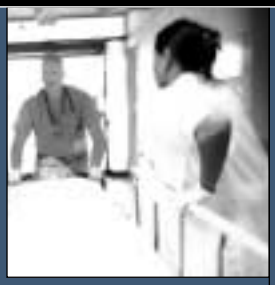
AN ASSESSMENT OF THE

SAFETY NET

in Detroit, Michigan



Urgent Matters

The George Washington University Medical Center

School of Public Health and Health Services

Department of Health Policy

Acknowledgments

The *Urgent Matters* safety net assessment team would like to thank our community partner, the Voices of Detroit Initiative (VODI), for its help in identifying key safety net issues in Detroit and connecting us with stakeholders in the community. At VODI, Lucille Smith was instrumental in coordinating our site visits, interviews and focus groups and an essential resource through the course of the project. We would also like to thank Amani Younis for her help in facilitating two of our focus groups.

The Voices of Detroit Initiative is a partnership between the leading health system providers in Detroit, federally qualified health centers and the Detroit Health Department. VODI focuses on bringing all segments of the community together to address the issues of access to cost-effective health care for the uninsured.

We would also like to acknowledge William Schramm at the Henry Ford Health System for providing us with important information and resources regarding the emergency department at Henry Ford Hospital. The *Urgent Matters* team would also like to recognize the many individuals in the Detroit health care community who gave generously of their time and provided important and useful insights into the local safety net system. The Detroit, Michigan, Safety Net Assessment would not have been possible without their participation.

We are especially grateful to Pam Dickson, MBA, Minna Jung, JD, Chinwe Onyekere, MPH, John Lumpkin, MD, MPH, Calvin Bland, MS, and Risa Lavizzo-Mourey, MD, MBA, of The Robert Wood Johnson Foundation for their support and guidance throughout this project.

Finally, we would also like to thank Dina Moss for her assistance with editing this report and acknowledge Patrick McCabe and Becky Watt Knight from GYMR for their communications expertise.

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.

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MARCH 2004

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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 Detroit. 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 Detroit, we are deeply indebted to the Voices of Detroit Initiative. 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 Detroit, Michigan 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 Detroit assessment draws upon information collected from interviews with senior leaders in the Detroit health care community and from on-site visits of safety net facilities. The research team also met with key stakeholders in Detroit 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 Detroit, 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 Henry Ford Hospital 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 Detroit. It provides background on the Detroit 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 Detroit

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

- The Detroit safety net is in a fragile state following a steady decline in health care resources previously available to some low-income and uninsured residents. Any further hospital closures within the Detroit Medical Center system could cause the safety net to collapse, leaving low-income and uninsured residents virtually "on their own" in terms of their access to vital health care services.
- There is a severe undersupply of primary care services for low-income and uninsured residents of Detroit and Wayne County. Most primary care for these populations is provided by a handful of community health centers and clinics that offer services at no- or low-cost. Access for individuals who are covered by Medicaid is hampered by a very limited supply of private physicians who are willing to accept Medicaid rates.
- Access to timely specialty care is largely dependent on an individual's access to primary care. Community Health Centers have partnered with the three major health systems in Detroit to provide specialty care for that center's patient population; however, access is uneven across these arrangements. Some of these patients have very good access to primary care, specialty care, inpatient services and prescription drugs, all at deeply discounted prices. Others, however, are less likely to receive these services in a timely or coordinated fashion, if at all.

- Funding for behavioral health care services is inadequate, affecting the infrastructure of delivery of care. As a result, patients report that they do not know where to go for care, and providers report that they have few options for follow-up care. The emergency departments of the health systems appear to be the default provider for patients with either acute or chronic behavioral health needs.
- A significant percentage of emergency department visits at Henry Ford Hospital are for patients whose conditions are non-emergent. Nearly one-fifth (19.5 percent) of all emergency department encounters that did not result in an inpatient admission were for patients who presented with non-emergent conditions. More than one-fifth (22.1 percent) were for patients whose conditions were emergent but could have been treated in a primary care setting.
- Pressures on the Detroit safety net can only be alleviated with an infusion of additional dollars targeted toward the expansion of primary care, specialty care, behavioral health and other health service capacity for low-income and uninsured residents. After decades of sustained neglect and retrenchment, the safety net needs more significant and stable financing to have the capacity to serve the populations in need of care.
- Two important initiatives have created the potential for a reorganized and rejuvenated safety net. The proposed creation of a Health Authority promises to consolidate safety net financing and coordinate health care delivery for low-income Detroit residents. At the same time, the Voices of Detroit Initiative (VODI) can serve as a model for other communities wishing to leverage scarce resources on behalf of the underserved. VODI has worked closely with safety net providers in the community and has helped to establish a coordinated strategy for strengthening the safety net.

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

- The Detroit Health Care Stabilization Workgroup should continue its efforts to strengthen the safety net through the creation of a Health Authority. Such a move will consolidate and leverage resources to maximize revenues earmarked for care for uninsured and underserved residents.
- The Health Authority can play an important role in providing a coordinating function across safety net providers and other key health leaders. This function would build on collaborative work already undertaken by VODI. Such coordination could help support growth that is efficient and appropriately targeted to existing needs. The Health Authority should ensure that any new safety net funding goes directly to care for uninsured and underserved residents of Detroit.
- Stakeholders involved in the Detroit safety net must work to attract sufficient numbers of clinicians to the city. Shortages of primary care physicians in Wayne County and the City of Detroit jeopardize private sector health care delivery as well as safety net services. A revitalized safety net will never be possible without an influx of talented and committed primary care providers and specialists interested in working with both insured and uninsured Detroit residents. Even with additional funding available for services, more work will need to be done to attract sufficient numbers of clinicians to the city.
- The Detroit and Wayne County Health Departments should have clear roles within the Health Authority and contribute significantly to the health and well being of residents in the community. At present, the services provided by city and county health departments are too limited to meet even basic public health needs.

