

Contract No.: 500-96-0016(03)  
MPR Reference No.: 8644-200

**MATHEMATICA**  
Policy Research, Inc.

**Beyond Coverage:  
SCHIP Makes Strides  
Toward Providing a  
Usual Source of Care to  
Low-Income Children**

*Final Report*

*December 23, 2005*

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This report was prepared for the Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (DHHS), under contract number 500-96-0016 (03). The contents of this publication do not necessarily reflect the views or policies of CMS or DHHS, nor does the mention of trade names, commercial products, or organizations imply endorsement by CMS, DHHS, or Mathematica Policy Research, Inc. (MPR). The authors are solely responsible for the contents of this publication.

## ACKNOWLEDGMENTS

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The authors would like to acknowledge the contributions of several Mathematica Policy Research, Inc. (MPR) staff who contributed to this report. We thank Davene Wright and Anna Katz for providing research assistance and Judith Wooldridge and Shanna Shulman for reviewing and commenting on an earlier draft of this report. We also thank Patricia Ciaccio for editing the report and Margaret Hallisey for producing it. Susan Radke and Johanna Barraza-Cannon also provided helpful comments that improved the report substantially.

**BEYOND COVERAGE:**  
**SCHIP MAKES STRIDES TOWARD**  
**PROVIDING A USUAL SOURCE OF CARE TO**  
**LOW-INCOME CHILDREN**

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The State Children’s Health Insurance Program (SCHIP) aims to extend health insurance coverage to low-income children and to facilitate children’s access to affordable, quality health care. To meet this goal, SCHIP strives to provide children with a usual source of care, serving as a bridge between providing coverage and promoting access. Nearly all states’ Title XXI child health plans included one or more strategic objectives related to ensuring that SCHIP enrollees have a usual source of care.

A usual source of care has been considered an important goal for children’s health care since the 1960s (Sia et al. 2004). Having a usual source of care has been linked to many positive outcomes, such as increased use of preventive care, decreased use of emergency room care, and better continuity of care. However, no standard definition of “a usual source of care” exists, although it is frequently described as a usual *place* where a child receives sick or routine care or a usual *person* who provides that care.

This report synthesizes qualitative and quantitative evidence on the extent to which SCHIP enrollees report having a usual source of care. We review data from the state annual SCHIP reports submitted to the Centers for Medicare & Medicaid Services (CMS) and benchmark these data against *Healthy People 2010*, a compendium of health care goals developed by federal agencies (U.S. Department of Health and Human Services 2000). We augment this analysis with focus group results documenting SCHIP families’ perspectives and experiences, including the value they placed on having a usual source of care for their children, as well as the challenges they encountered in finding or retaining a usual source.

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## **SCHIP'S POTENTIAL TO PROVIDE A USUAL SOURCE OF CARE TO LOW-INCOME CHILDREN**

All major pediatric organizations now recommend that children have a usual source of care (Sia et al. 2004).<sup>1</sup> *Healthy People 2010* identifies the SCHIP program as a potential vehicle for achieving the national goal of increasing the percent of children with a usual source of care (U.S. Department of Health and Human Services 2000). Specifically, *Healthy People 2010* sets a target—that 97 percent of all children should have a specific place for primary care by 2010. Moreover, 85 percent of the population should have a usual primary care provider by 2010. *Healthy People 2010* recognizes that having a specific place for care improves access, particularly for preventive services, but that having a usual provider further enhances the timeliness, continuity, and coordination of care.

Children with health insurance coverage are more likely than those who are uninsured to report a usual source of care (Dey and Bloom 2005; Kaiser Commission on Medicaid and the Uninsured 2003; Moreno and Hoag 2001; Newacheck 1998; Rosenbach et al. 1999). For example, the 2003 National Health Interview Survey found that 75 percent of uninsured children had a usual place of care, compared to 98 percent of privately insured children and 96 percent of publicly insured children (Dey and Bloom 2005). Moreover, poor and near-poor children were less likely than those in nonpoor families to have a usual source (90 to 93 percent versus 98 percent). SCHIP has the potential to close these gaps by extending coverage to low-income, uninsured children.

The source of care may vary, however, depending on the mix of participating providers. In 2003, publicly insured children were less likely than privately insured children to have a doctor's office as their usual source of care. Among children with a usual source of care, 88 percent of privately insured children had a doctor's office as their usual place, compared to 63 percent of publicly insured children and 57 percent of uninsured children (Dey and Bloom. 2005). In contrast, only 11 percent of privately insured children identified a clinic as their usual place of care, compared to 33 percent of publicly insured children and 36 percent of uninsured children.

