Community Health Centers Play Critical Role in Caring for the Remaining Uninsured in the Affordable Care Act Era

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Project Methodology

The Remaining Uninsured Access to Community Health Centers (REACH) Project was a mixed-methods study to examine the impact of changes under the Affordable Care Act (ACA) on the ability of community health centers (CHCs) to serve the remaining uninsured.

Data Sources and Collection

Uniform Data System

Data on the characteristics of Federally-Qualified Health Centers was drawn from the Health Resources and Services Administration Uniform Data System (UDS) 2010, 2012, and 2014. The UDS data includes annual reports from FQHC federal grantees on the number of patients served, who are uninsured, and who are best served in a language other than English, as well as a variety of other organizational and health indicators. http://bphc.hrsa.gov/uds/datacenter.aspx

American Community Survey

Data on noncitizen population and low income immigrants was drawn from the 2014 American Community Survey (ACS), a nationally-representative survey of the population of the United States conducted by the U.S. Census Bureau. The data includes data on the proportion of low-income immigrants in each state who are foreign born. The data were obtained via IPUMS-USA, University of Minnesota, www.ipums.org.

Sample of Community Health Centers

Qualitative data on CHCs was drawn from a sample of 31 CHCs that were identified, enrolled, and interviewed for the REACH study. Site selection involved three phases to select states, regions, and CHC sites.

First, we selected four states that had significant numbers of immigrant residents and that provided a contrast in Medicaid expansion and political climate towards immigrants. We picked states with large numbers of immigrants, or policy activity focused on immigrants, because undocumented immigrants are formally excluded from the ACA and, together with some groups of lawful permanent immigrants, are likely to comprise the largest group of remaining uninsured residents across states. California, New York, and Texas have the largest immigrant populations in the nation. Georgia, while traditionally home to a smaller immigrant population, is among the top 10 states with the greatest increase in immigrant population in the past 10 years. California and New York expanded their Medicaid programs and have their own state exchanges, while Texas and Georgia rejected Medicaid expansion and did not establish state exchanges. California is the most immigrant-accepting state in the country, with policies such as driver's licenses for undocumented residents and in-state tuition for undocumented students. Texas and New York are in the top third of inclusive states in a set of public policies, while Georgia falls in the bottom third of immigrant inclusion policies.

Second, within each state, we selected one of the largest urban/metropolitan regions with significant non-citizen populations and a second region that provided a contrasting political, economic, and social context in which CHCs operate. To select each region, we used zip code level ACS data to identify areas in each state with high numbers and percentages of non-citizen residents. We cross-referenced the ACS data with data from the UDSMapper (http://www.udsmapper.org), online software that generates maps of UDS data, to confirm that the regions also were home to at least three CHC systems. We also spoke with a representative from each state's primary care association to learn more about the state context and the variation among potential regions, such as attitudes towards immigrants and undocumented immigrants, relationship of CHCs with local health departments or public hospital systems, and the capacity and resources of CHCs in the area. Based on this information, we selected the urban

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areas of Los Angeles County, Houston (Harris County), Atlanta (Fulton County & DeKalb Counties), and New York City (the five boroughs) and the secondary regions of Fresno County, CA, Southern Texas, South and Eastern Georgia, and the Hudson Valley Region, New York.

Finally, once we identified the regions of focus for each state, we utilized the UDSMapper to generate lists of all of the CHCs in that region. We ranked all CHCs from largest to smallest immigrant patient population based on the percent of their patients who they reported in the 2013 UDS data were "best served in a language other than English," which we describe as a limited-English proficiency (LEP) population. We excluded CHCs that served less than 10% LEP patients. For all CHCs that met the criteria for inclusion, we categorized each as a "small" or "large" system. This categorization was based on the median patient population size for the region. Based on the list of included CHCs we randomly selected eight to be initially recruited in to the study, with a goal of up to six respondents. Sites were recruited by email and phone invitation to the organization director, chief executive or operating officers, or other primary contact.

In total, 31 CHC sites were enrolled and participated in the study. Another 4 did not respond to the invitation to participate and 4 refused enrollment because they did not have time to participate and because of organizational policies that limited participation in research studies.

State	Region	n
California	Los Angeles County	6
	Fresno County	3
Texas	Houston	5
	Southern	1
Georgia	Atlanta (Fulton County & DeKalb Counties)	4
	South & Eastern	4
New York	New York City	5
	Hudson Valley	3

Data collection activities involved requesting copies of sites' complete UDS data (including financial and staffing information not available in the public data from HRSA), completing a brief survey, participating in a 60-90 minute phone interview, and, for a subsample of sites, participating in a site visit. Once each site was enrolled in the study they shared their UDS data with the research team. A representative of the CHC leadership (e.g. Director, CEO, COO, etc.) participated in the phone interview with two members of the REACH study research team. We developed a standardized interview guide that included questions about the overall impact of the ACA on each site; their patient population and their needs; their outreach and enrollment strategies; examples of barriers and strategies for patients access care; their system of care and financial strategy; experiences with state and local context and partnerships; and innovations, best practices, and lessons learned.

Site visits were conducted by one member of the research team at CHCs in the urban regions - in Los Angeles (n=2), New York City (n=2), Houston (n=2), and Atlanta (n=3). A site visit protocol was developed and implemented to guide interviews with CHC leadership and staff regarding their day-to-day operations and experiences serving uninsured patients.

Data Analysis and Interpretation

Analysis of national and site level UDS and ACS data

We conducted descriptive analysis to determine the mean proportion of uninsured patients, changes in numbers of patients, insurance status, the mean proportion of patients served in a language other than English, and the proportion of the state low income population that is foreign born.

Analysis of qualitative CHC site data

Each interview with the 31 CHC sites and 9 site visits was transcribed. All transcripts were uploaded into Dedoose software for analysis. Research team members engaged in an iterative process to develop codes. An initial set of three transcripts were independently coded by three team members to identify key issues, topics, and themes that were emerging. An initial list of codes was generated and applied independently by two research team members to another set of 5 transcripts. Research team members met to discuss discrepancies in the coding and to finalize the list of codes. The remaining transcripts were each independently and blindly coded by two reach team members and reconciled by a third.

After coding was complete, we extracted data from the Dedoose software on the most common codes and trends in groupings of codes. Based on this information, we generated code trees that grouped together individual topics and issues into broad themes. Individual excerpts within these broad themes were explored by a member of the research team to describe the details, variation, and significance of each code among the 31 respondents. Results and observations from the site visits were integrated into the interview findings to corroborate or add variation to the information within each theme.

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[1]Rodriguez, Michael A., Maria Elena Young, and Steven P. Wallace. "Creating Conditions to Support Healthy People: State Policies that Affect the Health of Undocumented Immigrants and Their Families." Los Angeles, CA: UCLA Center for Health Policy Research. April 2015. (Report) http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1373

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