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*Preparing people to lead extraordinary lives*

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# Chapter One: Executive Summary

## INTRODUCTION

The healthcare landscape in Illinois has changed dramatically over the past several years in response to health reform at both the federal and state levels. In March 2010, the Patient Protection and Affordable Care Act (commonly referred to as the ACA) was signed into law. The ACA was passed with the goal of meeting the Triple Aim of: 1) improving patients' experience of care; 2) improving population health; and, 3) reducing the per-capita cost of healthcare. One of the major provisions of the ACA allowed for expanded Medicaid coverage, which went into effect in Illinois in 2014. The coverage expansion follows the state's shift to Medicaid managed care in 2012, a law change that required at least 50% of Medicaid recipients to either choose or be auto-assigned into managed care plans. Today, some three to five years after implementation of major federal and state health reforms, the safety net is still working to fully respond to these monumental shifts in health care financing and delivery.

This study extends previous research examining the impact of the Affordable Care Act on the safety net. Our analysis draws upon several years of experience in the reformed health care environment; extends the range of safety net actors to include Federally Qualified Health Centers (FQHCs), free and charitable clinics (FCCs), and safety net hospitals; and identifies challenges as well as potential solutions to the system-wide impacts of ACA implementation and other forms of health reform on Cook County's safety net, while also identifying future research needs.

## METHODS OVERVIEW

To examine the Cook County safety net, we used a cross-sectional, mixed-methods design that combined both quantitative and qualitative data in order to: 1) create current, provider-specific snapshots of FQHCs, FCCs, and safety net hospitals, 2) identify each safety net member's unique and common challenges after implementation of federal and state health reforms, and 3) uncover opportunities for philanthropy and policy to strengthen the overall safety net. Given how rapidly changes can occur during health reform implementation, it is important to note that this study was carried out three years after the federal Medicaid expansion and individual mandate provisions of the ACA took effect; four years after Cook County implemented its "CountyCare" program which allowed the Cook County Health and Hospital System (CCHHS) to enroll the Medicaid expansion population one year before the rest of the state; and five years after Illinois began the expansion of enrolling its Medicaid beneficiaries into managed care plans. Thus, the study was conducted at a stage of health reform implementation which could no longer be considered brand new, but had also not yet fully matured.

Our quantitative work, which formed the foundation of the portraits of each provider setting, involved secondary analyses of three separate data sets: 1) Illinois hospital emergency room utilization data spanning 2012-2015 for selected conditions (diabetes, asthma, and hypertension); 2) 2005-2015 data from Illinois health centers extracted from the federal Uniform Data System (UDS), an information system used by the U.S. Department of Health and Human Services (HHS) to monitor the performance of health centers nationwide; and 3) survey data reported by Illinois's free and charitable clinics as part

of a 2015-2016 national census survey undertaken by Julie Darnell, PhD, MHSA, one of this report's authors.

The qualitative work was conducted using convenience sampling in each of the above specified provider settings. For hospitals operating within the Cook County safety net, we conducted key informant interviews with four hospital executive leaders representing both public and nonprofit entities. For FQHCs, we conducted seven key informant interviews with executive leaders, conducted four focus groups of various FQHC staff, and carried out observations of clinic environments and patient/staff interactions at two separate FQHC locations. In total, we talked with 29 FQHC participants. For the free and charitable clinic sector, we conducted two focus groups involving 10 executive leaders of FCCs located in Cook County, as well as three focus groups encompassing 26 patients of FCCs based in Chicago. Regardless of provider setting, participants across all focus groups and key informant interviews were asked to complete a two-page questionnaire (see Appendices B and E).

## CROSS-CUTTING THEMES

FCC and FQHC providers, while operating under different models, have always grappled with the challenges of meeting their missions while balancing resource constraints and patient needs. Leaders, staff, and patients across the Cook County safety net system reported that the safety net needs increased coordination between providers, including community-based partners.

Each safety net sub-system shares a comprehensive knowledge of the vulnerable communities and populations residing within Cook County, which has enabled them to plan and respond effectively to the changing environment. Nonetheless, they reported that health reform has posed many **unanticipated** and **unintended consequences**:

- Navigation of the changing insurance and provider landscape has proved difficult for insured, underinsured, and uninsured patients, as well as for providers and their staff.
- The marketplace and many health services remain unaffordable, even though health care reform provided coverage to many previously uninsured residents.
- The safety net system recognizes the need for greater support of its quality improvement activities as well as enhanced capacity to respond to the demand for patient-centered care in a way that better addresses the social determinants of health. FCCs also need systems and standards for monitoring their patient population that are similar to the UDS for FQHCs.

These anticipated and unintended consequences have required FCCs, FQHCs, and hospitals to **constantly adapt to the reformed environment** and have revealed the **depth of each of the systems' organizational capacity and assets**. While at capacity and challenged, the safety net remains guided by its mission-driven instincts and extensive knowledge of the County's vulnerable populations.

## RECOMMENDATIONS

This study is unique from others that have examined the safety net in that we intentionally asked participants to discuss both the anticipated effects and the unintended consequences of health reform implementation. This distinct line of inquiry invited new questions as well as ideas and broadened areas

of research. Our preliminary project deepened our understanding of a small but representative sample of the Cook County safety net. In addition to recommendations for policymakers and philanthropy, our work also highlights the need for further research in order to best guide health reform and related policy.

### **HIGH PRIORITY POLICY RECOMMENDATIONS:**

At the federal level:

- Continue to implement and expand health reform and access to health insurance, including maintaining both the ACA and Medicaid while continuing to protect and improve access to quality health care for people served by the safety net, which is under increased threat in the current political climate.
- Further investment in the health care workforce is needed, particularly through the National Health Service Corps (NHSC). There is also a need to reduce the cost of higher education and health professions education, and make education and training programs more equitable and accessible.
- There is a need to reduce the number of annual patient quota requirements for FQHCs. This will allow providers to have more time with each patient, ensuring adequate time to provide the quality of care needed while simultaneously strengthening provider-patient relationships. To this point, free and charitable clinics—which are not constrained by the same kinds of productivity expectations manifest in a 15-minute visit in other health provider settings—illustrate the potential that exists for compassionate “human” care when providers have ample time with their patients.

At the state level:

- Reduce the number of MCOs and ensure that patient communication is clear and understandable.
- Medicaid rates need to be increased such that providers’ costs of service provision are covered. Both dental care and mental health services (such as psychiatry) were identified as areas where Medicaid rates are too low, thereby reducing the availability of these services.

### **PHILANTHROPY:**

Participants were asked to specify their top requests for additional funding from private foundations that would further strengthen the safety net and, ultimately, their ability to better serve vulnerable populations. Our findings led us to three overarching recommendations for private philanthropy:

- Facilitate and help support efforts that regularly bring together safety net providers, both within and across the diverse inpatient and outpatient provider settings.
- Provide general operating support.
- Provide targeted support in the following high-priority areas:
  - Connection to community resources;
  - Collection, reporting, and use of health information;
  - Staff training;
  - Utilization of community health workers;

- Equipment and physical plant updating; and
- Innovation and pilot program testing.

It is important to note that while private philanthropy and individual donations are important in helping to support the safety net, without continued federal and state-level support, these contributions will never completely fill the gap that public dollars are meant to fill. This is particularly true for equipment and physical capital updating.

## CONCLUSION

We conducted this project during the height of a national discussion about yet another potential transformation of health care in the United States. Despite widespread uncertainty, our findings underscore that whatever changes are to come, the health care safety net is comprised of dedicated, mission-driven, and talented professionals who serve hundreds of thousands of vulnerable and complex individuals each year. These systems are sources of excellence in healthcare and serve as anchors within their communities. However, they are in need of increased support in order to weather the storm of a constantly changing and demanding health care landscape. We should continue to monitor the impact on the safety net in Illinois and elsewhere across the country as further health reform unfolds.

# Chapter Two: Introduction to the Safety Net in Cook County

## INTRODUCTION

The purpose of a health care safety net is to work to guarantee the right to healthcare for all people. Research on the healthcare safety net within the context of substantial health reforms at both the federal and state levels is valuable, especially because recent years have marked a time of momentous change in terms of access to health insurance and other health reforms discussed in this report. Health reform also remains an unresolved and heated political issue, making ongoing monitoring and research critical to informing future decisions. What have been the unintended consequences of recent health reforms? Who remains uninsured and underinsured? What policy reforms are needed to advance access to high-quality and culturally responsive healthcare? What can policymakers, philanthropy, advocates, and the public do to advance health reform and ensure healthcare access for all? These are some of the overarching questions that stimulated this research.

The healthcare landscape in Illinois has changed dramatically over the past several years in response to health reform at both the federal and state levels. In March of 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law. The ACA was passed with the goal of meeting the Triple Aim of: 1) improving patients' experience of care; 2) improving population health; and 3) reducing the per capita cost of healthcare. One of the major provisions of the ACA allowed for expanded Medicaid coverage, which went into effect in Illinois in 2014. Coverage expansions began a year earlier in Cook County under the provisions of a Medicaid waiver, which allowed the Cook County Health and Hospitals System (CCHHS) to enroll patients in Medicaid under its "County Care" program; CCHHS successfully enrolled nearly 100,000 individuals in Medicaid in 2013. The coverage expansion followed the state's shift to Medicaid managed care in 2012, a law change that required at least 50% of Medicaid recipients to either choose or be auto-assigned into managed care plans. Today, some three to five years after implementation of major federal and state health reforms, the safety net is still working to fully respond to these monumental shifts in healthcare financing and delivery at both the federal and state level.

Understanding health reform as a process, this study sought to examine how the safety net in Cook County, Illinois has been affected by federal and state health reforms and the ways in which it is working to adapt to the reformed environment. We considered health reform broadly, including both the Affordable Care Act as well as significant changes that have taken place at the state level. This research was done in order to provide a portrait of the safety net during a period of change and uncertainty, as well as to identify ways that policymakers and the philanthropic community can help strengthen the safety net system overall. Our goal was to generate new information about what is happening in the post-ACA implementation era and to lay a foundation for future discussions about what can be done to reinforce the safety net.

In exploring the impact of health care reform and the adaptation of the Cook County safety net to it, we gave special attention to: 1) pinpointing the operational assets that the safety net can leverage to ensure its continued survival; and 2) identifying how policymakers and the philanthropic community can help the safety net succeed.



We defined the safety net broadly, including public and non-profit hospitals, Federally Qualified Health Centers (FQHCs), and free and charitable clinics (FCCs). Our study is distinct from other safety net research in that we encompassed both hospital and primary care providers in a single study, which allowed us to direct our attention to exploring the connections among different types of providers and permitted us to examine the safety net as a holistic system of care. Secondly, we extended our analysis of the primary care safety net beyond the well-known formal members (e.g., FQHCs) and deliberately included the less-studied free and charitable clinics.

Our study was guided by the following research questions: How has the implementation of major state and national health reforms impacted the healthcare safety net in Illinois, particularly in Cook County? What existing assets has the safety net leveraged (or what assets can be leveraged) to manage these policy changes? What opportunities or unintended consequences have emerged for the safety net in light of ongoing health reform?

To answer these questions, we used a mixed-methods study design, combining quantitative analyses of existing organizational data with qualitative analyses (case studies, key informant interviews, and focus groups) of a select number of safety net organizations.

Through collaboration between Julie Darnell at the Loyola University Chicago Stritch School of Medicine, Health & Medicine Policy Research Group (Margie Schaps, Sekile Nzinga-Johnson, Wesley Epplin, Tiffany Ford, Morven Higgins, and Nicole Laramée), independent consultants Susan Cahn and Peter Shin, and safety net providers across the County, we were able to better understand and analyze the current state of the safety net in Cook County and provide policy, philanthropic, and research recommendations for the future.

## BACKGROUND

This study extends previous research examining the impact of the Affordable Care Act on the safety net. Research conducted in fall 2014 on the Cook County Health and Hospital System and other safety net hospitals reported optimism about the future, while acknowledging significant challenges ahead.<sup>1</sup> Understandably, the healthcare landscape in Illinois has shifted dramatically since 2014 in response to both federal and state-level reform. Our late 2016 analysis draws upon nearly three years of experience in the reformed environment; extends the range of safety net actors considered to include FQHCs, free and charitable clinics, and hospitals; and identifies challenges as well as potential solutions to the system-wide impacts of ACA implementation and other health reforms on Cook County's safety net.

It is estimated that more than one million people in Illinois have gained insurance coverage under the ACA, either through Medicaid or the marketplace.<sup>2,3</sup> As a result, the percentage of Illinois residents in

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<sup>1</sup> Coughlin, T. A., Long, S. k., Peters, R., Rudowitz, R. & Garfield, R. Evolving picture of nine safety-net hospitals: Implications of the ACA and other strategies. (2015). *Kaiser Family Foundation Issue Brief*. 1-13. Retrieved from <http://files.kff.org/attachment/issue-brief-evolving-picture-of-nine-safety-net-hospitals-implications-of-the-aca-and-other-strategies>

<sup>2</sup> Kaiser Family Foundation. (2016). Marketplace enrollment as a share of the potential marketplace population. *Kaiser Family Foundation, State Health Facts*. Retrieved from <http://kff.org/health-reform/state->

2016 without insurance dropped to approximately 5%, down from 15% in 2013. Illinois’s current uninsured rate is significantly better than the national average of 8%. At the County level, Cook County’s uninsured rate of 5% is on par with the state. The highest uninsured rates in Cook County can be seen among the Black/African American and Latino/Hispanic populations (both 8%), while the lowest uninsured rates can be seen among Asian (5%) and White populations (3%).<sup>4</sup>

CCHHS was fortunate to apply for and receive a federal Medicaid waiver in 2013 that allowed individuals to enroll in Medicaid a full year earlier than the ACA’s 2014 enrollment period. CCHHS called their plan “CountyCare” and enrolled approximately 100,000 individuals in 2013.

At the state level, in 2014, Governor Quinn’s Administration proposed a large restructuring of the state’s Medicaid program, which became a federal Section 1115 Medicaid waiver application. However, the plan was derailed in 2015 when the new Rauner Administration took office and no longer supported the waiver. At that time, the waiver had been submitted to the federal government and was being negotiated, but these negotiations ceased with the state leadership change. While the failure of the waiver and the change in leadership have presented new challenges—including a budget impasse that has resulted in cuts to vital health and human services—the state has still been able to enroll over 50% of Medicaid recipients in managed care plans as mandated in a state law passed in 2012. This shift to managed care has resulted in changing patient and payer mixes for all safety net institutions as the state assigns individuals to specific primary care sites for care. Only 21% of Illinois Medicaid beneficiaries remain in a fee-for-service arrangement.<sup>5</sup>

Some national studies have illustrated that there has been a significant impact on safety net inpatient and outpatient systems and the care they provide since ACA implementation (most examining the first year of implementation). Implementation has led to a number of changes, such as a more complex patient mix that includes previously uninsured patients, stretching the capacity of many providers; allowed dozens of FQHCs across the country to develop new facilities; and expanded National Health Service Corps, which has had a positive impact on physician availability for safety net institutions. Hundreds of thousands of newly insured Illinoisans means that safety net providers who were previously the only choice for many patients now have competition and must change their operations to improve the patient experience. New regulations and the demands of new laws have forced new models of care onto already financially stretched systems. These and numerous other Illinois-specific impacts of the ACA and concomitant Illinois reforms—both those that are enabling and those that are challenging—will be unpacked in this study, which will outline both policy and funding supports needed to strengthen the safety net systems.

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[indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/?currentTimeframe=0](http://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0)

<sup>3</sup> Kaiser Family Foundation. (2016). Medicaid expansion enrollment. *Kaiser Family Foundation, State Health Facts*. Retrieved from <http://kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0>

<sup>4</sup> Enroll America. (2016). *Research & maps: Illinois*. Retrieved from <https://www.enrollamerica.org/research-maps/maps/state-profiles/illinois/>

<sup>5</sup> [Smith, V. K., Gifford, K., Ellis, E., Rudowitz, R., Snyder, L., Hinton, E., & Health Management Associates. \(2015\). Medicaid reforms to expand coverage, control costs and improve care: Results from a 50-state Medicaid budget survey for state fiscal years 2015 and 2016. Kaiser Family Foundation. Retrieved from http://kff.org/report-section/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-managed-care-reforms/](http://kff.org/report-section/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-managed-care-reforms/)

## LANDSCAPE OF THE COOK COUNTY SAFETY NET

The safety net in Illinois is large, diverse, and includes an array of providers, including hospitals, FQHCs, and free and charitable clinics.

Unlike many states in the U.S., over 90% of Illinois hospitals are not-for-profit. Chicago is home to one of the largest public hospital systems in the country, CCHHS, which is comprised of two hospitals, fifteen outpatient clinics, a public health department, and a jail health service. In addition to CCHHS, 15 other hospitals in Illinois meet the state's definition of a safety net hospital. The state defines safety net hospitals as those eligible for Disproportionate Share Hospital Payments through the federal government and that have a Medicaid Inpatient Utilization Rate (MIUP) of at least 50%, or a MIUP of 40% and a minimum 4% charity care.

Federally Qualified Health Centers were established as part of the "War on Poverty," and their roots can be traced back to the 1960s. Health centers are community-governed providers of comprehensive primary care. Today, there are more than 1,300 health center grantees operating more than 9,000 delivery sites across the country. As of 2015, there were 44 Illinois health center systems serving approximately 1.2 million patients. Currently, Illinois has over 350 FQHC sites and many are part of large systems; for example, Access Community Health Network has over 40 sites in the Chicago area.

Free and charitable clinics are defined as volunteer-based nonprofits that provide health services to the uninsured and medically underserved at either no cost or for a small fee. The nation's 1,000+ FCCs collectively provide approximately 4.3 million volunteer hours annually to nearly two million patients (approximately 2.4 volunteer hours per patient).<sup>6</sup> There are nearly 50 FCCs in Illinois. Of these, half are located within Cook County—concentrated mostly in the city of Chicago. The high number of medical schools in the Greater Chicagoland area has influenced the composition of the FCC sector in Chicago. FCCs are a heterogeneous group, ranging from all-volunteer clinics open one night a week to full-time operations with a large paid staff supporting a corps of volunteer providers.

Our study examined challenges that exist within each safety net provider type and sought to understand how each unique component of the Cook County safety net has responded to the reformed environment.

## METHODS

We conducted a cross-sectional, mixed-methods study of Free and Charitable Clinics, Federally Qualified Health Centers, and hospitals in Cook County, Illinois from November 2016 through January 2017. We used convenience sampling to select seven federally qualified health centers, nine FCCs, and four hospitals based on their size, distribution throughout the County, population served, and services provided. We conducted a combination of focus groups, key informant interviews, surveys, and observations with executive leaders, staff, and patients. Our use of multiple sites, sources, and data

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<sup>6</sup> Darnell, Julie S. (2010). Free clinics in the United States: a nationwide survey. *Archives of internal medicine.* (170)11 946-953.

collection methods increases the trustworthiness of our data. We have dedicated both a quantitative and qualitative chapter for FCCs, FQHCs, and hospitals to provide a statewide overview of each system and a deeper understanding of the ways health reform implementation is impacting the safety net in Cook County, Illinois.

*Below is a list of the substantive chapters:*

- **Chapter 3**...Overview of Free and Charitable Clinics in Illinois
- **Chapter 4**...Overview of Federally Qualified Health Center in Illinois
- **Chapter 5**...Overview of Hospitals in Illinois
- **Chapter 6**...In-Depth Qualitative Analysis of the Impact of Health Reform for FCCs
- **Chapter 7**...In-Depth Qualitative Analysis of the Impact of Health Reform for FQHCs
- **Chapter 8**...In-Depth Qualitative Analysis of the Impact of Health Reform for Hospitals
- **Chapter 9**...Analysis of the Cross-Cutting Themes That Emerged Across Chapters 6 Through 8
- **Chapter 10**...Recommendations and Future Directions

## **POLITICAL CONTEXT**

This research took place during a period of significant political change. At the time of this report, Illinois was going through its second year without a state budget, which has slowed or in some cases stopped payments for health and social services, impacting all types of health and social safety net providers. The change in governors in 2015 also led to shifts in several state health reforms by Illinois's Executive Branch, which resulted in further uncertainty. In addition, this study began during a heated national debate over health reform heightened by the 2016 presidential election. The resultant uncertainty as to the future direction of health reform significantly impacted the conversations in this study both before and following the election. Widespread concerns regarding threats to the safety net and to specific marginalized communities were also an issue that surfaced during the study, which occurred in the midst of the 2016 presidential election and at sites serving these marginalized communities. That national health reform remains a subject of contentious policy debate makes this research all the more relevant for policymakers, philanthropy, and the public at large.

## **APPLYING THIS PAPER TO YOUR WORK**

The authors of this research hope that it will provide new insights for policymakers, foundations, health advocates, researchers, and the general public. It is our hope to build upon this study and its findings through future research, which is outlined in Chapter 10. Also, the authors encourage discussion and feedback from readers and hope that readers will contact our research team leaders Julie Darnell (Loyola) and Margie Schaps (Health & Medicine) to offer insights, perspectives, and questions, as we intend for this research to contribute to ongoing conversations about health reform at the County, state, and federal level.

# Chapter Three: Overview of Free and Charitable Clinics in Illinois

## INTRODUCTION

With the passage of comprehensive health reform at both the national and state levels, the entire health system has undergone profound change. As the front-line providers to low-income and vulnerable populations, the healthcare safety net has, of course, been swept up in these broader health system reforms, as the reforms themselves have targeted low-income and vulnerable populations and, to varying degrees, the organizations as well. The safety net is generally thought to include a host of organizations such as federally qualified health centers (FQHCs), public and private hospitals serving a disproportionate share of Medicaid and uninsured patients, free and charitable clinics, state and local public health departments, family planning agencies, school-based health centers, etc. While continuing to fulfill their missions to serve those who are vulnerable and underserved, these safety net providers nonetheless have been affected greatly by health reforms and have had to figure out how to adapt to the reformed health system.

In order to fully understand the impact of health reform and the safety net's reaction, it is necessary first to have a clear picture of the nature of the safety net and the contribution each member makes to it. While other chapters will profile hospitals and FQHCs, this chapter considers free and charitable clinics, perhaps the least well-known member of the safety net.

Free and charitable clinics have been called the "safety net for the safety net" yet little is known about them compared with their better-studied counterparts, FQHCs. A chief impediment to amassing knowledge about the free and charitable clinic sector is the lack of a regular data source akin to the Uniform Data System, the dataset used by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services to collect performance measures about health centers. Health centers are required to report annually to HRSA, producing a steady stream of information about their clinics' operations, patients, services, revenues, costs, and outcomes. No such data source exists for free/charitable clinics.

Another limitation to studying free and charitable clinics stems from having no comprehensive list of all free and charitable clinics. In the absence of any federal regulatory requirements imposed on free/charitable clinics, the federal government keeps no such list, except for a subset of roughly 200 free clinics that participate in the federal government's medical malpractice program under the Federal Tort Claims Act (FTCA). Some states, like Florida and Georgia, keep lists because free/charitable clinics are receiving a state appropriation, or as in the case of California, the state tracks outpatient clinics by type.

Yet another challenge is the lack of a standard definition of a free and charitable clinic. For the purposes of administering the FTCA medical malpractice program, the federal government has a fairly strict definition of a free clinic that recognizes only those clinics that charge no fees whatsoever and are not involved in third-party billing. But their definition is not the only definition accepted by the free and charitable clinic provider community. In fact, there are numerous (one national, 21 state) free and

charitable clinic member associations which have adopted more lenient definitions. While each membership organization uses a slightly different definition of a free/charitable clinic to award membership status, the various definitions coalesce around the following core characteristics of free and charitable clinics:

- Private, nonprofit entity or part of an entity that has a tax-exempt status;
- Supported by volunteers;
- Charging no fees, nominal fees, or low fees directly to patients for services;
- Providing a range of healthcare services, including medical, dental, mental, and behavioral health;
- Mission to serve the uninsured and underserved;
- Supported by private sources of funding; and
- Not otherwise designated as a FQHC or Rural Health Clinic.

In general, “free” clinics follow the more classic (federal) definition in which services are provided at no cost to patients while “charitable” clinics charge a fee, though in practice some free clinics in fact charge nominal fees, say \$2 per prescription, but still call themselves a free clinic. There is no universal consensus about what constitutes a free clinic and what constitutes a charitable clinic, and the sector mostly sidesteps making a distinction between them in favor talking about free *and* charitable clinics together. The sector also has not developed clear boundaries concerning the upper limit of patient fees or on third-party billing as a percentage of revenues. Thus, whether a clinic ought to be considered a free or charitable clinic will depend on a clinic’s own interpretation of its organizational identity and, where applicable, the criteria used by the free/charitable clinic membership organization. The imprecise nature of the sector makes free and charitable clinics a difficult sector to study, but their fluidity also makes them organizationally nimble, an especially advantageous asset during times of uncertainty and change.

## METHODS

To portray free/charitable clinics in Illinois and overcome the many data collection challenges noted above, this study leverages a one-of-a-kind national data set of free and charitable clinics that has been developed by Julie Darnell of Loyola University Chicago with support from AmeriCare (through funding from the General Electric Foundation) and the National Association of Free & Charitable Clinics. In brief, the national dataset is a census of all known free and charitable clinics in the United States plus a cross-sectional portrait of a sample of free and charitable clinics during 2015 and 2016. The census contains a listing of all known free and charitable clinics and their geographic locations (compiled from dozens of sources). The portrait is derived from a national census survey, which is still underway but near completion. Survey administration began in mid-July 2015 and will conclude at the end of February 2017. Over the course of the survey administration period, more than 1,300 free and charitable clinics have been invited to participate in the web-based survey. To date, 831 have responded.

The questionnaire was based on previous survey of free clinics that was developed and administered in 2005-2006,<sup>7</sup> but unlike its paper-and-pencil predecessor, the 2015-2016 survey was designed to be completed online. Dozens of practitioners in the free and charitable clinic sector provided input and feedback on draft versions of the survey. The survey instrument was pilot tested in 17 clinics before it was finalized. The final survey collects comprehensive information concerning eight topical areas: clinic characteristics; quality and health information technology; cost of care; patients; services; staff and volunteers; future plans; and the impact of the Affordable Care Act.

For this study of free and charitable clinics in Illinois, we extracted the survey data reported by the subset of free and charitable clinics from Illinois. We identified 47 free and charitable clinics operating in Illinois during the survey administration period. Of these, 31 have completed the survey (response rate=66%), though one organization ceased operating its free medical clinic after taking part in the survey. Because we have elected in this profile to omit responding clinics that have closed, the analysis of survey results includes just 30 clinics.

## RESULTS

### ILLINOIS CENSUS

There are 46 known free and charitable clinics currently operating in Illinois, as shown in Figure 1. These 46 clinics are situated in 16 counties across the state, though a clinic's service area likely reaches beyond its own county. Cook County is home to more than half of all clinics (n=24) (see Figures 2), with the vast majority (n=20) concentrated in the City of Chicago. Though only 23% of Illinois's population resides in Chicago, a much higher percentage of Chicago's population is uninsured compared with the state as a whole (18.5% in Chicago vs. 8.1% in Illinois), and Chicago has a much higher percentage of persons in poverty (22% vs. 13.6%). In addition, Chicago has an abundance of medical schools and health professions training programs, which provide favorable supply conditions for starting a clinic and for attracting volunteer providers. Thus, both the supply and demand conditions make Chicago a more likely location to find a free or charitable clinic.

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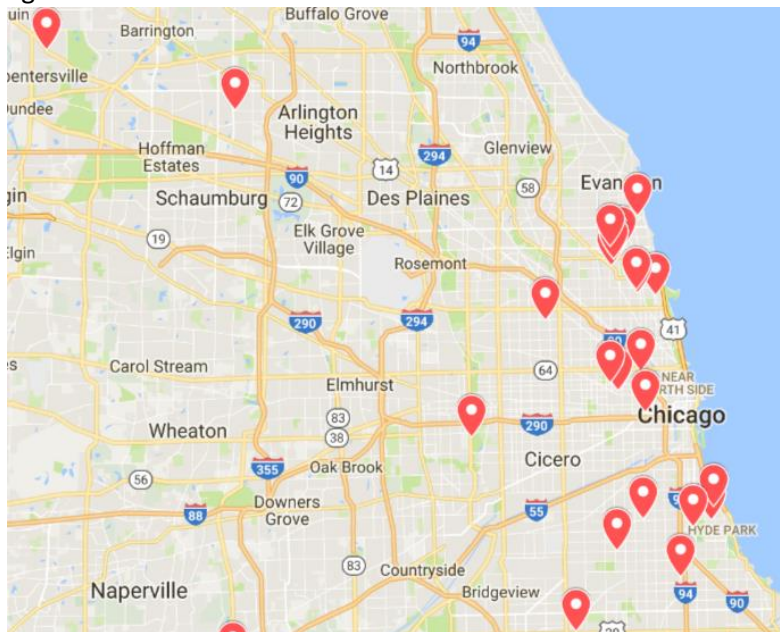
<sup>7</sup> Darnell J.S. Free Clinics in the United States: A Nationwide Survey. (2010). *Archives of Internal Medicine*, 170(11), 946-953.

Figure 1: Distribution of Free and Charitable Clinics in Illinois and their Corresponding County Locations



Champaign (4)
Cook (24)
DuPage (1)
Fulton (1)
Kane (1)
Kankakee (1)
Lake (2)
Lee (1)
Livingston (1)
McHenry (1)
McLean (2)
Macon (1)
Peoria (1)
Sangamon (1)
Will (2)
Winnebago (2)

Figure 2: Distribution of Free and Charitable Clinics in Cook County





## CLINIC CLOSURES, MERGERS & ACQUISITIONS

Over the past decade, the free and charitable clinic sector in Illinois has undergone significant changes in the number and composition of its clinics. These changes have largely involved clinic closures and mergers. Specifically, 13 clinics, including the one mentioned above, have closed. Some closed in anticipation of the ACA and some reportedly as a consequence. Others closed due to reasons seemingly unrelated to the ACA, such as the death or retirement of the founder or the costs of medications and overhead. Mostly, however, Illinois's clinic closures appear to be related to declining patient volume due to the health insurance coverage expansions through Medicaid and the marketplace as well as expanded capacity from newly-opened FQHCs sites. Distinct from closures, five free clinics have merged their operations with FQHCs. In one case, the FQHC named the resulting satellite site after both the FQHC and the free clinic, and the FQHC continues to acknowledge the free clinic's commitment to compassionate care. Mergers have not just occurred between free clinics and FQHCs. There is one example of one free clinic merging with another, which led the "receiving" clinic to open a second satellite site to better accommodate patients from the free clinic that ceased its operations at its original location.

## CLINIC FOUNDINGS

While some clinics have closed permanently, others have opened. Since 2010, when the Affordable Care Act was signed into law, among the 30 clinics responding to the survey, five new clinics have been founded, each in a different city across the state: Aurora, Bloomington, Chicago, North Chicago, and Peoria. Reflecting the diversity of the sector, three of the new clinics are student-run, one focuses on specialty care, and another is faith-based. Overall, responding clinics vary in age. The oldest clinic dates to 1971 and the youngest clinic was founded in 2016. The mean founding date of clinics is 2000, and half of all clinics were founded after 2003.

**Key Finding: The free and charitable clinic sector in Illinois is dynamic and vibrant. Brand new clinics replace closed clinics, and while other clinics have decided to change organizational form in response to environmental opportunities, they have nonetheless enhanced the capacity of the newly-formed entities to serve the uninsured and underserved.**

## CLINIC CHARACTERISTICS

The free and charitable clinic sector is a study in diversity. The sector includes clinics that are free, charitable, and hybrid; young and old; faith-based and secular; student-led and staff-led; full-time and part-time; bricks-and-mortar and mobile; large and small; all volunteer-run and staff-based; walk-in and scheduled; medical and dental; primary care and specialty care. What they have in common is a reliance on private donations for operating support, in-kind contributions for goods and services, and volunteer providers to deliver care.

### Types of Clinics: Free, Charitable, and Hybrid

Clinics were eligible to participate in the survey if they were a free clinic or a charitable clinic. We also included a subset of free/charitable clinics that are known as “hybrid” clinics, which are defined as free/charitable clinics that bill a third-party payor, typically Medicaid (see Figure 3).

Figure 3: Survey Definitions of Free Clinic, Charitable Clinic, and Hybrid Clinic

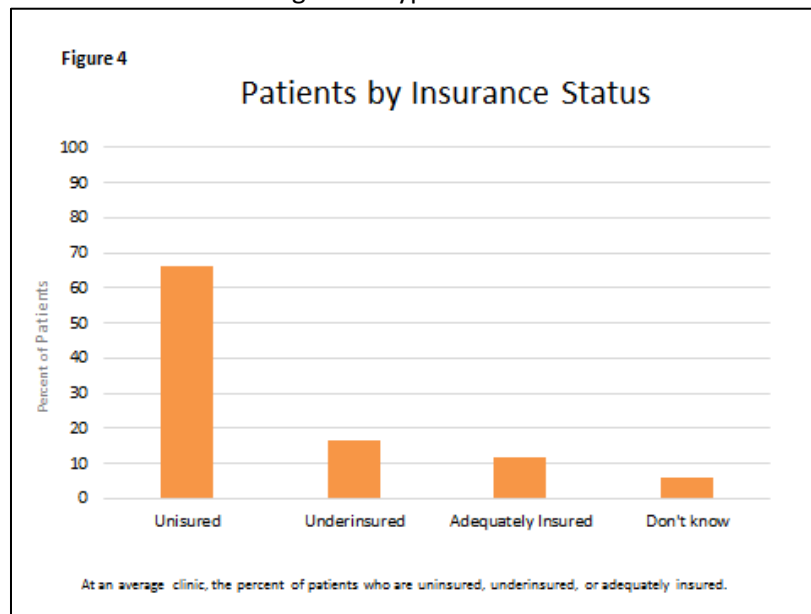
**Free Clinic:** The nonprofit clinic provides all goods and services at no charge directly to uninsured and/or underserved patients. “Services” include medical, dental, mental health/behavioral health, and/or medications. Clinic may request or suggest donations. Clinic does not bill any third-party payers, including Medicaid, Medicare, or commercial insurers. Clinic may be bricks-and-mortar clinic or mobile unit.

**Charitable Clinic:** The nonprofit clinic provides goods and/or services for a fee directly to uninsured and/or underserved patients. “Services” include medical, dental, mental health/behavioral health, and/or medications. Clinic may use a flat fee or sliding fee scale. Payment from the patient is expected at the time of service, and may or may not be waived if the patient has no ability to pay. Clinic may bill patients but does not bill any third-party payers, including Medicaid, Medicare, or commercial insurers. Clinic may be bricks-and-mortar clinic or mobile unit.

**Hybrid Clinic:** The clinic is a free clinic or charitable clinic as defined above, except that it also bills one or more third-party payers, such as Medicaid, Medicare, or commercial insurers. Clinic has not been designated as a Federally-Qualified Health Center (FQHC), FQHC Look-Alike, or Rural Health Clinic.

In Illinois, as depicted in Figure 4, responding clinics are overwhelmingly free clinics (80%). Four clinics (13%) described themselves as “hybrid” clinics and just two (7%) as “charitable” clinics.

