

**SURVIVAL STRATEGIES FOR MICHIGAN'S HEALTH CARE SAFETY NET
PROVIDERS**

Report to the Blue Cross Blue Shield of Michigan Foundation

Peter D. Jacobson, JD, MPH
University of Michigan School of Public Health

Vanessa Dalton, MD
University of Michigan Medical Center

Julie Berson-Grand, MPH (PhD candidate)
University of Michigan School of Public Health

Carol S. Weisman, PhD
Pennsylvania State University College of Medicine

November 2003

EXECUTIVE SUMMARY

INTRODUCTION

Health care safety net organizations face a vastly increased demand for services at a time of decreased revenues. Their ability to develop and implement coping strategies will determine whether the health care safety net infrastructure survives and what types of policy interventions are required for long-term sustainability.

In this project, we report the results of an in-depth study of the strategic adaptations Michigan health care safety net organizations have considered. The project examines how changes in the health care environment are influencing the strategic adaptations of health care safety net organizations, and the implications for access to health care among the uninsured and other underserved groups.

Research Methods

The project uses a multiple-site case study approach focusing on health care safety net organizations in selected Michigan communities. Our primary methodological approach is to conduct a broad range of qualitative interviews with key individuals within the selected organizations.

Site Selection and Interviews. After constructing a map of Michigan health care safety net providers, we identified clusters of various organizational types within a geographical area. We then selected six sites based on the following criteria: geographic diversity within Michigan; diversity of organizational types; diversity of types of services provided; a mix of affluent and non-affluent areas.

If available at each location, we selected four organizational types, including free clinics, family planning organizations, public health departments, and Federally Qualified Health Centers (FQHCs). Within most of the organizations, we interviewed the administrator, the medical or clinical director, the financial or marketing director, and a member of the board of directors. Prior to the interviews, we developed an interview protocol focusing on threats to organizational survival, strategic responses to the threats, and opportunities for organizational change. Altogether, we conducted 74 interviews at 20 organizations.

RESULTS

Threats and Challenges

Population Characteristics and Need. Almost uniformly, our respondents note that the primary threat to organizational survival is the increasing demand for services.

This threat takes two forms: demand far exceeds organizational capacity; and there is a trend toward serving a sicker patient population.

Financial Challenges. Financial challenges remain a constant threat to organizations' ability to provide clinical services. Decreases in funding threaten the ability to serve existing clients, let alone respond to the increasing community needs.

Community Challenges. A source of variation in our results is that the local environment in which health care safety net organizations operate affects their ability to provide services. Supportive (usually affluent) communities can contribute financial and human resources (i.e., volunteers) to facilitate clinic survival. But threats to the organizations can come directly from other organizations within the community, such as difficulties with local hospitals, a lack of referral sources, and competition for patients. Additional community challenges include the ability to find adequate staffing, a negative reputation for poor quality care, and political realities.

Strategies

Financial. To maintain their financial viability, the two primary financial strategies are the introduction of or increase in patient fees and fundraising efforts. Our interviews suggest considerable debate among free clinic and FQHCs about the need to raise fees. So far, free clinics have not adopted fees, but family planning organizations and health departments have increased their fees. Except for the free clinics, recruiting a higher percentage of paying clients is an important strategic adaptation.

Almost all of the organizations report an increased or continued emphasis on fundraising as a critical strategy for addressing the financial threats. Most organizations pursue funding through a mix of grants and donations, but limit grant applications to those specifically tied to their mission or to support existing programs.

Expansion. A number of the organizations are actively considering expansion plans to obtain additional clinic space. As a result of federal funds, FQHCs are in a stronger position to consider expansion, even though they operate in less affluent areas.

Retrenchment. In contrast to expansion plans, a number of organizations are retrenching. Many safety net organizations have made decisions to limit and/or turn away patients, as well as to implement cuts in services. Several organizations are also considering imposing some level of cost-sharing such as co-pays.

Operational Strategies. Many health care safety net organizations have made changes to or enhanced their operational strategies. Operational strategies include strategic planning, model change, adoption of a business model or more business-like practices, and increased data collection. Most of the organizations in our sample are engaging in a regular strategic planning process.

Care Delivery Model. Except for the FQHCs in our sample, most organizations are either considering or are in the process of changing their care delivery approach. Our interviews revealed no consensus over the best strategy between a primary care model relative to a gatekeeper (or referral) approach.

Business Strategies. One of the consistent refrains in our interviews is whether to adopt explicit business strategies. Several respondents are attempting to operate as a business, but some are adamantly opposed. Most organizations recognize the need to improve efficiency, quality of care, and responsiveness to patients. Family planning organizations and FQHCs also view maintaining a loyal customer base as a central component of their survival strategies.

Data Collection. The concept of what is involved in data collection, analysis, and its potential value varies widely by organization. But a common finding across our sample organizations is the lack of technological capacity to collect and analyze data.

Partnerships. A key aspect of our sample organizations' strategic response is to initiate or strengthen collaborative relationships and partnerships with private sector entities. These partnerships include collaborations with other service providers in the community, participation in indigent drug programs, and utilization of volunteers. The most consistently successful collaborative strategy is the pharmaceutical industry's indigent drug program. Despite the emphasis on partnerships, we found considerable dissatisfaction with existing arrangements. In several instances, the partnership runs in only one direction—in favor of the hospital. All free clinic respondents complain that specialty referrals to hospitals are negligible and hospitals are simply sending uninsured patients back to the clinics.

Organizational Issues

Mission. We define organizations as mission transforming if they are engaged in a fundamental change, particularly if that change is oriented toward expansion.

Deliberate Mission Change. A number of organizations are undergoing a deliberate change in mission. Health departments are explicitly shifting their mission from direct service provision to a more limited focus on core public health services (defined as surveillance, policy development, and assurances).

Consequent Mission Change. Individual organizations may not define themselves as mission transforming, yet the challenges facing all safety net providers cause a number of organizations to make changes that for practical purposes fall under our definition of mission change. All of the family planning organizations, as well as a handful of health departments and FQHCs, have been forced to increase fees and limit services, challenging their underlying mission to serve the uninsured.

Most of our free clinic respondents are struggling with how to define their mission. At this point, it is premature to conclude that their actions amount to consequent mission change. Unlike health departments, FQHCs, and family planning organizations, which view themselves as permanent entities in the health care landscape, most free clinics were founded as a temporary solution to serving the uninsured and underinsured. But many free clinics are now viewing themselves as a permanent part of the safety net.

Leadership. Stable leadership is often paramount in determining an organization's overall success. Aside from family planning organizations, which consistently report active boards of directors committed to their mission, few sample organizations benefit from the support of an active, fully engaged board. Change in leadership at the administrative level is a common concern among our respondents.

Conflict. Our interviews reveal two sources of organizational conflict that impede organizational success: internal conflict between administrators and staff, and conflict between the CEO and governing board.

Staffing. Challenges related to staffing significantly affect many organizations' ability to implement strategies and provide consistent high-quality care. Specifically, organizations struggle to recruit qualified staff and limit staff turnover. While most organizations are able to find qualified physicians, the relative low pay scale makes it particularly difficult to recruit and retain staff in short supply nationally, such as nurses and pharmacists.

Quality of Care. Our study is not designed to measure quality of care, but an unexpected finding is differences in perceived quality of care. Board members and staff describe the care delivered as being of high quality. In contrast, some CEOs and a number of medical directors raise concerns over the ability to provide quality services.

POLICY CONSIDERATIONS

Overview of the Trends

Recent studies show that the health care safety net has survived, if in somewhat more perilous shape than advocates would prefer. Our analysis confirms that the safety net has survived in Michigan, but with a different spin. The recent literature misses the coupled phenomena of higher demand, as the uninsured population rises, and reduced resources, as cash-strapped states reduce their investment in social services. Thus, we have no way of knowing whether the safety net will survive in its present form, especially since resources in the private sector cannot compensate for reductions in public funding.

Our results indicate two fundamental structural changes in how health care safety net services are organized and delivered. The first shift is that local health departments

(LHDs) are moving away from providing direct services of last resort, such as family planning and primary care for uninsured and underinsured populations, toward providing core public health services, such as surveillance, policy development, and assurances.

The second structural shift is in health care safety net organizations themselves. Initially, these organizations viewed themselves as a temporary solution to a short-term problem, awaiting universal health insurance. Many of our respondents said that their goal is to go out of business. Instead, our study suggests that health care safety net organizations, especially free clinics, are now a permanent part of the safety net's institutional structure. As a result, many of our respondents indicate the need to operate as a business, with greater attention to efficiency, in order to survive. While the small business approach may not be incompatible with the narrower charitable mission, it certainly forces more complex operational considerations and tradeoffs.

Several policy implications emerge from these trends. One is the shift from public to private in providing safety net services, parallel to what has occurred in other sectors of the economy. In this case, however, what's lost is a visible public commitment to the uninsured, along with a sense of shared values for taking care of society's most vulnerable citizens.

Adaptive Strategies

Perhaps the best way to characterize the organizations' adaptive strategies is that they remain a work in progress. No clear consensus emerges, either within or across organizational types, as to the optimal strategies to pursue. Everyone seems to agree that they need to raise more funds, establish collaborations with other health care providers (usually local hospitals), and adapt to a new way of providing health care safety net services. But there is little agreement on which strategies to adopt, and virtually no evaluation of adaptive efforts to date. Depending largely on local community resources, the adaptive strategies veer between developing expansion plans to meet the added demand and retrenchment because of the inability to serve existing patients.

Organizations in poor urban and rural areas have far fewer options than organizations in more affluent communities. The organizations capable of undertaking mission transforming strategies are either located in affluent areas or, in the case of FQHCs, are able to leverage their federal dollars. Because so much of an organization's adaptive capabilities are dependent on local community resources, clinics in less affluent areas are at a substantial disadvantage in competing for funds.

Our interviews suggest that clinics (both free clinics and FQHCs) maintain a complex relationship with local hospitals. On many levels, they are both partners and competitors. Each seems to view the other's motives warily, and there is considerable strain in the relationship. Clinics feel that hospitals have not permitted sufficient specialty referral arrangements, but have willingly referred non-emergency patients back to the

clinics. If accurate, the findings are troublesome and at odds with conventional wisdom. Public policy has encouraged public-private partnerships, but if the major private sector partner is not fully committed to the arrangement, alternative strategies will need to be developed. In short, we do not view collaborations as a panacea and they may be very difficult to implement effectively.

Best Practices. We anticipated being able to identify a range of “best practices” that other clinics could adopt. Unfortunately, our interviews do not reveal many tangible best practices that have been evaluated.

Cyclical vs. New Era. One of the issues to emerge during our interviews is whether the current crisis is merely cyclical (that is, just part of another down cycle that will change once the economy improves), or part of a new era that will be less tolerant of or willing to support the uninsured and underinsured populations. There is no consensus on the issue, though we conclude that the more persuasive argument is that we have entered into a new era that will dramatically change how to think about providing health care safety net services.

Differences Within and Across Organizational Types. Our results show considerable variation within and across organizational types. For free clinics, it seems fair to conclude that each organization operates within its own dynamic and set of constraints, even though each confronts the same threats and is considering a similar range of adaptive strategies. For the most part, there is only minor variation within the other organizational types (i.e., FQHCs, health departments, and family planning clinics), there are considerable differences across organizational types. For instance, FQHCs and family planning organizations are engaged in a larger set of diverse strategies than either health departments or most free clinics.

Differences Across and Within Communities. We found considerable differences across communities based on urban-rural and affluent-non-affluent dimensions. Our results within each community are very consistent.

Policy Recommendations

Medicaid. Our respondents’ most consistent policy recommendations involve Medicaid, specifically reimbursement policies and the adequacy of reimbursement rates. The most prevalent complaint is that enrollment with managed care providers is difficult for the uninsured and underinsured populations. Many are forced to enroll with a primary care provider which lacks facilities close to where the patients live. Free clinics often provide primary care for Medicaid patients, without being reimbursed by the Medicaid provider. Under Medicaid rules, the money for primary care follows enrollment, not treatment. As a result, the enrolling plan benefits from the Medicaid reimbursement without providing services to a subset of its enrolled population. Clinics need to be able to

bill for services provided even when the patient is enrolled in another plan. Somewhat surprisingly, our interviews do not reveal consistent opposition to Medicaid managed care.

Indigent Drug Programs (IDPs). All of the respondents are grateful for the pharmaceutical industry's indigent drug programs. But respondents raise several suggestions for improvement, such as reducing burdensome paperwork requirements and developing a standard application process using a web-based system.

Mental Health Services. Many respondents note the increasing numbers of patients presenting with mental health problems. But their organizations are not prepared to provide adequate services for this population. The state needs to address this problem.

School-Based Clinics. Several respondents suggest the need to open school-based clinics to provide education and prevention. We think this is an issue worth exploring in greater detail.

County Health Plans. At this point, it is difficult to determine whether county health plans will operate to alleviate the strain on free clinics. We have some reason to be skeptical because the county health plans do not appear to have the resources needed to reduce referrals to free clinics. In fact, our free clinic respondents said that these plans have not alleviated their burden so far.

Implications for Access. Our study is not designed to measure access in a rigorous, quantitative manner. All we can say with any degree of certainty is that the organizations in our sample consistently report being unable to meet the demand, and their assessment that this demand is not being met in any systematic way. It seems inescapable that large numbers of the uninsured and underinsured populations lack access to health care services. We can safely assume that many of the people whom our sample organizations turn away or are unable to serve do not find adequate alternatives. The fact that the health care safety net has survived is welcome news for those fortunate enough to be served. But our results should not be interpreted to mean that we are any closer to providing access for the bulk of the uninsured and underinsured populations.

Summary—State Responsibility. Our respondents are united that the state cannot abjure its obligations to the uninsured and underinsured populations. At a minimum, the state of Michigan must:

- Alter the Medicaid reimbursement formula as outlined above
- More aggressively solicit FQHC funding from the federal government
- Provide resources (such as technology for data collection and analysis, free transportation, and assistance in program evaluation) to assist free clinics
- Allow local health departments to allocate resources as needed rather than identifying specific programs to be cut
- Reaffirm its commitment to being an active participant in seeking solutions

Recommendations to Clinics

Organizational Structure. To the extent that clinics will be operating as small business, they will need to address several uncomfortable questions about how that would alter how the organization operates. For instance, it will require paying more attention to capital needs to serve existing patients as well as expanding into new markets. They may also need to reexamine the organizational structure, locations, staffing mix, and how the clinic operates.

Leadership. Our results clearly suggest that leadership is the most critical ingredient of clinic success. Our analysis suggests two concerns. One is that conflict between the board and the administrator is making it difficult to meet clinic objectives. The other is that successful clinics may be too dependent on one (often dynamic) leader. For the long-term, clinics need to ensure leadership succession and transition.

Expansion vs. Contraction. Even though our results suggest that mission transforming organizations are in a better position to survive, we recognize that not every organization is in a position to expand its scope of operations. Some respondents make it clear that retaining a narrower mission is paramount, even if that means turning patients away. In less affluent communities, clinics lack the resources to engage in mission transforming activities.

Image, Reputation, and Amenities. Another subtext of our interviews is concern for how patients and the community perceive the clinic. Many respondents note the need to change the mentality that the clinics are just for poor people. Implicit in these observations are two destructive notions—that the clinics are not good enough for those who have money and that this is all the poor deserve. Repeatedly, our respondents note the need to improve on customer service (i.e., lack of sensitivity to patients), the clinic's physical surroundings, and their general reputation in the community. Based on our results, clinics should invest in improving their image and reputation in the community.

Data Collection and Analysis. Building and maintaining effective data collection and analysis capabilities is crucial for long-term survival and success. In our view, developing better data capacity is a crucial challenge facing health care safety net providers. Few of our respondents are able to provide adequate encounter and trends data to indicate the magnitude of the problems they face and the extent to which they are able to serve the community. The state government needs to play a more active role in ensuring that these needs are met.

Policy Challenges

At first glance, it might seem that FQHCs would be the optimal policy solution. With the resources of the federal government giving them the ability to hire full-time staff

and expand to meet capacity, FQHCs may well emerge over time as the dominant institutional provider of health care safety net services. In the meantime, our results indicate a more equivocal balance between investing in FQHCs or free clinics. Each has certain advantages and each inheres certain deficits.

Another contentious policy consideration is the role of faith-based organizations. In the shift to private sector responsibility for providing health care safety net services, what role should religious organizations play, especially if state or federal funding is involved? According to our results, religiously-based clinics will remain an integral part of the health care safety net for the foreseeable future.

A third policy decision for the state is to assess whether it is appropriate for LHDs to abjure direct services. The arguments for retrenchment are compelling as long as services are available in the private sector. But our study seriously questions the assumption that LHDs can utilize the assurance function to monitor the delivery of health care safety net services. To put the matter bluntly, there does not appear to be an adequate private sector response to assure.

A final policy challenge relates to Title X. We have celebrated the recent reduction of Michigan's teen pregnancy rates. But to maintain these successes, policymakers need to address the continued shrinkage of family planning funds and attempts to defund successful organizations on ideological grounds. The present family planning safety net is responding to challenges in a way that may compromise access to basic reproductive health care for some populations; many organizations are moving away from their Title X programs, and new providers are not emerging. Policymakers should consider the Title X legislation's impact on the program's ultimate survival and subsequently, on unintended pregnancy rates.

CONCLUSION

Health care safety net services in Michigan are under severe pressure. Short of national health insurance coverage, there are no magic policy responses to alleviate the pressure. Adaptive strategies will enable most to survive and attempt to fulfill their mission, but will not be sufficient to respond to increasing demands for services.

CHAPTER 1: THE BACKGROUND

INTRODUCTION¹

Communities, health care safety net providers, and public policymakers face a question not raised since the emergence of government-sponsored health care in the 1960s: what happens if providers of health care safety net services do not survive the current environmental threats? One possibility is that the private sector will serve communities and recipients of health care safety net services as well as or better than the current organizations. But another possibility is that the private sector will not be willing or able to serve these communities and recipients. If health care safety net providers lose the capacity to deliver these services, what options will be available to policymakers for response?

Two mutually reinforcing trends drive these questions: the simultaneous increase in the number of uninsured and underinsured people needing health care services and decrease in the available resources to provide health care for them. At a time when the number of people without adequate access to health services is increasing substantially, it is ironic that health care safety net organizations are confronting threats to their survival and to their ability to care for the uninsured and underinsured. These threats stem from reductions in public funding for key programs, increasing unemployment rates (and hence rising uninsurance rates), the rising cost of providing services,² and competition with managed care organizations for Medicaid reimbursement. Health care safety net organizations' ability to develop and implement coping strategies will determine whether the health care safety net infrastructure survives and what types of policy interventions are required for long-term sustainability.

These issues raise fundamental questions about how to shape public policy at a time of rapid change in the health care delivery system. For a variety of reasons, much of the policy response to health care safety net problems will occur at the state level. Yet Michigan and other states lack information state policymakers need to respond with knowledgeable solutions. This research is designed to address the information gap.

The research performed in this study is potentially significant on three levels. First, this report is intended to stimulate more attention to the difficulties health care safety net organizations face, including the unique challenges confronting the family planning safety net, and the consequences to society if these entities fail. Neither local public health departments nor private sector health care organizations are likely to be able to provide health care services to the growing numbers of uninsured Americans without new policy initiatives.

Second, this research will help health care safety net organizations identify strategies ("best practices") that other organizations have successfully implemented. The

management of these organizations will be able to better serve the uninsured and underserved groups if they know and understand the best practice options for operating a health care safety net organization.

Third, these findings will assist local and state policymakers in developing effective policy responses to address the threats to health care safety net organizations. By studying sample organizations' perspectives, strategies, and transformations, we will provide information about the issues and options confronting key members of the health care safety net. We will also provide policymakers and health care managers with information on variation in adaptive strategies and community contexts and suggest implications for improving health care safety net providers' ability to survive. The timing of the project for addressing policymakers is particularly propitious as the new Granholm administration tackles public health issues in this tight fiscal environment.

BACKGROUND

Nationwide, health care safety net organizations are experiencing several serious pressures. First, the number of uninsured persons has been increasing steadily, by about one million persons per year over the last decade, and now stands at 41.2 million Americans or 14.6% of the population.³ The number of uninsured rose dramatically in the aftermath of the economic bubble of the 1990s and is expected to continue to increase, particularly if growth in the U.S. economy continues to slow. In turn, concerns about the health care safety net's resilience are again being raised and analyzed, especially as federal and state revenue shortfalls are likely to reduce public subsidies for the safety net.⁴

Recently, the Institute of Medicine (IOM) predicted that the combination of higher unemployment rates and rising health insurance premiums will cause a rapid increase in the number of people without health insurance.⁵ Despite increased rates of the uninsured, the financial resources for safety net organizations have been declining. Federal support for some key programs has been reduced, and Medicaid reimbursement to health care safety net organizations has declined. For example, the Bush administration has effectively reduced funding for comprehensive family planning services through the Title X Family Planning program in favor of funding abstinence only education programs.⁶ Though President Bush has increased funding to federal community health centers in the Health Centers Initiative (S. 1533), fewer than half the states have been awarded monies, and the demand is greater than even the suggested increased allocation would cover. Another concern is the growing enrollment in Medicaid managed care plans, which now operate in most states. Medicaid reimbursements have been a key source of revenue for safety net organizations and have enabled these organizations to cross-subsidize care provided to the uninsured.⁷ The growth of Medicaid managed care means that health care safety net organizations compete with these plans for Medicaid patients, and many safety net organizations report declining Medicaid patient volume and revenues. Furthermore, higher managed care penetration is associated with less charity care provided by physicians

because of reduced reimbursement rates.⁸ Thus, the financial viability of health care safety net organizations is threatened at a time when demand for their services is growing.

