AN ASSESSMENT OF THE

SAFETY NET

in San Diego, California

Acknowledgments

The Department of Health Policy is the home for health policy research and studies at the George Washington University Medical Center, School of Public Health and Health Services. The Department of Health Policy is dedicated to providing policymakers, public health officials, health care administrators, and advocates with the information and ideas they need to improve access to quality, affordable health care. This report and other *Urgent Matters* safety net assessments are available at the Department of Health Policy website www.gwhealthpolicy.org or the *Urgent Matters* website www.urgentmatters.org.

AN ASSESSMENT OF THE
SAFETY NET
in San Diego, California

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Foreward

After several years of decline, the number of Americans without health insurance is climbing rapidly. Meanwhile erosion in tax revenues is driving states to cut funding for Medicaid. Both trends are hitting all health care providers hard, as they are simultaneously attempting to cope with a nursing shortage, escalating labor costs, and the adoption of expensive new technologies.

These forces are felt the most in the health care safety net. These providers of care for the poor, uninsured and other vulnerable populations have not had to face such a confluence of challenges in recent memory. They must survive in an industry in upheaval, while attempting to serve the ballooning numbers of our fellow Americans in need. They must also continue to provide a set of highly specialized services, such as burn, trauma and neonatal care to a broad swath of their local communities.

It is against this backdrop that we have assessed the "state of the safety net" in San Diego. Due to the foresight of the Robert Wood Johnson Foundation, a team of researchers at The George Washington University Medical Center led by Marsha Regenstein, PhD, MCP, has assessed the health of the safety net in ten United States communities. In each community we worked with a Community Partner—a local organization that helped us to identify the key issues and stakeholders. In San Diego, we are deeply indebted to the Community Health Improvement Partners. These community partners have also committed to convening opinion leaders and others in their region to discuss the implications of the reports' findings. All of this was done as part of the *Urgent Matters* project, a national program designed to spur awareness of safety net issues while finding practical ways to relieve one symptom of distress—crowded emergency departments.

Our goal is to provide new analysis and information on what is happening today in the critical systems of care for the underserved in these communities. By doing so we seek to inform the health care discussions in these places and the nation, and to lay a foundation for rational change and improvement. We do not presume to know all the answers. But we believe that an objective analysis by an unbiased team can be immensely helpful to communities in need of a critical analysis of their safety net. This report seeks to meet this need.

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Executive Summary

The *Urgent Matters* program is a new national initiative

of The Robert Wood Johnson Foundation, designed to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. *Urgent Matters* examines the interdependence between emergency department (ED) use and the health care safety net in ten communities throughout the United States. One component of this program was the development of comprehensive assessments of the safety nets in each of the ten communities that served as the focus of this study. This report presents the findings of the San Diego, California, safety net assessment.

Each of the *Urgent Matters* safety net assessments was prepared by a research team from The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, in close collaboration with the project staff from the hospitals selected for this study and a community partner. The San Diego assessment draws upon information collected from interviews with senior leaders in the San Diego health care community and from on-site visits of safety net facilities. The research team also met with key stakeholders in San Diego as well as with residents who use safety net services.

To set the context for this study, the team drew upon secondary data sources to provide demographic information on the populations in San Diego, as well as data on health services utilization, coverage statistics, and related information. The assessment includes an analysis of data that indicates the extent to which the emergency department at the University of California at San Diego provides care that could safely be provided in a primary care setting.

This report examines key issues that shape the health care network available to uninsured and underserved residents in San Diego. It provides background on the San Diego health care safety net and describes key characteristics of the populations served by the safety net. It then outlines the structure of the safety net and funding mechanisms that support health care safety net services. The report also includes an analysis of key challenges facing providers of primary and specialty care services and specific barriers that some populations face in trying to access them.

Key Findings and Issues for Consideration: Improving Care for Uninsured and Underserved Residents of San Diego

The safety net assessment team's analysis of the San Diego safety net generated the following key findings:

- The San Diego safety net is a patchwork of systems struggling to meet the health care needs of its low-income and uninsured residents. Partnerships among provider groups are major strengths of the community. However, it is not clear whether these partnerships will be able to offset larger system issues such as inadequate financing, lack of insurance coverage, and gaps in needed services.

- The county's role in funding caring for the uninsured has diminished substantially, as a result of state funding reductions. This has placed greater pressure on safety net providers to piece together streams of funding to care for low-income residents. As a consequence, providers are increasingly dependent on Medi-Cal revenues to support safety net programs. Despite additional funding for the county indigent program from tobacco settlement monies, many uninsured residents continue to lack access to primary and specialty health care services.

- The demand for safety net services is increasing while the availability of providers willing to serve the uninsured and underserved is declining. Providers are facing low reimbursement rates from Medi-Cal and from the county's indigent program, making it more difficult to treat low-income and uninsured patients. As a result, services, particularly specialty care services, are in short supply for these populations.

- San Diego's mental health system is significantly under-funded and suffers from a lack of capacity. Although the county reports the average wait time for outpatient services is less than two weeks, many informants and patients report significantly longer wait times to see a mental health specialist. As a result, some patients forgo immediate treatment and seek care only in a medical emergency. Providers are expecting to see more patients turn to the ED for care in the face of still further anticipated cutbacks in mental health services.

- A significant percentage of ED visits at the University of California, San Diego are for patients whose conditions are non-emergent. More than one-fifth (21.9 percent) of all emergency department encounters that did not result in an inpatient admission were for patients who presented with non-emergent conditions. Another fifth (22.3 percent) were for patients whose conditions were emergent but could have been treated in primary care settings.

- Outreach for Medi-Cal and Healthy Families is widespread and enrollment in these programs has increased since January 2001 by 97 percent in Healthy Families and by 19 percent in Medi-Cal. Nevertheless, 18 percent of county residents remain uninsured and continue to identify the hospital ED as their main source of care. Furthermore, many uninsured, working residents are unfamiliar with community clinics' sliding scale payment policies and may forgo care because of the cost.

The Urgent Matters *safety net assessment team offers the following issues for consideration:*

- Community Health Improvement Partners (CHIP) should expand its health needs assessment project to include measures of primary and specialty care capacity. Using this information, CHIP could create effective tools to educate residents about available safety net services and link needy patients with important resources in the community. The organization should also continue to seek funding for important outreach programs such as Reach Out and SD-KHAN.

- A public awareness campaign, coupled with outreach efforts highlighting the importance of primary care and preventive check-ups, could improve residents' ability to navigate the health care system and help reduce the use of the ED for non-emergent care. Education efforts targeting the working poor would be especially helpful in this regard.

- Safety net providers should be encouraged to continue to collaborate and coordinate care on behalf of uninsured and underserved residents. The development of a formal referral network between the hospitals and other safety net providers could improve access and outcomes for patients who do not have a medical home.

- San Diego safety net providers must be aggressive in educating state and federal policymakers about the importance of adequate Medi-Cal reimbursement rates. Reductions in rates are likely to discourage primary care and specialty care providers from caring for Medi-Cal patients. Such reductions may also cause providers to limit the amount of free or discounted care they provide to uninsured residents.

- Small business leaders and local policy makers should work together to examine and address the significant financial and health care delivery problems of the San Diego safety net. Rising insurance premiums are leaving more workers at risk of becoming uninsured or underinsured. At the same time, increasing costs, inadequate reimbursements, and lack of specialty care providers are eroding the ability of community clinics and hospitals to fill the gaps. These problems require significant effort on the part of both the business and health care sectors.

Introduction

In 2000, the Institute of Medicine (IOM) published a report on the health care system serving uninsured and underserved individuals in the United States. Entitled *America's Health Care Safety Net: Intact but Endangered,* the report examined the viability of the safety net in the face of major changes in the financing and delivery of health care. The IOM report concluded that the safety net in America is under significant pressure from changing political and financial forces, including the growth in the number of uninsured, the reduction or elimination of subsidies funding charity care, and the growth of mandated managed care.

The Robert Wood Johnson Foundation established *Urgent Matters* in 2002 to further study the dynamics of the health care safety net. While the IOM report focused its review principally on ambulatory and primary care settings, *Urgent Matters* takes IOM's research a step further and examines the interdependence between the hospital emergency department (ED)—a critical component of the safety net—and other core safety net providers who "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[1]

The purpose of *Urgent Matters* is to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. The program consists of three key components: 1) technical assistance to ten hospitals whose EDs serve as critical access points for uninsured and underserved patients; 2) demonstration grants to four of these ten hospitals to support innovative and creative solutions to patient flow problems in the ED; and 3) comprehensive assessments of the safety nets in each of the communities that are home to the ten hospitals. This report presents the findings of the safety net assessment in San Diego, California.

Each of the *Urgent Matters* safety net assessments has been prepared by researchers at The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, in close collaboration with the hospital ED project staff and a community partner—an organization that is well-positioned to convene key stakeholders in the community to work together to strengthen safety net services on behalf of community residents. The *Urgent Matters* grantee hospitals and community partners are listed on the back cover of the report.

These assessments have been developed to provide information to communities about the residents who are most likely to rely on safety net services. They are designed to highlight key issues affecting access to care for uninsured and underserved residents, as well as to identify potential opportunities for improvement.

The safety net assessments were conducted over the summer and fall of 2003. Each assessment draws upon information developed from multiple sources. The San Diego assessment team conducted a site visit on July 21-23, 2003, touring safety net facilities and speaking with numerous contacts identified by the community partner and others. During the site visit, the community partner convened a meeting of key stakeholders who were briefed on *Urgent Matters*, the safety net assessment, and the key issues under review. This meeting was held on July 23, 2003, at the office of San Diego, Community Health Improvement Partners.

Through the site visits and a series of telephone conferences held prior to and following the visit to San Diego, the assessment team interviewed many local informants, including senior leaders at hospitals and health systems, community health centers and other clinics, public health and other service agencies and

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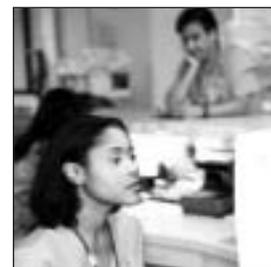
mental health agencies. Individual providers or provider groups, advocates, and policymakers were interviewed as well. The team also drew upon secondary data sources to provide demographic information on the population in San Diego as well as data on health services utilization and coverage.

While in San Diego, we conducted focus groups with residents who use safety net services. We held three groups with a total of 35 participants; two of the focus groups were conducted in English and one was in Spanish. The assessment team worked with the community partner to recruit patients who were likely to use safety net services. The assessment included an application of an ED profiling algorithm to emergency department data from the University of California at San Diego. The algorithm classifies ED encounters as either emergent or non-emergent cases.