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 the *Urgent Matters* program 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, the *Urgent Matters* program 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 the *Urgent Matters* program 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 Detroit, Michigan.

These assessments have been developed to provide information to communities about the residents who are most likely to rely on safety net services.

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 this 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 through multiple sources. The Detroit assessment team conducted a site visit on July 16-18, 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 the *Urgent Matters* project, the safety net assessment, and the key issues under review. This meeting was held on July 18, 2003, at the Herman Kiefer Building.

Through the site visits and a series of telephone conferences held prior to and following the visit to Detroit, 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

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 Detroit as well as data on health services utilization and coverage statistics.

While in Detroit, we conducted focus groups with residents who use safety net services. We held four groups with a total of 45 participants; two of the focus groups were conducted in Arabic, one was in Spanish and one was in English. The assessment team worked with the community partner to recruit patients who were likely to use safety net services. Finally, the assessment included an application of an ED profiling algorithm to emergency department data from Henry Ford Hospital. The algorithm classifies ED encounters as either emergent or non-emergent cases.

Section one of the Detroit safety net assessment provides a context for the report, presenting background demographics on Detroit. 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 Detroit 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 Henry Ford Hospital. This analysis includes demographic information on patients who use the emergency department and examines the extent to which the emergency department at Henry Ford Hospital 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 Detroit area may want to consider as they work together to improve the care for the uninsured and underserved residents in their communities.

Background

Wayne County encompasses an area of roughly 614 square miles in southeast Michigan. It is the most populous county in the state, with approximately two million residents.[2] The county is home to Detroit, the largest city in Michigan with nearly 900,000 residents.[3] The population in Wayne County is very diverse, as is the city of Detroit (see Table 1). Half of the population in the county is white and about 42 percent of the residents are black. Detroit's population is largely minority, with eight out of ten residents identifying as black. There are sizeable populations of Arab-Americans in and around Wayne County, and a growing Latino population that is currently estimated to be 4.2 percent of the county and 5.2 percent of the city population. About 6.4 percent of Detroit residents were born in a country other than the U.S. and nearly one in ten residents speak a language other than English in the home.[4]

Table 1 A Snapshot of Wayne County, Detroit and Michigan

Selected Demographics	Wayne County	City of Detroit	Michigan
Population			
Population	2,013,098	889,888	9,797,198
Size (square miles)*	614		56,804
Density: Persons/square mile*	3,356		175
Race			
White	51.1%	11.0%	80.2%
Black	42.0%	81.4%	13.9%
Asian	2.1%	1.3%	2.1%
Other^	4.8%	6.4%	3.8%
Latino origin and race	4.2%	5.2%	3.4%
Birthplace/Language			
Foreign born	7.2%	6.4%	7.7%
Language other than English spoken at home	9.9%	9.5%	5.5%
Age			
18 years and over	71.7%	69.1%	73.8%
65 years and over	11.4%	10.2%	11.9%
Median age (in years)	34.5	31.2	36.2

Source: American Community Survey, 2002, U.S. Census Bureau, unless otherwise noted.
** Source: State and County QuickFacts, 2001, U.S. Census Bureau.*
^ Includes persons reporting more than one race.

The total populations of Wayne County and Detroit have experienced a net decrease over the past decade, at the same time that the state and surrounding counties have seen a population increase (see Table 2). Detroit saw a 7.5 percent decline in population from 1990 to 2000, and Wayne County experienced a 2.4 percent decline. Macomb and Oakland Counties each saw increases in population of around 10 percent.

Table 2 Population Trends

	1990 – 2000 % Change
City of Detroit*	-7.5%
Wayne County	-2.4%
State of Michigan	+6.9%
Macomb County	+9.9%
Oakland County	+10.2%

Source: U.S. Census Bureau, http://quickfacts.census.gov, unless otherwise noted.
**Center for Urban Studies, Wayne State University, http://www.cus.wayne.edu/research_tools/data_access/files/DETROIT19902000.xls*

As Table 3 illustrates, Wayne County has a relatively high poverty rate. Roughly one-third of county residents have incomes below 200 percent of the federal poverty level (FPL),[5] compared to one-quarter of residents statewide. Lower income levels are particularly prevalent in Detroit. The median income in the city is approximately $30,500, which is $13,000 lower than the state average and $20,000 to $30,000 lower than surrounding counties.[6]

Wayne County also has a higher proportion of uninsured residents than does the state, with 12.3 percent uninsured compared to 10.6 percent.[7] Countywide, nearly 250,000 individuals are uninsured, and another 316,000 are covered by public programs such as Medicaid, MIChild (The State Children's Health Insurance Program), or the county PlusCare program, described later.

Table 3 Income, Poverty Level and Insurance Coverage in Wayne County and Michigan

	Wayne County	Michigan
Income and poverty (2002)		
Median household income	$39,853	$43,795
Living below poverty*		
<100%	16.4%	10.6%
100%-199%	16.5%	14.9%
Insurance coverage (2000)*		
Commercial	58.8%	66.1%
Medicare	13.3%	13.2%
Medicaid and MIChild	15.7%	10.1%
Uninsured	12.3%	10.6%

Source: U.S. Census Data, 2002 American Community Survey unless otherwise noted.
**2000 REACH Data, National Association of Community Health Centers.*

Structure of the Wayne County Safety Net

Four large not-for-profit health systems dominate health care delivery in Wayne County: Detroit Medical Center (DMC), Henry Ford Health System (HFHS), Oakwood Healthcare System and St. John Health. Together, these four health systems provided $261 million in uncompensated care in 2002.[8] Three of these four systems comprise the core of the safety net for Detroit and Wayne County—HFHS, St. John Health and DMC. Since the sale of Detroit's only public hospital, Detroit Receiving, to DMC in 1981,[9] these three health systems have maintained a commitment to serving Detroit and Wayne County residents who are uninsured or underserved. DMC provided the greatest portion of free care among the four systems in the county last year,[10] and is considered by many to be the principal safety net provider in the area.