Gaps in Literature and Information

Regardless of national attention from the IOM and some key studies of health system change, the ways in which health care safety net organizations have adapted, or failed to adapt, to the changing health care environment have not been well-documented. Recently the IOM provided an overview of the fraying health care safety net, tellingly titled *America's Health Care Safety Net: Intact But Endangered*.⁹ Although the IOM committee found that until now most safety net providers have been able to adapt to the changing environment, the organizations have found it increasingly difficult to maintain their missions while protecting their fiscal margins.¹⁰ The report states that "...the committee was continuously frustrated by its inability to find a single source where such information was collected and analyzed." In further commenting on the need for safety net providers to participate in Medicaid managed care, the report added that "...little is known about what adaptive strategies appear to be the most successful." The report suggests efforts be made "...to document and analyze the effects of changes in these programs on the safety net and the health of vulnerable populations."

One of the IOM's main recommendations is to improve the nation's ability to monitor and assess the safety net's capacity and financial stability. Specifically, the IOM calls for "identifying and disseminating best practices" and "informing federal, state, and local policymakers of failures of safety net systems and providers."¹¹ Information on "best practices" is notably lacking. Another important gap in the literature is that previous studies of the health care safety net have often left out family planning centers, even though these centers may be the sole source of health care for indigent women and adolescents.

Recent studies show that the health care safety net has survived, if in somewhat more perilous shape than advocates would prefer.¹² But as we will see, our analysis suggests that any celebrations are premature. For one thing, those studies were conducted during the boom times of the 1990s, predating the two trends noted earlier. For another, we will argue that how health care safety net services are now being provided differs in fundamental ways from even the late 1990s.

Some experts have noted various ways that safety net organizations might evolve, ranging from direct competition with other providers to maintaining or expanding their original missions through a variety of change strategies.¹³ Among the latter, the possibilities include redefining the organization's target population or service mix; forming partnerships with other safety net providers in the private or public sectors; and contracting with managed care plans. One study offers general strategies available to safety net providers.¹⁴ To date, however, studies have not systematically assessed these strategies,

examined how organizations identify and choose strategies, nor identified the success of the strategies.

In this project, we address these gaps through an in-depth study of the strategic adaptations Michigan health care safety net organizations have considered. The project is designed to examine how changes in the health care environment, such as the growth of managed care, are influencing the strategic adaptations of health care safety net organizations, and the implications for access to health care among the uninsured and other underserved groups. We specifically include family planning safety net organizations to examine their unique challenges and strategic adaptation. As described below, our study focuses on key survival strategies these organizations have considered, how they are being implemented, and the extent to which these adaptations constitute “best practices” that other organizations can use. Our goal is for the dissemination of these findings to lead to widespread adoption of successful strategies by safety net providers in both the private and public sectors. Absent a systematic assessment of these organizations’ survival strategies, each safety net provider is unlikely to benefit from experiments that have succeeded and may well simply replicate those that have failed.

Trends in Michigan and the United States

The state of Michigan is strongly representative of national demographics and health care trends. As a state, Michigan has an excellent mix of urban/rural environments, racial/ethnic composition, and socioeconomic diversity. The population distribution by age and race/ethnicity in Michigan closely mirrors that of the nation, as does Michigan’s population distribution by metropolitan status. Eighty-eight percent of Michigan’s population resides in a metropolitan area; close to the national average of eighty-one percent. Michigan has a per capita income of \$29,612 while the US average is \$29,276. As of March 2003, Michigan’s unemployment rate mirrors the national rate of 6.7%.¹⁵ Michigan and the U.S. have similar poverty rates, with an average of 10.8% and 13.2% of the population, respectively (as of 1998), classified as low income (below 200% of the federal poverty level).¹⁶ A comparison of critical health indicators also rates Michigan’s health similar to the nation. Of 24 indicators used in a recent study by the Michigan Department of Community Health (MDCH), Michigan rates better than the US on nine, worse than the US on four, and has no significant difference in the remaining eleven indicators.¹⁷ For instance, Michigan fares better on mammography rates, teen pregnancy, and tuberculosis, but fared poorly on diabetes, infant mortality (especially for minorities), obesity, access to abortion services, and tobacco use.

Policy and market changes taking place at both the national and local level greatly affect the ability of safety net providers to continue to provide health care to low-income populations. These changes include: an increase in the demand for safety net services; a shift from fee-for-service reimbursements to capitated payments in the Medicaid program; the rising cost of services, such as contraception; an increase in the rate of Medicaid managed care penetration; a decline in the public revenues available for safety net services;

and greater time demands from managed care organizations, resulting in a decline in physicians' income.

In addition to these stressors, health care safety net providers in Michigan have worked in a political environment that has not been very supportive of public health. Since the early 1990s, state officials have emphasized downsizing government, cutting taxes, enhancing education, and limiting Medicaid. In the years leading up to Governor Granholm's election, the Engler administration allocated funding for abstinence only programs, limited access to abortion services, and attempted to defund Planned Parenthood.¹⁸ Though the Granholm administration may well be more receptive to the needs of public health and safety net providers, the state's dire fiscal situation and budget deficit constrain efforts to alleviate the pressures placed on health care safety net providers.

Demand for Safety Net Services. Until recently, Michigan has had a relatively low level of uninsurance, primarily due to a strong union presence, broad eligibility standards for the state's Medicaid program, and an insurer of last resort—Blue Cross Blue Shield of Michigan (BCBSM).¹⁹ Because a high number of low-income Michigan residents have employer-sponsored insurance coverage, the rates of uninsurance have remained relatively low at 10.4%, compared to the national average of approximately 14.6%.²⁰ That is not likely to last much longer, as a result of increasing unemployment rates. The uninsured rate grew from 9.9% in 2000 to 10.4% in 2001, and the evidence strongly suggests that the number of people without insurance in Michigan will grow faster than national trends, especially in the state's poorer inner-city and rural areas.

Adding to the overall problem, key facilities that typically care for these populations have been operating under precarious circumstances or are on the verge of closing. Recently, the Detroit Medical Center (DMC) closed its Sinai Hospital, cut its staff by more than 21,000 and threatened to sell eleven of its clinics in the Detroit metropolitan area. So far, five or six have been sold, though plans for further activity are on hold. The primary concern is that the clinics would most likely be purchased by private practitioners unlikely to serve the low-income population²¹ that is either uninsured or on Medicaid, which comprises 55% of the clinics' population.²² The Detroit Mayor's announcement that the clinics would remain open has not alleviated fears for those who would lose access and care. As a result, the Detroit Health Department said it would attempt to help the situation by starting a clearinghouse to provide information about free and low-cost health care.²³ Although DMC is undergoing a four-year turnaround effort, the possibility of closing primary care clinics remains in the plan.²⁴ "The consequences of the closing or failure of a so-called safety net hospital like DMC's Detroit Receiving Hospital or Hutzel Women's Hospital would cascade throughout the city, resulting in overflowing emergency departments, hospital beds filled and patients with physical and mental illnesses with no place to go."²⁵

Shift to Medicaid Managed Care. In 1997, Michigan implemented Medicaid managed care. To cut costs, the state shifted health care payments from fee for service to

capitation. The state also placed a cap on the amount of money available for Medicaid services, which resulted in a lower Medicaid reimbursement rate and drastically reduced funding for the program. In FY1997-98, Medicaid funding was reduced by \$121.8 million in anticipation of savings from the shift to capitated managed care.²⁶ During the 18-24 months after managed care was implemented, the Medicaid program experienced reductions in funding totaling nearly \$400 million. Reductions were largely based on the assumption that costs under capitated managed care would be 5-15% below fee-for-service payments. These actions resulted in a huge cost savings for the state, but hurt providers who were responsible for the costs associated with shifting their management and financial systems from fee for service to capitation.

In 1996, Michigan had approximately 25% of its Medicaid enrollees in HMOs; in 1999 it rose to 50%,²⁷ and by 2001 Medicaid managed care enrollment was at 100%.²⁸ Initially, the shift to Medicaid managed care increased competition among providers for publicly insured patients and Medicaid revenues. The plan was to expand enrollment without increasing the budget; but this was dependent on a series of federal waivers allowing cost savings which never materialized. In response, the state continued to reduce the Medicaid reimbursement rate through the 1990s. Several providers stopped accepting Medicaid managed care patients and left more uninsured and underinsured people demanding services.

Despite a 13% increase in the number of enrollees over the last decade, Medicaid outlays as a percentage of the state's general revenue fund only increased by 2%. This reflects the harsh budget constraints shouldered by Michigan's Medicaid program. In FY 2002, the enacted budget did not include rate increases for any Medicaid providers but focused on cost containment strategies—hiring freezes and budgetary savings requirements.²⁹ Even though Michigan has one of the lowest Medicaid reimbursement rates and health care facilities have closed because of these low rates (i.e., Albion's Trillium Hospital),³⁰ the same approach is underway for FY 2003.³¹

Reductions in Funding for Local Health Departments. Throughout the 1990s, local health departments (LHD) in Michigan saw their budgets and staffs shrink following state budget cuts in public health.³² From the mid 1980s to the late 1990s, the Detroit Health Department closed six primary care clinics because of funding cuts, which led to a massive loss in providing personal health services and an increased burden on Detroit hospitals, free clinics, and community organizations. During this time, it became increasingly difficult for LHDs to perform their duties because of a lack of consistent, stable resources, and an expectation at the state level that LHDs should be able to provide more services with less money. Although LHDs are often asked to operate in a tight funding environment, the budget cuts in the 1990s were particularly crippling. For example, the gross appropriation to the Health Systems Local Grants Unit decreased in FY 1996-97 by over \$3 million from the previous year. In addition, local public health infrastructure grants were consolidated with the state/local cost sharing program.³³ Historically, state budget cuts did not eliminate funding for specific programs, but instead

reduced funding across the board. This allowed LHDs to maintain most, if not all, of their services by cross-subsidizing funding across programs. In the early 2000s, however, the state targeted specific programs for elimination, leaving LHDs without the ability to cross-subsidize and unable to provide certain services.

The public health code established in 1978 mandates that the state government share the responsibility for providing these services with local governments. Cost-sharing between the locals and the state was established because local health departments lacked the resources to independently fulfill all of their obligations.³⁴ Instead of reaching 50/50 rate, the state's share in the cost sharing agreement remained relatively constant at 20% for several years.³⁵ Though the target was met in 1994, it was short-lived. In 1996, the state's contribution fell back below 50% and has remained under 50%.

Declining funding for comprehensive family planning services. Public family planning clinics have traditionally been the source of reproductive health care for low-income women and adolescents. Family planning safety net services in Michigan are provided by a network of local health departments, community health centers, and Planned Parenthood clinics. Sources of funding for family planning services include Medicaid payments, state pregnancy prevention funds, and Title X of the Public Health Service Act.

The cost of providing reproductive health services, particularly contraceptive services, has risen significantly over the past decade. Yet funds earmarked specifically for comprehensive family planning services, Title X, and the State Pregnancy Prevention Funds, have not kept up with rising costs during the same period.³⁶ Just as important, Public Act 133 (PA 133), signed by Governor Engler in 2002, gave priority for Title X funding to those organizations that have no association with abortion services. Organizations that perform abortions, refer for abortion services, or have a pro-choice mission will only receive family planning funding if there are no other available providers in the area.³⁷ The impact of PA 133 will largely depend on how Governor Granholm implements this policy. But family planning advocates are concerned that this bill will shift funds away from the State's network of Planned Parenthoods to organizations that may not be willing to or capable of providing the full spectrum of reproductive health services. In all likelihood, Medicaid will not fill that gap because of limited reimbursement to out-of-network providers and administrative inefficiencies. Finally, neither state nor federal funds are available for any services associated with pregnancy termination except in cases where the woman's life is in jeopardy.

Creation of the Michigan Department of Community Health. In 1996, Governor Engler abolished the Michigan Department of Public Health and created a single state "Super-Agency" that combined several state departments to eliminate duplication of services and increase efficiency. The new department, the Michigan Department of Community Health (MDCH), combined many programs, including the former departments of Mental Health and Public Health and the Medicaid program.³⁸ In 1997, the Office of

Services to the Aging, the Adult Home Help Program, and the Social Services to the Physically Disabled Program were also brought into MDCH.³⁹

Aside from overall budget reductions in creating and operating MDCH, the public health component of the budget experienced significant changes. Its budget was reduced by \$36.2 million, or 5.3%, and 545 FTEs were transferred to other state departments. The mental health component of the new department saw a decrease in funding between FY1995-96 and FY1996-97 of \$13.6 million.

Just as important, our background interviews indicate that creating the new agency led to a strained relationship between the state health establishment and local public health departments. Respondents indicate that the sense of shared mission between the state and local health departments has been lost because MDCH does not view the local health departments as their partners, and instead sees them as special interest groups. One respondent pointed out that the term “public health” cannot be found anywhere in MDCH—not in the agency’s name, not in any departments, and not on the agency web site.⁴⁰ The reorganization of several state departments into one agency led to the early retirement of many health professionals. The loss of so many professionals at once resulted in a loss of institutional memory about previous programs and policies affecting public health at the state level. Further, respondents report that a large amount of data, including fiscal data, were lost when the new agency was created.

Funding From the Federal Government. Recently, there have been two main spurts of proposed funding to public health from the federal government. Catalyzed by the events of 9/11, the federal government has increased funding for bioterrorism preparedness initiatives. Based on \$31.2 million received from the federal government to upgrade state and local bioterrorism preparedness, former Governor Engler created the Office of Public Health Preparedness and Response to Bioterrorism. This new office is now MDCH’s responsibility.

In part because of the dramatic increase in uninsureds in 2001, Congress enacted the President Bush’s legislation to reauthorize federal health programs for the poor and uninsured on October 28, 2002. The “Health Care Safety Net Amendments” are designed to expand the health safety net to rural areas and inner cities. President Bush is renewing his call to double the number of patients served by community health centers over the next five years by creating 1200 new health centers by 2006.⁴¹ Though this is well-timed and well-intentioned, Michigan safety net providers have expressed concern that Michigan has received very little of these federally allocated funds (and certainly nowhere near the amount of funds relative to the uninsured and underinsured population).

Michigan’s Budget Deficit. The state’s recent attempt to balance the budget and reduce spending will certainly exacerbate the problems safety net providers are facing. In December 2002, the state legislature passed then-Governor Engler’s plan to cut \$337.4 million from state services to address the \$460 million shortfall. Of all the departments hit,

MDCH was slated to absorb the largest dollar cut at \$83 million.⁴² Despite these cutbacks, newly elected Gov. Granholm faces a looming \$1.7-billion deficit in 2003-2004 and has recently proposed another austerity plan that includes cuts of \$60 million from the Michigan Medicaid program.⁴³ The cuts mean restricted eligibility, reduced benefits, payments to providers, as well as 1,600 lost jobs and \$56 million in lost wages.⁴⁴ This is particularly harmful as Medicaid supports more than 1.25 million people, 34,000 of whom have enrolled since July of 2002. Physicians and health care advocates state that the tactic of freezing reimbursement rates hurts the poorest patients (those not eligible for Medicaid) because fewer health care providers can use Medicaid funds to subsidize care for the uninsured.⁴⁵ With Medicaid providers backing out, yet more pressure is placed on Michigan's fragile health care safety net. The IOM suggests that states' plans to cut Medicaid spending have extended consequences and will likely to lead to a lower level in "public funding for health insurance, few public funds available for other purposes, and higher taxes."⁴⁶

Developing County Health Plans. Several Michigan counties are trying to address and alleviate the problem of the uninsured through community-based initiatives that enroll uninsured individuals and families into organized health plans that provide a designated set of benefits. The county health plans are designed either to complement or as an alternative to safety net providers which have traditionally provided health care to the uninsured. While these programs differ across communities, common elements include providing enrollees with a medical home, and offering care management that enhances early detection of medical problems, promotes preventive care, and reduces inappropriate utilization of emergency and inpatient services.⁴⁷ Covered services in these plans vary, but most include doctor visits, health check-ups, outpatient lab tests, outpatient x-ray tests, and prescriptions from pharmacies if on the list of covered drugs. Services must be provided at participating locations and by participating providers, and may be limited if funds are not available. Members are referred to community providers for low-cost or free additional services such as family planning services, breast and cervical cancer screening services and mental health and substance abuse counseling services. Free clinics are generally not participants in these county-wide plans.

Because insurance products in Michigan are subject to a variety of regulations, the plans are created as "benefit products," rather than "insurance products."⁴⁸ The health plans enroll individuals whose incomes are 250% (in some plans it is 150%) or less of poverty, and who are not eligible for any government-sponsored health care program. In addition, the plans provide care for the State Medical Plan (SMP) population, which is a state-run coverage program for very low-income individuals, often with special health needs, who are ineligible for Medicaid. In general, the plans conduct limited marketing to avoid overpromising benefits that exceed their budget.

Detroit has responded to its uninsured population through the Voices of Detroit Initiative (VODI). This model creates a health care delivery system through the implementation of the medical home concept. VODI provides primary care services and

direct referrals for secondary and tertiary care. In conjunction with the Wayne County Medical Society, VODI is organizing a volunteer specialty care physician network to provide free care to the uninsured referred from free clinics in the VODI network. VODI has also worked to restore a network of basic medical centers to underserved populations in Wayne County, and has recently assisted in the opening of the Community Health and Social Services Center, MidTown Center in Detroit.

RESEARCH METHODOLOGY

Research Objectives

Our research objectives are to understand:

- How health care safety net organizations serving uninsured and underinsured populations make choices about their future roles and services.
- How changes in the health care environment influence their strategic adaptations.
- Key adaptive strategies being considered and their implementation.

The project is designed to examine how changes in the health care environment are influencing the strategic adaptations of health care safety net organizations and how these adaptations affect access to health care among the uninsured and other underserved groups. Our primary goals are to:

- Provide affected communities, safety net providers, and policymakers with documented information on the various adaptive strategies being considered and implemented.
- Suggest strategies for improving access to health care among uninsured and underinsured persons.
- Make recommendations to policymakers on how to respond to the changing health care environment.

Design

Theory and prior empirical work provide a basis for anticipating a range of strategic adaptations for exploring factors likely to be associated with specific survival strategies employed by safety net organizations. Of particular interest is how the managers, providers, and board members in safety net organizations understand their commitments to serve the uninsured and underinsured, and how these obligations are maintained or are changed as a consequence of strategic adaptation. Accordingly, the project uses organizational entities comprising the safety net as the focal point (unit of

analysis in research methodology terms) for examining how safety net organizations adapt to changes in their environments.

For this research, we define the health care safety net as those organizations and programs, in both the public and private sectors, that have a legal obligation or a commitment to provide direct health care services to the uninsured, underinsured, and other underserved groups. Broadly defined, these organizations include: public and private hospitals that provide a disproportionate share of services to underserved groups; community and migrant health centers; public health departments (both state and local) which directly provide safety net services; organizations funded by federal categorical programs such as Title X family planning clinics, Title V prenatal care programs, and Title XV breast and cervical cancer screening program providers; and other community-based organizations that provide uncompensated or reduced-price services.

The project employs a multiple-site case study approach focusing on health care safety net organizations in selected Michigan communities. Our primary methodological approach is to conduct a broad range of qualitative interviews with key individuals within the selected organizations. The case studies provide detailed information about the adaptive strategies the selected safety net organizations have considered and implemented. Although the in-depth qualitative information obtained in a small number of case studies does not produce statistical generalizations from a sample to a larger population, the validity of case study results is enhanced by the use of explicit selection criteria for the cases, the use of a standard protocol across cases, and multiple data sources within cases. Thus, the lessons learned from these cases will be broadly applicable to other organizations confronting similar environmental circumstances.⁴⁹

Mapping the Health Care Safety Net

To identify the full range of Michigan's safety-net providers, we gathered data from several sources. For those organizations receiving state or federal funds, we obtained data from the Michigan Department of Community Health, the state legislature, and Community Health Center funding from the U.S. Department of Health and Human Services. For clinics that do not receive state or federal funds, we relied on lists compiled by organizations such as the Michigan League for Human Services and the Free Clinics of the Great Lakes Region (FCGLR).

After compiling the data, we constructed a map of Michigan health care safety net providers (attached at Appendix "A"). The map identifies each safety net organization according to its institutional type (i.e., free clinic, FQHC, health department), services provided (i.e., primary care, family planning), and location. These organizations were labeled and placed on a physical map of Michigan, ensuring that our site selection would represent the geographic and environmental diversity of health care safety net providers in Michigan. We have eliminated hospitals from our sample because of resource limits and the fact that others have studied these institutions.

Site Selection

Once all organizations were mapped, we identified clusters of various organizational types within a geographical area. After closely examining the clustering, we selected organizations in six communities based on the following criteria:

- Geographic diversity within Michigan.
- Diversity of organizational types.
- Diversity of types of services provided.
- Mix of affluent and non-affluent areas.

If available at each location, we selected four organizational types, including community-based free clinics, family planning organizations, public health departments, and Federally Qualified Health Centers (FQHCs). Family planning clinics could be based at both public health departments and community-based clinics. (Our data analysis includes all organizational types. At Appendix “B”, we report specific results for family planning clinics.) The free clinics include a mix of secular, church-supported, and faith-based organizations.⁵⁰ Altogether the sample includes 20 organizations.⁵¹

Community Demographics. The selected communities are categorized into three types: rural (A and B), mid-sized urban (C and D) and urban (E and F). As shown in Figure 1, the county population of the communities varies significantly, ranging from just over 11,000 residents in Community A to over 2 million in Community F.⁵²

The racial and ethnic composition of participating communities, shown in Figure 2, ranges from non-white minority populations of less than 5% (Community B) to almost half of all county residents (Community F). With the exception of Community B, the largest minority population in the participating communities is African-American. The largest percentage of African-Americans reside in Communities F (42%) and D (20%), while Communities A, C, and E have African-American populations of around 10%.