Section one of the San Diego safety net assessment provides a context for the report, presenting background demographics on San Diego. It further describes the structure of the safety net, identifying the providers and facilities that play key roles in delivering care to the underserved. Section one also outlines the financial mechanisms that support safety net services. Section two discusses the status of the safety net in San Diego based on the site visits, telephone conferences and in-person interviews. This section examines challenges to the safety net, highlighting problems in access to needed services, growing burdens on hospital emergency departments, stresses on safety net providers, declining rates of insurance coverage, and other barriers to care faced by the underserved.

Section three presents findings from the focus groups and provides insights into the challenges that uninsured and underserved residents face when trying to access services from the local health system. Section four includes an analysis of patient visits to the emergency department at the University of California at San Diego. This analysis includes demographic information on patients who use the emergency department and examines the extent to which the emergency department at the University of California at San Diego may be providing care that could safely be provided in a primary care setting. Finally, section five presents key findings and issues that safety net providers and others in the San Diego area may want to consider as they work together to improve the care of uninsured and underserved residents in their communities.

Background

San Diego County encompasses a total area of roughly 4,200 square miles, spanning 65 miles from north to south and 86 miles from east to west.[2] The county's Health and Human Services Agency (HHSA) has divided the county into six geographic service regions: North Coastal, North Inland, North Central, Central, East, and South.[3] Despite the county's large service area, the total population of 2.8 million is concentrated primarily along the central and coastal areas of the county, as the North Inland and East regions are fairly rural in nature.

San Diego County has a population that is both increasing and getting older. San Diego is the third most populated county in California and its population is expected to increase by 29 percent to 3.9 million in 2020.[4] In the past decade alone, the county population increased by over 300,000 (13 percent) and the median age rose from 31.0 to 33.7 years.[5] As Table 1 illustrates, the county is also ethnically and racially diverse, and has become even more so over the past decade. Nearly one-quarter (23.4 percent) of San Diego County's residents are foreign born and about one-third are members of racial or ethnic minorities. Approximately 36 percent speak a language other than English at home.

Table 1	A Snapshot of San Diego and California	
	San Diego County	**California**
Population		
Total population	2.8 million	33.8 million
Size (square miles)*	4,200	155,959
Density (persons/square mile)*	668	215
Race		
White	67.9%	66.4%
Black	6.2%	7.0%
Asian	10.5%	13.0%
American Indian/Alaska Native	0.8%	1.7%
Native Hawaiian and other Pacific Islander	0.5%	0.6%
Other	13.3%	11.1%
Hispanic origin and race	28.8%	34.0%
Birthplace/Language		
Foreign born	23.4%	26.9%
Language other than English spoken at home	35.7%	40.6%
Age		
20 years and over	77.5%	76.9%
65 years and over	10.9%	10.3%
Median age (in years)	33.7	33.6

Sources: American Community Survey Profile, 2002, U.S. Census Bureau unless otherwise noted.
*State and County QuickFacts, 2000, U.S. Census Bureau.

While income and poverty statistics have improved in the county over the past decade,[6] a significant number of county residents live in households with incomes below the federal poverty level (FPL).[7] About one of every eight residents—approximately 350,000 individuals—is poor and an additional 500,000 are near poor, with incomes between 100 and 200 percent of the FPL (see Table 2).

Nearly 6.6 million California residents are uninsured.[8] San Diego County has a slightly lower rate of uninsured compared to the state, with approximately 530,000 uninsured county residents.[9] Approximately 83 percent of the uninsured are from working families in low-wage jobs and small businesses that are unable to provide adequate health care benefits.[10] San Diego County also has a lower percentage of adults and children who are covered by public programs such as Medi-Cal (California's Medicaid program), and Healthy Families, the State Children's Health Insurance Program.

Table 2	Income, Poverty Levels and Insurance Coverage in San Diego County and California	
	San Diego County	**California**
Income and Poverty (2002)		
Median household income	$50,384	$49,738
Living below poverty	12.4%	14.2%
Insurance Coverage (2000)*		
Private insurance	57.7%	55.8%
Medicare	11.1%	10.6%
Medi-Cal and Healthy Families	13.2%	14.3%
Uninsured	18.0%	19.4%

Source: American Community Survey Profile, 2002, U.S. Census Bureau unless otherwise noted.
* Source: Resources to Expand Access to Community Health (REACH) Data, 2002, National Association of Community Health Centers. [11]

Structure of the Safety Net

In San Diego County, most health services for beneficiaries of state and county funded programs are delivered through contracts with commercial health plans and local providers. In the past, the county owned and operated a public hospital and the health department played a large role in the direct provision of care. However, the county sold its public hospital to The University of California, San Diego (UCSD) in the 1970s. The county maintains its obligation to provide health care to indigent residents through its County Medical Services program and an operating agreement with UCSD that covers emergency outpatient and inpatient indigent health services.[12] The county also contracts with 36 health centers to provide care to the uninsured. Additional services for the uninsured and underserved are provided through various collaborative partnerships between the public and private sector.

Safety Net Providers

San Diego's health care safety net includes the major hospital systems, health plans that participate in Medi-Cal managed care (also called Healthy San Diego), community clinics, small office clinics and private physicians that provide care for free or at reduced rates, the county health department, and other programs and organizations committed to serving uninsured and underserved populations.

Table 3 shows provider and hospital capacity in the county in 1999. In San Diego County, the physician supply is comparable to that of the state. With the exception of emergency department visits, hospital use in San Diego is also comparable to hospital use statewide.

Table 3	Physician and Hospital Supply, San Diego County and California	
	San Diego	**California**
Physician Supply *(per 100,000)*		
Primary-care providers	78.1	79.7
Pediatricians	63.0	63.1
OB/GYN	27.2	30.0
Medical specialist	30.6	26.9
Surgical specialist	41.7	36.3
Hospital Supply/Utilization *(per 1,000)*		
Inpatient beds	2.0	2.09
Hospital admissions	86	95
Emergency department visits	225	277

Source: Data are for 1999. Billings and Weinick. 2003. Monitoring the Health Care Safety Net Book II: A Data Book for States and Counties. Washington, DC: Agency for Healthcare Research and Quality.
Note: Figures apply to 100,000 persons who would be the provider's patient population. Adult primary-care providers represent the number of providers per 100,000 individuals 18 years of age and older; pediatricians represent the number of providers per 100,000 children ages 17 and younger; ob/gyns represent the number of providers per 100,000 adult females.

Community Clinics: The county's 70 community clinic sites are the main source of primary care for San Diego's uninsured and underserved population.[13] In many locales, these clinics appear to be the only source of primary care either because few primary care providers are willing to accept low-income residents who are unable to pay the costs of care out-of-pocket or because of geographic isolation. The clinics provide a wide range of medical care, specialty services, and enabling services such as interpreter services and transportation.

In 2000, community clinics saw nearly 400,000 unduplicated patients; two-thirds of these patients had incomes below 100 percent of the FPL and an additional 23 percent had incomes between 100 and 200 percent of the FPL.[14]

In 2000, uninsured patients accounted for the highest percentages of clinic patients (68 percent), clinic visits (59 percent), and patient revenue (52 percent).[15]

Community clinics generally operate during normal working hours and few clinics are able to provide weekend and extended hours due to limited financial and staffing resources. In addition to primary care, a small number of community clinics provide limited specialty care such as optometry, podiatry, and some mental health and dental care services. Some office-based practices with largely privately-insured patients provide some level of charity care as well.[16]

Community clinics include federally-qualified health centers (FQHCs), which receive federal grant funding from the Health Resources and Services Administration (HRSA) and are governed by a patient-majority board.[17] FQHCs receive special federal grants to serve in areas considered to be at high-risk for poor health outcomes and lacking access to primary care. Three of these health centers, which are located in the city of San Diego, have a patient mix that is about 35 percent Medicaid and 50 percent uninsured.[18]

The FQHCs are located throughout the county and serve diverse communities. For example, in the southernmost part of the county, San Ysidro Health Center provides services to over 40,000 residents of border communities and inner-city locations and serves populations considered to be difficult to serve due to language or cultural barriers.[19] Although the communities that surround the San Ysidro Health Center are comprised of residents who do not meet federal poverty definitions, 87 percent of the community residents have incomes above 100 percent of the FPL—only 30 percent of the health center's clientele have incomes above 100 percent of the FPL.[20] On the opposite side of the county, North County Health Services (NCHS) provides primary care and limited specialty services to more than 51,000 patients in largely rural areas.[21] NCHS was established in the 1970s.

In addition to these safety net primary care providers, the health department runs six clinics that provide basic public health functions such as immunizations,

sexually transmitted disease, tuberculosis and HIV services. The health department does not provide primary care services and is therefore not a source of regular care for the uninsured.

Hospital Care: All hospitals in San Diego County participate in providing safety net care. However, three health systems provide the majority of hospital care to uninsured and underserved patients in the San Diego area: the University of California, San Diego (UCSD), Sharp Health Systems, and Scripps Health System. These systems are responsible for up to 90 percent of inpatient indigent care provided in the county.[22] Children's Hospital is also widely recognized as a safety net hospital for Medi-Cal children.[23] When the county sold its only public hospital to the University of California, San Diego in 1971,UCSD agreed to continue to serve the county's indigent population.[24] Although the county has contracts with other hospitals for the care of the indigent population, it relies significantly on UCSD Hillcrest as a safety net hospital.

Medi-Cal Health Plans: In 1998, San Diego County adopted a Geographic Managed Care model for Medi-Cal recipients. Under this new system called the _Healthy San Diego_ program, the state contracts with various non-profit managed care plans and pays for services on a capitated basis.[25] There are seven plans with Medi-Cal contracts, with Community Health Group and Sharp Health Plan accounting for over 65 percent of the total Medi-Cal managed care population in the county (See Table 4).

In 2002, these seven plans had a combined Medi-Cal enrollment of approximately 175,000.[26] The enrollment process for Medi-Cal is separate from enrollment in a managed care plan. For residents who also receive cash aid and other services through the CalWORKs program,[27] enrollment in one of the health plans is mandatory.

Table 4	Medi-Cal Plan Enrollment, San Diego County
Medi-Cal Plan	**Percent of Medi-Cal Enrollees in Plan**
Community Health Group	37.7
Sharp Health Plan	28.2
Blue Cross	8.9
UC San Diego	7.5
Universal Care	7.2
Kaiser Foundation Health Plan	5.4
Health Net	5.1

Source: Medi-Cal Policy Institute, County of San Diego, 2003. See www.medi-cal.org.