Detroit has experienced a significant reduction in health care service capacity in the last several years. More than 1,200 hospital beds have been closed in the city of Detroit since 1998 (see Table 4). More than 4,400 hospital full-time equivalent positions have been lost as well. The community is still feeling the effects of the closing of Mercy Hospital and its six clinics, along with 15 of DMC's satellite clinics.[11] These clinics previously provided preventive and primary care to thousands of Medicaid and uninsured patients.

Table 4 Recent Hospital Closures in Detroit

Hospital Name	Year Closed	# of Beds Closed	# of FTEs Lost
Saratoga Community Hospital*	1998	203	587
Sinai Hospital of Detroit^	1999	623	2,270
New Center Hospital	1999	146	410
Mercy Hospital	2000	248	1,201

Source: "Strengthening the Safety Net in Detroit and Wayne County," Report of the Detroit Health Care Stabilization Workgroup, 2003. Data from the Southeast Michigan Health and Hospital Council.
** Saratoga Community Hospital merged with Holy Cross Hospital to form St. John NorthEast Community Hospital, part of St. John Health.*
^ Sinai Hospital merged with neighboring Grace Hospital to form Sinai-Grace Hospital, which is part of DMC.

Even with these losses in health service capacity, the closures continue. St. John Health closed St. John NorthEast Community Hospital in the spring of 2003, consolidating it with a hospital seven miles away.[12] DMC's remaining five clinics are being sold to a private physician group. These clinics serve a high proportion of Medicaid patients and patients covered by county-funded programs.[13] Additional DMC closures were also considered this year but were forestalled with a $50 million emergency aid package from the Governor that kept Detroit Receiving and Hutzel Women's Hospital open, at least until May of 2004. These two hospitals are virtually synonymous with the safety net in Detroit, and their threatened closure has served as a catalyst for the development of proposals for a reorganized and rejuvenated safety net in the Detroit area.

Provider Capacity: Despite serving as a major medical center for many years, Detroit lacks an ample supply of primary care and specialty care physicians. Depending on the type of provider, physician supply in Wayne County is less than or similar to that of the state (see Table 5). Over the past five years, twenty Detroit primary care centers have closed, taking with them a substantial number of primary care physicians who previously were available to care for low-income residents.[14] The county has 69.2 primary care providers per 100,000 patient population and 28.9 surgical specialists per 100,000 patient population compared to 75.5 and 33.4, respectively, for the state.[15] The county has more hospital beds and admissions per 1,000 residents than does the state and about the same proportion of emergency department visits (369 compared to 358).

Table 5 Physician and Hospital Supply, Wayne County and Michigan

	Wayne County	Michigan
Physician supply *(per 100,000)*		
Primary care providers	69.2	75.5
Pediatricians	51.4	51.7
OB/GYN	26.8	28.5
Medical specialist	25.9	26.1
Surgical specialist	28.9	33.4
Hospital supply/utilization *(per 1,000)*		
Inpatient beds	2.73	2.42
Admissions	123	109
ED visits	369	358

Source: Data are for 1999. Monitoring the Health Care Safety Net Book II: A Data Book for States and Counties, 2002, Agency for Healthcare Research and Quality.
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.

Primary Care: Primary and preventive services in Wayne County are provided by a combination of Federally Qualified Health Centers (FQHCs), free or low-cost clinics, the local health department, and school-based programs.[16] The hospital systems generally do not provide primary care services. All of Wayne County's FQHCs are located in Detroit, and they include the Community Health and Social Service Clinic (CHASS), the Detroit Community Health Connection (DCHC), and Detroit Health Care for the Homeless. These three FQHCs represent the primary care safety net in Detroit.

As can be seen from Table 6, each of the Detroit FQHCs serves a largely minority, uninsured or publicly insured population.[17] More than nine out of ten patients at the three centers are members of racial or ethnic minorities, with CHASS serving primarily Latino patients and the others serving mostly black patients. Three-quarters of CHASS patients are uninsured, as are about half of the patients at DCHC and about five in six patients served by Detroit Health Care for the Homeless. Although Medicaid covers one-third of patients at DCHC, it and other public programs cover relatively few patients at the other two FQHCs. Commercial insurers cover even fewer.

In 2002, the three FQHCs served a total of 31,030 patients, 19,792 of whom were uninsured when they received care. While the combined patient load of these FQHCs is almost two-thirds uninsured, they serve only about 8 percent of the total uninsured population in the county.

Table 6 FQHC Patient/Visit Characteristics, 2002

	CHASS	DCHC	Detroit Health Care for the Homeless
Total patients served	11,456	15,102	4,472
Total encounters	81,109	58,464	21,454
Average encounters per patient[18]	7.1	3.9	4.8
Race (percent of patients)[19]			
White	5.6%	3.7%	6.2%
Black	15.8%	83.3%	82.8%
Latino	75.5%	6.3%	7.3%
Coverage (percent of patients)			
Uninsured	75.7%	48.3%	85.5%
Medicaid	10.2%	33.7%	4.9%
Other public	6.0%	--	9.5%
Medicare	1.5%	5.9%	--
Commercial	6.5%	8.2%	0.1%
Total grants from federal, state, local sources	$3,712,000	$3,592,000	$814,000
Grants funds per uninsured patient (2002)	$427.58	$492.86	$212.98
Average grant funds per uninsured encounter	$60.22	$126.37	$44.37

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy Medical Center Department of Health Policy analysis of 2002 UDS data.

Two FQHC expansion initiatives are currently underway. Detroit Health Care for the Homeless received an $886,000 expansion grant from the Health Resources and Services Administration in summer 2003, which will provide funding to open a site in the Northwest region. The Detroit Community Health Connection, in partnership with the Arab-American and Chaldean Council, has also received over $600,000 to open a new site of care. These expansions are in addition to an earlier expansion to CHASS, which provided funding to open CHASS Midtown, another full-service primary care site, in December 2001.