## **ADVANTAGES ASSOCIATED WITH A USUAL SOURCE OF CARE**

Many studies have documented that children who have a usual source of care are more likely than those without a usual source to access health care services. For example, people with a usual source of care are more likely to receive preventive care visits within the recommended time frame (Ettner 1999; U.S. Department of Health and Human Services

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<sup>1</sup>The American Academy of Pediatrics uses the term "medical home" instead of "usual source of care." The definition of a medical home is more extensive than that of a usual source of care, requiring "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective" medical care provided by a single physician who "manage(s) or facilitate(s) essentially all aspects of pediatric care" (Sia et al. 2004). The analysis in this report is restricted to the definition of a usual source of care. Since the medical home concept entails more than having a usual source of care, provision of a usual source does not necessarily imply provision of a medical home (Bethell et al. 2004).

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2000; Irvin et al. 2002). They also are more likely to use physician services at higher rates (Smith and Bartell 2004; Lambrew et al. 1996; Bartman et al. 1996). In addition, having a usual source of care is associated with earlier, more accurate diagnoses and fewer unmet needs (Starfield and Shi 2004). It also is associated with fewer and shorter hospital stays (Berman et al. 1999; Smith and Bartell 2004; Christakis et al. 2001; Starfield and Shi 2004). People with a usual source of care are also more likely to be satisfied with their health care (Smith and Bartell 2004; Irvin et al. 2002; Starfield and Shi 2004), to form stronger and more trusting relationships with their doctors (Roberge et al. 2001), and to better comply with care regimes (Irvin et al. 2002).

Several studies suggest that the benefit of having a usual source of care may depend upon the type and continuity of that source. One study, for example, suggests that having a usual provider increases physician utilization rates more than having a usual place of care (Lambrew et al. 1996). Furthermore, the disadvantage associated with health clinics and emergency rooms may be eliminated when children see the same physician at that location (Kasper 1987). While many studies consider only whether individuals have a usual source of care at one particular time, others have found that maintaining the same usual source over time promotes greater patient satisfaction (Smith and Bartell 2004) and interpersonal communication between doctor and patient (Flocke 1997). Moreover, a continuous usual source of care is associated with fewer unmet needs (Smith and Bartell 2004) and reduced likelihood of an emergency department visit or hospital stay (Christakis et al. 2001).

## METHODOLOGY

To assess the extent to which SCHIP enrollees have a usual source of care, we reviewed the annual state SCHIP reports submitted to CMS for a five-year period—fiscal years 1999 through 2003. These reports reflect states' strategic objectives and performance goals related to improving utilization and access under SCHIP. During this five-year period, 44 states and the District of Columbia reported at least one measure related to provision of a usual source of care. Some states gauged the percent of enrollees who identified a usual source of care, and other states used less direct measures. In states where more than one annual report contained usual source of care data, we present the most recent data. We review the range of measures that states reported and present data for the 17 states that directly measured the percent of SCHIP enrollees with a usual source of care. All 17 states relied on survey data to measure the percent of SCHIP enrollees with a usual source of care.<sup>1</sup>

We supplemented data from the annual reports with evidence from focus groups conducted by Mathematica Policy Research, Inc. in eight states between April 2003 and May

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<sup>1</sup> Presence of a usual source of care is typically measured through surveys. In addition, a growing number of studies have used administrative claims data to measure the continuity of ambulatory care. These studies consistently demonstrate that increased provider continuity of care is associated with a reduced likelihood of emergency department visits (see, for example, Brousseau et al. 2004; Christakis et al. 2001; and Gill et al. 2000). However, claims data cannot distinguish whether families perceive that they have a usual source of care, which may be a key determinant of access to care (Williams 2002).

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2004. We conducted 51 focus groups with parents of SCHIP enrollees—500 parents in total—in one rural and one urban area in each of eight states: Georgia, Kansas, Kentucky, Maryland, Ohio, Pennsylvania, South Carolina, and Utah. We used the experiences articulated by these parents to develop additional themes related to parents’ perspectives on the value of, and challenges in, obtaining a usual source of care for their children.

## STATE REPORTING ON USUAL SOURCE OF CARE

Our review of the annual reports revealed that states are using a wide array of measures to assess the provision of a usual source of care to SCHIP enrollees. The most common measure was the percent of SCHIP enrollees who had a usual person or a usual place of care, as reported by the child’s parent. Several states using this measure also reported the percent of enrollees who had a usual source of care before enrolling in SCHIP, which allowed us to assess enrollees’ experiences before and after SCHIP enrollment.

Other states used measures less directly related to assessing whether SCHIP enrollees had a usual source of care. One such approach was to include delivery system characteristics (for example, the percent of counties with HMO coverage). This measure is based on the premise that members typically choose (or are assigned) a primary care provider when they enroll in a managed care plan. Similarly, some states reported physician participation data—such as the number or percent of primary care providers (PCPs) who participate in SCHIP—as an indicator of provider availability. Other states presented utilization data—such as the HEDIS® “Access to PCPs” measure—which reflects the percent of children who visited a primary care physician during the previous year (although not necessarily the child’s usual source of care). A few states reported the percent of children who had emergency room visits in the previous year as a proxy for the absence of a usual source of care. Finally, a few states conducted a Consumer Assessment of Health Plans Survey, reporting the percent of SCHIP parents who had a “big problem,” a “little problem,” or “no problem” finding a personal doctor or nurse for their child. None of these approaches, however, directly captures the prevalence of a usual source of care among SCHIP enrollees.