Behavioral Health: In 1998, the state contractually carved out mental health benefits from Medi-Cal managed care plans, giving counties the responsibility to structure the mental health system for Medi-Cal patients. In San Diego County, the county mental health system coordinates services for the uninsured, Medi-Cal and Special Education patients. The county is a direct provider of some mental health services including clinical and psychiatric assessments, medication management, individual and group therapy, and emergency psychiatric services. Outpatient and specialty services are also available through contracts with private and community-based providers. The county and contracted providers deliver services at 22 outpatient clinics for adults, 13 clinics for children, and a single adult psychiatric hospital that is equipped with 23 beds. The County also contracts with 11 hospitals on a fee-for-service basis, and contracts for an additional 20 beds for children and adolescents through UCSD.[29] In fiscal year 2002, approximately 37,000 adults and 10,000 children received outpatient services through the county mental health system.[30]

United Behavioral Health (UBH), a contract agency of the County of San Diego, manages the Medi-Cal private provider network for patients who need specialty mental health services. Through UBH, the county contracts with various providers in the community to deliver care on a fee-for-service basis; there are approximately 800 such providers. After a Medi-Cal patient is assessed, UBH provides patients with the names and phone numbers of three providers to contact.[31]

Children enrolled in Healthy Families[32] who are diagnosed as Severely Emotionally Disturbed (SED) receive basic mental health services through a network of providers from participating health plans contracted by the state. This system is referred as the Children's County Mental Health Service System. In these cases, children receive care from one of thirteen county mental health outpatient clinics. For uninsured and under-served children who do not qualify for these services, some mental health programs and services are also available for a reduced or sliding fee scale at community-based organizations, such as the St. Vincent de Paul Center.[33] Many children may also seek mental health services in hospital emergency departments.

Dental Care: Like behavioral health benefits, Medi-Cal dental benefits are carved out and Medi-Cal patients are linked to dental benefits through Denti-Cal, a system where the state contracts with providers to deliver dental care services. All Medi-Cal patients are eligible for Denti-Cal. Medi-Cal dental care covers adult and pediatric care. For Healthy Families, the state contracts with various commercial health plans to deliver dental services. Services covered under the Healthy Families and Medi-Cal program include diagnostic and preventive services, restorative services and oral surgery.

Community clinics and community-based organizations also provide some free or low-cost dental care to uninsured or underinsured residents. Such sites include the St. Vincent de Paul Center Dental Clinic and the San Diego Children's Dental Health Center.

Additionally, the San Diego County Health and Human Services Agency, in partnership with San Diego's Dental and Dental Hygienists' Societies and the Dental Coalition, established the Share the Care/Dental Health Initiative, which consists of volunteer dental providers offering emergency dental care to low-income children. Emergency dental services are also available to residents eligible for the County Medical Services program.

Community-based Organizations: Community-based organizations play a key role in forging public and private partnerships to stretch health care resources. Two prominent organizations include the Community Health Improvement Partners (CHIP) and Reach Out. These entities provide support services, coordination of resources, political advocacy, and community collaboration.

In 1995, the CHIP organization was created to conduct health needs assessments that track select health indicators and provide a framework for public and private partnerships to increase access to care. Nearly 30 organizations are official CHIP partners and various "work teams" include representatives from the health systems throughout the county, clinics and health centers, health agencies, health plans, the county Health and Human Services Agency, trade associations, and other community-based organizations. These work teams meet regularly to identify community needs and to address access to care, mental health, substance abuse, violence and injury prevention, and general health care issues. For example, CHIP has organized initiatives to train and educate community

providers about the behavioral health system and relevant programs available in their service area.

Reach Out provides telephone support services, primarily to uninsured adults. Reach Out also partners with a limited network of physicians who provide medical services at reduced rates. Services include primary care, some specialty care, and pharmacy and laboratory services. Reach Out provides services to about 3,000 callers each year and approximately 4,000 patients through its provider network. Most of the organization's funding comes from grants and private donations. The grants have not been scheduled for renewal, and the organization is currently looking for other funding opportunities.

County of San Diego SD-KHAN: San Diego Kids Health Assurance Network (SD-KHAN) is a County Health and Human Services Agency (HHSA) program that has developed a network of approximately 60 public and private partners that work together to link uninsured children with medical and dental care. SD-KHAN is a program that works closely with CHIP and has become an affiliate program of the CHIP organization. SD-KHAN staff provides considerable telephone support services such as health insurance enrollment advice, health education, periodic follow-up, and connections with available providers. The program receives approximately 9,000 calls annually, and the volume is expected to increase should Medi-Cal and Healthy Families reduce eligibility or benefits. [34] The program is financed mostly by state and county funds, although program staff is concerned about potential cuts to funding for the next fiscal year.

Community clinics generally operate during normal working hours and few clinics are able to provide weekend and extended hours due to limited financial and staffing resources.

Financing the Safety Net

The safety net in San Diego County is funded through multiple sources including federal, state, and local dollars:

Medi-Cal and SCHIP

The principal sources of funding for safety net services in the county are Medi-Cal, the state Medicaid program, and the State Children's Health Insurance Program, Healthy Families. In 2001, total Medi-Cal payments to providers were $1.1 billion.[35] Over 337,000 residents are covered by Medi-Cal[36] and enrollment has increased by 19 percent since January 2001.[37]

Healthy Families expands coverage for low-income children in families with incomes too high for Medi-Cal but still below 250 percent of the FPL. Enrollment in Healthy Families requires a monthly premium of $4 to $9 for each child, up to a maximum of $27 for all enrolled children in a family.[38] Over 53,000 children in the state are currently enrolled in the program[39] and county enrollment has increased by 97 percent since January 2001.[40] Healthy Families and Medi-Cal became more integrated when the state created one application for both programs, and applicants are typically screened for both programs.[41] Even with this improvement in the application process, an estimated 63,000 children eligible for Medi-Cal or Healthy Families remain uninsured.[42] Total state and federal costs for the Healthy Families program were $688 million for fiscal year 2002.[43]

California is currently facing one of the worst economic crises in its history and the state budget deficit is projected to be $7.9 billion for fiscal year 2004.[44] In an attempt to control costs, the state has proposed a number of changes to the Medi-Cal program. Moreover, starting on January 1, 2004, provider reimbursement was slated to be reduced by 5 percent for all Medi-Cal providers, with the exceptions of long-term care, clinical laboratories, rural clinics and FQHCs. However, a court-ordered preliminary injunction prevented the implementation of these cuts.[45] It remains to be seen how this injunction will affect California Governor Arnold Schwarzenneger's proposal to reduce the rates by 10 percent. Rates for Healthy Families Programs, inpatient hospitals, and long-term care are to remain frozen at 2003 levels.

Budget cuts are expected to have a significant effect on Medi-Cal eligibility and funding for outreach services. The Medi-Cal application process is already considered to be unnecessarily long and difficult, and extensive assistance is required for completing the relevant forms. Although collaboration among the stakeholders has helped reduce barriers to enrollment in Medi-Cal by providing education, advertisements, applications, and follow-up care, funding for outreach services may be reduced as state and federal funding diminishes. In the absence of outreach efforts, Medi-Cal enrollment numbers may decline and increase the number of uninsured persons seeking care.

The California legislature also approved a measure to eliminate the optional second year of Medi-Cal coverage for people transitioning off Temporary Assistance to Needy Families (TANF).[46,47] California will stop offering Medi-Cal coverage to TANF recipients as they make their way from welfare to work when their earned incomes rise above the eligibility threshold. The elimination of this option means that these workers must find alternative sources of coverage or risk being uninsured.

In January 2002, the federal government approved California's waiver to expand the Healthy Families Program to cover parents of children eligible for Healthy Families or Medi-Cal. The 2003-04 Governor's budget did not include funding for the expansion plan. In November 2003, newly-elected Governor Arnold Schwarzenneger sought additional cuts, proposing a reduction in Medi-Cal provider payments by 10 percent and caps on Healthy Families enrollment.[48]

County Medical Services

Some uninsured residents receive care through the County Medical Services (CMS) program, which pays for some health care services for medically indigent adults residing legally in the county and who are not eligible for any other publicly funded health care program. CMS is restricted to the medically indigent who have incomes of less than $802 per month, and are

suffering from conditions that would lead to death or disability if left untreated.[49] In fiscal year 2001/2002, the CMS program spent an estimated $51 million on primary, specialty and hospital care.[50] In fiscal year 2002-03, CMS served 20,338 patients. [51]

CMS reimburses its providers under contract from three pool reserves, each of which has limited levels of funding. The pools are the Primary Care Pool, the Specialty Physician/Outpatient Non-physician Reimbursement Pool, and the Hospital Reimbursement Pool. Thirty-six primary care clinics can claim reimbursement from the Primary Care Pool. These clinics have entered into contractual arrangements with the county to provide care for patients meeting the CMS program eligibility criteria. The 36 clinics receive fee-for-service reimbursements based on 250 percent of the Medi-Cal fee schedule and 100 percent for labs and dental services. The Specialty Physician/ Outpatient Non-physician Services Reimbursement Pool pays specialty physicians and ED groups on a 100-125 percent Medi-Cal fee schedule. University of California, San Diego (UCSD) receives a rate of 120 percent of the Medi-Cal fee schedule for services to CMS patients from this pool. The Hospital Reimbursement Pool pays contracting hospitals a fixed rate for each day of care, depending on the level of care provided, but irrespective of what services are provided. Contracting hospitals may share resources remaining in the pool at year-end, but may also receive lower per-diem rates in the case of pool shortfall.

Additional Funding for the Safety Net

San Diego County receives additional funding from state and local general revenues to pay for care for uninsured and underserved populations. These funds are used to provide services for low-income residents with no other source of coverage. For example, the county receives realignment revenue, which is made up of a portion of state sales tax and vehicle license fees. These funds may be spent on the uninsured, on public health, on Medi-Cal shortfalls and for other county health programs.[52] The realignment effectively transferred programs for indigent health care from the state level to the county level and provided the counties

with dedicated tax revenues. These dedicated tax revenues are based on sales tax and vehicle license fees and therefore fluctuate depending on the economy and policy decisions made at the state level.

San Diego County also receives funding under Proposition 99, which requires revenue from state taxes on tobacco products to be distributed to counties, hospitals, clinics, and doctors who care for the uninsured. Proposition 99 provides limited funds for the uninsured; funding for San Diego County was calculated at $8 per uninsured county resident in 1997.[53] In June of 1999, the San Diego County Board of Supervisors was the first county in the state to allocate all monies from the tobacco settlement to health care, which will become another source of funding for the county. Since that time, $52.4 million has been directed to the CMS program.[54]

San Diego's hospitals, a primary source of care for the uninsured, received $55.8 million in disproportionate share hospital (DSH) funds in fiscal year 2000-2001.[55,56] In the same year, UCSD reported nearly $35 million in DSH payments, and Children's Hospital received $7.7 million. The two large health systems, Scripps and Sharp Healthcare, reported $9 million and $2.8 million, respectively. [57] In 2002, uncompensated care costs, which include Medicare and Medicaid uncompensated care, bad debt, charity care, and county indigent care totaled more than $322 million.[58]

The uninsured also receive a significant amount of care through FQHCs, which are congressionally mandated to provide care to uninsured and underserved populations. These health centers receive federal grant funding to provide services to the uninsured bringing additional federal funds into the county. Over three-quarters of health center funding comes from federal grants and Medi-Cal sources.[59] County and local contracts represent 5 percent, or $5.5 million, of health center revenues.[60]

The safety net assessment team conducted interviews with key

stakeholders in the San Diego health care community and visited safety net facilities on July 15 to 17, 2003, during its assessment of the safety net. The analysis was greatly informed by the interviews with safety net providers and local stakeholders. Informants discussed important changes in local health policy and programs, emergency department use and crowding, issues relating to access to care, and significant barriers that patients face.[61]

Coordination of Services

The San Diego safety net is a patchwork of systems struggling to meet the health care needs of its low-income and uninsured residents. Partnerships among provider groups are major strengths of the community. Collaboration has enabled the CHIP organization to conduct valuable research and training, and to set goals for the community. Collaboration has also improved the coordination of resources and information. Reach Out and the SD-KHAN are just two examples of successful outreach programs that link uninsured residents with important health services. Finally, collaboration between the county and San Diego hospitals has improved the quality of care for patients. For example, the county and the hospital community collaborated to minimize the time hospitals divert ambulances to other facilities, thus reducing the resource burden placed on other emergency departments when a hospital goes on diversion.

