Health Professional Shortages in the San Joaquin Valley:

The Impact on Federally Qualified Health Clinics

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The Central Valley Health Policy Institute
California State University, Fresno

2006

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Published by:
Central Valley Health Policy Institute
Central California Center for Health and Human Services
College of Health and Human Services
California State University, Fresno

This publication was funded by a grant from

The California Endowment

Suggested Citation:

Riordan, D.G., Capitman, J.A. (2006). Health professional shortages in the San Joaquin Valley: The impact on federally qualified health clinics. Fresno, CA: California State University, Fresno.

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This report was supported through a grant from the California Endowment to California State University, Fresno. The views expressed in this report are those of the authors and do not necessarily reflect those of the funders or the University.

THE CENTRAL VALLEY HEALTH POLICY INSTITUTE

The Central Valley Health Policy Institute was established in 2002 at California State University, Fresno to facilitate regional research, leadership training and graduate education programs to address emerging health policy issues that influence the health status of people living in the San Joaquin Valley. The Institute was funded in July, 2003 by The California Endowment, in partnership with the University, to promote health policy and planning in the region.

Additional information about the Central Valley Health Policy Institute, it's programs and activities (including this report), a health related calendar, and academic and community resources may be found at: www.csufresno.edu/ccchhs/HPI

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www.CVHPI.org

ACKNOWLEDGEMENTS

The authors would like to thank the following people for their invaluable assistance with the publication of this report.

Editing and Design

Cheryl McKinney Paul

Geographic Information Systems and Mapping

Antony Martin Joy

Leadership and Project Support

Kathleen A. Curtis, Associate Dean ad interim, College of Health and Human Services, California State University, Fresno
Director Centeral California Center for Health and Human Services
Carole Chamberlain, Program Officer, The California Endowment
Benjamin Cuellar, Dean, College of Health and Human Services, California State University, Fresno
Jeromina Echeverria, Provost and Vice President for Academic Affairs, California State University, Fresno
The Members of the Regional Advisory Council, Central Valley Health Policy Institute

Cover Photograph by: Jill K. Richards

TABLE OF CONTENTS

List of Tables

List of Figures

EXECUTIVE SUMMARY

In an effort to respond to regional concerns regarding health professional shortages in California's San Joaquin Valley and the effect of these shortages on the health of Valley residents, the Central Valley Health Policy Institute at California State University, Fresno conducted a survey to evaluate the effects of these shortages on Valley residents. The survey had three primary objectives:

1) Describe the impact that health professional shortages have on access to primary health care in the eight counties of the San Joaquin Valley (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare)
2) Describe current patterns of federal, and other resources, coming to community, private, and rural health clinics in the San Joaquin Valley
3) Identify new approaches to addressing the consequences of health professional shortages

This report provides preliminary findings from responses to the survey completed by eight federally qualified health clinics (FQHCs). The clinics were all members of the Central Valley Health Network. The survey was constructed, following an extensive review of the literature, consultation with regional health providers, and pilot testing, with both quantitative and qualitative questions in an attempt to provide each clinic the opportunity to describe their experiences as comprehensively as possible. The questionnaire included 17 items that used a Likert type scale to indicate how often various clinic, patient and access dynamics were a factor that limited the provision of healthcare to their target population. An additional 15 open ended questions allowed clinics to express their unique experiences and strategies to address the effects of those dynamics.

All eight clinics rated access to specialists and site limitations (size and location) as "very important" or "extremely important" in limiting the ability to provide health care to their target population. All but one clinic rated medical referrals as difficult "most of time" or "almost always" due to health professional shortages. Seventy-five percent of the clinics also rated substance abuse, mental health and case management referrals as difficult "most of the time" or "almost always". Factors rated as "extremely important" by all sites in limiting access to specialists were Medi-Cal and county indigent care program reimbursement rates.

Issues of concern for clinics in relation to the health professional shortages were identified through the qualitative analysis. They include inadequacy of funding, recruiting issues, capacity issues, and access to specialists. Strategies that clinics are currently using to decrease the impact of health professional shortages included expanding funding opportunities, participating in the Health Disparities Health Collaboration Program, developing relationships for providing non-physician services, and using technology to increase clinic efficiency.