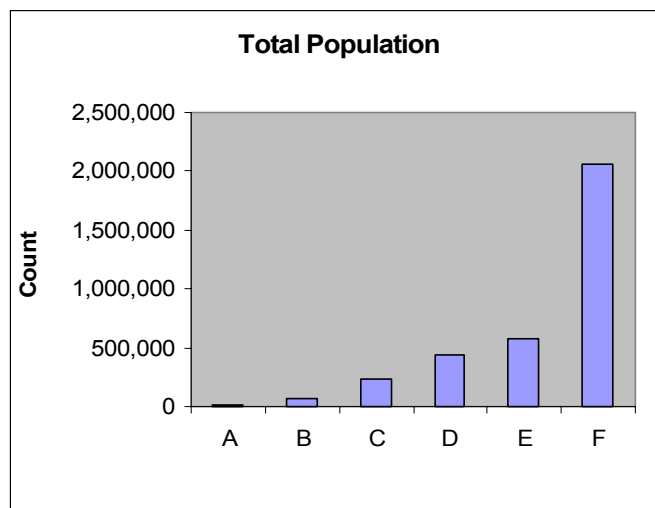


Figure 1

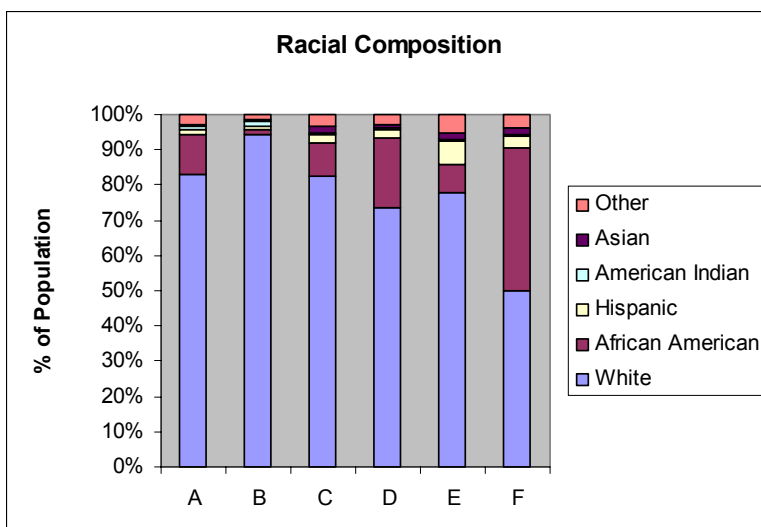


Figure 2

The Hispanic population in all participating communities is significantly smaller, with the highest percentage of Hispanics residing in Community E (7%). Although both Asian and American Indian populations are under 2% in all participating communities, higher percentages of American Indians reside in rural areas. A greater percentage of Asians is found in urban areas.⁵³

Selected economic indicators present a complex picture that cannot be easily categorized according to population-based groupings. Both the largest urban and smallest rural communities have the highest percentage of residents living below 100% of poverty (19% and 23%, respectively), and rural Community B (9%) and urban Community E (8%) have the lowest poverty levels (Figure 3). Unemployment rates range from a low of 3% in Communities C and E to a high of 7% in Community A. The source of insurance within each of the communities, however, is relatively similar, as is the rate of uninsured, with a low of 10% in Community E to a high of 14% in Community F (Figure 4).

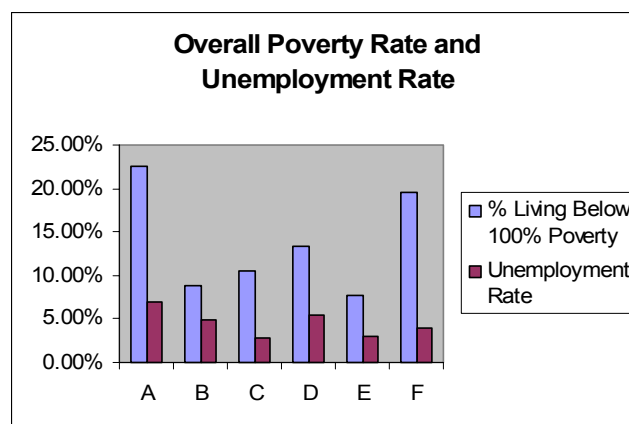


Figure 3

Data Collection

The Interviews. Within most of the organizations, we interviewed the administrator, the medical or clinical director, the financial or marketing director, and a member of the board of directors.⁵⁴ Altogether, we conducted 74 interviews. The interviews were transcribed and then analyzed using a qualitative analysis software program. We promised confidentiality to each respondent and to each organization. Thus,

all results will only be reported in the aggregate—no individuals or organizations will be identified.

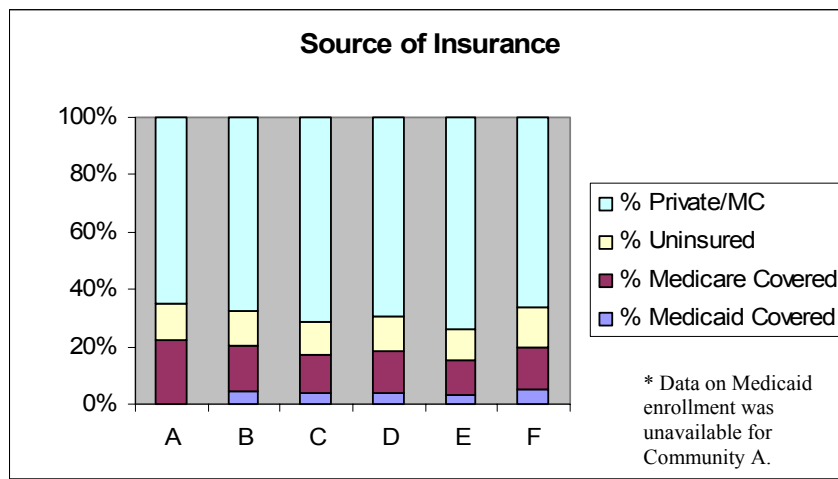


Figure 4

Except for a handful of joint interviews, we conducted each interview separately. This allows us to triangulate the results, meaning that we are able to capture differences within an organization that would not be revealed through focus group interviews. We developed a standard interview protocol (attached as Appendix “C”) to guide the interviews. The protocol was pretested and revised as appropriate. The interviews were structured to obtain information on:

- Perceived threats to organizational viability (including services no longer provided because of financial constraints and the impact of recent Title X legislation on family planning organizations).
- Perceived opportunities for organizational change.
- Financial and nonfinancial resources available to the organization.
- Financial and nonfinancial resources needed to remain in operation.
- Contemplated and implemented strategies for obtaining financing and organizing service delivery.
- Likely implications of organizational changes for serving uninsured and underinsured populations.
- Perceptions of facilitators and barriers to implementing changes.
- Perceptions of organizational prospects for the next five years.
- Recommendations for policymakers in addressing the problem of uninsurance and underinsurance in Michigan.

Datasheet. In addition to the interview data, we obtained relevant documentation from each organization, as available. We created a basic documentation form (attached as Appendix “D”) to collect organizational information on: current populations served, including: payer type; trends in patient volume and populations served; and current service mix. We also obtained annual reports, along with recent strategic plans or marketing

reports. These documents are useful in understanding the circumstances confronting the organizations as well as their information system capacities and ability to track the impact of organizational changes. Where possible, we compare and contrast our interview results with the available documentary material.

Collaboration with Existing Programs and Studies. The impact of changes in policy and cultural institutions has caused a state of increasing concern among Michigan safety net organizations and public health advocates. Throughout this project, we conducted additional interviews with community informants who are knowledgeable about the subject of the research and may operate similar or related programs. We also communicated frequently with state officials, though their input was purely informational. Except as noted in the report, these contacts were used for background only.

Hypotheses. During the planning phase, we developed a set of hypotheses that would help guide our inquiry. These hypotheses are:

- Organizations that are more dependent on public funding have less leeway to consider or adopt “mission transforming” strategies than organizations that are less dependent on public funding.
- Organizations with governing boards that are more active in generating resources, including fundraising, have more leeway to consider or adopt expansion or “mission transforming” strategies than organizations whose governing boards do not generate significant resources.
- Organizations with highly specific missions (e.g., family planning organizations or those based on a founder’s vision) have less leeway to consider or adopt expansion or “mission transforming” strategies than organizations with broader or more generic missions.
- Organizations with wider networks (i.e., partnerships) have more options and are more likely to adopt expansion or “mission transforming” strategies than organizations that are less dependent on networks.
- Family planning organizations face a unique set of challenges and consequently tend to implement a different set of strategies than other non-family planning safety net organizations.

Data Analysis. To analyze the data, the investigators met regularly to discuss and revisit themes and supporting details. Following the interviews, the primary interviewer provided an organization-specific summary that everyone read. Each of the investigators also read the transcribed interview tapes. We used these summaries and transcriptions to help develop appropriate analytical categories and to identify cross-cutting themes. In addition, we separately analyzed the supporting documentation (i.e., strategic plans and the data sheets) to provide background, context, and, in some instances, comparisons for the interview results.

Along with the case summaries and transcriptions, we analyzed the data by using N6 qualitative data analysis software, the latest version in the NUD*IST series. Qualitative analysis software offers a number of tools to organize and compare complex data in one file. After reading through a selection of the transcripts, we chose a list of key words for preliminary analysis using a text search, which places the selected word or phrase in context. The results of these text searches led to the development of nodes, which organize the data into broader concepts. Our final analysis and conclusions are based on the combined results of the tree nodes, using the case summaries, and the interview transcripts.

Research Limitations

The case study approach is the most appropriate study methodology to address these particular research questions and precautions were taken throughout the research process to ensure the reliability and validity of the findings. Despite this, there are a few possible limitations of the study. First, we are unable to guarantee that we have captured the full range of clinics. Resources limited the number of clinics we could include. For example, clinics that recently went out of business would not have been included in our mapping. Thus, the study is based solely on clinics that are open and are surviving.

Secondly, we did not have full control over who we were able to interview. For board members in particular, we relied on our contact at each clinic to arrange the interview. As a result, our sample is not random and there may be some bias in our interviews toward positive outcomes.

Another limitation is the availability of documentary evidence. For the most part, financially constrained safety net providers do not maintain the documentary evidence that is usually examined. Because the primary form of data collection is through the interviews, obtaining complete documentary evidence is not critical, but would be useful for corroborating the interview results.

Finally, these findings may neither be generalizable to other states nor to other types of health care safety net providers. Our methodology does not permit us to determine causality or draw formal inferences. Indeed, it is conceivable that selecting organizations in other parts of Michigan would have yielded different results. Even though our results may indicate how similar organizations may respond, they are not necessarily representative of the overall health care safety net. Because our study is based on organizations, we do not capture other attempts to provide health care safety net services, such as county sponsored health plans that have recently been developed.

Organization of the Report

The remainder of this report is organized as follows. In the next chapter, we describe and analyze our interview results, focusing on the organizations' strategic adaptations. In Chapter 3, we discuss the policy implications of our findings.

CHAPTER 2: RESULTS

In this chapter, we present the results of our interviews. The chapter is organized into three major sections reflecting the most important cross-cutting themes: threats and challenges to survival; adaptive strategies, and internal organizational issues. As the results include findings from a variety of organizations and contexts, we will identify patterns as well as noteworthy examples of where these patterns diverge. Tables 1 and 2 present a summary overview of the findings.

Threats and Challenges

Our analysis of the interviews reveals a number of significant threats and challenges to Michigan health care safety net organizations' ability to provide clinical services to the uninsured and underinsured. We identify three main themes that our respondents indicate are significant threats to organizations' survival: population characteristics and burgeoning need; financial challenges; and community challenges.

Population Characteristics and Need. Almost uniformly, our respondents note that the primary threat to organizational survival is the increasing demand for their services. This threat takes two forms. Challenges to organizational survival result from the increasing needs of their patient population, which more and more exceed organizational capacity. Closely related is the trend toward serving a sicker patient population.

Need Exceeds Capacity. The need of existing and potential clients exceeding capacity is a consistent concern for all of the free clinics and FQHCs in our sample. Except for the mental health center and a clinic in one of the more affluent communities, our respondents are unable to satisfy the community's unmet needs (particularly in the areas of behavioral health and non-medical services). Most are clearly straining to provide services to meet a portion of the overall need. Increases in unemployment, small businesses dropping insurance benefits, and employers increasing employee cost-sharing contribute to this problem throughout the state. The growing number of uninsured and underinsured clients, as well as the rising costs of prescription drugs, only exacerbate the threat. The CFO of one urban FQHC provides an illustration of the extent of the problem. "The majority of our folks that are seen here, they can be lined up as early as 7 a.m. and we don't open until 8 a.m. and the line can be around the building for those folks...they will camp out if necessary."

The problem with excess demand is both practical and conceptual. Practically, excess demand puts too much stress on systems designed and funded for lower capacity. The conceptual concern is finding ways of expanding to meet the need given limited resources.

Table 1

THREATS/CHALLENGES	Organization																				
	HD1	HD2	HD3	HD4	HD5	HD6	FP1	FP2	FP3	FQ1	FQ2	FQ3	FQ4	FQ5	Free1	Free2	Free3	Free4	Free5	MH1	
Need greater than capacity				X		X				X	X	X	X	X	X	X	X	X	X	X	
Declining funding	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Competition for patients	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Organizational reputation						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Transition to Medicaid		X				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Difficulties with local hospitals			X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Growing number of uninsured	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Political barriers	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Concerns about quality of care				X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lack of specialty referrals						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Rural Area	X	X								X	X	X	X	X	X	X	X	X	X	X	X
Unions		X	X																		
Competition for Title X funds																					

Table 2

ORGANIZATIONAL STRATEGY	Organization																				
	HD1	HD2	HD3	HD4	HD5	HD6	FP1	FP2	FP3	FQ1	FQ2	FQ3	FQ4	FQ5	Free1	Free2	Free3	Free4	Free5	MH1	
Turn away patients										X											X
Cut services		X	X	X																	
Increase patient fees		X																			
Recruit paying patients							X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Formal strategic plan							X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Fundraising							X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Expanding clinical services																					
Use volunteers	X									X											
Collaboration	X	X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Improve customer services							X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Use business models							X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Improve efficiency	X						X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Data collection							X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Cross training staff		X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Collaboration with academic center																					
County Health Plan		X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lobby		X	X	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

In contrast to the free clinics and FQHCs, the family planning organizations and all but one of the health departments do not contend that their capacity to provide services is challenged. Family planning organizations view themselves as a niche provider with the capacity to deliver services to an expanding population. In fact, the family planning providers in our sample are actively recruiting *more* patients. As most health departments are involved in retrenchment of clinical services, it follows that they would not feel threatened by an inability to meet need.

Sicker Patients. Free clinics and FQHCs express concern over the increased severity of their patients' health problems. Patients increasingly present with multiple chronic diseases, with diabetes and behavioral health needs among the most common problems. The executive director of an urban free clinic describes client acuity levels as "through the roof." In that clinic, delays in care have led to more severe complications and calls to 911 have gone from three times per year to at least once a month. The board member of one mid-sized urban FQHC notes that the deterioration of health is so severe that patients at age 30 are presenting with health problems formerly seen at 50. As with excess demand, increasing acuity levels strain clinics' ability to provide adequate primary care or gatekeeper services. In contrast, this is not an issue at the health departments or family planning organizations.

Separate and apart from increasing acuity levels, several free clinic respondents identify that patients present with a deteriorating lifestyle over time which affects clinics' ability to provide care (especially preventive services). "The underlying structure of their lives is the problem. Lifestyle change, such as exercise or understanding and following a diet, is not always an option."

Financial Challenges. Financial challenges remain a constant threat to the ability of safety net organizations to provide clinical services. Decreases in funding and loss of revenue from the transition to Medicaid managed care threaten the ability to serve existing clients, let alone respond to the increasing community needs.

Declining Funding. All organizations in the sample are concerned about stagnant and declining funds, contributing to a universal sentiment that health care safety net organizations are being asked to provide more with less. Appropriations at the state level for health departments remain stagnant, while demand for services continues to increase. The finance director at one urban health department complained of local funding reductions, "cuts, cuts, cuts—five percent per year for the past three years." FQHCs also struggle with limited funding, including low levels of reimbursement from Medicaid and a shift to serving a greater percentage of uninsured patients. Title X family planning funds and the state pregnancy prevention monies have not kept up with inflation or the rising costs of contraceptives, making it difficult for family planning clinics to provide services. One health department executive director explained: "clearly [family planning] is not a priority for policymakers."

Free clinics are dependent on a limited number of local donors for their financial survival, making a potential reduction from these supporters an omnipresent threat. Clinics in more affluent areas have greater funding opportunities than those in less affluent areas. Yet many free clinic respondents note substantial local competition for funds, from other clinics, and from the entire range of non-profit organizations. Not only is there increased competition for funds, the competition comes at a time when foundations have less money to disburse because of low returns on their investment portfolios.

Transition to Medicaid Managed Care. FQHCs are most clearly threatened by Medicaid managed care because their revenue model is highly dependent on Medicaid reimbursement. Low levels and long wait times for Medicaid reimbursement continue to put pressure on budgets which are highly dependent upon these revenues for survival. The shift to Medicaid managed care in one urban FQHC has also created a great deal of confusion regarding enrollment with a primary care provider, which is a new experience for patients formerly covered under a fee-for-service model. As a result, this FQHC initially lost 98% of its Medicaid patients.

Restrictions on Medicaid reimbursable services are also a challenge to family planning organizations and one health department, as these organizations dipped into financial reserves to provide services not covered by Medicaid. Even though family planning services are technically covered at other organizations, family planning entities often find themselves providing other “non-family planning” care, such as screening for infections, which is not reimbursable. Rather than declining to screen women during their family planning visit, many centers will absorb the cost of these services. Since free clinics do not charge (or charge a minimal fee) for services, none of them is directly threatened by changes in Medicaid reimbursement. Still, many free clinics attribute an increase in demand from clients covered by Medicaid who are unable to make timely appointments with their assigned primary care providers.

Community Challenges. A source of variation in our results is that the local environment in which health care safety net organizations operate affects their ability to provide services. On the positive side, our results show that supportive communities can contribute financial and human resources (i.e., volunteers) to facilitate clinic survival. But threats to the organizations can come directly from other organizations within the community, such as difficulties with local hospitals, a lack of referral sources, and competition for patients. Additional community challenges include the ability to find adequate staffing, a negative reputation for poor quality care, and political realities.

Difficulties with Local Hospitals. Aside from family planning organizations, a majority of organizations face difficulties in their relationships with local hospitals. These challenges range from strained collaborations to local hospitals wielding so much power that they are able to dictate how clinical services are delivered in one urban health department. Indeed, in less affluent areas, respondents at two clinics note the inability to

develop any collaborative relationships or patient referral arrangements with local hospitals.⁵⁵

In one mid-sized affluent community, the local hospital initially opposed the free clinic's formation and refused to be represented on the clinic's board of directors. As the clinic's medical director explains, the hospital fears that the free clinic might take away paying patients from the hospital, creating an environment where, "the poor will expect the services or feel it's an entitlement." A rural FQHC comments that the hospitals in its area are building clinics that would refuse to serve the uninsured, yet at the same time treating the FQHC as a competitor. Instead of referring Medicaid or paying patients to the FQHC, physicians at the hospital-owned clinics send patients to the closest urban area, limiting the FQHC's ability to cross-subsidize services for the uninsured. Other organizations are also concerned with the growing number of ER patients being redirected to their clinics. Even in the case of an urban free clinic which is sponsored by a hospital, the collaborative relationship has foundered from internal competition for revenue, as well as resistance from the hospital to commit to needed expansions.

Our finding that local hospitals are a threat to so many organizations is particularly interesting given that on paper, most hospitals are viewed as collaborators with health departments, FQHCs, and free clinics. In fact, our separate analysis of the available strategic plans suggests that among the free clinics, there seems to be an overwhelming strategic emphasis on collaborative partnerships with hospitals, as well as relationships with local physicians, and other community entities. The reality of current collaborative efforts suggests that plans for expanded collaborations may not yield the expected benefits.

Lack of Referral Sources. As an indication of the problems with collaborative relationships, all but one free clinic, as well as most health departments and FQHCs, report problems with outside referrals, particularly for specialty referrals. The executive director of an urban free clinic describes her referral network as "calling and begging." The director of a mid-sized urban clinic believes that referrals are becoming increasingly difficult because of changing physician demographics, with the "older generation retiring and the younger generation not as giving." A health officer from one mid-sized urban health department agrees, explaining that "in the early 1980s, the County Medical Society feared competition from the Department's clinics, and asked the Health Department not to compete. Now, the Medical Society wants clinics for the uninsured because the Medical Society won't serve them." Several free clinic directors express frustration with hospital partners' refusal to provide greater specialty referrals. Family planning organizations, which offer a relatively contained niche service, do not experience problems with specialty referrals.

Competition for Patients. Almost all of the health departments, FQHCs, and family planning organizations observe that competition exists within their communities for clients. One rural FQHC cites competition from rural health clinics designed to siphon paying clients from the FQHC to the sponsoring hospitals. These clinics not only take

insured patients away from the FQHCs, but also refuse to accept referrals. Many health departments believe that competition for clients exists, yet they are unable to effectively compete with private local providers on any profitable services because of barriers imposed by state and federal regulations.⁵⁶

By contrast, none of the free clinics is concerned with competition for their largely uninsured clients, though some of the free clinics believe that other providers in their community view them as competitors. This latter belief may have adverse implications for the success of collaborative relationships and patient referrals.

Staffing. The majority of health departments, FQHCs, and family planning organizations have concerns about staffing. These organizations employ full-time paid staff. Recruiting and retaining qualified staff, particularly nurses and pharmacists, is a challenge cited by both rural and poor urban providers. For instance, an urban health department reports hiring a nurse in December and watching her leave two months later for a job paying twice as much. Staffing shortages not only affect the ability of organizations to meet growing client need (i.e., by adding longer clinic hours), but also raise concerns over the quality of care provided in some clinics.