Despite all of their successes, these collaborative efforts provide direct services to very limited numbers of residents, leaving many uninsured residents without medical homes. Moreover, it is not clear that these partnerships will be able to offset larger system issues such as inadequate financing, lack of insurance coverage, and gaps in needed services. Indeed, the strains on the safety net are likely to continue or worsen, as population growth, high unemployment rates,[62] and state budget shortfalls lead to increases in the number of uninsured.

Inadequate Primary Care Services

Many community clinic sites appear to be at capacity resulting in very long waiting times for appointments and services. Few health centers have been able to extend their hours through the weekend. Because these clinics and health centers rely heavily on Medi-Cal reimbursement, future cuts in Medi-Cal rates may force primary care sites to restructure their operations, conserve resources, limit benefits, or reduce staff.

Private physicians are also finding it more difficult to provide primary care services to uninsured and under-insured patients. Some are limiting the amount of time spent on patient education and prevention because such services are not reimbursed by Medi-Cal.[63] As noted earlier, primary care physicians are increasingly unwilling to participate in the Medi-Cal program due to low reimbursement rates.[64] Informants noted that anticipated cuts in Medi-Cal rates and the associated decreases in net revenue for providers caring for Medi-Cal patients are expected to discourage provider participation even more.

One additional factor driving providers' unwillingness to accept more Medi-Cal or uninsured patients is their perception that many of these patients do not show up for their scheduled appointments. Regardless of the reasons for high no-show rates, providers are reluctant to schedule appointments for uninsured patients, who may not present for care, when privately-insured patients could be scheduled in their place. For all these reasons, it has been difficult to find physicians willing to participate in programs like Reach Out and provide services at discounted rates.

Inadequate Specialty and Hospital Care

Access to specialty and hospital care seems to be difficult for both Medi-Cal patients and the uninsured. In some cases, patients may have to wait three to six

Emergency department crowding in San Diego stems from a number of factors, including ED closures, staffing shortages, fractures in the primary care system, and patient preferences.

months for an appointment.[65] Informants point to the decreasing number of specialists willing to accept the low reimbursement rate from Medi-Cal and CMS as part of the problem. Despite the availability of specialists in the county, many are reluctant to serve uninsured and publicly insured patients. Part of this reluctance is economic, and stems from the fact that they generally result in lower payment rates for providers. In addition, providers may perceive these patients to be difficult to manage and less likely to comply with appointment times and clinical recommendations.[66] Hospitals are also experiencing difficulties in finding medical and surgical specialists to serve the emergency department due to inadequate payment rates.[67]

Emergency Department Use and Crowding

Emergency department crowding in San Diego stems from a number of factors, including ED closures, staffing shortages, fractures in the primary care system, and patient preferences. Some of these problems stress the system by flooding EDs with non-emergent cases and causing a crowding issue. Others cause strains that are much more serious, forcing hospitals to close their EDs to trauma cases and divert patients to other area hospitals.

San Diego County has seen a significant decrease in ED capacity in the past few years. Since 1997, San Diego has lost four EDs to closures.[68] As a result, some hospitals in the area have experienced an increase in their ED volumes. Safety net hospitals such as Scripps Mercy and UCSD Hillcrest have diverted incoming ambulance patients for 300 to 400 hours per month.[69] Informants believe extremely long wait times are also causing a significant number of patients to leave the ED without seeing a physician.

Some San Diego hospitals are trying to manage the increased volume by developing more efficient practices and coordination of activities with other hospitals. Others, however, continue to report shortages of specialists and nurses, making it difficult to address increases in ED patient volumes and waiting times.[70]

In addition to capacity and staffing issues, other factors in the community are driving the increased reliance on the ED. As mentioned previously, the number of safety net primary care and specialty care providers is not sufficient to meet the growing demand for services. Clinics and physicians offices provide extended hours only a few days a week. Furthermore, San Diego is a strong managed care market, in which providers are paid a fixed fee for each designated member, regardless of the amount of services provided. As a result, there are few incentives for physicians to see patients after-hours; instead, they may refer patients to the ED.

For some patients, the ED is much more convenient because it is available 24 hours a day, seven days a week. The UCSD hospital ED is often crowded, in part because many residents know that they will receive care in the emergency department, regardless of their insurance status.[71]

Inadequate Behavioral Health Services

The mental health system in San Diego County is difficult to navigate and lacks adequate resources and providers. As a result, many Medi-Cal and uninsured patients do not obtain preventive care, forgo immediate treatment, and eventually seek care in the hospital emergency department. Although United Behavioral Health (UBH) links Medi-Cal patients to providers based on their specialties, informants indicate that Medi-Cal patients tend to have difficulty selecting the provider who is best suited for their specific mental health needs, and often complain that they cannot find a health care provider they can trust.[72] The County Mental Health Services reports that system-wide average wait times for outpatient services have been less than two weeks for the past six years. However, private providers and patients report significantly longer wait times to see a mental health specialist.[73]

The state contracts with health plans to provide services for children enrolled in Healthy Families who have been diagnosed as severely emotionally disturbed. The health plans and the county work collaboratively to

coordinate care and assign these children to an outpatient clinic. While this process has been viewed as positive, there have been cases in the past where children waited as long as six months to receive care at a clinic.[74]

For the uninsured, community clinics provide limited outpatient mental health services and may at times refer patients to the emergency department for care. Private hospitals appear to have inadequate capacity to treat and admit patients who present to the emergency department with complex conditions.[75] Despite the availability of psychiatric beds at the county psychiatric hospital and additional capacity through fee-for-service arrangements, the need for mental health services outstrips the available supply.

Access to adequate substance abuse services for uninsured residents is also limited in the majority of community clinics and community-based organizations.[76] Moreover, many providers are unaware of available treatment programs or do not fully understand how to connect patients with services. Not surprisingly, hospital EDs are a common source of care for patients with substance abuse problems. The limited number of county detox centers and rehabilitation beds are believed to be contributing to an increase in hospital ED visits.[77]

Inadequate Dental Services

Although San Diego County has a large proportion of dentists relative to other parts of California, access to timely and affordable dental care remains a significant problem. Lack of access to dental services stems from several factors, including the location of services, limited hours of operation, costs of care, and availability of providers offering dental services. In some areas, there are several dental clinics that provide services during normal business hours. However, the lack of weekend or extended hours at most clinics makes it difficult for many employed patients to access those services. Access problems are exacerbated when clinics can offer dental care only once or twice a week. When extended hours are available, the wait times and appointment delays are very long and may deter patients from seeking care.

Only a handful of clinics are able to operate their own dental practices, and provide regular services every day of the week.[78] The South Bay Family Dental Clinic, operated by San Ysidro Health Center, is one such site. Often, even when dental care is available, it is located in parts of the county that are difficult to access. The eastern part of the county is particularly underserved.[79] Although additional practices are expected to open in this part of the county, patients may continue to forgo seeking care because of cost, even when reduced or sliding scale fees are available.

For Medi-Cal patients, access to dental care is hampered by the lack of understanding about how to navigate the Denti-Cal system. Denti-Cal and dental benefits are not administered by Medi-Cal health plans. Instead, patients must go through another administrative system to receive care.

High Cost of Prescription Drugs

Access to affordable prescription drugs remains a significant problem for low-income populations. Although many community clinics operate pharmacies and provide medications at reduced rates, the price remains beyond the reach of many uninsured families. As a result, some patients will cross the nearby border to Mexico to get medications at lower prices. Otherwise, patients may forgo medications and, consequently, end up in the ED with more severe health problems or other complications.

Provider Issues

Primary care and specialty providers are threatening to leave the state, reporting that inadequate reimbursement is driving them out of the California health care market.[80] Even though county reimbursement rates are equal to or greater than Medi-Cal, services under the County Medical Services program are still well below the actual costs of providing care, and doctors and hospitals must absorb the additional costs of treating CMS patients.[81] Moreover, the state of California has one of the lowest Medicaid rates in the nation, and San Diego County has one of lowest rates in the state.[82] A recent report to the San Diego

Regional Chamber of Commerce shows that one in four California hospitals and one in ten physicians is expected to either stop serving Medi-Cal patients or leave the state. [83]

Looking ahead, compliance with a number of new state requirements will place added financial burdens on hospitals and other health care providers. As of January 1, 2004, the state is requiring hospitals to have a specified nurse-to-patient ratio (AB 394). Although the ratio depends on the department, the nurse staffing ratio is expected to be maintained 24 hours a day.[84] Additionally, hospitals are required to secure structural protection against earthquakes (SB 1953). Many informants believe that, in order to comply with these new mandates, facilities facing significant financial constraints and small profit margins will meet these standards by sacrificing monies and services for the uninsured.

There is also a growing concern that the number of uninsured residents will continue to rise. Recent hikes in premiums in employer plans are causing coverage to become less affordable to small businesses.[85] Those businesses that maintain coverage often pass at least some of their costs onto workers, many of whom drop coverage as premiums and co-payments become too difficult to absorb. The addition of even more workers to the existing pool of underinsured or uninsured residents will put added strain on limited safety net capacity. Therefore, the burden of providing care to the uninsured is likely to grow as rising premiums are forcing many smaller employers and their workers to forgo coverage.

In 2003, Former Governor Gray Davis signed the "Pay or Play" legislation (SB 2) that would require firms with 50 or more employees either to provide health insurance or pay a fee per worker into a state purchasing pool.[86] The monies collected would then be allocated to help pay the cost of health care for the uninsured. However, as of the first quarter of 2004, this legislation had not been enacted and many believe it will not be enacted under the current administration.[87]

Informants suggest that the county has historically not been a major funding source in subsidizing the cost of care for the uninsured and underserved populations.[88] A 1999 report[89] analyzing data from 1991-1996 found that San Diego County spent less than other counties in the state, both in terms of total dollars and as a percent of the county's health budget, on care for the uninsured. Some of this decline reflected a drop in state CHIP/Proposition 99 funding. Also during this time, the County Board of Supervisors adopted a policy to pursue the federal government to cover the costs of treating undocumented immigrants rather than using county funds.[90] While county spending for health care increased in every other California county studied during the time period covered by the report, San Diego County spending decreased by 25 percent.