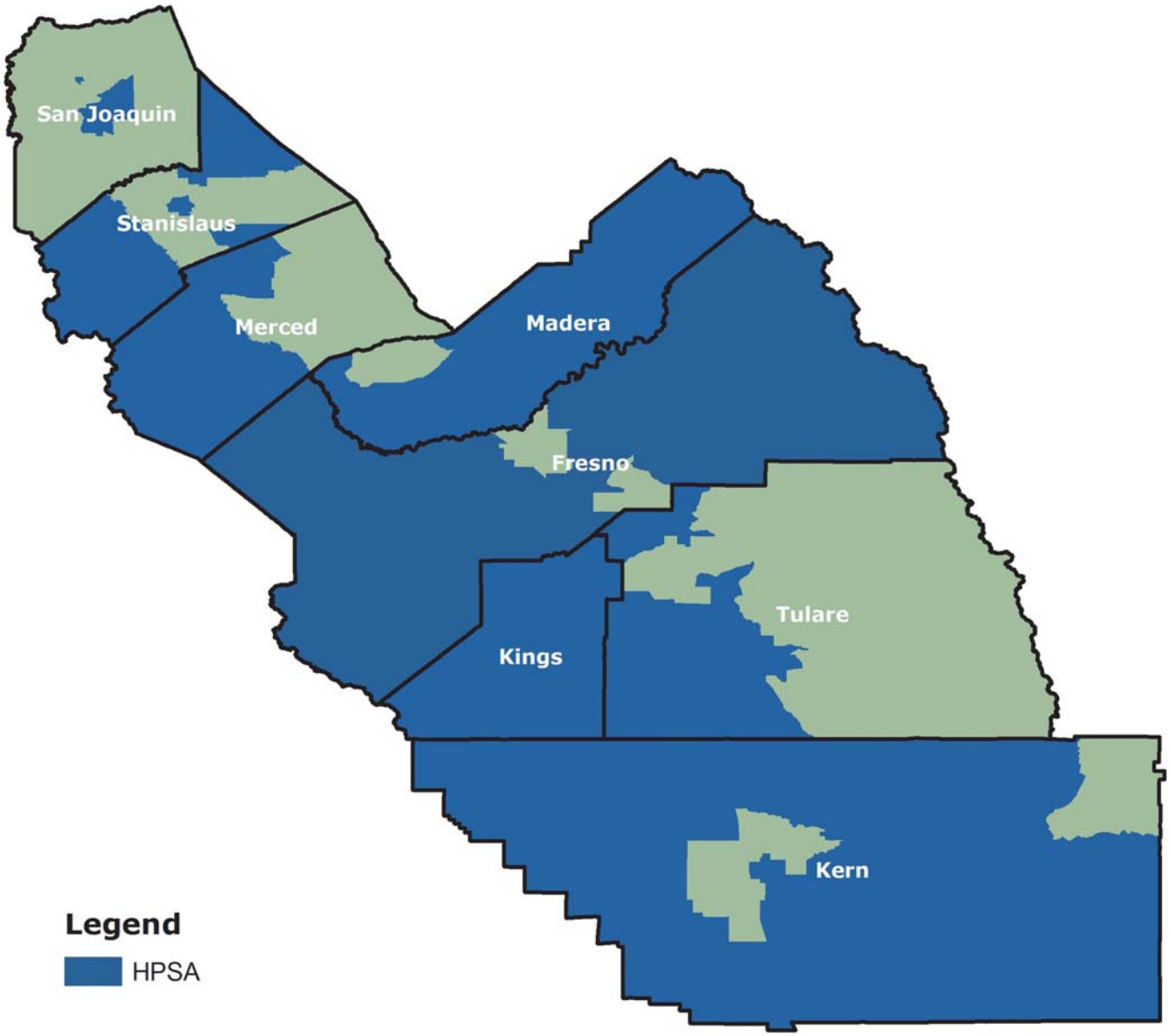
Clinics also offered a number of solutions to address health professional/support staff shortages. The most common solution suggested was to increase funding of FQHCs through increases in rates, reimbursements, and capital funding. Half of the clinics addressed the need for the region to demand its fair share of federal, state and private resources. A revision of the Health Professional Shortage Areas' scoring methodology was suggested by several clinics.

The next step for this project includes expanding the survey to include both regional and state primary care clinics including rural health clinics and FQHC "look-a-likes". Exploring the feasibility of statutory and regulatory changes to improve clinic efficiency and increasing access to mental health and dental professionals and physician specialists is also planned. We will also pursue further study into expanding the use of community health workers in the primary care clinic setting.

This survey is an effort to accurately describe how health professional shortages impact the provision of health care to patients seeking services at Federally Qualified Health Clinics. These findings can be used to compare differences between primary care settings (FQHCs, Rural Health Clinics, and licensed primary care clinics), to evaluate regional differences in the impact of health professional shortages and to provide direction to policy makers in resource allocation decisions. Efforts such as these are critical to developing healthcare reforms that effectively address the needs of providers and their patients in the San Joaquin Valley.

Figure 1

Designated Primary Care Health Professional Shortage Areas (HPSA) in the San Joaquin Valley



U.S. Department of Health and Human Services, Bureau of Primary Health Care, 2006

INTRODUCTION

In an effort to respond to regional concerns regarding health professional shortages in California's San Joaquin Valley, and the effect of these shortages on the health of Valley residents, the Central Valley Health Policy Institute at California State University, Fresno conducted a survey to evaluate the effects of these shortages on Valley residents. The survey had three primary objectives:

1) Describe the impact that health professional shortages have on access to primary health care in the eight counties of the San Joaquin Valley (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare).
2) Describe current patterns of federal, and other resources, coming to community, private, and rural health clinics in the San Joaquin Valley.
3) Identify new approaches to address the consequences of health professional shortages.

This report provides preliminary findings from responses to a survey completed by eight federally qualified health clinics (FQHCs). The clinics were all members of the Central Valley Health Network. The next step in this project will be to expand the survey to include San Joaquin Valley rural health clinics, federally qualified health clinic "look-a-likes", and clinics in other state regions. Both qualitative and quantitative responses were collected, analyzed and integrated in an attempt to describe health professional shortages in the context of a community health clinic environment.