Free or low-cost clinics such as the Mercy Clinic and the St. Frances Cabrini Clinic of Most Holy Trinity Catholic Church also provide basic primary care, limited prescription drugs, and social services to the uninsured and underserved. Because funding is very limited, staff is comprised mostly of part-time or volunteer physicians, nurses and other health professionals. There are nine such clinics in the county, and six of them are located in Detroit.[20] School-based health centers and clinics also provide some services to school-aged children but they are extremely limited in number and scope and are rarely the principal source of primary care for children in the city. In addition, the Arab-American and Chaldean Council operates a primary care clinic that provides limited services primarily to Arabic-speaking patients.

Specialty Care: Each of the Detroit FQHCs has developed a partnership with one of the safety net hospital systems, which then provides specialty and inpatient care to their patients. For example, CHASS has been operating in the Detroit area for more than 30 years and has longstanding ties to the Henry Ford Health

System. CHASS patients are referred to HFHS for specialty care at greatly reduced rates; generally, patients are charged about 10 percent of the routine fee for care. CHASS patients who require inpatient care use HFHS as well. This relationship also promotes coordination across sites of care and sharing of information about patients and their use of health services. DCHC and Detroit Health Care for the Homeless have each partnered with a safety net hospital; however access to specialty care appears to be problematic for patients using those systems.[21]

Public Health: Over the past two decades, the Wayne County Health Department and Detroit Health Department have gradually reduced their roles in providing direct services to the uninsured. The Detroit Health Department currently operates three clinic sites: Grace Ross Health Center, Herman Kiefer Family Health Center, and Northeast Health Center.[22] The Herman Kiefer Center is the largest of the three and provides basic health services in addition to public health related services such as health education and prevention and screening. Herman Kiefer operates a dental clinic that offers affordable services to Detroit residents. The clinic, however, is often overbooked and very difficult to access.[23] It also subsidizes medications for CHASS patients who receive care from the main clinic location.

Medicaid Plans: Health plans play a role in the county's safety net. Most Medicaid or county-supported beneficiaries must enroll with county qualified health plans in order to receive program benefits and care.[24] The State of Michigan contracts with nine health plans to manage and deliver care for its nearly 290,000 Medicaid enrollees.

Several plans in the Medicaid managed care market are experiencing financial problems and some are limiting access to services to which patients are contractually entitled.[25] Three of the HMOs—Great Lakes, OmniCare, and Wellness Plan—are currently under state supervision, and must demonstrate to the state that they can meet certain financial requirements in order to bid for Medicaid managed care contracts in 2004.[26] As of December 2003, these three plans had a combined Medicaid enrollment of over 151,000.

Voices of Detroit Initiative: Some uninsured Wayne County residents receive health services through their enrollment in the Voices of Detroit Initiative (VODI), an organization that is affiliated with the W. K. Kellogg Foundation's Community Voices project. VODI programs connect uninsured county residents with a medical home. VODI outreach workers provide significant support and care management services on a one-on-one basis, such as patient education concerning disease management, assistance with follow-up care, and help with enrollment in county programs. The outreach workers are stationed at hospital emergency departments, clinics and local health departments. VODI staff work with patients in the community and with safety net providers to maximize very limited community resources. VODI enrolls individuals in a "virtual network," through which VODI clients can get primary care from a network of providers who have agreed to use a sliding fee scale. The initiative is considered a "virtual network" because VODI is not itself an insurance program: it makes no payment for services provided. The program has served over 16,000 Detroit uninsured and underinsured residents.[27]

Detroit has experienced a significant reduction in health care service capacity in the last several years.

Financing the Safety Net

The Detroit safety net is funded by a combination of federal, state, and local revenues.

Medicaid and MIChild

Medicaid is the primary health insurance program for low-income families and children in Wayne County. Table 7 shows Michigan income eligibility levels for various Medicaid enrollment groups. Like the state Medicaid program, which has enrolled nearly all of its 1.2 million beneficiaries in managed care plans, the county Medicaid program relies heavily on managed health plans to establish provider networks and deliver services to enrolled beneficiaries.

Children eligible for Medicaid are covered under Healthy Kids, the state's Medicaid program for children under age 19 and for pregnant women of any age.[28] The MIChild program is Michigan's State Children's Health Insurance Program, providing coverage to children who live in families with incomes of 150 to 200 percent of the FPL and who do not qualify for Healthy Kids. Services include primary, specialty and inpatient services, emergency services, pharmacy, dental care, prenatal care, vision and hearing services, and mental health and substance abuse services for children through age 18.

Table 7 Medicaid and MIChild Income Eligibility Requirements in Michigan

Medicaid Enrollment Groups	Percent of Poverty
Pregnant women	185
Infants ages 0-1	185
Children ages 1-5	150
Children ages 6-19	150
Supplemental Security Income	74
Medically needy—individual	57
Medically needy—couple	56
State supplementary payment recipients*	76
Medicare beneficiaries*	100
MIChild	200

Source: Kaiser Family Foundation, State Health Facts Online, <www.kff.org>, 2003 data unless otherwise noted.
** 2001 data.*

In 2001, fewer than 5,000 children in Wayne County were enrolled in MIChild,[29] for which their families each paid $5.00 per month.[30] The state has a low MIChild participation rate as well. As of September 2003, there were approximately 26,000 children enrolled in the program statewide.

Michigan's anticipated $1.7 billion deficit in fiscal year 2003-2004 will affect the Medicaid program statewide. In fiscal year 2003, the state reduced funding to Medicaid outreach and support activities.[31] The state has already eliminated adult dental care, chiropractic and podiatry services for adult Medicaid enrollees, a move that the state anticipates will save approximately $27 million in direct costs.

Other County Programs

As part of its commitment to caring for uninsured and underserved populations following the sale of its public hospital, the county funds programs that provide health services to some uninsured residents. The Wayne County Health and Community Services (HCS) Department oversees three such programs: PlusCare, HealthChoice, and the County Card program.