The free clinics in our sample are mostly dependent on volunteer nurses and physicians (though several employ a full-time nurse). Many free clinics desire a greater number of volunteer providers, but most say that their pool of volunteer practitioners remains stable for now. Although a shortage of volunteers is only viewed as an immediate threat in one poor mid-sized urban clinic, many of our respondents indicate concern that the pool of volunteer providers is not expanding. They note that physicians are under increasing financial pressure and must serve a larger number of paying patients. Hence, they might have less time available to volunteer their services. Free clinics in less affluent areas experience difficulties in recruiting and retaining paid staff.

Reputation. Many of our respondents indicate that the organizations need to improve their community reputation for quality of care and adequate facilities. They express concern that paying patients avoid the clinic because of its poor reputation. For instance, health departments in two poor communities, where a need for direct clinical services remains, are aware of how inadequate amenities and long waiting times contribute to their poor reputation in the community. Half of the FQHCs in the sample, which are all interested in recruiting insured patients, also express the need to improve their reputation in the community as “the poor people’s place.” One mid-sized urban FQHC admits to past problems related to quality of care, such as understaffing and poor equipment. Some of these problems have been addressed and rectified, but the FQHC continues to struggle with community perceptions of low quality care.

In comparison, free clinics generally perceive their reputation in the community to be favorable. To be sure, they are equally concerned with maintaining their reputations, but believe they enjoy considerable community support. Private family planning

organizations face a different challenge to their reputation because of the ongoing controversy surrounding both the types of services they provide and their support for abortion rights. As a result, these organizations put considerable effort into maintaining community alliances.

Political Challenges. Except for the free clinics in our sample, which experience few political barriers to successful service delivery, each of the other organizational types confront political threats to their survival. Health departments often express the lack of support for public health at both the state level and from their local communities. As the chief health officer of one mid-sized urban community explains, “It won’t turn around until people are hurt. The general population doesn’t know about cutting family planning, but cut [funding for] parks and people will complain. It is not politically feasible to keep family planning and cut parks.”⁵⁷ Health departments face increased competition for funds amidst ongoing budget reductions, as well as pressure from state and local government to become more efficient in providing services.

FQHCs are subject to political challenges from the federal government, including significant strings attached to funding, such as community representation on governing boards, and broken promises for funds never received. State politics also challenge FQHCs, in that the state was not adequately advocating for additional centers to serve the growing numbers of the uninsured, particularly in urban areas. Even though the federal government has increased allocations to FQHCs, Michigan officials offer limited support and advocacy for capturing new centers and enhanced funding. As a result, Michigan has fewer FQHCs than it should to serve its substantial low-income population.

Family planning organizations are specifically targeted by both community-based and political opposition because of the types of services they provide and their organizational mission. The presence of anti-abortion protestors at private family planning clinics remains a threat. Additionally, the Michigan legislature has attempted to defund some family planning organization by giving funding allocation priority to those organizations not engaged in providing or referring for abortion services. Family planning organizations consider these threats to be serious, yet they are committed to survive and to maintain their mission. As one CEO puts it, “We are not going away. We will become a service provider without county support.” In fact, the sampled family planning organizations view the loss of public funding as an opportunity to free themselves from the regulatory constraints and financial losses associated with Title X funding.

Cyclical vs. Permanent Change. Our interviews reflect a debate as to whether the current environment is just another down cycle or represents a permanent change for the worse. An unexpected finding is that a number of respondents do not view the current threats and challenges as a cyclical phenomenon. Instead, they argue that recent changes represent fundamental departures from the past that will be difficult to overcome. The CEO of one rural free clinic, reflecting the sentiments of several respondents, remarks that “What’s different now is the different philosophy at the governmental level, both state and

federal. Compassion from the 1960s is lacking. Therefore, supporters are not as optimistic or as energized—a sense of helplessness and hopelessness pervades.”

Others argue that safety net providers have always experienced ups and downs and have always recovered when the economy improves. Although the chief health officer of a mid-sized urban health department believes that the current financial cycle will eventually turn around, he agrees that the political climate has changed: “At the federal level, there’s a different sense of what government should do and what services should be offered—an I’ve got mine, they don’t deserve [theirs] mentality that’s different from fifteen years ago.” Likewise, the executive director of an urban FQHC comments on the “ugliness of this cycle and its viciousness,” brought on by the current political climate, but remains optimistic that the organization will pull through the existing challenges.

Strategies

To meet the threats and challenges presented in the previous section, health care safety net organizations have developed and implemented diverse adaptive strategies. We have organized the strategic responses around five major themes: financial; expansion; retrenchment; operational; and partnerships.

Financial. With mounting financial challenges, many safety net organizations are forced to devise strategies to maintain their financial viability. The two primary financial strategies are the introduction of or increase in patient fees and fundraising efforts.

Add/Increase Patient Fees. All of the sampled family planning organizations plan to add new patient fees or increase existing fees to maintain the organization’s financial viability. As a free clinic’s executive director describes, “[T]he sad fact of the matter is that what we’ll do is we’ll start charging money that allows us to operate.” Fees in one mid-sized urban family planning organization are to be based on a “price comparison” strategy, where fees could be increased to a level where they would maintain a competitive balance with local providers. Both rural area health departments, as well as a less affluent mid-sized urban department, also plan to introduce some fees in order to maintain existing services. Only one of the FQHCs concludes that, as one board member explains, there is “no choice but to raise the co-pay and to charge for services.”

At present, none of the free clinics plans on imposing fee-based services, although some of the free clinics may charge a minimal fee to encourage patients to take responsibility for their health. More importantly, our interviews suggest considerable debate among free clinic and FQHC respondents about the need to raise fees or, for free clinics, the eventual inability to avoid some type of fee structure (perhaps based on a sliding scale, as required in FQHCs).

Fundraising. Almost all of the organizations report an increased or continued emphasis on fundraising as a critical strategy for addressing the financial threats. Most

organizations pursue funding through a mix of grants and donations. The time intensive nature of grant applications results in a common approach where most organizations limit grant applications to those specifically tied to their mission or to support already existing programs. A handful of respondents indicate that they would pursue money regardless of fit, but that is a decidedly minority view. Our results also suggest that organizations with active board involvement in fundraising efforts are more successful than those organizations without active board engagement, primarily because most funding is raised through local community sources.

The private family planning organizations have a long history of successful fundraising, but all the sampled family planning organizations plan to increase fundraising efforts to address the financial strain caused by the growing need and the potential loss of public funding. Interestingly, our analysis of the strategic plans suggests that FQHCs focus more attention on fundraising than free clinics. Each FQHC strategic plan cites “obtaining more funding” as a primary strategic goal. One free clinic’s plan contains a specific program to generate funding “to sustain and grow their operation,” but another clinic’s strategic plan omits a fiscal plan.

Free clinics are adopting or considering a range of fundraising strategies. Several are at the early stages of establishing donor lists and holding fundraising events. Only one mid-sized urban clinic has an individual donor list sufficient enough to avoid long-term dependence on government and foundation grants. The most sophisticated effort in our sample includes a donor mailing list with a letter sent each year showing “what we’ve done, our needs, and a reply form.” Also, the clinic sends a letter to service clubs volunteering the executive director as a speaker, then adding the club to the donor list. To maintain volunteer relationships, the clinic invites all volunteers to dinners and parties.

The variation in clinic fundraising strategies results from differences in board of directors’ involvement and in the affluence of the surrounding community. Clinics in poor urban and rural areas are at a clear fundraising disadvantage and reliant on scattered donations and fundraising events. Clinics in more affluent areas are able to solicit and receive funding from local foundations and businesses.

All but one FQHC includes fundraising in the financial strategies, with the goal of the funds often focused on capital campaigns to increase capacity. Health departments are the least invested in fundraising strategies, with only three briefly mentioning it as a possible strategy.

There is considerable variation in the level of sophistication with which organizations are able to solicit funds. Small clinics in less affluent areas lack a strong donor base and are relegated to yearly fundraising events.⁵⁸ Some free clinics are dependent on a small group of donors and therefore vulnerable to the donors’ financial situation. As one board member of a mid-sized urban free clinic explains, “We need an assurance of a steady yearly income source over time, but we have no real strategy for

achieving it.” In response to these concerns, some free clinics emphasize fundraising experience as a criterion for hiring a new executive director.

Expansion. A number of the organizations are actively considering expansion plans as a response to increasing community demand. Strategies related to expansion include expanding clinic space, recruiting paying and insured patients, and an orientation toward long-term strategies. For free clinics, our interviews suggest that expansion is a luxury limited to more affluent areas. As a result of access to federal funds, FQHCs are in a stronger position to consider expansion, even though they operate in less affluent areas. Yet one respondent captured the paradox of needing to expand to meet increased demand at a time when many clinics are already spread thin

Expanding Clinics. All of the family planning organizations are expanding their clinics to neighboring communities where they believe demand exists for their services. Two of the FQHCs, one rural and one urban, are also actively engaged in expansion to new communities. In addition, the urban FQHC has purchased property to expand its current clinic “to respond to greater need and to provide new services.” As many of the health departments are moving away from direct provision of clinical services, none of them plans on expanding clinics.

Two of the free clinics oppose expansion (in one case, adamantly so). One organization wants to limit the number of patients it will see, and the other cites its inability to meet the demands of the existing patient population.⁵⁹ At the same time, two free clinics in the most affluent communities are actively seeking to expand. A third free clinic put its expansion plans on hold because of reductions in donations, citing the “tension between reality and dreams.”⁶⁰

Recruit Paying/Insured Patients. Except for the free clinics, recruiting a higher percentage of paying clients is an important strategic adaptation in our sample organizations. None of the free clinics, whose mission is to serve the uninsured, would tolerate or desire the bureaucracy necessary to recruit patients with insurance coverage.

All family planning organizations intend to target paying populations to address their financial challenges by marketing themselves as a niche provider of quality services. Populations of interest include college students, males, older women in need of menopausal services, and the gay and lesbian community. With the exception of one clinic that is unable to meet the medical needs of its current patients, FQHCs also plan to market to paying and insured populations. One rural FQHC, for example, is trying to convince insured retirees new to the area to use their physicians instead of returning to their pre-retirement communities for medical care. A common struggle among all FQHCs is the issue of overcoming their reputation of poor quality care in the community among the middle class.

In contrast, none of the health departments or free clinics is attempting to recruit paying patients. Although health departments would certainly not turn away payment for traditional public health services, such as immunizations, their shift away from direct service provision would preclude them from recruiting insured patients.

Focus on Long-Term Problems. Our interviews reveal a split between long-term and short-term strategic responses. By short-term, we mean that clinics focus on day-to-day survival. Organizations that consider or actively pursue expansion of sites and services are oriented toward the long-term.

All study family planning organizations and FQHCs report being involved in strategic planning focusing on long-term goals. The free clinics in more affluent areas with stable donor bases are able to plan for the future; free clinics in poor communities, as well as a faith-based clinic dependent upon one major donor, focus more on the short-term. The executive director of an urban free clinic remarks that the clinic has no strategic plan other than “getting through the week, keeping the doors open, and keeping patients alive.” With the exception of one rural health department involved in administrative mergers and a mid-sized urban department focused on immediate cutbacks, most health departments are also involved in long-term planning.

Retrenchment. In contrast to strategic expansion, a number of organizations are responding to the threats to their survival through retrenchment. Many safety net organizations are making decisions to limit and/or turn away patients, as well as to implement cuts in services. Several organizations are also considering imposing some level of cost-sharing such as co-pays. It should be noted that while many organizations emphasize either expansion or retrenchment, the two strategies are not mutually exclusive.

Limit/Turn Away Patients. Two of the free clinics, both in poor areas, actively turn away patients as a solution to their capacity problems. As the executive director of one urban clinic where they are no longer taking any new patients elaborates, “even if they are crying, we won’t let them in.” Half of the FQHCs, two rural and one urban, also resort to turning away patients or making patients wait several months for an appointment. Only one sample family planning organization is currently turning away patients, though all family planning organizations are considering plans to divert uncompensated care to local health departments if needed. None of the health departments is actively turning away patients, but some effectively do so through long wait times for appointments and clinic closures.

Cut Services. Most health departments are focusing on moving away from direct primary care services to concentrate their efforts on providing “population-based core public health” functions (i.e., assurances, surveillance, and policy development) and have chosen to cut services, especially when other local providers are available. As the chief health officer of one urban health department expresses, “It’s a dead end for health departments to provide medical care. We should not be competing with the private sector

for primary care.” The chief health officer of another mid-sized urban health department agrees, explaining that in response to a significant budget deficit “the question is how deeply services will be cut, not what the options are.”⁶¹ Only the health departments from the two poorest communities in the sample, one urban and one rural, plan no service cuts, at least in part because there are no private sector alternatives for primary care services. One FQHC also planned to cut services.

Two of the free clinics have explicitly cut back on services, either by posting signs indicating that no new patients will be accepted or by cutting back on clinic hours. It is important to note, however, that even free clinics in affluent areas that are considering expansion have been forced to impose restrictions on available services because of capacity constraints. As a result, they have resorted to long queues for services. For instance, one clinic actively seeking to expand has a long waiting list to provide routine physical examinations. In effect, this is tantamount to a service reduction even if services are not technically being cut.

Operating Strategies. Many health care safety net organizations are making changes to or enhancing their operating strategies in response to the threats and challenges. Operational strategies include strategic planning, model change, adoption of a business model or more business-like practices, and increased data collection.

Strategic Planning. Our interviews indicate that all of the family planning organizations, along with the majority of health departments, free clinics, and FQHCs are engaging in a regular strategic planning process. The two free clinics in less affluent areas are not conducting any strategic planning. Several other organizations are discussing the need for a strategic plan, but have not yet begun the process.

In addition to the interview responses, we requested that each organization provide us with a copy of their most recent strategic plans. Altogether we were able to acquire strategic plans for four county health departments, three FQHCs, and two free clinics. Unfortunately many of the organizations in our study have not yet completed their strategic plans, and others (specifically family planning centers) prefer to keep them confidential. The common themes in the written strategic plans were the development of collaborative partnerships, funding initiatives, needs assessment efforts, and organizational performance. Where appropriate, we have incorporated the findings from our review of the written strategic plans.

Change in Health Care Delivery Model. Except for the FQHCs in our sample, most organizations are either considering or are in the process of changing the organization’s approach to providing care to patients. In particular, administrators at the free clinics are re-examining which health care delivery model to follow given the challenges presented. Our interviews reveal no consensus over the best strategy between a primary care model relative to a gatekeeper (or referral) approach. About the only consensus is that many respondents admire the integrated primary care model FQHCs use.

Free clinic respondents note concerns about their inability to provide or monitor continuity of care as driving reconsideration of the best care delivery approach. Indeed, one clinic is shifting from a primary care strategy to a gatekeeper model, while another is going in the opposite direction “because primary care services were not available to meet the need.” And a third clinic has shifted away from a nurse practitioner primary care model to a multi-disciplinary urgent care clinic because a “primary care model is inappropriate for a volunteer-based clinic where no continuity of care is possible.”

All of the family planning organizations are engaged in changing their health care delivery strategy. Even as other organizations are cutting back on services, family planning organizations operate under a strategy to expand certain services for their paying customers and when necessary, increase fees, and limit uncompensated care.

Most health departments are also involved in shifting their organizational model from a direct provider of clinical services to a focus on core public health services. Health departments that deviate from this trend are located in rural and poor urban and mid-sized urban communities where there are few alternatives with the capacity to care for the uninsured. In contrast, none of the FQHCs is involved in model change.⁶²

Business Strategies. One of the consistent refrains in our interviews is whether to adopt business strategies in managing the day-to-day clinic operations. Beyond recognizing the need to operate more efficiently, the interviews display no consistent response as to the appropriateness of adopting a more business-like approach to service delivery. Several respondents are very clear that they attempt to operate as a business, but some are adamantly opposed. Consistent with our interview results, our analysis of the written strategic plans reflects that ambivalence. For instance, one of the free clinics has adopted an explicit business approach in its strategic plan, while another ignores the issue altogether. Three out of the four health departments in our sample have identified improved performance through better “business practices,” staff development, and the maintenance of an effective organizational structure as one of their principal goals. The FQHCs’ strategic plans also identify an explicit business approach as a primary strategic goal.

All family planning organizations, as well as a number of FQHCs, and free clinics operate under an explicit business approach or are discussing the need to operate in a more business-like way. The executive director of a mid-sized urban free clinic explains that “A clinic needs a leader who understands business—it’s a business requiring organization, planning and control.” Outside of rural areas, FQHCs also frame their organization as a business. A board member at a mid-sized urban FQHC disagrees with the belief among colleagues that organizations serving the uninsured should not function as a business by stating that they “need to look at the clinic as a business, not a political cause.” The chief health officer of one urban health department was hired specifically to implement explicit business practices, such as limiting direct service delivery to those programs that can be

justified on a cost-effectiveness basis, a process that the respondent describes as “a cultural shift from counting widgets to measuring outcomes.”

Even if respondents do not specifically invoke a business model, most organizations recognize the need to improve efficiency, quality of care, and responsiveness to patients. For example, a number of the organizations cross-train their staff to perform multiple administrative or clinical tasks as a strategy to overcome financial and staffing challenges. Most of the health department respondents are reexamining all programs based on cost-effectiveness and efficiency analyses (though available data are limited).

Family planning organizations and FQHCs also view maintaining a loyal customer base as a central component of their survival strategies. Indeed, many of our respondents mention concerns about patient satisfaction. Except for free clinics, the organizational types in our sample are highly dependent upon word-of-mouth and clients who return for services on a regular basis. Therefore, family planning organizations regularly administer customer satisfaction surveys and make decisions based on client feedback. The clinical director of a family planning organization explains that “You can get all the new patients in the world but if they don’t come back... that’s what counts... if the patient returns.” The majority of FQHCs also rely on customer service, with a number of agencies planning to improve amenities by increasing physical capacity.

Data Collection. The concept of what is involved in data collection, analysis, and its potential value varies widely by organization. But a common finding across our sample organizations is the lack of technological capacity to collect and analyze data.

All of the family planning organizations rely on data collection, including patient satisfaction surveys and evaluation of service quality, to identify options for the future. Yet only a handful of other organizational types emphasize data collection as part of their strategic plan. For instance, very few organizations conduct needs assessments or program evaluations. As part of its mission transformation, an urban health department plans to develop a data warehouse to measure program outcomes over time.⁶³ A mid-sized urban free clinic also collects a great deal of data, but has limited capacity for analysis. According to the executive director, funders are more interested in numbers than the analytic component, making it difficult to utilize the data to dispel myths about the uninsured. More importantly, respondents in free clinics differ widely as to the need, resources, and ability to collect and analyze data given limited staff capabilities and time.

Data collection among FQHCs is generally limited to minimal program evaluation and benchmarking against other FQHCs as required by federal regulations. Nevertheless, one urban FQHC collaborates with academic researchers to collect data to improve the planning process as well as its funding opportunities.

Partnerships. A key aspect of our sample organizations’ strategic response is to initiate or strengthen collaborative relationships and partnerships with private sector

entities. These partnerships include collaborations with other service providers in the community, participation in indigent drug programs, and utilization of volunteers. Our analysis of the written strategic plans confirms the importance organizations place on establishing partnerships.

Collaboration. With the exception of one urban free clinic and one rural FQHC, all of the organizations have active collaborations or plan to increase collaborations with other service providers, especially hospitals, in the community as a survival strategy. A rural FQHC eschew partnerships because of a desire to remain independent and negative experiences working with local hospitals. An urban free clinic refuses to pursue cooperative arrangements in order to maintain the core mission to provide primary care for a limited group of sick clients.

Free clinics depend on their collaborations with community providers to establish continuity of care and fill gaps in service, although they are often viewed as competitors. Health departments contract out services to local providers and participate in community-wide coalitions to address health issues ranging from improving access for the uninsured to addressing health disparities. Two of the poorest health departments in the sample also collaborate with academics.

Family planning organizations emphasize collaboration as an important piece of their overall strategy, including contracts with local health departments and participation in community-wide efforts to address issues such as teen pregnancy. The family planning organizations utilize these relationships to address community health problems and to bolster their own reputation in the community. Many family planning respondents comment on the value of these alliances in their political struggles.

Despite the emphasis on partnerships, our results indicate considerable dissatisfaction with existing arrangements. In several instances, the partnership runs in only one direction—in favor of the hospital.⁶⁴ All free clinic respondents complained that specialty referrals to hospitals are negligible and hospitals are simply sending uninsured patients back to the clinics. Clinic administrators (and two FQHC administrators) also argue that hospitals view them more as competitors for revenue than as collaborators. A medical director forthrightly states that hospitals have not been supportive and “fear that the poor will expect the services or feel it’s an entitlement.” In one partnership, the hospital has consistently delayed the clinic’s expansion plans.

To be sure, there are several examples of successful partnerships. For instance, one urban free clinic emphasizes that its partnerships with community organizations encourage a strong sense of community ownership. Several respondents also speak favorably about establishing alliances with other clinics (though few have done so). In fact, two FQHCs are exploring the possibility of contracting with hospitals to provide care for the uninsured and underinsured populations.

Indigent Drug Programs. The most consistently successful collaborative strategy is the pharmaceutical industry's indigent drug program. Given the rising costs of and increased demand for prescription drugs, participation in various indigent drug programs is a crucial collaboration utilized by free clinics, family planning organizations, and FQHCs. Without it, clinics could not afford to provide more than minimal pharmaceutical assistance. Family planning organizations are able to provide prescription contraception at a discount because of bulk purchasing contracts with pharmaceutical manufacturers. The demand for low- to no-cost prescription drugs has caused some free clinics to hold clinic days specifically devoted to prescription renewals. Because of the time-consuming nature of filling out paperwork for clients with low literacy skills, one rural FQHC allocates a staff member specifically to the indigent drug program.⁶⁵

Volunteers. With the exception of one rural health department, only the free clinics are heavily dependent on volunteers to maintain service levels. With physicians' schedules tightening and a shortage of nurses and pharmacists, some free clinics face serious challenges to find a sufficient pool of volunteers to meet client needs. One mid-sized urban clinic that has been particularly successful at recruiting volunteers achieves stability through a conscientious building of relationships including annual dinners and parties to recognize volunteers' contributions. Free clinics have also established relationships with teaching hospitals and universities to take advantage of residents and nursing students and often operate in the evening hours to better accommodate volunteer schedules. Clinics in less affluent urban areas report that their volunteer pool remains stable, but it is not expanding and they express concern about meeting future needs.