BACKGROUND

All eight San Joaquin Valley Counties have Medically Underserved Areas and Populations (MUA/P) designations, with Madera County listed as a county-wide MUA/P. These counties also experience shortages in dental, mental health and primary care professionals (Figure 1), as determined by the United States Health Resources and Services Administration, Bureau of Health Professionals. As shown in Figure 2, six out of the eight Valley counties have county-wide mental health professional shortage area designations.[1]

A recent report from the California Institute for Nursing and Health Care[2] calculated a national average number of filled registered nursing (RN) positions (both full-time and part-time) at 787 per 100,000 persons and compared that average to California and 24 metropolitan statistical areas (MSAs) in California. They used a grading rubric based on the number of standard deviations a state, or MSA, was from the national mean. All six San Joaquin Valley MSAs included in the analysis were below the national mean, with four out of the six MSAs receiving grades of D or F due to their averages being one or more standard deviations below the national mean. Those same four MSAs (Bakersfield MSA, Merced MSA, Stockton-Lodi MSA, and Visalia-Tulare-Porterville MSA) were also below the state average of 622 per 100,000 filled nursing positions. (Table 1)

Table 1:

Number of Filled RN Positions, per 100,000 Persons, in Selected California MSAs, California and the United States[2]

Location	Component CA Counties	Filled RN Positions per 100,000
Bakersfield MSA	Kern	345
Fresno MSA	Fresno, Madera	632
Merced MSA	Merced	257
Modesto MSA	Stanislaus	660
Stockton-Lodi MSA	San Joaquin	533
Visalia-Tulare- Porterville MSA	Tulare	429
California	All	622
National Mean	N/A	787

The Central Valley Health Policy Institute used data from the American Medical Association[3] and California Department of Finance[4] population data to compute physician rates per 100,000 persons as of December 2005 (Tables 2a-c). Regionally, the Central Valley experienced greater shortages for all physicians, primary care physicians and specialty physicians than any other region in the state.

Table 2a:

California Physicians, per 100,000 Persons, by Region and Statewide

Region	Total Estimated Population [1]	Total Physicians[2]	Rate per 100,000 Persons
Northern/Sierra Counties	1,391,273	3,141	226
Sacramento Area	2,036,680	6,316	310
Greater Bay Area	7,096,848	29,427	415
San Joaquin Valley	3,730,194	6,467	173
Southern California	20,319,653	59,816	294
Central Coast	2,235,983	6,128	274
California	36,810,631	111,295	302

Table 2b:

California Primary Care Physicians, per 100,000 Persons, by Region and Statewide

Region	Total Estimated Population [1]	Primary Care Physicians[3]	Rate per 100,000 Persons
Northern/Sierra Counties	1,391,273	1,490	107
Sacramento Area	2,036,680	2,688	132
Greater Bay Area	7,096,848	12,067	170
San Joaquin Valley	3,730,194	3,243	87
Southern California	20,319,653	24,323	120
Central Coast	2,235,983	2,588	116
California	36,810,631	46,399	126

[1] State of California, Department of Finance, (2005). *E-1 City / County Population Estimates with Annual Percent Change—January 1, 2004 and 2005*

[2] American Medical Association, (Dec. 16, 2005). *Physician- Related Data Resources*

[3] Includes family medicine, family practice, general practice, general preventative medicine and public health, internal medicine, obstetrics and gynecology, pediatrics

Table 2c:

California Specialists, per 100,000 Persons, by Region and Statewide

Region	Total Estimated Population [1]	Specialists[4]	Rate per 100,000 Persons
Northern/ Sierra Counties	1,391,273	772	55
Sacramento Area	2,036,680	1,803	89
Greater Bay Area	7,096,848	8,690	122
San Joaquin Valley	3,730,194	1,608	43
Southern California	20,319,653	17,502	86
Central Coast	2,235,983	1,767	79
Statewide	36,810,631	32,142	87

[4] Selected specialists based on those with the most problematic access for uninsured as reported by the California Healthcare Foundation

METHODOLOGY

The eight FQHCs surveyed included a total of sixty clinic sites serving the San Joaquin Valley residents of Fresno, Kern, Madera, Merced, San Joaquin, Stanislaus and Tulare counties. Kings County is not represented in these survey results. These clinics serve almost 300,000 patients, providing over one million medical visits per year.[5] The survey was conducted by telephone (5 clinics), in person (2 clinics) or by email (1 clinic). Table 3 describes the survey participants. Note that some surveys were conducted with more than one staff member.

The survey was constructed, following an extensive review of the literature, consultation with regional health providers, and pilot testing, with both quantitative and qualitative questions in an attempt to provide each clinic the opportunity to describe their experiences as comprehensively as possible. The questionnaire included 17 items that used a Likert type scale to indicate how important or how often various clinic, patient and access dynamics were a factor that limited the provision of healthcare to their target population. An additional 15 open ended questions allowed clinics to express their unique experiences and strategies to address the effects of those dynamics.

Table 3:

Number of Survey Participants by Clinic Position

Clinic Position	Number of Participants
Chief Executive Officer	5
Chief Operating/Financial Officer	3
Chief Medical Officer	2
Deputy Chief Executive Officer	1
Director of Operations	1
Director of Integrated Services	1
Grants Management Coordinator	1
Site Administrator	1

RESULTS

Quantitative Analysis

Quantitative analysis was conducted using SPSS 11.0 for Windows. We examined the frequency of responses to questions addressing the importance of health professional/support staff shortages, as well as other factors, on providing quality healthcare, how often those shortages affected the provision of care and the impact of referral difficulties.

Participants were asked to rate the importance ("not important" to "extremely important") of a variety of clinic, patient and access issues in limiting the clinic's ability to provide health care to their target population. Table 4 summarizes their responses. Note that no participants rated any issue as "not important".

All sites rated access to specialists and site limitations as "very important" or "extremely important". There were mixed results regarding the importance of transportation problems and access to pharmacy services, although the majority rated those issues as "very important" or "extremely important". Regarding support staff shortages, the clinics were evenly split between "somewhat important/important" and "very important/extremely important". The majority of clinics ranked lack of child care for patients as 'less important" than other issues in limiting their ability to provide health care for their patients.