First implemented in 1993, *PlusCare* provides limited health care coverage to county residents who are between the ages of 19 and 64, are not eligible for Medicaid, and have incomes below $250 per month. Approximately 25,000 individuals are enrolled in the program,[32] the majority of whom are single, unemployed males.[33] The program provides limited coverage for physician services, pharmacy, inpatient and outpatient hospital care, and dental care. Although the program had previously been funded to support as many as 35,000 residents, budget constraints have limited enrollment to 10,000 fewer people. In 2001, PlusCare had a budget of $44 million, which included state general funds, the federal share of the Medicaid program, and county general funds.[34] The $44 million budget has remained flat since fiscal year 1996.[35] Unable to meet annual increases in medical costs and enrollment, the program has had to maintain financial stability by limiting enrollment, services, and provider reimbursement rates.

HealthChoice is a program that partners with small businesses to provide health care coverage to uninsured low-wage workers. The county contracts with two health plans to provide services, such as prescription drugs and x-rays, and pays a capitated fee for various services. The program also has a separate contract to provide dental and vision care. To participate, the employer and the employee must each pay one-third of the program's cost. Because of this shared contribution, many refer to HealthChoice as the "one-third share program." The program is popular with county employers, especially those in businesses employing between 10 and 15 employees.[36] In 2000, HealthChoice had a budget of $16.8 million to cover approximately 20,000 individuals.[37] An estimated 15,000 residents are currently enrolled in the program.

County Card is a new prescription drug program for Wayne County residents who are 60 years of age or older. County Card members will be able to receive a 5 to 30 percent discount on prescription drug purchases at all CVS pharmacies in Wayne County and throughout the country. [38]

CareFirst, a county indigent care program that had provided some health services to residents who were not eligible for Medicaid or PlusCare, was recently discontinued after only one year of operation. The program, which was administered by the Wayne County Health and Community Services Department, did not require program participants to be U.S. citizens and therefore provided some access to care for legal immigrants in the county. The program covered primary care services and limited pharmacy services. It did not cover hospital inpatient, specialty, or emergency care. Approximately 30,000 residents were enrolled in CareFirst.

Wayne County spent a total of $51.3 million in 2002 on health and welfare related expenses. [39] County programs are funded through a special indigent care pool that combines federal, state, and county dollars. Contributions from county and state general funds are leveraged to draw down federal Medicaid matching dollars.[40] The indigent pool monies are then distributed to eligible county hospitals, based on each hospital's estimated Medicaid outpatient payments. Since 1992, these funds have been combined in the Urban Hospital Care Plus, a nonprofit corporation that serves to maximize Medicaid matching funds and distribute them according to a formula to eligible participating hospitals.[41]

Some county area hospitals receive additional Medicaid funds in the form of disproportionate share hospital (DSH) payments. DSH payments are intended to compensate hospitals that serve a disproportionate share of Medicaid and uninsured patients. In 2001, Michigan received a total of $45 million in Medicaid DSH payments.[42] Table 8 shows the ten Michigan hospitals with the highest DSH payments in 2001.[43] Eight of these hospitals are located in Detroit, and the three hospitals with the largest DSH payments are affiliated with DMC.

Table 8 DSH Payments to Michigan Hospitals, 2001

Hospital Name	Location	Total DSH Payments in 2001
Children's Hospital of Michigan	Detroit	$14,023,796
Harper Hospital	Detroit	8,798,272
Detroit Receiving Hospital	Detroit	7,747,288
Detroit Riverview Hospital	Detroit	3,405,078
Sinai-Grace Hospital	Detroit	2,561,372
Hurley Medical Center	Flint	2,147,735
Henry Ford Hospital	Detroit	1,319,206
Aurora Hospital	Detroit	1,175,067
St. John Northeast Community Hospital	Detroit	769,130
Oakwood Hospital Heritage Center	Taylor	735,282

Source: Michigan Department of Community Health, 2001 Regular DSH Payments. www.michigan.gov/mdch

Federally Qualified Health Center Support

The three FQHCs in Detroit receive grants from the Health Resources and Services Administration, other federal funds (depending on the programs available at the FQHC), as well as state and local monies to offset the costs of caring for the uninsured. In 2002, CHASS received approximately $3.7 million in grants from these multiple sources; during the same period, DCHC received nearly $3.6 million and Detroit Health Care for the Homeless received about $814,000. These grants have multiple purposes but are usually provided to support general or targeted services for uninsured patients who use the health center.[44] CHASS received an average of approximately $427 per uninsured patient over the course of the year to provide the full range of medical, pharmaceutical, and enabling services such as interpreter services, transportation, case management, and social services. DCHC received approximately $493 in grant funding for each uninsured patient and Detroit Health Care for the Homeless received $213 per uninsured patient.

The safety net assessment team conducted interviews with key stakeholders in the Wayne County and Detroit health care communities and visited safety net facilities during its assessment of the local safety net. Our analysis of the Detroit safety net was greatly informed by the information we collected during the interviews with safety net providers and other 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.[45]

Overview

The Detroit safety net faces many challenges in its efforts to provide care for the city's neediest residents. A growing number of working families are moving out of the city or county, which has implications for both the local economy and the health care safety net. Not only does this exodus result in a shrinking economy and tax base, but it also makes it difficult to sustain a robust health sector with the revenue and capacity needed to support a safety net. In addition, low Medicaid rates and decreasing numbers of commercially insured patients in the Detroit area are steadily reducing the revenue base for providers and health systems in the market. Under these circumstances, business-minded health care organizations are moving to communities with a better patient mix.

As a result, Wayne County's health care system has eroded over the past several years with hospital and clinic closures and other reductions in provider capacity. Wayne County is now experiencing a severe undersupply of primary care providers, which makes access especially difficult for uninsured and underserved residents.

Shortages of Primary and Specialty Care Services

Detroit faces severe problems in access to primary and specialty care services. Too few providers are available to care for uninsured and underserved patients. Several informants stated that there are few, if any, private physicians who provide primary care to the safety net population. In addition, the number of hospital clinics is shrinking as hospitals close or sell off ambulatory facilities. While the new owners of these facilities often commit to serving the uninsured and underserved, it is uncertain how this commitment can be maintained given the current instability in the region and the lack of community representation within these organizations. Patients do have access to quality care at the three Federally Qualified Health Centers, but it appears that knowledge of the facilities is not widespread.