In this report, we focus on the 17 states that reported the percent of enrollees with a usual person or place of care.<sup>2</sup> These measures most directly gauge the provision of a usual source and also represent the family’s perception of whether they have a usual source. This perception is important, as establishing a relationship with the family is a fundamental goal of a usual source of care. Where feasible, we distinguish the likelihood of having a “usual place” versus a “usual person.” The latter is less common but more effective.

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<sup>2</sup> All 17 states gathered these data through enrollee surveys. Because these data are self-reported, they may be subject to survey response bias. One state, Texas, reported two types of usual source of care data. We used the most recent data on the percent of children with a usual person when comparing to the *Healthy People 2010* benchmark. We used the earlier data to examine the percent of children with a usual place before and after SCHIP.

## EVIDENCE FROM THE STATES

As Table 1 shows, 10 states reported the percent of SCHIP children who had a usual *person* from whom they received care, with results ranging from 67 to 96 percent. In addition, five states reported the percent of SCHIP children who had a usual *place* for care, with results ranging from 81 to 99 percent. Two states included usual source of care data, but did not specify whether their data represent a usual person or a usual place. Consistent

**Table 1. Percent of SCHIP Enrollees with a Usual Source of Care in 17 States**

State	Program Type and Dominant Delivery System	Date of Survey	Sample Size and Response Rate	Definition of Usual Source of Care	Percent of SCHIP Enrollees with a Usual Source of Care
<b>States Reporting the Percent of Children With a Usual Person</b>					
Alaska	M-SCHIP FFS	2003	n = 1,998 Response rate: 70%	Personal physician/nurse	67
California	COMBO MC	2002	n = 6,005 Response rate: 87%	Personal physician	67
Iowa	COMBO MIXED	2001 to 2003	n = 1,698	Personal doctor/nurse	86
North Carolina	S-SCHIP FFS	2000	n = 923 Response rate: 40%	Personal doctor/nurse	72
North Dakota	COMBO PCCM	2003	N.A.	Personal doctor/nurse	78
Ohio	M-SCHIP FFS	2001	n = 3,900 <sup>a</sup>	Personal doctor/nurse	90
Rhode Island	M-SCHIP MC	2001	n = 1,485 Response rate: 32%	Regular doctor	96
Texas	COMBO MC	2002	N.A.	Usual pediatrician/ family practice physician	94
Utah	S-SCHIP MC	2002	Age 0-12 n = 1,013	Personal doctor/nurse	86
Wyoming	S-SCHIP FFS	2002 <sup>b</sup>	n = 247 Response rate: 16%	Regular doctor	85

State	Program Type and Dominant Delivery System	Date of Survey	Sample Size and Response Rate	Definition of Usual Source of Care	Percent of SCHIP Enrollees with a Usual Source of Care
<b>States Reporting the Percent of Children With a Usual Place</b>					
Florida	COMBO MC	2003 <sup>b</sup>	N.A.	Usual place	Over 95
Maine	COMBO PCCM	2000	n = 806 Response rate: 72%	Regular doctor's office/health center	98
Missouri	M-SCHIP MIXED	1999 <sup>b</sup>	n = 2,414	Regular doctor/clinic	91
New Hampshire	COMBO MC	2001 <sup>b</sup>	S-SCHIP only	Usual place	99
Virginia	S-SCHIP MC	2001	n = 1,257	Particular place for routine care	81
<b>States Not Defining Usual Source of Care</b>					
Alabama	S-SCHIP FFS	2003	N.A.	Undefined	92
West Virginia	COMBO FFS	2000	N.A.	Undefined	60

Sources: State Title XXI annual reports from fiscal years 1999 through 2003.

Notes: M-SCHIP denotes that the state operates a Medicaid expansion program; S-SCHIP denotes that the state operates a separate child health program; COMBO denotes that the state operates both an M-SCHIP and an S-SCHIP program. Dominant delivery system is defined according to the type of system accounting for two-thirds or more of SCHIP enrollees in FFY 2003, based on the SCHIP Enrollment Data System (SEDS). MC denotes managed care; PCCM denotes primary care case management; FFS denotes fee-for-service; and MIXED denotes a mixed system in which no single type accounts for more than two-thirds of SCHIP enrollees. Data should not be compared across states due to measurement differences.

N.A. = not available.

<sup>a</sup>Count is approximate.

<sup>b</sup>Date of annual report in which the survey was presented. Date of survey not reported.

with other data sources, the percent of children with a usual place typically is higher than the percent with a usual person, given the higher likelihood that families identify a place they go for care as opposed to a specific provider at that place (U.S. Department of Health and Human Services 2000).