Table 4

Percentages and Number (n) of Clinic, Patient and Access Issues in Limiting the Ability to Provide Health Care, by Level of Importance

Issue	Not Important	Somewhat Important/ Important	Very Important/ Extremely Important
Site limitations (size, location, etc.)	0% (0)	0.0% (0)	100.0% (8)
Access to specialists	0% (0)	0.0% (0)	100.0% (8)
Professional staff shortages	0% (0)	12.5% (1)	87.5% (7)
Behavioral health staff shortages	0% (0)	12.5% (1)	87.5% (7)
Patient financial problems/lack of insurance	0% (0)	12.5% (1)	87.5% (7)
Prescription medication costs	0% (0)	12.5% (1)	87.5% (7)
Reimbursement Rates	0% (0)	12.5% (1)	87.5% (7)
Funding	0% (0)	12.5% (1)	87.5% (7)
Transportation problems	0% (0)	25.0% (2)	75.0% (6)
Access to pharmacy services	0% (0)	37.5% (3)	62.5% (5)
Support staff shortages	0% (0)	50.0% (4)	50.0% (4)
Lack of child care	0% (0)	62.5% (5)	37.5% (3)

Respondents were then asked, "How often do health professional shortages make it difficult to provide mandated services to your target population (as enumerated in Section 330 of the Health Centers Consolidation Act)?" Responses are summarized in Table 5.

There was lower consensus between the clinics regarding how often professional shortages made it difficult to provide mandated services to their patients, when compared to the previous question rating the importance of access issues in limiting the provision of health care. All but one clinic rated medical referrals as difficult "most of time or almost always". The majority of clinics also rated substance abuse, mental health and case management referrals as difficult "most of the time or almost always". Providing most types of preventive services was less of a problem for the majority of the clinics, with the exception of preventive dental services.

Answers to the question, "How often is it difficult to complete a referral for the following services for patients that are uninsured, have Medi-Cal, or have private insurance?" are shown in Table 6.

A majority of the clinics reported that their uninsured patients had difficulty accessing specialists "half or more than half of the time" in every listed specialty, except for nephrology. An equal percentage of clinics reported difficulty with referrals to specialists in seven out of the 20 listed specialties for their Medi-Cal and uninsured patients "half or more than half of the time". In fact, more clinics reported referral difficulties for their Medi-Cal patients, than their uninsured patients, for dermatology, otolaryngology and pediatric dermatology specialties. Clinics were not unanimous in their response to specialty access for patients with private insurance. For only three specialties, gastroenterology, nephrology and otolaryngology, did all clinics agree that access was limited "less than half of the time".

Clinics were also asked to rate the importance of various factors in limiting access to specialists. Two factors rated as "extremely important" in limiting access to specialists, by all sites, were the reimbursement rates from Medi-Cal and county indigent care programs. The low numbers of providers who accept Medi-Cal or uninsured patients

was ranked as "very important" by 25% of the clinics and "extremely important" by 75% of the clinics. All sites ranked the low number of regional specialists as "important or very important", with 50% stating lack of specialists was "extremely important". Excess demand for specialty care, related to population growth, and the high health needs of the FQHC patient population were ranked as "important to extremely important" by seven out of the eight clinics (87.5%). Excess demand is a reflection of the imbalance between the size of the population in need and the capacity to provide for those needs.

Table 5:

How Often Health Professional Shortages Make It Difficult to Provide Mandated Services, by Percentage and Number (n) of Clinics Responding

Service	Rarely or never/ Sometimes	About half of the time	Most of the time/Almost always
Family Medicine	37.5% (3)	62.5% (5)	0.0% (0)
Internal Medicine	50.0% (4)	50.0% (4)	0.0% (0)
Pediatrics	62.5% (5)	25.0% (2)	12.5% (1)
Obstetrics	50.0% (4)	25.0% (2)	25.0% (2)
Gynecology	62.5% (5)	12.5% (1)	25.0% (2)
Diagnostic lab services	75.0% (6)	25.0% (2)	0.0% (0)
Diagnostic radiological services	25.0% (2)	50.0% (4)	25.0% (2)
Preventive health services	62.5% (5)	12.5% (1)	25.0% (2)
a. Prenatal and Perinatal Services	62.5% (5)	25.0% (2)	12.5% (1)
b. Breast and Cervical Screening	62.5% (5)	25.0% (2)	12.5% (1)
c. Immunizations	75.0% (6)	12.5% (1)	12.5% (1)
d. Blood lead levels, communicable disease testing, cholesterol screenings	62.5% (5)	37.5% (3)	0.0% (0)
e. Pediatric eye, ear and dental screenings	62.5% (5)	25.0% (2)	12.5% (1)
f. Family planning services	75.0% (6)	0.0% (0)	25.0% (2)
g. Preventive dental services	12.5% (1)	25.0% (2)	62.5% (5)
Emergency medical services[1]	57.2% (4)	14.3% (1)	28.6% (2)
Pharmaceutical services[1]	42.9% (3)	42.9% (3)	14.3% (1)
Other medical referrals	12.5% (1)	0.0% (0)	87.5% (7)
Substance abuse services referrals	12.5% (1)	12.5% (1)	75.0% (6)
Mental health services referrals	25.0% (2)	0.0% (0)	75.0% (6)
Case management services referrals	12.5% (1)	12.5% (1)	75.0% (6)
Referral for enabling services	37.5% (3)	37.5% (3)	25.0% (2)
Health education referrals	37.5% (3)	25.0% (2)	37.5% (3)

[1] Missing one response; percent is of those responding

Table 6:

Percentage of Clinics Reporting Difficulty Making Referrals to Specialists "About Half of the Time", "Most of the Time" or "Almost Always" by Specialty and Insurance Status