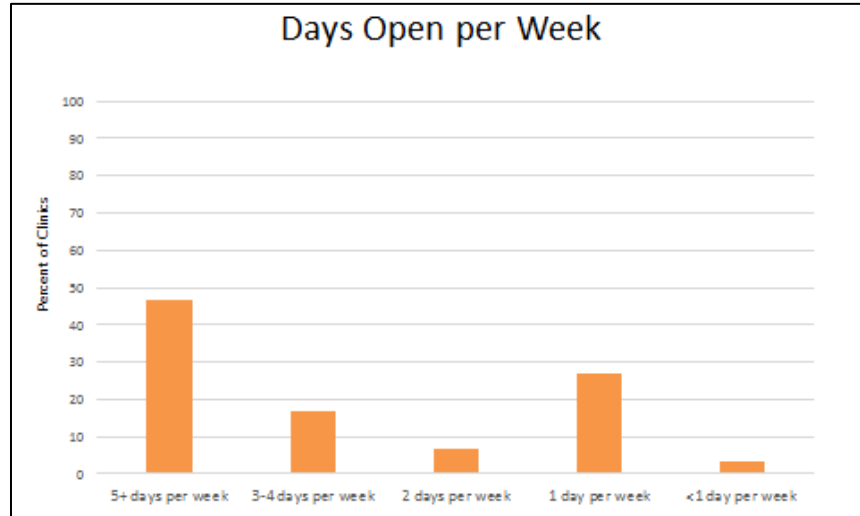
Figure 4: Types of Clinics



## Hours Open

Clinics' capacity to treat patients varies widely (Figure 5). Clinics are open to see patients, on average, 3.3 days per week (median = 3.5 days). The hours open ranges from about a .5 day per week to 5 days per week. Nearly half of clinics report being open to see patients five or more days per week. And on the other side of the spectrum, 30% of clinics are reportedly open one day per week or less frequently.

Figure 5: Days Open per Week

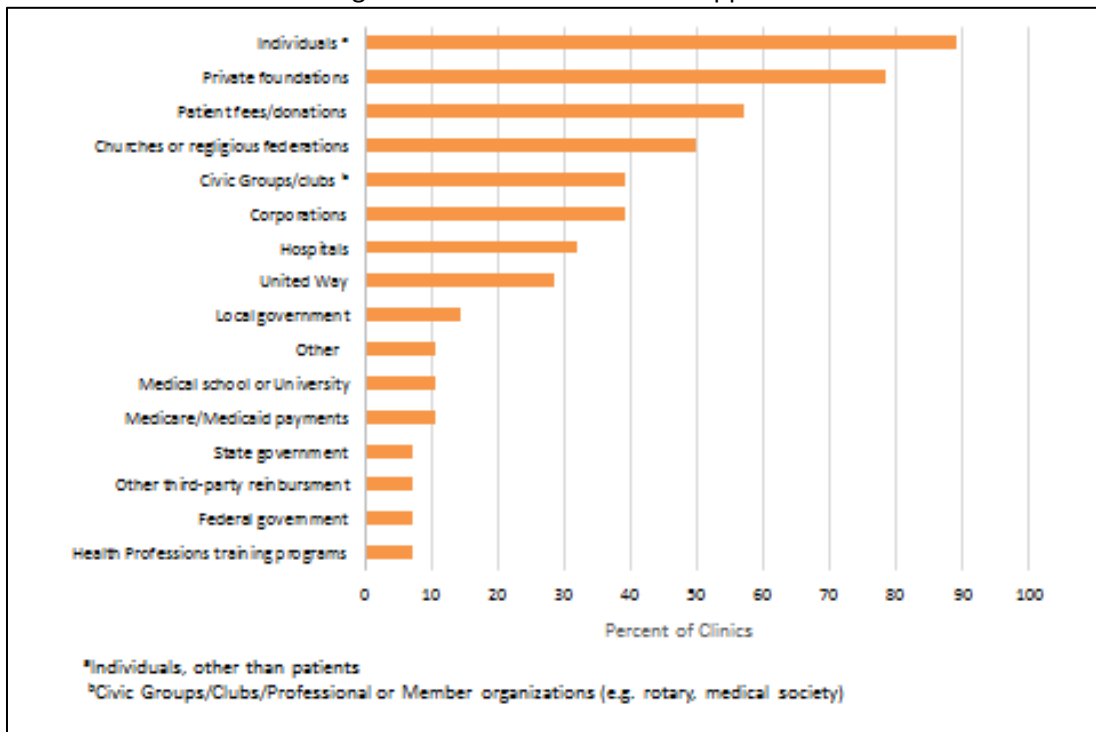


## Budgets & Financial Operating Support

In light of the large variation in operational capacity, it is not surprising to find that the sizes of clinics' operating budgets also vary considerably, ranging from \$700 to nearly \$3 million. The mean reported cash budget (excluding in-kind donations) is \$405,790. Half of all clinics have budgets below \$253,652, suggesting that the underlying distribution of budgets across clinics is positively skewed with larger clinics pushing up the mean.

Clinics rely on multiple funding sources to support their operations, as shown in Figure 6. Of the 16 different funding sources queried on the survey, clinics reported a mean (and median) of five. The number of funding sources ranged from zero to 12. The most frequently cited source of funding is individuals (other than patients); more specifically, nearly 90% of clinics reported receiving funding from individual donations. A majority of clinics cited private foundations (79%) and patient fees or donations (57%). Exactly half reportedly receive funding from churches or religious federations. Nearly two in five clinics mentioned corporations as well as civic groups/clubs/professional or member organizations, such as the Rotary or a medical society. One-third acknowledged financial support from hospitals. Less commonly reported are support from a medical school or university (11%) and health professions training programs (7%). Among government sources, just two clinics (7%) reportedly receive funding from the federal government, two clinics receive funding from state government, and four clinics (14%) cite funding from local government sources. Medicaid/Medicare payments and other third party billing is reportedly a source of funding for 11% and 7% of clinics, respectively.

Figure 6: Sources of Financial Support



**Student-Run Clinics**

With eight medical and osteopathic schools, Illinois has an unusually large number of medical professional training programs. Reflecting this environment, nearly one in five (17%) of the responding clinics identified themselves as “student-run.” Typically in these settings attending physicians supervise students in direct patient care but leave the administrative tasks to the students. Oftentimes the students take responsibility for health education activities as well.

**Faith-Based Clinics**

Many free and charitable clinics are faith-based. However, contrary to conventional wisdom, the majority of clinics are secular. Slightly more than one-third of clinics are reportedly faith-based. Of the 11 clinics declaring a faith tradition, the most frequently cited is Christian, accounting for about three-quarters of all clinics with a religious affiliation (27% Catholic, 45% Protestant). Two clinics (18%) are affiliated with the Islamic tradition and one clinic (9%) has a Jewish religious tradition.

**Type of Clinic Space**

Clinics vary considerably in the kind of space they occupy, from bricks-and-mortar clinics to mobile units. Most responding clinics operate from permanent structures, but four clinics (14%) are mobile units. Nearly 40% of clinics report running their clinic in a facility that they own, with another 25% reporting that the clinic inhabits rented space. Just over one in five clinics reside in borrowed or donated space.

**Key Finding: The Illinois free and charitable clinic sector is highly heterogeneous, embracing clinics that are: free, charitable and hybrid; young and old; faith-based and secular; student-led and staff-led; full-time and part-time; bricks-and-mortar and mobile; large and small; all volunteer-run and staff-based; and walk-in and scheduled. They share in common a reliance on private (not public) sources of funding and in-kind contributions.**

## **PATIENTS**

**Key Finding: Illinois’s 46 free and charitable clinics annually serve approximately 100,000 patients each year, including almost 20,000 new patients.**

### *Volume of Patients*

The responding free and charitable clinics in Illinois report serving, on average, 1,650 unduplicated patients per year, of which 775 (47%) are estimated to be new patients. This would suggest that the 46 clinics in the state collectively serve nearly 100,000 patients annually. Furthermore, it suggests that almost 20,000 new patients enter a free or charitable clinic every year.

### *Relationship with Patients*

Overwhelmingly, responding clinics characterize the relationship they have with patients as “ongoing” rather than “episodic.” Specifically, slightly more than three-quarters say that their clinic provides repeated care to the same patients whereas about one in five clinics say either that their patients rarely use the clinic more than once (7%) or that the clinic provides intermittent services to patients (15%).

### *Characteristics of Patients*

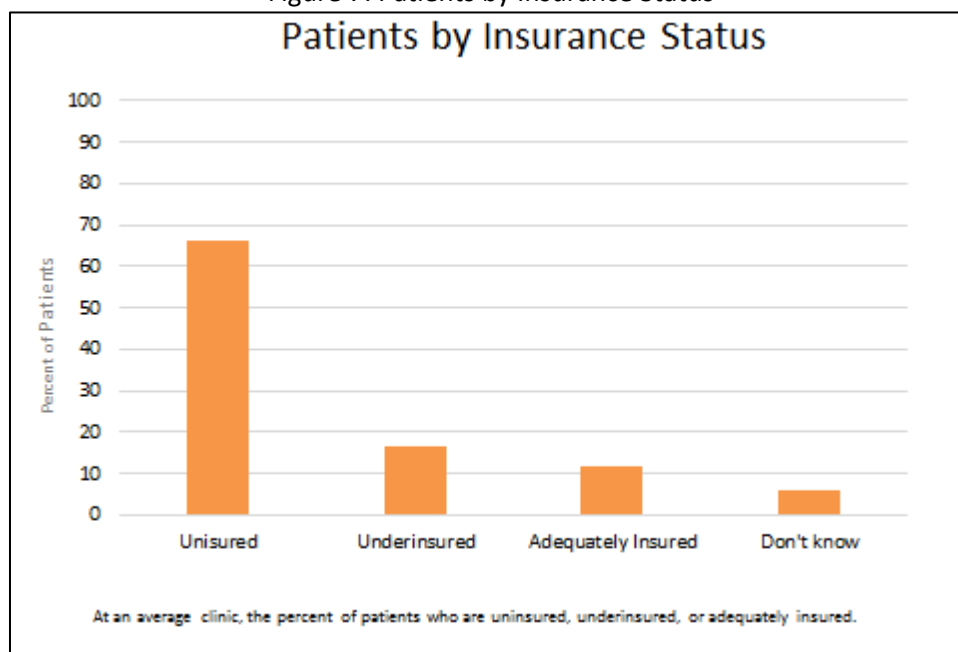
In general, free and charitable clinics serve patients who possess one or more attributes that are known to impede their access to care, such as member of a racial/ethnic minority group, lack of health insurance, inability to pay, transgender and gender nonconforming status, non-citizen status, lack of housing, and cultural barriers. In addition, clinics increasingly have developed patient eligibility screening criteria (e.g., insurance status, income, and geographic location) as mechanisms to target their limited resources to their most needy patients and manage patient demand with respect to their capacity constraints.

### *Health Insurance Status*

Historically, screening based on health insurance status has been the most common type of eligibility test adopted by clinics. In Illinois, 38% of clinics report seeing only patients who have no insurance coverage. A similar percentage (35%) of clinics reports having no screening based on health insurance

status. The insurance coverage expansions and mandate under the Affordable Care Act has prompted some clinics to revisit their health insurance eligibility criteria to take account of the “under-insured” population. More than half (55%) of clinics report seeing patients who are underinsured because of unaffordable coverage or are underinsured because of uncovered services. At an average clinic, 66% of patients are reportedly uninsured, 17% are underinsured, and 12% are adequately insured (Figure 7). The finding of only two-thirds of patients having no insurance represents a significant departure from earlier national estimates of 92% uninsured.<sup>1</sup>

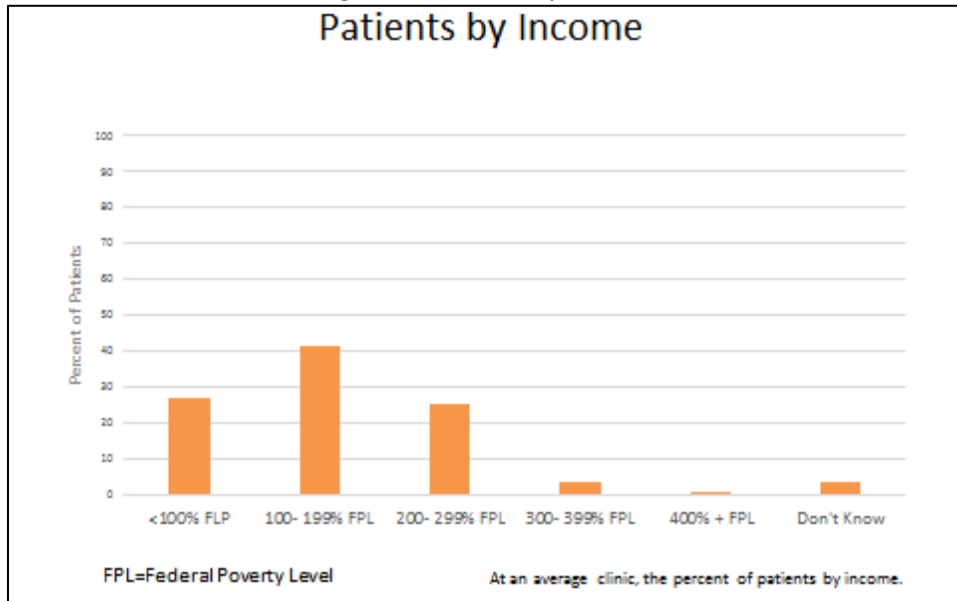
Figure 7: Patients by Insurance Status



### Income

Income, like health insurance, is sometimes used as a condition of eligibility. In Illinois, nearly one-third of responding medical clinics report requiring patients to meet certain income requirements in order to receive medical services. Among the clinics that screen patients based on income, the maximum income allowed ranges from 185% Federal Poverty Level (FPL) to 400% FPL, and the average is about 250% FPL. Clinics estimate that about one-quarter of patients have incomes below 100% FPL, 41% have incomes between 100-199% FPL, 25% have incomes that are 200-299% FPL, and just 4% have incomes at 300-399% FPL (Figure 8). Thus, nearly two-third of free and charitable clinic patients would be considered to be “poor” or “near-poor.”

Figure 8: Patients by Income



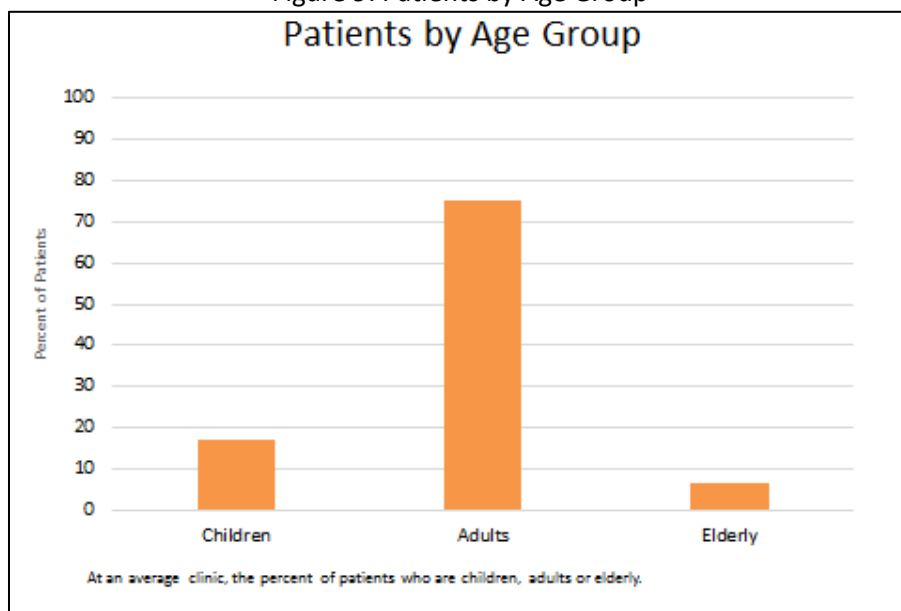
### Gender

Males and females constitute an equal share of patients seen by free and charitable clinics in Illinois. At an average clinic, exactly half of patients seeking care at free and charitable clinics are female and half are male. This overall clinic average masks, however, the within-clinic variation by gender. Across clinics, the percentage of patients who are female ranges from 8% to 70%, and the percentage of patients who are male ranges from 30% to 92%, suggesting that some clinics are either predominantly male or predominantly female.

### Age

Most of the patients receiving care at free and charitable clinics are low-income adults ages 18-64 (Figure 9). In fact, at an average clinic, 75% of the patients are reportedly nonelderly adults. All responding clinics reported serving nonelderly adults to some extent. Given that free and charitable clinics target their services to the uninsured, the focus on nonelderly adults makes sense because this age group is more likely to be uninsured than poor children, who are eligible either for Medicaid or the Children's Health Insurance Program (CHIP), and adults 65 and older, who qualify for Medicare. Though the sector targets the nonelderly adult population, 42% of clinics reported serving children. Overall, clinics estimate that nearly one in five patients are children (17%). These findings suggest gaps in access for a population that has near universal access to insurance. Illinois's All Kids program covers children up to 18 regardless of immigration status with incomes up to 318% of the federal poverty level (with cost-sharing above 147% FPL). Far fewer patients, on average, are elderly (7%). More than half of the clinics reported seeing some elderly patients, presumably because some elderly fall through the cracks due to factors such as ineligibility due to immigration status; not enrolling in Medicare Part B (medical insurance), which covers services and supplies; or trouble affording medications under Medicare Part D.

Figure 9: Patients by Age Group

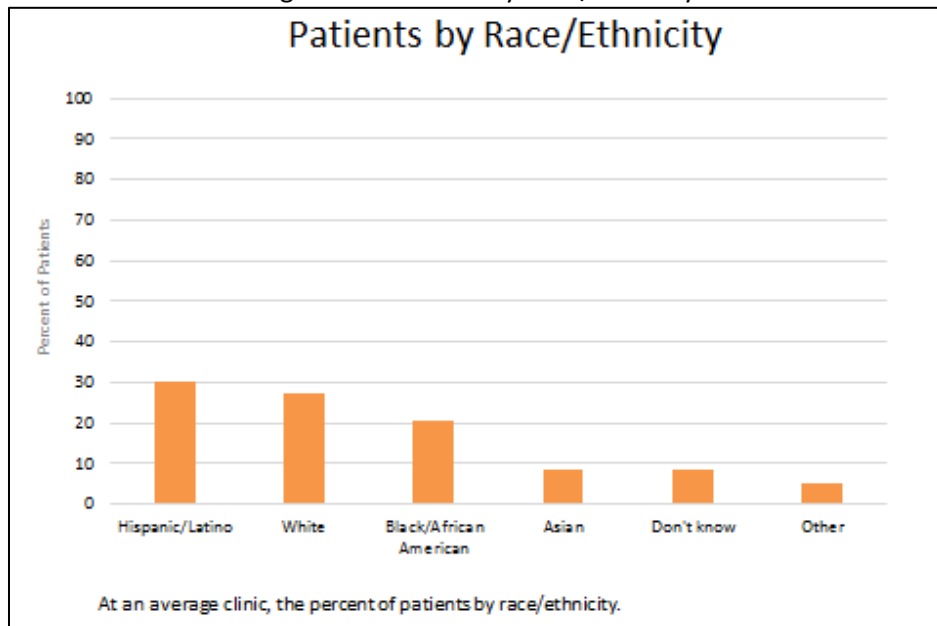


### *Race/Ethnicity*

Free and charitable clinics disproportionately serve patients who are members of racial and ethnic minority groups (Figure 10). At an average clinic, 30% of patients are Hispanic or Latino and 20% are African American whereas Hispanics make up approximately 17% of the state’s population and African American/Blacks constitute 15% of the overall population. Whites make up slightly more than one-quarter of the patient population and Asians just 9%. Free and charitable clinics’ focus on racial/ethnicity minority groups is not surprising because it is well documented that Hispanics are three times more likely to be uninsured and African Americans are 1.5 times more likely to be uninsured compared with their White counterparts.



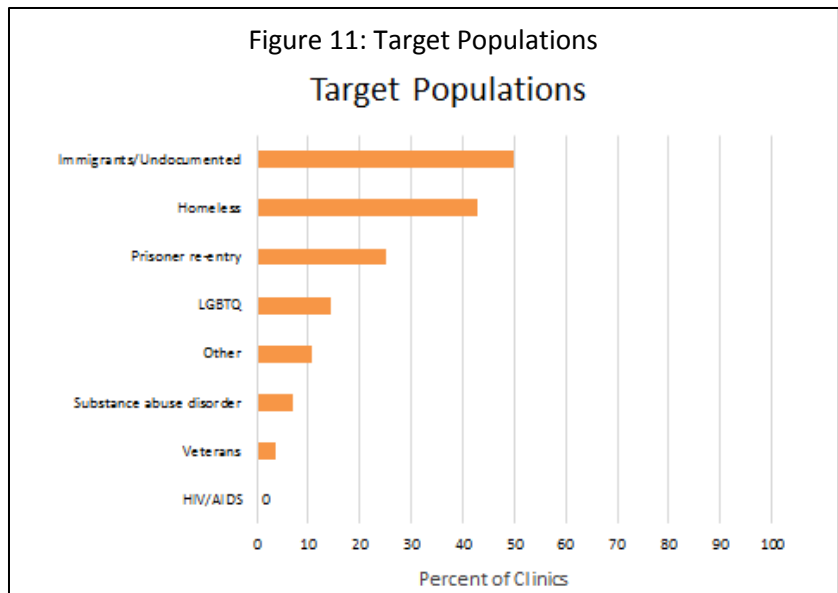
Figure 10: Patients by Race/Ethnicity



*Special Populations*

Most free and charitable clinics “regularly seek to serve” one or more special populations, as depicted in Figure 11. That is, just 36% of responding clinics report that they do not seek to serve any of the following special populations:

homeless; immigrants/undocumented; persons with substance abuse disorders; persons with HIV/AIDS; lesbian, gay, bisexual, transgender, and queer persons; prisoner re-entry populations; or veterans. It is striking that every special population mentioned, except persons with HIV/AIDS, is a target population of one or more free and charitable clinics. Immigrants/undocumented and the homeless receive the most attention. Altogether, these findings suggest that the sector as a whole is serving Illinois’s most vulnerable populations.



**Key Finding: As providers for Illinois’s most vulnerable residents, Illinois’s free and charitable clinics address emerging vulnerable populations: the *underinsured*.**

## **SERVICES**

### ***Volume of Patient Visits***

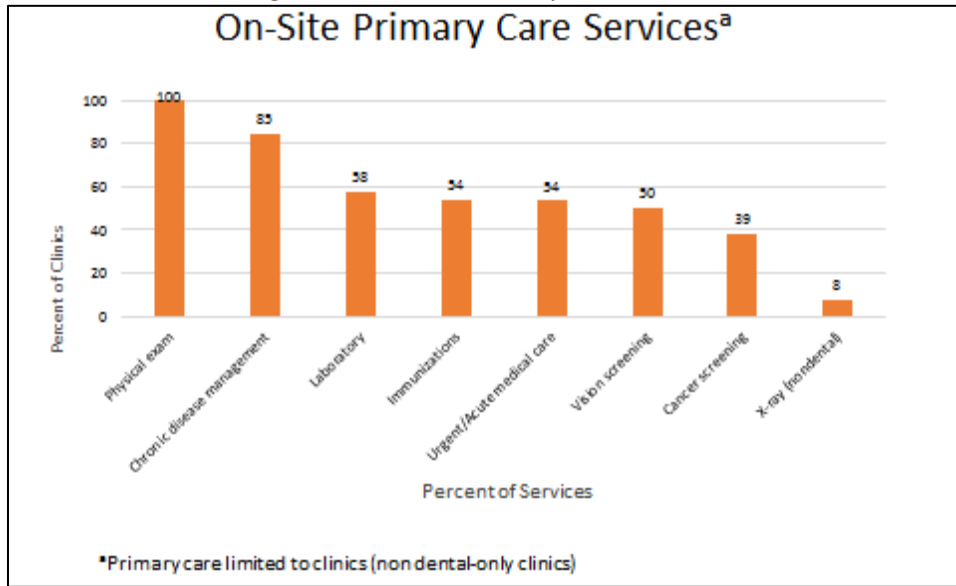
The respondents to the survey provide, on average, a total of 3,514 healthcare visits per clinic per year. This total includes medical, dental, and mental health/behavioral health visits. Note that any documented contact with a licensed healthcare provider constitutes a visit. When examined separately, medical visits account for the largest share of visits; an average clinic provides 3,134 medical visits per year, 985 dental visits per year, and 728 mental and behavioral health services visits per year. Based on these findings, we estimate that Illinois’s 46 clinics provide about 162,000 healthcare visits annually.

**Key Finding: Illinois’s 46 free and charitable clinics annually serve approximately 100,000 patients each year, including almost 20,000 new patients.**

### ***Primary care and other healthcare services***

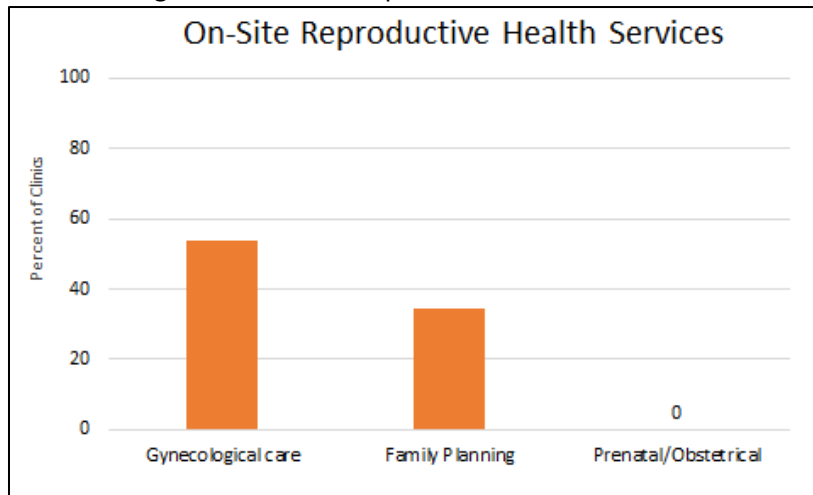
Healthcare services available at free and charitable clinics in Illinois range from basic to comprehensive. The survey asked about the availability of a range of services related to primary care (Figure 12), reproductive health (Figure 13), certain health conditions (Figure 14), and other selected services (Figure 15). Across all the primary care service examined in the survey, it is notable that a half or more of the clinics report providing each type of service, with the exception of cancer screening and non-dental x-rays. For instance, among responding medical clinics, fully 100% reported offering physical exams. The vast majority of clinics (85%) also offer chronic disease management. In addition, most clinics have the ability to perform laboratory work on site (58%), offer immunizations (54%), and address acute medical needs (54%). Exactly half reportedly offer vision screening.

Figure 12: On-Site Primary Care Services



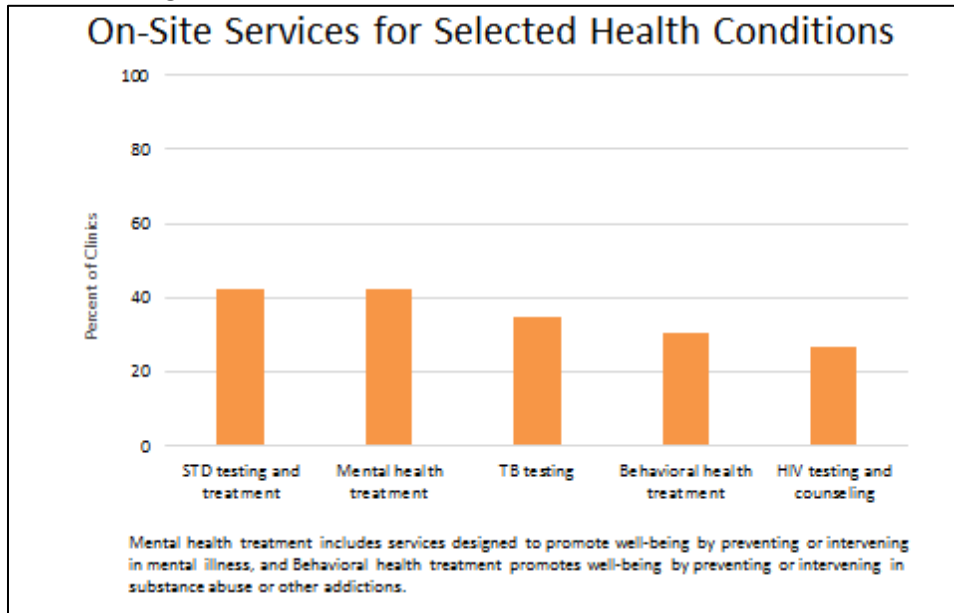
The availability of reproductive health service on-site is more limited than general primary care. The most frequently cited type of care available on site is gynecological care (54%). About one-third offer family planning services and none reportedly offer prenatal or obstetrical care.

Figure 13: On-Site Reproductive Health Services



The availability of services to test and treat selected conditions—sexually transmitted diseases (STDs), mental illness, substance use disorders and other addictions, and HIV/AIDS—is more sporadic, as none of these services is offered on-site at a majority of clinics. A substantial minority (42%) say that they provide treatment for STDs as well as mental health treatment. Tuberculosis testing and behavioral health treatment are reportedly available at, more or less, one-third of clinics. About one-quarter of clinics offer HIV testing and counseling.

Figure 14: On-Site Services for Selected Health Conditions



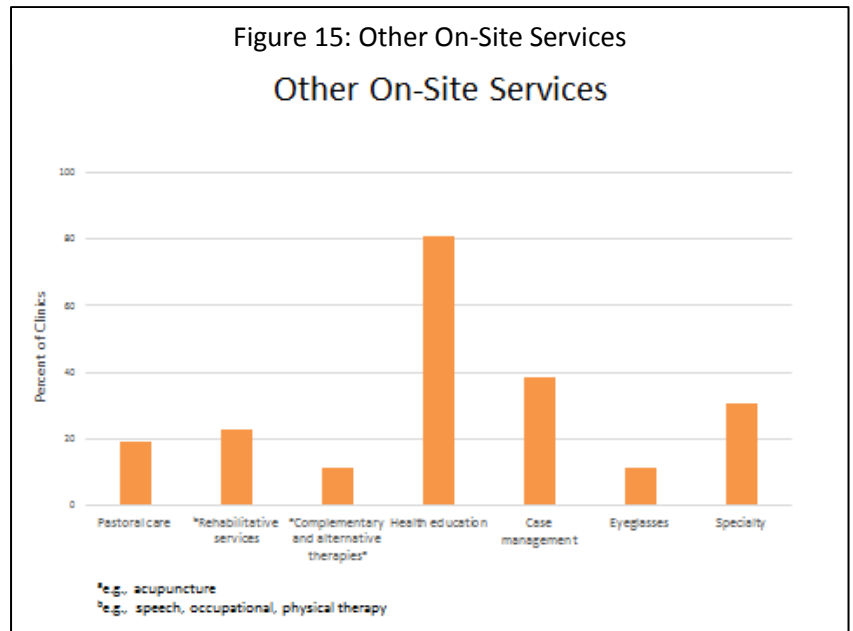
Free and charitable clinics are known to offer other kinds of services that do not fit neatly in other categories. The survey queried about the availability of seven other kinds of services. Among the services examined, health education is, by far, the most common, with 81% of clinics offering health education. Other services are less widely available.

### Dental care

The ACA specified dental services in the essential health benefits package for children, but not for adults, which means that adults newly insured through the marketplace are not guaranteed dental coverage. In addition, Illinois’s Medicaid program does not cover preventive or periodontal dental services for adults, and other dental services have restrictions. The uninsured have even fewer options. As a result, access to dental services for low-income populations is a particularly acute challenge in Illinois, especially for the uninsured.

Until now, the types of dental services offered by free and charitable clinics have been largely unknown. The 2005-2006 national survey of free clinics,<sup>1</sup> which estimated that approximately 35% of all free clinics offered dental services, simply questioned clinics about their provision of “dental services” as a whole, leaving unanswered whether a clinic was providing emergency, preventive, basic, or comprehensive

Figure 15: Other On-Site Services

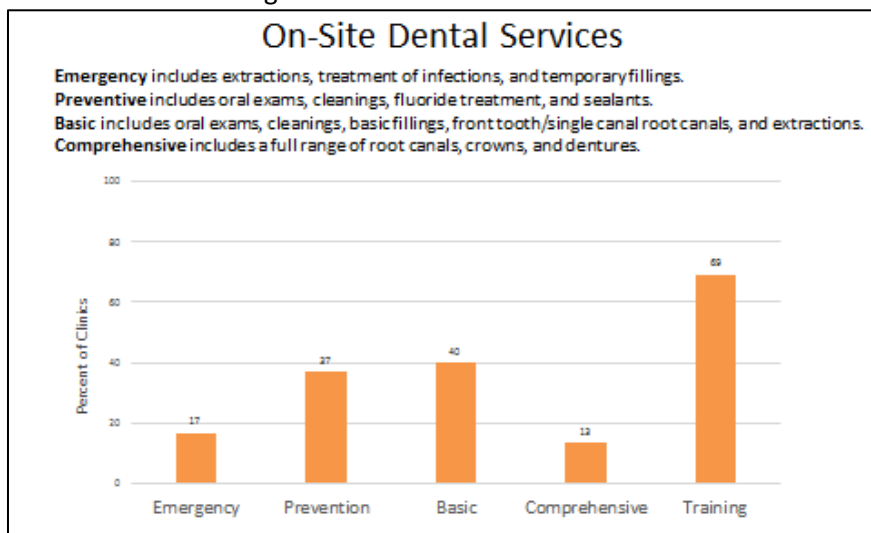


services. The 2015-2016 national survey has improved this line of questioning by asking about the scope of dental services.

Among the responding clinics, five (17%) report offering emergency dental services, which includes extractions, treatment of infections, and temporary fillings (Figure 13). More than one-third (37%) reportedly offer preventive services: oral exams, cleanings, fluoride treatment, and sealants. Two in five clinics report providing basic dental services, which include oral exams, cleanings, basic fillings, front tooth/single canal root canals, and extractions. Comprehensive services mirror the scope of services that one would find in a private dentist's office and includes a full range of root canals, crowns, and dentures. Four clinics (13%) characterize their dental services as comprehensive. In all, 40% of clinics offer one or more of these types of dental services.

**Key Findings: 40% of Illinois's free and charitable clinics provide dental services, and the level of care goes well beyond tooth extractions.**

Figure 16: On-Site Dental Services

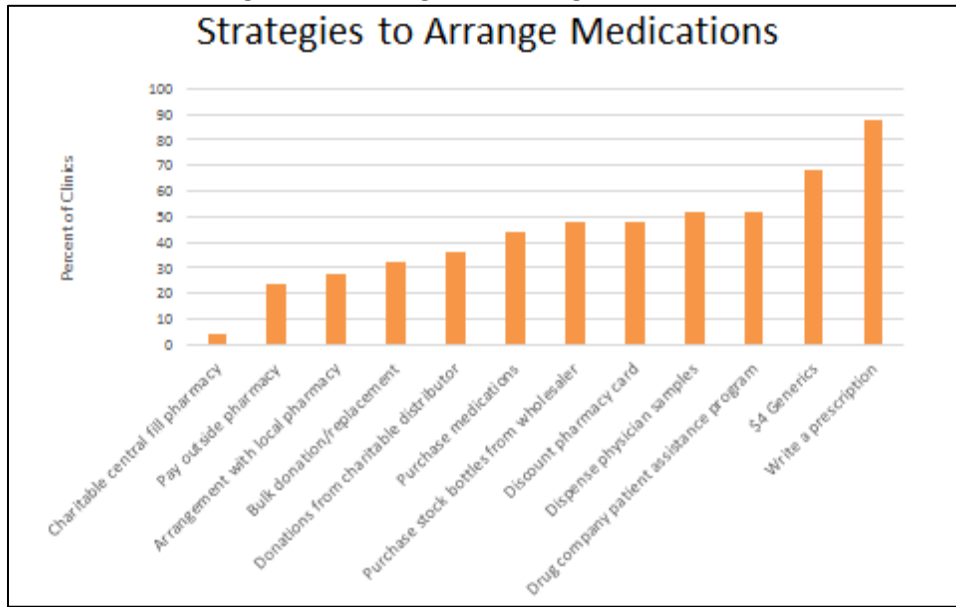


### Medications

Helping patients obtain access to needed medications is, arguably, one of the most highly valued services offered by free and charitable clinics, especially since so many of their patients have chronic illnesses. On-site pharmaceutical facilities exist at a majority of Illinois's free and charitable clinics (54%), either through a dispensary (46%), or less commonly, through a pharmacy (8%).

Clinics use numerous strategies to obtain needed medications, as described below in Figure 14. Nearly all (88%) report writing prescriptions, and two-thirds take advantage of \$4 generics at local pharmacies. Most clinics dispense physician samples (52%) and participate in drug company patient assistance programs (52%). Other strategies, such as arranging a discount pharmacy card (48%), or purchasing stock bottles from wholesalers (48%), are used in close to half of all clinics.