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States varied widely in the wording of survey questions within the “usual person” and “usual place” categories. As a result, the variation in state results may, in part, reflect their different measures.<sup>3</sup> For example, a usual place was defined as “a regular doctor’s office or health center” in Maine, whereas it was defined as “a particular place for routine care” in Virginia and as “a usual place for sick care and health advice” in Texas. The latter two definitions may include children who use the emergency room as their usual source of care. Within the “usual person” category, California parents were asked whether their child had a “personal physician,” whereas parents in several other states were asked whether their child had a “personal doctor or nurse.”

The *Healthy People 2010* goals offer two national benchmarks against which we can compare state data. By 2010, 85 percent of all people should have a usual primary care provider,<sup>4</sup> and 97 percent of all children should have a usual place for health care other than the hospital emergency room (U.S. Department of Health and Human Services 2000).<sup>5</sup> Figures 1 and 2 compare the performance of state SCHIP programs to the *Healthy People 2010* benchmarks. Of the 10 states reporting data on the percent of children with a “usual person” (Figure 1), 6—Iowa, Ohio, Rhode Island, Texas, Utah, and Wyoming—were at or above the *Healthy People 2010* goal for a usual provider. In addition, two of the five states reporting “usual place” data (Maine and New Hampshire) surpassed the *Healthy People* benchmark for that measure (Figure 2).

Six of the 17 states reported the percent of enrollees who had a usual source of care before and after SCHIP enrollment. As Table 2 shows, these states used several methodologies to assess SCHIP enrollees’ experiences before enrollment. Two states used retrospective studies, asking SCHIP enrollees to recall their experience before enrollment compared to after enrollment. Another state compared the experience of new enrollees before SCHIP to the experience of established enrollees after enrolling in SCHIP. Finally, one state used a pre/post design, surveying a single cohort of SCHIP enrollees at two times: (1) just after enrollment, to assess their experience before SCHIP, and (2) one year later, to assess their experience on SCHIP. Two states did not report their study designs.

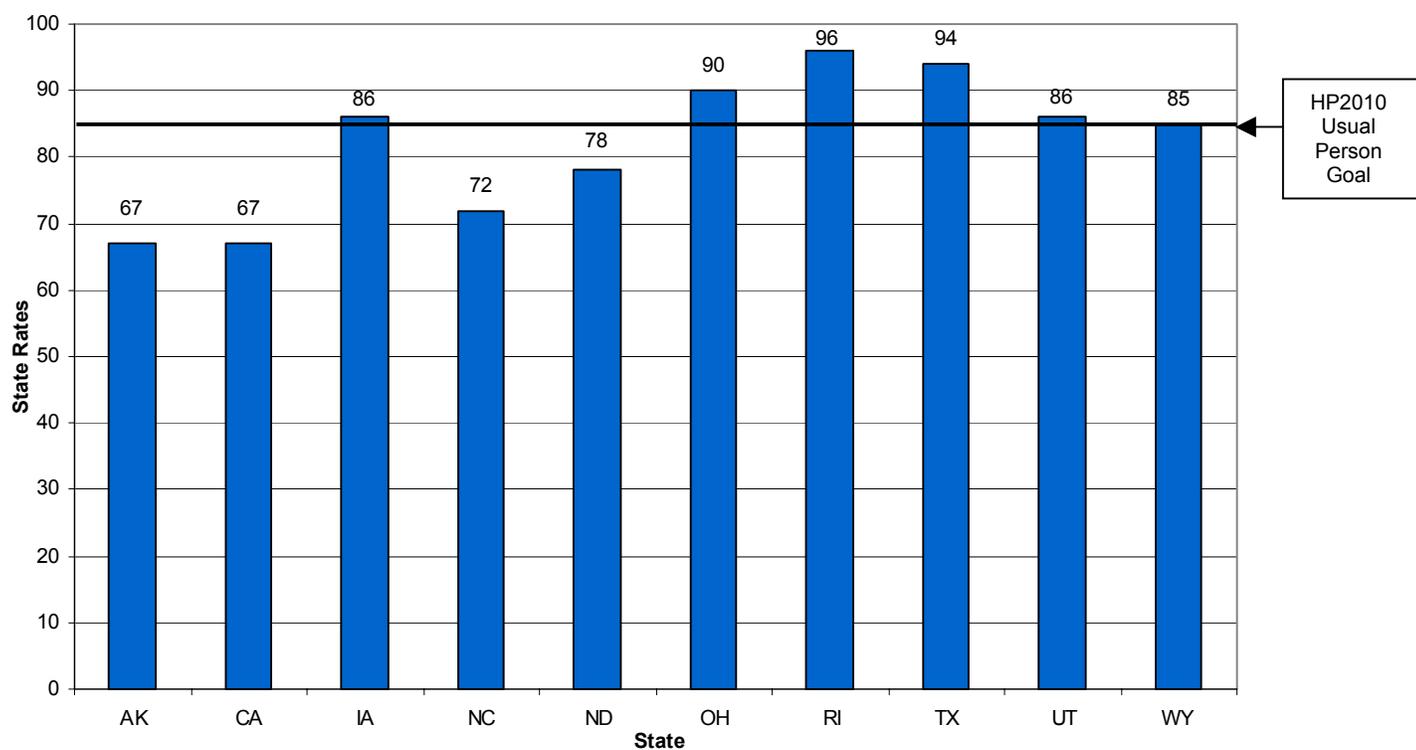
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<sup>3</sup> These data should not be used to make comparisons across states because of differences in the definitions used by each state.

