



Section H

Barriers to Access

BARRIERS TO SERVICE DELIVERY

The information presented in this Section of the Needs Assessment Report, drawn from extensive interviews and review of publications, support the following recommended actions to address system, funding, and operational barriers to the delivery of care to the Target Population.

Actions To Confront Barriers

- The Coalition and other key stakeholders in the delivery of care to the Target Population should maintain/escalate efforts to cause state and local governments to address the myriad of coverage and funding issues related to effective coverage of the Safety Net population. These are not issues that will easily be resolved, but persistence is essential. The recent decision to include qualifying adults in Healthy Families is evidence of success over time.

- Individual Community Clinics need to continue efforts to modify hours of operation to meet the needs of the Target Population. This needs to be a component of all expansion planning.
- The Coalition and other key stakeholders need to establish priorities for expansion and/or new site development in accordance with the findings in Section G of this report.
- Individual Community Clinics and other allies identified and enlisted by the Coalition must escalate efforts to cause local governments to address the transportation needs of the indigent population of Orange County. This barrier must be addressed to fully realize the potential of a coordinated system of care.
- The Coalition and other key stakeholders in the delivery of care should establish dialogue with the business community to explore ways of addressing the issue of employer-based and affordable basic private coverage for the working poor who are a significant component of the Target Population.

- As stated in Section E of this report, Community Clinics and other key stakeholders should:
 - Actively engage the leaders of the medical community to develop a reliable system of specialty care, dental care, and mental health care for the Target Population, and
 - Facilitate the parameters, terms, and conditions, including reimbursement methodologies, to assure accessibility and affordability of services.
- While many collaborative efforts currently exist, Community Clinics should focus on optimizing the benefits of teamwork with these key organizations. The Coalition, individual Community Clinic Administrators and staff should increase efforts of collaboration with ethnically-based advocacy groups to:

- Develop innovative programs for attracting bilingual persons into staff/volunteer roles in the Clinics,
- Inspire pursuit of education/careers in health care,
- Assist Clinic staff in developing greater cultural sensitivity, and
- Identify effective ways of overcoming ethnicity-based barriers to service delivery.
- Develop a multitude of health information and health education material in various languages that is culturally sensitive and at an appropriate literacy level. This process should include evaluation of all commercially available literature, evaluation and redesign of all forms, questionnaires, and other materials given to patients, and actual development and production of patient education material that can be used across the System of Care.

- The Coalition should proactively confront the “image” issue through initiatives to:
 - Adopt quality of care standards, and focus energy and expertise on continued development of a process for measuring and improving quality of care; and
 - Continue the current emphasis on development of the infrastructure to support collection and analysis of clinical data, as well as production and presentation of information regarding the quality of care and patient satisfaction; and
 - Ensure uniform, appropriate and effective involvement of qualified physicians to provide Medical Director oversight and protocols to mid-level practitioners; and
 - Implement a “public information” campaign that demonstrates the standards and performance of the Community Clinics.

- The Coalition should work with the Community Clinics to:
 - Initiate an aggressive fund development and grant application process to identify all available sources of funding consistent with the mission and philosophy of each Clinic; and
 - Urge and work with county officials to secure increased designation of Medically Underserved Areas (MUA) and Medically Underserved Populations (MUP) as a means of leveraging federal funding for delivery of services to the Target Population through qualification of additional Community Clinics as FQHCs and 330 Look-Alike clinics.
 - Provide the necessary administrative infrastructures to assist Community Clinics in pursuing all potential revenue sources; and
 - Provide an infrastructure and training to support Community Clinic financial and managerial operations; and

- Complete the development of a plan for a system of care that will address the structures, initiatives, and priorities for serving the Target Population.

BARRIERS TO SERVICE DELIVERY

During the process of interviewing Community Clinic Administrators, key stakeholders, and community leaders, and reviewing publications relevant to issues surrounding the delivery of health care services to the Safety Net Population in Orange County, numerous barriers were identified. These barriers emanate from various sources or causes, many have far-reaching ramifications. Some will not be easily remedied. However, they all do need to be acknowledged and addressed or they will remain impediments to building an effective system of care—particularly for the Target Population.

Patient Barriers to Access

Perceptions of the barriers precluding patients from accessing care when it is needed based on interviews with clinic administrators, key county stakeholders, and other community leaders and *pmpm*[®] analysis of relevant documentation and publications.