Figure 17: Strategies to Arrange Medications



## **STAFFING & VOLUNTEERS**

### ***Paid Staff***

A defining attribute of free and charitable clinics is their heavy reliance on volunteers to deliver care. Casual observers sometimes think, in fact, that the sector is completely volunteer run. More typically, however, free and charitable clinics have some paid staff who augment their (often large) volunteer corps. In Illinois, three-quarters of the free and charitable clinics report having a staff member in a paid position. The mean number of paid staff in full-time-equivalent (FTEs) is six, but ranges from .2 to 37 at the largest clinic. Given the presence of a large outlier clinic, the median (n=3 FTEs) may better approximate the size of the workforce. In other words, half of all clinics have more than three paid staff and half have fewer than three.

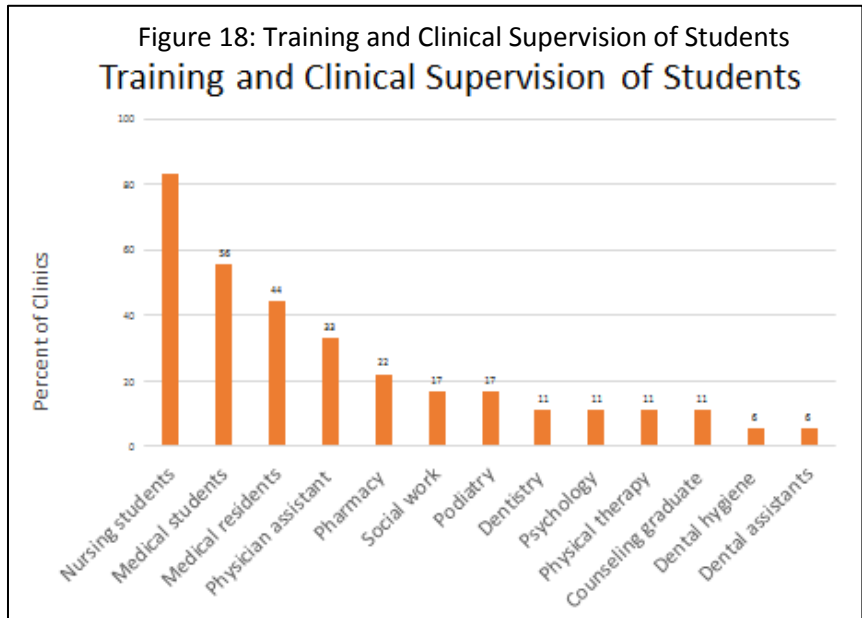
### ***Volunteer Hours***

As mentioned previously, volunteers are the engine that drive free and charitable clinics. Due to the nature of the activity, however, it can be difficult to quantitatively measure the contribution that volunteers make. The survey attempted to do this when it asked clinics to estimate the number of total volunteer hours, but only 14 (of 30) filled in an answer. Based on their survey responses, the mean number of volunteer hours per clinic per year is 5,510 (median = 1,012). Given the large discrepancy between the mean and median, it would be prudent to present the number of volunteer hours as a range. In this case, if we make use of both the median and the mean, we could say that the number of hours per clinic per year ranges from 1,012 to 5,510. If we apply these averages to the population of free and charitable clinics in Illinois (n=46), we estimate that volunteers contribute somewhere between 46,552 hours to 253,460 hours.

**Key Finding: Though difficult to pinpoint, volunteers commit tens of thousands (if not hundreds of thousands) of hours each year to free and charitable clinics in Illinois.**

**Training**

Most free and charitable clinics in Illinois are providing hands-on training for future healthcare professionals (Figure 15). More than two-thirds (69%) of responding clinics report providing clinical training or supervision to students. Overall, one or more clinics is involved in training students across 13 different health professions programs. These include students in medicine (medical students, residents, and physician assistants), nursing, psychology, social work, dentistry (dentists, dental hygiene, dental assistants), pharmacy, podiatry, physical therapy, and counseling. Training of nursing students (RNs and APNs) and medical students is cited most frequently, 83% and 56%, respectively.



**Key Finding: Training students across 13 different health professions programs, free and charitable clinics play a valuable role in training the future health professions workforce.**

**QUALITY AND HEALTH INFORMATION TECHNOLOGY**

**Quality Assurance Plan**

In light of an increased focus on quality at the national level, many free and charitable clinics are developing written quality assurance plans and processes and/or engaging in quality improvement activities. In Illinois, just 30% of responding clinics report having a written, board approved quality assurance plan. This compares with 46% nationally,<sup>8</sup> however, the national data were based only on

<sup>8</sup> Darnell, J.S., & Marty Hiller. (2012). "Chapter 4: Free Clinics" in *Quality Incentives for Federally-Qualified Health Centers, Rural Health Clinics and Free Clinics: A Report To Congress*. Washington, DC: U.S. Congress. Available from: <http://www.healthit.gov/sites/default/files/pdf/quality-incentives-final-report-1-23-12.pdf>.

clinics that were members of the National Association of Free Clinics and known to be much higher resourced (average budget of \$830,000 and 9.4 FTEs) than the average clinic in Illinois. Nevertheless, Illinois free and charitable clinics appear to be lagging behind their peers, suggesting an area where targeted attention could help clinics make progress.

### *Performance Measures*

Despite lacking formal plans, the responding free and charitable clinics are, to a great extent, collecting and reporting on quality data. For instance, 62% of Illinois clinics say they are collecting and reporting on clinical outcome measures (e.g., hbA1c, blood pressure under control); 46% are collecting and reporting on clinical process measures; and 60% are administering surveys of patient satisfaction and experiences with care. Furthermore, all but one clinic (96%) are reportedly collecting and using at least one type of quality indicator: patient outcome, clinical process, or patient experience.

**Key Findings: Though most free and charitable clinics lack formal quality assurance plans, nearly all clinics are nonetheless collecting and reporting on performance data.**

### *Adoption and Use of Health Information Technology*

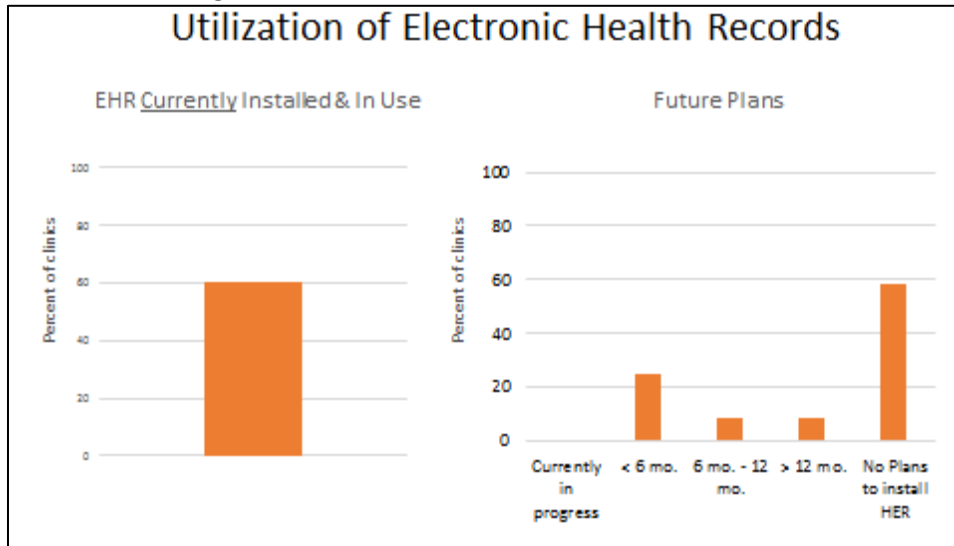
Electronic health records (EHRs) are tools to collect patient data and, ultimately, help clinics monitor how well their patients are doing. A majority (60%) of free and charitable clinics report having an electronic health record installed and in use (Figure 16). Of those 40% of responding clinics that currently do not have an EHR in use, 33% say that they plan to adopt an EHR within the next year. The majority of those currently without an EHR (n=7; 58%) report, however, that they have no plans to do so. It would be worthwhile to investigate further the reasons these seven clinics give for electing not to adopt health information technology, assess the potential value added by adopting a EHR, and help support efforts to install and use the technology where it is permissible.

These current findings, when compared with historical data, point to an increase in EHR adoption among Illinois's free and charitable clinics in recent years. For instance, in 2014, 52% of clinics responding to a survey sponsored by the Illinois Association of Free and Charitable Clinics said that they were using EHRs. Those without EHRs cited "inadequate funding" and "lack of staff/volunteer time" as barriers. Thus, attempts to achieve higher EHR adoption levels among Illinois's free and charitable clinics likely will require both a greater understanding of the problem and a greater investment of time and human capital to overcome the challenges.

**Key Finding: While a majority Illinois's free and charitable clinics currently have (or plan to adopt) an electronic health record, near universal adoption may be out of reach without an investment of resources.**



Figure 19: Utilization of Electronic Health Records



**IMPACT OF THE AFFORDABLE CARE ACT**

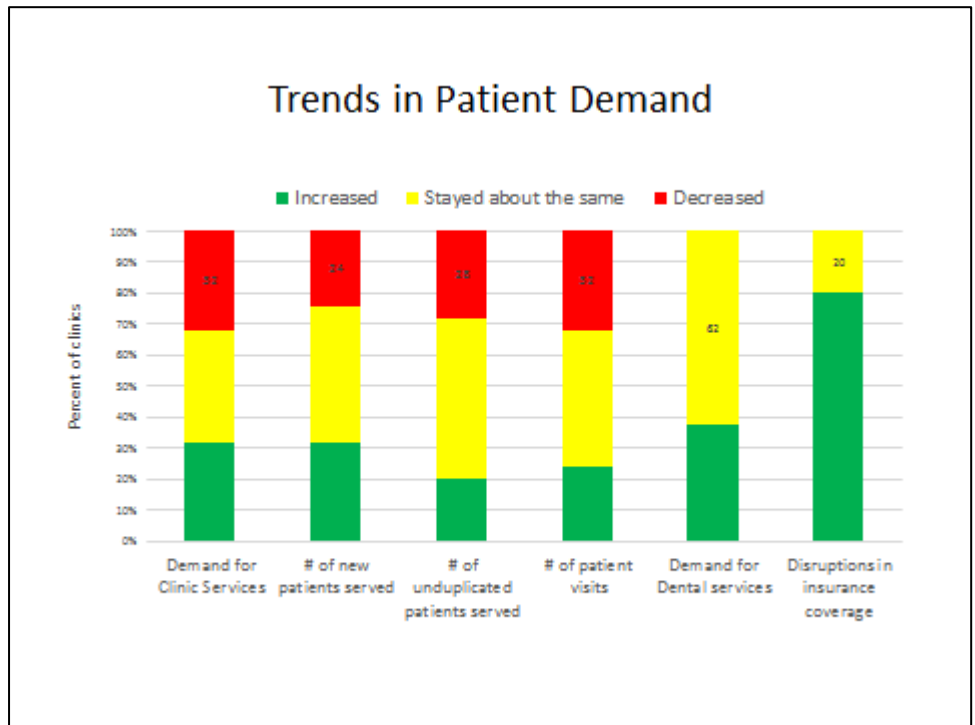
Through the state marketplaces and expansion of Medicaid, the ACA greatly expanded the availability of insurance coverage options for low-income persons. At the same time, the individual mandate helped to encourage persons who might not otherwise sign up to purchase coverage. While expanding coverage, the ACA also enhanced the capacity of the safety net to serve the millions of newly-insured, mostly through a significant federal investment in the health center program. These forces would be expected to reduce demand for services at free and charitable clinics, which serve the low-income uninsured population. Moreover, one would predict that the decrease in demand at free and charitable clinics would be greater in states, like Illinois, that implemented the Medicaid expansion. The survey asked clinics to indicate the trends (i.e., increased, stayed about the same, decreased) in patient demand, clinic capacity, and the availability of donated goods and volunteer services, which are summarized in Figures 17-19.

***Trends in Patient Demand***

Despite prognostications of far-reaching reductions in patient demand at free and charitable clinics following implementation of the ACA, the reports from Illinois clinics suggest a “mixed bag.” While some clinics (typically one-quarter to one-third) do report decreases in demand, about the same number of clinics report increases, offsetting the declines. The most common experience reported with regard to patient demand after implementation of the ACA is “stayed the same.”

It is interesting to compare new patients with unduplicated patients because more clinics report declines in unduplicated patients than in new patients. One explanation for this finding is that free and charitable clinics were actively helping their existing patients to sign up for Obamacare. In the end, whether the sector experiences a net loss in patients will depend on whether the clinics experiencing declines are losing proportionately more patients than clinics gaining patients.

Figure 20: Trends in Patient Demand



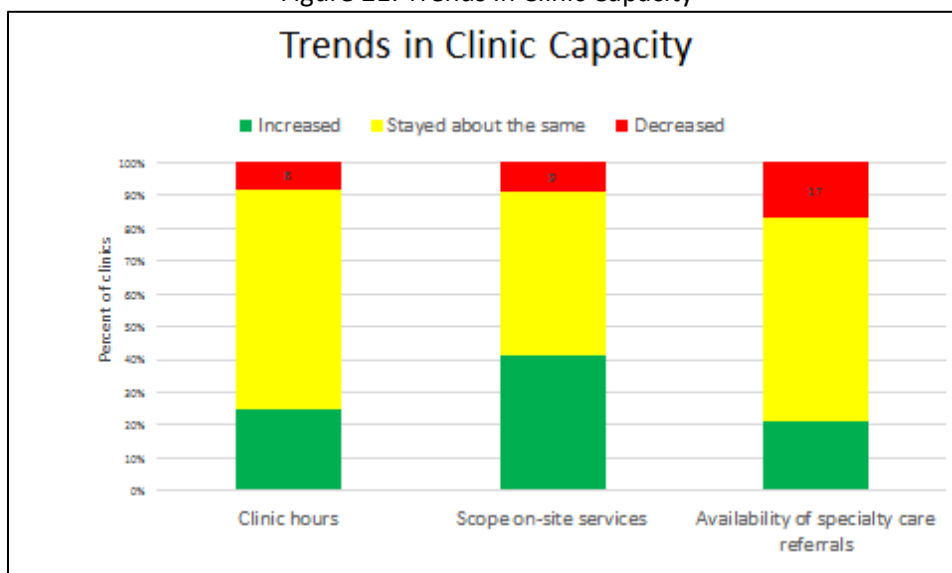
Demand for dental service stands in sharp contrast to the other services as no clinics report declines in demand in dental. This is not surprising because the ACA did not expand access to affordable dental coverage for adults.

Of note, the high percentage of clinics reporting that their patients were experiencing disruptions in coverage (80%) adds to the body of evidence about the difficulties some face in obtaining health insurance and keeping continuous coverage.

### *Trends in Clinic Capacity*

“Stayed the same” is how clinics characterize trends in clinic hours, services, and specialty care referrals. In fact, in each case, the percentage of clinics endorsing “stayed the same” is half or more. The fact that so few clinics reduced their clinic hours (8%) or reduced their scope of services (9%) shows that the sector was able to maintain (and in some cases increase) its capacity despite considerable uncertainty about continued support from donors.

Figure 21: Trends in Clinic Capacity



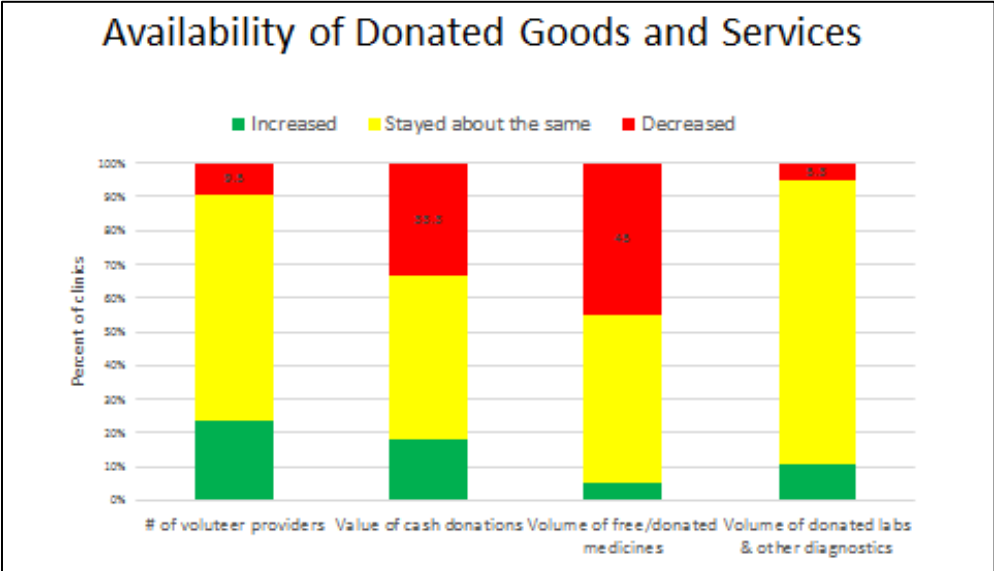
**Trends in the Availability of Donated Goods and Volunteer Services**

Volunteers, private donations, and in-kind goods, especially medicines, are the most important resources for free and charitable clinics. After the ACA was fully implemented, it was unclear how the donor community and volunteers would react. Thus, it is essential to understand the trends in the availability of these resources since implementation.

Responding clinics report overwhelmingly that the number of volunteer providers either stayed the same or improved after ACA implementation. The same pattern does not hold, however, for cash donations. While nearly half of all clinics say their cash donations “stayed the same,” one-third of clinics report a decline. Similarly, 45% of clinics report a decline in the volume of free/donated medicines. By contrast, clinics report little change in their volume of donated labs and other diagnostics. The findings concerning cash donations and donated medications suggest that a sizeable minority of clinics are facing challenges securing needed resources. Fortunately, these resource constraints do not seem to have affected clinic capacity in a meaningful way, with a caveat that this survey tells the story of only surviving clinics.

**Key Finding: Following implementation of the ACA, declines in patient demand at free and charitable clinics are occurring, but do not appear to be widespread. Free and charitable clinics have maintained their capacity in spite of resource constraints.**

Figure 22: Availability of Donated Goods and Services



# Chapter Four: Overview of Federally Qualified Health Centers in Illinois

## INTRODUCTION

Under the Affordable Care Act (ACA), the Federal government made enormous investments in the health care infrastructure through direct grant funding and through an increase in third-party financing from coverage expansions to low-income individuals. A major piece of President Obama's health care policy program was the five-year, \$11 billion expansion in community health center funding to develop and support broader access to health care, which was later extended two more years to 2017 with \$3.6 billion of additional annual funding.

In general, health centers enjoy bi-partisan support and are widely acknowledged for their mission, unique program requirements, and effective care delivery model. Federal health center appropriations, which averaged about \$1.7 billion annually prior to the ACA, help support their mission to expand access to uninsured and underinsured patients.<sup>9</sup> Health centers are recognized especially for the following:

- Health centers are federally mandated to locate in low-income communities that have designated provider shortages or serve medically underserved populations;
- Health centers provide a broad array of primary care services, including, dental care, vision services, pharmacy services, and behavioral health services, as well as enabling services to better effectuate the care provided;
- Health centers are governed by a patient-majority board which help to ensure financial resources effectively address local health care needs;
- Health centers provide care regardless of patient's income and insurance status;
- Health centers serve as an economic engine in many disenfranchised communities, employing nearly 190,000 clinical and administrative staff;
- Health centers are shown to provide high quality care;<sup>10</sup> and
- Health centers can generate significant cost savings.<sup>11</sup>

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<sup>9</sup> Heisler EJ. *Federal Health Centers: An Overview*. 2016. Congressional Research Service. <https://fas.org/sgp/crs/misc/R43937.pdf>

<sup>10</sup> Cole MB, Galarraga O, Wilson IB, Wright B, Trivedi AN. At Federally Funded Health Centers, Medicaid Expansion was Associated with Improved Quality of Care. *Health Affairs* 2017; 36(1)40-48; Kaiser Family Foundation. Quality of Care in Community Health Centers and Factors Associated with Performance. 2013. <https://kaiserfamilyfoundation.files.wordpress.com/2013/06/8447.pdf>

<sup>11</sup> Evans CS, Smith S, Kobayashi L, Chang DC. The Effect of Community Health Center (CHC) Density on Preventable Hospital Admissions in Medicaid and Uninsured Patients. *J Health Care Poor Underserved* 2015; 26(3): 839-51; Richard P, Ku L, Dor A, Tan E, Shin P, Rosenbaum S. Cost savings associated with the use of community health centers. *J Ambul Care Manage* 2012;35(1):50-9.

At the same time, health centers confront a number of challenges to maximizing the value of the federal investment in expanding access. In meeting and maintaining performance goals, health centers face significant provider recruitment and retention problems. For instance, a recent survey of health centers found approximately two-thirds struggled to recruit physicians and about half had unfilled vacancies for not only midlevel clinicians but also behavioral health staff.<sup>12</sup>

Additionally, health centers face significant financial challenges stemming from potential changes to their largest revenue sources, Medicaid and federal health center grant funding. Currently, Medicaid is the largest source of financing, accounting for nearly half of all revenues. Health center Medicaid Prospective Payment System (PPS)<sup>13</sup> payments are intended to cover a wide range of ambulatory services and are adjusted annually to reflect changes in the Medicare Economic Index (MEI) as well as changes in the scope of services.<sup>14</sup> Although evidence suggests health centers are cost-effective, states are increasingly seeking to change the payment methodology toward one in which payment is bundled under alternative methodologies, such as periodic payments, payments tied to savings, or the use of per capita payments spanning all Medicaid-enrolled health center patients.<sup>15</sup>

Health centers also face the potential loss of \$3.6 billion in annual health center funding should Congress fail to renew funding levels beyond 2017. This “funding cliff” would represent a loss of 70% in grant revenues.<sup>16</sup> As a result, health centers are unlikely to maintain, let alone expand, access to care in underserved communities.<sup>17</sup> Uncertainty around these issues and potential instability in funding streams are likely to impact efforts to further expand access.

Like other health centers nationally, Illinois health centers were expected to benefit substantially under the ACA due to increases in health center funding and the expansion of Medicaid coverage.<sup>18</sup> As of 2015, there were 44 community health center (CHCs) statewide, serving 1.23 million patients, compared to 36 CHCs serving 1.09 million in 2009.<sup>19</sup> This chapter examines the role of CHCs over the past decade both statewide and in Cook County, home to more than half of CHCs in Illinois.

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<sup>12</sup> National Association of Community Health Centers (2016). [http://nachc.org/wp-content/uploads/2015/10/NACHC\\_Workforce\\_Report\\_2016.pdf](http://nachc.org/wp-content/uploads/2015/10/NACHC_Workforce_Report_2016.pdf)

<sup>13</sup> Alternatively, states, in agreement with FQHCs, may also use an Alternative Payment Methodology (APM) that pays at least the PPS rate.

<sup>14</sup> 42 CFR 405.2462

<sup>15</sup> Shin P, Sharac J, Barber Z, Rosenbaum, S. *Community Health Centers and Medicaid Payment Reform: Emerging Lessons from Medicaid Expansion States*. 2016. RCHN Community Health Foundation and the Commonwealth Fund. <http://publichealth.gwu.edu/sites/default/files/downloads/GGRCHN/Community-Health-Centers-and-Medicaid-Payment-Reform-45.pdf>

<sup>16</sup> Rosenbaum S, Will Health Centers Go Over the “Funding Cliff.” *The Milbank Quarterly*, 2015, 93(1): 32-35.

<sup>17</sup> Ku L, Zur J, Jones E, Shin P, Rosenbaum S. How Medicaid expansions and future community health center funding will shape capacity to meet the nation’s primary care needs. RCHN Community Health Foundation, 2013 <http://www.rchnfoundation.org/wp-content/uploads/2013/11/GG-caseload-impact-brief-34.pdf>

<sup>18</sup> Shin P, Sharac J, Rosenbaum S. Community Health Centers and Medicaid at 50: An Enduring Relationship Essential for Health System Transformation. *Health Affairs*, 2015, 34(7): 1096-1104.

<sup>19</sup> In 2015, an additional 3 health center “look-alikes” that do not receive federal CHC funding served an additional 13 thousand patients. No data is available on look-alikes prior to the ACA.

## METHODS

This analysis is based on publicly-available federal health center data. CHCs must submit annual reports to the Bureau of Primary Health Care. These reports include tabulated patient counts by age, gender, income categories, and insurance type as well as information on health center staffing mix, visits, quality of care, expenditures, and revenues. Cook County health centers were identified by the address of the main health center site.

## RESULTS

### PROFILE OF ILLINOIS HEALTH CENTERS TODAY

According to the most recent federal data available, in 2015 there were 44 Illinois CHCs which served 1.2 million patients, including 11,271 migratory or seasonal agricultural workers, 38,271 homeless people, and 99,716 people living in public housing. Twenty-three CHCs were located in rural areas and served 634,814 patients (52%).<sup>20</sup> Illinois CHCs include three migrant health centers, eight health care for the homeless CHCs, and four public housing CHCs.

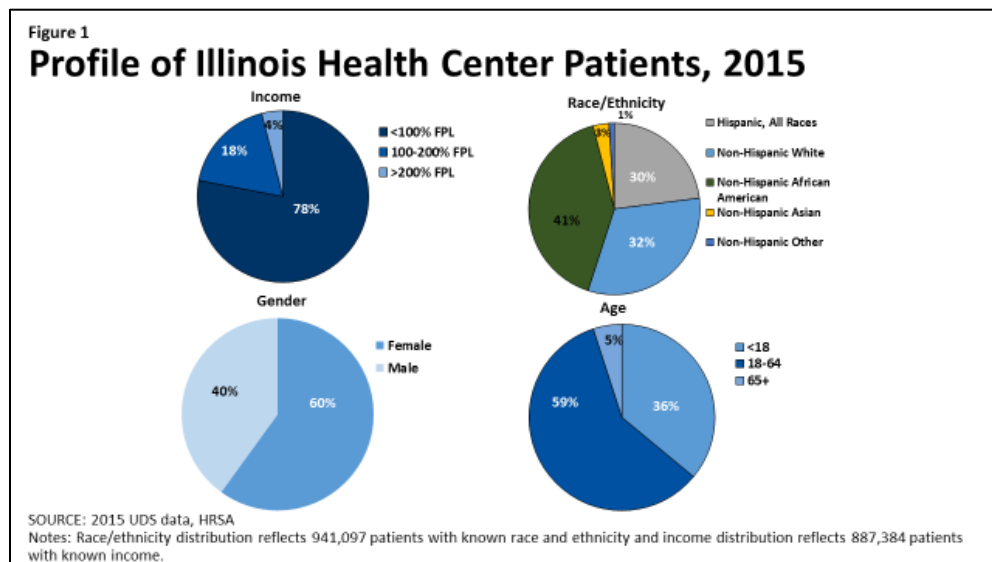
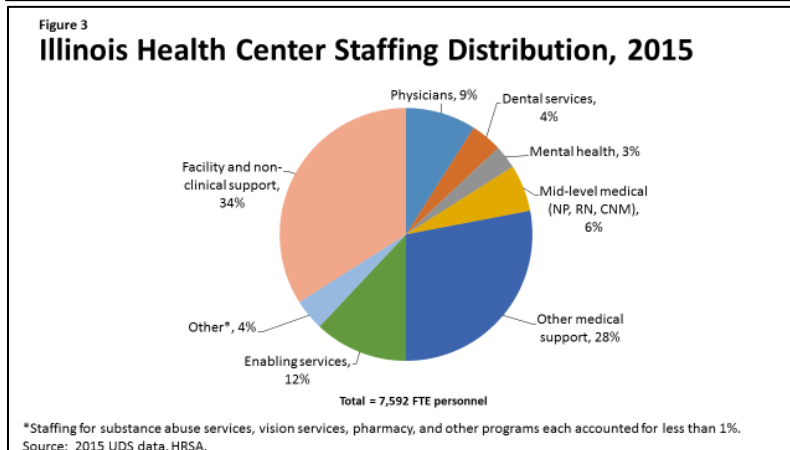
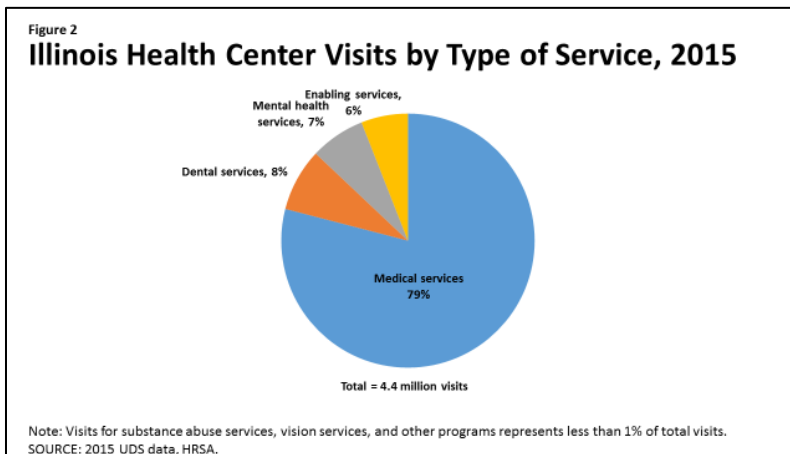


Figure 1 shows that Illinois's 1.2 million health center patients tend to be poor, female, and racial and ethnic minorities. Approximately 78% of patients have incomes less than Federal Poverty Level (FPL) and 60% are racial and ethnic minorities. The majority of patients are working age adults, accounting for 59% of all health center patients. Given CHCs are mandated to serve medically underserved areas or populations, health center patients are largely low-income, with 94% of their patients earning less than 200% of the federal poverty level. Consequently, four in five CHC patients statewide are either uninsured or on Medicaid.

<sup>20</sup> Map of health center sites available at [http://www.iphca.org/Portals/0/Maps/IL\\_All\\_Sites\\_And\\_Legend.pdf?ver=2016-05-17-090326-770](http://www.iphca.org/Portals/0/Maps/IL_All_Sites_And_Legend.pdf?ver=2016-05-17-090326-770)

In 2015, Illinois CHCs reported approximately 4.4 million visits (Figure 2). The 3,448,865 visits for medical services accounted for the vast majority of health center visits (79%). The 333,915 visits for dental services were a distant second, accounting for 8% of total visits, followed by 395,723 visits for mental health services (7%). Enabling services—which include case management, interpretation, transportation, outreach, and eligibility assistance—accounted for just two percent of total visits. Substance services and vision services remains difficult to access, accounting for less than one percent of total visits.

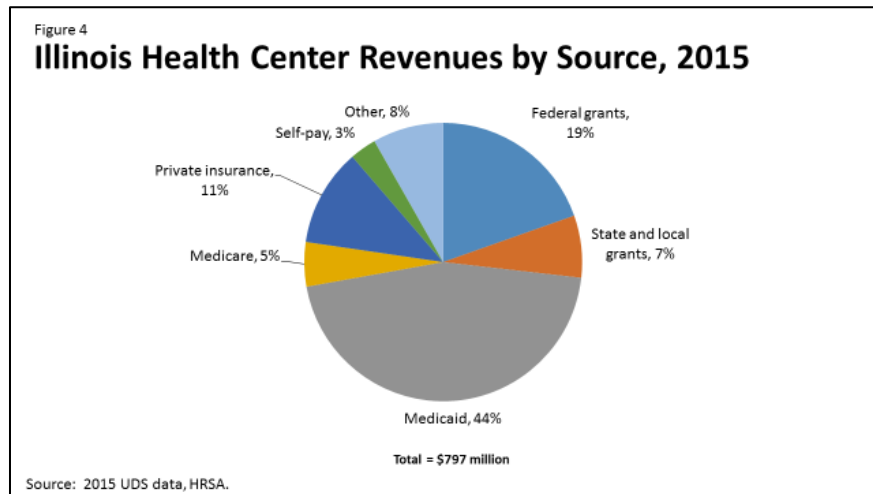


Health centers in Illinois employed 7,592 full-time equivalent (FTE) staff in 2015 (Figure 3). Health center staffing largely consisted of medical staff with 717 physicians accounting for 9%, mid-level staff (297 nurse practitioners, 70 certified nurse midwives, and 99 physician assistants) at 6%, and 3,292 other medical support (e.g., lab and x-ray personnel, and nurses) at 28%. Additionally, mental health professionals and dental services staff accounted for 3% and 4%, respectively. The 901 enabling services personnel accounted for 12%. Finally, the 2,593 facility and non-clinical support represented one third of health center staff.

In 2015, health centers received \$797 million in revenue. Given that Medicaid and uninsured patients account for the majority of patients, it is not surprising to find that CHCs rely heavily on Medicaid and federal health center grants (Figure 4). Medicaid revenue totaled \$353.6 million, which accounts for 44% of funding; \$149.2 million in federal health center grants accounted for 18% of revenue. Health centers also receive \$22.3 million in co-payments and fees from uninsured patients (according to a

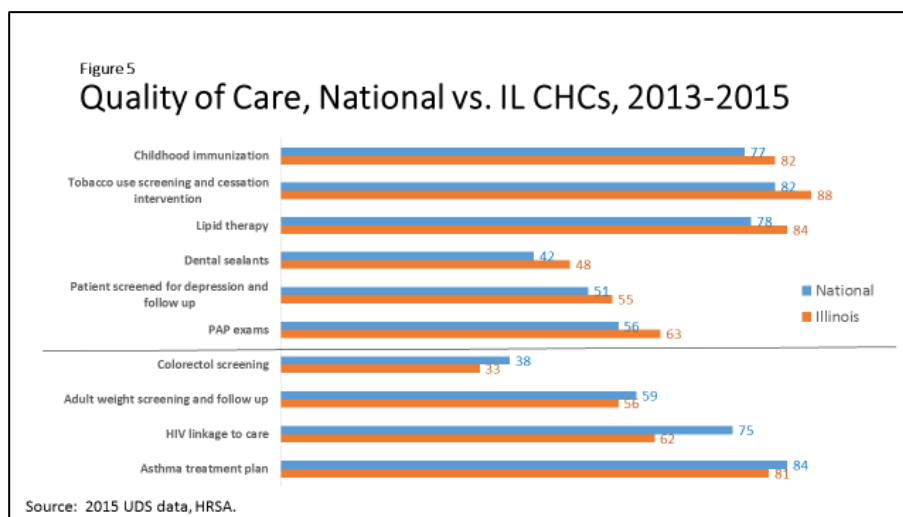


sliding-fee scale based on income and family size) and revenue from this so-called “self pay” category accounts for 3% of income. Private insurance and Medicare accounted for 11% and 5% of revenue, respectively. Health centers also rely on other grants, including state and local grants, to subsidize the cost of care.



**Key Finding: Illinois CHC quality measures exceed national CHCs on childhood immunization, tobacco use cessation intervention, lipid therapy, dental sealants, patient screening for depression, and PAP exams.**

Figure 5 shows Illinois CHCs outperform health centers nationally on numerous quality measures. Illinois CHC quality measures exceed national CHCs on childhood immunization, tobacco use screening and cessation intervention, lipid therapy, dental sealants, patient screening for depression and follow up, and PAP exams. However, the quality data suggest Illinois CHCs may require additional support on a number of services, particularly for HIV linkages to care: approximately 62% of Illinois CHCs reported being able to follow up treatment within 90 days of first diagnosis compared to 75% nationally. The percent of hypertensive patients with controlled blood pressure for Illinois CHCs and CHCs nationwide



were nearly the same (63.9% vs. 63.8 %) as were the percent of patients with diabetes who had Hba1c less than or equal to 9% (57.5% vs. 56.8%).