<sup>4</sup> The 85 percent goal is based on data from the 1996 Medical Expenditure Panel Survey (MEPS). It pertains to the total population and not specifically to children. The 2010 target was established using the method “better than the best.” In other words, the objective is to exceed the baseline rate of 79 percent exhibited by whites in 1996.

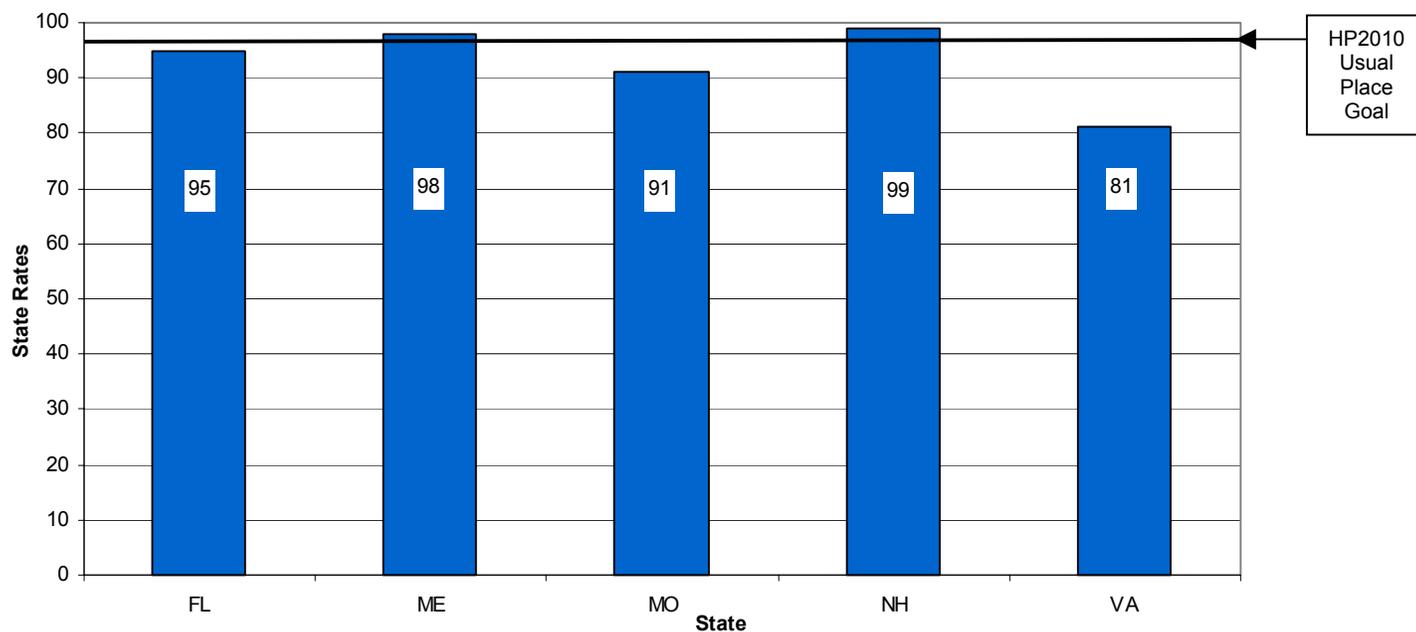
<sup>5</sup> The 97 percent goal is based on data from the 1998 National Health Interview Survey (NHIS). The 2010 target was established using the method “better than the best.” In other words, the objective is to exceed the baseline rate of 95 percent exhibited by white children under age 18 in 1998.

**Figure 1. Percent of SCHIP Enrollees with a Usual Source of Care, Where “Usual Source” Is Defined as a Usual Person**



Source: State Title XXI annual reports from fiscal years 1999 through 2003.

**Figure 2. Percent of SCHIP Enrollees with a Usual Source of Care, Where “Usual Source” is Defined as a Usual Place**



Source: State Title XXI annual reports from fiscal years 1999 through 2003.