Organizational Issues

The range of strategic adaptations and choices just discussed takes place within an organizational context motivating these decisions. Our analysis of the interview results indicates that our sample organizations face five themes related to internal organizational issues: mission, leadership, conflict, staffing, and quality of care. Written strategic plans also confirm the interview results, especially concerns about internal operations, including clarification of lines of responsibility, training and satisfaction of employees, and improvement of communication at all levels of the organization.

Mission. We define organizations as mission transforming if they engage in a fundamental change, particularly if that change is oriented toward expansion. Mission transformation is often part of a deliberate organizational process to incorporate specific strategies to counter new threats and challenges. Because a number of organizations are reluctant to recognize certain activities which are tantamount practice to mission transformation, we have added a new category—what we now call consequent mission change.

Deliberate Mission Change. Although it is difficult to establish a pattern by organizational type, a number of agencies are undergoing a deliberate change in mission.

Health departments are most explicit in their desire to change, shifting their mission from direct service provision to a more limited focus on core public health services (defined as surveillance, policy development, and assurances). The chief health officer of one urban health department no longer defines the organization as a safety net provider and plans to only offer services where it is most cost-effective for the government. Another urban health department would prefer to shift its mission completely to core services, but an underlying philosophy of social justice prevents it from eliminating primary care services when few alternatives exist in the private sector.

In contrast to most health departments, some free clinics are changing their mission to better reflect the greater range of services necessary to meet the complex medical and non-medical needs of their patients. For example, one mid-sized urban clinic plans to expand its mission to include a greater capacity for outreach and advocacy. Another urban free clinic is increasing its provision of primary care to address the deficit of primary care providers willing to serve the uninsured. Two FQHCs serving poor communities are also shifting their mission to expand physical capacity to improve their reputations and serve a broader community. Family planning organizations are consistently broadening their mission to provide quality services to a wider range of patients, in particular those who are able to pay for services.

Consequent Mission Change. Although certain organizations may not define themselves as mission transforming, the pressures and challenges facing all safety net providers force a number of organizations to make changes that for practical purposes fall under our definition of mission change. All of the family planning organizations, as well as a handful of health departments and FQHCs, have been forced to increase fees and limit services, challenging their underlying mission to serve the uninsured. As the CEO of one rural FQHC explains, “[While there is] not a formal change in mission, [we are] now saying, for the first time, that the clinic can’t serve all the uninsured who come through the door.”

Most of our free clinic respondents are struggling with how to define their mission. At this point, it is premature to conclude that many of the free clinics’ actions amount to consequent mission change. At a minimum, most of the clinics are reconsidering the nature of their mission. Unlike health departments, FQHCs, and family planning organizations, which view themselves as permanent entities in the health care landscape, most free clinics were founded as a temporary solution to serving the uninsured and underinsured. Free clinics are shifting their perspective and have concluded that they will not be able to work themselves out of business through the creation of universal health care. Instead, many free clinics are establishing themselves as an integral part of the health care safety net for an indefinite period of time.

This recognition that they are emerging as a permanent part of the institutional structure providing care to uninsured and underinsured populations is driving respondents to reconsider the nature of the clinics’ mission. As a tentative finding, the fundamental mission of providing care to the uninsured remains intact. What appears to be under

discussion is whether to expand capacity to meet the burgeoning demand or whether to focus more narrowly on just serving a smaller number of patients. As noted earlier, decisions regarding which services to offer are part of this discussion.

Leadership. The leadership of an organization is not only critical in influencing the level and types of strategies employed to address threats and challenges, but is often paramount in determining an organization's overall success. Two themes related to leadership, the activity level of governing boards and leadership turnover, dominate our interviews.

Active Board. Aside from family planning organizations, which consistently reported active boards of directors committed to their mission, few sample organizations benefit from the support of an active board. Weak boards are a challenge to a number of organizations, especially the FQHCs. Our respondents characterize weak boards as disinterested or unable to advocate for the organization. In fact, only the family planning organizations and one free clinic emphasize the board's value in helping their organizations gain a stronger presence in the community through outreach and fundraising efforts.

According to the executive director of one mid-sized urban free clinic, "[T]he most effective free clinics have strong leadership from the board and staff." In addition to their commitment to the mission, active or strong boards are often praised for their involvement within the community in strategic planning, fundraising, and advocacy efforts.

Leadership Turnover. Many respondents express the need for stable leadership. Change in leadership at the administrative level is a common theme among half of the health departments and a minority of free clinics and FQHCs. In the case of the two free clinics with recent changes in leadership, the reasons for leadership turnover range from the director's inability to develop cost-efficient strategies in a mid-sized urban clinic to lack of leadership and "sensitivity to the community and community needs" in an urban facility. In one urban health department, leadership change was clearly initiated by the county board of directors, who brought in a new chief health officer to change the department's mission.

Explanations for turnover at two mid-sized urban FQHCs are unclear, however. One board member suggested that "The clinic [requires] a unique set of skills to handle this population and work in an environment that is different from the industry standard," demanding both professional competence and human sensitivity. Finding leaders willing to take on such demanding work remains a challenge, particularly in less affluent areas. None of the participating family planning organizations have experienced recent turnover in leadership, although one organization declined to participate because it is undergoing leadership change.

Conflict. Conflict often serves as a barrier to implementing desired change. Two categories emerge as the main sources of organizational conflict: internal conflict between administrators and staff and conflict between the executive director and governing board.

Internal Conflict. The majority of health departments, FQHCs, and family planning organizations struggle with a degree of internal conflict. Most internal conflict centers on staff resistance to change, particularly where organizations are moving to cut services. Direct service staff, who are often responsible for implementing changes such as fee increases and limitations on services, are concerned about compromising their mission to provide services to the underserved. As the chief financial officer of an urban FQHC describes it, “Staff likes things the way they’ve always been. They are advocates for the clients, not for the future.” Staff at some FQHCs also express frustration with the requirement to hire from within the community. Health departments and a mental health center that have undergone significant mission change report a gradual weeding out process, where staff that are unwilling to work within the new system chose early retirement or quit. Free clinics, which have few full-time staff, do not face significant problems with internal conflict.

Executive Director/Board Conflict. As noted above, many respondents note the absence of active board support. A related finding is that several organizations experience considerable conflict between the board and clinic administrators which impedes the organization’s ability to agree on appropriate strategic adaptations.

FQHCs express the greatest concern over conflict between the executive directors and governing boards. Aside from two rural organizations, administrators from all FQHCs struggle in their dealings with boards that are required to include significant representation from the communities they serve. In one mid-sized urban community, the board members who represent the community resist cutting services over fear of losing minority staff. One board member explains that the executive director wants “to grow the business, but the board wants to be a custodian of the budget for the community.”

Two of the health departments report conflict between the executive director and board. According to the administrators, the conflict is largely driven by lack of clarity and emphasizing dollars over programs. One faith-based urban free clinic has also experienced conflict between the board and executive director concerning a mission change that focuses more on clinical services than on the founders’ emphasis on “doing it for the love of Jesus.” None of the family planning organizations report conflict between the organizations’ executive directors and the governing boards.

Staffing. Challenges related to staffing significantly affect many organizations’ ability to implement strategies and provide consistent high-quality care. Specifically, agencies often struggle to recruit qualified staff and limit staff turnover.

Recruiting qualified staff and preventing turnover is a significant concern for both urban and rural health departments, as well as all FQHCs. Most organizations are able to find qualified physicians. But the relatively low pay scale makes it particularly difficult to recruit and retain staff in short supply nationally, such as nurses and pharmacists. One mid-sized urban FQHC adds that it is difficult to retain staff because of the complex set of skills required to work in their environment. Staff are expected to exhibit compassion and ability to work with the uninsured, as well as the capacity to collaborate with volunteers. Staff recruitment and turnover are less of a concern for free clinics and family planning organizations, where high staff morale appears to be the norm. Nonetheless, free clinics (especially in less affluent areas) struggle to find adequate numbers of qualified volunteers.

Quality of Care. The majority of FQHCs and family planning organizations emphasize quality of care as a central part of their mission and strategy. Many FQHCs include quality in their missions as a means of combating stereotypes in the community that FQHCs provide poor quality of care. Family planning organizations rely on their ability to provide high quality niche care at a lower price than their competitors to maintain a loyal client base.

One unexpected finding is the difference in perceptions of the level of quality within the organization. Board members and staff almost universally describe the care provided in terms of its high quality. In contrast, some executive directors and a number of medical directors raise concerns over the abilities of both the clinical and program staff to provide quality services. Executive directors and medical directors of FQHCs and health departments more commonly express concerns about the quality of clinical care provided by staff than their counterparts at free clinics and family planning organizations. The latter argue forcefully that their organizations provide high quality clinical services.

FQHC respondents mention scheduling and patient flow issues as ongoing quality of care concerns. At free clinics, continuity of care is an ongoing concern. Both organizational types are concerned about low productivity and patient “no-show” rates.

CHAPTER 3: POLICY CONSIDERATIONS

In this chapter, we will place our findings in the broader policy context. We will first discuss the overall trends the results suggest, and then consider specific aspects of the results. Next we will discuss our policy recommendations. Finally, we will suggest future research directions.

One overriding conclusion dominates our analysis: unmet need continues to rise—expanding faster than organizational capacity to meet it. Even the successful organizations in our sample are unable to keep up with rising demand. Though no one statement can capture the range of insights and feelings expressed during our interviews, the following comes close: “We’re not the answer. We can’t do everything. I’ve had to come to peace with doing what we do well for those lucky enough to get in.”

Overview of the Trends

Recent studies show that the health care safety net has survived, if in somewhat more perilous shape than advocates would prefer. Our analysis confirms that the safety net has survived in Michigan, but with a different spin. For one thing, we think those studies are a bit too celebratory. The studies reflect the economic boom of the mid- to late-1990s, and do not adequately reflect on the problems safety net organizations will confront as a result of the stagnant economy of the 2000s. Thus, the recent literature misses the coupled phenomena of higher demand, as the uninsured population rises, and reduced resources, as cash-strapped states reduce their investment in social services. For another, we have no way of knowing whether the safety net will survive in its present form, especially since resources in the private sector cannot compensate for reductions in public funding.

Perhaps more importantly, the literature misses certain structural shifts in providing safety net services, further suggesting that the survival hosannas are premature. Our results indicate two fundamental structural changes in how health care safety net services are organized and delivered. The first shift is that local health departments (LHDs) are moving away from providing direct services of last resort, such as family planning and primary care for uninsured and underinsured populations. Instead, LHDs are placing more emphasis on core public health services. For those who previously received health care at LHDs, the biggest change will be that LHDs will seek to assure that alternative primary care services will be available. Many questions remain as to how LHDs will react if alternative service providers are not available. Our interviews suggest that some LHDs (particularly those in less affluent or rural areas) will remain as primary care providers, while others (especially in affluent communities) will not.

As a long-term strategy, leaving primary care to the private sector makes considerable sense, since LHDs will continue to find their resources strained. But in the short-term, capacity limits in alternative sources may make it difficult for the uninsured

and underinsured to obtain primary care or family planning services. Focusing on assurances is an appropriate strategy so long as there are services to assure. That will not be the case in all areas. Indeed, our results show that in less affluent locations this assumption is not warranted.

The second structural shift is in health care safety net organizations themselves. Initially, these organizations viewed themselves as a temporary solution to a short-term problem. They perceive themselves as filling a niche in the social safety net, often serving a church-related or faith-based mission, until a more stable governmental system emerges. Many of our free-clinic respondents say that their goal is to go out of business. A medical director captures this sentiment, saying “We want to go out of business. This is not the way to do business.” As one clinic director puts it, “Free clinics as gap filling is not the answer for the uninsured.” More graphically, a clinic medical director said that “Free clinics are a band-aid on an intolerable system.”

What has happened is markedly different from these expectations. Our study suggests that health care safety net organizations, especially free clinics, are now a permanent part of the safety net’s institutional structure. Far from going out of business, these organizations are confronted with vastly more complex choices. Should they transform their mission statements into becoming more aggressive organizations, seeking grant funds to expand capacity? Or, should they pursue their original vision even if it means turning away patients in need? How can they reconcile their original mission and vision with the realities they now face?

Another set of questions deals with the implications of mission and vision transformations. Many of our respondents indicate the need to operate as a business to survive, with greater attention to efficiency. Should health care safety net organizations begin to perceive themselves as small businesses, making decisions about expanding capacity for serving new markets? If they are small businesses, how will they generate the capital needed to meet the increased demand? What skills and technologies will they need for moving beyond their narrower mission? And what kinds of organizational alliances will be needed? Inevitably, one set of alliances will be with other private sector providers. Another set of alliances will be to form statewide and regional free clinics trade associations.

As both a conceptual and a practical matter, operating as small businesses rather than as charitable organizations raises vastly different issues for safety net organizations. While the small business approach may not be incompatible with the narrower charitable mission, it certainly forces more complex operational considerations and tradeoffs. Nevertheless, many of our respondents (such as a family planning organization’s marketing director) accept the need to become “more like a business...including compromising the mission in order to survive.”⁶⁶ A free clinic financial officer ascribes the clinic’s success to adopting private sector practices. “It’s like running a business—product development, staff, tax. Know your community and your business.” More

pointedly, an FQHC board member notes that we “need to look at the clinic as a business, not as a political cause.”⁶⁷

Several policy implications emerge from these trends. One is the shift from public to private in providing safety net services, parallel to what has occurred recently in other sectors of the economy. In this case, however, what is lost is a visible public commitment to the uninsured, along with a sense of shared values for taking care of society’s most vulnerable citizens. By shifting the burden of what was once a public obligation to provide care of last resort to free clinics and other private sector providers, existing economic disparities are likely to be exacerbated. In affluent communities, free clinics may be able to generate private money and volunteers to meet the increased demand. But in less affluent areas, the loss of public involvement will most likely lead to a serious decline in access for the uninsured and underinsured populations. At least in the short-term, state funding will not be available in amounts nearly sufficient to meet the growing demand. Thus, the ability to rely on community support and resources will be crucial for long-term survival and success. In more affluent communities, our results indicate that the private sector has contributed to clinics’ success. Outside of the more affluent areas, it seems highly improbable that the private sector can replace governmental support.

There are two other trends that warrant mentioning, even if their implications are not yet clear. One is a general tendency for hospitals to avoid providing care to the uninsured and underinsured populations. Although this plays a prominent role in our interviews, because the study does not include hospital administrators, we are unable to comment on how extensive the phenomenon really is.

A second trend is that there is a new cadre of uninsured in Michigan—primarily those who were formerly employed (often in the auto industry) and who have little experience with the health care safety net. Aside from adding to the clinics’ burden, our respondents are split as to whether this population will present with different problems than clinics currently see. Some respondents conclude that their patients’ health conditions are stable over time, but a greater number of respondents observe higher rates of depression, hypertension, and obesity as complicating primary care delivery. Representing the latter view, the chief health officer of a health department states that “The uninsured are more disenfranchised than previously. They are on the wrong side of the law (i.e., drug use and domestic violence), have mental health/substance use problems, have a poor (or no) family structure, and have no parenting skills. They are less capable—not just poor—with no basic skills.” Higher unemployment rates will only exacerbate any problems.

Overall, these trends have important implications for access to health care for uninsured and underinsured populations. The combined trends clearly demonstrate that the need will not be met any time soon; the uninsured who go without access will far outnumber those who are lucky enough to be served. And recent changes to the Title X allocation in Michigan may significantly decrease access to family planning services for low income women, particularly the uninsured and underinsured.

Discussion of the Results

Hypotheses. As noted in Chapter 1, we set forth several hypotheses at the beginning of this study. While our results suggest considerable variation in how health care safety net organizations are responding to the structural changes noted in the previous section, we are able to offer some conclusions about our hypotheses. Our interviews suggest that the dichotomy of mission transformation versus non-mission transformation masks an important intermediate category. During the analysis of our results, we identified the need to make a distinction between deliberate mission change and consequent mission change. The importance of this distinction is that some organizations are engaged in mission-transforming activities even if they are reluctant to acknowledge the nature of their activities, hence the category of consequent mission transformation.

Most of the organizations in our sample have developed or are in the process of developing new strategic plans that involve some reconsideration of the mission. Mission transforming organizations, usually clinics in more affluent areas and those with direct federal financial support, are expanding service delivery options and are more active in soliciting funding. In contrast, smaller organizations, especially those retaining a narrower mission of serving the poor or those in less affluent areas, have been forced to turn away new patients or reduce services. The level of available community resources, particularly physician volunteers and local funding, helps explain differences across organizations. What follows represents our conclusions based on the consequent-deliberate distinction.

First, organizations that are more dependent on federal funding have no less leeway than other organizations to adopt mission transforming strategies. Thus, we reject the hypothesis that federal funding would unduly constrain organizations. Our interviews with the FQHCs in our sample suggest that these organizations face some constraints (recalcitrant community boards, for example), but the respondents indicate that they have wide latitude to consider a range of strategic options. At least one of the FQHCs in our sample clearly fits within the consequent category.

Second, organizations with active governing boards indeed have more leeway to consider and adopt mission transforming strategies. Our hypothesis regarding the importance of an active board seems to be correct. Those organizations with boards actively engaged in fundraising and generating community-wide support are also organizations that are considering expanding and mission transforming strategies. Organizations with inactive boards or less aggressive boards, tend to be less adaptive, and subject to considerable internal conflict.

Third, our results tentatively suggest that organizations with highly specific missions are less adaptive or mission-transforming. Overall, mission-transforming organizations are better able to adapt to environmental changes. These conclusions are subject to a number of caveats. To some organizations, usually those in less affluent areas,

change is irrelevant. No matter what happens, they can only serve a limited number of clients. In addition, church-supported clinics vary somewhat, with some being very expansive and others being tied very closely to the church's mission. It is likely that faith-based clinics will validate the hypothesis, but we only have one in our sample. Furthermore, it seems clear that the family planning organizations we sampled have very specific missions, but considerable consequent mission change. The interactions that many family planning organizations have with national organizations may account for both the pressure to adhere to a single mission and the need for aggressive strategies (i.e., consequent change) to meet the mission.

Fourth, organizations with wider networks have more options and are more likely to adopt expansive or mission transforming strategies than those with fewer network opportunities. For instance, those clinics with access to more volunteers (especially in affluent areas) are able to consider expansion opportunities that are unavailable to clinics with fewer volunteers. But there is one important caveat to this conclusion. Clinics' relationships with hospital partners are quite complex. In some instances, extensive clinic-hospital networks have actually impeded expansion. Nonetheless, the organizations with more collaborations are considering or adopting a wider range of expansive options.

Fifth, our findings support the hypothesis that family planning organizations face a unique set of challenges and respond with a different set of strategies than our other organizations. Some of the differences in the strategies are striking. For instance, family planning organizations are far more concerned about the potential effects of state legislation regarding the allocation of Title X funds than other organizations providing family planning services. More importantly, at least within our family planning sample, the existence of a strong national federation influences its affiliates to respond similarly. In particular, having a national organization motivates affiliates to operate on a business/competitive model, and imposes clear benchmarking expectations on levels to achieve relative to other affiliates. (With regard to appreciation for national trends and benchmarking, these findings may also apply to FQHCs). Different funding sources, independence from government, stronger boards of directors, and a narrow mission may explain the differences.

Survival. By far, the most consistent interview responses concern the threats health care safety net organizations face in the current environment. As we will see below, there are differences about the implications of these threats, but there is little disagreement about what the threats are.

By definition, the organizations in our sample have survived. But as our findings demonstrate, continued survival is hardly assured. What emerges from the interviews is a distinction between threats to survival and barriers to success. The distinction is important because it determines an organization's strategic responses, particularly how it expresses and achieves its goals. For example, respondents at an FQHC suggest that after years of success, they are now much more concerned with survival (and do not much enjoy the

shift). To them, this meant “moving from what you want to do to what you need to do to survive. The environment is so hard now that we are purely reactive—surviving day-to-day.”

In general, the mission transforming organizations speak in terms of barriers to success, while the non-mission-transforming organizations talk largely about threats to survival. For those organizations in more affluent areas that are thinking about expanding, the concern is not whether they will survive. Rather, they are mainly dealing with impediments to expansion. According to the director of a mission transforming free clinic, “Our impact is limited and we are not meeting the community’s needs. We can survive, but that’s not the goal.”

In contrast, the other organizations are concerned that they might not survive at all. According to a free clinic board member, “We are always living on the edge—never sure about funding from year to year. The clinic will survive, but how well is unclear.” Under these circumstances, expanding to meet the growing need is all but impossible. All efforts are directed just to survive from day to day. In this sense, the free clinics and FQHCs in our sample present strikingly different attitudes. As noted earlier, many free clinic respondents acknowledge that they want to work themselves out of a job. By contrast, FQHCs start out with the expectation of being permanent. This is reflected in two ways: one is that FQHCs begin with a stable funding source (the federal government); the other is that FQHCs hire physicians, while free clinics usually rely on volunteers. As a consequence, FQHCs are able to focus on the long-term, but free clinics must focus on short-term survival.