**TRENDS OVER THE LAST DECADE**

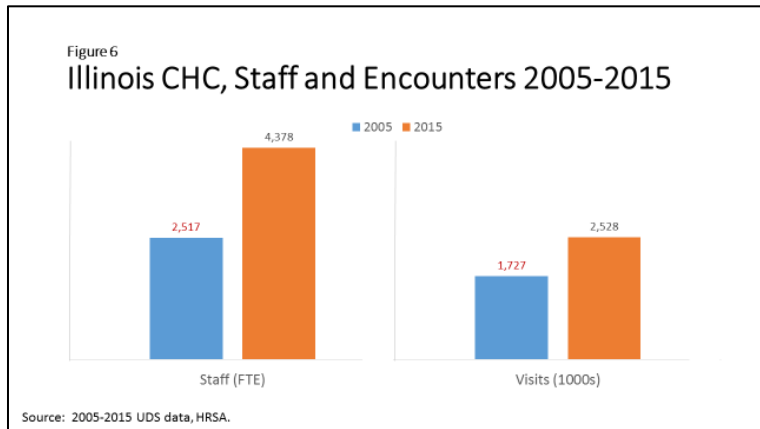
*The Number of Health Centers Increased by One Third Between 2005 and 2015*

Between 2005 and 2015, the number of CHCs statewide increased from 33 to 44. The expansion of health centers helped to expand their reach to at-risk populations. In 2005, there was only one migrant health center, two healthcare for the homeless grantees, and three public housing grantees. By contrast, in 2015 there were three migrant health centers, eight homeless grantees, and five public housing grantees. Statewide, the number of homeless patients increased from 19,865 to 38,271 and the number of migrant and seasonal migrant worker patients increased from 8,986 to 11,271.<sup>21</sup>

**Key Finding: Between 2005 and 2015, the number of CHCs statewide increased from 33 to 44. The expansion of health centers helped to expand their reach of high at-risk populations.**

*The Number of Staff and Visits Increased Substantially Between 2005 and 2015*

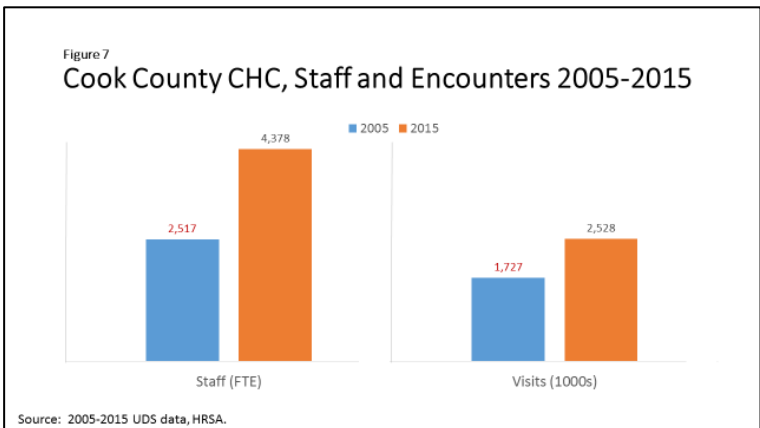
Over the past decade, Figure 6 shows the number of visits for CHCs statewide increased 56% from 2,800,286 to 4,377,694 and the number of CHC staff also increased from 4,150 to 7,592 FTEs (83%). The number of visits for Cook County CHCs also increased from 1,726,997 to 2,527,522 (46%) and the number of staff increased from 2,517 to 4,378 FTEs (74%) (Figure 7).



*The Number of Health Center Patients Increased by Over 50% in the Past Decade*

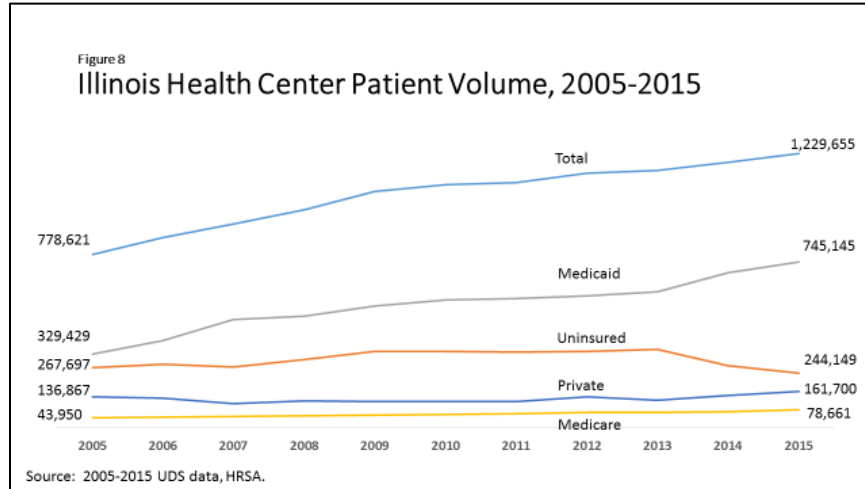
The overall number of patients served by CHCs statewide grew by 58%, from 778,621 patients to 1,229,665 patients between 2005 and 2015 (Figure 8).

As a share of total patients, the number of Medicaid patients more than doubled (126%), rising from 329,429 to 745,145. The largest



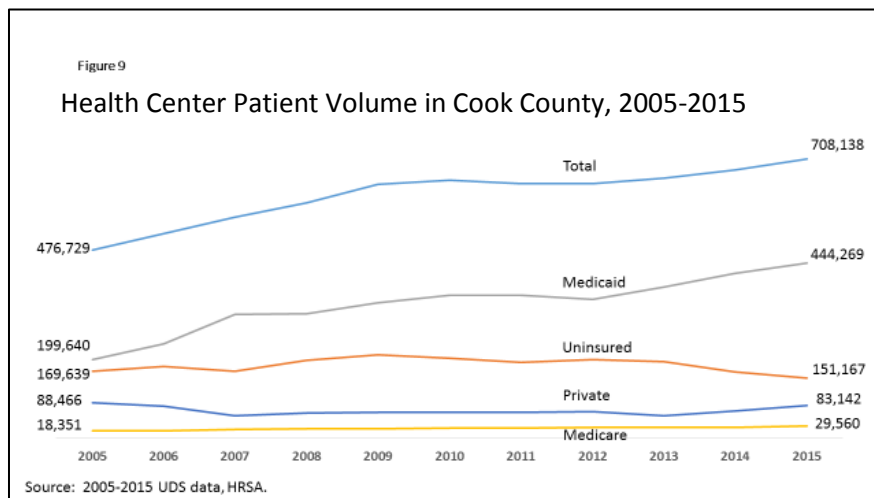
<sup>21</sup> Number of public housing patients not available in 2005.

increase in Medicaid patient volume occurred in between 2013 and 2014 (when the State waiver expanded Medicaid).



Statistically, CHCs also saw a significant increase in the number of patients with private insurance starting. However, given that health centers generally serve low-income communities in which most residents qualify for Medicaid under the ACA, much of the patient growth can be attributed to the increase in Medicaid patient volume.

Similarly, as Figure 9 shows, the number of patients served by CHCs in Cook County increased by 49% from 476,729 to 708,138 between 2005 and 2015. Part of this growth is also attributable to the number of CHCs which increased from 19 to 23 as well as to expansion of coverage. Other factors that likely contributed to the increase in patient volume include expansion of services, more effective outreach and enrollment efforts, and changes in demography over time.<sup>22</sup>

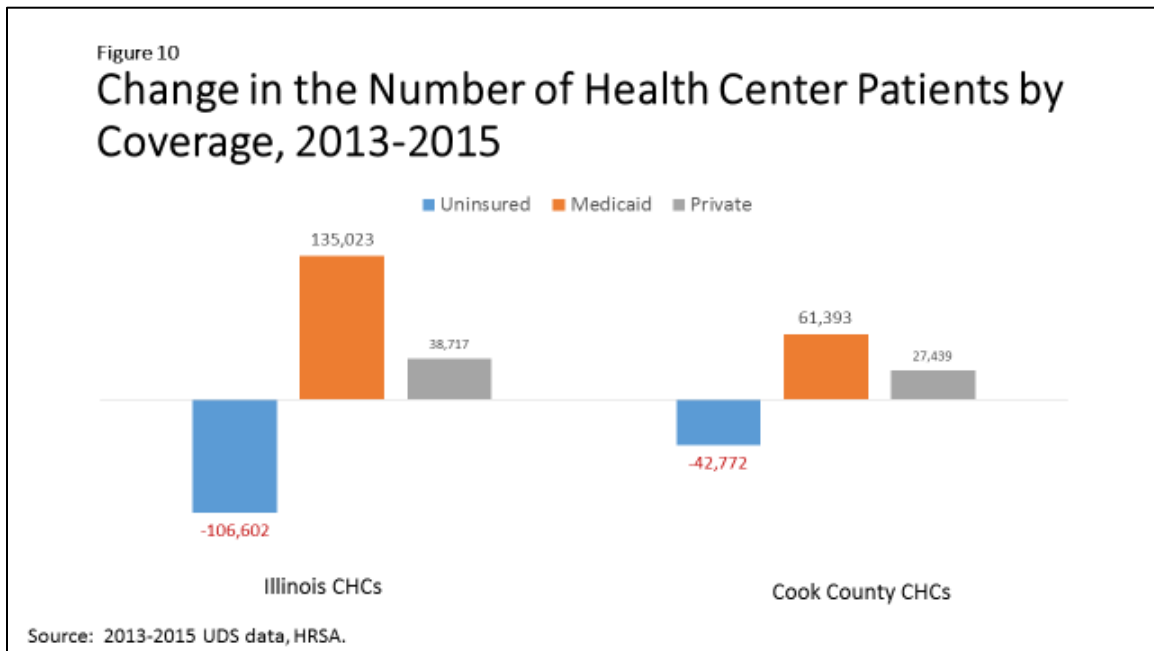


<sup>22</sup> Kaiser Family Foundation (2015). Health Center Patient Trends, Enrollment Activities, and Service Capacity: Recent Experience in Medicaid Expansion and Non-expansion States <http://files.kff.org/attachment/issue-brief-health-center-patient-trends-enrollment-activities-and-service-capacity-recent-experience-in-medicaid-expansion-and-non-expansion-states>

### Medicaid was Critical to Reducing Uninsured Patients Between 2013 and 2015

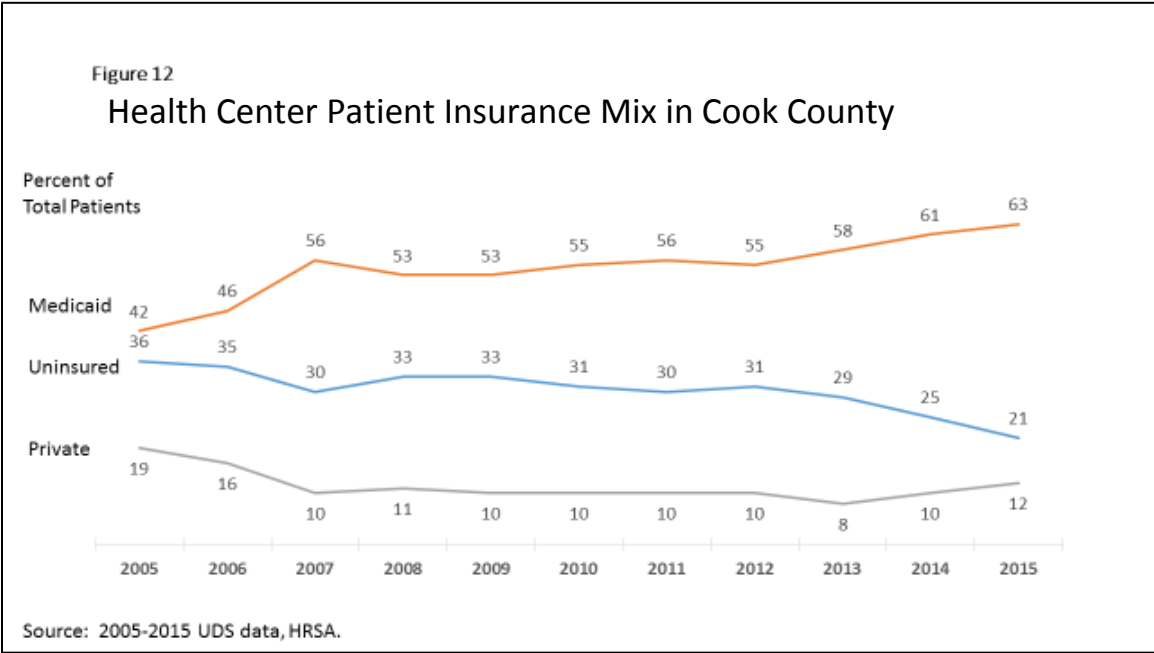
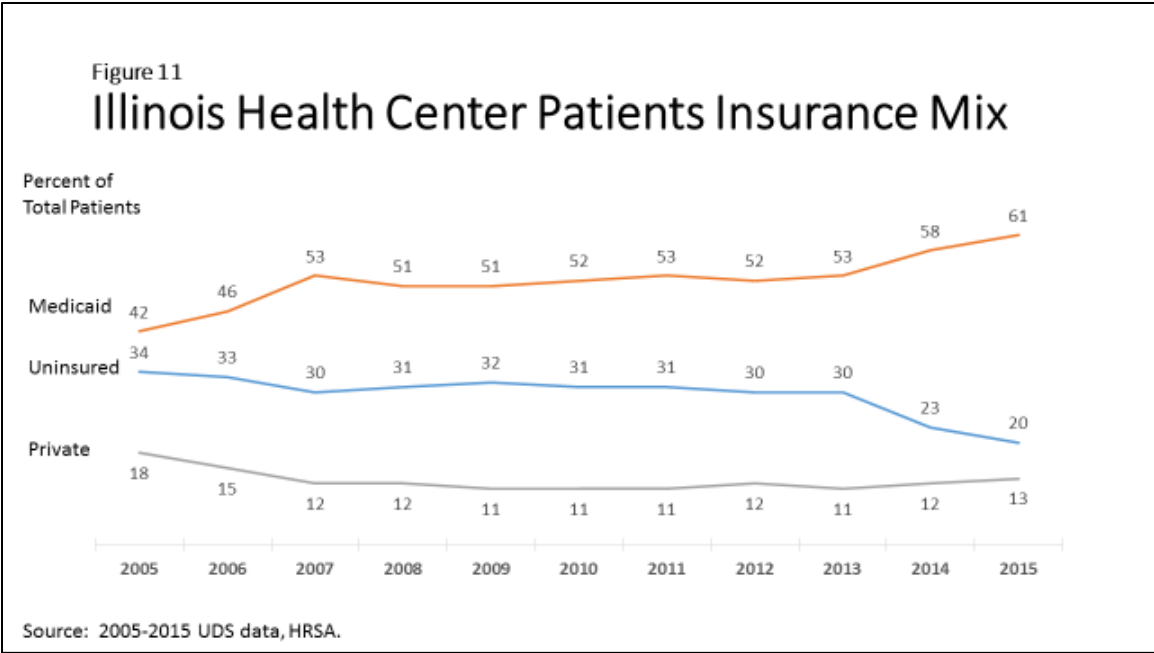
As the Medicaid patient volume increased, the number of uninsured declined substantially. Figure 10 shows the number of uninsured declined by 106,602 patients (-33%) statewide while the number of Medicaid patients increased by 135,023 patients (22%) between 2013 and 2015. Increased access to private insurance or the health care marketplace likely played a role in reducing the number of uninsured patients, albeit a smaller role than Medicaid. Health centers statewide added only 38,717 patients with private insurance (18%) between 2013 and 2015.

Cook County CHCs reported similar trends. The number of uninsured declined by 42,772 patients while the number of patients covered by Medicaid increased by 61,393 and private insurance grew by 27,439. However, it is worth noting the 40% decline in the number of uninsured patients and the 45% increase in Medicaid patient volume at Cook County CHCs during this time. Approximately 71% of the increase in private patient volume also occurred at Cook County CHCs.



### Three in Five CHC Patients Have Medicaid

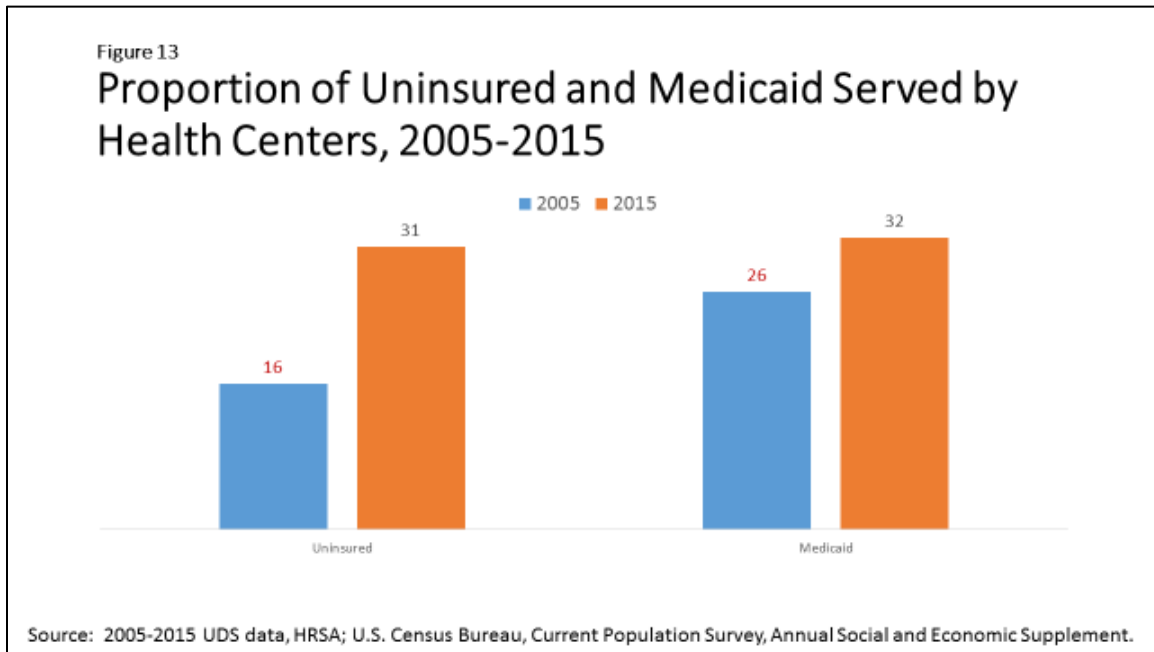
Figures 11 and 12 show that Medicaid covers more than 60% of health center patients. Approximately 61% of CHC patients statewide and 63% of Cook County CHC patients rely on Medicaid for their coverage. Private insurance is the next largest source of coverage, accounting for just 13% of health center patients statewide and 11% of Cook County CHC patients.



**Uninsured Patients Increasingly Rely on Health Centers**

Despite significant decreases in the number of uninsured CHC patients, Figure 13 indicates a larger share of the state’s uninsured population increasingly depend on health centers. Between 2005 and 2015, the

proportion of the state's uninsured population served by CHCs increased from 16 % to 31%.<sup>23</sup> In other words, health centers provide care to approximately one in three uninsured patients statewide.



### *Comparison of Patient and Revenue Mix Raises Concerns*

Figure 14 suggests there may be significant cost shifting occurring at CHCs to cover the cost of care furnished to Medicaid patients, possibly from state or local grants meant to cover uninsured care. Medicare and private insurers were more closely aligned than Medicaid for both CHCs statewide and in Cook County. The proportion of revenue from patient collections and federal grants altogether also appears to mirror the proportion of uninsured patients. However, Medicaid covered 61% of CHC patients statewide, but accounted for only 44% of CHC revenues. Furthermore, according to 2015 federal data, health centers nationwide receive, on average, 82% of Medicaid charges while Illinois CHCs receive only 63%.<sup>24</sup> How much further Illinois CHCs will be able to move forward under this arrangement is unclear, particularly if grant funding is not extended.

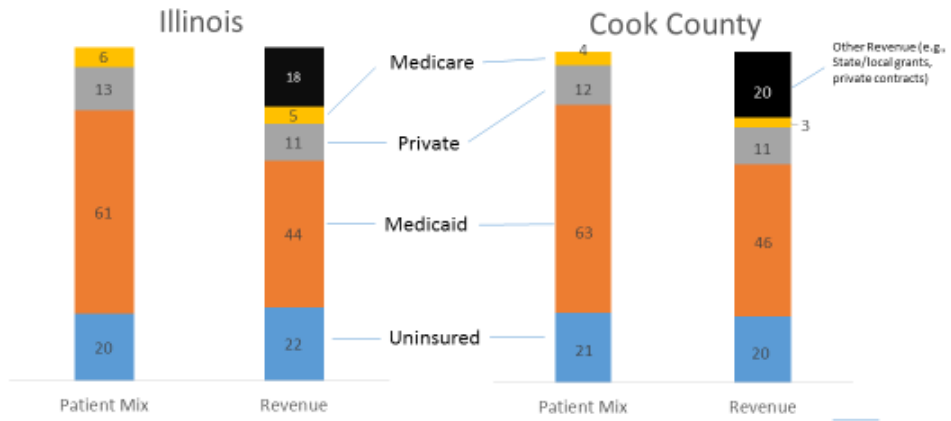
**Key Finding: Community health centers provide care to approximately one in three uninsured patients statewide.**

<sup>23</sup> U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement: the number of IL uninsured in 2005 and 2015 are 1,666,000 and 792,000, respectively.

<sup>24</sup> <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2015&state=IL> (Table 9D)

Figure 14

## Comparison of Patient and Revenue Mix, 2015



NOTES: Revenue uninsured are derived from federal grants and self-pay. SOURCE: 2015 UDS data, HRSA

# Chapter Five: Overview of Hospitals in Illinois

## INTRODUCTION

Safety net hospitals provide care to low-income, medically, and socially vulnerable populations, including Medicaid beneficiaries and the uninsured. While approximately 15% of hospitals in the country are defined as “safety-net” by the National Association of Public Hospitals and Health Systems, over 50% of low-income and uninsured populations rely on these providers as their primary source of care.<sup>25</sup> Safety net hospitals play an essential role in the U.S. health care system by providing care for our neediest populations. They offer a full range of services, including specialty services that many other hospitals do not, such as trauma and burn care, and often serve as training facilities for medical and nursing students.<sup>26</sup> They are also major providers of behavioral health care, specifically mental health care and the treatment of substance use disorder.<sup>27</sup>

Safety net hospitals include hospitals that are both publically and privately funded; they range from large teaching institutions to small community-based hospitals. Many face significant challenges serving diverse and complex patient populations regardless of patients’ ability to pay, and therefore require substantial infrastructure investments.

## METHODS

This analysis is based on hospital data provided by the Illinois Department of Public Health from reports generated through mandated reporting requirements. All hospitals are required to report on disease specific ED and inpatient hospitalizations.

## RESULTS

### THE AFFORDABLE CARE ACT AND SAFETY NET HOSPITALS

The Affordable Care Act (ACA) has made fundamental changes to the healthcare landscape in terms of coverage and financing. It extended coverage to the uninsured through Medicaid expansion, premium subsidies, and tax credits designed to help people afford health insurance policies through the marketplace. This new coverage led to additional revenues for hospitals and providers that are now reimbursed for care for previously uninsured patients.

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<sup>25</sup> Texas Health Institute. *Safety-Net Hospital Systems Transformation in the Era of Health Care Reform: Experiences, Lessons, and Perspectives from 13 Safety-Net Systems Across the Nation*. 2015. Blue Shield of California Foundation. [http://www.texashealthinstitute.org/uploads/1/3/5/3/13535548/safety-net\\_systems\\_transformation\\_in\\_era\\_of\\_reform\\_-\\_full\\_report.pdf](http://www.texashealthinstitute.org/uploads/1/3/5/3/13535548/safety-net_systems_transformation_in_era_of_reform_-_full_report.pdf)

<sup>26</sup> Coughlin TA, Long SK, Peters R, Arguello R. Strategies in 4 Safety-Net Hospitals to Adapt to the ACA. 2014. Kaiser Family Foundation. <https://kaiserfamilyfoundation.files.wordpress.com/2014/06/8600-strategies-in-4-safety-net-hospitals-to-adapt-to-the-aca.pdf>

<sup>27</sup> Illinois Health and Hospital Association (IHA). Illinois Safety Net Hospitals. 2016. Illinois Health and Hospital Association (IHA). <https://www.ihatoday.org/uploadDocs/1/safetynetbackgrounder2016.pdf>



Nationally, more than 20 million gained health insurance coverage, including approximately one million Illinois residents. But the ACA also reduced Medicare and Medicaid disproportionate share hospital (DSH) payments over time, which were a major source of revenue for safety net hospitals for many decades.<sup>26</sup> While safety net hospitals continue to serve many of the remaining uninsured patients—now below 900,000 in Illinois and 28.5 million nationally at the end of 2015, the latest official national data available—they also have to contend with reduced DSH payments for uncompensated care.<sup>28,29</sup> This burden falls heavily on safety net hospitals that serve a large portion of undocumented immigrants who are ineligible for Medicaid or ACA subsidies to purchase marketplace insurance coverage. To meet the needs of these populations, some safety net hospitals offer necessary but unprofitable complex services regardless of whether the funding exists to do so.

Another ACA-related phenomenon is the migration of many patients to other area hospitals now that they have insurance coverage. As a result, safety net hospitals have had to make significant changes to the way they function in order to compete with private hospitals for newly insured patients. Safety net hospitals are now recognizing the importance of being a hospital of choice rather than a hospital of last resort.<sup>25</sup>

The ACA has affected safety net hospitals in several other ways including:

- *Improved Patient Billing:* Inefficient and sometimes non-existent patient billing previously left payments unclaimed. One local example is a hospital which consolidated three different billing offices into one single billing system post ACA implementation.
- *Improved Cost Reductions and efficiencies:* In some cases, hospitals have streamlined services such as renegotiating outside contracts and supply chains changing to not only better serve patients, but to also reduce costs.
- *Delivery System Reforms:* Many safety net hospitals are finding new, more effective and efficient ways to deliver care within their walls or with external partners to improve patient outcomes and address cost. Safety net hospitals are developing more community-based partnerships and new systems of care and focusing on primary care and service integration. One mechanism that is available to hospitals is applying for a Medicaid 1115 Waiver which allows for creative mechanisms of care delivery. One Chicago hospital has used the 1115 Waiver to create a managed care plan, contracting with community partners to add more than 150 access points to its network.
- *Hospital Organizational and Culture Changes:* Many safety net hospitals and systems have realized the need to change organizational structures and leadership teams as health reform has unfolded. At the same time, many Safety Net Hospitals also realized they needed to change the culture of their institutions to be more patient-centered and patient-friendly in order to

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<sup>28</sup> Kaiser Family Foundation (KFF). Key Facts About the Uninsured Population. 2016. Kaiser Family Foundation (KFF). <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

<sup>29</sup> AP News. Number of Uninsured in Illinois Dropped in 2015. 2016. AP News. <https://www.apnews.com/2ad017774fec468da72b491d31aab0ec/Number-of-uninsured-in-Illinois-dropped-in-2015>

compete with other institutions. As a result, those that are able, have invested in staff training to facilitate culture change.

- *Infrastructure and Technology Investments*: The federal American Recovery and Reinvestment Act of 2009 (ARRA) included millions of dollars for hospitals to invest in electronic health records, which most safety net hospitals in Chicago received. The ACA’s emphasis on payment for quality rather than services, offered ongoing incentives for IT investments, recognizing the potential to make these systems more efficient and cost effective, more timely in sharing information, and more appealing to patients.<sup>26</sup>

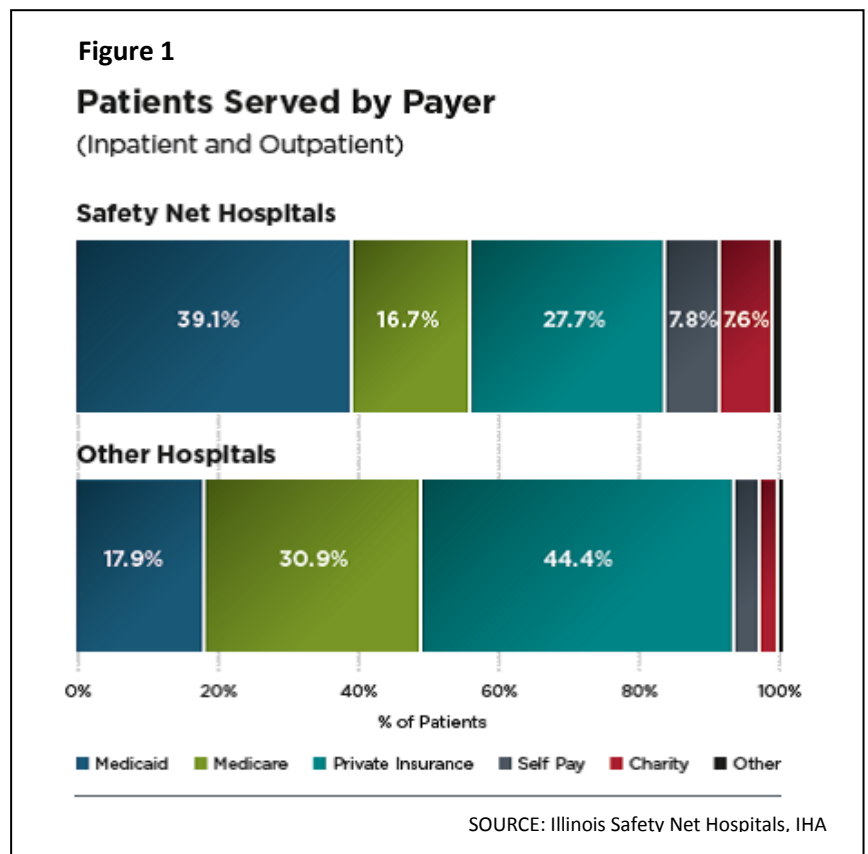
**SAFETY NET HOSPITALS IN ILLINOIS**

Illinois currently has 40 safety net hospitals—making up 19.1% of all Illinois hospitals, according to the Illinois Health and Hospital Association, which defines safety net hospitals as having either:<sup>30</sup>

- Medicaid Inpatient Utilization Rate (MIUR)<sup>30</sup> of at least 50%; or
- MIUR of at least 40% and a charity percent<sup>30</sup> of at least 4%

In 2015, there were 25 safety net hospitals in Cook County. Several of these individual hospitals are part of a larger hospital system, for example, Provident and Stroger Hospitals are part of Cook County Health and Hospitals System (CCHHS) and Mt. Sinai and Holy Cross are part of the Sinai system. Illinois’s safety net hospitals reflect the communities they serve and therefore have unique qualities and face unique challenges influenced by the economic conditions and other characteristics of these communities. Illinois safety net hospitals are largely dependent on government funding. Most face significant financial challenges—about two thirds operate on negative margins or margins under two percent. Nearly 40% of patients at Safety Net Hospitals in Illinois are covered by Medicaid compared to 17.9% for all other hospitals.<sup>27</sup>

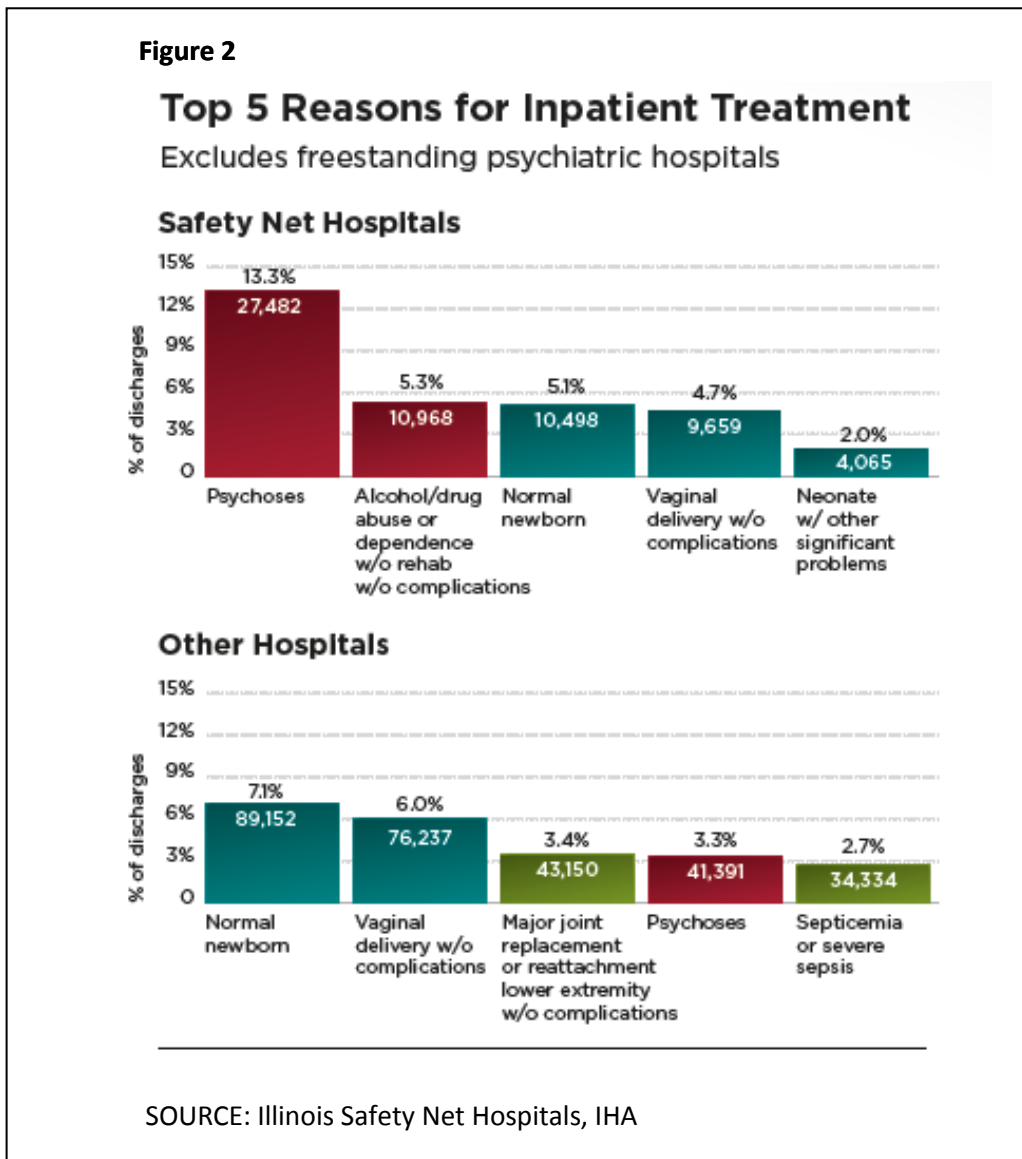
They also treat more patients who are uninsured and pay out of pocket



<sup>30</sup> Illinois Health and Hospital Association (IHA). Safety Net Hospital Constituency Section. n.d. Illinois Health and Hospital Association (IHA). <http://www.ihatoday.org/Member-Groups/Constituency-Sections/Safety-Net-Hospitals.aspx>

for services.<sup>27</sup>

Safety net hospitals in Illinois care for almost 40 percent of all patients hospitalized for a mental health condition or substance use disorders.<sup>27</sup> The majority of admissions to safety net hospitals in Illinois are related to behavioral health issues, however psychiatrists required to care for these patients are in short supply.<sup>27</sup> Additionally, 82.5% of safety net hospitals are located in a Mental Health Professional Shortage Area—a federally designated area with 30,000 or more people per psychiatrist.<sup>27</sup>



Safety net hospitals, on average, contract with more than two thirds of the Medicaid Managed Care Organizations (MCO) in their area, creating the additional operational responsibilities of dealing with administrative burdens created by MCO contracts.<sup>27</sup> Furthermore, the current budget crisis in Illinois sometimes delays critical reimbursements to hospitals. When hospitals are reimbursed, a major portion of the payments first go to one of 13 managed care companies in the state.