Specialty	Uninsured (n)	Medi-Cal (n)	Private Insurance (n)
Allergy/Immunology	75.0 (6)	62.5 (5)	25.0 (2)
Dermatology	62.5 (5)	75.0 (6)	25.0 (2)
Endocrinology	75.0 (6)	75.0 (6)	37.5 (3)
Gastroenterology	50.0 (4)	50.0 (4)	0.0 (0)
Nephrology	37.5 (3)	37.5 (3)	0.0 (0)
Neurology	62.5 (5)	50.0 (4)	12.5 (1)
Orthopedics	75.0 (6)	75.0 (6)	25.0 (2)
Otolaryngology	50.0 (4)	62.5 (5)	0.0 (0)
P.T. and O.T.	50.0 (4)	37.5 (3)	12.5 (1)
Psychiatry	75.0 (6)	62.5 (5)	42.9 (3)[a]
Pulmonology	75.0 (6)	62.5 (5)	12.5 (1)
Specialty care – Diabetes	50.0 (4)	50.0 (4)	25.0 (2)
Substance abuse	62.5 (5)	37.5 (3)	12.5 (1)
Surgery (not vascular)	50.0 (4)	37.5 (3)	12.5 (1)
Urology	62.5 (5)	37.5 (3)	12.5 (1)
Vascular Surgery	62.5 (5)	50.0 (4)	25.0 (2)
Pediatric allergy/ immunology	62.5 (5)	62.5 (5)	12.5 (1)
Pediatric Dermatology	50.0 (4)	62.5 (5)	37.5 (3)
Pediatric Neurology	50.0 (4)	25.0 (2)	25.0 (2)
Pediatric Psychiatry	57.2 (4)[a]	57.2 (4)[a]	42.9 (3)[a]

[a] Missing one response: percent is of those responding

Qualitative Analysis

Qualitative responses to open ended questions were reviewed with six topic areas emerging. The areas included inadequacy of funding, recruiting issues, capacity issues, specialty access, current strategies to reduce the impact of shortages and recommendations for solutions to alleviate health professional and support staff shortages.

Inadequacy of Funding A recurring theme throughout the survey was inadequacy of funding. One clinic commented that their reimbursement was only 55% of billings due to denials from insurance providers, lack of insurance and the undocumented status of patients. Note that few categorical health programs, of very limited scope, are provided for undocumented patients. One clinic reported that "categorical programs, such as the Family PACT (Planning, Access, Care and Treatment) Program, have even poorer reimbursement rates than Medi-Cal. It was of concern that the Health Resources and Services Administration (HRSA) has issued what is essentially an unfunded mandate for FQHCs to be more responsive in providing healthcare to the community. One clinic expressed that this mandate meant that HRSA "expects them to meet the health needs of 35,000 more patients by December 2006, a 9.7% increase, without an increase in baseline or capital improvement funding". It was also noted that FQHC grant renewals are a competitive process and that federal funding has been "redirected towards other issues, such as rebuilding from hurricane Katrina".

Even if a particular clinic felt they were doing an adequate job of fund development, they noted that state and federal health policy continues to provide inadequate reimbursement for specialty services, behavioral health and case management, resulting in provider shortages and decreased access to those services. One clinic stated that "policy also dictates practice style, in that reimbursement is limited to one visit per day". For example, if a primary care provider finds that a patient is in acute need of the clinic's behavioral health services those services are not reimbursable if they are provided on that same day. The result is a missed opportunity for a "patient friendly" referral, a decrease in the likelihood that the patient will return for needed intervention, and less efficiency in clinic operations. Another barrier to providing healthcare voiced by clinics was that their limited resources for case management resulted in clinics not having a good "close the loop" system or the ability to address barriers that prevent patients from adhering to provider recommendations. Clinics found this to be especially true for uninsured patients with chronic disease who may have both cultural and financial barriers to adhering to provider recommendations (sliding scale co-pays and difficulty taking time off from work).

The prospective payment system (PPS) received mixed reviews from clinics. In 2000, federal law was amended to convert Medicaid payments to FQHCs, and rural health clinics, from cost-based methodology, which ensured that service providers were reimbursed for necessary costs, to a prospective payment system. The PPS established a provider specific rate based on the average reasonable costs per visit in fiscal years 1999 and 2000. States were required to increase rates based either on the Medicare Economic Index or a determination that there had been a change in the scope of services. The objective of the PPS was to increase clinic efficiency and control Medicaid costs by encouraging clinics to keep costs below the prospective payments. Two clinics reported that the PPS had improved their ability to meet their patients' needs by allowing increased reimbursement with changes in scope of treatment. However, five clinics gave the PPS negative reviews. One clinic noted that they were penalized by being efficient within the cost-based reimbursement system. In other words, their base rate started out lower than other clinics because they were already running their clinic efficiently. Other comments included "… it is time consuming, cumbersome and it has taken forever to receive reimbursement for scope changes"; "it doesn't strengthen the safety net because it requires providers to see a higher volume of patients, with accompanying lower level of care, due to the low reimbursement"; and "it is fixed, static money so as growth occurs and costs go up, covering costs becomes problematic". It was also noted that the PPS doesn't allow for reimbursement for multiple services in one day, so it dictates how providers practice, it is inconvenient for patients, and can result in less favorable outcomes.

Recruiting Issues A second recurring theme was the difficulty in finding professional and/or support staff that are a "good match", in that they share in the mission of the clinic and fit into the clinic culture. Recruiting success for professionals varied by site, as did recruiting strategies. Although the National Health Services Corps (NHSC) could potentially provide much needed personnel, some clinics reported that the NHSC program is of limited benefit with many clinic sites ineligible for the program due to the narrowness of the Bureau of Health Professions' definition of a Health Professional Shortage Area (HPSA). Several clinics commented that the NHSC program has gone "down hill" over the past 10 years or so. They noted that few geographic areas qualify and NHSC participants rarely stay after the required time period.