*SCHIP Makes Strides Toward Providing a Usual Source of Care*

**Table 2. Overview of Studies That Compared the Percent of Children with a Usual Source of Care Before and After SCHIP**

State	Program Type	Date of Survey	Sample	Definition of Usual Source of Care	Methodology
Alabama	S-SCHIP	2003	N.A.	N.A.	Pre-SCHIP experience of new enrollees compared to SCHIP experience of established enrollees
Florida	COMBO	2003	N.A.	Usual place	N.A.
Iowa	COMBO	2001 to 2003	n = 1,698	Personal doctor/nurse	Pre/post (surveyed at two points in time)
Missouri	M-SCHIP	1999 <sup>a</sup>	n = 2,414	Regular doctor/clinic	Retrospective (surveyed at one point in time)
New Hampshire	COMBO	2001 <sup>a</sup>	S-SCHIP only	Usual place	N.A.
Texas	COMBO	2000	n = 602	Usual place for sick care/health advice	Retrospective (surveyed at one point in time)

Source: State Title XXI annual reports from fiscal years 1999 through 2003.

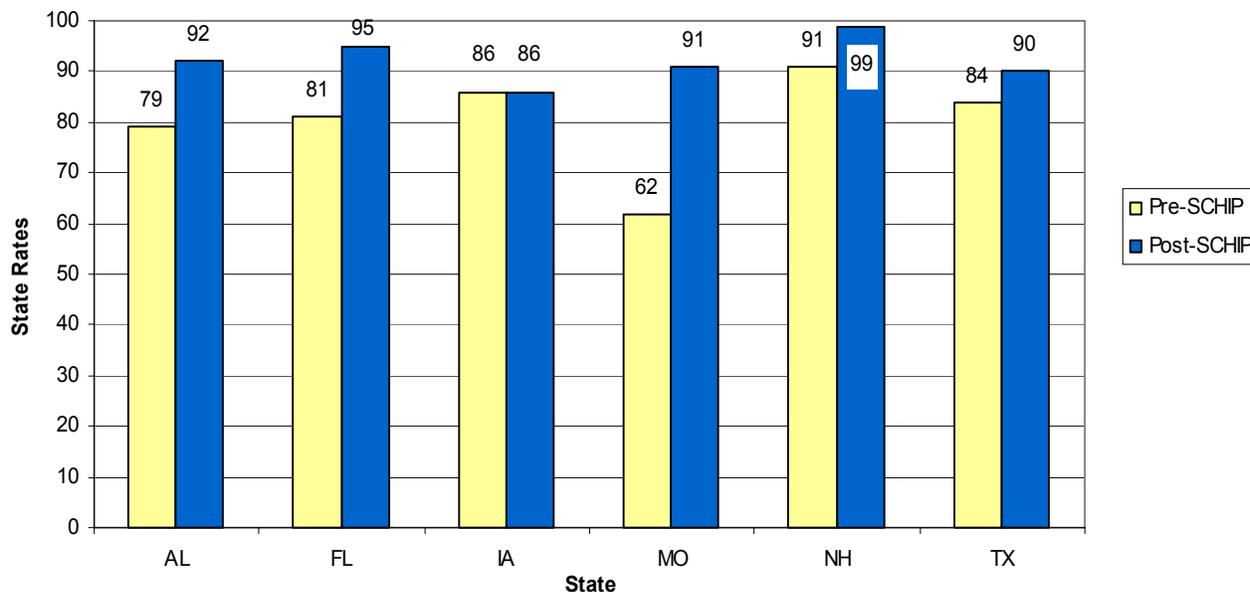
Note: M-SCHIP denotes that the state operates a Medicaid expansion program; S-SCHIP denotes that the state operates a separate child health program; COMBO denotes that the state operates both an M-SCHIP and an S-SCHIP program.

N.A. = not available.

<sup>a</sup>Date of annual report in which the survey was presented. Date of survey not reported.

Of the six states reporting pre-SCHIP data, only Iowa showed no change in the percent with a usual source (defined as a personal doctor or nurse) after enrolling in SCHIP, compared to before SCHIP. (Nevertheless, Iowa met the *Healthy People 2010* “usual person” goal both before and after SCHIP.) Among the remaining states, Missouri registered the greatest improvement, with 91 percent of parents reporting a usual source for their child after SCHIP enrollment, compared to 62 percent before enrollment. SCHIP enrollment was associated with a 13 to 14 percentage point increase in the likelihood of having a usual source of care in Alabama and Florida, 8 percentage points in New Hampshire, and 6 percentage points in Texas.

**Figure 3. Percent of Children with a Usual Source of Care Before and After Enrolling in State SCHIP Programs**



Source: State Title XXI annual reports from fiscal years 1999 through 2003.

Note: Florida, New Hampshire, and Texas reported data on the percent of SCHIP enrollees with a “usual place,” Iowa and Missouri reported on “usual provider,” and Alabama did not define the type of usual source of care.

Of the six states, Texas was the only one to include the statistical significance of its results, reporting that its increase from 84 percent pre-SCHIP to 90 percent post-SCHIP was not statistically significant. At the same time, Texas reported a statistically significant shift in the type of usual source. Before SCHIP enrollment, 43 percent of children had a doctor’s office outside of a hospital as their usual place of care, as opposed to a clinic, emergency room, doctor’s office within a hospital, or other location. After SCHIP enrollment, the rate increased to 61 percent. These data suggest that SCHIP coverage may have facilitated access to care in physicians’ offices as an alternative to clinics or other settings.