## **SAFETY NET HOSPITALS ARE INCREASINGLY SHIFTING TO AMBULATORY SERVICES**

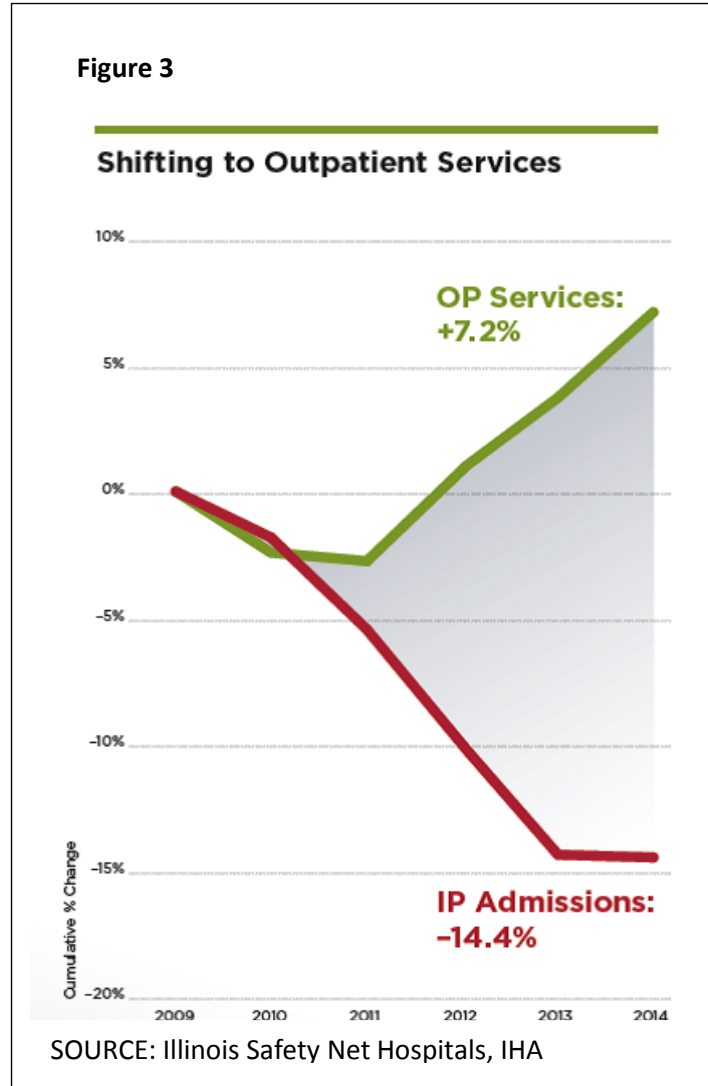
According to Illinois Department of Public Health (IDPH) Annual Hospital Questionnaires from 2009 to 2014, safety net hospitals are increasingly providing more cost-effective outpatient services. From 2009 to 2014, outpatient services increased by 7.2% and inpatient admissions decreased by 14.4 percent.<sup>27</sup>

These providers are also transforming in other ways, including providing outside services such as home health, ambulance services, dental care, immunization programs, and opening women's health centers.

### **ECONOMIC ENGINES**

Illinois safety net hospitals have a positive economic impact on their communities. In 2016, they created 68,590 jobs and had an \$11.7 billion economic impact.<sup>27</sup> In 2013 and 2014, Illinois safety net hospitals provided \$725.5 million in community benefits including charity care, research, education, and the elimination of bad debt, according to the IHA. Those that are not-for-profit corporations must follow Illinois law and provide significant levels of free or charity care to qualify for their tax exemption. Charity care provision and what qualifies as charity care continue to be debated and litigated in Illinois.

In 2014, Illinois safety net hospitals admitted over 250,000 patients, provided more than 900,000 emergency department visits, and more than four million outpatient visits. While millions of Americans still have no health insurance, the ability of safety net hospitals to survive and thrive is important to the health and wellbeing of this country, especially where communities rely on them as the sole source of primary, specialty, and tertiary care.<sup>27</sup>



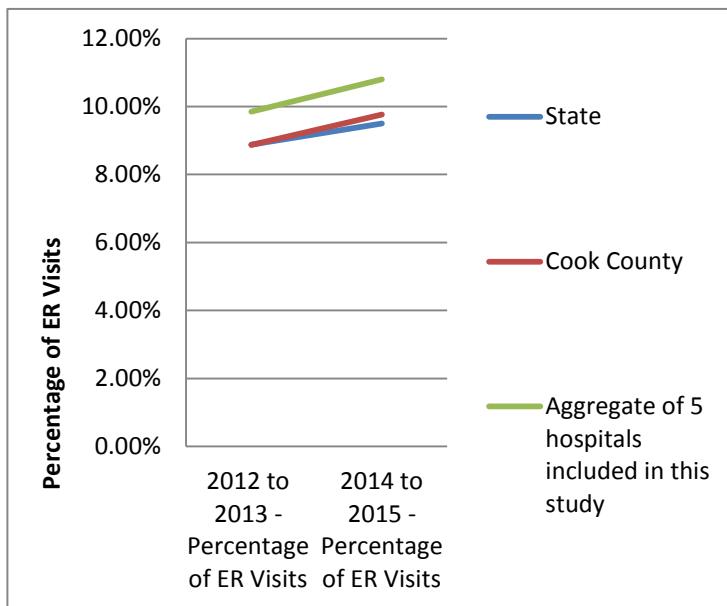
**Key Finding: Illinois safety net hospitals have a positive economic impact on their communities. In 2016, they created 68,590 jobs and had an \$11.7 billion economic impact.**

**HOSPITAL EMERGENCY ROOM UTILIZATION FOR DIABETES, CHILD ASTHMA, ADULT ASTHMA, AND HYPERTENSION FROM 2012 TO 2015**

**Table 5.1: Hospital Emergency Room Utilization for Diabetes 2012-2015**

	Percentage of ER Visits, 2012 to 2013	Percentage of ER Visits, 2014 to 2015	Percent Increase/Decrease
State	8.88%	9.50%	6.98%
Cook County	8.87%	9.76%	10.03%
Aggregate of five hospitals included in this study	9.85%	10.80%	9.64%

Figure 4: ER Utilization with Diabetes Diagnosis, 2012-2015



Hospital Emergency Room data and inpatient data were requested from IDPH to help researchers examine utilization trends from 2012 to 2015 (before and during the ACA implementation and state health reforms). Unfortunately, IDPH was unable to provide hospital inpatient utilization data, but outpatient data for the state, Cook County as a whole, and the hospitals interviewed for the study were provided.

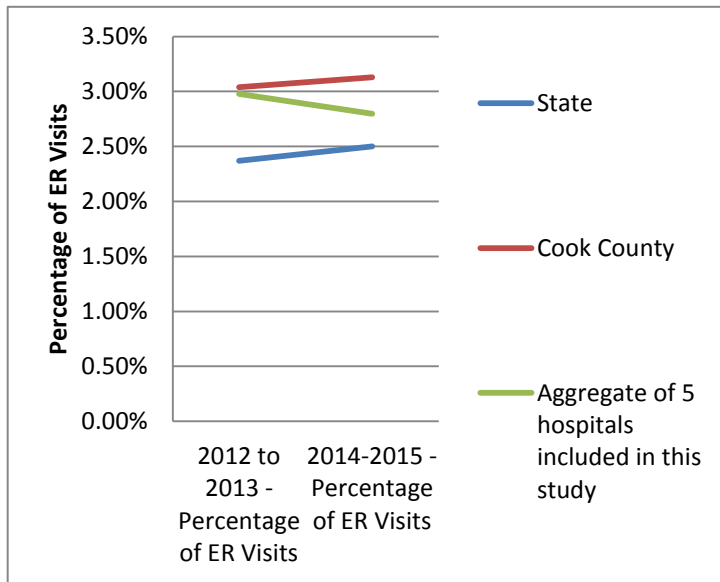
As expected, ER utilization with a diabetes diagnosis increased during this time period for the state, the County as a whole, and the hospitals

studied. While we cannot be certain, this may be because newly insured patients are using health services for the first time and have not yet begun to use primary care sites for this care. Certainly further research is needed to determine if this trend continues as patients become more familiar with how to access health services.

**Table 5.2: Hospital Emergency Room Utilization for Child Asthma 2012-2015**

	Percentage of ER Visits, 2012 to 2013	Percentage of ER Visits, 2014-2015	Percent Increase/Decrease
State	2.37%	2.50%	5.49%
Cook County	3.04%	3.13%	2.96%
Aggregate of five hospitals included in this study	2.98%	2.80%	(6.0%)

Figure 5: ER Utilization for Child Asthma, 2012-2015

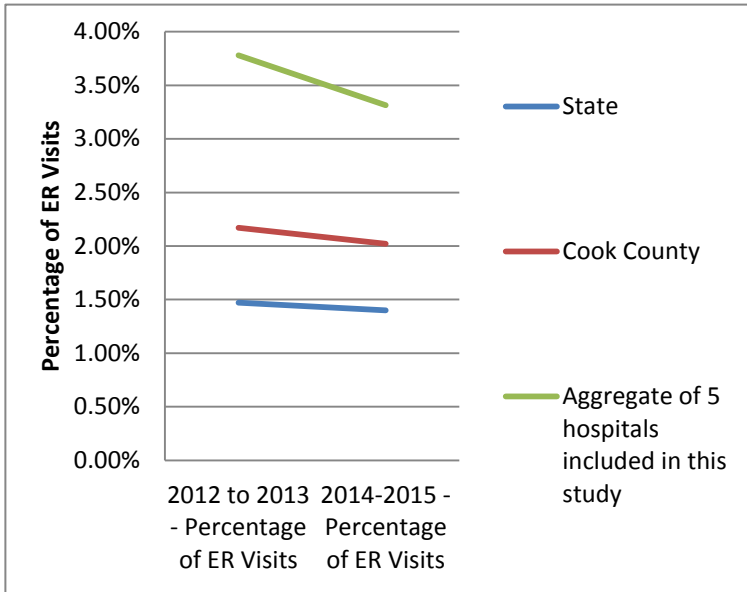


Interestingly, hospital ER utilization for childhood asthma declined for the hospitals studied, while it increased in Cook County and across the state. This difference is likely due to the fact that none of the hospitals in our study group were primarily children’s hospitals and the volume of children seen in their ERs is quite small.

**Table 5.3 Hospital Emergency Room Utilization for Adult Asthma 2012-2015**

	Percentage of ER Visits, 2012 to 2013	Percentage of ER Visits, 2014-2015	Percent Increase/Decrease
State	1.47%	1.40%	(4.8%)
Cook County	2.17%	2.02%	(6.9%)
Aggregate of five hospitals included in this study	3.78%	3.31%	(12.3%)

Figure 6: ER Utilization for Adult Asthma, 2012-2015

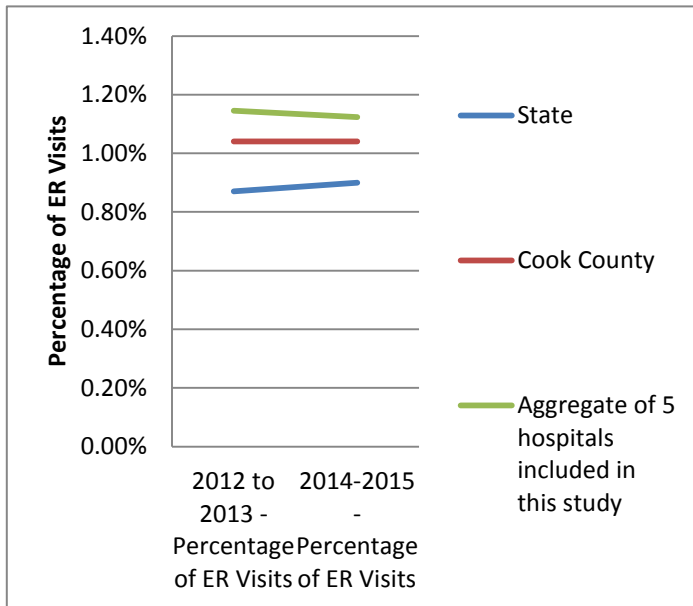


Adult Asthma ER utilization declined for the state, the County, and the study group. Interestingly, the percent of ER visits that adult asthma represents for the study hospitals is significantly less than the state and the County.

**Table 5.4: Hospital Emergency Room Utilization for Hypertension 2012-2015**

	Percentage of ER Visits, 2012 to 2013	Percentage of ER Visits, 2014-2015	Percent Increase/Decrease
State	0.87%	0.90%	3.45%
Cook County	1.04%	1.04%	0.00%
Aggregate of five hospitals included in this study	1.15%	1.12%	(2.6%)

Figure 7: ER Utilization for Hypertension, 2012-2015



All three groups—the state, county, and studied hospitals—had very little change over the four year period in the percentage of ER visits for hypertension. Without additional data, including updated utilization data, little can be inferred from the ER utilization data analyzed. It will be important to continue to monitor ER utilization over time to see the impact of reform on how people use different health system access points.



# Chapter Six: Focus Groups with Free and Charitable Clinic Leaders and Patients

## INTRODUCTION

This section of the report will detail the methodology and findings among free and charitable clinics and the patients they serve. For additional context on the general landscape of free and charitable clinics (FCCs) in Illinois, see Chapter Three.

## METHODS

The qualitative component of this mixed-method study of FCCs in Cook County relies on methods consistent with high quality, qualitative social science research. The Chicagoland area FCCs safety net includes 20 providers that were identified by Julie Darnell at Loyola University Chicago as part of a national survey of the sector. FCCs are heterogeneous beyond their shared mission to provide care free of charge or, in the case of charitable clinics, for a nominal fee. A goal of the research was to engage a diverse sample of these providers and to capture the perspectives of the different types of patients who seek services from them.

### **STUDY DESIGN AND SETTING**

We conducted a cross-sectional focus group study of FCCs in Chicago, Illinois. A total of five focus group meetings were organized with clinic leaders and patients of FCCs—two with leaders of FCCs and three with patients. The focus groups with clinic leaders were held at an event space in downtown Chicago whereas the patient focus groups were held at three Chicago-based free clinics. Each focus group followed a series of guided questions and lasted approximately two hours.

### **PARTICIPANT RECRUITMENT AND DATA COLLECTION**

#### ***Participant Recruitment***

We contacted all 20 medical clinics in the Chicagoland area in-person, via phone, or email to invite them to participate. As noted above, our goal was to achieve participation from a diverse range of medical clinics. Of the 20 known medical clinics, nine agreed to participate (45%). In spite of the smaller than anticipated number of participating medical clinics, the group represented clinics that: 1) have large and small operating budgets; 2) are religious and secular; 3) offer walk-in and scheduled appointments; 4) are staff-led and student-run; 5) mobile and permanent; 6) free-standing and affiliated; 7) open daytime, evening, and weekend hours; 8) operating full-time and part-time; and 9) all volunteer-run and staff-based.

For the patient focus groups, we partnered with three of the Chicago-based free medical clinics to recruit patients. We identified a convenience sample of FCCs representing one large, one medium, and one small clinic. When initially approached by the research team about the study, all three clinics agreed to facilitate the focus groups by recruiting patient participants and hosting a session. Free clinic staff identified potential participants by posting recruitment flyers (designed by the research team) and making personal contact. Patients meeting the inclusion criteria (i.e. patient of the clinic, age 18 years or

older, and able to speak English), were invited to participate. Clinics were instructed to recruit patients until the group reached its capacity of 10 participants. We also instructed each clinic to try and recruit a diverse array of patients who had varied backgrounds and experiences utilizing the clinic and applying for and receiving health insurance coverage.

### ***Data Collection***

In November and December 2016, we conducted five focus groups using standardized, semi-structured focus group guides. The interview guide was created by Dr. Darnell and the research team at Health & Medicine Policy Research Group (Margie Schaps, Wesley Epplin, and Tiffany Ford) plus independent consultant Susan Cahn. (See Appendix A for a copy of the instrument.) The guide was used for both the focus groups with the leaders of FCCs as well as with staff from Federally Qualified Health Centers. Drs. Darnell and Cahn developed a separate standardized focus group guide for the focus groups with free clinic patients (Appendix D). Drs. Darnell and Cahn, experienced moderators, also shared the moderating responsibilities. A volunteer took notes at all five focus groups. All focus groups were audio-taped and professionally transcribed verbatim. In addition, participants also filled out a two-page questionnaire that included basic organizational and demographic information as well as patient health status and information on health care needs and utilization.

We distributed a \$50 Visa card plus breakfast/lunch to the clinic leaders who participated in the focus groups. We awarded a \$40 Target gift card and dinner to all participants in the patient focus groups. The study protocol was approved by the institutional review board at Loyola University Chicago. Tables 7.1 and 7.2 provide descriptive statistics of the focus group participants for clinic leaders and patients based on their questionnaire responses.

**Table 7.1: Description of Participants and Organizational Settings: Focus Groups with Leaders of Free/Charitable Clinics**

Description of Participants (n=10)	
Job Title (%)	
Clinic Manager	10
Clinical Manager	10
Co-Coordinator	10
Community Health Manager	10
Director	10
Executive Director	10
Founder and Co-Director	10
Physician	10
Program Coordinator	10
Program Director	10
Tenure with safety-net entity	
Mean (in years)	5.6
Range	.2 - 16
Age (in years)	
Mean (SD)	42 (16.2)
Range	24 - 64
Gender (%)	
Female	60
Male	40
Educational Attainment (%)	
Bachelor's	40
Master's	50
Professional degree beyond bachelor's	0
Doctorate (MD, DNP, PhD, etc.)	10
Description of Organizational Setting (n=9)	
Organizational Age (year)	
Year founded (Mean, SD)	1991 (15.5)
Range	1970 - 2014
Unduplicated Patients (#)	
Mean (SD)	3,053 (3,293)
Range	130 – 11,000
Visits (#)	
Visits (Mean, SD)	4,647 (6,052)
Range	130 – 20,000
Delivery Sites (#)	
Mean (counting mobile units)	13 (32.7)
Mean (excluding mobile units)	1.1 (.4)
Range	1-100
Services Provided (%)*	
Inpatient	0
Outpatient primary care	89
Mental health/behavioral health	56
Dental	22
Other (e.g., social services, vision, testing & screening)	33
Geographic Location(s) of Delivery Sites (%)*	
Chicago-North	56

Chicago-South	44
Chicago-West	33
Suburban Cook	11

\*Percentages exceed 100 because clinics may provide more than one type of service.

**Table 7.2: Description of Participants: Focus Groups with Patients of Three Free/Charitable Clinics**

Participants' Access to Care and Health Insurance Status (n=26)	
Focus Group Setting (%)	
CommunityHealth	35
Old Irving Park Community Clinic	38
Port Ministries Free Clinic	27
Insurance Status (%)	
Uninsured	81
Coverage through marketplace	8
Medicaid	4
Other	4
Reasons Why Uninsured (n=21) (%)*	
Cost too high	42
Ineligible for Medicaid or marketplace coverage	33
Lost job or changed employers	23
Have no need for health insurance	10
Do not know how to find information on insurance	8
Other ("kicked off ACA" or "not eligible because of my heart condition")	8
Self-employed or employer does not offer insurance	4
Regular Source of Care / "Place Usually Go" (n=25) %	
Free Clinic	88
Another doctor's office or private clinic	12
Access to Care Barriers (since becoming a patient of free clinic) (%)	
Trouble finding a general doctor who would see you	15
Told by doctor's office/clinic that they would not accept you as a new patient	15
Told by doctor's office/clinic that they would not accept your health care coverage	50
Had trouble finding a doctor/clinic you could afford	48
Did Not Get Needed Care (since becoming a patient of free clinic) (%)	
Did not get dental care that you needed	42
Did not fill a prescription for medicine because of the cost	31
Did not get specialist care that you needed	27
Did not get doctor care that you needed	15
Participants' Demographic Characteristics and Health Status	
Age (in years)	
Mean (SD)	49 (12.9)
Range	23-68
Gender (%)	
Female	73%
Male	27
Race/Ethnicity (%)	
Hispanic or Latino/a	50
White	31
Black	15
Other	4
Educational Attainment (%)	
Grade 1 - 11	23
High school diploma or GED	19
Some college	35
Associate	12
Bachelor's or more	12

Working Status (%)	
Full-time	15
Part-time	35
Retired	12
Unemployed	38
Income (%)	
< \$20,000	65
\$20,000 - \$29,999	12
\$30,000 - \$39,999	12
\$40,000 - \$49,999	4
\$50,000 - \$59,999	8
Residence in Cook County (in years) (n=23)	
Mean (SD)	32 (17.1)
Range	1 - 60
Residence (%)	
Chicago: Old Irving Park, Belmont Gardens, Portage Park	38.4
Chicago: Back of the Yards, New City, Fuller Park	23
Chicago: Other	19
Cook County: Harwood Heights, Norridge	4
DuPage: Lisle	4
Chronic Condition	
Yes	69
No	31
Health Status (n=25) (%)	
Very Good or Excellent	16
Good	48
Fair or Poor	36

\*Percentages exceed 100 because more than one reason may apply.

## DATA ANALYSIS

The focus group transcripts were analyzed using Nvivo 11.0 software™. Drs. Darnell and Cahn developed a series of themes and subthemes for coding the clinic leader and patient focus group transcripts. The initial themes were developed using the interview guides and revised using the transcripts. The research team also reviewed the transcripts to clarify mispronunciations and unclear comments by the participants. In order to validate the coding of the files, Dr. Cahn reviewed the coding and made additions and revisions as needed. The coded results were then cross-tabulated to explore the differential experiences of the patient subgroups by insurance status, the type of health care problem, and Medicaid eligibility. In a final analysis, Nvivo was also used to examine the frequency of common words across the clinic leaders and patients to describe experiences with the safety net and health care reform.

## FOCUS GROUP RESULTS

In two focus groups with ten clinic executive directors or managers and three focus groups with 26 patients, a detailed picture emerges of the essential role that free and charitable clinics play in Cook County's safety net patchwork. Focus group participants were asked to consider five key issues, using the same questions for clinic leaders as were used with safety net clinic and hospital personnel. Clinic patients were also asked questions concerning how they became patients at the clinic and what had been their experience applying for and using insurance under the Affordable Care Act (ACA).

Administrators and patients reflected on the sector's fundamental resilience and flexibility and the challenges that these clinics and their patients have faced under a shifting health care landscape. The responses discussed in detail below highlight the need for true charity care, and the unmet needs and gaps created as Medicaid has expanded in Cook County. None of the traditional barriers to care has been eliminated entirely in the new environment for Medicaid- and marketplace-eligible individuals or for the County's undocumented residents who have even fewer options. Patients and their FCC providers mentioned the lack of affordability, problems navigating the system and accessing inconvenient locations, and disappointing experiences with providers. In addition, Medicaid managed care has disrupted access for Medicaid beneficiaries. However, participants were also able to articulate specific ways that FCCs can be strengthened and linkages improved among all safety net providers.

## STATUS OF THE SAFETY NET

**Key Finding: The promise of improved coordination under the ACA has not been realized, leaving a fragmented safety net fighting for resources.**

In order to understand the impact of the ACA on FCCs and the safety net, it is necessary to describe the FCC perspective on the safety net's composition and function. The administrator of a larger FCC captured succinctly both the providers that comprise the safety net and how it is operating today:

*"I'll start by using the word 'fragmented,' and the safety net includes, obviously [federally qualified] health centers and other community health centers, clinics from our sector, and hospitals. And, often I think what we lack is, ideally, a more integrated approach to how to address health care issues across the County..."*

The highly fragmented nature of the sector was echoed by her peers, many of whom shared the same confusion that was expressed by their patients. “I have been here for about a year and I find the environment very confusing for both providers and patients... the neighborhood hospitals, Cook County clinics, Cook [county hospital], and the Illinois Department of Public Health [are] places that don’t understand [each other] and don’t work together at all.” Or, “there is no interconnection. I feel like everybody is doing the same job, but in their own bubbles, so until we all integrate together, the system won’t be very effective.” The image portrayed by FCC providers does not vary significantly from previous descriptions. In addition, health care reform had not improved coordination, rather it further stretched the limited resources these providers have to coordinate care outside the clinic. Although one provider noted that in the early years of the ACA new opportunities to partner with other safety net providers had existed and “we [FCCs] didn’t feel so alone during that time and then it went away.”

**Key Finding: Access problems persist for those with new coverage as well as the uninsured.**

As a result of the continued fragmentation of the sector, not surprisingly, patients cannot effectively navigate the system to access basic health care services. FCCs describe the current safety net as inaccessible and confusing:

*“for the Chinese population...for them the safety net is a bit inaccessible because they don’t know what is offered. It’s a language barrier that they have to cross and after that it’s the long waits ...and maybe they have to go to several different locations because they have a specific condition...”*

*“Within the last year, I have seen families who were able to get coverage under the Affordable Care Act and then it was interrupted...and they’re having difficulty navigating and being informed that their provider that they were following up with is no longer accepting their plan or they lose coverage all together...”*

*“There are barriers that come from this, the system, even Medicaid, for example we have friends of the [clinic], doctors out there in the community willing to see patients, but they can’t. Who they work for will not let them see patients unless they are in our clinic.”*

These administrators are describing a safety net system that has also been disrupted—especially the informal networks that enabled FCCs to link to other providers, in some cases including other members of the safety net. From an organizational perspective, the safety net is struggling with the increased demand from patients for assistance navigating healthcare insurance and delivery systems and the associated administrative burden that has resulted from interruptions to prior systems of accessing care.

**Key Finding: The unique culture of care at free and charitable clinics sets them apart from other safety net providers and helps to explain persistent demand.**



The FCC model is distinct from the other safety net providers that rely on public funding and are counted as part of the traditional health care delivery system. There is a unique culture of care that emerges when care is delivered by volunteer physicians and other providers and managed by a few, if any, paid staff, relying on small grants and in-kind contributions. These distinctions continue to set the sector apart even as its patient population and their needs change. In addition, this culture has enabled these clinics to overcome questions regarding their viability in a reformed health care system with expanded coverage. Despite a more limited set of services, rotating groups of providers, and varying diagnostic and pharmacy services, FCCs serve as medical homes for their patients.

Patients at these clinics—both the uninsured and underinsured—have been patients for up to a decade or since the passage of the ACA and seek routine primary care, chronic disease management, and, more recently, preventative services and wellness programs. First, almost all patient participants explained that they were made to feel welcome from the moment they arrived at clinics. The physicians and providers treated them with respect, and they received follow-up care, appointments, medication, and regular phone call reminders. Table 7.3 provides detailed quotes describing the exceptional patient experience at the three clinics. The type of care that FCCs provide is “care that is worth the wait” as the comments on Wait Time show. Patients are treated humanely, the doctor takes time to ask about more than just health problems, and, in the end, patients are likely handed medication and not a bill. One might even conclude that FCCs are delivering health care the way it is supposed to be delivered, care that is truly patient-centered because it is not rushed and maximizes communication between the patient and provider.

The FCC administrators also describe the distinctive type of care that FCCs are trying to offer. In the focus groups, two different approaches emerged among the clinics. One group of providers seeks to function as a medical home, managing patients’ chronic diseases and providing prevention, counseling, and even extended wellness programming. A second group of providers, some of whom focus on specific populations such as the homeless or Chinese restaurant workers, try to provide basic primary care and then link them to other providers. Administrators commented:

*“We have a very limited staff...Our goal is to be the medical home for our patient to really help them learn about their care , about prevention, trying to keep our patients coming back to us and not...getting lost out there in the system.”*

*“My goal as a volunteer is to see to it that whoever comes into the clinic at least gets basic medical needs, at least prescription, some basic lab work...some sort of initial management to their specialty chronic conditions, and get them into some integrated health system if possible.”*

FCC patients have used other providers and generally describe feeling unwelcome elsewhere: “It’s very hard when you go and they ask you; ‘Do you have insurance?’ No, I don’t...you can see the face of the person and you are treated immediately like someone [who is] not a human being.” Some participants described waiting hours to see providers, who are rushed, and leaving with large bills:

*“So my blood pressure was up and down, up and down, so I am like, one of my friends, she called, she is like, I can go with you, she is like, it’s not okay. So I don’t really like to go to the hospitals, but I did. So we went there, I was sitting...eight hours, the doctor came [for] 15 minutes, to tell me, tomorrow it’s going to be worse...And they had a bill for...over \$3,000 for sitting eight hours waiting for them.”*

However other respondents had very positive experiences seeking emergency or specialty care, especially at Stroger Hospital. A patient with high blood pressure was seen immediately and others received diagnostic tests and appointments with specialists. Several patients with insurance had or were also using other providers inconsistently. Regardless, those who were going onto Medicare or Medicaid and knew they would no longer be able to seek services at the clinic (which target their services to the uninsured) did not want to leave.

FCCs, old and new, had well-defined missions as the ACA was implemented and were prepared to adapt and respond to new demands. FCC patients, who considered themselves genuinely lucky to be clinic patients, either anticipated having access to affordable coverage or knew that they were ineligible due to their status. As administrators and patients experienced the implementation of the ACA and Medicaid expansion and reform, both groups encountered anticipated and unanticipated effects and consequences.

**Table 7.3: Patient Description of FCC Culture of Care**

Patient Experience	Quotations
How FCC staff treat them	<ul style="list-style-type: none"> <li>• I was treated with respect, everybody was so kind.</li> <li>• They know you, they know your voice, that’s how you feel...</li> <li>• Here they don’t think about time, they don’t think about money. They only think about the need[s] of the patient.</li> <li>• You can feel the warm environment here. [It] is like you feel like welcoming...You feel safe. Everybody is treated the same way with respect.</li> </ul>
How FCC providers treat them	<ul style="list-style-type: none"> <li>• [They are] people doctors, the people who work here are people doctors, where they care about you genuinely.</li> <li>• However, they are doing it to get the doctor’s to come here...it’s like a certain kind of person, a certain human being can do this not every doctor could do this.</li> <li>• [He] always has time to listen for the detail and he showed that he cares, we are not business.</li> <li>• When you see the doctor smiling, you immediately open your mouth, you are talking about all your problems.</li> </ul>
Visit follow-up	<ul style="list-style-type: none"> <li>• They give me the pills and tell [me] to come back in a month. But if I feel that my blood pressure is high I come and they receive me.</li> <li>• One time I came and ... my blood pressure was [high], they were doing it from one arm [to the other]. He made me come back three days in a row. And when I say he made me, they call at my house in the morning to make sure I could have checked my blood pressure, regular clinics don’t do that.</li> </ul>
Getting an appointment	<ul style="list-style-type: none"> <li>• I do remember filling out some paperwork, but they were, they really expedited the procedure, it didn’t take me long to get in to see a doctor at all.</li> <li>• Wait, I don’t have to wait. If I am sick, it’s like if it’s my turn I just come in.</li> <li>• There was a delay of eight to twelve months.[referring to dental care]</li> </ul>

Patient Experience	Quotations
Wait Time	<ul style="list-style-type: none"> <li>• We do not spend too much time waiting like in the other clinics.</li> <li>• You may have to wait a few minutes in the front, but it's not like they are going to double and triple book you, because it's a free clinic, so waiting up in the front is not a big deal.</li> <li>• The thing about waiting is that you know that they are going to take their time with you too.</li> </ul>

**IMPACT OF HEALTH REFORM**

The ACA and state Medicaid reforms have had both positive and negative effects on the County's FCCs. However, during the past six months there has been an increased level of uncertainty and concern about their ability to meet demands for their services. Those who assist patients with navigation have patients who can no longer access their regular providers or get their medications due to out-of-pocket costs. FCCs continue to frequently see insurance-eligible patients because the marketplace is unaffordable. One FCC administrator expressed frustration and sadness that the informal health networks built with care over the years were being eliminated: "So I found that actually the worst part is that the friendships that we spent years cultivating and that people were willing to bring our patients into their clinics to help them, it disappeared and it just disappears."

The passage of the ACA also created new opportunities, such as potential partnerships and a re-evaluation of their care delivery models. However, most clinic leaders concluded—like the hospital and FQHC executives—that the complexity of Illinois's Medicaid expansion and the pent up demand for care, had prevented clinics from taking full advantage of the historic health care transformation. The comments below describe these opportunities and challenges:

*"I think in the early, the first year or two of the ACA, there were some resources flowing out of Washington, that indirectly could, could benefit our sector, and for those of us who were lucky enough to – to access some of those funds, it—it was a good thing...a good opportunity...to partner with some Federally Qualified Health Centers and other community-based organizations around a coordinated approach to navigation."*

*"We knew that we already had it that time, people who had insurance coming to us for their care even though they can use it and either paying if they could or not paying if they couldn't afford it...so we actually [were/are] looking that may be the shift to be able to accept some health insurance which has been an incredible challenge."*

*"In terms of population health, we have an ACE [Accountable Care Entity] comprised of high risk women and children. So we have been trying to work with our population health group and that's kind of moving slowly but working with the community health workers, the case managers trying to identify the high-risk children in our area, children with asthma, children at risk for diabetes...and minimize their use of the emergency department."*

In addition, the nature of the FCC sector leads clinics to leverage every possible opportunity to improve care for the most vulnerable. This tendency was described as follows by one clinic administrator: "one of the first things that came to mind for me is that, this sector is incredibly hardworking and generous, and I feel that every time I am—not only at my clinic—but in meetings like these." In addition, they have

embraced the role of navigator, drawing on their unique culture and persevering in sorting through the confusion for their patients. This was especially true for the clinics serving specific populations, some of whom operate out of mobile vans, because their mission is to link their patients to the traditional healthcare system as opposed to taking on the role of a medical home.

The clinic leaders described the anticipated reduction in medical visits as Medicaid coverage was expanded to a new group of low-income adults. The patients described reduced waits for appointments, especially among the few specialists that offer services at these sites, and generally less crowded waiting rooms. Although clinic leaders had not anticipated treating many Medicaid patients, they discussed the need for increased outreach in the community. Another clinic elected to shift from medical to dental care to maximize use of their capacity (see ACA Adaptation below). The unanticipated and unintended consequences of health reform have introduced additional challenges. First, the initial efforts after passage of the ACA to create linkages to better serve and connect patients were not highly effective and have not been sustainable for the FCC sector as a whole. At the time of our focus group clinics expressed a desire to respond to the return to silos by playing a larger role at the policy level.

### *Impact of the ACA on Patients*

**Key Finding: Three years after the ACA extended health insurance coverage, signing up for ObamaCare continues to be out of reach for some, suggesting the need for ongoing enrollment support to help people (want to) take advantage of the public programs to which they are eligible.**

Numerous patients report being unable to complete the insurance application process, being denied coverage, and simply giving up. FCC clinic patients commented that while “Obamacare” was supposed to be good, the law had not improved their situation at all: “Medicaid is not that great, a lot of places won’t take you...I didn’t get approved for it. And my daughter has MS and asthma and every other thing you could think of, they wouldn’t approve her and she is 44 years old. And they just told her no.” Several patients tried to apply and reported that their applications were lost and/or denied after months of waiting: “I filled it out online, everything online...They said, they will email you, and they just email you, you know then your application went through and you are going to hear from them sooner or later or something [in] the mail. I never got that thing...” Another patient shared, “It was a good idea on paper [but it] didn’t work out that way, in the next year.”

At the same time, a few patients were still waiting to hear about coverage, complete their application, and use their benefits. One irregular user of the health care system, who was referred for a colonoscopy, was successfully navigated, enrolled, and will now be on Medicaid. The Medicaid patients who came to the FCC describe a system that is not meeting their expectations. When probed about her experiences, one patient offered:

*“The doctors...they’re in a rush, you know? And I don’t like to be rushed...A lot of things [fall through the cracks], like my son, he had to go to the hospital and they wouldn’t—it was some—*

*he had a scratch and it was some type of ointment that he needed and he need it for the scratch and they wouldn't prescribe it for him..."*

In short, the traditional healthcare system and healthcare reform with its applications and limitations, contrasted starkly with everything they have experienced at their FCC provider.

**Key Finding: The Affordable Care Act is not affordable enough.**

The cost of care was the major barrier for most of the patients at all three focus groups. However, several patients from two of three sites reported seeking and paying for private care. One patient even reported exhausting a large portion of her savings. At the same time, patients who are ineligible for the ACA due to their immigration status had experience with employer insurance. They were aware of the high cost of using the emergency room as well as elective procedures and medications.

Already sensitive to the issues of cost, participants were shocked to learn that their premiums were in the hundreds of dollars. Some participants had already had to forgo COBRA coverage due to the cost and wondered aloud what they would do if they became ill: "I am still not sure what I am going to do in an emergency because I don't have insurance and they take care of your daily doctor stuff, but what happens...if I have a heart attack?" A female patient with a complex medical history complained that, "[with] my preexisting conditions, you know it's going to cost me like \$900 or \$800...even with my husband, if I was to go on his insurance under the Obamacare."