Several clinics reported that they have used the J-1 Visa Waiver Program with good success. The J-1 Visa Waiver Program waives the requirement for graduates of foreign medical schools that are completing a residency or training programs in the U.S., to return to their home country for two years before applying for immigrant status. In return for receiving this waiver, the physician must provide primary care or general mental health care in federally designated rural and urban communities that have shortages of primary care physicians or psychiatrists. Clinics also indicated that recruiting for the interview has been successful, but relocations to our area have often proved to be a "deal breaker." One clinic commented that they had a 50/50 chance of finding providers that are a good "fit".

The recruitment of medical residents, doing their residencies at local hospitals, has not proved to be a successful recruitment strategy for the FQHCs. Several clinics noted that although relationships with medical residents extended care for their patients, because they were willing to see clinic patients that had been hospitalized, particularly for obstetrics and pediatrics, they were not willing to work at the clinics. Clinics cited unwillingness to work extended hours, a lack of engagement in the mission of community clinics and the perception that the Central Valley is unattractive as a place to live as reasons for unsuccessful recruitment of medical residents.

Clinics commented that there are no shortages of support staff, such as medical assistants to hire. They have found, however, that low wages resulted in clinics being forced to take individuals at the "bottom of their class, train them and watch them move on". Several clinics noted that support staff also tends to call in sick on evenings and weekends. Other factors noted by respondents that limit the use of support staff were space shortages and lack of reimbursement for the services they provide. Many clinics use support staff as case managers, to make appointments, follow-up with patients and retrieve off-site reports. They are often needed to "multi-task" a variety of clinic operations. These sites noted that shortages and/or lack of experience and training, resulted in clinic inefficiency with providers seeing fewer patients and generating less clinic billing.

Capacity A third concern expressed by the respondents was the increase in the sheer numbers of patients. Several clinics noted that as safety net hospital solvency is threatened, and the number of uninsured increases, the demand for the services provided by FQHCs also increases. Respondents felt that providing services will not only continue to be difficult due to provider shortages, but may be impossible due to site limitations. Many clinics stated that they would add services but they just don't have the space to accommodate more providers and/or support staff. Most clinics felt that they

were open an adequate number of hours per week and had adequate staff for extended hours, but these efforts were still was not enough to meet the needs of the growing number of individuals in their service area.

Specialty Access Lack of access to specialists was an area of great concern for most clinics. However, two clinics reported that they did not have much of a problem accessing specialists, due to strategies unique to their clinics. One clinic was contracting with community physicians to provide a number of in-house specialty services. The other clinic had developed an extensive referral network, over a number of years, based on community relationship building.

However, the remaining clinics had much to say as to how a lack of specialty access affected the health of their patients. One paradox to specialty access, noted by most clinics, is that for some specialties access is better for the uninsured than for Medi-Cal patients because the uninsured are willing to pay out-of-pocket for some specialty services, such as dermatology. This paradox reflects the complexity and perverseness of our current health system.

One clinic reported that delays in access to specialty treatment for Medi-Cal patients, with the result of sicker patients, is more of a problem than no access to specialty providers and that access to specialists is easier if the Medi-Cal patient is hospitalized. The need for more specialists in the community to commit to treating Medi-Cal and uninsured patients, along with providing more adequate compensation, was stated by many clinics as contributing to access issues. To illustrate how adequate compensation affects access, one clinic related that when Medi-Cal rates increased for providing obstetric services, community physicians were willing to see patients for obstetric services, but those same physicians would not provide gynecology services to those same patients.

The impact of the lack of specialty access was illustrated with a number of stories. One patient died in the hospital after a pulmonologist refused to treat him, even when the primary physician offered to personally pay for the services. Other respondents noted that specialists often establish barriers for underinsured or uninsured patients. Examples mentioned included: refusing to see patients until they have completed certain treatment or diagnostic tests; requiring completion of a 13-page referral form which, after review, the specialist would then decide if the patient would be seen; and treatment choices based on the patients' insurance status. Clinics also cited many examples of how the lack of access resulted in sicker patients and chronic illness for both children and adults. For example, one clinic noted that the lack of ear, nose and throat specialists for children has resulted in chronic illness and possible hearing loss. Another clinic described a situation where lack of access to local chemotherapy resulted in the delay of treatment because the patient could not afford the time or money to drive to Stanford University for treatment.

In response to the question, "Do you and/or your professional staff ever feel it is necessary to act beyond your/their scope of practice" five of the eight clinics responded "yes". Comments from clinics answering "yes" included "this is a loaded question" and "our providers often express frustration about feeling the need to step outside their scope or expertise to give patients some kind of care". Reasons for providing treatment outside the scope of practice was attributed to the limited access to specialists, due to the lack of specialists in the area, or long wait times for specialty appointments. Many clinics wanted to expand to include as much specialty care as possible and one clinic noted that they are looking into the use of telemedicine.

Non-physician shortages in dental and behavioral health professionals, and limited access to pharmacy services were also noted as problems. Many clinics related their struggle in recruiting dentists/hygienists. One clinic stated that "hygienists are now demanding as much pay as dentists". Clinics reported that in order to maximize the scope of practice of employees, dentists are hired and end up cleaning teeth, as well as providing dental services. Barriers in providing behavioral health services, due to a lack of bilingual, linguistically competent staff, were noted as a problem at some sites, but not others. Several clinics cited that barriers to providing behavioral health services were the inability to be paid for two visits on the same day and failure to achieve patient "buy in". Respondents also noted that the lack of reimbursement for behavioral health services from providers with a Masters in Social Work (MSW) was also a problem.

