Addressing the Specialty Care Disparity for the Uninsured

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BACKGROUND

The Arizona Safety Net is a coalition of over 40 free, charity, low cost and FQHC clinics in Maricopa County that provide essential primary care to the uninsured. Despite the robust system for primary care there is no County, State or Federal system in place for those same patients who are in need of specialty care. The uninsured are dependent on their provider phoning a physician-friend in that specialty for a favor, sent to the emergency department for non-emergent conditions only to be told to follow up with the specialist as an outpatient, have blind referrals sent to a dead-end, or more commonly, are told that there are no resources for them. In response to the disparity in specialty care the Arizona Safety Net created a referral system using the Virginia G. Piper St. Vincent de Paul Medical Clinic as its' hub. The Safety Net referral system has been in place since 2016 but overall has been underutilized.

ARIZONA SAFETY NET

Improving health equity for Arizona's uninsured through collaboration, quality improvement, and improved access to care.

OBJECTIVE

This study evaluated the needs for specialty care in the uninsured, causes of low utilization of the referral system and the effects of quality improvement interventions across the Safety Net to increase individual Safety Net clinic/provider utilization of the referral system.

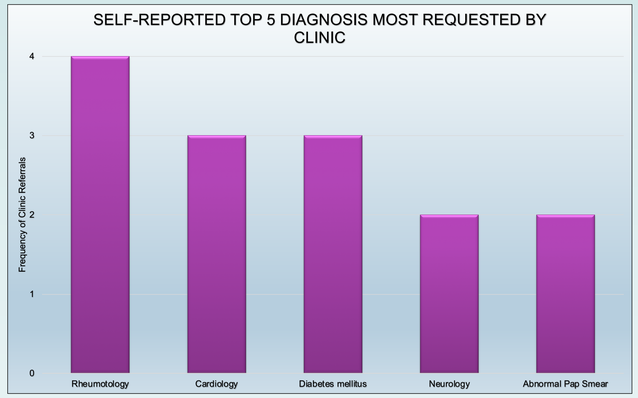
METHODS

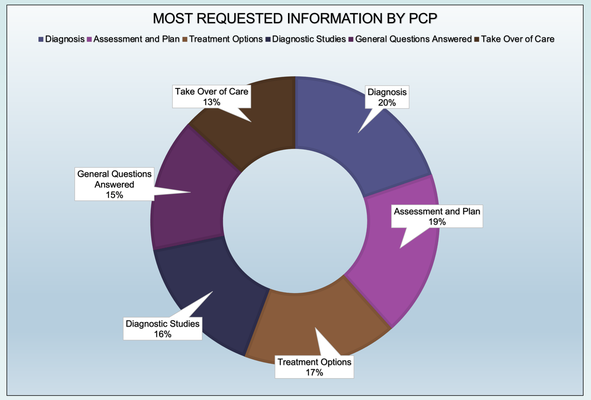
A needs assessment was conducted with a survey among the various Arizona Safety Net clinics, gathering clinics' uninsured population needs including top specialist/services needed, information desired from specialist and barriers present for referring.

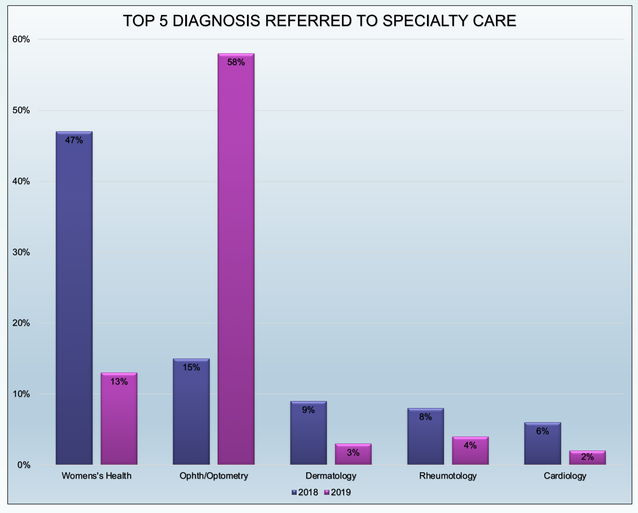
Over multiple PDSA cycles the following interventions were implemented:

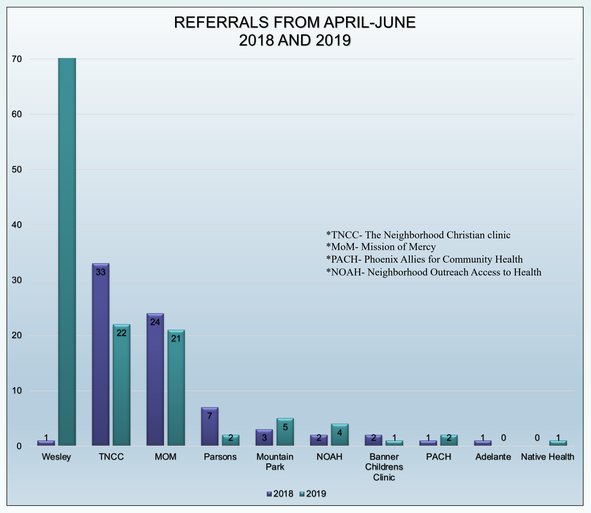
1. Information was disseminated to increase awareness and education for referring clinics on the referral process
2. A set of process maps were distributed to the clinics delineating responsibilities through the referral process
3. A calendar for specialists days was made available
4. Example appropriate and inappropriate referrals were provided for each specialty along with specialty based checklists for referring