Patients at one of the clinics expressed anger and disappointment, but others were more accepting. These patients who had been on and off different types of coverage did not have a universal expectation that they would be covered. In addition, focus group participants had identified an alternative source of care at the FCCs. These clinics were generally able to provide most of the care they needed: "It's just the only thing it just lets you get insurance with preexisting conditions. That's what they should say, insurance with pre-existing conditions."

In one focus group, the conversation turned to what a person could/should pay for health insurance and someone suggested two percent of their income. Despite considerable knowledge of hospital, physician, and pharmacy costs, patients living at or just above the poverty level could not conceive of paying even moderate sums for insurance or healthcare. On the other hand, these patients face difficult choices when trying to pay for the healthcare they need: "I am a single parent with my son not having any help from his father who is also here. So for me...to look for some healthcare was always, 'Should I go to work or to doctor?' Because I was losing my money from my work, so I always chose, 'No, I am not going to doctor. I am going to work.'" It is clear from these patients that the lack of affordability and the high cost of even routine care remain the primary barrier to access for low-income families even with expanded coverage in Illinois.

**Key Finding: FCCs have responded to the demand from newly-eligible Medicaid and marketplace patients for help with enrollment and navigation.**

**ORGANIZATIONAL ADAPTATION TO THE REFORMED ENVIRONMENT**

FCCs are adept at responding to environmental changes and maintaining services despite significant resource constraints. Their response to health reform has demonstrated a sustained commitment to serving Cook County's most vulnerable patients. They have continued to try and guide patients through provider networks and even the application process. In one instance, a small FCC phoned pharmacies as far away as Indiana to try and secure an asthma ventilator for a Medicaid patient. Clinic staff and doctors have tried to understand where their newly enrolled patients can receive care:

*"I think a big barrier with a lot of our patients in accessing...state funded or federally funded programs, and this is not any new news, but it's so confusing...they are confused, they don't know what they are eligible for and what they are not eligible for, and to be quite honest with you, neither do I, and so...let's get on the computer and it was essentially...just trying to Google search and make phone calls and when our patients had a lot of barriers communicating, in general, whether that be a language barrier or education, there are a million different things to try and navigate these types of systems."*

This role of navigating the Medicaid system has been added to the constant challenge of patching together treatments and medications for the uninsured. In addition, none of the patients suggested that FCC providers' respect and care for patients had been compromised in any way in the process of assuming this new role. Those clinics that define themselves as medical homes have maintained follow-up and availability for their patients, but continue to try and link patients to social services.

Whereas for the smaller providers who offer initial assessments and urgent care, more typically providing navigational services to Medicaid patients is understood as critical for this population—a population that may not have had access to routine, preventive care.

*"I think for us, it's make sure that the patients are able to get as many services as they're eligible for. And so when the patients come in and they don't have insurance, we find that if they're eligible for example and if so, we [link] them with ACA and navigate us through [other providers]."*

*"They're [doctors] not allowed to see patients without coverage, just can't get through the door, and even when there is a free, lower cost clinic, to get the correct Medicaid to enter that guy's clinic, well maybe there is a 50-50 chance that we are gonna be able help patient get in there... They are going to have to change that the six-week thing is the right time to enroll or not enroll, oh my god, so it not only did it confuse the patients, [it] confused us."*

*"In the last seven years, we've made a concentrated effort to stay closer to our community where we are more familiar with the available resources. Eighteen years ago, we would go to a school, see the children, and then rely on the nurse or the counselor, okay, what is available here."*

The navigator role is also valued by FCC patients. In fact, one patient suggested that the clinic add an advocate to the staff, who could direct patients to community resources.

FCCs take a holistic view of their patients and because they recognize at the outset patients' lives are complex, they also adapted by adding or expanding services. When the demand for medical care declined as anticipated, one clinic was able to get funding and shift medical capacity to dental care. The clinic is now a major dental provider: "Nobody had dental insurance so our medical numbers went down and then funding all of a sudden opened up for dentals...so then dental started to rise. So we kind of just switched things over and used staff to kind of try to hang onto as much staff as possible." FCC patients appreciated having access to prevention and wellness programming and it was a logical adaptive strategy that enabled clinics to focus on prevention and self-management. Nutrition consults and classes are more recent offerings that focus on chronic disease management. In addition, an FCC that operates a mobile clinic developed an outreach program in order to follow-up with patients who no longer felt safe coming to the clinic.

Although it is unique to a few larger FCCs and those serving special populations, it is critical to mention that some providers explored new relationships with safety net providers serving the Medicaid population. This move was based upon the knowledge that there were going to be significant numbers of patients who remained uninsured and that there were new incentives (e.g. the readmission penalty) to create linkages to the safety net. However, as emphasized throughout this chapter, implementation of the ACA and Medicaid expansion have not always fostered or enabled coordination across the safety net.

The assumption of an expanded role for FCCs in treating and navigating care for the insurance-eligible and underinsured represents a shift in models and policies for these organizations. It also reflects an underlying demand for access to free care as patient cost sharing has increased, narrow managed care networks were introduced, and, more recently under the ACA, marketplace plans were unaffordable. As the patient focus groups demonstrated, some FCCs that operate walk-in clinics with few formal registration procedures welcome these patients and do not question their insurance-status. Other patients acknowledged that once they aged into Medicare or enrolled in Medicaid, they would no longer be able to seek services at the clinic. FCCs have previously had less ambiguous policies concerning providing services to the insured. Therefore, the recent change in their patient population, i.e. an increase in insured clients, signifies a departure for these organizations. FCC administrators acknowledged in their focus groups that some former patients who had enrolled in Medicaid or the marketplace had recently lost coverage and returned for care. Another FCC administrator explained how they assist patients for an interim period:

*"The struggle we face is when we have insurable patients who have not yet for whatever reason successfully enrolled in Medicaid. But now there is that nuance, which is we also have a protocol that allows us to see insurable patients for a period of time while we help navigate the waters and help them get enrolled. That's been a struggle, but not all of our partners have the same requirements, and so we are just really smart about how we navigate certain people."*

For Cook County's FCCs, adapting to meet the needs of Medicaid patients who cannot find a doctor or who are auto-assigned to a managed care network and others who fail to enroll, is a response to the change in demand—a response that ultimately directs resources away from the uninsured and ineligible, who are FCCs primary target population. Consequently, FCCs will certainly need to revisit their policies

regarding the underinsured as well as navigate some of the high-need patients back into the healthcare system. In addition, convening or partnering with the other members of the safety net may enable regional solutions to emerge.

## **ORGANIZATIONAL ASSETS, CAPABILITIES, AND STRENGTHS**

**Key Finding: the FCC model and culture of compassionate care are an asset in a fragmented, confusing health care environment.**

FCCs have significant organizational assets. Chief among them is a unique culture of compassion and a commitment to their mission to provide access to care to those who have neither a medical home nor insurance. It should be underscored that this commitment as expressed daily by the providers and staff during calls and visits, touched virtually every patient in the focus groups from the moment they enrolled at the clinic. Moreover, this has been especially helpful as FCCs faced significant challenges navigating their patients.

Another related asset that was mentioned earlier, is their focus on the whole patient. FCCs treat patients with urgent and chronic care health needs, and numerous patients reported presenting with uncontrolled hypertension and diabetes. One patient described significant chronic care needs, “Because when I came here I don’t know what’s going to happen to me. I have to control my blood pressure and my blood, my heart, my thyroid, oh my gosh, so many problems. And now I feel so good...” Whenever possible, FCCs offer or link patients to preventive services. For example, an elderly man was referred to the Park District: “[It was] impossible to find the things you needed because when I come in with the problem for my leg, because I can’t bend it anymore, too much maybe only 10%. And they made me the prescription for going to the City Park and give me the gym in the swimming [pool].”

With regard to the sector as a whole, FCC administrators cited their peers’ desire to collaborate and willingness to help each other as a valuable asset. The two focus groups offered another opportunity to connect with each other and discuss environmental challenges as well as possible solutions for the sector as a whole. These clinics believe that they will benefit from increased collaboration. An operator of a mobile clinic commented, “Because I think that you know we’re not trying to function in a silo approach, but we have all the different organizations working with the same, essentially the same, mission but not having the ability to interact consistently.” However, the FCC model limits their ability to participate in shared learning because these clinics operate with skeletal staffs, all of whom play a role in direct patient care during operating hours. As discussed later in this report, philanthropy can facilitate effective collaboration among FCCs and other safety net providers, and FCCs are likely to be leaders in these efforts.

In considering the question of organizational assets, clinic leaders also discussed the future of charity care and their relationship to Cook County’s many hospitals and health systems. It is clear that treatment of the uninsured meets federal charity care requirements whereas treating individuals with high deductible marketplace plans does not. From the perspective of one of the larger providers interviewed, it “opens up doors and, yes, we have a business case and it is a win-win-win, with the patient being the primary beneficiary...if [they are] struggling around meeting the charity care



requirements one of the easiest ways for them to overcome that hurdle is by partnering with the sector.”

Within the context of the IRS requirement, this is a business argument as opposed to an appeal to a hospital’s mission. Other FCCs understand that the sector should be positioning itself for this role, but did not see how they could actually contribute: “As one of the smaller clinics, and knowing that there are many of us out there, the piece of organizing to give not only information...to the association...and I think the ACA was a time when many of us [said] we got to find the people who know what’s going on and who can help us figure that out because we are not going to staff that internally and cannot...” Both clinic leader focus groups reached the conclusion that convening for information sharing and working with the state FCC association should be a priority as a new round of reform-related changes loomed on the horizon.

# Chapter Seven: Key Informant Interviews and Focus Groups with Federally Qualified Health Centers

## INTRODUCTION

This section of the report will detail the methods and findings among federally qualified health center (FQHC) executive leadership and staff. For additional context on how the landscape of FQHCs has changed in light of state and federal health reform, please see Chapter Four.

## METHODS

### SETTING AND STUDY DESIGN

We conducted a cross-sectional mixed method study of FQHCs in Cook County, Illinois. Convenience sampling was used to select eight federally qualified health centers based on their size, distribution throughout the County, population served, and services offered. We organized four focus group meetings with staff; conducted key informant interviews with executive leadership at seven FQHCs; and conducted observations at two FQHCs. In addition, we also surveyed 29 FQHC participants. All key informant interviews and focus groups took place at the health centers themselves or a site convenient for the participants. Our use of multiple sites, sources, and data collection methods increases trustworthiness of our data.

### DATA COLLECTION AND PARTICIPANTS

In November and December 2016 and January 2017, we conducted seven key informant interviews with executive leadership of seven different FQHCs using semi-structured focus group guides. Several FQHCs faced either resource or time limitations so we were only able to conduct four FQHC focus groups with staff. Two of the remaining three FQHCs allowed Health & Medicine researchers to collect observational data by observing their office procedures and patient behavior in waiting rooms. Julie Darnell at Loyola University Chicago and the research team at Health & Medicine Policy Research Group (Margie Schaps, Wesley Epplin, Tiffany Ford, and Nicole Laramee), in addition to independent consultant Susan Cahn created a standardized, semi-structured interview guide (Appendix A) that was used for both the focus groups with the leaders of free and charitable clinics, staff from federally-qualified health centers, and leadership of the participating hospitals. Wesley Epplin and Tiffany Ford, experienced interviewers and focus group facilitators, shared the moderating responsibilities for the FQHC interviews and focus groups, while Nicole Laramee, a Health & Medicine Intern, assisted with notetaking and observations at FQHCs. All interviews and focus groups were audio taped and Health & Medicine staff and a professional transcription service transcribed them. Participants also completed a two-page questionnaire (Appendix B). Data from these questionnaires has been compiled in Tables 6.1 and 6.2 below.

**Table 6.1: Characteristics of Participants for FQHC Key Informant of Executive Leadership**

Description of Participants (n=5)	
Job Title (%)	
President and Chief Executive Officer (CEO)	40
CEO	20
No Response	40
Tenure with safety-net entity (in years)	
Mean (SD)	14 (9.7)
Range	19 (3-22)
Age	
Mean (SD)	57 (8.7)
Range	17 (47-64)
Gender (%)	
Female	20
Male	40
No Response	40
Educational Attainment (%)	
Bachelor's	20
Master's	40
Professional degree beyond bachelor's	0
Doctorate (MD, DNP, PhD, etc.)	0
No Response	40
Description of Organizational Setting (n=5)	
Organizational Age	
Year founded (Mean, SD)	1981 (20.7)
Range	48 (1944-1992)
Unduplicated Patients (#)	
Mean (SD)	69,102 (64,258)
Range	162,000 (20,000-182,000)
Delivery Sites (#)	
Mean (SD)	14 (12.61)
Range	31 (5-36)
Services Provided (%)	
Inpatient	60
Outpatient primary care	100
Mental health/behavioral health	100
Dental	80
Other (e.g., social services, vision, testing & screening)	20
Geographic Location(s) of Delivery Sites (%)	
Chicago-North	60
Chicago-South	40
Chicago-West	80
Suburban Cook	40
DuPage	20
Other	0

**Table 6.2: Characteristics of Participants for FQHC Focus Groups of Staff**

Description of Participants (n=29)	
Job Title (%)	
Office Manager	6.89
Outreach and Enrollment Manager	3.45
Registered Nurse (RN)	6.89
RN Clinical Care Manager	3.45
Medical Assistant Team Leader	3.45
Dental Clinic Administrator/Dental Hygienist	3.45
Patient Benefits Specialist (Benefits Advocate)	10.34
Lead Benefits Specialist	3.45
Bilingual Medical Assistant	3.45
Marketing and Public Relations Manager	3.45
Patient Benefit Services Manager	3.45
HIV/AIDS Program Manager	3.45
Registration Representative	3.45
Accounting Clerk	3.45
Medical Assistant	10.34
Greeter	3.45
Director of Nursing	3.45
Patient Services Manager	3.45
Certified Application Counselor/State Health Insurance Program (SHIP) Counselor	10.34
Care Coordinator	3.45
SHIP Program Manager	3.45
Tenure with safety-net entity (in years)	
Mean (SD)	7.69 (8.4)
Range	32 (1-33)
Age	
Mean (SD)	36.7 (11.2)
Range	39 (23-62)
Gender (%)	
Female	90
Male	10
Educational Attainment (%)	
High School	38
Associates	7
Bachelor's	24
Master's	28
Professional degree beyond bachelor's	0
Doctorate (MD, DNP, PhD, etc.)	3

## DATA ANALYSIS

During our key informant interviews and surveys with FQHC staff, participants were asked to discuss the following key questions:

- How would you characterize the safety net in Cook County?
- How has the implementation of major national and state health reforms impacted the healthcare safety net in Cook County?
- How has the safety net adapted to the reformed environment?
- What are the unique assets of the Cook County's safety net providers?
- How can private philanthropy and policymakers support the safety net?

The research team used a combination of qualitative analytic tools, including content analysis of case studies, and thematic analysis using both open and axial coding of key informant interviews, FQHC observations, participants surveys, and focus group transcriptions. Researchers coded data separately and then conducted peer debriefings to ensure their individual interpretations of the data were not due to researcher bias.

Through our key informant interviews with FQHC executive leadership, focus groups with staff, clinic observations, and participant surveys, several key themes emerged, and are shared below.

### **STATUS OF THE SAFETY NET**

As key informants and focus group participants were asked to describe the safety net system in Cook County, several themes emerged. A key finding was that the system has grown considerably to meet demand through the Affordable Care Act (ACA). Almost all of our respondents, in both interviews and focus groups, reported that the system is near capacity and can be complex and difficult for patients and staff to understand and navigate. One person discussed the systemic challenges of ACA roll out as follows:

*“When you look at, not the Affordable Care Act so much as the state’s rollout of the Affordable Care act as well as the changes in Medicaid, I think the thing you didn’t talk about was the state’s policy...how many different contracts did they expect a 40 million dollar organization to manage or, even a 200 million dollar organization to manage? You know, it’s too many. It’s too complex.”*

Our interviews with key informants, focus groups, observations, and surveys revealed that several partnerships are developing, but it is difficult for providers and systems to move out of entrenched siloes to strengthen collaborations. This risks leaving the system more disconnected and less coordinated than most would want. Another key informant interviewee reflected on the complexity of developing and maintaining such partnerships among providers:

*“There’s a certain amount of uncertainty...um, I don’t think that we all know how to play together and, um, actually share resources...we talk about it and we talk about silos. But yet there’s, in my opinion, there’s no specific behaviors or strategies and tactics to bring people together.”*

**Key Finding: An increased patient population creates the need for additional partnerships and system-wide coordination and collaboration.**

Analysis also revealed that safety net patients and staff face significant social and economic challenges related to the social determinants of health (SDOH), meaning the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These conditions create opportunities and barriers to accessing health care and determine both physical and mental health. In this study we identified barriers such as lack of access to transportation, fair employment, increased housing costs and housing instability, food insecurity, and multiple levels of violence. Examples of the identified barriers to health care access are mentioned throughout this chapter and in Appendix C.

Respondents also noted that as policy and programs continually change, it is difficult for FQHCs to plan for the future. A common theme throughout our analysis was FQHC leaders and staff’s fear around working in a state without a budget for over a year and a half, coupled with the uncertainty of a new federal administration that is proposing to shift public policy in a way that will not support many of the individuals served in these systems, the workforce that serves them, and the financing and delivery systems that have been created to provide health care to millions. Our analysis revealed that these joint fears have increased anxiety and stress levels and lowered morale for safety net workers. Despite their stated concerns, FQHC staff and leadership expressed their commitment and deep respect for the resilience of the safety net and their persistence in providing the necessary services to their patients despite a volatile political and economic climate at both the state and federal levels. One FQHC leader explained the impact that the 2016 presidential election had on their staff’s morale and productivity, saying that:

*“...[it] is jolting, the first the morning after we had a support group for the staff... everybody was sort of just sitting around just sort of in shock...we were barely functioning the morning after.”*

In addition to the unsettling impact that the new political climate had on FQHC staff mental health, they reported that they also worried about the added layer of fear, stress, and anxiety among the marginalized patient populations seeking services through the safety net. The same FQHC leader went on to say:

*“...ACA rollover had started so the first thing was, okay what are we going to tell the patients, the clients that are coming? Because they are going to ask us, you know, ‘what’s the point?’...everyone [is] just waiting...everyone that I talk to, it’s just that, we are just waiting.”*

It is important to note that some FQHC staff and leaders also reported the duality of navigating aforementioned issues as both workers within the safety net and often as members of the marginalized

populations whose lives are most likely to be impacted by public policies enacted under the new administration.

### **System Structure**

Participants' attempted to describe the overall structure and function of Cook County's safety net system, often describing it as near capacity but also evolving. To add to these structural challenges, thematic analysis revealed that the Cook County safety net system has become complex and difficult to navigate often resulting in both a delay in care and an unintended use of the system. One nurse shared her perspective on the patient experience:

*"People don't want to come in here when they're sick and have to go through all of these things...They come in last minute instead of [using] preventative care. Because 'if I come in [to get] preventative care, I have to jump through all these hoops before I can get care'...and the health centers are eating the cost."*

Other FQHCs providers echoed her sentiments. Our analysis revealed another unintended outcome for the system has been a need for a greater level of coordination and connection between the partners each organization would like to (and needs to) connect with. Many recognize this is related to the fast pace of change as well as the limited time to develop partnerships that are meaningful and practical for patients and providers. An FQHC executive leader stated:

*"The safety net in Cook County is still somewhat uncoordinated and disconnected. And when I think about the safety net, I really—I don't think about a net that if you fell in it, you would be caught completely by the net. You would probably fall through."*

Our analysis revealed that while many patients who gained insurance through the marketplace have had subsidies available to help offset costs, unaffordable deductibles of the lowest cost plans have led patients to rely on the sliding fee scale to pay for healthcare rather than their insurance. Respondents also shared that the ever-increasing out of pocket costs of the marketplace discourage many people from purchasing insurance, particularly those who are younger and relatively healthier. This makes marketplace insurance of less value to patients, because it mostly protects against catastrophically high costs of care rather than allowing them to afford the cost of routine visits. This is also challenging for providers who may then pay the deductible and put the patient on a sliding scale fee so that the insurance may begin to cover the costs.

### **Managed Care Implementation**

While most of those interviewed believed in the goals of managed care, implementation has presented many challenges for systems, providers, and patients. A key area of needed growth is around strengthening and maintaining the patient/provider relationship. Reported factors that have contributed to the disruption of patient/provider relationships include auto-assignments, inaccessible assignment locations, and insurance companies baiting patients by incentivizing the switching of plans. A contributing challenge faced by many patients is housing insecurity. Many do not have the same address or contact information from year-to-year and so are auto assigned to managed care organizations (MCOs) and associated primary care providers that they had often never seen and may not be located where they reside. Having an inconsistent place for receiving mail was mentioned as a significant barrier

in many focus groups and interviews. During one of the focus groups, an FQHC staff member described the experience well, explaining:

*“The addresses are different. The phone numbers are different. We find quite a few patients—even patients that just received Medicaid last year, don’t have the same addresses and phone numbers. So...they’re not getting their redetermination packets. So, therefore, they may not get redetermined so they may become ineligible, or if they don’t choose the assignment, if they just became eligible and didn’t—according to the patient, ‘I didn’t receive any information telling me to choose,’ or ‘I didn’t choose in a timely manner.’ They get auto-assigned and they auto-assigned to providers that they’ve never seen before, but again, still, they’d been coming to us forever.”*

In addition, many FQHC staff and executive leadership discussed the large number of managed care organizations that exist, making the current healthcare landscape more complex and competitive than these systems would like. The fact that contracts between MCOs and FQHCs—and between MCOs and hospitals—are often changing poses significant challenges to providers’ ability to know where they can refer patients, and policy reform on this point may be needed. Providers discussed the numerous managed care organizations that health centers are required to contract with in order to maintain care for their patients and ensure reimbursement. One provider offered insight and recommendation for addressing this challenge:

*“...there’s so many MCO plans that if they kind of worked together and not be too competitive, I guess, you know for each other to be able to kind of know whatever we want to have an opening up, I guess, of doors if we are all working together instead of competing against each other... but cooperative, I think.”*

### Care Provision

**Key Finding: There is a greater need to work toward strengthening and maintaining the patient/provider relationship.**

The process of providing care in a reformed safety net environment has impacted both patients and providers. Hundreds of thousands in the Cook County area are newly insured and using the safety net for the first time. Many of the newly insured have previously untreated and complex healthcare needs, including mental health needs. As noted earlier, it can be difficult to reach many of the newly insured because many face housing insecurity, inconsistency of mailing address and other contact information, and have varying literacy levels. In addition, many have not received preventive care for extended periods of their lives and may have untreated health issues that have worsened over time. This level of complexity is challenging for providers both in terms of the time required to serve these patients and the referral partnerships needed to address needs beyond the center’s primary care capability or array of services.



**Key Finding: The complexity of the patient population requires additional resources and funding for care provision and coordination.**

While many residents who previously lacked insurance now have coverage, there continues to be many FQHC patients who are not prepared to properly utilize their coverage or remain uninsured, either because they are ineligible or they are unclear about how to become insured.

*“Just having the card does not equal coverage, because people don’t know how to use it or where to go—or can’t access their hospital or they you know or don’t understand that they need to renew their benefits. So it’s there, but it’s still—I think probably a little confusing for patients and staff...But we are doing our best, sure.”*

Even for people who are insured, their healthcare needs often exceed capacity, particularly for behavioral health services and other uncovered health related expenses. One staff member explained:

*“You need a glucometer. You need...like whatever it might be, it’s out of pocket and a lot of people can’t afford it and choose not to get it then, and that impacts health for sure.”*

As previously noted, systems and staff are working at capacity, while also navigating the increased pace of the reform environment. Wait times for both adult and pediatric behavioral health services have extended due to a limited number of providers who are willing or able to accept the insufficient reimbursement from Medicaid. Respondents noted that the ability to pause and reflect on their work and think about how to improve patient care and efficiency is often compromised in order to keep pace with the workload.

**IMPACT OF HEALTH REFORM**

*Operations and Resources*

Health reform led to a shift from 55% of the U.S. population being uninsured to just 28-30% uninsured. Overall health reform has provided new revenue for FQHCs. Many centers have been able to utilize the increased income to build new buildings, add new services like dental care and mental health, and add entire new departments dedicated to improving care coordination and service delivery.

**Key finding: Health reform has provided new streams of revenue for FQHCs to expand and improve upon care provision.**

Our respondents reported that health reform has had a significant and mostly positive impact on operations and resources in a multitude of ways. The most significant impact has been increasing insurance coverage among the safety net population. This has decreased the likelihood of patients using the Emergency Department (ED) for care and increased use of preventive and primary care, both of great benefit to patients. This change is taking time and effort though, as many patients who have not had insurance for years may need support determine what services are available to them and how to access primary care.

FQHC staff and executive leadership also reported that health reform has led to more care coordination which has improved quality of care and also contributes to fewer ED visits and hospital readmissions.

They reported that this system change is promising but is also complex and requires additional resources and coordination to fully realize the promise of care coordination.

The impact of health reform on service delivery has increased demands on providers because of the aforementioned complex needs of patients. In addition, operations have shifted to value-based care. For example:

*“So, we’re expected and held to those standards [of value-based care]...Yet we’re also expected to produce higher quality...And right now there’s small incentives for that, but not enough to make changes when you’re still held to this volume.”*

There is a need to broaden the operations focus on making decisions to both improve quality and strengthening the system to meet the complex needs of the diverse patient population. Two notable issues respondents suggested were expanded hours and days as well as patient transportation, which is expensive and only covered for limited services by Medicaid. When speaking about the need for an expanded clinic schedule, one staff member described a difficulty that many of the FQHC patients face, which underscores the need for flexible health center hours and days:

*“And then of course there’s other factors of, you know, they are working these multiple jobs and having not good hours and so even just the logistics is difficult for them to get care...”*

An anticipated outcome of health reform has been the increasing use of health data and information technology (IT) to improve patient outcomes and care. Demands are new and expensive both for the clinical and financial analytics needed for technological advancement interoperability and a shift toward value-based care. While the ACA provided some financial resources for improved IT systems and electronic health records (EHRs), support has been insufficient. When asked to elaborate on how their IT infrastructure has grown since ACA implementation one respondent said:

*“This is something that we’re struggling with and we see a pathway for ourselves and we’re really struggling to get there, not only because it costs a lot of money to get there, [but because]we have so much robust data.”*

Respondents noted that health reform has increased the need for comprehensive system interoperability that would facilitate sending and receiving patient EHRs. There is a need to both strength intra and intersystem communications and for a system-wide [regional or state] Health Information Exchange.

Additionally, health reform has contributed to the increased volume of health information generated over the past few decades. There is now an even higher demand for health data to be analyzed in a meaningful way to provide value and improve health outcomes. Respondents also noted that this can inform new career pathways and identify necessary skillsets to support systems, staff, and patients.

### **Workforce**

Our analysis revealed that health reform has produced an increased patient population, which has added stress to a system that already faced a shortage of physicians and other provider types. FQHCs are spending significant resources on recruiting and retaining medical assistants, CNAs, and other staff who are often lost to institutions, such as hospitals, with larger budgets for staff salaries. Primary care

physician shortages as well as interest in having providers work at the top of their licenses has created opportunities to hire a greater number of advanced practice nurses and physicians assistants to meet workload requirements. Some respondents also noted that the ACA has included funding for Teaching Health Center grants to establish primary care residencies at FQHCs, which has helped some to reduce the gap in the number of primary care providers. FQHC leaders noted that an increased investment and larger number of Teaching Health Center sites would be welcomed. One key informant also shared that the number of doctors has not kept up with demand because the Center for Medicare and Medicaid Services have not increased the number of residencies nationwide in decades (aside from the Teaching Health Center workaround).

FQHCs are also committed to being Patient-Centered Medical Homes and are moving care toward the goal of adopting a patient-centered approach. Each of the workforce issues discussed here requires FQHCs to teach and train new providers and other health workers and to help develop a robust primary care health workforce.

**Key finding: To ensure access to high-quality healthcare for all, additional investments in our health workforce will be needed.**

Finally, there have been changes to staff structure and responsibility due to managed care implementation. Respondents reported a shift in responsibility with staff helping patients understand how managed care works, guiding them to access care within their plan's network, and helping them deal with related stress and frustration. One respondent noted how this utilizes a significant portion of staff time and resources:

*"And so we do have like a team overview MCOs, and contracts and things like that. And then we have just the team that's for kind of to be the point person when there's any changes from the state in our Medicaid plans to kind of decipher the information that is going back out to our staff and then like our patients, that's kind of like where it falls you know. And in that we know our contacts with our MCOs and trying to you know build those relationships and continue improving them so that we can make things better."*

The increased administrative burden due to managed care implementation is an issue that arose in every focus group and almost all key informant interviews. In sum, an unintended workforce challenge of the complexity of our new system—particularly the large numbers of MCOs and new systems of care—has resulted in reports of higher levels of stress, frustration, and provider burnout, which impacts providers, their clinics, and their patients.

**Key finding: FQHCS serve as leaders amongst the safety net in training our county's primary care providers.**

### *Managed Care*

In addition to the issues raised above with regard to workforce, managed care has had significant impacts on FQHCs' daily operations, and their ability to help patients access necessary healthcare. A provider offered an example of the complexity of challenges that emerge in implementation:

*“So that managed care coordinator is kind of more of an external person who’s helping us to understand all the different chain of plans. And then plans are expecting different things of our patients, and us so we have to separate these patients depending on plans...and panel size. And do different things for different...plans which has been very challenging. And then getting down to the care coordination team, which is more of an internal team, run by the nurse. They all have different requirements. They all have different hospital partners. They all have different preauthorization plans. You can and cannot go to different hospitals. You can and cannot have different prescriptions written or not. So, it’s varied from before when patients had Medicaid.”*

Through conversations with FQHC staff and executive leadership, it became clear that they agreed with the overarching goal of managed care: to coordinate the healthcare needs of the patient population and focus on value-based, rather than volume-based care. Yet, consistent with the quote above, they also noted an array of complex challenges related to implementation including:

- The complexity of health insurance leads some patients to delay seeking primary and preventive care.
- Insurance enrollment changes, leading to a greater need for developing “health insurance literacy” among patients.
- The increased pace of contract changes and cancellations which is difficult to keep track of resulting in increased pressure for coordinators, providers, and patients to ensure proper access within patients’ networks.
- Limitations of some plans’ coverage and the location of in-network providers present a challenge to both patients and providers.
- Patients’ utilization of their freedom to change their primary care providers, which can unintentionally lead to a reduction in continuity of care.

Finally, relationships between FQHCs and hospitals are strained and sometimes severed when contracts between MCOs and hospitals are cancelled or modified. At times, this leads to patients not being able to see their provider of choice or go to their preferred hospital, which can lead to confusion and frustration and can disrupt provision of care.

## **ORGANIZATIONAL ADAPTATION TO THE REFORMED ENVIRONMENT**

### ***Adjustments***

FQHC staff that we met with shared the adjustments that they have made as a result of health reform in order to meet its increased demands and requirements. Using funding from the Affordable Care Act, they have grown their organizations, including building new centers and expanding to more neighborhoods. As noted previously, they have allocated more staff to assist patients with administrative functions. In some instances, they have created entirely new teams or departments. For example, FQHCs had to create ACA Outreach and Enrollment Teams to help with initial enrollment and who have also aided patients with managed care coordination. They also hired more administrative staff and master’s educated health professionals. These adaptations aided in patient care but were sometimes undertaken without adequate resources, and not always in keeping with community health centers’ history of hiring from the communities they serve.

*“Community health centers used to hire people from the community and train them. We can’t afford to do that anymore.”*

Despite the addition of dental and behavioral health services in various FQHCs countywide, the need for these services still greatly surpasses the supply. FQHCs also try to enable providers (APNs, nurses, and others) to practice at the top of their licenses as a tool to address provider shortages and expand the workforce. They have also created career pathways for employees who normally would not see career progression as a tool to increase retention rates. An innovative learning collaborative of FQHC leadership has been developed over the last few years which provide opportunities to share new information, tools, staffing ideas, and more. Other organizational adjustments include:

- Increasing patient care coordination;
- Adjusting hours to accommodate more patients;
- Contracting with additional hospitals;
- Reaching patients through technology:
  - Patient portals allow patients to see results of tests and health records, communicate with providers, and schedule appointments;
  - Text messaging reminds patients of appointments; and
- Adoption of EHR systems

As systems continue to adapt, and if resources exist, they will need to ensure patients have access to devices and Internet access so that they can take full advantage of technological resources. Also, managing, maintaining, upgrading, and protecting security, privacy, and legal compliance are important areas of continued growth.

### ***Creative Approaches and Innovations***

FQHCs have utilized innovative and creative approaches to meet health and social needs of patients. They have continued to build upon their history of partnering with community-based organizations to help patients with social and community problems outside of the clinic. As examples, partnerships with the region’s food depository and network of food banks, as well as with medical legal partnerships, help patients with such issues as food and housing insecurity. In addition, some FQHCs have developed a collaborative learning center to provide learning opportunities for staff, helping with workforce development and continuing education. Another FQHC is redeveloping a closed school as a community center which will include opportunities to access health services, partner with hospitals to provide specialty care, collaborate with other community-based organizations to help patients deal with issues related to social determinants of health, and serve as a meeting space and community center. Another site has a new research building and team focused on engaging community members in helping the FQHC develop research questions that are responsive to the community’s needs and interests. The site also includes a campus that had separate offices for other community-based organizations, which helps with ease of referring patients to those organizations.

**Key findings: FQHCs have developed creative solutions for ensuring their patient’s needs are met both inside and outside of the clinical setting.**

Other FQHCs in Cook County have developed creative solutions for ensuring their patients have access to care during the night and on weekends, which can help to reduce ED usage. For example, many staff reported their clinics have already increased hours. Some have used innovative ways of pooling resources at clinics with close geographic proximity so that, for example, a weekend clinic does not have a skeleton crew, but instead has brought together primary care, dental, and mental health at one clinic, perhaps using clinicians who usually work at different clinics. One interviewee shared a similar idea for FQHCs pooling staff and resources during nights and weekends to provide care for all of their patients. The respondent proposed setting up a governance structure to equitably manage data and records, funding, and staff and to ensure that patients remain with their chosen FQHC and primary care provider.

## **ORGANIZATIONAL ASSETS, CAPABILITIES, AND STRENGTHS**

### ***Mission Driven***

A host of organizational assets were identified and observed throughout this data collection process. FQHCs are mission driven and committed to always being there to serve their patients, despite financial constraints and other challenges that they may face. One respondent beautifully captured the intention and commitment of the FQHC mission:

*“... what really bounds us together is our mission and staying focused, and being able to be nimble...making sure that our patients know that we are always going to be here. And I think right now with health care and especially anyone that’s been—doing healthcare, everyone is waiting because they don’t know what it’s going to mean. But regardless of anything and some of us have been doing what we’ve been doing and we’ve watched administrations come and go, that the piece that always had to bind us is the needs of our patients and family.”*

The strong commitment to their mission, both at the organizational and staff level, is a sentiment that was reflected throughout all forms of data collection among FQHCs. The interviewees expressed that most people at FQHCs want to work in the safety net and enjoy providing care for people who need it. They noted that they chose the career because they care and want to help patients. Their work is supported and successful when there is committed and strong leadership—at the team, executive, and board levels.

**Key findings: FQHCs remain committed to serving the patient population in greatest need in Cook County.**

### ***Coordination of Care***

Another strength of Cook County FQHCs is their efforts to coordinate the care of patients, allowing them to remain connected to their healthcare providers and access the care that they need. Care coordination also helps clinics provide greater healthcare value, focusing on the right care at the right time, provided in the right setting. FQHCs are comprised of a skilled workforce to meet patients’ complex care coordination needs during the process of health reform.

