut-off date for site selection. A total of 63 FQHCs responded by that date.
- *Diversity in safety-net structure.* Access issues faced by the uninsured in communities with a safety net made up primarily of one large hospital system may differ from the issues faced by those in communities in which safety-net responsibilities are shared more evenly among a relatively large number of providers. For the study, communities were selected so that the sample would reflect a mix of safety-net structures.
- *Location.* Because visits to the four communities were to be handled in two trips (in order to keep within the project budget), two communities in Northern California and two in Southern California were selected.
- *Demographics* (qualitative assessment). Researchers tried to avoid selecting communities in which access to specialty care appeared to be good or bad solely because of the relative wealth of the area. Since most demographics pertain to the county level rather than the community level, this element was ascertained on the basis of discussions with key stakeholders in the local health system.
- *Willingness to allow researchers to recruit focus group participants.* The FQHCs needed to be willing to allow researchers to recruit focus group participants (described below) at their health center.

Before each site visit, researchers reviewed county-level census data for each community and searched the Web for other socioeconomic data and general information on the local health care system, such as the number of hospitals and clinics. They also attempted to interview the FQHC CEO, representatives from a local advocacy group, and the local medical association by telephone in each community. These pre-site interviews allowed them to both gauge whether the community met the participation criteria and identify important safety-net providers for the interviews.

Two members of the project team conducted two-day site visits to each community. To the extent possible, they tried to interview the same types of “core” respondents in each site, including the FQHC medical director, the major safety-net hospital emergency room director, a discharge worker, and the director of internal medicine. Recognizing that the structure of the safety net varies by community, researchers supplemented the core interviews with interviews with other respondents identified in the pre-site interviews as either providers important to the safety net or individuals knowledgeable about the local care provided to the uninsured (see Table 14). Interview protocols were tailored to each respondent type. Generally, these protocols

covered an overview of the local safety net; demand for specialty care services; barriers to specialty care; and federal, state, or local policies influencing access. During the interviews, researchers probed for more in-depth information on access to specialty services for uninsured patients suffering from the three focus conditions: childhood asthma, adult diabetes, and adult cancer (other than breast and cervical cancer).

**Focus groups.** Through focus groups with uninsured patients in each case study community, researchers sought insight into specialty care access from the consumers’ perspective. The findings were also used to supplement data collected from the surveys and site visit interviews. Focus group participants were recruited at the FQHCs with the permission of the CHC directors. Since the target focus group size was eight to ten participants, researchers attempted to recruit 16 participants in each community, assuming that several would be likely not to attend. Because the FQHC directors in two of the communities noted that the patient population was more than 50 percent Hispanic, recruitment and the focus groups were conducted in Spanish in those communities.

**Table 14. Number of Interviews Conducted, by Type of Organization and Community**

ORGANIZATION	COMMUNITY 1	COMMUNITY 2	COMMUNITY 3	COMMUNITY 4
<b>Pre-site interviews</b>				
FQHC	1	1	1	1
Local advocacy group	1	1	2	1
Medical association	1	1		1
<b>Onsite interviews</b>				
FQHC	2		1	1
Hospital	5	4	3	3
Local foundation		1	2	2
Health clinic	2	1		2
<b>Other*</b>	2	3	2	
<b>Total interviews</b>	14	12	11	11

\*Other interviews include private physicians, the local health department, county medically indigent program office, county mental health agency, and other local advocacy groups interviewed onsite.



In order to qualify for the focus groups, potential participants had to meet the following criteria: English/Spanish speaking (depending on the community); in need of specialty care in the previous two years; and uninsured when specialty care was needed. At least eight hours were spent recruiting participants at FQHCs. In three communities, when researchers were unable to recruit 16 participants after eight hours, they sought help from FQHC staff in two of the communities and from an advocacy organization in the third community.

The focus groups were held approximately one week after recruitment at the CHCs in three communities, and at a local hotel in the fourth because the CHC did not have conference space (see Table 15). One project team member led the groups while the other took notes. The focus groups were also voice-recorded. Participants were asked about their experience seeking specialty care services, including where treatment was requested and received, whether payment

was requested and/or made, and whether they were able to obtain all the care they needed for their condition(s). Participants were offered dinner during the session and were given \$50 for their participation. Attendance ranged from 5 to 13 participants. Each focus group ran anywhere from 90 to 120 minutes (including time for dinner).

*Secondary data sources.* Two secondary data sources were used in this analysis. Hospital data from Solucient (2003) supplied information on the characteristics of hospitals identified as safety-net providers and non-safety-net providers. The original data source is primarily hospitals' Medicare cost reports. Data available from the Census Bureau's website by ZIP code were used to compare respondent and non-respondent FQHC communities; to provide background information on the case study communities before the site visits; and to analyze differences in FQHC medical director survey results for rural and urban areas and for communities with different racial/ethnic compositions

([www.census.gov/epcd/www/zipstats.html](http://www.census.gov/epcd/www/zipstats.html)). Other census data that would have been useful, such as percent below poverty or other income statistics, were not readily available at the ZIP-code level.

**Table 15. Focus Group Participants, Language, and Location**

	NUMBER OF PARTICIPANTS		Language of Focus Group	Location of Focus Group
	Female	Male		
<b>Community 1</b>	6	0	English	Hotel
<b>Community 2</b>	3	2	English	CHC
<b>Community 3</b>	6	0	Spanish	CHC
<b>Community 4</b>	11	2	Spanish	CHC

## Endnotes

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23. Referral organizations could include hospitals, private physician practices, health centers, or other organizations.
24. In speaking with focus group participants it was difficult to know clinically whether a need always existed for specialty care, but the kinds of examples described by the participants seemed to indicate that specialty care was needed.

25. Private physicians collectively may also provide a high volume of care to the uninsured, but their role is likely smaller than that of hospitals and it was felt they would be more difficult to survey.
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34. Other types of organizations to which the responding medical directors refer include county-operated clinics, other community clinics, one independent practice association, one research foundation site, and a radiology group in Mexico.
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38. Researchers asked about the importance of negative financial margin and positive financial margin separately, because it was felt they might be viewed differently. For example, it might not matter to its charity care policies how much a hospital makes, as long as it is not "in the red."
39. Staff at the FQHC claimed that, counter to the agreement, the county physicians were completing the laboratory work at the hospital instead of sending it to the FQHC, and that some county physicians were sending bills to uninsured patients.
40. Each FQHC's community is defined as the ZIP code in which it is located. While the results point to important patterns across the participating communities, the survey data draw from a single respondent per community and should not be taken as the precise level of access for a given community. Therefore specific community responses are not identified in this report.
41. Rural is defined as a population density of fewer than 100 people per square mile.
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64. For example, one can be 95 percent confident that if 50 percent of the sample reported something, the true value would lie within 50 percent plus or minus 5 percent.