More recently, the governor has proposed a redesign of the Medi-Cal program, but it is unclear what the final proposal will include and its impact on the San Diego safety net. As discussed earlier, major hospital systems, health plans, local health officials, and community advocates have worked hard to minimize gaps in health care for low-income populations. However, such private and public partnerships may not be adequate in the face of increasing financial stresses and sustained growth in the number of uninsured residents requiring care.

The County Health and Human Services Agency (HHSA) has re-affirmed its commitment to low-income residents.[91] In 1998, HHSA established the Consumer Center for Health Education and Advocacy to educate patients about health care access and act as advocates for patients seeking care through Medi-Cal, Healthy Families, CMS and the mental health system.[92] Also, since fiscal year 1999-2000, the county has allocated $52.4 million from tobacco settlement monies to care for the uninsured.[93] As a result, funding to the CMS program has increased over the last few years, raising eligibility levels under this program.[94] However, many informants contend that, overall, this has had little or no significant impact on the viability of the safety net. Many feel the health care needs of the growing uninsured and underserved far exceed available capacity provided by the county and the private sector.

Barriers to Care

Transportation

Compared to urban communities, transportation in rural areas is a major barrier to care. In the city and along the suburban coastline, buses are considered to be reliable and accessible for residents to use. However, in more isolated areas of the county, public transportation is inconvenient or unavailable. In response, many community clinics are providing free transportation. For example, North County Health Services provides van services for thousands of patients to four of its clinics in Oceanside.

Language and Cultural Factors

The high proportion of minorities and immigrants can have a significant impact on the safety net because these populations tend to require more supportive services such as health education, assistance in applying to public and social service programs and benefits, and maintaining follow-up care.

Interpreter services appear to be available for many residents in the county. Safety net hospitals and clinics have bilingual staff or certified interpreters available to assist Spanish-speaking patients. For less common languages such as Vietnamese or Somali, hospitals generally use telephone language lines. Most communication problems occur during a patient's first entrée into the health care system. Many first-time patients do not understand the importance of preventive exams and check-ups and may fail to schedule or miss appointments. Depending on their country of origin, immigrant patients may be more comfortable accessing the hospital ED than using primary care providers who require scheduled appointments.

Enrollment

As noted earlier, one in seven residents (13.2 percent) is covered by public programs such as Medi-Cal and the State Children's Health Insurance Program. There are many more residents who, although eligible for Medi-Cal or Healthy Families, are not enrolled.[95]

Difficulties in the application process and immigration status were most commonly mentioned by informants. The application process for Medi-Cal and Healthy Families is long and difficult.[96] Applicants may require substantial assistance in completing the forms. In response, many local groups have collaborated to reduce barriers to enrollment by helping with education, advertisements, applications, and follow-up care. However, the state eliminated funding for some outreach activities and application assistance. County funding for some outreach activities carried out by programs such as SD-KHAN has been exhausted and no additional funding has been identified.

Enrollment of legal immigrant children with undocumented parents is particularly problematic. Some undocumented parents are reluctant to apply for public assistance programs because they fear the information related to their application for health programs will affect their chances of obtaining permanent resident status.[97] Also, a 1994 ruling by the county redefined its responsibility for indigent care and excluded undocumented immigrants from eligibility for any county services because the County Board of Supervisors believes this issue is a federal responsibility, not a local one.[98] Because county funds cannot be dedicated toward undocumented immigrants, outreach and education of undocumented parents with legal immigrant children has been difficult.[99]

The safety net assessment team conducted focus groups

with residents who receive their care from safety net providers in the San Diego area. The focus groups were held on July 21, 2003, at the La Maestra Clinic and a county health services building. Focus group participation was voluntary. Participants were recruited with the help of the local community partner, Community Health Improvement Partners, as well as other safety net providers and community groups. Recruitment efforts involved displaying flyers announcing the sessions and their schedules. Participants received $25 each in appreciation of their time and candor. A total of 35 individuals participated in the focus groups. Two focus groups were conducted in English and one was in Spanish.

At the time of the focus groups, 15 participants were uninsured, 14 were covered by Medi-Cal, four had private insurance, one had San Diego's County Medical Services coverage, and one was on Medicare. Several of the participants had small children who were covered either by Medi-Cal or Healthy Families. Twenty of the 35 focus group participants were currently employed; however, none of these jobs provided health insurance benefits.

The results of these groups highlighted difficulties that many uninsured and underserved residents have in accessing timely and affordable health services in the San Diego area. Their comments addressed issues related to primary care and prevention, access to specialty and inpatient services, their use of the ED for emergent as well as non-emergent care, their understanding of the health care system and the opportunities that are available to them, and their feelings about the provider community.

Overall Impressions of the San Diego Health Care Safety Net

Levels of satisfaction with the quality of health care were very high among those who received care through Medi-Cal, Healthy Families, in community clinics or through the assistance of programs such as Reach Out. Participants also reported feeling like they were treated equally by health care providers in community clinics and hospitals regardless of insurance status. Participants

"I don't go unless it's an emergency because I wouldn't know where to go without insurance, except for the hospital."

noted, however, that there is a great need in San Diego for more information about affordable primary care for the uninsured. Participants agreed that outreach for Medi-Cal and Healthy Families is widespread and is in many ways very successful. Still, they stressed that people without insurance are often uninformed about health care options besides the ED.

Spanish-speaking participants, most of whom were from Mexico, noted that there are ample interpreter services available in their neighborhood clinics. Some of these participants said that some providers discriminate against Mexican patients because of their insurance status or their inability to speak English. Several participants experienced medical complications and billing problems while receiving hospital care, and speculated that English-speaking patients would have not encountered similar difficulties.

Health Insurance Coverage and Access to Care

For a variety of reasons, the uninsured participants generally reported that they delayed seeking care until absolutely necessary. Some lacked awareness of low-cost or free services; others were misinformed about eligibility for such services. Four uninsured participants reported that they did not know where they would be "allowed" to seek health care services. Three others shared the view that community clinics exist for the very poor, but those who work are charged expensive fees for services or are not "eligible" to attend the community clinics at all. One uninsured man stated, "I make too much for the health centers. But I don't make enough to go where I'd really like to go."

Lacking knowledge of other options, many uninsured participants viewed the hospital as the first and only

resort for access to health care, and would only go there if the situation was dire. One uninsured participant whose children are covered by Healthy Families stated that because health care is so expensive, she would not seek medical services for herself unless it was a life or death situation: "I wouldn't go anywhere unless the emergency squad came and carried me off." Other uninsured participants agreed, and this sentiment was echoed in other groups. One woman stated, "I don't go unless it's an emergency because I wouldn't know where to go without insurance, except for the hospital."

Uninsured participants stated that they commonly tried to self-medicate or use home remedies to avoid having to pay for health care. Several uninsured participants reported that they often cross the border to Mexico for prescriptions, but most try to manage their health on their own, and wait until a condition requires urgent care. One woman stated, "I just deal with it myself… My friend is a nurse so I'll ask her what's the best way to doctor myself."

Three uninsured participants had received assistance finding medical care from Reach Out. Participants explained that Reach Out can help people find affordable options or charity care for serious or chronic problems, but according to the participants, it is "rare" to find a doctor or clinic that will provide free or reduced-fee services on a longer term basis for primary care.

Participants with children on Healthy Families reported that the process for enrolling is very time-consuming and requires great diligence. One mother reported, "I had to do a ton of legwork to get my daughter on, which I guess is the payoff for having such affordable coverage." Another parent reported that she lost her job and health benefits for her children so immediately tried to enroll in Healthy Families. However, the enrollment process took six months due mainly to errors and lost paperwork. During that time, she was not aware of any other options for care or assistance, and had to purchase hundreds of dollars worth of prescriptions for one daughter's asthma and another's behavioral health condition. At one point, she took her daughter to the ED during a severe asthma attack and charged the visit on her credit card.

One uninsured parent reported that his company had increased employee health insurance premiums. He explained that he could not afford the $400 per month that he would have had to pay for himself and his 16-year old daughter. He stated, "For me, I thought it'd be cheaper to just pay as I go versus spending money that I simply don't have. Right now, my concern is my daughter. I am told I will qualify for Healthy Families for her, but the paperwork is still being processed. I just pray nothing happens to either of us."

Specialty Care and Mental Health Services

Uninsured participants, as well as those covered by Medi-Cal, reported long wait times for appointments with specialists. A few commented that there are not enough specialists in San Diego of all different types. Some participants discussed how Medi-Cal does not pay competitive enough rates to keep specialists in their provider network. They also mentioned that the HMOs require you to wait "because they hope to wait you out." One woman covered by Medi-Cal explained that she waited three months between two related surgeries because the specialist was backlogged with patients. She attempted to see a different specialist, but had to wait and finally went to the hospital ED due to pain. After being admitted to the hospital, she received her second surgery, but regretted having had to endure the suffering and hospitalization before finally accessing the specialty care she needed.

The mental health system for the poor in San Diego County was reported to be tremendously inadequate and very difficult to navigate. Participants agreed, however, that mental health was just one more service that was difficult to access—no more or less so than other specialty or dental care.

Dental Care

Medi-Cal beneficiaries believed that dental care services are not covered because they are not available at their clinics. Some uninsured participants noted that some clinics help patients access dental care; however, in general, this is considered a "luxury" service at those

clinics. Participants indicated that in their neighborhoods, there are several community clinics that provide services at significantly reduced fees or on a sliding fee scale. Some participants found even the reduced rates to be unaffordable, and preferred to forgo any routine check-up or procedure. One informant described the situation as a decision between a $150 reduced fee for a dental visit and one week's worth of groceries. As an alternative, a few participants said they crossed the border to Tijuana to get inexpensive root canal work.

Prescriptions

Many participants reported having difficulties finding pharmacies that make medications available to low-income and uninsured populations. Although many community clinics are able to provide medications at reduced rates, the prices are still not affordable for many uninsured families. Participants of all backgrounds reported that a common alternative to obtaining high cost of prescription medications in the U.S. is traveling across the border to Mexico with a prescription. Some participants indicated that it was very easy to get pharmacists or doctors in Mexico to write prescriptions without an examination of any kind.

Emergency Department

Most participants stated that hospitals in the San Diego area were generally equal in terms of their quality and timeliness in providing care. Most agreed they would prefer "whichever hospital is closest" in an emergency. The hospitals that first came to mind for most participants were Sharps and Scripps hospitals in Oceanside and Escondido.

Some of the Mexican participants described negative experiences with a few of the hospitals, indicating that some took longer to treat Spanish-speaking patients, regardless of whether they were covered by Medi-Cal or not. Uninsured participants identified the hospital as their main source of care, and several stated that the hospital ED is the only place uninsured people can go for health care. Participants in one group pointed out that there is no longer a county hospital in the San Diego area. One participant explained, "The message is, they don't care about the poor people. We aren't really supposed to get health care anywhere, unless we pay for it."