### *Size Matters*

Finally, FQHCs with multiple sites and larger staff sizes benefit in a number of ways, including: 1) full staffing at more sites; 2) the flexible use of staff as new needs and situations arise; and 3) greater access to resources, such as financing, technology, and infrastructure, which can lead to flexibility to utilize these assets in innovative ways. Smaller systems, despite often having less resources and funding, also have valued assets that cannot be understated, such as being uniquely equipped to serve the needs of specific patient populations or communities.

# Chapter Eight: Key Informant Interviews with Hospital Leaders

## INTRODUCTION

This section of the report will detail the methodology and findings among safety net hospitals. For additional context on the general landscape of safety net hospitals in the U.S., Illinois, and Cook County, see Chapter Five.

## METHODS

### SETTING AND STUDY DESIGN

We conducted a cross-sectional mixed method study of hospitals in Cook County, Illinois. Four hospitals were selected using convenience sampling based on their type (one public, two primarily serving the safety net population, and one member of the state's largest hospital system serving a mix of safety net and privately insured patients), size, distribution throughout the County, population served, and services offered. We conducted key informant interviews with executive leadership at each of the hospitals and surveyed all four participants.

### DATA COLLECTION AND PARTICIPANTS

Key informant interview participants were contacted via email or phone to invite them to participate. Julie Darnell at Loyola University Chicago and the research team at Health & Medicine Policy Research Group (Margie Schaps, Wesley Epplin, and Tiffany Ford), in addition to independent consultant Susan Cahn created a standardized, semi-structured interview guide (Appendix A) that was used for the focus groups with the leaders of free and charitable clinics, staff from federally qualified health centers, and leadership of the hospitals. Margie Schaps conducted the interviews at each hospital. All interviews took place at the hospitals, were audio taped, and were transcribed by Health & Medicine staff and a professional transcription service. Participants also completed a two-page questionnaire (Appendix B).



**Table 8.1: Characteristics of Participants for Hospital Key Informant of Executive Leadership**

Description of Participants (n=5)	
Job Title	%
Executive Director Managed Care	20
President and Chief Executive Officer (CEO)	40
CEO	20
Chief Operating Officer	20
Tenure with safety-net entity (in years)	
Mean (in years)	7 (2.5)
Range	5 (4-9)
Age	
Mean (SD)	55 (6.1)
Range	12 (48-60)
Gender (%)	
Female	20
Male	80
Educational Attainment (%)	
Bachelor's	0
Master's	60
Professional degree beyond bachelor's	0
Doctorate (MD, DNP, PhD, etc.)	40
Description of Organizational Setting (n=5)	
Organizational Age	
Year founded (Mean, SD)	1885 (17.7)
Range	89 (1830-1919)
Unduplicated Patients (#)	
Mean (SD)	163,430 (132,108)
Range	263,711 (36,289-300,000)
Delivery Sites (#)	
Mean (SD)	122 (218.8)
Range	449 (1-450)
Services Provided (%)	
Inpatient	100
Outpatient primary care	100
Outpatient specialty care	100
Mental health/behavioral health	100
Dental	75
Other (e.g., social services, vision, testing & screening)	100
Geographic Location(s) of Delivery Sites (%)	
Chicago-North	75
Chicago-South	75
Chicago-West	75
Suburban Cook	50
DuPage	0
Other	0

## DATA ANALYSIS

During our key informant interviews and surveys with hospital executive leadership, participants were asked to discuss the following key questions:

- How would you characterize the safety net in Cook County?
- How has the implementation of major national and state health reforms impacted the healthcare safety net in Cook County and your system in particular?
- How has the safety net, and your system in particular, adapted to the reformed environment?
- What are the unique assets of your system and Cook County's safety net providers?
- How can private philanthropy and policymakers support the safety net?

We used thematic analysis using both open and axial coding of key informant interviews. Researchers coded data separately and then conducted peer debriefings to ensure their individual interpretations of the data were not due to researcher bias.

Through our key informant interviews with hospital executive leaders, several key themes emerged.

### **STATUS OF THE SAFETY NET**

When working to understand the safety net in the County, many hospital leaders described the different components of the safety net, and discussed how the system was working together. They acknowledged the many components of the safety net and the different ways they relate to one another. One hospital leader defined the safety net as:

*“any of the providers who are providing either health or social services to vulnerable populations or [those] below the poverty level. So it would be of course the hospitals, FQHCs, any of the organizations that deal with social determinants like housing, food, transportation.”*

This definition set the stage for a broader discussion of the safety net as it included an acknowledgement of the importance of considering social determinants of health (SDOH) in the provision of healthcare services. This theme arose throughout the hospital interviews and underscored the value of understanding health and healthcare within the broader context and conditions in which people live.

### ***Collaboration and Coordination***

The hospital leaders we interviewed echoed comments made by Federally Qualified Health Center (FQHC) leadership and staff participants, by describing the full nature of the system and the need for further service coordination. They discussed the need for greater collaboration and emphasized that there is an “urgent need” for partnerships with FQHCs. Some hospital leaders expressed more positive sentiments and felt that FQHCs and hospital partnerships were doing well working together to address patient needs, while others identified inter-system competition as a barrier to collaboration among health systems in the safety net. One hospital has actually worked with an FQHC to bring their services into the hospital. One hospital leader indicated that health reform was “truly an opportunity to

collaborate on a more integrated system of care.” Despite the difficulties that exist in the extensive system that is the County safety net, interviewees expressed optimism and an overall willingness to partner in order to better serve the health needs of the population. At the same time, there is serious fear among most of these leaders about the threat of repeal of the Affordable Care Act (ACA); they see it as critical to the patients they serve, the financial well-being of their institutions, their physical facilities, and to the systems they have built and strengthened through expansion since health reform implementation began. Three of the four systems participating in interviews believed strongly that the ACA has enabled them to provide better, more appropriate, and more cost effective care to a growing number of people in the County.

### *Shift in Patient Population and Payer Mix*

As expected, health reform has shifted the payer mix for members of the safety net. Hospital leaders report a decrease in self-pay patients, which for most providers has allowed them to better coordinate care, hire necessary staff, reform service delivery models, and expand services to new populations in need (for example, behavioral health services). One leader in particular discussed the difficulties faced by many patients because of high deductible marketplace insurance, leaving the hospital in a position to cover these costs. This was certainly an unintended and unexpected consequence of the way the marketplace has been structured in Illinois. Technically speaking, this high deductible, if covered, by the hospital is not considered charity care, rather it is uncompensated care. One hospital leader explained it by saying that:

*“Now patients are showing up. They don’t have any insurance still or the insurance they did have set an out-of-pocket and deductible so high, they flip right back into charity care.”*

**Key Finding: Both increased complex patient population and high cost of deductibles through the marketplace are putting unintended burdens on safety net providers.**

Our analysis revealed that health reform also facilitated a shift in the patient population seeking care. When asked about that shift, one hospital leader said:

*“We see people who are sicker, but fewer visits to the emergency department, which is good... We see more people who are linked into primary care which is very appropriate and it’s good for everybody... And we probably see people [now] who put off visits because they didn’t have insurance... So I think that’s all good.”*

This topic emerged across interviews with other hospital leaders as well. They consistently reported that the safety net has grown and has continued to care for some of our sickest and most complex patients. One leader asserted:

*“...the fact that we [are now] seeing patients who were routinely denied care based on previous medical conditions. I think that’s a huge win for this country.”*

However, they also reported that there are still populations whose needs are not being met. This includes undocumented residents, those requiring acute behavioral or oral health services, homeless individuals, and those returning to the community from the justice system. One respondent explained the new health reform landscape best, saying that the safety net:

*“...is not built with a healthcare model to take care of everybody that needs care. We have many folks three, four years ago that jumped on the public exchanges, they jumped on to now the new Medicaid plans, and even with that transition into that care model we are still finding that there are patients without access to care. So whether its FQHC development, whether its Cook County services, whether its state services, whether its behavioral health nor specific in services lines, we don't have the infrastructure to adequately care for these communities.”*

Our analysis of these barriers to care for some patient populations has helped us to identify policy and funding recommendations to address this issue and will be discussed in Chapter Ten.

## **IMPACT OF HEALTH REFORM**

The incredible pace and volume of system expansion over the last few years has forced hospitals to reimagine and recreate the ways that they provide care for their patients. Our interviews revealed that contracts with various managed care organizations often create an unstable fiscal environment for hospitals and disrupt the flow of their resources and funding. One respondent expressed frustration surrounding changing managed care contracts that “vary year to year of what we’re in and what we’re out of network for.” This change is coupled with an increased Medicaid patient population that has made it challenging for safety net hospitals to, as one respondent stated, “build healthcare models that can be sustained on that revenue.”

Another hospital leader noted the strain of the increased patient population and low reimbursement rates on their organization’s operations and decision making, yet noted that they remained fairly optimistic, saying that “we’re unique in Illinois...in that our state Medicaid has opportunities to improve.” Arguably the most significant systems reform we have seen in Cook County has been the development of CountyCare—created by the Cook County Health and Hospitals System and facilitated through a Medicaid 1115 Waiver in 2012, it now has over 150 entry points into the system.

### ***Technology***

Health reform has coincided with (and been partially financed through) the uptick in use of technologies, like telehealth and electronic health records. These changes have allowed for a streamlined and more confidential health data collection process. It has also challenged the safety net workforce to consider the quality and efficiency of technology-based patient data as well as how to best use technology for care coordination, prevention, and patient education. Finally, it has required safety net hospitals to ensure patient electronic data is kept private and secure.

## **Key Finding: Changing managed care contracts interrupts service delivery for hospitals.**

### *Revenue*

For most of the systems interviewed, the increased revenue brought to the system through Medicaid expansion in particular, and through newly insured marketplace patients, has allowed them to expand services, shift delivery system models, add needed staff, and in some cases replace old facilities. This has breathed new life into some of these systems and allows them to better serve their patients. It is fair to say that for some of these systems, they feel certain that without this revenue they will not be able to offer the level of service they have recently been able to provide.

### *Care Coordination*

Safety net hospital leaders report a significant investment in care coordination which has great benefits for their patients, particularly those with complex medical needs. One system has hired 200 care coordinators to work with their patients and partners to ensure patients are getting the right services at the right time in the right place. While this is of great benefit, it is also very expensive to create new systems of care, and sustaining this level of staffing is expected to be challenging unless enrollment increases.

### *Social Determinants of Health*

Another key impact of health reform was the increased attention it drew to addressing social determinants of health through its public health and population health focus and by value-based payments rather than fee-for-service. In light of this, many hospitals have turned to community-based models in order to confront these issues. Collaborating with community partners has been viewed as important and productive for all of these systems, but often challenging because many small, community-based services do not have the infrastructure in place for billing and handling accounts receivable. Particularly in our state, currently without a budget, there are often delays in payments that are very difficult for providers, especially small providers, to withstand. Respondents shared that their organizations are viewed as experts in the field in conducting research and practice which confronts social determinants of health. For a description and framing of the social determinants of health and the structural determinants of health inequities, see Appendix C.

## **ORGANIZATIONAL ADAPTATION TO THE REFORMED ENVIRONMENT**

### *Innovation*

Creativity has been a critical adaptation that hospitals have made in the current reformed environment. Hospitals have begun to position themselves to more comprehensively serve the increased and complex needs of their patient populations through creative use of partnerships with other organizations, new

models of care such as using community health workers, expanding behavioral and oral health services, and improving clinic and pharmacy hours.

### **Adjustments**

Another way that hospitals have been able to adapt to the increased patient population is through creative use of their existing staff. Hospital leadership is doing what they can to ensure that all staff is able to work at the top of their licenses. For example, one respondent shared that an “ophthalmologist could be doing surgeries and the optometrist can be doing more of the primary eye care.” Finally, when faced with decisions to cut critical community programs due to lack of resources, one respondent shared that hospitals have been both creative and community-centered when reviewing “every other expense opportunity and reduced as much as possible,” before eliminating valued programs.

As hospitals create new teams and try to advance culture change to better serve their patients and comply with state and federal reforms, they are challenged in their ability to have resources and time to train and support staff development. At many of these institutions, staff have been accustomed to practicing in the same way for decades and change can be challenging; therefore these efforts require sustained support.

**Key Finding: Hospitals are challenged to think about how to pay for services and programs that their patients need.**

While many hospitals described their wide array of services as organizational assets, some acknowledged that there was still a great need for more comprehensive services. Leaders at these organizations described their steadfast commitment to connecting their patients with necessary services, whether they provided them in the hospital or elsewhere in the community. One participant stated “we partner for services that we don’t have... [we are] extremely creative in terms of finding the services that patients need one way or the other.”

Other adaptations to the reformed environment have included increased community programs, staff support, training and development, and overall investment in human capital.

## **ORGANIZATIONAL ASSETS, CAPABILITIES, AND STRENGTHS**

### ***Commitment to the Safety Net Population***

Having a sense of pride was a common theme that emerged in hospital interviews with executive staff as well as a long standing commitment to their organizational missions to serve vulnerable populations. One hospital leader elaborated:

*“We see everybody who is in medical need anyway. And we always have [for] 100 years. You know, we always will no matter what happens with the ACA.”*

## Workforce

We interpreted the respondents' reports that their organizations were mission driven, have committed staff, and responsive leadership as key organizational assets that can only be strengthened if given the appropriate level of funding and resources. One hospital leader discussed their commitment to creating career ladders for their employees so that people could learn more skills, stay with the health system, and have greater earning potential. Yet another leader shared that employee turnover is getting worse, resulting in higher recruitment and training expenses.

**Key Finding: Safety net hospitals are committed to the well-being of the populations they serve. This commitment extends beyond medical care.**

## Anchor Institutions

Hospital respondents also cited their ability to be anchor institutions in the communities that they serve as an organizational asset. One respondent spoke of their organization's role in workforce development among communities, making sure that they hire a significant portion of their workforce from the communities they serve. This commitment connects healthcare services with the non-healthcare related needs of their patient population as well as communities' economic vitality. One interviewee explained:

*"Nobody cares about coming in, sorry, for the screening mammogram if they don't know where, you know, their next meal is coming from. They don't know if they've got to check for safe and reliable housing. Workforce development is very, very important. We have I think the highest number of recently incarcerated men return to the community. And part of our goal is to increase hiring from the community and having a just and safe policy around that philosophy and create a culture that embraces—not labels—people who have, you know, paid for their mistakes and that are now back and ready to work, and there has to be meaningful jobs."*

The respondent elaborated by stating that they are "working with a number of different organizations looking at how they come together to increase the hiring from these very challenged communities." The commitment to serving as anchor institutions and extending beyond medical care speaks to hospitals' efforts to take on the challenge of making progress on the social determinants of health.

# Chapter Nine: Cross-Cutting Themes

## INTRODUCTION

The previous chapters have identified important cross-cutting themes and issues for Cook County’s safety net. The analysis highlights that few assumptions regarding health care reform locally or nationally proved entirely true. The safety net has been responding and reacting constantly during the past three years since full Affordable Care Act (ACA) implementation. In addition, our conclusions regarding the status of the safety net, the impact of health reform, and the sector’s adaptation and assets, point to a clear set of recommendations for philanthropy and policy which are presented in Chapter 10.

## STATUS OF THE SAFETY NET

Figure 1: The Overall Safety Net in Cook County Described by Providers



Leaders, staff, and patients of Cook County’s safety net providers all commented that the safety net was fragmented, and that coordination between the different providers occurred inconsistently. These providers all remained committed to their shared mission to serve the most vulnerable, but, as one free and charitable clinic (FCC) executive director noted, early hope of greater ongoing coordination through partnerships and information sharing had not been fully realized. Federally Qualified Health Center (FQHC) staff concurred: “We talk about it and we talk about silos...But in my opinion, there’s no specific behaviors or strategies and tactics to bring people together.” Therefore, FCCs, FQHCs, and even some hospitals identified increasing communication and overcoming some of the artificial separations between different providers as an important strategy for the sector given the current level of uncertainty and the expectation that the environment will continue to change rapidly.

Safety net fragmentation also creates barriers for patients trying to access care (one that has been well documented in the literature). However, this study has found that fragmentation has been exacerbated by the recent disruption of existing care networks, both formal and informal. The introduction of



Medicaid managed care organizations (MCOs), including auto-assignment and MCOs' limited networks, interrupted existing provider relationships. This is affecting how both FQHCs and FCCs navigate and treat patients. FCCs that work with patients with Medicaid managed care reported trying to help them change plans or file for a redetermination when homeless patients were assigned to a suburban network by mail. FCC patients that have been enrolled in Medicaid during the past few years have lost access to their doctors and some are asking for assistance in making network choices. FQHCs often discover that patients, who are enticed by health plan incentives, have chosen to enroll in managed care plans with narrow networks and the FQHC will not be reimbursed for services provided.

For the administrators and staff at the County's safety net clinics, this confusion has resulted in an overextended staff, beyond the normal pressures. At FQHCs, the administrative burden has increased at the same time patients need additional navigation and support to maintain continuity of care. While FCCs may not be involved in insurance-related reporting and claims, these clinics' few staff and voluntary providers have always extended themselves to try and meet the needs of every patient, many of whom have delayed treatment and/or are high-need because they suffer from multiple chronic conditions. The FCC model relies on the idea that the volunteer providers can treat a range of problems, but they are challenged to address health and navigational issues simultaneously.

At the County's FQHCs, the emerging issue is newly insured patients with ACA or marketplace coverage who are receiving routine preventive care for the first time in years or even decades. FCC clinics also report increases in patients with multiple chronic conditions, who had lost access to coverage, pharmacy benefits, and care due to their immigration status. The healthcare system, including traditional safety net providers, is focused on meeting the needs of the Medicaid expansion population, reducing unnecessary use of hospital emergency rooms, and the need for charity care, but also may have inadvertently reduced access to charity care for the remaining uninsured in the process. FCCs must spend additional time coordinating access to affordable or no cost services for these uninsured patients, an unintended consequence they had not foreseen. It is clear that all parts of the Cook County safety net are still struggling to address the significant unmet needs of their underinsured and uninsured patients.

The issue of affordability remains the number one barrier to accessing health care for both patients who are eligible and ineligible for coverage. FCC patients frequently make just too much money to qualify for Medicaid and have remained outside the healthcare system. Moreover, new co-pays for visits and prescriptions for the Medicaid population result in continued use of FCCs and have negative long term impact on their health. The FCC patients in our study were acutely aware that they could not pay hundreds of dollars for marketplace insurance, but were at risk for catastrophic illness. Many patients still relied on the availability of free or minimal cost care and access to County's Stroger hospital.

With regard to specific health care services, the demands for dental and mental health care, which predated ACA implementation, continue to grow. The greatest barrier providers and patients face is limited capacity. For example, there are few non-English speaking mental health providers and even fewer who are willing to accept Medicaid rates. Many FQHCs are adding behavioral health services and dental clinics to their facilities, but demand continues to far outstrip capacity. The experiences of an uninsured FCC patient in the study battling depression, who could not pay for treatment, demonstrates the benefits of therapy for this population. However, only a few patients have the good fortune to obtain the very limited number of behavioral health appointments provided voluntarily. The undocumented were never eligible for federally-funded programs, but an increased demand from Medicaid has reduced their access to the few specialty providers who were willing to treat them.

The challenges and demands faced by providers are captured in the figure below that highlights the words used by providers to describe the Cook County safety net.

## IMPACT OF FEDERAL AND STATE HEALTH REFORMS ON THE SAFETY NET

The detailed qualitative results in this report highlight a series of anticipated, unanticipated, and unintended consequences of health reform for Cook County's safety net. FCC and FQHC providers, while operating under different models, have always grappled with the challenges of meeting their missions while balancing resource constraints and patient needs. Their comprehensive knowledge of the County's vulnerable communities and populations has enabled them to plan and respond effectively to the changing environment. Yet, health reform has posed many unanticipated and unintended consequences. The fast pace of the health reform rollout in Illinois has challenged safety net providers at all levels to keep up with new requirements. Table 9.1 reports these different challenges in detail and is further evidence of the administrative burden imposed on providers, including FCCs who largely operate outside the more traditional elements of the healthcare system.

There are several key conclusions concerning the impact of health reforms that emerged from this research. First, navigating the changing insurance and provider landscape proved difficult for insured, underinsured, and even uninsured patients and their providers alike. While providers expected to assist patients with enrollment and navigation, they did not anticipate the full extent of the difficulty patients would face or how time consuming it would be to try and resolve these issues. Moreover, the Medicaid population often did not know a) that their managed care plan did not include their current providers or b) who their providers actually were. So, in some cases, patients continued to go to the providers they were accustomed to even though they were "out of plan." For patients with chronic conditions, such as HIV or diabetes, this posed significant risks according to their providers.

Another unanticipated and unintended consequence is the provision of uncovered services by FQHCs and the ongoing use of FCC resources for Medicaid-eligible patients. At the same time, however, it should be underscored that given resources to provide navigation for their patients, FCCs and FQHCs are uniquely qualified to meet these ongoing demands. FCCs and FQHCs both described treating complex patients with multiple chronic conditions who had often delayed care and required more time and resources than were sometimes available. These patients and the healthcare system would benefit from ensuring that they have regular access to primary care, including case management, and community resources.

Second, the marketplace and many services remained unaffordable although health care reform provided coverage to many uninsured Cook County residents. This echoes perceptions of the post-reform safety net described above. Neither Cook County nor Illinois are alone in facing this issue, and national experts had identified this problem as the next ACA challenge as insurers left the marketplace, destabilizing exchanges in many states.<sup>31</sup> FQHCs commented that healthy, young individuals simply were not enrolling, and FCC patients who were eligible for coverage were resigned to paying the IRS penalty rather than the monthly premiums they perceived they could not afford. Low-income patients at FCCs, uninsured and in Medicaid, indicated that they could only pay a minimal amount, equivalent to several

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<sup>31</sup> NASHP Annual Meeting 2015

hundred dollars annually, for insurance and health care expenses, including premiums and co-pays. Hospital executives described having to provide services free of charge for individuals enrolled in high-deductible plans, who were not eligible for charity care. In addition, the undocumented are finding it increasingly difficult to access charity care outside of Stroger Hospital, which is also focused on expanding its Medicaid population.

Third, the safety net recognizes the need for greater support of its quality improvement activities as well as enhanced capacity to respond to the demand for patient-centered care that addresses social determinants of health. FCCs also need systems and standards for monitoring their patient population similar to the Uniform Data System for FQHCs. However, most clinics have a limited ability to respond to these needs because of the administrative burden of managing multiple MCO contracts for FQHCs, intense patient care coordination for FCCs, and the lack of reimbursement to support attention to the social determinants of health. Some FCCs operate without an electronic medical record system while others have invested in these systems. Of course, their patients reported that everyone at the clinic knows them and the details of their conditions. FCC patients who suffer from hypertension and diabetes all reported receiving routine screenings and medications.

**Table 9.1: Summary of the Impact of Health Reform on the Safety Net**

Impact of Health Reform on Free and Charitable Clinics	
<b>Anticipated Effects</b>	<ul style="list-style-type: none"> <li>● Reduction in medical patients</li> <li>● Increase in referrals to Medicaid, hospitals, and FQHCs</li> <li>● Increase in immigrant patients</li> <li>● Population-specific FCCs maintain services, but explore new operational and financial models</li> <li>● Expansion of services such as dental, behavioral health, and alternative treatment</li> </ul>
<b>Unanticipated/Unintended Consequences</b>	<ul style="list-style-type: none"> <li>● Increase in administrative burden for newly enrolled Medicaid patients</li> <li>● Increase in numbers of underinsured Medicaid and Marketplace patients</li> <li>● Increase in difficulty in effectively navigating the expanded Medicaid and health systems</li> <li>● Reduction in access to charity care</li> </ul>
Impact of Health Reform on Federally Qualified Health Centers	
<b>Anticipated Effects</b>	<ul style="list-style-type: none"> <li>● Greater number of insured patients</li> <li>● Caring for the complex needs of newly insured</li> <li>● Ability to expand services and physical facilities</li> <li>● Increase in patient access to preventive services</li> <li>● Expansion of services such as dental, behavioral health, and alternative treatment</li> </ul>
<b>Unanticipated/unintended Consequences</b>	<ul style="list-style-type: none"> <li>● Complexity of navigating the many MCOs in the state for systems, staff, and patients</li> <li>● Competitive environment among providers</li> <li>● Significant increase in provider time required to address complex patient needs</li> <li>● Patients not utilizing preventive care services as much as expected due to complexity of systems</li> <li>● Increase in administrative burden for care coordination of complex patient</li> <li>● Large numbers of patients with high deductible plans opting to use the sliding fee scale rather than their insurance</li> <li>● Great need for training and staff support to make system-level culture change</li> <li>● Lack of resources to support new patient population navigate preventive health services</li> <li>● Large numbers of people who remain uninsured</li> </ul>

<b>Impact of Health Reform on Hospitals</b>	
<b>Anticipated Effects</b>	<ul style="list-style-type: none"> <li>● Greater number of insured patients</li> <li>● Significant restructuring of care models</li> <li>● Significant influx of funding for hospitals who historically served more uninsured</li> <li>● Stronger community-based partnerships</li> <li>● Greater connections to primary and preventive care</li> <li>● Large numbers of people who remain uninsured</li> <li>● Caring for the complex needs of newly insured</li> </ul>
<b>Unanticipated/unintended Consequences</b>	<ul style="list-style-type: none"> <li>● Complexity of navigating the many MCOs in the state for systems, staff, and patients</li> <li>● Competitive environment among providers</li> <li>● Increase in administrative burden for care coordination of complex patients</li> <li>● Large numbers of patients with high deductible plans</li> <li>● Challenge working with community-based organizations that were not resourced to handle complex payment and collaboration agreements</li> <li>● Great need for training and staff support to make system-level culture change</li> <li>● Caring for the complex needs of newly insured with limited resources</li> </ul>

**ORGANIZATIONAL ADAPTATION TO THE REFORMED ENVIRONMENT**

Safety net clinics began adapting when the ACA passed in 2010 and have continued to be nimble in responding to the shifting environment. This research has highlighted the commitment of safety net clinics to serve the under and uninsured and the expanding Medicaid population, but this has required constant adaptation to many unanticipated and unintended consequences. The safety net recognized early on that patients were going to need assistance and one FCC even applied for and became an early navigator for the state. In the face of the introduction of dozens of MCOs into Medicaid programs, FQHCs have continued to dedicate resources to helping their clients, some of whom will no longer use their clinics. Similarly, FCCs have tried to understand the different barriers their clients face and guide them, frequently accessing provider websites and [getcoveredillinois.gov](http://getcoveredillinois.gov) or [healthcare.gov](http://healthcare.gov) together with their clients.

As noted above, FQHCs and FCCs are aware that they need to be a medical home and address nonmedical needs to improve the health of their patient populations. The largest and older FCCs have demonstrated resilience by continuing to introduce new programs and services and pursuing foundation funding when it is made available. Patients have benefited from a range of wellness programming that has been introduced from nutrition education to exercise and cooking classes. This complements the ongoing provision of patient education during routine visits. The FQHC’s care delivery model has made it difficult to provide these services regularly. FQHCs have taken advantage of funding opportunities through the ACA to expand physical facilities and the range and number of providers, and at the same time have added new services and adapted care models to better serve their patients. In recognizing the need to address patients primary care needs and reduce Emergency Department use, hospitals have

adapted by bringing primary care into their institutions, expanding hours for certain services, and connecting with community resources like churches to serve primary care needs.

## ORGANIZATIONAL ASSETS, CAPABILITIES, AND STRENGTHS

Figure 2: Perceptions of Own Safety Net Institutions by Focus Group Participants and Key Informants



The quantitative and qualitative data reported here portray the depth of the organizational capacity and assets of the safety net. Although strained and challenged, the safety net is guided by its mission-driven instincts and knowledge of the County’s vulnerable populations. Whether navigating an irregular health care user for a colonoscopy, explaining how a health plan works, or treating an HIV positive or LGBT youth, these providers make a significant difference in Cook County. All of the safety net providers in the study have developed ties to the communities they serve and are known to provide quality care. Despite the rapid, ongoing—some might say relentless—pace of changes introduced by federal and state health reform, they continue to focus on meeting their patients’ needs. However, they acknowledge that they have no time to reflect, train, and then adapt to new state and federal regulations. Consequently, if they are to realize their full potential and continue to achieve their missions in the future, they need additional education and training as well as opportunities to share information.

Because FCC patients shared their insights into the care they receive at FCCs, we have a more detailed picture of the compassionate care that is delivered to them with respect and includes ample time to talk to the provider about concerns and problems. In addition, patients are generally able to get affordable medications to manage chronic conditions. As a result, the limitations of FCCs, such as wait times and provider turnover, are not viewed as barriers or signs of poor quality. Similarly, hospitals and FQHCs have responded to the increase in Medicaid patients, providing additional case management and navigation services for their patients. In the initial years of health reform, these providers were more engaged around Medicaid enrollment, but now they have shifted to meeting the needs of patients who have not had regular access to care.

An essential asset or strength of the safety net is its unique skills and knowledge of vulnerable populations; a capacity that enables these providers to serve as medical homes. In fact, it can be argued that these assets are directly related to the challenges that Cook County's safety net has faced during the implementation of health reform and the sector's future opportunities. Several FCCs described their objective to serve as the patient's medical home. The data show that they do so by diagnosing, treating, and managing chronic diseases and engaging in follow-up and promoting preventive care. Figure 2 depicts how safety net clinics provide these services in the words of administrators of FCCs. In addition, whenever possible, FCCs provide health education and wellness programming. Similarly, FQHCs have deployed resources to disentangle the confusing enrollment and referral processes in order to assist complex, high-need patients who require access to diagnostic and specialty care. Alternately, hospitals have had to make difficult choices regarding treatment for the uninsured and underinsured. The sector, as a whole, is well-positioned to coordinate and direct resources to effectively manage and treat the County's uninsured and underinsured populations. But, the sector and its advocates will need the support of the philanthropic community and policymakers to help realize improved health for Cook County's most vulnerable.

# Chapter Ten: Recommendations and Future Directions

*“...perhaps if we were able to collaborate in ways that ... go beyond the conventional collaborations. We could start with a blueprint like Healthy Chicago 2.0...to enable us to think a little bit smarter perhaps about how we address such human issues around accessing quality, especially in areas like mental health, behavioral health, oral health, and other areas, access to subspecialty services that are so daunting for all of the individuals we are privileged to serve.”*

## SUMMARY STATEMENT

We sought to examine the implementation of the Affordable Care Act (ACA) and state level health reforms to learn how this seismic shift in healthcare was impacting safety net organizations within Cook County, Illinois. With the passage of the ACA and implementation of state health reform, many in the health community anticipated that there would be both new opportunities as well as inherent challenges as healthcare institutions prepared to care for millions of newly insured individuals. Anticipated shifts within the healthcare community included the need for changes in delivery systems, staffing patterns, and in relationships between organizations at the federal, state, County, and community level. Anticipations also included that necessary changes would need to be made to practice, workforce, and to the way that healthcare was provided.

As members of the health policy and research community, we believed it was important to begin to examine the implementation process of the ACA and simultaneous state-level health reforms to uncover their impact on the safety net at the local (Cook County) level. We intentionally focused on both the anticipated and unanticipated (or unintended) consequences for Federally Qualified Health Centers (FQHCs), free and charitable clinics (FCCs), and hospitals. Our multi-pronged, qualitative analysis of the implementation of these reforms on the Cook County safety net revealed that health reform implementation can be characterized as having both *anticipated effects* and *unintended consequences*. Our analysis suggests that many of these anticipated effects and unintended consequences have been ubiquitous across the entirety of the safety net system—FCCs, FQHCs, and hospitals. We have also learned that while some impacts of health reform implementation have been similar systems-wide, there have also been *unique* implementation impacts on each sub-system within the safety net. Taken together, we believe that our findings can lead to future opportunities to strengthen the safety net system.

## RECOMMENDATIONS

### POLICY

During the research process, both executive leadership and focus group study participants were asked specifically about their ideas for policy change. Policy recommendations emerged from all sectors; many were the same across safety net providers, while others are focused on a specific provider type within



the safety net system. There are fewer policy opportunities to directly impact the FCC sector than for other, more traditional safety net providers, which are supported by public financing. Nonetheless, as this research has demonstrated, FCCs are playing a vital role in assisting and navigating the newly insured. This role has been funded in the past and could be encompassed in policies that address support for charity care or programs for the uninsured. This section lays out the specific policy changes participants recommended, as well as proposes recommendations in response to some of the suggestions raised by study participants during the research process.

### **High Priority Policy Recommendations:**

At the federal level:

- Continue to implement health reform, including maintaining the ACA and Medicaid, and protect access to quality healthcare for people served by the safety net, which is under increased threat within the current political context.
- Investments in health workforce are needed, especially through the National Health Service Corps (NHSC). There is a need to reduce the costs of higher education and health professions education and make education and training programs more equitable and accessible to all.
- There is a need to reduce the number of patients required to be seen annually by FQHCs in order to allow providers to have more time with each patient. This would give providers the ability to offer a higher quality of care while strengthening provider-patient relationships.

At the state level:

- Illinois should reduce the number of managed care organizations (MCOs) and ensure that communication to patients is clear and understandable.
- Medicaid rates need to be increased such that providers' costs of service provision are covered; both dental care and mental health services (such as psychiatry) were identified as areas where Medicaid rates are too low, thereby reducing the availability of these services.

Federal, state, and local laws and policies all govern and impact the operations of different parts of the safety net. Depending upon current laws and potential future policy change, a recommendation can be made at one level of government or it can be approached from multiple levels. The chart below has been organized to help highlight policies that fit into the following categories: state, federal, or both state and federal.

While each policy recommendation is complex, we have provided a brief summary format of each recommendation in the chart. Some ideas are policy change recommendations, while others share policy considerations or issues in need of policy solutions. The latter are noted as a “*consideration*” and are included because they could be useful for further policy development.