### **FAMILY EXPERIENCES WITH A USUAL SOURCE OF CARE**

Focus groups with SCHIP parents illustrate that parents value SCHIP’s provision of a usual source of care and are generally satisfied with the choice of providers under SCHIP. However, their stories also highlight some barriers to obtaining a usual source of care under SCHIP.

**Parents value having a usual source of care for their children.** Parents universally preferred having a usual source of care for their children. They perceived that having a usual source of care made it easier for doctors to be familiar with children’s medical histories and thereby aided diagnosis and treatment of ailments. One Georgia parent described how

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having a usual doctor facilitated her son's treatment, saying that this doctor "knows [my son's] history, he knows what he's allergic to, he knows every little what triggers what. [When my son got sick, this doctor] knew what was going on when he walked through the door and he didn't have his chart. Cause he knew him." Parents also appreciated that a usual source of care fosters stronger doctor-patient relationships. One Kansas parent described her child's usual doctor as "part of (the) family." A Kentucky parent echoed this preference for a personal doctor-patient relationship, saying that she valued "a pediatrician that was more concerned for [her daughter] as a person, as well as for her illness...not just do their job, but be a friend also." A Utah parent suggested that such a relationship is particularly important when the child has mental health issues: "They develop a bond with the child and that's half the issue...knowing what's going on and moving forward."

Parents also said that medical appointments frighten young children less when the children are familiar with the doctor. As one Utah parent explained, "Children that are young, they get scared really fast" and "getting your kids used to the same person" helps to relieve that fear. One South Carolina parent agreed that her children's relationship with their doctor made accessing the health care system a more comfortable experience: "My children go right in there and tell [their doctor] what's wrong with them. They love him." Another South Carolina parent shared a similar experience: "[My son] is not afraid to tell [his doctor] if he's sick or what's wrong, or anything. He trusts her, so it's a big difference." One Ohio parent said that developing a relationship with a particular pediatrician is important for the comfort level of the parent, as well. "That's the main thing, the term stability," this parent stated. "Not only for the children. For us. When your child is sick, you want to have confidence in that doctor. And the only way you can build up that type of confidence is to build up a relationship over time."

**SCHIP makes it easier for children to have a usual source of care, although some barriers remain.** The focus groups confirmed the annual report findings that SCHIP has succeeded in providing a usual source of care to many children. One Pennsylvania parent, for example, expressed gratitude for SCHIP's provision of a usual source of care: "I always wanted my children and us to go to a family type, not so much of a hospital, but family doctor. Really personal. And (family doctors) are able to take SCHIP.... I like that." A few parents, however, said that SCHIP had not yet provided a usual source of care for their children.<sup>6</sup> In some cases, the reason for this was administrative troubles. For example, one Georgia parent reported that the doctor listed on her child's SCHIP card refused to see the child, saying that the practice was no longer taking new patients. This parent then had difficulty working with SCHIP to get a new doctor on the card. As a result, she "end[ed] up at the emergency room every time [her] son [got] sick, sitting four, six, maybe eight hours." One parent in Maryland also regularly took her child to the emergency room for care. This parent said that only one doctor in the child's pediatric practice accepted SCHIP, so her child went to the emergency room when that doctor was unavailable.

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<sup>6</sup> It should be noted, however, that a small percentage of children with private insurance coverage do not have a usual source of care (1.9 percent in 2003 [Dey and Bloom 2005]), signifying that barriers remain regardless of insurance coverage.

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**Parents are concerned about continuity in their usual source of care.** Maintaining continuity in a usual source of care was a major concern for parents. Discontinuities in a usual source of care may occur when children switch between SCHIP and Medicaid or other coverage. In fact, a few parents mentioned that fear of losing their pre-SCHIP doctor initially prevented them from applying to SCHIP. Upon enrolling in SCHIP, many parents were relieved to discover that their pre-SCHIP doctor accepted SCHIP. The following story of a Utah parent illustrates this experience: “When I [gave birth to] my daughter...[her doctor] must have been the pediatrician on call. He came in, looked her over, we loved him.... He just was luckily covered by SCHIP when we got enrolled in SCHIP.” Most parents expressed satisfaction with the selection of doctors on SCHIP. One Maryland parent summed up the experience, saying, “I’m extremely happy with our doctors [on SCHIP].... They’ve always been excellent.... When I had insurance through my employer, it was very good insurance. And this is lined up with it exactly.”

Other parents discovered that their child’s provider did not participate in SCHIP. For some of these parents, a wide selection of doctors often was not a consolation for the loss of the one doctor they knew and trusted. In the words of one Georgia parent, “My little boy’s been sick since the day he was born...and the pediatrician that we used in this entire time...was not on the plan... And I have a really hard time pulling him out of there.” For this parent, it was not worth sacrificing the history with the pre-SCHIP doctor to have expenses paid by SCHIP: “When [my son] was just in the hospital, [his old doctor] came and saw him anyway. And I just paid for that out of pocket because she knew what was going on.”