Members of the focus groups described the hospital ED as the option of last resort. Many emphasized that they would only go to the ED if home remedies were not effective *and* the illness or condition caused severe pain. The focus group participants confirmed that while some may seek care at community clinics, many show up in the ED for primary care. Many of the participants stated that appointment times at primary care sites require long waiting periods during limited hours of the day. As a result, patients choose to go to the ED or forgo immediate treatment (although they will eventually end up at the ED with a more severe condition).

Many foreign-born parents did not understand the importance of routine preventive services, mainly because they have not had access to such services in the past. In many cases, they have only seen a doctor at time of illness. Therefore, some felt more comfortable going to the ED as opposed to seeing a primary care physician.

Overview

The emergency department plays a critical role in the safety net of every community. It frequently serves as the safety net's "safety net," serving residents who have nowhere else to go for timely care. Residents often choose the ED as their primary source of care, knowing they will receive comprehensive, quality care in a single visit. When and why residents use the emergency department depends largely on patients' perceptions of the quality of care in hospital EDs, primary care providers' willingness to see low-income, uninsured populations and the accessibility of timely care outside of the ED. Whether it serves as a first choice or last chance source of care, the ED provides a valuable and irreplaceable service for all community residents, including low-income, underserved populations.

Problems arise, however, when using the ED leads to crowding and ambulance diversion. When the ED is too crowded, quality of care and patient safety can be compromised. Many factors cause crowding, including limited inpatient capacity, staff shortages, physicians' unwillingness to take call, and increased demand for services from uninsured as well as insured patients. It is important to focus on all these issues when trying to address the problem.

In this section of the report, we provide an analysis of ED use at University of California at San Diego. Using a profiling algorithm,[100] we were able to classify visits as either emergent or non-emergent. We were able to further identify what portion of those visits were primary care treatable, preventable/avoidable or non-preventable/non-avoidable. Communities should use this information to further understand the dynamics of health care delivery. These data, however, do not tell the whole story and should not be viewed as a comprehensive analysis of emergency department use in the community.

1) Non-emergent, primary care treatable
2) Emergent, primary care treatable
3) Emergent, preventable/avoidable
4) Emergent, non-preventable/non-avoidable
5) Other visits not classified according to emergent or non-emergent status

According to the algorithm, ED visits are classified as either emergent or non-emergent. Emergent visits are ones that require contact with the medical system within 12 hours.

Emergent visits are further classified as either needing ED care or treatable in a primary care setting. Visits classified as "primary care treatable" are ones that could have been safely provided in a setting other than an ED. These types of visits are ones that generally do not require sophisticated or high-tech procedures or resources (such as CAT scans or certain laboratory tests).

The ED Use Profiling Algorithm

In 1999, John Billings and his colleagues at New York University developed an *emergency department use profiling algorithm* that creates an opportunity to analyze ED visits according to several important categories.[101] The algorithm was developed after reviewing thousands of ED records and uses a patient's primary diagnosis at the time of discharge from the ED to apportion visits to five distinct categories. These categories are:

When and why residents use the emergency department depends largely on patients' perceptions of the quality of care in hospital EDs, primary care providers' willingness to see low-income, uninsured populations and ease of access to timely care outside of the ED.

Visits that are classified as needing ED care are classified as either non-preventable/non-avoidable or preventable/avoidable. The ability to identify visits that would fall in the latter category may offer opportunities to reduce costs and improve health outcomes: patients who present with emergent but preventable/avoidable conditions should be treated earlier and in settings other than the ED.

A significant percentage of visits remain unclassified by the algorithm in terms of emergent status. Visits with a primary ED discharge diagnosis of injury, mental health and substance abuse, certain pregnancy-related visits and other smaller incidence categories are not assigned to algorithm classifications of interest.

The data from the ED utilization category must be interpreted cautiously and are best viewed as an indication of utilization rather than a definitive assessment. This is because the algorithm categorizes only a portion of visits and does not include any visits that result in an inpatient admission. For many hospitals, visits that result in an inpatient admission are not available in ED electronic databases. Presumably, since these visits warrant inpatient treatment, none would

fall into the non-emergent category. Excluding these visits may inflate the primary care treatable (both emergent and non-emergent) categories. However, ED visits that result in an inpatient admission generally do not comprise more then 10-20 percent of total ED visits and would likely have a relatively small effect on the overall findings. A larger effect could occur if more visits were categorized by the algorithm. Since a sizeable percentage of ED visits remain unclassified, percentages or visits that are classified as falling into one of the four emergent or non-emergent categories should be interpreted as a conservative estimate and may understate the true values in the population.

ED Use at UCSD

As part of the *Urgent Matters* safety net assessment process, we collected information on ED visits at the University of California at San Diego (UCSD) for the period July 16 through December 31, 2002. There were 11,360 ED visits over the six-month period that did not result in an inpatient admission. Table 5 provides information on these visits by race, coverage, age and gender.
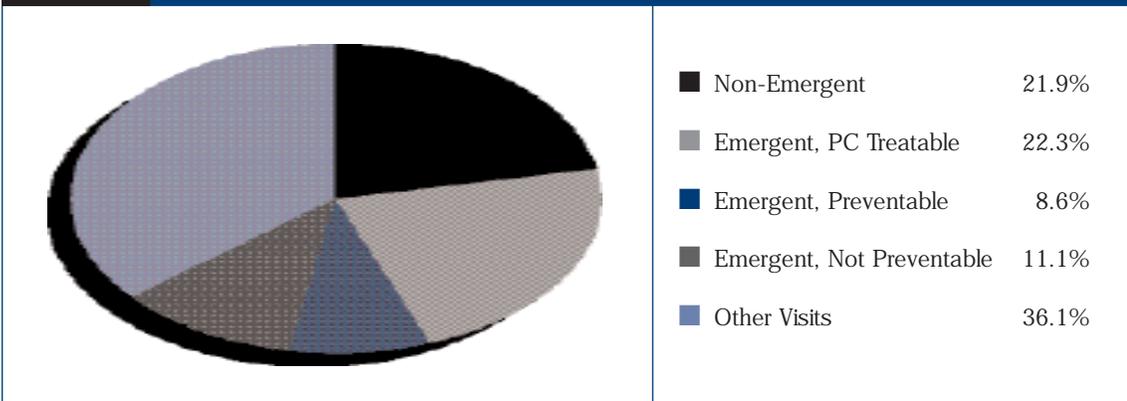
Table 5	Demographic Characteristics of ED Visits						
Race		**Coverage**		**Age**		**Gender**	
Black	19.0%	Commercial	18.8%	0-17	8.4%	Female	48.6%
White	53.0%	Medi-Cal	24.6%	18-65	84.5%	Male	51.4%
Hispanic	20.7%	Medicare	11.2%	65+	7.1%		
Other/Unknown	7.3%	Uninsured	18.9%				
		Other	26.5%				

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by UCSD emergency department.

Key Demographic Characteristics of ED Visits

■ About half of ED visits at UCSD were for patients who were white and another one-fifth were for Hispanic patients.

■ Approximately one-quarter of the visits were for patients covered by Medi-Cal. Nearly one-fifth of the visits were for individuals who were uninsured.

■ Children and seniors together comprise only about 15 percent of ED visits.

Figure 1 Visits by Emergent and Non-Emergent Categories

■ Non-Emergent	21.9%
■ Emergent, PC Treatable	22.3%
■ Emergent, Preventable	8.6%
■ Emergent, Not Preventable	11.1%
■ Other Visits	36.1%

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED-use profiling algorithm to data provided by UCSD emergency department.

A significant percentage of visits to UCSD's ED could have been treated in settings other than the ED. As Figure 1 demonstrates, 21.9 percent of ED visits at UCSD were non-emergent and another 22.3 were emergent but primary care treatable. Thus, four of ten ED visits that did not result in an inpatient admission could have been safely treated outside of the ED.

Table 6 compares the rate of visits that were emergent, that required ED care, and that were not preventable or avoidable against rates for other categories of visits. For every visit that was in the emergent, not preventable category, there were nearly two non-emergent visits and another two emergent but primary care treatable visits.

Medi-Cal patients used the ED for non-emergent conditions at higher rates (2.26) than did patients covered by other payers. Commercially insured and uninsured patients had the same rates of use of the ED for non-emergent conditions. According to the analysis, uninsured patients did not use the ED for non-emergent conditions at significantly higher rates than did Medicaid patients or patients who were commercially insured.[102,103] Black patients had higher rates of ED use for non-emergent conditions, compared to patients of other races (2.52 vs. 1.87 and 1.86). This also held true for use of the ED for emergent, primary care treatable conditions.

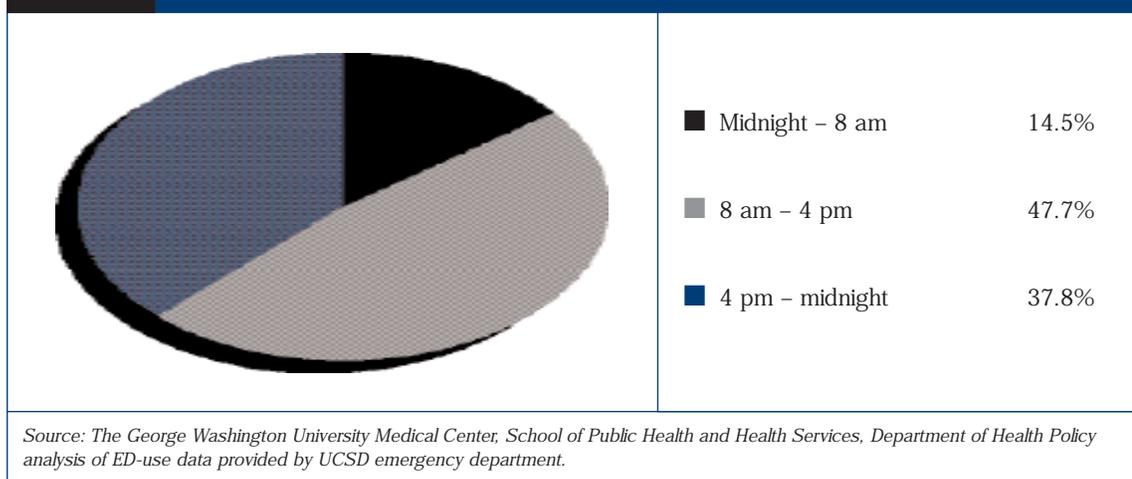| Table 6	Relative Rates for ED Visits at UCSD Medical Center			
	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**1.97**	**2.01**	**0.77**	**1.00**
Insurance status				
Commercial	1.91	1.92	0.66	1.00
Medi-Cal	2.26	2.29	0.85	1.00
Medicare	1.51	1.63	0.71	1.00
Uninsured	1.81	1.86	0.66	1.00
Age				
0-17	3.03	3.36	0.98	1.00
18-64	1.97	1.97	0.76	1.00
65+	1.38	1.62	0.74	1.00
Race				
Black	2.52	2.39	0.99	1.00
White	1.86	1.97	0.78	1.00
Hispanic/Latino	1.87	1.89	0.63	1.00
Gender				
Female	2.22	2.05	0.78	1.00
Male	1.84	1.98	0.77	1.00

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided by UCSD's emergency department.