**Table 10.1: Safety Net Policy Recommendations and Considerations**

<b>State-level Policy Recommendations and Considerations</b>	
<p><b>Medicaid and Funding</b></p> <ul style="list-style-type: none"> <li>● Increase reimbursement rates for Medicaid services (which help determine capitation rates from MCOs) such that the rates are sufficient to cover the costs of services provided, thereby increasing their availability</li> <li>● Specifically, dental care and mental health services need to have higher Medicaid reimbursement rates</li> <li>● Mandate notification of any changes to MCO contracts</li> <li>● Reduce the number of MCOs, as having so many contracts poses multiple challenges</li> <li>● <i>Consideration:</i> Ensure that Medicaid reimbursements are available for all necessary services</li> <li>● <i>Consideration:</i> Test methods for risk adjusting payments to account for socio-demographic factors affecting patient populations</li> <li>● <i>Consideration:</i> Streamline enrollment processes and communication to patients</li> </ul>	<p><b>General State Recommendations</b></p> <ul style="list-style-type: none"> <li>● Pass a state budget: Respondents noted the difficulty of keeping their doors open and conducting long-term planning without a state budget</li> <li>● Include FCC staff and leadership in state government and other statewide health-related task forces that study and guide health reform, the health safety net, and improve on the social determinants of health</li> <li>● Provide full and guaranteed funding for the Illinois Breast and Cervical Cancer Program (IBCCP)</li> <li>● Illinois’s Good Samaritan law should cover volunteers who are serving in charitable clinics or hybrid clinics to respond to clinic models recognized in the sector</li> </ul> <p><b>Reduce Health Workforce Shortages</b></p> <ul style="list-style-type: none"> <li>● Provide funding for health professions, student scholarships, and loan repayment programs</li> <li>● Ensure that scope of practice laws facilitate providers practicing at the top of their professional scope of practice and competency</li> </ul> <p><b>Improve Service Delivery</b></p> <ul style="list-style-type: none"> <li>● <i>Consideration:</i> Provide long-term care for the uninsured population</li> <li>● <i>Consideration:</i> Provide health insurance for all residents of the state</li> </ul>

## Federal-level Policy Recommendations and Considerations

### Medicaid and Funding

- Raise FQHC reimbursement rates to better reflect patient mix and current size
- Provide full reimbursement for people who are in jails
- Decrease the number of patients FQHCs are required to see annually; increase the amount of time providers are able to spend with each patient
- Increase the Federal Medical Assistance Percentages (FMAP) of Medicaid to help facilitate the state's ability to increase Medicaid reimbursement rates
- *Consideration:* Address concerns that phase-out of the Disproportionate Share Hospital (DSH) payments will have detrimental effects
- *Consideration:* Provide funding and flexibility for health systems to provide housing and housing support to patients
- Maintain Medicaid as an entitlement program

### Reduce Health Workforce Shortages

- Increase funding and availability of the National Health Service Corps
- Utilize Federal policy to reduce the cost of education (higher education and health professions education)
- Increase the number of residency programs for doctors, specifically in primary care
- Maintain and expand the Teaching Health Center Model to add more sites for training primary care providers

### System Reforms

- Maintain the ACA: Stop threats to both Medicaid and the ACA, as this makes long-term planning difficult and threatens the solvency of the healthcare system
- Target resources for "hot-spotting"
- Consider relaxing Federal Trade Commission regulation on collaborations, shared management agreements, and mergers among healthcare institutions
- Address the gap between affordability and premium and cost-sharing subsidies in the marketplace
- *Consideration:* Increase ability of health systems to purchase low-cost drugs
- The Federal Tort Claims Act (FTCA) program does not extend its medical malpractice protections to volunteers, board members, paid staff, and certain contract employees affiliated with charitable or hybrid clinics. These policies ought to be updated to reflect current practice to expand FCCs' capacity

## Recommendations and Considerations for Both State and Federal Policy

### Improve the Structure of the System

- *Consideration:* Cost analysis of insurance for people who remain uninsured is needed to demonstrate the financial costs of providing care
- *Consideration:* Increase collaboration between policymakers and healthcare providers in policy formation and setting reimbursement rates
- *Consideration:* Strengthen the stability of the provider community by approving a state budget and resolving the status of the ACA and Medicaid at the federal level
- Both Federal and state laws related to FCCs (e.g., the Federal Tort Claims Act and Illinois's Good Samaritan Act) must keep pace with evolving clinic models recognized by the sector in order to ensure that volunteers, who closely relate to capacity, are protected as they provide care

### Improve Service Delivery

- *Consideration:* Fully reimburse for value-based care to further incentivize the move away from volume-based care
- Fund, develop, and mandate participation in a Health Information Exchange

### Increase the Safety Net Workforce

- Develop and fund residency programs for physician assistants (PAs) and advanced practice nurses (APNs) to help train and grow the primary care workforce
- *Consideration:* Incentivize individuals to join the healthcare workforce and to enter into health professions in which there is a shortage by providing sufficient reimbursement
- *Consideration:* Ensure affordable, quality education so that individuals living in the community in which a health center is placed can access education, be hired in health fields, and work at their local FQHCs
- *Consideration:* State and federal financial support for health workforce education and training

### Focus on the Social Determinants of Health

- Funding should be committed to helping hospitals, FQHCs, and FCCs leverage their positions in the communities they serve and to better fulfill their anchor missions by focusing on the social determinants of health (e.g., education, transportation, housing, employment opportunities, and community violence prevention)

### Role of Policymakers

This study reports new information on the uninsured population's willingness to pay for insurance coverage and on the on-the-ground impact of Medicaid managed care on Cook County's most vulnerable populations. This kind of information can benefit healthcare systems, community-based organizations, and both external and internal stakeholders. Participation in policy discussions at the state level can also enable free and charitable clinics to make the business case for a more coordinated approach to charity care across the County.

## **PHILANTHROPY**

One of the chief aims of this study was to make recommendations to the philanthropic community on strategies they could support to help strengthen the safety net. The findings generated from our analyses of existing data as well as focus groups and key informant interviews with executive leadership and key staff working/volunteering in each of the provider settings (FQHCs, hospitals, FCCs) led us to three overarching recommendations for private philanthropy:

### **1) Facilitate and help support efforts that regularly bring together the safety net.**

Opportunities for providers across the sectors to share experiences would be highly valuable. However, achieving this objective will require some creativity and financial underwriting to involve organizations that exist on “shoestring budgets,” and are not structured to spend time on organizational development.

Working alongside state associations (such as the Illinois Primary Care Association and Illinois Association of Free and Charitable Clinics), private philanthropy can play a critical role in creating the infrastructure necessary for shared learning (e.g., learning collaboratives) as well as convening safety net providers for ongoing dialogue. For instance, the dissemination of this research study may provide an opportunity to bring together safety net providers (studied in isolation) to begin to discuss the many issues identified in our quantitative and qualitative analyses. No matter the focus, clinic leaders agree that the reformed environment demands more information sharing and more collaboration than ever before.

### **2) Provide general operating support.**

Focus group participants and systems leaders expressed a strong desire for general operating support and related reforms aimed at improving the processes for applying for funding and tracking grant expenditures. Table 10.2 illustrates these themes in selected quotes from leaders of safety net organizations. The safety net providers perceive general operating support as an investment in their organizational missions. At the same time, additional general operating support may create more flexibility in settings with very limited budgets, thereby enabling staff to engage in the shared learning experiences recommended above.

### **3) Provide targeted support in the following priority areas:**

- (a) The need to do a better job connecting patients with community resources;
- (b) The need for better systems to collect, report, and use health information;
- (c) The need to increase staff training;
- (d) The need to help patients better navigate the health system and more effectively use available insurance coverage;
- (e) The need for updated equipment and facilities repairs/updating; and

- (f) The need for funds that will allow safety net providers to innovate and create pilot programs that better serve their patients.

Targeted philanthropic attention on these priority areas would help safety net providers to: tackle the social determinants of health; initiate and expand quality improvement initiatives; practice at the top of their license; improve staff satisfaction; better coordinate care; understand new and evolving regulations and systems; and reduce the widespread confusion that was remarked upon so frequently in each conversation held through this study. Support for new innovation and pilot programs would allow safety net providers to test new staffing structures, test new programs, and test new coordination models that may improve patient care. It must be noted that while it was primarily the hospital leaders who identified the need for “brick and mortar” and equipment support, the need for this investment may pose a challenge to local philanthropy. Nonetheless, because safety net providers have so little support for these items, and are now in a position of competing with much better capitalized institutions, these providers feel increased pressure to find ways to improve their physical facilities and equipment.

**Table 10.2: Participants’ Comments on the Need for General Operating Support and the Challenge of Funding Their Programs**

- *“I am stating the obvious: general operating support to allow us to do the work we absolutely need to do, without needing to define it in a unique creative innovative way because we are unique, creative, and innovative. This is a – it is always a challenge.”*
- *“I am actually less worried about...finding a specific something, because granters kind of love to just jump into a thing. It’s a capital piece...that’s their machine. It’s just getting the rest of it that is just much harder, [like] pulling teeth.”*
- *“This thing has to be repeated, the Gen Op support. But do [not] ask us to track where your money is going, [then it is] not actually Gen Op support. Administrative resources and time tracking where each dollar goes, and I know that’s you know, there is lot of talk out there ... but this [has] got to stop if we want to support these organizations in doing the actual work.”*
- *“I am new with this...and I’ll lay another thing out there: consistency [in] applications, if there could be some consistency in the way the applications are arranged, because the challenges on a regular basis of jumping through whatever application [hoop] you are, you are doing, it’s similar to data collection on any medical thing...”*

## FUTURE DIRECTIONS FOR RESEARCH

This study was unique from others that have examined the safety net in that we intentionally asked participants to discuss both the anticipated effects and the unintended consequences of health reform implementation. This distinct line of inquiry invited new questions, new ideas, and broadened areas of research. Our preliminary project deepened our understanding of a small sampling of the safety net in Cook County. It also identified a host of future research directions. In addition to recommendations for

policymakers and philanthropy, there is also a need for further research to guide health reform and policy.

- **Social Determinants of Health:** A significant theme in this study was the importance of factors that impact health outside of the clinical environment (see Appendix C for a full discussion of the social determinants of health). In addition to policy change focused on the social determinants of health, there is also a significant need for research on how the safety net can help patients ameliorate negative social factors, such as lack of high-quality and accessible transportation, jobs, housing, food, and education, each of which has a significant impact on health.
- **Health Reform Within Broader Geographic Context:** As this study was conducted in Cook County, it represents merely a snapshot of the effects of health reform implementation on the safety net in a dense urban and surrounding suburban area. More research is needed to examine implementation in sprawling suburban and rural areas across the state. Eventually, this analysis can be utilized nationally as well.
- **Ongoing Monitoring and Research on Health Reform:** This research was conducted retrospectively, which means that there was a time gap between initial ACA implementation and our data collection. Therefore, some health system changes were not described as being directly influenced by the ACA when they likely were. In order to make future research more timely and responsive to current challenges, research should be conducted prospectively rather than retrospectively. There is also a need for ongoing research and monitoring of how these health reforms are impacting the healthcare safety net system, health workers, and patients in order to more fully understand, respond to, and strengthen the safety net system, as health reforms are enacted and implemented at the national, state, and local levels.

While a major strength of the organizations in the safety net is their commitment to their missions, at times it was difficult to tease apart what work was being done because of health reform and what would have happened anyway because of the organizational mission. Nonetheless, it was clear that additional funds due to health reform facilitated the expansion of many efforts that were already planned or existing regardless of reform. In order to more clearly understand when interventions were developed and what facilitated their implementation, additional forms of analysis are necessary in future research. In particular, an in-depth historical analysis of health systems would be beneficial in order to better understand the impacts of health reform.

In this process of monitoring and research, there is a need for development of criteria for measuring success and mechanisms to respond appropriately both as reforms fall short of their intended purposes and as individuals and groups fall through the cracks during and after reform.

- **Broader Sample of Systems, Staff, and Safety Net Clients:** In this study, we conducted in depth interviews with executive-level leadership at hospitals. Future research should include hospital staff to deepen our understanding of workforce capacity in safety net hospital settings. A useful next step in this work would be to conduct additional research that includes executive leadership, staff, and patients across all safety net provider types, and particularly include a greater number of hospitals.

- **Workforce:** Our preliminary analysis revealed that safety net providers want to hire staff from the communities in which they serve. However, many community members are often enrolled in for-profit institutions that produce high levels of educational debt and lower levels of professional training. This represents a barrier to their employment within the healthcare system. Our findings underscore the urgent need to research the equity implications of for-profit institutions.
- **Other Policy Research Issues:**
  - Research on the wraparound and care coordination services available to members of the HIV+ population is needed, including a cost analysis on providing these services to the larger safety net population.
  - There is a need for a cost analysis of insuring the undocumented and other currently uninsured adults.
  - Additional research is needed that examines how Illinois ranks among other states on Medicaid reimbursement rates to inform our previously stated policy recommendation.
  - Since participants did not identify local policy change ideas for improving the health safety net, such recommendations are not included; this is an area in need of future research.
  - The level of frustration among safety net providers about the frequency of changes in contracts that hospitals and FQHCs have with managed care organizations revealed a need for additional research on this topic. Specifically, an examination of laws governing MCO contracting in other states that might reveal best practices for ensuring that disruption from these changes are minimized.

## CONCLUDING STATEMENT

Safety net organizations pride themselves on their commitment to serve underserved populations. As such, they serve all individuals, regardless of insurance or ability to pay, and are expected to absorb the costs of care. Safety net organizations in Cook County have accepted this charge and serve some of our County’s sickest and most complicated patients (and many of the newly insured who have gone without care for years or even decades). The safety net helps advance the right to healthcare, and health reforms at all levels of government have significant impacts on the ability of the safety net system to guarantee access, improve operations, and improve stability.

Due to safety net provider’s long-term position of having insufficient budgets and high-need patients—and the monumental health reforms that have taken place in Illinois and nationally—the safety net has been increasingly challenged at the same time that it has grown to cover more people and create new models of care as these providers shift towards an increased focus on preventive and primary care.

We conducted this study during the height of a national discussion about yet another complete transformation of healthcare in the U.S. Despite widespread uncertainty, our findings underscore that whatever changes are to come, we must continue to monitor their impact on the safety net here in Illinois and strengthen those systems that serve the most marginalized in our communities. The ability to access healthcare is fundamental to people’s ability to thrive and contribute to their families and communities.





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**Appendix A: Combined Discussion Guide**

**DISCUSSION GUIDE**

**FOR INTERVIEWS AND FOCUS GROUPS WITH**

**HOSPITAL, FQHC AND FREE/CHARITABLE CLINIC EXECUTIVES/STAFF**

**Guiding Questions:**

1. *How would you characterize the safety net in Cook County?*
2. *How has the implementation of major national and state health reforms impacted the healthcare safety net in Cook County?*
3. *How has the safety net adapted to the reformed environment?*
4. *What are the unique assets of the Cook County's safety net providers?*
5. *How can private philanthropy and policymakers support the safety net?*

**Focus Group**

Date of focus group	/       /	
Focus group location		
Moderator		
Assistant Moderator		
Observer/Note taker		
Number of participants		
Time of focus group	Start:	End:

**Interview**

Date of interview	/       /	
Interview location		
Interviewer		
Interviewee		
Time of interview	Start:	End:

## Introduction

Welcome! As you know, we are here today to discuss the status of the safety net during a period of change and uncertainty and to suggest ways that policymakers and the philanthropic community can help support the safety net. As part of this discussion, we want to hear about the impact of health reform on your clinic(s)/hospital as well as on your patients.

Thank you for agreeing to be a part of this important discussion. My name is \_\_\_\_\_ with \_\_\_\_\_ and I'll be moderating and I am joined by, \_\_\_\_\_, from \_\_\_\_\_ who will be taking notes. This is [*name of Assistant Moderator*], the Assistant Moderator, and s/he will be taking some notes as we talk so that we can remember the conversation better later. Also, that is [*name of Observer/Note Taker*] over there. [*Notetaker*] will be taking notes as well.

Keep in mind that we will be audio recording our conversation so that we can review and report our discussion accurately. Be assured that we will not use your name or any other identifiers.

Again, we greatly appreciate your willingness to give your time to be here today.

For this study, we are defining the Cook County safety net broadly, including public and nonprofit hospitals, Federally Qualified Health Centers, and free and charitable clinics. We are also considering health reform broadly as well. While the Affordable Care Act is the most momentous health reform over the last few years, there have been other significant changes, such as the mandate to move many of Illinois' Medicaid patients into managed care. So in our discussion today, please feel free to reference any policy and practice health reforms that impact your work or health system.

## Ground Rules for Focus Group

Before we begin, I would like to remind everyone of the ground rules for a successful discussion. We hope you were able to review the consent information that was shared with you before today. There is another copy at your seat. Do you have any questions?

1. As the consent document states, your participation is completely voluntary and you may leave the room at any time during our discussion today.
2. We want to hear from everyone in the room and know we will all respect each other and share the floor during this discussion.
3. Finally, what is said in this room should stay in this room as we ask that you all respect the privacy of your fellow participants and do not share any information discussed here today.

Does anyone have any questions before we begin? [*Wait for questions*]

Now that we all understand the rules, I'm going to turn on the recorder



**GUIDING QUESTION #1: How would you characterize the safety net in Cook County?**

**Let's begin by thinking about the safety net as a whole.**

1.1 How would you characterize the safety net in Cook County?

1.2. Who would you identify as members of the safety net in Cook County?

PROBES-FOLLOW-UP QUESTIONS

- How are the various organizations in the safety net similar or different?

1.3. How well is the safety net functioning as a system?

PROBES-FOLLOW-UP QUESTIONS

- Facilitators
- Barriers
- Are you better connected to other providers today than you were before?
- Unanticipated changes in the safety net

1.4. Could you describe a better safety net system for Cook County? What would it look like? What might need to change in order to accomplish that? Please feel free to think big and beyond current political and economic limitations.

**GUIDING QUESTION #2: How has the implementation of major national and state health reforms impacted your [FQHC/free & charitable clinic/hospital] safety net in Cook County?**

**For this next set of questions, we are focusing on the impact of health reforms (national and state) on your organization, its operations and resources.**

2.1. Describe how health reform and the changes it has brought about in the health care system have impacted your [clinic/hospital]. Please include ways you think your operations have improved?

PROBES – FOLLOW-UP QUESTIONS

- Funding/Financing, reimbursement, in-kind support
- Services: Are there services/programs that you can/cannot offer your patients? (Medications, referrals, visits)
- Staffing composition (paid and volunteer), staffing models
- Facilities, Technology:
- Engagement with the community, partnerships
- Barriers & facilitators

2.2. What/who do you feel is falling through the cracks post-ACA implementation?

PROBES-FOLLOW-UP QUESTIONS

- Increase/decrease numbers of patients
- Increase/decrease in insured, uninsured
- Increase/decrease in patient care needs (acuity)
- Increase/decrease in non-healthcare related needs
- Change in payer mix
- Change in patient care
- Services: Are there services/programs that you can/cannot offer your patients? (Medications, referrals, specialty visits)
- What is the remedy? (Policy change? Programmatic? Budget changes?)

2.3. What are the unmet needs of your uninsured and underinsured patients? What remaining barriers to accessing care exist for your patients?

2.4. What are the areas where the safety net in Cook County is positioned to address gaps in the post-ACA environment? What about your institution specifically?

PROBES-FOLLOW-UP QUESTIONS

- Flexible resources – space, staff, hours?
- Understanding of the population
- Manage patients during eligibility cycles

2.5. Are there specific ways your system is thinking about or planning to address these gaps?

PROBES – FOLLOW-UP QUESTIONS

- Address social determinants of health
- Facilitators
- Barriers

***GUIDING QUESTION #3: How has the [FQHC/free & charitable clinic/hospital] safety net adapted to the reformed environment?***

3.1. With regard to the challenges you just mentioned, can you describe what you are doing to continue your operations?

PROBES – FOLLOW-UP QUESTIONS

- Changes to operating hours
- Partnerships with other providers
- Changes in services and programs, including new care models, team-based care
- Identifying new resources
- Consider becoming an FQHC, accepting Medicaid, charging a fee
- Are you and how are you expanding your use of technology and collecting and using new data and information?
- Facilities and/or locations
- Funding/Financing/Reimbursement



**GUIDING QUESTION #4: What are the unique assets of the [FQHC/free & charitable clinic/hospital] safety net?**

**We have now discussed the impact of reform on your organizations and patients, I would like to focus on your [clinic's/hospital's] organizational assets in this new environment.**

4.1. What do you see as are your organization's most important assets, capabilities, and strengths?

PROBES – FOLLOW-UP QUESTIONS

- Mission, well-known leaders, strong community presence
- Staff skills & expertise/Volunteer skills & expertise, Cultural competence
- Location
- Quality of services, Effective programs
- Access to patients, knowledge of the population
- Partnerships, Community engagement/community relationships, access to community leaders/influential people
- Fundraising, Communications/marketing

4.2 What are the potential opportunities to build on your [clinic's/hospital's] assets?

PROBES-FOLLOW-UP QUESTIONS

- Introducing new care models
- Using your resources in new ways, more effectively
- Identifying new resources
- Partnerships

4.3 How do the organizational assets you described uniquely position your organization to contribute to the overall safety net?

PROBES-FOLLOW-UP QUESTIONS

- What gaps does your clinic/hospital fill?
- If your clinic/hospital didn't exist, what would be lost?
- What are the opportunities for your clinic in the future?

4.4 What concerns do you have about maintaining these assets/capabilities/strengths?

PROBES-FOLLOW-UP QUESTIONS

- What do you attribute to the ACA/state health reform
- How has your organization's financing and/or financial health changed and has it increased or decreased your organizational assets?

**GUIDING QUESTION #5: How can private philanthropy and policymakers**

**support the FQHC/free & charitable clinic/hospital safety net?**

**Now that we have discussed the impact of the ACA and the current environment on your organizations, we would like to discuss the role of philanthropy and policymaking in supporting your [clinic/hospital].**

5.1 Are there gaps in your [clinic/hospital] that you are unable to fill currently, and what would you need to allow your clinic to help fill these gaps?

5.2 What role can private philanthropy play to ensure your [clinic's/hospital's] success?

PROBES-FOLLOW-UP QUESTIONS

- What would your top request for additional funding be from a private foundation?
- Where can funds be best used to support your operations?
- Operational Challenges (noted in discussion)
- Gaps (noted in discussion)
- Sustainability
- Achieve mission
- Training
- Technical Assistance
- Leadership

5.3 How can policymakers help ensure your [clinic's/hospital's] success?

PROBES-FOLLOW-UP QUESTIONS

- County policy
- State policy
- Federal policy

**Closing**

Thinking about our discussion today, is there anything we didn't ask or you forgot to mention that you want to raise or clarify?

Thank you so much for your time and willingness to speak with us. We appreciate your insight.

I'm turning off the recorder now.

*Turn off recorder.*

General probes:

Tell me more about...

Say more.

Keep talking.

Can you give me an example?

It sounds like you're saying...

Can anyone build on that last thought?

## Appendix B: Brief Survey of Health Professionals

### Brief Survey for Safety Net Providers Participating in Focus Groups/Key Informant Interviews

*So that we may characterize the participants in this study, we ask you to answer the questions below.*

1. **When were you hired by (or become a volunteer for) the clinic/hospital?** *Please write it in the space below.*

MONTH/YEAR

2. **What is your current job title (volunteer position) at the clinic/hospital?** *Please write it in the space below.*

3. **What is your age?** *Please write it in the space below.*

4. **What is your gender?** *Check one answer.*

- Male  
 Female

5. **What is the highest level of school that you have completed?** *Check one answer.*

- High school diploma  
 Associate's degree  
 Bachelor's degree  
 Master's degree  
 Professional degree beyond a bachelor's degree  
 Doctorate degree

6. **In a word or phrase, how would you describe the current state of the overall health safety net in Cook County?** *Please write it in the space below.*

7. **In a word or phrase, how would you describe the current state of your clinic/hospital?** *Please write it in the space below.*

[REDACTED]

***So that we may characterize the organizations represented in this study, we ask you to answer the questions below.***

**1. In what year was your organization founded?**

[REDACTED]  
YEAR

**2. In 2015, how many unduplicated patients did your organization serve? Please write it in the space below. You may estimate.**

[REDACTED]  
# OF UNDUPLICATED PATIENTS

**3. In 2015, how many visits/encounters did your organization provide? Please write in the number of visits or encounters, whichever aligns best with your method of reporting. You may estimate.**

[REDACTED]  
Encounters

[REDACTED]  
Visits

**4. How many delivery sites does your organization operate? Please write it in the space below.**

**5. What services does your organization provide? Please check all that apply.**

- <sub>1</sub> Inpatient
- <sub>2</sub> Outpatient primary care
- <sub>3</sub> Outpatient specialty
- <sub>4</sub> Mental health/behavioral health
- <sub>5</sub> Dental
- <sub>6</sub> Other (write in) \_\_\_\_\_

**6. Where does your organization operate delivery sites? Please check all that apply. If you operate sites outside of Chicago, please write in the city.**

- <sub>1</sub> Chicago-North
- <sub>2</sub> Chicago-South
- <sub>3</sub> Chicago-West
- <sub>4</sub> Suburban Cook County (write in City) \_\_\_\_\_
- <sub>5</sub> DuPage County (write in City) \_\_\_\_\_
- <sub>6</sub> Other (write in City) \_\_\_\_\_

**THANK YOU FOR TAKING THE TIME TO FILL OUT THIS SURVEY.**

## Appendix C: Social Determinants of Health

What are the social determinants of health (SDOH) and structural inequities?

The **social determinants of health** are the conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”<sup>i</sup>

“**Structural inequities** refers to the systemic disadvantage of one social group compared to other groups with whom they coexist and the term encompasses policy, law, governance, and culture and refer to race, ethnicity, gender or gender identity, class, sexual orientation, and other domains.” When thinking about structural inequities, references to these identities are needed to highlight the ways in which structural inequities not only *disadvantage* some groups of people, but also *advantage* other groups. People have multiple, intersecting identities which **requires an intersectional approach** to understanding and attempting to both ameliorate suffering from and work to dismantle structural inequities and disadvantages.”<sup>ii</sup>

**Funding Opportunity:** Several participants in this research expressed a need for new funding focused on the SDOH, to help them to assist patients with unmet needs outside of the clinic.

**Policy change:** Ultimately, making progress on the social determinants of health requires tackling the social and economic processes that lead to the inequitable distribution of money, power and resources. This is a political process that includes the engagement of the agency of disadvantaged and oppressed communities with the responsibility of their government.”<sup>iii</sup>

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<sup>i</sup> National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in action: Pathways to health equity*. Washington, DC: The National Academies Press. doi: 10.17226/24624. <https://www.nap.edu/download/24624>

<sup>ii</sup> National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in action: Pathways to health equity*. Washington, DC: The National Academies Press. doi: 10.17226/24624. <https://www.nap.edu/download/24624>

<sup>iii</sup> Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).

**Appendix D: Focus Group Discussion Guide for Free and Charitable Clinics**

**DISCUSSION GUIDE  
FOR FOCUS GROUPS WITH  
PATIENTS OF FREE/CHARITABLE CLINICS**

**Focus Group**

Date of focus group	/       /	
Focus group location		
Moderator		
Assistant Moderator		
Observer/Note taker		
Number of participants		
Time of focus group	Start:	End:

**Introduction for Focus Group**

Hello everyone and thank you for agreeing to be a part of this discussion about your experiences getting health insurance and the healthcare you need. By way of a reminder, you will be participating in a Focus Group. A Focus Group is a confidential group discussion led by a moderator around a set of questions.

My name is [*name of Moderator*] and I'll be the Moderator of today's Focus Group. I have a set of questions here in front of me to help guide our conversation. This is [*name of Assistant Moderator*], the Assistant Moderator, and they will be taking some notes as we talk so that we can remember the conversation better later. We will also be using a recorder during our discussion. Thank you for agreeing to be a part of this important discussion. We will not use your name or any other identifiers in the transcriptions or reports.

## Ground Rules

Before we begin, it will be helpful to discuss a few ground rules that help make focus groups run more smoothly.

1. Your participation is entirely voluntary.

Please understand that this focus groups is completely voluntary. If you do not wish to participate, you may opt out. Just let us know.

2. We want to hear from everyone.

Your honest feedback will help us tell the story about why this clinic is important and whether people have access to the healthcare they need. We will try to give everyone an opportunity to answer each question.

3. There are no wrong answers.

There are no correct answers to the questions that we will be asking and remember that everyone is entitled to our own opinions. We ask you not to tell us what you think we want to hear, but what you actually have and are experiencing when you seek health care. Also, everyone's experiences are important and valid. Please speak up whether you agree or disagree with what's being said.

4. Finally, what is said in the room should stay in the room.

We want everyone to feel comfortable sharing their experiences in this space. So, we are asking that you all respect the privacy of fellow focus group participants and do not share any information discussed here today.

Please be assured that no information identifying you will be used in any reports. Eventually we hope to publish what we learn today. Again, all written reports/articles will not include any information that identifies any specific person.

Questions: Does anyone have any questions before we begin?

*Turn on recorder.*

***You've all been asked to be here today because you share at least one thing in common: each of you is a patient of \_\_\_\_\_. Given this, we'd like to find out about your experiences in getting healthcare services—medications, medical care, dental care, mental health care – both here at \_\_\_\_\_ and elsewhere.***

**1. What prompted you to seek out healthcare services at \_\_\_\_\_?**

Probes-Follow-up questions

- Urgent or Chronic condition or Well care/Preventive care
- Check up, job physical
- Medications/Prescription needed
- Medical
- Dental
- Mental health/behavioral health

**2. \*\*\*There are other places you could go to get care (hospital emergency room, community health center, the County, etc.). How did you end up at a free/charitable clinic?\*\*\***

Probes-Follow-up questions

- Reasons: uninsured, cost, referral, didn't know where else to go, convenience, recommendation from family/friend, poor experience elsewhere, can't find a provider willing to see me, can't afford to go elsewhere, convenience
- Cost: how does that influence where you go (and continue to go)
- How long have you been coming to this clinic?
- How did you learn about this clinic?
- Where else have you gotten care?
- Why do you keep coming back?
- Is the clinic your regular doctor/medical home or just some place you use occasionally
- Would you recommend this clinic to a friend/family member? Why or why not?
- How far do you travel?

**3. Have you tried to get care somewhere else? If so, what happened?**

Probes-Follow-up questions

- Who/what: clinic, individual doctor, ER,
- Insurance affordability: co-pays, deductibles
- Provider affordability: sliding fee scale (how much are the fees)
- Can't find provider willing to accept Medicaid
- Preferred provider not in network
- Didn't like doctor
- Don't know where to go

**4. What are the things that you like about the free/charitable clinic (assets, strengths) that you don't find from another place?**

Probes-Follow-up questions

- Volunteers



- No cost/nominal fee
- Cultural fit
- Safe environment
- Providers: MDs, NPs, etc.

**5. What haven't you been able to get from the free/charitable clinic (or anywhere else) that would help you become healthier?**

**And, what could the clinic do differently to help you become healthier?**

**What changes could we make to our health system to help you become healthier?**

Probes-Follow-up questions

- Unmet needs
  - Services: specialty, medications, medical, dental, vision
  - Nonhealthcare: job training, food, housing assistance, etc.
  - Social services/community services (referrals to)
  - 24-hour availability/reach doctor after-hours
  - Same day appointments
  - Shorter wait times (in clinic), less time to wait for appointment
  - See same doctor every time go to clinic
  - Alternative modalities like diet, exercise, meditation, or chiropractic care
  - Legal/cultural
  - Wellness programs
- What is the biggest barrier to getting the care you need?
  - Insurance
  - Time
  - Cost (here, at other locations)
  - Convenience: location, hours
  - Trouble getting an appointment / Wait list
  - Something else
  - Clinic doesn't offer service
  - Finding a provider willing to see me
  - Affordability-premiums, copays, deductibles
  - Administrative hassle, redeterminations
  - Stigma (Medicaid)

**Next, we'd like to find out what you know about the new health reform law – called *ObamaCare* or the *Affordable Care Act*, your opinions about it, and any experiences you might have had applying for health insurance coverage.**

**6. What do you know about the new health reform law?**

Probes- Follow-up questions

- Mandate
- Subsidies
- Expanded coverage – Medicaid
- New marketplace

**7. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?**

Probes-Follow-up questions

- Very favorable
- Somewhat favorable
- Somewhat unfavorable
- Very unfavorable
- Don't know

**8. Can you tell us what, if anything, has changed for you because of health care reform?**

Probes-Follow-up questions

- Have insurance?
- Got care that they had delayed?
- Lost your coverage

**9. If you applied for health insurance in the marketplace or Medicaid, can you tell us about your experience getting (and keeping) your health insurance plan?**

Probes-Follow-up questions

- Eligibility for health insurance coverage
- Experiences with ACA/marketplace/Medicaid
  - bronze, silver, gold and platinum
- Compliance with insurance mandate
- Difficulties in maintaining coverage/disenrollment
- Cost
- Willingness to pay (% of income)

**10. Do you think you are better off or worse off under the health reform law, or don't you think it has made much difference? Why/Whynot?**

Probes-Follow-up questions

- Better off
- Has not make a difference
- Worse off
- Don't know

**11. The future of the Affordable Care Act is uncertain in light of the recent Presidential election.**

Probes-Follow-up questions

- How, if at all, might you imagine your access to health care changing under the Trump Administration?
- For those of you who have health insurance, would you keep it if you didn't have to?

**Closing**

Thinking about our discussion today, is there anything we didn't ask or you forgot to mention that you want to raise or clarify?

Thank you so much for your time and willingness to speak with us. We appreciate your insight.

*Turn off recorder.*

General probes:

Tell me more about...

Say more.

Keep talking.

Can you give me an example?

It sounds like you're saying...

Can anyone build on that last thought?

**Appendix E: Brief Survey of Free Clinic Patients  
Survey of Focus Group Participants**

**1. Are you currently covered by any of the following types of health insurance or health coverage plans? Check one box.**

- 1  Not insured / Uninsured
- 2  Insurance through an employer [SKIP TO QUESTION #3]
- 3  Insurance purchased directly through an insurance company [SKIP TO QUESTION #3]
- 4  Insurance purchased through the Health Insurance Marketplace (for example, through [getcovered.illinois.gov](http://getcovered.illinois.gov) or [www.healthcare.gov](http://www.healthcare.gov)) [SKIP TO QUESTION #3]
- 5  Medicare, for people 65 and older, or people with certain disabilities [SKIP TO QUESTION #3]
- 6  Medicaid or Medical Assistance [SKIP TO QUESTION #3]
- 7  TRICARE or other military health care [SKIP TO QUESTION #3]
- 8  VA [SKIP TO QUESTION #3]
- 9  Any other type of health insurance or health coverage plan [SKIP TO QUESTION #3]

**2. If you are currently uninsured, which of these are the reasons why you do NOT have health insurance? Check all that apply.**

- 1  Not eligible for health insurance through the Health Insurance Marketplace or Medicaid
- 2  Never had or have no need for health insurance
- 3  Do not know how to find information on available health insurance options
- 4  Cost is too high
- 5  Lost eligibility for Medicaid
- 6  Lost job or changed employers
- 7  Self-employed or employer does not offer coverage
- 8  Became ineligible for coverage because of age or because left school
- 9  Other (write in) \_\_\_\_\_

**3. In what year did you first start going to [NAME OF CLINIC]? Please write the year in the space below.**

\_\_\_\_\_  
YEAR

**4. Is [NAME OF CLINIC] the place you USUALLY go when you need medical care?**

- 1  YES, I usually go to NAME OF CLINIC
- 2  NO, I usually go to another doctor's office or private clinic
- 3  NO, I usually go to a community health center that offers a discounted fee
- 4  NO, I usually go to a retail clinic like WalMart or CVS
- 5  NO, I usually go to an urgent care center
- 6  NO, I don't go to any place most often

**5. Since becoming a patient of [NAME OF CLINIC], has there been a time when you...**

- Had trouble finding a general doctor who would see you 1  Yes 2  No
- Were told by a doctor's office or clinic that they would not accept you as a new patient 1  Yes 2  No
- Were told by a doctor's office or clinic that they did not accept your health care coverage 1  Yes 2  No 3  Uninsured
- Had trouble finding a doctor or clinic you could afford 1  Yes 2  No

**6. Since becoming a patient of [NAME OF CLINIC], has there been a time when you...**

- Did not fill a prescription for medicine because of the cost 1  Yes 2  No
- Did not get doctor care that you needed 1  Yes 2  No
- Did not get specialist care that you needed 1  Yes 2  No
- Did not get dental care that you needed 1  Yes 2  No

**7. Do you have a chronic health condition, such as diabetes, high blood pressure, asthma, heart disease, COPD, lung disease, emphysema or COPD, arthritis, or cancer?**

- 1  Yes
- 2  No

**8. In general, would you say your health is:**

- 1  Excellent
- 2  Very Good
- 3  Good
- 4  Fair
- 5  Poor

**9. How long have you lived in Cook County? Please write it in the space below.**

NUMBER OF YEARS

**10. What is your zip code? Please write it in the space below.**

ZIPCODE

**11. What is your gender?**

- 1  Female
- 2  Male

**12. In what year were you born? Please write it in the space below.**

YEAR OF BIRTH

**13. Would you describe yourself as...**

- 1  Hispanic / Latino
- 2  White / Caucasian
- 3  Black / African American
- 4  Asian
- 5  American Indian / Native American / Alaska Native
- 6  Pacific Islander / Native Hawaiian

**14. What is your current working status?**

- 1  Working full-time
- 2  Working part-time
- 3  Student
- 4  Retired
- 5  Not employed

**15. What is your yearly household gross income?**

- 1  Less than \$20,000
- 2  \$20,000 to \$29,999
- 3  \$30,000 to \$39,999
- 4  \$40,000 to \$49,999
- 5  \$50,000 to \$59,999
- 6  \$60,000 to \$69,999
- 7  \$70,000 to \$79,999
- 8  \$80,000 or more

**16. What is the highest level of school that you have completed?**

- 1  Grade 1 – Grade 11
- 2  High School Diploma / GED
- 3  Some college
- 4  Associate's degree
- 5  Bachelor's degree

6  Master's degree, professional degree, or doctorate beyond a Bachelor's degree