RESULTS

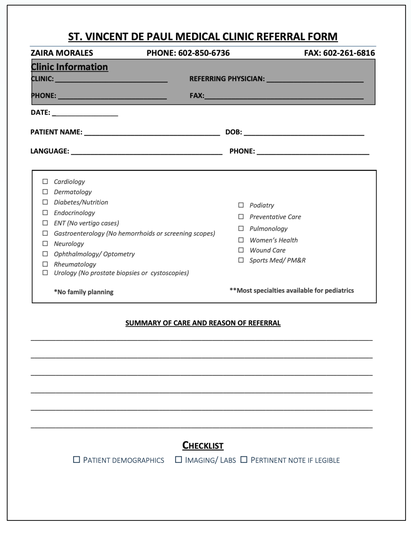








REFRENCE MATERIAL



ST. VINCENT DE PAUL MEDICAL CLINIC REFERRAL FORM

ZAIRA MORALES PHONE: 602-850-6736 FAX: 602-261-6816

Clinic Information

CLINIC:_____ REFERRING PHYSICIAN:_____

PHONE:_____ FAX:_____

DATE:_____

PATIENT NAME:_____ DOB:_____

LANGUAGE:_____ PHONE:_____

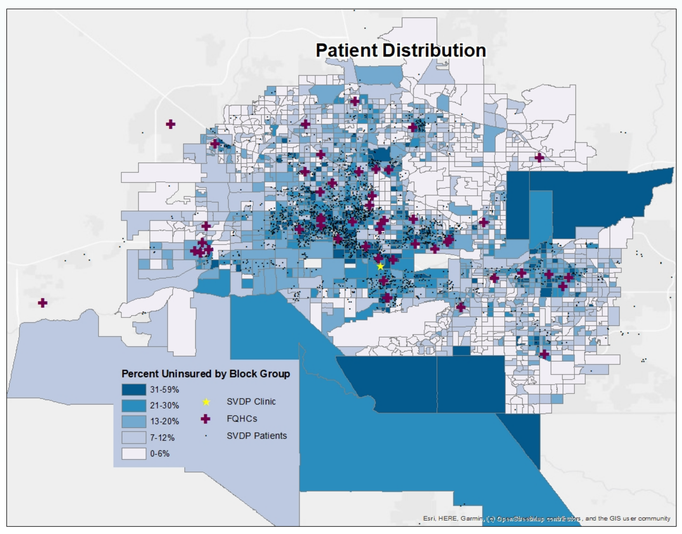
- ☐ Cardiology
- ☐ Dermatology
- ☐ Diabetes/Nutrition
- ☐ Endocrinology
- ☐ ENT (No vertigo cases)
- ☐ Gastroenterology (No hemorrhoids or screening scopes)
- ☐ Neurology
- ☐ Ophthalmology/ Optometry
- ☐ Rheumatology
- ☐ Urology (No prostate biopsies or cystoscopies)
- ☐ Podiatry
- ☐ Preventative Care
- ☐ Pulmonology
- ☐ Women's Health
- ☐ Wound Care
- ☐ Sports Med/ PM&R

*No family planning **Most specialties available for pediatrics

SUMMARY OF CARE AND REASON OF REFERRAL

CHECKLIST

☐ PATIENT DEMOGRAPHICS ☐ IMAGING/ LABS ☐ PERTINENT NOTE IF LEGIBLE



CONCLUSION

There is a mismatch between what the providers' perceived specialty care needs are and what they are actually referring for. Although the needs and referrals do not correlate the top 5 specialties have not changed over time. The referring providers are getting the information needed from the specialists and feel the visits have a morbidity and/or mortality benefit for the patient. Despite being seen as a benefit the referral system continues to be underutilized. Reasons provided by providers/clinics are that:

1. It is too much work
2. They do not know what to include
3. Why refer if they just get denied?

DISCUSSION

The Arizona Safety Net clinics confirmed that there is a need for specialty care for their uninsured patients, and that when seen, patients are benefiting, yet the majority of patients are not being referred and the specialty schedules are only being filled to half capacity.

The main barrier identified by the team receiving and approving the referrals is that the referral form is not being filled correctly. If denied, referral requests typically are repeated without the additional information being requested. There is a lack of transparency between the safety net representatives and the different departments in their respective clinics. Information regarding specialty care, appropriate referrals and the referral process is not being communicated to the referral specialists, providers or clinic leadership.

There were a number of clinics that stated their uninsured population is too small to create a separate referral process, implying uninsured patients needing specialty care is not a priority.

After the interventions of this QI project were implemented and all the resources were made available on a web platform there was one clinic that had a significant change. The Wesley Health Center was able to increase specialty care visits by 7,000% when compared to the same time frame during the previous year. This increase coincided with a change in their Safety Net representative.

If each Safety Net Clinic was able to identify a champion for the uninsured to attend the Safety Net meetings who could commit to and create change we would need to begin developing a plan to systemically address the disparity in specialty care as the current system is only a band aid to a much larger problem. Until the uninsured have an effective advocate at the clinics where they receive care this systemic problem will continue to be ignored.

BIBLIOGRAPHY

1)Brennan VM. Free Clinics, Local Responses to Health Care Needs. JHU Press; 2013. 2) Damico A. Garfield R. Orgera K. The Uninsured and the ACA: A Primer - Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act. Henry J. Kaiser Family Foundation; 2019. 3)Ezeonwu MC. Specialty-Care Access for Community Health Clinic Patients: Processes and Barriers. Dove Press. 2018.