- ***Office Hours and Location***
 - Hours of operation need to be modified to better meet the needs of the Target Population. Popular opinion is that this means offering evening and weekend hours, but there may be other patient preferences to consider. Issues of not having paid time off work, obtaining convenient transportation, and obtaining childcare often preclude keeping follow-up appointments and, more importantly, accessing care at the onset of a health problem. This is a perceived barrier for all population segments. While some Community Clinics have been able to address this need, issues of funding, staffing and security have not been uniformly overcome.
 - In many neighborhoods and communities there is not an appropriate health care facility to serve this population. The lack of adequate distribution of Community Clinics sites on a location-specific basis is addressed in detail in Section G of this report.

- ***Office Hours and Location(continued)***

- Successful collaboration with the multiple school districts in Orange County to provide prevention and wellness programs has been limited. Access to school-age children is not only important for providing direct health and wellness education, but also as a means of building an understanding and acceptance of health care that can influence the entire family. There appears to be a resistance on the part of school boards to support the programs of the Community Clinics.

- ***Transportation***

- Input was received from nearly all interviewees regarding the inadequacy of public transportation to meet the needs of the indigent, working poor, and Senior populations. Perceptions are that there are insufficient routes, many requiring numerous transfers, limited operating hours, and inconvenient stops. Further, the consensus of respondents is that there is a great deal of apathy on the part of the Orange County Transit Authority regarding this public transportation issue. While this is not an issue the Coalition or its Community Clinics can directly impact, they must fulfill their advocacy role on behalf of their patients.

- ***Cost***

- There is a significant lack of affordable employer-based health insurance, particularly among smaller employers. This is coupled with a lack of affordable individual-based health insurance programs.
- While some Community Clinics have been able to develop a relationship with physicians for specialty referrals, the cost of this care was probably one of the most frequently identified barriers to an effective system of care for the Target Population. Need far exceeds the specialty physician services available on a sliding fee schedule. While some physicians in the community may now be engaged, overall it appears the leadership of the medical community is prepared to participate in system development when there is a specific proposed plan for some level of compensated services. The medical community will not spearhead a solution to this problem, but, if presented with a specific request, will respond.

- **Cost (continued)**

- Even when there are funding programs available to members of the Safety Net and Target Populations, they cannot easily navigate the complex and cumbersome eligibility and enrollment processes.
- When addressing the “affordability” or total cost of care to members of the Target Population, one must include transportation, childcare, and uncompensated time off work.

- **Economic Priorities**

- Patients’ economic conditions force choices such as paying for the essentials of daily living rather than seeking routine and preventive care. Choices are made to acquire food, housing and clothing rather than purchase health insurance.

- **Language and Culture**

- There is a lack of sufficient numbers of bilingual professional staff—particularly in specific fields such as dentistry and social services. This is an issue for all provider organizations including the Community Clinics.
- Because of the need to often rely on interpreters (staff, family, or others) it was reported that there often is a lack of understanding between providers and patients regarding care needs and care instructions. When there are interaction difficulties caused by this barrier, patients sometimes misinterpret this communication issue and instead ascribe it as an “unwelcome” environment.
- Many interviewees indicated the Community Clinics are more adept at dealing with these language barriers than are other providers.
- Many immigrants do not seek care for fear of exposure due to their undocumented status. Even many who meet all legal requirements may not feel confident of their status and avoid accessing health care services.

- **Language and Culture (continued)**

- Interviewees indicated that there are still many immigrants operating under an erroneous belief they may be held financially responsible for health care costs on a retrospective basis.
- In some cases patient ethnicity is a barrier. Latino/Hispanic patients are not comfortable at a clinic predominantly serving Asians, or Caucasian patients do not want to access a clinic where most patients are Latino.

- **Image of Community Clinics**

- Some interviewees indicated that members of the Target Population do not adopt a Community Clinic as their “health home” because they (the patients) perceive these providers to be of lesser quality—either because they are free or “low cost” or because they do not have “real doctors” on staff. It was raised in the interview process not only from the perspective of the perceptions of patients, but also in terms of how some community leaders perceive the quality of care delivered by some of the Community Clinics. The issue of the use of mid-level providers is also addressed in Section E of this report, where analysis of Community Clinic OSHPD data demonstrates that, while there is some variability by Region, physicians do provide between 50% and 80% of all general medical services in the Community Clinics. As stated in Section E findings: Community Clinics and key stakeholders in the system of care must confront the underlying inferences of substandard services regarding the utilization of mid-level providers and the quality of care provided by these practitioners.
- While most interviewees expressed confidence in the quality of care provided in the Community Clinics, some voiced concerns. This input was often directed at the lack of standardization across the Community Clinics, the perceived lack of uniform medical protocols, and the perceived lack of quality standards.