Most clinics reported that they did not employ pharmacists due to cost, space and/or shortages. Several clinics noted that large pharmacy chains often refuse to participate in Medi-Cal due to the paperwork and the low reimbursement rate for filling prescriptions. Furthermore, most clinics found that access to medications was a problem primarily for two populations. Medicare, Part D enrollees, who are no longer eligible for Pharmacy Assistance Programs, and dual eligible enrollees (those enrolled in both Medi-Cal and Medicare). Medication access is also a problem for the undocumented/uninsured, especially those with chronic diseases, who are unable to enroll in Pharmacy Assistance Programs. It was reported that some access to needed medications can be provided in the short term with samples, but long term access for chronic conditions is limited.

Current Strategies to Reduce the Impact of Shortages

FQHCs have employed a number of strategies to try and reduce the impact of health professional and support staff shortages. Although specifics and outcomes are somewhat unique to each clinic, strategies came under the general categories of 1) increasing funding opportunities, 2) participating in the Health Disparities Health Collaboration Program, 3) developing formal and informal relationships with pharmacies and county mental health services, and 4) using technology to increase clinic efficiency.

Funding opportunities The clinics surveyed have taken advantage of funding opportunities ranging from accessing multiple federal, state and foundation funding opportunities (six sites) to relying only on the Section 330 grant funding (two sites). FQHCs struggle to accommodate a growing number of residents who rely on their clinics for their health care needs. This, in turn, increases the need for clinics to access additional funding. One respondent noted that their clinic "receives proportionately very little money in grant funding, as do all Central Valley non-profits/government agencies" referring to the recent report from the Congressional Research Service on a comparison of the San Joaquin Valley to the Appalachian Regional Commission Area.[6]

Health Disparities Health Collaboration Programs All clinics were already, or will soon to be, participating in Health Disparities Collaboration programs. Positive comments regarding the programs included, "initial data indicates a health improvement in patients", "it has moved the standard of care forward … there is an increase in shared information", and "it has had a moderate impact on improving the health of the population". Three clinics were not sure of the impact of the programs, as they had just started or were just about to start participating in the programs. Several negative responses were noted that addressed possible barriers to the success of these programs including, "finding support staff to run the data", "they are hard to start up and sustain, difficult to expand due to the fact that they are data driven" and "while they do bring the latest standards of care to providers, they also require provider time that is not financially compensated (not seeing patients)".

Develop relationships for providing non-physician services Three clinics reported that instead of hiring in house pharmacists they have developed relationships with small private pharmacies through contracts and co-location at clinic sites. One clinic has developed a collaboration with county mental health services to provide services at the clinic on an emergency basis and if county providers are not busy at their clinic six blocks away.

Technology Two clinics reported using technology to streamline clinic operations. One is developing a template and expanding staff for follow-up and treatment compliance. The other clinic is developing a centralized system for appointments, registration and documentation. The importance of these strategies is illustrated by another clinic acknowledging a need to streamline due to an excess of paperwork that slows everything down and results in a "flow problem".

RECOMMENDATIONS

The clinics surveyed offered a number of solutions to address health professional/support staff shortages.

Modify and Increase Reimbursement Rates

Clinic respondents offered the following comments and suggestions to improve rates, "We need to offer competitive salaries to both professional and support staff." Changes in reimbursement should include a change in the state's rules that would allow clinics to receive reimbursement for more than one visit/service per day. It was reported that this change in health policy has failed at the legislative level and is currently being discussed at the regulatory level with the Department of Finance. The Department of Finance has been resistant to changing this policy because they feel it would increase costs and they can't visualize that this is merely a "cost shift" from two visits on two days to the same two visits (and costs) on one day. Another comment related to funding was that "all categorical programs should be rolled into Medi-Cal, so that they are all part of the prospective payment system". Finally, it was noted by one clinic that we need "funding so there is enough space to bring the community into the clinic" and funding for "brick and mortar" improvements.

Clinics also commented on the need for modifications of the regulations to "allow reimbursement for behavioral health services provided by a Master of Social Work" mental health professional.

Health Policy Changes

Half of the clinics voiced frustration regarding the inequities in federal, state and private funding to community based organizations in the San Joaquin Valley. Comments included: we should "demand an increase in federal, state and private funding to at least national per capita standards". Specifically, three clinics recommended that there be changes in the HPSA scoring methodology to accurately reflect the need in the San Joaquin Valley. The urban/rural mix in the Valley has confounded HPSA calculations for health professional shortages.

Work Force Development

Two clinics recommended workforce development both locally and through relationships with academic centers. Developing externships/internships for nurses and physician assistants in a community health center setting could increase the pool of mid-level professionals. However, for many clinics space is a problem so workforce development would have to be coupled with funding for capital expansion.

Other Recommendations

There were several suggestions unique to specific clinics. One suggestion was that we "demand that community providers accept Medi-Cal and uninsured patients." It was also suggested that clinics educate the public as to the breadth and benefits of services FQHCs provide to the community. The implication was that it may encourage community health providers and funders to support the FQHC mission with additional resources. One clinic suggested that policy be changed to remove the five year practice restriction for dentists licensed in other states to allow them to qualify for California licensure by credential.