While the partnership between the FQHCs and hospitals helps provide a coordinated continuum of care to the uninsured and underserved, the reach of these services is extremely limited. The care provided by the FQHCs is considered high quality by many—indeed some of the care is described as outstanding. Yet the quantity of this care is so limited that it cannot be viewed as providing a true safety net for the needy. The three health centers are the principal primary care safety net providers for patients of Detroit and Wayne County, yet they serve only a small percent of the total uninsured population in the county.

While the addition of two new primary care sites will provide some relief, primary care capacity will remain well below the levels needed to provide even a minimum amount of care to the uninsured and underserved residents of Detroit and Wayne County. Financing for the centers is also well below what is necessary to support their services. Given that many of the patients have chronic conditions with multiple health needs, the available funding provides a relatively low payment per encounter. All told, these payments are not sufficient to support the operations of the centers over the long term in their mission to serve the uninsured and underserved.

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Medical and surgical specialists are in extremely short supply. While some patients who receive care from FQHC networks may have access to timely and affordable care, other patients face difficulties securing specialty care. Many who are referred for care wait months to actually see a specialty provider. Others forgo care completely because of the time delay. Some specialty physicians will provide care to uninsured patients at discounted rates. However, these arrangements typically result from longstanding relationships that particular physicians have with previously insured patients and involve temporary, discounted care (until coverage resumes, for example).

Although volume estimates are not available, charity care among specialty physicians appears to be relatively uncommon in the Detroit area. While some private physicians will take an occasional charity patient, the paucity of primary care and specialty physicians willing to treat uninsured and underserved patients creates a situation in which residents have only one real option if they need health services, and that is the emergency department.

Inadequacies in Mental Health and Substance Abuse Services

The mental health system in Wayne County and the State of Michigan is substantially under-funded and in complete disarray. Many informants questioned the very existence of a mental health system for uninsured and underserved residents. Mental health care is available for small numbers of people statewide. This care consists mostly of limited managed mental health services provided to some individuals with severe mental health needs.[46] Like much of the health system, mental health services have been neglected for years and are only now gaining the attention of Governor Granholm and other state leaders.[47] Over the past several years, responsibility for mental health services was placed within the Department of Community Health, with decreasing funding and attention from the state. In addition, several closures of state psychiatric facilities, with no corresponding increases in community-based support for behavioral health care, further eroded the ability of the mental health system to provide services to patients in need.[48]

These deficiencies in mental health services have placed added pressures on emergency departments, which, along with primary care sites, have seen increases in the number of patients with mental health and substance abuse problems.[49] For example, Detroit Health Care for the Homeless estimates that between 80 and 90 percent of its patients have mental health or substance abuse problems.

Lack of Availability of Dental Care for Adults

Dental care for children appears to be fairly accessible, especially for children covered by Healthy Kids, MIChild, and other county programs. Access to dental care for low-income adults, however, is essentially nonexistent. As part of its recent budget cuts, Medicaid no longer covers routine dental care for adult enrollees.[50] Adults can use the free dental clinic at Herman Keifer Public Health Department, but access is extremely limited. Appointment times are inconvenient and patients face long waits for care. Typically, patients either pay for dental care out of pocket or forgo care until their pain is great enough to bring them to an emergency department.

Adverse Impacts of Medicaid Cuts

Michigan, like many other states, is cutting back on resources for public programs, including Medicaid. As a result of these cuts, the state has reduced outreach and enrollment support for its Medicaid program and eliminated a number of benefits. The impact of limited outreach efforts is most notably seen in the low enrollment numbers for the state's SCHIP program MIChild. Fewer than 5,000 children in Wayne County were enrolled in MIChild, despite its low cost of only $5.00 per family per month.[51]

Low reimbursement rates have also created a number of problems in the Medicaid managed care market. Low Medicaid rates serve as disincentives to providing services to enrolled populations, making it difficult to

piece together comprehensive networks of providers for Medicaid managed care patients. The quality of the care offered by participating providers is questionable as well. According to our informants, the state was lenient in its review of health plans that applied to participate in the Medicaid managed care program and may have allowed less experienced or lower quality providers to enter the market.[52] Also, many of these plans did not include clinicians who practiced in locations that were near or easily accessible to enrolled populations. There are indications, however, that the state has tightened its requirements for participating plans and will look more closely at network capacity and financial and accounting capabilities in awarding/negotiating its next round of contracts.

Language and Cultural Barriers

Language and cultural barriers to care are greatest for the Latino and Arab communities in the Detroit area. CHASS treats a largely Spanish-speaking clientele, and virtually all staff and most clinicians who work at the site are fluent in Spanish and do not need to rely on interpreters to communicate with patients. Some of the staff and clinicians at the Henry Ford Health System are also Spanish-speaking, although their numbers are much more limited. According to informants, hospitals in the Detroit area do not have sufficient interpreter services and many patients rely on family members or friends to communicate with health care providers.

Arab residents appear to have a very difficult time finding specialist physicians who can communicate with them, and often make health care decisions based on the availability of Arabic-speaking providers. Arabic-speaking residents commonly use family and friends to interpret in health care encounters and find options for interpreter services at area clinics and hospitals to be extremely limited. Arabic-speaking residents are able to obtain some help from the Arab-American and Chaldean Council, which provides limited primary care services and also supports the Arab community in a wide range of social service supports and activities

The attitudes of the Arab-American and Chaldean community towards accessing health care services are often shaped by their experiences in their countries of origin. For example, some Arab Americans come from countries that provide health care free of charge and are therefore more comfortable accessing care in the ED, where they are not required to provide upfront payment for care. Others come from countries that have a pay-as-you-go system and expect to pay prior to receiving care. Many residents in both the Arab-American and Latino communities rely on home remedies before seeking health care from Detroit providers.