Barriers to Service Expansion

Barriers inhibiting the expansion of appropriate health care services for under-served populations are based on interviews with clinic administrators, key county stakeholders, and other community leaders and *pmpm*[®] analysis of relevant documentation and publications.

- ***Financial Constraints***

- The ability of the Community Clinics to adequately serve the Target Population is severely constrained by the **lack of sustainable funding sources** in the face of a growing under-served population, limited access to investment and administrative capital, and increased competition from non-safety net providers for access to constricting revenue streams. This is not an issue faced only by the Safety Net providers in Orange County. In their October 15, 1999, “blueprint for action”, the California Primary Care Association stated:

“Current reimbursement and capitation levels for patients with any payment source simply are not sufficient to underwrite the cost to CCHC (Community Clinics and Health Centers) of providing care to a growing number of uninsured patients. It is no longer realistic to expect that CCHCs serving large numbers of uncompensated patients can be self-sustaining. Rather, they must be directly supported in these efforts by foundations and others in a position to provide such support until such time as public policies are in place to fully support the cost of providing indigent care.”

The estimated market penetration rates presented in this report make it clear that there is a significant need for increased levels of funding if the Community Clinics are to substantially expand the level of service to the Target Population. In most cases the ability to increase capabilities and capacity through expansion of programs, space, and equipment has a long lead-time following the availability of funds. This barrier is one of the most significant facing the Coalition and member Clinics, and one that requires swift and effective action.

- ***Need to fully explore all revenue sources***

- Whether philosophically based, or due to lack of available resources or lack of perceived need, some of the Community Clinics have not **aggressively** pursued all possible avenues of revenue. There are numerous private and community foundations, corporations, and governmental programs devoted to health care access, finance and delivery that appear not to have been pursued as means to financially support the needs of Community Clinics in Orange County. It is important that all opportunities be explored to garner revenue—including, FQHC and 330 status, other Federal, State, and County specialty grants, as well as Robert Wood Johnson, California Endowment, and Kaiser Foundation grants to name a few sources. Influencing public policy to expand insurance coverage for the Target Population should be a focus of COCCC advocacy efforts.
- Similarly, some of the Community Clinics, other than the free clinics, are not staffed, trained, or equipped to pursue contracts to serve Safety Net patients enrolled in state/local programs and to bill for those services.
- COCCC will receive approximately \$5,710,000 per year from the Measure H funding source. Commencing with the 2000-01 fiscal year funds have been allocated for expansion of Clinics' services, and development of a Needs Assessment upon which to design of a System Of Care. COCCC's plan is to have all Measure H funds allocated for the System of Care services and initiatives by the fifth funding cycle—2004-05. At that time programs operating outside the System of Care will need to have identified other funding sources for sustainability. Even if all Measure H funding is fully utilized for development and support of the Community Clinics' System of Care, it will require a much greater commitment of financial resources in order to adequately care for the Target Population.
- There may be additional areas within Orange County that meet the requirements to be designated as Medically Underserved Areas (MUA) and Medically Underserved Populations (MUP), thereby leveraging federal funding available to provide services to the Target Population. Such designation could enable more Community Clinics to pursue qualification as FQHC or 330 Look-Alike clinics to access these federal funds.

- ***Operational Constraints***

- While many of the Community Clinics are now actively using the C2K information system sponsored and managed through the Coalition, there is still limited use of technology solutions to improve efficiency and effectiveness.
- While the nursing shortage is affecting all providers of health care services, for the Community Clinics this inability to recruit qualified mid-level practitioners extends to other health care and staff support personnel. Without the resources to provide competitive salaries and appropriate working environments it will continue to be difficult for the Community Clinics to attract and retain qualified professional and support staff.
- The physical location and/or construction of many of the Community Clinics prohibit expansion. Thus enhancing the level of service to the Target population may mean relocation or operation of multiple sites.
- While the Community Clinics have embarked on many collaborative efforts, there is considerable variability in their size, structure and organization that inhibits the level of consolidation, integration, and standardization that might be optimal in a system of care.