Finally, it was proposed that we continue the vision of developing "an integrated and collaborative model of patient care for FQHCs as advocated, but not funded, by federal, state and private funders." This model would include adding specialists as clinic staff. Current efforts are in process to determine if adding specialists would necessitate only a policy clarification or require actual statute reform.

NEXT STEPS

Survey Expansion

The next step for this project includes expanding this survey to document experiences from other community clinics in the San Joaquin Valley and the state. This survey expansion would include rural health clinics and FQHC "look-a-like" clinics, and would increase our understanding of the effect of health professional and support staff shortages on primary care clinic operations.

Health Policy Changes

Exploring the feasibility and barriers to the implementation of a number of policy recommendations, proposed by the clinics, is also planned. The first recommendation of interest is the implementation of regulatory changes in Medi-Cal to allow reimbursement for mental health services provided by a Master of Social Work. Second is to make changes in the Business and Professions Code to ease the requirements for granting a license to out-of-state dentists. Third is to implement regulatory/legislative changes to allow reimbursement for more than one clinic service/visit per day. Finally, clarify what statute or regulatory changes are needed to allow clinics to hire specialists as staff, with appropriate reimbursement, and the impact of staff specialists on health outcomes and clinic solvency.

Community Health Workers (Promotoras)

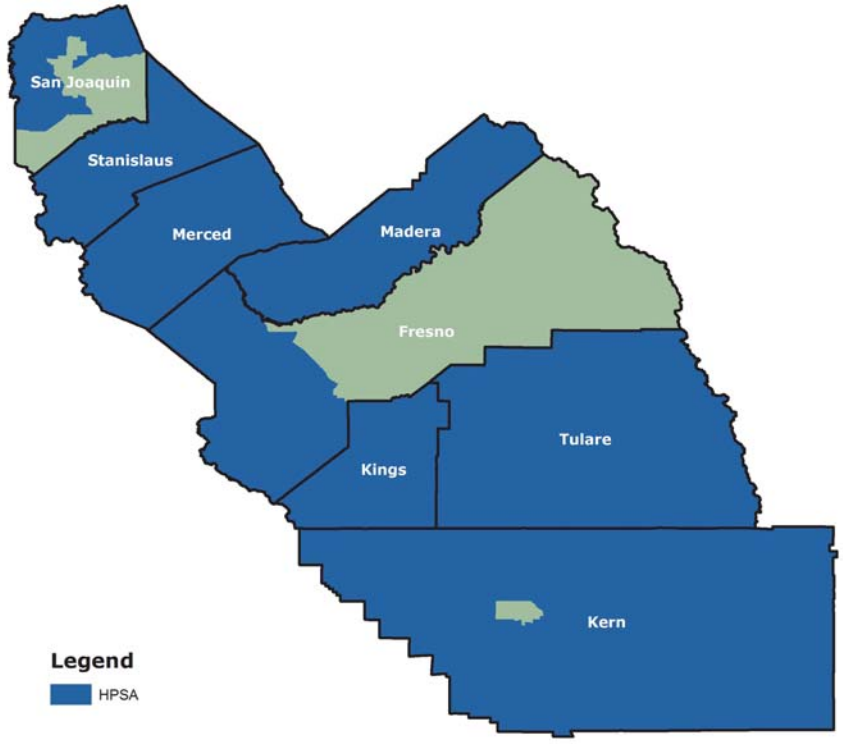
Another area of interest for further study is to evaluate the effect of advancing the use of community health workers (CHWs) or "promotoras" in the community clinic model as practice "extenders". These staff members could provide culturally competent health education and case-management that could enhance both clinic efficiency and medical efficacy. The study would include identifying best practices in training and scope of practice for CHWs, as well as exploring sustainable funding/reimbursement for services provided by CHWs.

CONCLUSION

This survey is an effort to clearly describe how health professional shortages impact the provision of health care to patients seeking services at Federally Qualified Health Clinics. These findings can be used to compare differences between primary care settings (FQHCs, Rural Health Clinics, licensed primary care clinics), to evaluate regional differences in the impact of health professional shortages and to provide direction to policy makers in resource allocation decisions. Efforts such as these are critical to developing healthcare reforms that effectively address the needs of providers and their patients.

Figure 2

Designated Mental Health Professional Shortage Areas (HPSA) in the San Joaquin Valley



U.S. Department of Health and Human Services, Bureau of Primary Health Care, 2006

REFERENCES

1. U.S. Department of Health and Human Services, Bureau of Health Professions. (2006). HPSA (health professional shortage areas) [Data file]. Retreived July 2006 from http://hpsafind.hrsa.gov/

2. Lin VW-H, Lee A, Juraschek S, Jones D, Hsiao I. California Registered Nurse regional workforce report card. Retrieved May 2006 from http://www.cinhc.org/news/documents/CINHCreport_finalWeb.pdf

3. American Medical Association (December 16, 2005). Physician-Related Data Resources. Retrieved February 27, 2006 from http://www.ama-assn.org/cgi-bin/sserver/datalist.cgi?State=CA

4. State of California, Department of Finance, (2005). E-1 City / County Population Estimates with Annual percent Change — January 1, 2004 and 2005. Retrieved February 28, 2006 from http://www.dof.ca.gov/HTML/DEMOGRAP/E-1text.htm

5. Central Valley Health Network. Health Center Snapshots. Retrieved May 2006 from: http://www.cvhnclinics.org/snapshots/index.html

6. Congressional Research Service. California's San Joaquin Valley: a region in transition. Retrieved December, 2005 from: www.house.gov/nunes/documents/ San_Joaquin_Valley_CRS_Report.pdf

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This document may be downloaded from:
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The publication of this report was made possible through a grant from

The California Endowment