Children were three times more likely to use the ED for non-emergent conditions than for emergent, non-preventable conditions. The same was true of their ED use for emergent, primary care treatable conditions.[104] Women tended to have higher rates than men for conditions that could be treated in a primary care setting.

Many fewer visits are classified as emergent but preventable or avoidable. However, the algorithm does not provide sufficient detail to determine why these visits tend to be lower than those in the emergent, non-preventable category.

Most ED visits at UCSD occurred between the hours of 8:00 am and midnight. As Figure 2 illustrates, nearly half of all visits that did not result in an inpatient admission occurred between the hours of 8:00 am and 4:00 pm. Only about 14.5 percent occurred between midnight and 8:00 am.

Figure 2	ED Visits by Admit Time

■ Midnight – 8 am	14.5%
■ 8 am – 4 pm	47.7%
■ 4 pm – midnight	37.8%

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED-use data provided by UCSD emergency department.

Interestingly, many visits to the ED for primary care treatable conditions occurred during business hours that commonly coincide with physician and clinic availability. Table 7 illustrates the rates of use of the ED for emergent and non-emergent conditions according to three time periods—8:00 am to 4:00 pm; 4:00 pm to midnight; and midnight to 8:00 am. Patients used the ED for primary care treatable conditions at relatively comparable rates during "regular business hours" and the hours of 4:00 pm to midnight.

Table 7	Relative Rates for ED Visits at UCSD, by Admit Time to the ED

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**1.97**	**2.01**	**0.77**	**1.00**
Admit time				
8 am – 4 pm	2.03	2.18	0.81	1.00
4 pm – midnight	2.04	1.95	0.77	1.00
Midnight – 8 am	1.70	1.72	0.68	1.00

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided UCSD emergency department.

These data support the assertion that patients are using the ED at UCSD for conditions that could be treated by primary care providers, at times during the day when primary care providers are likely to be available. This suggests that there are opportunities for improving care for patients in San Diego while also addressing crowding in the ED at UCSD. While this analysis does not address ED utilization at other San Diego hospitals, these findings are similar to other analyses of large urban ED populations and are likely to be similar to patterns at other hospitals in the area.

Key Findings

After examining important components of the San Diego safety net,

the assessment team identified the following key findings:

- The San Diego safety net is a patchwork of systems struggling to meet the health care needs of its low-income and uninsured residents. Partnerships among provider groups are major strengths of the community. However, it is not clear whether these partnerships will be able to offset larger system issues such as inadequate financing, lack of insurance coverage, and gaps in needed services.

- The county's role in funding caring for the uninsured has diminished substantially, as a result of state funding reductions. This has placed greater pressure on safety net providers to piece together streams of funding to care for low-income residents. As a consequence, providers are increasingly dependent on Medi-Cal revenues to support safety net programs. Despite additional funding for the county indigent program from tobacco settlement monies, many uninsured residents continue to lack access to primary and specialty health care services.

- The demand for safety net services is increasing while the availability of providers willing to serve the uninsured and underserved is declining. Providers are facing low reimbursement rates from Medi-Cal and from the county's indigent program, making it more difficult to treat low-income and uninsured patients. As a result, services, particularly specialty care services, are in short supply for these populations.

- San Diego's mental health system is significantly under-funded and suffers from a lack of capacity. Although the County reports the average wait time for outpatient services is less than two weeks, many informants and patients report significantly longer wait times to see a mental health specialist. As a result, some patients forgo immediate treatment and seek care only in a medical emergency. Providers are expecting to see more patients turn to the ED for care in the face of still further anticipated cutbacks in mental health services.

- A significant percentage of ED visits at the University of California, San Diego are for patients whose conditions are non-emergent. More than one-fifth (21.9 percent) of all emergency department encounters that did not result in an inpatient admission were for patients who presented with non-emergent conditions. Another fifth (22.3 percent) were for patients whose conditions were emergent but could have been treated in primary care settings.

- Outreach for Medi-Cal and Healthy Families is widespread and enrollment in these programs has increased since January 2001 by 97 percent in Healthy Families and by 19 percent in Medi-Cal. Nevertheless, 18 percent of county residents remain uninsured and continue to identify the hospital ED as their main source of care. Furthermore, many uninsured, working residents are unfamiliar with community clinics' sliding scale payment policies and may forgo care because of the cost.

Issues for Consideration

The *Urgent Matters* safety net assessment team offers the following issues for consideration:

- Community Health Improvement Partners (CHIP) should expand its health needs assessment project to include measures of primary and specialty care capacity. Using this information, CHIP could create effective tools to educate residents about available safety net services and link needy patients with important resources in the community. The organization should also continue to seek funding for important outreach programs such as Reach Out and SD-KHAN.

- A public awareness campaign, coupled with outreach efforts highlighting the importance of primary care and preventive check-ups, could improve residents' ability to navigate the health care system and help reduce the use of the ED for non-emergent care. Education efforts targeting the working poor would be especially helpful in this regard.

- Safety net providers should be encouraged to continue to collaborate and coordinate care on behalf of uninsured and underserved residents. The development of a formal referral network between the hospitals and other safety net providers could improve access and outcomes for patients who do not have a medical home.

- San Diego safety net providers must be aggressive in educating state and federal policymakers about the importance of adequate Medi-Cal reimbursement rates. Reductions in rates are likely to discourage primary care and specialty care providers from caring for Medi-Cal patients. Such reductions may also cause providers to limit the amount of free or discounted care they provide to uninsured residents.

- Small business leaders and local policy makers should work together to examine and address the significant financial and health care delivery problems of the San Diego safety net. Rising insurance premiums are leaving more workers at risk of becoming uninsured or underinsured. At the same time, increasing costs, inadequate reimbursements, and lack of specialty care providers are eroding the ability of community clinics and hospitals to fill the gaps. These problems require significant effort on the part of both the business and health care sectors.

1   Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academy Press, 2000): 21.

2   County of San Diego, www.co.san-diego.ca.us/general/ history.html (accessed November 2003).

3   County of San Diego Health and Human Services Agency, *San Diego County Child and Family Health and Well-Being: Report Card 2002*. See www2.sdcounty.ca.gov/hhsa/Service Details.asp?ServiceID=583 (accessed October 2003).

4   Employment Development Department, *County snapshot*, 2002, see www.calmis.ca.gov/file/COsnaps/sandiSNAP.pdf (as of October 2003).

5   Demographic and economic statistics were calculated using data from the 2002 American Community Survey, a project of the U.S. Census Bureau. The ACS is a sample survey subject to sampling variability. It has a 90 percent confidence interval. The ACS universe includes only household populations and excludes populations living in institutions, college dormitories and other group quarters. See U.S. Census Bureau, *American Community Survey Profile 2002: San Diego County, California, Profile of General Demographic, Social and Economic Characteristics* (Washington, DC: U.S. Census Bureau, 2003), www.census.gov/acs/www/Products/ Profiles/Single/2002/ACS/index.htm

6   Economic Research Bureau, San Diego Regional Chamber of Commerce, "San Diego Forecast to Experience Positive Economic Growth in 2003," *San Diego Economic Bulletin* 51, No 1 (2003), http://www.sdchamber.org/ economic/forecast2003.pdf (accessed January 2004).

7   In 2003, the federal poverty level was $8,980 for an individual and $18,400 for a family of four. (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2003.)

8   National Association of Community Health Centers, Resources to Expand Access to Community Health (REACH) Data 2002 (Bethesda, MD: NACHC, 2002). The REACH data are based on Census Bureau data and provide estimates on the number of persons by poverty level, age, gender, race, and primary sources of health insurance for each county in the U.S. in 2000. Estimates are based on the 2000-2002 pooled data from the Census Population Survey and the 2000 Census of the United States which are provided by the Bureau of Census.

9   Ibid.

10 Council of Community Clinics, San Diego, www.ccc-sd.org /site/about/cccxaboutchc.asp (accessed November 2003).

11 National Association of Community Health Centers, REACH 2002.

12 As of 1994, undocumented patients are not eligible for services.

13 Some small office clinics have contractual arrangements with the county to provide free care to uninsured patients. This arrangement is described in the financing section of this report.

14 Office of Statewide Health Planning and Development, Primary Care Clinics Annual Utilization Profile, 2000. See www.oshpd.cahwnet.gov/HQAD/HIRC/clinic/util/PCPivots /index.htm (accessed February 2004).

15 T. Silverman, *Overview of the Uninsured San Diego 2002* (Woodland Hills, CA: The California Wellness Foundation and the California Endowment, October 2002), www.work-and-health.org/regionalWG/OrangeSDCounty /SD2002.pdf (accessed July 2003).

16 The California HealthCare Foundation reports approximately 57 percent of primary care physicians and 65 percent of specialists provide care to Medi-Cal patients. The Foundation report cited in T. Fong, "Citing finances, fewer doctors caring for the indigent," *San Diego Union-Tribune*, 5 December 2003.

17 Community clinics also include Federally Qualified Health Center (FQHC) "Look-Alikes." An FQHC look-alike, based on a determination made by the Health Resources and Services Administration (HRSA), meets the requirements of the section 330 (migrant and community health center) grant programs but does not receive the grant. FQHC look-alikes receive no section 330 Federal funding but are eligible for cost-based reimbursement under Medicaid and Medicare and participate in the 340(b) Federal Drug Pricing program, http://bphc.hrsa.gov/CHC/CHCInitiatives /fqhc_lookalike.asp. In San Diego County, Imperial Beach Health Center is the only "look-alike" health center and is currently applying for FQHC status. Source: Personal Communication with interviewees. Interviews were held between summer 2003 and winter 2004.

18 The three health centers include Family Health Centers of San Diego, NMA Comprehensive Health Center, and La Maestra Family Clinic. Source: Uniform Data System (UDS), a national database of patient and health center characteristics managed by the Health Resources and Services Administration. Data are from 2002.

19 Uniform Data System, 2002.

20 San Ysidro Health Center. See www.syhc.org/english/ history/index.html (accessed October 2003).

21 North County Health Services, *2002 Annual Report*. See www.nchs-health.org/Annual%20Report%202002.pdf (accessed October 2003).

22 2000 Office of Statewide Health Planning and Development data.

23 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

24 S. Zuckerman, T. Coughlin, L. Nichols, D. Liska, B. Ormond, A. Berkowitz, M. Dunleavy, J. Korb, N. McCall, *Health Policy for Low-Income People in California* (Washington, DC: Urban Institute, 1 August 1998).