The distinction between barriers to success and threats to survival raises a further question: what constitutes success? Is survival tantamount to success or are there other criteria for judging success? In the short-term, we consider survival to be tantamount to success. One clinic administrator said succinctly, “Survival as a well-supported business is the success and the story.” In the long-term, we believe that additional criteria should be considered. As future measures of success, we would include: plans for expansion; mission transformation; demonstrated progress toward meeting the community’s needs; demonstrated community support, especially funding; stable funding sources; stable availability of volunteers (for free clinics); and desirable clinic amenities (i.e., avoiding the stigma of caring for the poor).⁶⁸ In considering these criteria, we should note that there are very successful clinics in our sample that adhere closely to their mission and maintain a high level of services.

Internal organizational changes are another important component of success. For instance, leadership stability, active board member engagement, improved staff morale, efficiency, and quality of care are all important indicators of success. In our sample, the health departments are particularly concerned with internal organizational change. Because of the shift from direct services to more of a monitoring function, health departments face critical opposition internally to the mission change. In contrast,

respondents in free clinics note little opposition to mission change. Yet many respondents identify concerns about customer service, clinic amenities, quality of care, and reputation in the community. Each of these represents internal issues that will help define whether a clinic succeeds and survives.

Adaptive Strategies. Perhaps the best way to characterize the organizations' adaptive strategies is that they remain a work in progress. No clear consensus emerges, either within or across organizational types, as to the optimal strategies to pursue. Everyone seems to agree that they need to raise more funds, establish collaborations with other health care providers (usually local hospitals), and adapt to a new way of providing health care safety net services. But there is little agreement on which strategies to adopt, and virtually no evaluation of adaptive efforts to date. Depending largely on local community resources, the adaptive strategies veer between developing expansion plans to meet the added demand and retrenchment because of the inability to serve existing patients.

Organizations in poor urban and rural areas have far fewer options than organizations in more affluent communities. Consistently, the organizations capable of undertaking mission transforming strategies are either located in affluent areas or, in the case of FQHCs, are able to leverage their federal dollars. Because so much of an organization's adaptive capabilities are dependent on local community resources, clinics in less affluent areas are at a substantial disadvantage in competing for funds.

Aside from fundraising efforts, the adaptive strategy most consistently pursued is to establish collaborative efforts with local hospitals. This strategy is not surprising given the conventional wisdom about the efficacy of such collaborations and the extent to which public policy favors them. In fact, other researchers have found that similar collaborative efforts can be effective,⁶⁹ and our most of our respondents are hopeful that they can help the clinic. But our overall findings suggest serious limits to this strategy. Making collaborative arrangements work effectively, given the unequal power relationship, is far more difficult than conventional wisdom suggests.

Our interviews suggest that clinics (both free clinics and FQHCs) maintain a complex relationship with local hospitals. On many levels, they are both partners and competitors. Each seems to view the other's motives warily, and there is considerable strain in the relationship. Clinics feel that hospitals have not permitted sufficient specialty referral arrangements, but have willingly referred non-emergency patients back to the clinics. Since we did not interview hospitals, we cannot adequately assess the clinics' claims.

If accurate, though, the findings are troublesome and at odds with conventional wisdom and what other researchers have concluded. Public policy has encouraged public-private partnerships, but if the major private sector partner is not fully committed to the

arrangement, alternative strategies will need to be developed. In short, we do not view collaborations as a panacea and they may be very difficult to implement effectively.

Best Practices. We anticipated being able to identify a range of “best practices” that other clinics could adopt or adapt. Unfortunately, our interviews do not reveal many tangible best practices that have been evaluated. Nor do our interviews identify best practices that were common to a number of organizations. In many instances, respondents note particular program strategies, but we have not obtained corroborating evidence for why they constitute practices that could or should be replicated elsewhere. For example, one free clinic has a contract with patients for life-style changes, but there is no monitoring or follow-up to determine if the contract makes a difference. In most instances, the best practices identified are too amorphous to be useful (i.e., undefined quality of care or efficiency strategies).

That said, several free clinic respondents emphasize the importance of involving neighborhood associations, the community, and local businesses. While this may sound either trite or obvious, doing so is essential for survival. Free clinics will not survive if they lack community support. Outreach programs are also important for patient recruitment and community presence.

Two other specific practices seem promising. One is a prescription refill clinic for established patients. A related strategy is to separate new and returning patients. According to the clinics, these strategies allow for better patient flow and continuity of care (checking blood pressure, identifying referral needs, etc.).

We think there may be two explanations for the dearth of identified best practices. Given how busy our respondents are, it is not surprising that they have not had time to identify and examine specific practices that would qualify as models for others to use. Also, the interview question may not have been clear to the respondents. There may well be practices the clinics use everyday that might not occur to a respondent as being something that others should consider. In any event, it may be that the best mechanism for identifying best practices is to explore them at regional or national meetings, such as the Free Clinics of the Great Lakes Region.

Cyclical vs. New Era. One of the issues to emerge during our interviews is whether the current crisis is merely cyclical (that is, just part of another down cycle that will change once the economy improves), or part of a new era that will be less tolerant of or willing to support the uninsured and underinsured populations. Our interviews revealed no consensus on the issue. To us, the more persuasive argument is that we have entered into a new era that will dramatically change how to think about providing health care safety net services.

Those who maintain that this is merely cyclical, especially respondents in health departments, make two arguments. They note that there is nothing new about budget

shortcomings and service retrenchment. During the 1980s, for example, social services were under similar pressure. Each time, better economic conditions result in budgetary and service delivery increases. No matter how bleak it seems, the situation always improves. As an FQHC respondent observes, “Each time, we ask ‘how will we live through this,’ but we do.”

Yet almost simultaneously, that same respondent articulates the case for the new era by suggesting that it is now generally worse than other times because of the political climate—“the ugliness of this cycle and its viciousness.” Those respondents rejecting the cyclical theory do so for several reasons. One reason is that political support in the state and federal capitols is lacking. Another is that the public tolerates substandard, minimal care for the poor—the deserving vs. undeserving poor argument has resurfaced. “What is different now is the different philosophy at the governmental level. Compassion from the 1960s is lacking. Therefore, supporters are not as optimistic or as energized. A sense of helplessness and hopelessness pervades.” This was perhaps the most pessimistic assessment we heard, though others talk about a cultural and psychological shift in what the government should provide that compounds a general breakdown in the health care system. Several respondents mention that the gap is growing wider and that patients are increasingly unable to navigate the health care system. Not only are “the people left behind disabled and chronically unemployed,” there is greater desperation among patients than seen 5 years ago. Structural changes in the economy (i.e., the shift from a manufacturing-based economy to an information-based economy) will exacerbate the problems in many states but especially in Michigan.

The “new era” view is consistent with our assessment of the trends as articulated above. If this were just another down cycle, the structural changes taking place would not be occurring. As a result of what we view as fundamental changes in the environment, the new institutional structure emerging will need to account for the reality that the old order is not likely to return.⁷⁰ For free clinics, one of the main consequences is that the “free” aspect could be in jeopardy.

Differences Within and Across Organizational Types. Our results show considerable variation within and across organizational types. Free clinics show the most variation within the same organizational type. For free clinics, it seems fair to conclude that each organization operates within its own dynamic and set of constraints, even though each confronts the same threats and is considering a similar range of adaptive strategies. For the most part, there is only minor variation within the other organizational types (i.e., FQHCs, health departments, and family planning clinics).

One of the more interesting differences within organizations concerns quality of care. Except for family planning organizations, there is considerable disagreement about the quality of care being provided. Most of the time, the differences are between the clinic director and medical director, with the medical director considerably less enamored with the quality of care delivered than the clinic director. In two health departments and one

clinic, however, the positions are reversed. Otherwise, we detect no patterns based on a respondent's position within the organization.

Family planning organizations represent a clear exception to this finding. Respondents express confidence in the quality of care they are providing, and all participants discuss their methods of monitoring and improving quality of care at length.

Competition. The level of competition for patients across organizations and services is mixed. Both health departments' family planning services and private family planning organizations consistently mention competition for paying or insured patients. In several instances, the competition resulted in clinic closures. FQHCs depend largely on Medicaid reimbursement and many report at least some competition for their paying population. Family planning agencies use paying clients to subsidize un- and under-compensated care in the Title X program. For FQHCs, Medicaid reimbursement is crucial to their survival. The free clinics in our sample report that they face no competition for patients. A possible explanation for these differences is that health departments and free clinics generally do not see insured or paying patients, making competition irrelevant.

Most study organizations encounter considerable competition for funds. The competition comes from other clinics and health care providers, and from all other non-profit organizations. The competition for funds is less a factor in wealthier urban areas than anywhere else. In the other areas, donations and grants from local foundations or citizens may be sufficient to provide the current level of services but will not enable clinics to expand.

Differences Across and Within Communities. As discussed above, there are considerable differences across communities based on urban-rural and affluent-non-affluent dimensions. Although this study is not designed to assess community-wide responses, our results within each community were very consistent. That is, we do not observe much variation in responses about the local environment and possible adaptive options.

Policy Recommendations

Our respondents are not shy about recommending state and federal policy changes. Not surprisingly, most argue that the government should bear the responsibility for providing health care to the uninsured and underinsured populations. Consistent with statements that the clinics are short-term solutions pending universal health insurance, most respondents are adamant that the state has an obligation to provide adequate resources: "There is no more safety net if current providers fail." Beyond the general need for additional funding for the clinics or, better yet, a direct state or federal program, our respondents offered specific suggestions for the state to adopt.

Medicaid. Perhaps the most consistent policy recommendations involve Medicaid, specifically reimbursement policies and the adequacy of reimbursement rates.⁷¹ The most prevalent complaint is that enrollment with managed care providers is difficult for the uninsured and underinsured populations. Many are forced to enroll with a primary care provider which lacks facilities close to where the patients live. Clinics often provide primary care for Medicaid patients without being reimbursed by the Medicaid provider. Under Medicaid rules, the money for primary care follows enrollment, not treatment. As a result, the enrolling plan benefits from the Medicaid reimbursement without providing services to a subset of its enrolled population. Beyond that, many respondents complained about too many enrollment rules and barriers for patients to penetrate (especially the newly unemployed).

In short, the state needs to “make Medicaid products fit the people to be served.” That means addressing Medicaid’s lack of portability, which is a barrier for this population, and improving the enrollment system so that eligible clients are more easily enrolled. Clinics need to be able to bill for services provided even when the patient is enrolled in another plan.

Somewhat surprisingly, our interviews do not demonstrate consistent opposition to Medicaid managed care beyond the general concerns about Medicaid reimbursement policy. Many respondents indicate that Medicaid managed care had not affected their programs at all. Those organizations that encounter problems just serve the Medicaid-eligible patients without compensation. This means that scarce resources were being diverted away from the uninsured and underinsured populations. Even though most express no interest in partnering with Medicaid managed care firms, several respondents who would like to do so say that partnering is very difficult to arrange.

Indigent Drug Programs (IDPs). All of the respondents are grateful for the pharmaceutical industry’s indigent drug programs. But respondents raise several suggestions for improvement, such as reducing burdensome paperwork requirements and developing a standard application process using a web-based system. Respondents also suggest that the programs shift from a patient-to-patient basis (i.e., individual patient applications) to estimates of yearly use or a stock bottle replacement system.

Ideally, the state would contribute financially to expanding IDP programs. In view of current budget realities, a more realistic approach would be for the state to help negotiate with the pharmaceutical industry on drug prices and availability. The state should also consider whether local health departments could be an effective distribution point for a more expansive regional IDP program.

Mental Health Services. A consistent issue throughout our interviews is the increasing numbers of uninsured and underinsured patients presenting with mental health problems. Our respondents are virtually unanimous in saying that their organizations are not prepared to provide adequate services for this population. Except for the mental health

clinic in our sample, clinics lack the staff expertise to provide mental health services and lack the infrastructure to help families obtain appropriate services. Only the state or federal government can address these concerns.

School-Based Clinics. Several respondents suggest the need to open school-based clinics to provide education and prevention. Our respondents do not elaborate on this issue, but indicate that children experience difficulty obtaining physician examinations and are missing school because of a lack of health insurance. We think this is an issue worth exploring in greater detail. State officials should examine the feasibility of funding or otherwise supporting such clinics.

County Health Plans. At this point, it is difficult to determine whether county health plans will operate to alleviate the strain on free clinics. We have some reason to be skeptical, however. The county health plans do not appear to have the resources needed to reduce referrals to free clinics. In fact, our free clinic respondents maintain that these plans have not alleviated their burden so far. In one instance, the county health plan was scheduled to absorb 6000 patients, but stopped at 2000. The result is increased demand at the clinic. Nor, as pointed out in Chapter 1, are these plans structured to focus on the uninsured and underinsured populations. Since they are just now getting started, we must await program evaluations to determine the extent to which they actually alleviate the clinics' burden.

Implications for Access. Our study is not designed to measure access in a rigorous, quantitative manner. Nor can the study draw conclusions regarding access within a given community. All we can say with any degree of certainty is that the organizations in our sample consistently report being unable to meet the demand, and their assessment that this demand is not being met in any systematic way. Despite the existence of county health plans, it seems inescapable that large numbers of the uninsured and underinsured populations lack access to health care services. We can safely assume that many of the people whom our sample organizations turn away or are unable to serve do not find adequate alternatives. The fact that the health care safety net has survived is welcome news for those fortunate enough to be served. But our results should not be interpreted to mean that we are any closer to providing access for the bulk of the uninsured and underinsured populations. If anything, economic trends suggest that we will soon be farther away than ever before.

Summary—State Responsibility. Our respondents are united that the state cannot abjure its obligations to the uninsured and underinsured populations. The shift to free clinics to provide health care safety net services presents an unknown and uncertain future.

At a minimum, the state of Michigan must:

- Alter the Medicaid reimbursement formula as outlined above
- More aggressively solicit FQHC funding from the federal government

- Provide resources (such as technology for data collection and analysis, free transportation, and assistance in program evaluation) to assist free clinics
- Allow local health departments to allocate resources as needed rather than identifying specific programs to be cut
- Reaffirm its commitment to being an active participant in seeking solutions

Recommendations to Clinics

Organizational Structure. To the extent that clinics will be operating as small business, they will need to address several uncomfortable questions. Even if becoming more business-like would not result in a mission change, it would most likely alter how the organization operates. For instance, it will require paying more attention to capital needs to serve existing patients as well as expanding into new markets. There may also need to be a reexamination of the organizational structure, locations, staffing mix (including top leadership), and how the clinic operates.

Most significantly, a small business approach could alter some aspects of dealing with the community. Now, according to several respondents, clinics rely on volunteers to help maintain the premises (i.e., plumbers and electricians often donate their time). Not only does this save valuable resources, it also has the advantage of incorporating the community as “a co-producer of health care.” It is a more informal means of operating that sustains community involvement and a personal connection to the community at large that is especially attractive to a mission-oriented non-profit function. Above all, as one respondent noted, free clinics are about “leadership and inspiring members to maintain a mission.” Shifting to a small business model could undermine this relationship by emphasizing productivity over personal connections, bids over volunteers, and revenue over the mission. While it is not inevitable that a small business model would have these undesirable effects, it is understandable why not all respondents embrace it. A challenge for the future is to use business principles to assure survival without compromising the mission of serving the uninsured.

Regardless of whether clinics adopt a small business strategy, they face a particular challenge in deciding the provider model that best fits the clinics’ new role (i.e., a gatekeeper model, a primary care approach, or an urgent care strategy). Another challenge is how best to deal with community collaborators, especially hospitals.

Leadership. Our results clearly suggest that leadership is the most critical ingredient of clinic success. Although few of our respondents mention leadership directly as a key component of survival, leadership issues constitute an important subtext to many of the interviews. Those clinics with leadership turnover and conflict between the board and the executive director are not as successful as those with stable leadership. Also, those clinics where the board is not actively engaged in fundraising and generating community support tend to be less successful.

Our analysis suggests two concerns. One is that conflict between the board and the administrator is making it difficult to meet clinic objectives. The other is that successful clinics may be too dependent on one individual (often dynamic) leader. At this crucial stage, reliance on strong individual leadership is essential for survival. But for the long-term, clinics will need to ensure leadership succession and transition. Current clinic leaders should recognize the need to nurture and develop the next generation of leaders.⁷²

Expansion vs. Contraction. Even though our results suggest that mission transforming organizations are in a better position to survive, we recognize that not every organization is in a position to expand its scope of operations.⁷³ Some respondents make it clear that retaining a narrower mission is paramount, even if that means turning patients away. In less affluent communities, clinics lack the resources to engage in mission transforming activities. A further impediment is that mission transforming strategies require staff and board members capable of implementing the strategy. Many organizations lack that capacity.

One respondent (an avowed advocate of national health insurance) argues that opposition to expansion is also rooted in concepts of fairness and justice. “If we do a good job of treating the uninsured, does the state think the problem has been addressed? Do we get the state off the hook? That’s why one of my mantras is ‘[My] clinic is not the answer. The answer is universal coverage for a basic level of health care.’” Clinics, in this sense, are caught in an unenviable dilemma. Our results suggest that most respondents have resolved the dilemma in favor of providing as much care as possible.

Image, Reputation, and Amenities. Another subtext of our interviews is concern for how patients and the community perceive the clinic. Many respondents emphasize the need to change the mentality that the clinics are just for poor people. Implicit in these observations are two destructive notions—that the clinics are not good enough for those who have money and that this is all the poor deserve. Repeatedly, our respondents note the need to improve on customer service (i.e., lack of sensitivity to patients), the clinic’s physical surroundings, and their general reputation in the community. Despite noting their concern, respondents did not offer specific strategies they were considering to correct the problems.

Based on our results, clinics should invest in improving their image and reputation in the community. Given the pressure that clinic staff are under, we suggest that clinic boards take the lead in developing and implementing reputation-enhancing strategies. Involving board members is consistent with our finding that one aspect of a mission transforming organization is an active board of directors engaged in community outreach and fundraising activities.

Data Collection and Analysis. We believe that building and maintaining effective data collection and analysis capabilities is crucial for long-term survival and success. One clinic director, who was surprised by the absence of data when he was hired, said that he is

“not able to manage the organization” without it. Indeed, a free clinic board member concerned about limited data availability asks “How will we measure success?”

There is an interesting split in our interviews regarding the importance of data collection and analytic capabilities. Some place great emphasis on the need to develop and use these techniques, but others feel that there are more important priorities and that they lack the staff to input and analyze data. Only two organizations use data analysis as an adjunct to fund-raising or advocacy, though several others have included it as a goal for their strategic planning.

One possibility is for a larger organization, such as the Free Clinics of the Great Lakes Region, to work with the state and private funders to explore how clinics can introduce, maintain, and use data to their advantage. As resources tighten, it will be critical for clinics to make the most efficient use of technology and data analysis, especially if we are correct that these clinics will be providing most of the health care the uninsured receive.

In our view, developing better data capacity is a crucial challenge facing health care safety net providers. Few of our respondents are able to provide adequate encounter and trends data to indicate the magnitude of the problems they face and the extent to which they are able to serve the community. In fairness, health care safety net organizations lack the staffing, training, and technology needed for basic data collection and analysis. The state government needs to play a more active role in ensuring that these needs are met.

It seems to us that effective data analysis is especially important for ensuring that scarce resources are being efficiently utilized. Aside from getting a better handle on service delivery, effective data collection and analyses are essential for showing the community why additional resources are needed. To take just one example, several respondents complain about the inability to show that clinics actually save hospitals money. Data analysis could go a long way toward making that case, which could, in turn, facilitate better financial arrangements with local hospitals.

Future Research and Policy Questions

Research. We have identified a number of potential research questions to build on this study. If we are correct about the emerging trends, several research questions should be considered.

First, we suggest a project looking solely at how free clinics are organizing in response to the institutional changes we have identified. This might include examining regional and national data-sharing, what types of organizational changes are involved in operating as small businesses, and what kinds of additional support the clinics need. What does it mean to suggest that free clinics must think in terms of operating on a small business model? In retrospect, our mixed organizational sample strategy has considerable

advantages, but it limits the number of free clinics we could visit. A separate analysis of free clinics would be appropriate.

Second, a related issue is to examine the development of regional and national organizations of free clinics. For example, the emergence of the Free Clinics of the Great Lakes Region is an important aspect of how clinics adapt to becoming permanent health care safety net providers. What is the process by which isolated free clinics come together to share information and strategies? How important are regional organizations in providing the infrastructure needed to sustain free clinics as replacements for governmental services? What added value does a regional organization provide, and can underfinanced clinics offer the support needed to sustain the regional entity?

Third, two respondents suggest that clinics should become more than just a health center—more of a community center to address the population's needs (i.e., attach a senior center, housing/day care programs). Is this a feasible concept? How could it be put into place? What role should the state play in developing demonstration projects?

An important set of issues should examine the optimal mix between FQHCs and free clinics. Do FQHCs offer advantages that free clinics can never match? Is reliance on FQHCs an acceptable strategy for Michigan? Should the state support free clinics as a complement to FQHCs?

Another research question to address is whether clinics provide better quality of care than the local health departments or hospital emergency departments that are being replaced? A related issue is which model of providing care, the gatekeeper approach (where the clinic acts largely as a referral source), the primary care model (where the clinic provides as much direct primary care as possible), or the urgent care model (where the clinic focuses on resolving immediate acute care needs) is more effective for the uninsured and underinsured populations? This, of course, presumes the availability of primary care referral sources.

A further research question is to determine how patients view the health care safety net. There are at least two aspects to this question. The first is to conduct community-needs assessments and patient satisfaction surveys to assess whether clinics are meeting patients' perceived needs. The second is to conduct a longitudinal study of where uninsured patients get their care. In particular, what happens when there are no referrals for specialty care?