Other parents were concerned about discontinuity in their relationship with the physician at their usual source of care as they transferred between health plans within SCHIP. One Utah parent explained, “My youngest was born with a heart condition. So, my previous pediatrician had known him from day one.... And a few months back when I renewed and they told me that I had to go through [a different health plan], I had to go through everything. [He got] new doctors, [I had] never met the cardiologist...and so it was scary.” Parents also cited administrative hassle as a reason for preferring continuity. As one Utah parent put it, when you have to switch doctors, “You’re starting over. You’ve already got the process flowing. You’ve spent the time and energy finding out who, what, when, where, and suddenly that doesn’t apply anymore and you have to start over.... It [is] an extreme hassle.”

Our focus groups also revealed two continuity issues specific to Kansas.<sup>7</sup> First, parents identified network incompatibility between SCHIP and Medicaid as an obstacle to a continuous usual source of care. As one Kansas mother explained, “I had problems with [my children] switching back and forth [between SCHIP and Medicaid] every other month. They’d be on SCHIP one month. They might be on Medicaid the next month.... And so, the same doctor they were going to [on Medicaid], they couldn’t go to if they had SCHIP

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<sup>7</sup> These concerns were substantiated during a Kansas site visit in March 2003.

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that month...so my kids have two doctors and two nurses.” Some Kansas children who were continuously enrolled in SCHIP also struggled to maintain one usual source of care. Several parents found that, each time they renewed SCHIP, they would get a new card with a new doctor. As one parent said, “We’ve had the same doctor all along. But every year when we get the renewal, they bump that doctor off and put a new doctor on his card.... And I have to call them every year and say, okay, we need to go back. This is supposed to be his doctor, you need to change it again.”

**Many parents prefer having a particular primary care provider as their usual source of care.** Most parents voiced a clear preference for having a usual physician to provide their children’s health care. Several parents were unhappy that their children were seeing more than one doctor, even when those doctors were all affiliated with a single place. As one Maryland parent said, “You find that when you enter the [SCHIP] program, sometimes you’re in a clinic where you don’t have just one specific doctor. Your child is seeing seven or eight different doctors and you’re not able to really [have]...one-on-one communication with one doctor.” An Ohio parent shared a similar preference for having a single provider at a clinic. “They have scheduled days that [my children’s doctor] is in [the clinic] and I make sure my kids’ appointments are set up on those days. And sometimes it’s a little busy in there...and so doctors try to say, ‘Okay, well, I can see you,’ and I say, ‘No, I’ll wait.’ I’ll wait for that doctor, that particular doctor.... I’ll sit there a couple hours, because I want to see who I want to see. I’m comfortable with her.”

Some parents were comfortable having more than one practitioner at their child’s usual place of care. As one Pennsylvania parent said, “My child’s pediatrician, there’s about eight in one office. But she’s seen all of them, and they’re all familiar with her records...so I still feel that it’s personal with every doctor.” However, this parent also felt that she was able to achieve a relationship with each of these doctors due to her child’s special health issues: “I guess because hers is like a little more severe than some of the other babies they have around. They’re all familiar with it.” An Ohio grandparent also expressed satisfaction with seeing more than one practitioner in a single clinic, saying, “Most of the doctors and the nurses or whoever is there, they truly care about the people that come and see them. You don’t have problems with those doctors.... They really want to be there.”

## DISCUSSION

Our review of the state annual reports indicates that many state SCHIP programs have achieved the usual source of care goals set forth in *Healthy People 2010*. In addition, evidence from several states suggests that children’s access to a usual source of care improved upon enrolling in SCHIP. These findings parallel National Health Interview Survey data, which showed a correlation between children’s enrollment in insurance programs (whether public or private) and attainment of a usual source of care. Furthermore, data from one state (Texas) demonstrated that gaining SCHIP coverage may facilitate access to care in physicians’ offices as an alternative to clinics or other settings. Within our focus groups, parents expressed gratitude for SCHIP’s provision of a usual source of care. Gaps remain, however, given the wide variation among states in the extent to which SCHIP enrollees have a usual source of care.

State reporting on SCHIP enrollees' identification of a usual source of care complements other performance-monitoring efforts currently ongoing under SCHIP. Core SCHIP performance measures relate to children's use of preventive care, access to PCP visits, and appropriate use of medications for asthma. Measurement of a usual source of care reflects another dimension of SCHIP's efforts to facilitate access—namely, the extent to which families perceive that they have a place or provider from which to seek care for their children when they need it.

Although states vary in how they define and measure the presence of a usual source of care among SCHIP enrollees, this report shows the value of tracking this indicator, particularly in relation to Healthy People 2010 goals. These data highlight where SCHIP has succeeded in providing a usual source of care, as well as where additional efforts may be required to fully realize SCHIP's dual goals of providing coverage and facilitating access.

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