25 Other Medi-Cal managed care models in California include: the County Organized Health Systems model that incorporates a single, county-run health plan; and the Two-Plan model that provides two health plan options (typically a publicly-owned plan and an HMO or commercial plan). Source: Medi-Cal Policy Institute, "Medi-Cal Facts: Medi-Cal Managed Care," No. 8 (March 2000).

26 The total Medi-Cal population in 2002 was approximately 320,000. Source: Medi-Cal Policy Institute, County of San Diego, available at www.medi-cal.org

27 CalWORKS is a state public assistance program operated by each county to provide cash aid and other services to needy families. See California Department of Social Services at www.dss.cahwnet.gov/cdssweb/california_169.htm

28 As of December 1, 2003, UCSD Health Plan discontinued operations.

29 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

30 Unpublished data from the County of San Diego Health and Human Services Agency, March 5, 2004.

31 If a Medi-Cal patient is not able to schedule an appointment with one of the providers, the patient must call back United Behavioral Health for additional referrals and assistance. Source: Community Health Improvement Partners, *The Help Connection: A Roadmap to Mental Health Services*, Second Edition (San Diego, CA: Community Health Improvement Partners, 2000).

32 The Healthy Families program covers children with family incomes too high for Medi-Cal but below 250% of federal poverty.

33 The clinic provides mental health services to roughly 25,000 patients per year. Personal communication with interviewee. Interviews were held between summer 2003 and winter 2004.

34 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

35 Includes 2001 fee-for-service, managed care payments, and Disproportionate Share Hospital payments less transfers. Source: California Healthcare Foundation. See http://www.chcf.org/topics/medi-cal/index.cfm?subsection=countydata&fuseaction=countydata&countyID=37 (accessed February 2004).

36 Medi-Cal Policy Institute, County of San Diego data. See www.medi-cal.org (accessed October 2003).

37 Unpublished data from the County of San Diego Health and Human Services Agency, March 5, 2004.

38 California Healthy Families. See www.healthyfamilies.ca.gov (accessed October 2003).

39 Medi-Cal Policy Institute, County of San Diego data. See www.medi-cal.org (accessed October 2003).

40 Unpublished data from the County of San Diego Health and Human Services Agency, March 5, 2004.

41 While the application process has improved, it is still considered by many to be extremely difficult and consequently, the enrollment process itself serves as a barrier to enrollment.

42 E. Brown, N. Ponce, T. Rice, and S. Lavarreda, *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey*, a publication of the UCLA Center for Health Policy Research (Los Angeles, CA: June 2002). See http://www.healthpolicy.ucla.edu/pubs/files/SanDiegoCounty.pdf (accessed March 2004).

43 The 2002 Federal Annual Report to the U.S. Department of Health and Human Services' Centers for Medicaid and Medicare Services. http://www.mrmib.ca.gov/MRMIB/HFP/Fed02AnnualRpt.pdf (accessed December 2003).

44 National Association of Community Health Centers, *Critical Condition II: Update on the Impact of the State Budget Crisis on Health Centers* (Washington, DC: NACH, September 2003).

45 J.L. Rabin, "Cuts in Medi-Cal Payments Blocked" *Los Angeles Times*, 24 December 2003.

46 Ibid.

47 TANF is the reformed welfare program whose provisions are designed to divert cash recipients into the workforce within a limited time period.

48 G. Lucas, "Governor proposes midyear budget cuts; Plans to slash $2 billion would hit health-and-welfare programs hardest," *San Francisco Chronicle*, 25 November 2003. www.may8.org/News/TIcutschron.html

49 CMS also indicate limit for resources for one person is $2000. Income and resource limits are adjusted according to family size.

50 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

51 Unpublished data from County Medical Services, County of San Diego, January 28, 2004.

52 T. Silverman, *Overview of the Uninsured San Diego 2002*.

53 Ibid.

54 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

55 T. Silverman, *Overview of the Uninsured San Diego 2002*.

56 Disproportionate Share Hospital (DSH) payments provide additional funding to hospitals that provide a disproportionate amount of care to Medicaid and uninsured populations.

57   Center for Medicare and Medicaid Services, "California: Total DSH Payments FY2000," Department of Health and Human Services, http://www.cms.hhs.gov/dsh/cadsh.asp (accessed November 2003).

58   California Healthcare Association, "Executive Summary Report, 2002: San Diego County."

59   S. Rosenbaum and P. Shin, *Health Centers as Safety Net Providers: An Overview and Assessment of Medicaid's Role* (Washington, DC: Kaiser Family Foundation, May 2003), www.kff.org/medicaid/4113-index.cfm

60   T. Silverman, *Overview of the Uninsured San Diego 2002.*

61   All information derived through interviews with informants was kept confidential. Many of the same questions were asked throughout the interview process. Opinions are included in the report only when they were voiced by several informants.

62   The unemployment rate in San Diego County has increased from 3.0% to 4.3% between 2000 and 2002. Source: Bureau of Labor Statistics, Washington, DC, 2003.

63   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

64   A.B. Bindman, W. Huen, K. Vranizan, J. Yoon, K. Grumbach, *Physician Participation in Medi-Cal, 1996-1998* (Oakland, CA: Medi-Cal Policy Institute, February 2002).

65   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

66   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

67   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

68   California HealthCare Foundation, *Emergency Departments in the Health Care System: Use of Services in California and the United States*, Issue Brief (Oakland, CA: California HealthCare Foundation, November 2002).

69   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

70   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

71   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

72   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

73   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

74   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

75   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

76   In addition to mental health, substance abuse is considered to be one of the top 5 priorities in the Community Health Improvement Partners' needs-assessment. See www.sdchip.org

77   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

78   Informants noted a more complete list of providers and associated charges can be found the San Diego County Dental Society website at http://www.sdcds.org/Public/access1.htm

79   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

80   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

81   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

82   L. Wulsin, et al.,*Clinics, Counties, and the Uninsured in California: Focus on San Diego.*

83   Economic Research Bureau, San Diego Regional Chamber of Commerce, "San Diego Forecast to Experience Positive Economic Growth in 2003."

84   On January 30, 2003, the California Healthcare Association filed suit to stop enforcement of the "at all times" staffing requirement. See K. Robertson, "Hospitals sue to curtail nurse-staffing law," *Sacramento Business Journal,* 31 December 2003.

85   Ibid.

86   L. Mahoney and W. White, "Governor Signs 'Pay or Play' Legislation Requiring Employers to Provide Coverage," *The Bureau of National Affairs* 11, no.40 (2003).

87   G. Lucas, "Governor proposes midyear budget cuts; Plans to slash $2 billion would hit health-and-welfare programs hardest," *San Francisco Chronicle,* 25 November 2003.

88   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

89   L. Wulsin, et al., *Clinics, Counties, and the Uninsured in California: Focus on San Diego.*

90   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

91   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

92   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

93   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

94   Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

95 D.C. Ross and I. Hill, "Enrolling eligible children and keeping them enrolled," *The Future of Children*, a Publication of the David and Lucille Packard Foundation (Spring 2003).

96 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

97 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

98 County of San Diego, Board of Supervisor Policy, M-59 Legislative Policy: Illegal Immigration, (San Diego, CA: Board of Supervisors). See http:www.sdcounty.ca.gov/cob/policy/M059.html (accessed March 5, 2004).

99 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.

100 The algorithm presented here uses a methodology that has been replicated in numerous communities in the country to categorize emergency department visits data. The algorithm does not address the issue of appropriate use of the ED for non-emergent and/or primary care treatable conditions. This issue has been discussed extensively in the peer-reviewed literature. For a summary of these discussions see L. Richardson and U. Hwang, "Access to Care: A Review of the Emergency Medicine Literature," *Academic Emergency Medicine* 8, no. 11 (2001): 1030-1036.

101 For a discussion of the development of the algorithm and the potential implications of its findings, see J. Billings, N. Parikh and T. Mijanovich, *Emergency Room Use: The New York Story*, (New York, NY: The Commonwealth Fund, November 2000).

102 It is important to note that these findings refer to the allocation of visits across emergent and non-emergent categories and do not address whether uninsured patients use the ED, per se, in greater numbers than insured patients. This assessment would not be possible in the absence of better data on ED use across many more hospitals in the San Diego area to determine whether uninsured patients were using ED care at higher rates than insured patients.

103 This finding is consistent with recent research showing increases in the numbers of commercially insured patients relying on emergency departments for care. See P. J. Cunningham and J.H. May, *Insured Americans Drive Surge in Emergency Department Visits*, Issue Brief 70 (Washington, DC: Center for Studying Health Systems Change, October 2003).

104 Children often use the ED for non-emergent care at higher rates than patients in other age categories. These findings are seen in several of the *Urgent Matters* ED use profiling analyses.

Urgent Matters Grantee Hospitals and Community Partners

Atlanta, Georgia
Community Partner: National Center for Primary Care, Morehouse School of Medicine
Project Director: George Rust, MD, MPH FAAFP
Grantee Hospital: Grady Health System
Project Director: Leon Haley, Jr., MD, MHSA, FACEP

Boston, Massachusetts
Community Partner: Health Care for All
Project Director: Marcia Hams
Grantee Hospital: Boston Medical Center
Project Director: John Chessare, MD, MPH

Detroit, Michigan
Community Partner: Voices of Detroit Initiative
Project Director: Lucille Smith
Grantee Hospital: Henry Ford Health System
Project Director: William Schramm

Fairfax County, Virginia
Community Partner: Fairfax County Community Access Program
Project Director: Elita Christiansen
Grantee Hospital: Inova Fairfax Hospital
Project Director: Thom Mayer, MD, FACEP, FAAP

Lincoln, Nebraska
Community Partner: Community Health Endowment of Lincoln
Project Director: Lori Seibel
Grantee Hospital: BryanLGH Medical Center
Project Director: Ruth Radenslaben, RN

Memphis, Tennessee
Community Partner: University of Tennessee Health Sciences Center
Project Director: Alicia M. McClary, EdD
Grantee Hospital: The Regional Medical Center at Memphis
Project Director: Rhonda Nelson, RN

Phoenix, Arizona
Community Partner: St. Luke's Health Initiatives
Project Director: Jill Rissi
Grantee Hospital: St. Joseph's Hospital and Medical Center
Project Director: Julie Ward, RN, MSN

Queens, New York
Community Partner: Northern Queens Health Coalition
Project Director: Mala Desai
Grantee Hospital: Elmhurst Hospital Center
Project Director: Stuart Kessler, MD

San Antonio, Texas
Community Partner: Greater San Antonio Hospital Council
Project Director: William Rasco
Grantee Hospital: University Health System
Project Director: David Hnatow, MD

San Diego, California
Community Partner: Community Health Improvement Partners
Project Director: Kristin Garrett, MPH
Grantee Hospital: University of California at San Diego
Project Director: Theodore C. Chan, MD