With regard to family planning services, a number of questions emerge. First, based on our respondents' experiences, Title X is difficult to manage, mainly because reimbursement is poor. Further, private organizations, a major provider of family planning services in Michigan, face constant political challenges. Are family planning organizations going to be less likely to apply for Title X funds as it becomes more and more costly? Will private organizations give up Title X to avoid state restrictions? And if so, how will that

affect access to family planning services for low-income women and adolescents. A possible beginning research strategy would be to examine service access and teen pregnancy rates in communities undergoing a loss of Title X services as compared to those communities with a stable Title X provider.

Finally, we think it would be worthwhile to consider a study that focuses on how communities respond to serve the uninsured. Based on our methodology, we could only offer limited assessment of the communities we selected. A study looking at two or three communities in Michigan could offer additional insights that could include a range of factors (such as the effect of county health plans) that we could not incorporate.

Policy. At first glance, it might seem that FQHCs would be the optimal policy solution. With the resources of the federal government giving them the ability to hire full-time staff and expand to meet capacity, FQHCs may well emerge over time as the dominant institutional provider of health care safety net services. In the meantime, our results indicate a more equivocal balance between investing in FQHCs or free clinics. Each has certain advantages and each inheres certain deficits.

Our results suggest that neither has an advantage in terms of community reputation, accessibility, ability to meet the demand, and survivability. Whether either offers better quality of care is not a question our study is designed to address. One potential advantage for FQHCs is that the federal government is increasing its investment in them. What we don't know at this point is how fast the federal commitment will expand, where and how the money will be allocated, and whether FQHCs will focus on the uninsured and underinsured populations, or will largely serve the Medicaid-eligible population. At the present time, therefore, we recommend that a mix of FQHCs and free clinics is an appropriate interim strategy until further research can identify which format presents the best long-term advantages.

Another contentious policy consideration is the role of faith-based organizations. In the shift to private sector responsibility for providing health care safety net services, what role should religious organizations play, especially if state or federal funding is involved? According to our results, religiously-based clinics will remain an integral part of the health care safety net for the foreseeable future. Making the case for governmental support, a board member observes: "Why are we in business? The government depends on faith-based organizations to do the government's work." The policy question, which is beyond the scope of this study to address, is whether the state or the federal government should facilitate that reality with direct financial support.

A third policy decision for the state is to assess whether it is appropriate for LHDs to abjure direct services. As a matter of state policy, what role should LHDs maintain in providing services of last resort? The arguments for retrenchment are compelling as long as services are available in the private sector. As one chief health officer put it, "It's a dead-end for health departments to provide medical care. We should not be competing

with the private sector for primary care....Holding onto the past won't work.” Philosophically, that is an entirely defensible position. But our study seriously questions the assumption that LHDs can utilize their assurance function to monitor the delivery of health care safety net services. To put the matter bluntly, there does not appear to be an adequate private sector response to meeting the demand. If so, what assurances can LHDs oversee?

A final policy challenge relates to Title X. We have celebrated the recent reduction of Michigan's teen pregnancy rates. But to maintain these successes, policymakers need to address the continued shrinkage of family planning funds and attempts to defund successful organizations on ideological grounds. Since current state funding does not cover the actual cost of care, the Title X program is increasingly difficult for organizations to manage. The present family planning safety net is responding to challenges in a way that may compromise access to care for some populations; many organizations are moving away from their Title X programs and new providers are not emerging. This study cannot assess the ultimate outcome of these changes. Policymakers should consider the Title X legislation's impact on the program's ultimate survival and, subsequently, on unintended pregnancy rates.

CONCLUSION

Health care safety net services in Michigan are under severe pressure. Short of national health insurance coverage, there are no magic policy responses to alleviate the pressure. Adaptive strategies will enable most to survive and attempt to fulfill their mission, but will not be sufficient to respond to increasing demands for services. Mission transforming organizations are in a better position to expand their reach, yet policymakers cannot rely on overburdened health care safety net organizations to meet the burgeoning needs of the uninsured population. Nor are public-private partnerships likely to be a panacea because available resources are limited and there is at least some competition between clinics and hospitals. New structures and strategies, such as regionalization, need to be considered, but increased federal funding may be the only viable option for substantially expanding organizational capacity.

* * *

Our report would not be complete without a word of thanks to the many people we interviewed. It is their insights that have helped shaped our analysis. Above all, we are impressed with their dedication and commitment to serving the uninsured. Without their financial and personal sacrifices, we shudder to think what would happen to the uninsured population in Michigan. As bleak as the current environment seems to many of us, it would be far worse without the people who are dedicating their professional lives to the challenge of helping the poor in an era that would just as soon forget about them. As one clinic director said, “[I]t's not just about the money—there's a whole culture/mission side to the clinic.” The men and women who work at the clinics have our deep admiration.

APPENDIX A

APPENDIX B

APPENDIX B: FAMILY PLANNING RESULTS

INTRODUCTION

Title X is the only federal funding program specifically aimed at contraceptive and family planning services and plays an important role in preventing unintended pregnancies. In addition to the threats discussed in Chapter 2, these providers face significant political opposition in Michigan specific to family planning providers, including recently passed legislation changing the allocation rules for Title X (PA 133). This legislation establishes priorities for allocating Title X funding to those organizations that do not engage either in any type of abortion services, including referral, or have a mission that considers abortion as part of reproductive health. In this Appendix, we discuss the findings from the analysis of a subgroup of Title X funding recipients, which includes health departments, FQHCs, and private family planning organizations.

At the onset of this study, we had several hypotheses specific to Title X organizations. Our main hypothesis was that these organizations face unique challenges, such as ideological opposition to the types of services they provide, and subsequently respond with a different set of strategies as compared to other safety net providers. We also predicted that within the group of Title X organizations, strategic responses would differ between organizational types. For instance, we hypothesized that the changes in allocation rules would be perceived as a greater threat by private family planning organizations than public health departments for two reasons. First, private organizations are more likely to be engaged in activities relating to abortion services and are also less likely to change their mission regarding a woman's right to choose. Second, we predicted that private organizations would be more likely to respond by expanding services, contracting with managed care and diversifying funding, than health departments because of regulatory restrictions health departments face. Finally, we expected that organizations with highly specific missions, such as a dedication to support a women's right to abortion services, would be less likely to employ mission transformation as a survival strategy.

The details of our methodology were discussed in Chapter 1. We asked each organization in our sample that received Title X funding additional questions regarding their family planning services, including the impact of PA 133 and any strategic response the organization is considering. We also questioned respondents about expected competition for funding as a result of the allocation changes. Otherwise, these organizations addressed the same interview protocol as the other participating organizations.

Participation

We invited thirteen organizations to participate in the study: seven health departments, five private organizations, and one community health center (FQHC). All but one private organization and one health department agreed to participate. An additional private organization initially agreed to participate, but withdrew before the site visit. As shown in Table 1, participating Title X clinics are located in geographically and economically diverse counties. These counties range from densely populated poor areas, to remote, poor counties, to mid-sized, wealthy communities, and represent a range of poverty rates, teen pregnancy rates, and other health indices.

In total, we conducted thirty-seven interviews at the ten sites. The participating organizations included three private clinics, six health department run clinics, and a single federally qualified health center (see Table 2). All participating organizations engage in direct service delivery, although two of the health departments no longer directly provide family planning services: HD5 contracts their family planning services to the local private organization and HD3 currently delivers family planning services, but plans to close the clinic shortly. Additionally, HD1 has an active Title X contract, but the clinic is located in another county. There are no other sources of publicly funded family planning services in this county. All participating clinics provide some primary care, but private Title X clinics limit their primary care services to reproductive health care, such as breast and cervical cancer screening. The FQHC provides the widest range of clinical services among Title X recipients in our sample. Only one of the private family planning centers is currently providing abortion services, and this service is entirely independent of their Title X program. All other participating organizations are located in counties with a dedicated abortion clinic except HD1 and HD2.

RESULTS

Threats and Challenges

Across organizational types, Title X organizations report a consistent set of threats and challenges to their survival (see Table 3). All participating organizations identify financial constraints as a major challenge, specifically the decline in family planning funds. As stated by a health department executive director: “The state has decreased their dollar allocation to family planning every year for the past three years and clearly it is not a priority for policymakers at the state level.” Facing stagnant or decreasing government funds, coupled with an increasing number of uninsured and underinsured patients, and the rising costs of providing family planning services, providers express concern regarding their ability to maintain service provision at the current level. “On an aggregate, safety net providers are being asked to do more and more—with, unfortunately, limited or reduced

resources” (CEO, Health Department). Other commonly reported challenges include: rising uninsurance rates, competition for family planning patients, and political challenges.

Although all organizational types report that declining funding and the absence of political support are threats to survival, private organizations are specifically under fire. Health department respondents acknowledge the controversial nature of family planning services, but they are not targeted as an organization. For instance, health departments believe that the current state and national administrations do not view *any* clinical services for the poor as a priority, including family planning services. Conversely, private family planning centers report being targeted because of their organizational mission and the types of services they provide. As one Executive Director of a health department put it: “There’s some folks who would be willing to provide money to the health department for family planning, but would not be willing to provide the same amount to [other organizations].” Further evidence of this sentiment is found in the multiple accounts of picketing at private family planning clinics.

Exactly how organizations are threatened by the Title X allocation changes differs notably between organizational types. Health departments and the FQHC are less concerned with the new legislation and expect its main impact to be on private organizations. In many instances, respondents at health departments and the FQHC are unaware or uncertain of the new legislation. Subsequently, these organizations have not specifically addressed the new Title X allocation in their planning process. However, neither health departments nor the FQHC in our sample regard this legislation as an opportunity for them to obtain more funding. This sentiment is best summarized by a CFO at a private organization: “[Some agencies] out there have just simply said we don’t want to mess with providing family planning, it’s not worth our time. As you know, we actually are paid significantly less per patient than it costs to serve them. So a lot of [organizations] just say no, we don’t even want to do that, so the thought of them necessarily wanting to do *more* of it—I don’t think that they do.” A health department executive director puts it simply: “It is not enough to cover the cost of our program at this point.”

Private organizations are more concerned about PA 133 than either health departments or the FQHC, but with less alarm than we expected. Though private organizations are specifically planning for the potential loss of Title X funds, they don’t anticipate that the new Title X allocation legislation will result in the organizations’ closure. As one CEO of a private organization stated, “We are not going away. We will become a service provider without county support.” While most private organizations report that the impact of PA 133 depends largely upon implementation, many feel confident that they will maintain funding in the next cycle.

An unanticipated finding was that private organizations report that losing Title X funds may actually be an *opportunity*. One executive director takes the following position: “I see that as an opportunity for us to really look at how we are doing business and look at building donor support, increasing the diversity in our revenue streams.” Similar

sentiments were repeated across all private organizations in our sample. The reasoning behind this is that the Title X program is impossible to manage financially, and places unwanted restrictions on these organizations, such as its sliding scale requirement. Without Title X, private organizations feel that they would have more freedom to “do business” the way they wanted, which would be more advantageous than struggling with Title X.

We also predicted that the emergence of new competitors for Title X funding would be an effect of the new allocation rules. Although many organizations are experiencing competition for family planning clients, they are not seeing evidence of increased competition for Title X funds. Instead, the prevailing theme is that Title X is burdensome, and few other organizations are capable or interested in taking over the program. Private organizations do not anticipate competition from health departments. In fact, health departments are closing their Title X clinics and either contracting out these services to private organizations or giving up the funding altogether. Our respondents do not view faith-based pregnancy centers as legitimate competitors for Title X funds. The dominant belief is that these centers are limited financially and cannot or will not provide the range of services required by Title X regulations. Ultimately, there is little expectation that new providers will emerge to take over Title X programs.¹

Organizational Response/Strategies

In contrast to the uniform group of challenges facing the family planning safety net, the responses to these challenges are much more diverse. Most study organizations have formalized a plan addressing their current challenges. However, some organizations employ a large number of diverse strategies, while others mention only a few. These differences appear to correlate with organizational type (see Table 4). Private organizations utilize a large number of strategies and exhibit a higher degree of consistency among them while health departments are using fewer strategies and have less uniformity as a group. Further, private organizations are expanding clinical services and targeting new clientele, while health departments emphasize service cuts at a time of severe budget constraints.

Private organizations have a well-developed strategic plan addressing their current challenges, including the possible loss of Title X funding and other funding shortages. In a significant shift from the past, all private organizations reported implementing or increasing patient fees as a key approach. A CEO of a private organization comments: “And the sad fact of the matter is that what we’ll do is we’ll start changing money that allows us to operate.” Several private organizations plan to refer uncompensated care patients to other local providers.

¹ An exception to this position was noted among those involved with direct service delivery. Several clinicians expressed some concern about local faith-based programs. The dominant theme was expressed by administrative informants.

Conversely, neither health departments nor the FQHC used patient fees as a primary strategy. The single FQHC in this sample has considered increasing fees, but no consensus had been reached at the time of our interviews.

Other strategies adopted by private organizations include diversification of their client base, and targeting insured or paying clients. They are adding insurance billing procedures, adding new clinical services such as perimenopausal care, and collaborating with community organizations to improve the organization's image. Intense collaborative efforts are aimed at increasing their client base through outreach, advertisement, and education and organizational reputation. A final, and important theme among private organizations was their emphasis on "customer service." This is a highly valued strategy among the private organizations and it is reported consistently. These efforts include nice waiting rooms, short waiting time, patient satisfaction evaluations, weekend and evening clinic hours and monitoring quality. The expected outcome of these efforts is client loyalty. As put by one clinical director, "You can get all the new patients in the world but if they don't come back... That's what counts."

In contrast to the large, uniform set of strategies private organizations use, health departments are turning to a smaller, more random set of responses. Yet a single dominant theme still emerged: health departments are cutting family planning services and are collaborating with local providers to divert service elsewhere. Among this sample of health departments, there is a shift away from direct service provision, including family planning services, toward a focus on "core public health" activities. One executive director describes this process: "What started to happen in public health is that public health has gotten away from its mission and started getting into the healthcare business... We should not be competing with medical care." Specifically with regard to family planning, health departments consistently report that they have difficulty financially managing these programs and lack state level support for the program. Therefore, many are opting to close their clinics. In fact, in 3 of 6 communities, health departments have either closed their family planning clinics, or are in the process of doing so. The other strategy common among health departments, collaboration, is also closely linked to their move away from clinical services. These collaborative efforts support other local organizations to provide services, ultimately relieving the health department from this task. For instance, health departments often collaborate with private family planning organizations, assisting them with funding and even clinic space.

Organizational Mission

Mission change was a major theme among this group of Title X organizations. All three organizational types are experiencing mission change, but there were significant differences in the direction and intent of these transformations. As health departments shift their focus to core public health services, prevention, and evaluation, these organizations deliberately reduce the level of services they provide and acknowledged a simultaneous shift in their mission. Private organizations report the essence of their mission is not changing; rather, they are broadening their mission to be more inclusive.

Nonetheless, there is some evidence that their fundamental mission is being compromised by their need to focus on revenue generating activities. Specifically, the organizations' plans to increase patient fees may decrease service accessibility for low-income women and adolescents, a population traditionally served by these organizations. This conflict was reflected in the interviews at all of the private organizations.

Consequent to the ongoing mission changes in Title X organizations, internal conflict is apparent at many organizations and is particularly salient in the private organizations. Health departments, while some of the clinical staff express concern, generally report that their activities are in line with their "core" mission. Conversely, at private organizations, there is a strong feeling that the strategic plan is in direct conflict with the organization's mission to care for the underserved but they feel there are no other options.

CONCLUSIONS

Family planning services in Michigan are undergoing significant structural change. Traditionally, providers include local health departments, FQHCs, and private family planning organizations. Service coverage varies throughout the state, with residents in some counties traveling long distances to neighboring areas for services. Existing family planning providers face the same challenges as other safety net providers, such as free clinics. Furthermore, they are confronted by political and ideological opposition, which has resulted in regulatory obstacles, such as PA 133 and community based hostility. These types of threats are not experienced by other primary care providers engaged in other types of service provision, such as immunization programs. The findings of this study suggest that the Title X program itself may be at risk and this situation could seriously threaten the accessibility of family planning services for low-income women and adolescents in Michigan.

The threats and challenges identified by participating organizations are consistent across organization types. Rising costs, increasing need and inadequate funding challenge all family planning providers. However, private family planning centers are plagued by ideological challenges to a greater extent than other providers such as health departments. Certainly, the tendency for private organizations to have mission statements dedicated to a woman's right to abortion partially explains why private organizations are targeted. Health departments are a less controversial presence in the community and may be the preferred provider for some women and the preferred Title X grantee for some legislators.

We expected the new Title X allocation process to be particularly threatening to organizations with highly specific missions, such as private family planning centers. We predicted that private organizations would be unable to change their mission regarding the right to abortion services, therefore jeopardizing their Title X funding and resulting in possible closure of these clinics. We anticipated that health departments and faith-based organizations would compete for Title X funding, thereby changing the structure of the

family planning safety net in Michigan. What we actually found was quite different. There is very little concern for increasing competition for Title X in Michigan. Health departments have great difficulty managing the program and, in many instances, are closing their Title X clinics. Further, we did not identify evidence of any serious competition for these funds from other organizations, including faith-based organizations driven by a pro-life mission. It is impossible to break even with Title X, so few organizations have the ability or desire to take on this program. In fact, it appears only the existing private family planning organizations *can* continue the program.

Though our hypothesis was wrong from a process standpoint, we did find significant reason for concern. There is a trend for health department based family planning programs to close. These closures are not related to PA 133. Rather, they reflect a larger transformation occurring among health departments: their move away from direct service provision. On the other hand, private organizations are committed to providing family planning services despite the opposition they face and appear to be adapting successfully: there is little indication that private family planning organizations will close as a result of current threats.

Even so, these challenges are not without cost. While private Title X organizations are not deliberately altering their mission, they are engaging in a number of survival strategies that result in *consequent* mission change. PA 133 is forcing private organizations to examine their vulnerabilities. Even if they are optimistic about their survival in the immediate future, these organizations may be concerned about their survivability with continued threats. Private organizations speak of “balancing mission with business,” meaning, that some mission compromises must occur for the business to survive. Specifically, private clinics are increasing fees, targeting insured populations, and planning to turn away uncompensated care. In two instances, these clinics were located in communities where the health department has closed its family planning clinic, leaving no other service options for low-income women. So, while we did not predict the process by which the new Title X allocation rule would affect the system of care, its apparent impact leaves us concerned that at least some poor women and adolescents will be left without accessible family planning services.

Unintended pregnancy continues to be an important problem. We have enjoyed recent successes with the decline in the teen pregnancy rate, which has been credited in part to the availability of affordable, effective contraception services supported by the Title X program. While many of Michigan’s Title X organizations appear to be “successfully adapting,” there are substantial changes occurring to the network of providers. These changes may hinder access to services by vulnerable populations such as low-income women and adolescents. As the Title X program becomes increasingly difficult to manage, organizations may become unable or unwilling to take on the program, leaving even less options for services and placing more women at risk for an unintended pregnancy.

APPENDIX C

APPENDIX C: INTERVIEW PROTOCOL

6/20/02

Health Care Safety Net Project

Interview Protocol

INSTRUCTIONS TO INTERVIEWER ARE IN CAPS. DO NOT READ THIS MATERIAL TO THE RESPONDENT. THESE QUESTIONS ARE INTENDED TO BE APPROPRIATE FOR ALL ORGANIZATIONAL INFORMANTS (EXECUTIVE DIRECTOR, MEDICAL/CLINICAL DIRECTOR, GOVERNING BOARD CHAIR, DEVELOPMENT/PLANNING/FINANCIAL PERSON). READ THE ENTIRE QUESTION, BUT USE PROBES ONLY IF NECESSARY.

INTRODUCTION (AFTER GETTING INFORMED CONSENT)

As you know, we are from the University of Michigan School of Public Health, and we are conducting a study of health care organizations that serve the uninsured and underinsured in the state of Michigan. Our funding for this project is from the Blue Cross Blue Shield of Michigan Foundation. The purpose of the project is to gather information on how health care safety net organizations are making choices about their future. We know that many organizations like yours are having problems related to financing, regulations, and operational issues, and we are exploring how organizations are coping with these problems. We hope that you will feel comfortable being very frank with us. We will not be identifying specific organizations or persons in our reports, but we hope to be able to provide the health care system and policymakers with some ideas about “what works” in health care safety net organizations.

Do you have any questions before we begin the interview?

1. NOTE THAT THIS IS A WARMUP QUESTION; DO NOT DWELL ON THE PAST BECAUSE THE FOCUS OF THE INTERVIEW IS THE FUTURE. First, we would like you to characterize how the environment of your organization has changed in the past 5-10 years. What have been the major changes affecting your organization? What trends do you see? What challenges and opportunities have presented themselves?

2. In light of these environmental changes, how do you perceive your organization’s future? Do you think there are any barriers to your organization’s ability to continue

delivery of services at the same level in the future? Are there any threats to your organization's survival in the current health care environment?

PROBES: What are these barriers or threats – growing number of uninsured? state policies? national policies? declining funding? declining patient base? growth of Medicaid managed care? How serious are these barriers or threats (e.g., is the organization in danger of closing?) Do they perceive that they have “competitors” for patients or revenues?

PROBE FOR FAMILY PLANNING CENTERS: How do you expect your organization to be affected by the proposed changes in Title X allocation (HB4655)? Do you expect new competitors for funds as a result of this legislation?

3. We would like to know how your organization responds to barriers or threats. Who, if anyone, in your organization is responsible for identifying the organization's options? For example, do you have a planning officer or committee, a development officer? Do you use the governing board? Is it an informal process?

4. How does your organization identify its options for the future and make choices among them? What types of information do you use? For example, do you conduct community needs assessments? stakeholder interviews? program evaluations? quality assessments? external benchmarking?

PROBES: Sometimes organizations compare themselves with other similar organizations or industry leaders in order to identify model programs or strategies that might work for them. Does your organization do that? **PROBE FOR WHICH ORGANIZATIONS THEY BENCHMARK AGAINST.**

PROBE FOR FAMILY PLANNING CENTERS: What lessons have been learned from Planned Parenthood affiliates around the country? **IF MANAGED CARE IS NOT MENTIONED, ASK:** Are you aware of other family planning centers' experiences with managed care contracting? Have these contracts been “successful” for family planning centers?