Opportunities for the Future

The Detroit safety net is showing scars from years of neglect. What remains in the city is a modicum of what would be needed to provide even a minimum amount of care to uninsured and underserved residents. The Detroit health care market has restructured itself over time to remain viable and competitive. In so doing, much of it has moved outside of the city, following the migration of insured patients to suburban communities. At the same time, this movement has encouraged even greater numbers of city residents to leave Detroit, seeking positions or other economic opportunities at or around the suburban health care delivery sites.

The potential closure of the bedrock of the Detroit safety net—Detroit Receiving and Hutzel Hospitals—has served as the tipping point, focusing state and national attention on the crisis. If these two hospitals close their doors, with no alternatives opening up for residents in the community, the remaining safety net hospitals may not be able to survive.

The cycle is truly self-perpetuating. Not surprisingly, Detroit's safety net has been eroding for years with relatively little fanfare or attention from anyone outside of the Detroit safety net itself. Hospital beds have disappeared, physicians have moved away, clinics have closed their doors, and emergency departments have been overwhelmed. And still the market does not seem to have bottomed out.

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Fortunately, initiatives at the state and local levels are attempting to shore up the safety net. As was mentioned earlier, for the past several years, the Voices of Detroit Initiative (VODI) has served as a broker among Detroit's principal safety net providers and other key stakeholders in the community. VODI steering committee members—including representatives from the three major health systems, the city health department, and each of the three FQHCs—have played a key role in shepherding and supporting applications for new FQHC expansion grants.[53]

Moreover, VODI has managed to leverage very scarce resources on behalf of the city's low-income and uninsured population. Detroit's health care community appears to be well organized, highly mobilized and comfortable with working in a collaborative and coordinated fashion. This collaborative spirit will certainly facilitate any efforts to strengthen the safety net in Detroit.

At the state level, Governor Granholm authorized substantial funding to maintain DMC's operations and commissioned a Detroit Health Care Stabilization Workgroup to make recommendations to stabilize the health care crisis in Detroit and Wayne County. The Workgroup consists of a Health Authority Design Subgroup that addresses legal, financial, structural, system design and legislative matters. An Advocacy Subgroup is charged with developing mechanisms to facilitate the implementation of the recommendations of the Workgroup.

In July of 2003, the Stabilization Workgroup submitted a report outlining its recommendations.[54] Chief among them is the creation of a Health Authority that would "…provide safety net services, facilitate care coordination, maximize revenues and enhance efficiency."[55] The Health Authority would be established through an intergovernmental agreement between the city of Detroit, Wayne County, and the state of Michigan.

According to the report of the Stabilization Workgroup, the Health Authority should concentrate its early efforts on:[56]

1) Providing improved access to health care services through an integrated and coordinated system of preventive, primary and specialty health care facilities and services whether owned or contracted.
2) Developing a strategic plan for the health care and preventive health services of those individuals served by the authority.
3) Aggressively seeking additional government and private funds for safety net services.
4) Receiving and disbursing public and private funds for the provision of safety net services rendered.
5) Striving to assure that persons receive appropriate and high quality health care services in a way that will maximize efficiency and efficacy.

The Stabilization Workgroup proposes a two-tiered approach. Early efforts would be aimed at consolidating current safety net financing and resources and developing more effective care delivery and management practices to enhance care and reduce costs. These efforts will also include proposals for expansions in FQHC capacity and increases in provider reimbursement under the Michigan Medicaid program.

In the longer-term, the Workgroup recommends developing additional sources of revenue to stabilize the Detroit and Wayne county safety net. The Workgroup estimates that an additional $246 million will be needed to accomplish this. This new money will come from a combination of sources, but will likely require the identification of significant new sources of revenue that can then be leveraged to draw down federal matching funds.

The amount of new money it will take to revitalize the safety net is still unknown. There is also some question about the degree to which current resources could meet these needs. Some local informants believe that the Detroit and Wayne County health care systems, broadly defined, already have sufficient resources to maintain a healthy safety net. They argue that if these resources were appropriately captured, consolidated and then used to draw down federal funding (all the while staying within the control of the new Health Authority), the needs of the uninsured and underserved in the community could be met. Others in the community believe that the safety net must be "made whole" through an infusion of new dollars, which can then be leveraged to maximize overall revenues.

While there are differing views concerning the funding of the safety net, the community is by no means divided on the issue of the Health Authority itself. On the contrary, the safety net community and others in Detroit and Wayne County are standing squarely behind the creation of the Health Authority and generally support its proposed strategies and recommendations. The Stabilization Workgroup is broad and diverse, and represents key providers and leaders whose involvement will be critical to the ultimate success of any plan that may be proposed. What remains to be seen, however, is whether sufficient capital and new revenue streams can be identified to stop Detroit's downward spiral and restore its safety net to a level that assures its residents appropriate access to vitally important health services.

The safety net assessment team conducted focus groups

with residents who receive their care from safety net providers in the Detroit area. The focus groups were held on July 17, 2003, at the Arab-American and Chaldean Council, the corporate headquarters for the Henry Ford Health System, and CHASS. Focus group participation was voluntary. Participants were recruited with the help of the local community partner, the Voices of Detroit Initiative, which involved displaying flyers announcing the sessions and their schedules. Participants each received $25 in appreciation of their time and candor. A total of 46 individuals participated in the focus groups. Two groups were conducted in Arabic, one was in Spanish and one was in English.

The focus group discussions highlighted the difficulties that many uninsured and underserved residents have in accessing timely and affordable health services in Detroit. Participants addressed issues such as 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.

Access to Health Care

Nearly all of the participants in the Detroit focus groups were uninsured and most did not have a regular source of care. The exceptions were the CHASS focus group participants—all of whom were Spanish-speaking residents who lacked insurance, but considered CHASS to be their medical home. Nearly all of the uninsured participants in the other groups reported that they would delay seeking health care until it became so serious, or caused such pain, that they would try to find a community doctor or seek care from the ED. Virtually all participants, with the exception of the CHASS patients, had no information about where to go for affordable health care. Participants reported that going to the ER, although extremely expensive, was often their only option because their condition had become so serious or painful.