5. What options for change do you believe are available to your organization at this point in time and why? If you are initiating any changes now, we would like to know what they are.

PROBES: Is your organization considering adding new clinical services? adding new markets (client populations)? improving current services? increasing market share for current services through marketing efforts? reducing clinical services or

markets? forming alliances or joint ventures with other organizations? contracting with managed care plans? Which options are believed to be realistic or effective, and why?

PROBE FOR ANY ORGANIZATION THAT HAS MANAGED CARE

CONTRACTS: How has the role of your organization been defined in these contracts? What is the relationship between your organization and the managed care plan?

PROBE FOR FAMILY PLANNING CENTERS: Has your organization identified any options in response to the proposed changes in Title X allocation? Has your organization considered ways of becoming more “competitive” for Title X funds? Are you considering discontinuing abortion-related services? Are you considering expanding into new service areas, like prenatal care, primary care, or men’s health? Are you considering participating in contracts with managed care plans? Why or why not?

PROBE FOR ORGANIZATIONS THAT HAVE CONSIDERED “MISSION TRANSFORMING” CHANGES: What do you think it takes to make major changes that involve fundamentally changing the mission or vision of your organization? What are the “necessary” things that have to be there to support major changes?

6. In thinking about changes for the future, what types of constraints do you face within your organization? For example, is there an internal constituency for change? Are some people opposed to change?

PROBES: Are there disagreements over specific options?

7. WITH RESPECT TO THE STRATEGIES IDENTIFIED IN QUESTION #5 ABOVE, ASK: You have told us about some options for change that your organization has considered or is implementing. We are interested in identifying some “best practices” for the field. Can you tell us about any particular successes you are having in implementing changes? We are particularly interested in knowing *how you know* when a change is successful or not.

PROBES: Do you have any evidence from evaluation projects or financial data that this is working? Do you think this change could be replicated in other similar organizations? What would you recommend that other organizations like yours do similarly or differently?

8. One final question. If you could make a recommendation to health care policymakers to help organizations like yours, what would it be?

THAT CONCLUDES THE INTERVIEW. THANK YOU VERY MUCH FOR YOUR TIME. WE WILL BE SENDING A COPY OF OUR REPORT AT THE END OF THE PROJECT.

APPENDIX D: DATA SHEET

Safety Net Study: Organizational Data Survey

Instructions

As part of our study, we would appreciate some additional information about your organization. Please answer the following questions to the best of your ability. If you do not have precise data, estimates are acceptable. Directions for the survey's return are located at the end of the survey.

Name of Organization: _____

1. How many clients did your clinic serve during the fiscal year 2001? _____

2. How would you best characterize the hours your clinic is open for clinical services? (Please check one)

- Weekday hours Weekday and weekend hours
 Weekday and evening hours Weekday, evening and weekend hours

3. What is the approximate age distribution of the clients served at your clinic? (Approximate percentage should total to 100%)

Under 18	_____ %
19-29	_____ %
30-49	_____ %
50-64	_____ %
65 and older	_____ %
Total	<u>100 %</u>

4. What is the approximate racial/ethnic distribution of the clients served at your clinic? (Approximate percentages should total to 100%)

White, non-Hispanic	_____ %
African American	_____ %
Hispanic	_____ %
Asian or Pacific Islander	_____ %
Native American	_____ %
Other: _____	_____ %
Total	<u>100 %</u>

5. What types of health insurance do the clients you serve have? (Approximate percentages should total to 100%)

Medicaid/Medical Assistance	_____ %
Medicare	_____ %
Private managed care/HMOs	_____ %

Other private insurance	_____	%
No insurance	_____	%
Other: _____	_____	%
Total:	<u>100</u>	<u>%</u>

6. Approximately what percentage of patients served in your center receive reduced rates because of financial need? _____%

OVER →

7. For the fiscal year 2001, please indicate what percentages of your revenue came from each of the following sources. (Percentages should total to 100%)

Public insurance payments (Medicaid, Medicare, indigent care programs)	_____	%
Other private/commercial insurance payments	_____	%
Private managed care/HMO	_____	%
Out-of-pocket payments	_____	%
Government grants	_____	%
Private foundation grants	_____	%
Private donations	_____	%
Other: _____	_____	%
Total:	<u>100</u>	<u>%</u>

8. From the following list, please “check” the services provided at your clinic. Do not include services that you refer to outside providers/clinics.

Primary Care

- | | |
|---|--|
| <input type="checkbox"/> General physical exams | <input type="checkbox"/> Screening for anxiety or depression |
| <input type="checkbox"/> Blood pressure checks | <input type="checkbox"/> Treatment for anxiety or depression |
| <input type="checkbox"/> Treatment for hypertension | <input type="checkbox"/> Colon cancer screening |
| <input type="checkbox"/> Diabetes screening | <input type="checkbox"/> Physical therapy |
| <input type="checkbox"/> Diabetes treatment | <input type="checkbox"/> STD/HIV screening |
| <input type="checkbox"/> Cholesterol screening | <input type="checkbox"/> STD treatment |
| <input type="checkbox"/> Cholesterol treatment | <input type="checkbox"/> Dental care |
| <input type="checkbox"/> Acute illness care | <input type="checkbox"/> EKG |

Pregnancy-related Care

- | | |
|--|--|
| <input type="checkbox"/> Pregnancy tests | <input type="checkbox"/> Prenatal screening services |
| <input type="checkbox"/> Adoption counseling | <input type="checkbox"/> Prenatal care |
| <input type="checkbox"/> Abortion counseling | <input type="checkbox"/> Vaginal deliveries |
| <input type="checkbox"/> Abortions | <input type="checkbox"/> Cesarean sections |
| <input type="checkbox"/> Infertility diagnosis | <input type="checkbox"/> Genetic screening/testing |
| <input type="checkbox"/> Ultrasound | |

Family Planning Services

- | | | | |
|--------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | Contraceptive counseling | <input type="checkbox"/> | Emergency contraception |
| <input type="checkbox"/> | Oral contraception | <input type="checkbox"/> | Barrier contraception |
| <input type="checkbox"/> | Depoprovera | <input type="checkbox"/> | Natural methods |
| <input type="checkbox"/> | Contraceptive patch | <input type="checkbox"/> | Sterilization services |
| <input type="checkbox"/> | Lunelle | <input type="checkbox"/> | Routine gynecological exams |
| <input type="checkbox"/> | IUD placement | <input type="checkbox"/> | Pap smears |

Mailing Instructions

Please return the survey in the envelope provided or to:

Peter Jacobson, JD, MPH
University of Michigan
Department of Health Management and Policy
School of Public Health
109 Observatory
Ann Arbor, MI 48109-2029

If you prefer, you may also fax us the survey: **(734) 764-4338**.

REFERENCES

- ¹ We would like to thank the Blue Cross Blue Shield of Michigan Foundation for its generous financial support. We especially appreciate the support and encouragement we received from our project officer, Nora Maloy, DrPH. We would also like to acknowledge outstanding research assistance from Meg Gallogly, MPH, Neela Moorty, MPH/MBA Candidate (2005), and Rima Abu-Isa, MPH.
- ² Gold, "Nowhere But UP: Rising Costs for Title X Clinics," *The Guttmacher Report on Public Policy* 5:5 (December 2002), pp. 6-9.
- ³ "After Declining for Two Years, Number of Uninsured Increased Last Year, Census Bureau Says" Kaisernetwork.org. Figures released by the Census Bureau on 9/30/02.
- ⁴ Felland LE, Lesser CS, Staiti AB, Katz A, and Lichiello P, The Resilience of the Health Care Safety Net, 1996-2001, *HSR* 2003; 38(Part II):489-502.
- ⁵ *A Shared Destiny: Community Effects of Uninsurance*. March 10, 2003. www.iom.edu p 2.
- ⁶ Dailard. "Abstinence Promotion and Teen Family Planning: The Misguided Drive for Equal Funding," *The Guttmacher Report on Public Policy*. 5:1 (February 2002), pp. 1-2.
- ⁷ See, e.g., Waitzkin H, Williams RL, Bock JA, McCloskey J, Willging C, Safety-Net Institutions Buffer the Impact of Medicaid Managed Care: A Multi-Methods Assessment in a Rural State, *American Journal of Public Health* 2002; 92:598-610. See also, Bernasek C, Farkas J, Felman H, Harrington C, Mendelson D, Ramchand R, Case Study: Michigan's Medicaid Prescription Drug Benefit, The Health Strategies Consultancy, LLC, prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, DC, January 2003.
- ⁸ See, e.g., Reed MC, and Cunningham PJ, Physicians Pulling Back From Charity Care, Issue Brief #42, Center for Studying Health System Change, Washington, DC, August 2001.
- ⁹ Institute of Medicine, *America's Health Care Safety Net: Intact But Endangered*, Washington, DC: National Academies Press, 2000.
- ¹⁰ Hegner R, "The Health Care Safety Net in a Time of Fiscal Pressures," National Health Policy Forum. April 2001, p. 7.
- ¹¹ *Recommendations of IOM Report*, Safety Net Recommendations www.iom.edu
- ¹² See, e.g., two reports prepared for the Kaiser Commission of Medicaid and the Uninsured, Washington, DC. Brennan N, Gutterman S, and Zuckerman S, The Health Care Safety Net: An Overview of Hospitals in Five Markets, The Urban Institute, Washington, DC, April 2001; Markus A, Roby D, and Rosenbaum S, A Profile of Federally Funded Health Centers Serving a Higher Proportion of Uninsured Patients, The George Washington University Medical Center, Washington, DC, June 2002. See also, Felland LE, Lesser CS, Staiti AB, Katz A, and Lichiello P, The Resilience of the Health Care Safety Net, 1996-2001, *HSR* 2003; 38(Part II):489-502; Hadley J and Holahan J, How Much Medical Care do the Uninsured Use, and Who Pays for It? *Health Affairs* 2003; 22(web exclusive):W3 66-W3 81; Felt-Lisk S, McHugh M, and Howell E, Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity? *Health Affairs* 2002; 21(5):277-283.
- ¹³ Baxter RJ and Mechanic DE, The Status of Local Health Care Safety Nets, *Health Affairs* 1997; 16(4):7-23; Grogan CM and Gusmano MK, How Are Safety Net Providers Faring Under Medicaid Managed Care? *Health Affairs* 1999; 18(2): 233-237; Wall S, Transformations in Public Health Systems, *Health Affairs* 1998; 17(3):64-80.
- ¹⁴ Felland LE, Lesser CS, Staiti AB, Katz A, and Lichiello P, The Resilience of the Health Care Safety Net, 1996-2001, *HSR* 2003; 38(Part II):489-502.
- ¹⁵ See, U.S. Department of Labor, Bureau of Labor Statistics, www.bis.gov, access on 14 May 2003.
- ¹⁶ Kaiser Family Foundation. State Health Facts Online. Michigan: Distribution of Total Population by Federal Poverty Level, 1999-2000. www.kff.org.
- ¹⁷ "Critical Health Indicators," Michigan Department of Community Health. www.michigan.gov/mdch/.
- ¹⁸ While these efforts will have an impact all women's access to family planning services, poor women and adolescents are particularly vulnerable to these restrictions.
- ¹⁹ Nortin SA and Lipson DJ, Portraits of the Safety Net: The Market, Policy Environment, and

Safety Net Response. Assessing the New Federalism, Urban Institute Occasional Paper #19. BCBSM is required by state law to provide coverage to anyone who applies during an open-enrollment period once a year at a community-rated basis.

²⁰ Press Release, September 30, 2002. www.census.gov. Also 16% in the nonelderly population, January 2003. www.kff.org.

²¹“DMC Clinics to Become Private,” *Detroit Free Press*. November 21, 2002. This is not limited to large urban hospitals. See, Maher P, “Hope Clinic Woes Cut Free Services,” *Ann Arbor News*, 14 September 2002, p. A1, A13.

²² “9 Detroit Health Clinics Expected to Stay Open,” *Detroit Free Press*, January 22, 2003. Askaria E, “Detroit’s Uninsured And Underserved: City’s 9 Clinics are Too Few,” *Detroit Free Press*, October 1, 2003. Askaria E, “City’s Primary Care Doctor’s are Few, Fleeing,” *Detroit Free Press*, October 2, 2003. Askaria E, “Clinic Experts Give Advice to Detroit,” *Detroit Free Press*, October 3, 2003. Askaria E, “Plans in the Works for New Clinic,” *Detroit Free Press*, October 3, 2003. Askaria E, “Called to Serve: Dr. Ann Gillett-Elrington Works Long Hours for Reduced Pay at a Nonprofit Detroit Clinic. She Says it’s What She’s Meant to Do” *Detroit Free Press*, October 7, 2003.

²³ “Detroit Medical Center Clinics to Remain Open, Mayor Says” Kaiser Family Network Daily Reports, January 23, 2003. Given the realities facing free clinics in Detroit, one anonymous reviewer called asked if the Health Department was joking.

²⁴ “The 4-year plan: What DMC is Doing to Cut Costs,” *Detroit Free Press*, February 7, 2003.

²⁵ “Detroit Medical Center: Health System on the Edge,” *Detroit Free Press* February 7, 2003. On 21 May 2003, DMC announced that Detroit Receiving Hospital “will eliminate inpatient services and become an emergency and trauma center only. Hutzel Women’s Hospital will stop performing all but high-risk deliveries, a reduction of 2500-3000 births a year.” Associated Press, “Detroit Hospital Chain Cuts 1000 Jobs,” <http://news.findlaw.com>, accessed on 21 May 2003.

²⁶ House Fiscal Agency. FY 1997-98 Appropriation Report Department of Community Health, Public Act No. 94 of 1997.

²⁷ Kaiser Commission on Medicaid and the Uninsured (2001). *The Health Care Safety Net: An Overview of Hospitals in Five Markets*, Washington, DC, 2001.

²⁸ KFF State Health Facts Online. Michigan: Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, 2001. www.kff.org

²⁹ *Fiscal Year 2003 Executive Budget* Department of Community Health, G-4

³⁰ “Medicaid Rate Hold Squeezes Providers,” *Detroit Free Press*, February, 11 2002.

³¹ *Fiscal Year 2003 Executive Budget* Department of Community Health, G-4

³² House Fiscal Agency. FY 1996-97, 1997-98 Appropriation Report Department of Community Health.

³³ House Fiscal Agency. FY 1996-97 Appropriation Report Department of Community Health, Public Act No. 352 of 1996.

³⁴ Information obtained through respondent interviews.

³⁵ Michigan association for Local Public Health, Cost Sharing Chronology.

³⁶ Director, Michigan Department of Community Health, Community Living, Children and Families.

FY99/00, 00/01, Family Planning Reported Expenditures and Users.

³⁷ Michigan PA133.

³⁸ House Fiscal Agency. FY 1996-97 Appropriation Report Department of Community Health, Public Act No. 352 of 1996.

³⁹ House Fiscal Agency. FY 1997-98 Appropriation Report Department of Community Health, Public Act No. 94 of 1997.

⁴⁰ Information obtained through respondent interviews.

⁴¹ “President Bush Signs Community Health Center Legislation into Law,” *NACHC News*, October 28, 2002. www.nachc.com

⁴² “State to Cut \$337.4 Million From Services,” *Detroit Free Press*, December 6, 2002.

⁴³ “Granolm is Bracing for Drastic State Budget Cuts,” *Detroit Free Press*, December 13, 2002.

⁴⁴ “Health Watcher Warns, Medicaid Cuts Cost More in Jobs, Economic Activity,” *Detroit Free Press* January 17, 2003.

- ⁴⁵ “Medicaid Rate Hold Squeezes Providers,” *Detroit Free Press*, February, 11 2002.
- ⁴⁶ *A Shared Destiny: Community Effects of Uninsurance*, March 10, 2003, www.iom.edu p 2 11.
- ⁴⁷ Silow-Carroll S, Anthony SE, Seltman PA, and Meyer J, *Community-Based Health Plans For the Uninsured: Expanding Access, Enhancing Dignity*, Washington, DC: Community Voices Publications, November 2001.
- ⁴⁸ Silow-Carroll S, Anthony SE, Seltman PA, and Meyer J, *Community-Based Health Plans For the Uninsured: Expanding Access, Enhancing Dignity*, Washington, DC: Community Voices Publications, November 2001. To date, there is limited information about the plans’ performance, but the Ingham County Health Plan enrolled roughly one-third of the county’s uninsured population as of February 2001.
- ⁴⁹ Yin RK, *Case Study Research: Design and Methods*, Thousand Oaks, CA: Sage Publications, 1994.
- ⁵⁰ The distinction between church-supported and faith-based clinics is that the latter incorporate an evangelical mission along with the social mission of providing health care. In our sample, the church-supported clinics focused solely on the health care mission.
- ⁵¹ Not every area had each of the organizational types we had hoped to interview. In one urban area, a family planning agency refused to participate and a potential substitute free clinic declined because of having had several site visits right before we contacted the organization.
- ⁵² The lack of available data makes it impossible to compare the sites on a smaller unit than the county.
- ⁵³ Some organizations noted recent increases in the area’s Hispanic population and in the clinic’s patient population. Others noted a shift from African Americans to Hispanics in the area and the clinic.
- ⁵⁴ Not all sites had a person for each position. In some sites, scheduling conflicts made it impossible to interview certain people.
- ⁵⁵ In fairness, many hospitals are straining to provide emergency care to the uninsured and underinsured. Hospitals are under considerable financial pressure, especially in less affluent areas.
- ⁵⁶ As we will see below, another factor is an emerging consensus among our health department respondents that local health departments should not compete with the private sector for providing direct services.
- ⁵⁷ Supporting this view, another respondent said that “There’s more pressure for road repair, drug and crime enforcement, and no political pressure for social services.”
- ⁵⁸ In a less affluent urban area, one clinic’s annual event was just one of 5 medical fundraising events during the same month.
- ⁵⁹ Both clinics are located in less affluent areas and most likely would be unable to raise sufficient capital even if they wanted to expand.
- ⁶⁰ Likewise, an FQHC in a rural area put its expansion plans on hold because the environment is too risky.
- ⁶¹ One health department has established the following criteria for program decisions: 1) is the health department that sole provider in the community; 2) does the funding cover the cost of the service; 3) can the program be sustained into the future; and 4) is it a core program as defined by the IOM?
- ⁶² One issue for FQHCs is whether to hire physicians or contract with a physicians’ group. In the case of the mental health center, the state government dictated the direction of the model change. Mental health centers shifted from a fee-for-service model to a capitated pre-paid health plan that focused on serving certain core populations.
- ⁶³ The mental health center in the sample also implemented a data warehouse with a centralized computer system to standardize costs of services across multiple sites.
- ⁶⁴ A free clinic director said that “Hospital executives run when they see me coming” for fear of sending them patients, when in reality the hospital sends the patients to the clinic.
- ⁶⁵ An urban free clinic refused a volunteer pharmacist’s offer to donate a computerized system because operating it would involve too much training time.
- ⁶⁶ This is not a universal view. At a presentation Jacobson made to the Free Clinics of the Great Lakes Region, several representatives from faith-based organizations adamantly rejected the small business analysis and the need to compromise the mission. At the same time, the director of a faith-based organization in our sample repeatedly noted the need to operate based on a sound business plan.
- ⁶⁷ Reflecting a commonly held (but damaging perception), an FQHC financial officer said that there is a “perception that it is not a business when serving the underserved.” At another FQHC, respondents noted that affluent retirees would not use the clinic because it is perceived to be for the poor.

⁶⁸ One clinic financial director said that the clinic “is successful in growing because of strong connections to the hospital, the neighborhood provides input into operations, and there are other supportive institutions. Strong institutional support is needed for success.” We should point out, however, that other respondents at this particular organization focused on the difficult relations between the clinic and local hospitals.

⁶⁹ See, e.g., Felland LE, Kinner JK, and Hoadley JF, *The Health Care Safety Net: Money Matters But Savvy Leadership Counts*, Center for Studying Health System Change, Washington, DC, August 2003, concluding that “Collaboration among public and private organizations also helped bolster the safety net in many communities” (p.3). On the other hand, we agree with the authors’ other conclusions regarding the importance of leadership and community support. See also, the articles collected in the *Journal of Public Health Practice Management*, 2003; 2003; 9(3):179-254.

⁷⁰ A health department’s Chief Health Officer noted that “Memory is moving out of the system. Expectations and the scope of what is possible and reasonable to do will change because there is no memory of what was done.”

⁷¹ A fairly typical comment from a free clinic director was that if “Medicaid paid providers a decent amount, more providers would enroll, reducing the clinic’s patient population.”

⁷² Leadership succession may be particularly stark at organizations led by dynamic, seemingly irreplaceable leaders. At a mission-driven free clinic, the current director seemed reluctant to increase the budget because she won’t be here forever. “Who will replace me and work at this salary?”

⁷³ One of our reviewers noted the following as a possible strategy for free clinics to pursue. “Currently, there are basically two federal designations from the Bureau of Primary Health Care: 1) FQHCs; and 2) FQHC look-a-likes. The FQHC is eligible for all Bureau programs while, look-a-likes can only get cost-based reimbursement. When the FQHC legislation was first proposed, it was directed to Section 330 funded programs only. As the story goes, a member of congress from the east coast who cosponsored the legislation was jammed by clinics in his district that provided the same services as Section 330 sites, but were funded through other sources (state, local or foundations). The proposed legislation was amended to include those clinics with the caveat that the look-a-likes would only be eligible for cost-based reimbursement (which was what they wanted anyway) and not the Section 330 grant. In all other ways, the clinics have to look like 330 funded clinics, e.g., have a community board of directors, a sliding fee scale, and serve anyone requesting services regardless of their ability to pay.”