"A lot of people don't go to the doctor when they don't have insurance because they don't want that extra bill. They have enough bills on them from the times they had to go in the past that they probably haven't finished paying yet. They figure, I'm not going unless I'm about to die and then I won't care about that bill until after."

Several participants in the English-speaking group had been employed in jobs that provided health insurance for various periods of time. Some had also been covered by Medicaid either as children or during a pregnancy. The group was very knowledgeable about the cost of health care, but did not have access to information about community health centers or other sites of care that offered discounted or free health services. Most had never heard of the three community health centers in the Detroit area.

All participants in the CHASS focus group had diabetes and lacked health insurance; nevertheless, they reported being "covered" by the REACH program. [57] Participants reported that they are treated at CHASS for a full range of health care needs, including those related to their diabetes. Women in the focus group reported getting annual screenings at CHASS for breast and cervical cancer at little or no cost.

Participants in the other groups reported that they did not have any regular source of primary care due to being uninsured. They occasionally paid out of pocket for doctor's visits, but mostly avoided seeking health care until a condition became very serious. Some participants said they believed doctors were primarily motivated by financial considerations. One woman stated, "*The first thing you see no matter where you go*

is, 'Payment must be rendered upon treatment.' That's what they care about."

Another participant described needing back surgery but delaying it because of the cost. She stated half-jokingly that she would wait until the pain and discomfort in her back outweighed the pain and discomfort of paying a hospital bill. One uninsured man explained, "*A lot of people don't go to the doctor when they don't have insurance because they don't want that extra bill. They have enough bills on them from the times they had to go in the past that they probably haven't finished paying yet. They figure, I'm not going unless I'm about to die and then I won't care about that bill until after.*"

Some participants had gone to Herman Kiefer, a local public health department clinic, but complained about long waits and quality concerns, primarily because the clinic is underfunded. Some women preferred to use other clinic sites to access family planning and STD screening services.

Some of the focus group participants discussed the potential closure of Detroit Receiving and the financial problems experienced by DMC. They knew a great deal about the system's financial problems and reported that other hospitals would suffer if DMC closed. One woman stated, "*You talk about overcrowding. It's crowded now. Imagine what Henry Ford would look like if DMC closes. They need to come up with something to either save that hospital or get people doctors somewhere else.*"

Some of the Arabic-speaking participants discussed differences between the U.S. health care system and the system in their home countries. They were surprised at the way the health care system works here and never expected it to be largely private and so expensive. One man stated, "*It's almost as if we traded one type of health for another. We are better off here, yes. But we have to do the best we can without the insurance here.*"

Prescriptions

Participants pay out of pocket for prescriptions, but most participants avoided filling prescriptions if at all possible. REACH patients at CHASS receive some of their diabetic supplies and medicines for free and have to pay for others. One woman explained that she needs two types of insulin and the program covers only one. Every 15 days she must pay $62 for the other type of insulin, but she says it is an expense she has grown accustomed to paying, like rent or the electricity bill. Participants agree that prescription medication is cheaper at the clinic than at other pharmacies, and they report that doctors at CHASS try to give them as many free medications as they can.

Hospital/Emergency Care

Most participants viewed going to the hospital as the last possible resort because of the extreme expense. Participants stressed that while emergency care is a last resort, it becomes the only option after delaying primary health care for too long. One uninsured man stated, "*If something happens, take me to the emergency room. Other than that, I'm not going to worry about anything unless I'm practically dying.*" Another woman noted, "*What's the difference? If I can't pay, it doesn't matter if it costs $200 or $2,000. I can't pay. At least at the hospital I know I'll get what I need in there and be done with it.*" Another woman stated that people who are uninsured are often unemployed and have few financial resources—at which point getting another hospital bill is often the least of their worries. She said, "*If I need something, I will go. I will chalk up a bill, I will go.*"

Participants in the CHASS group reported that they seek primary health care at CHASS before going to the ED. Three participants in the focus group had been referred to the REACH program at CHASS through the ED at Henry Ford. They reported that it was "smart" of Henry Ford to refer uninsured patients to the CHASS clinics because it could prevent ED visits. One woman reported, "*That's the last time I went to the hospital. They told me about REACH and now I come here. I probably would've gone there three or four*

more times since then but now I can come here and it's better. They take care of me."

The participants in the Arabic-speaking group were also very reluctant to use the emergency department, because of the cost of care. According to one participant, "*Actually, we try our best to avoid [the ED] because everyone who shakes your hand when you are in the emergency department will end up billing you for something, and we cannot afford that.*" The individuals in the groups did not prefer any one hospital to others in the Detroit area. Most of the participants used DMC or Henry Ford Hospital, although other hospitals had provided care for focus group participants as well.

Dental Care

Participants discussed the difficulties they had in finding affordable dental care. Some focus group participants had found dentists who would provide care at reduced rates, but they appeared to be very few and far between. A few of the participants said they found dentists who treated them at no cost but they did not want to take advantage of these providers so they put off care whenever they could. Several said they went to clinics and EDs if they had painful dental episodes but found that the providers generally wanted to pull the tooth instead of trying to treat or repair the problem.

Very few of the Arabic-speaking participants had any experience with dental care in the U.S. and they were interested in finding out more information about the availability of such services. As one participant said, "*I have been putting up with excruciating tooth pain for about a year, and I have no choice. I sometimes feel like pulling all my teeth out to get rid of the pain, because I certainly cannot afford to pay for a dentist.*" The participants were told that a dentist is available at discounted rates at the Arab-American and Chaldean Council for a certain number of hours each month. The Spanish-speaking group received some dental services from CHASS, but these tended to be for dental problems and not regular preventive dental care.

Mental Health Care

Participants were aware of mental health counselors who were available at reduced fees through the Arab-American and Chaldean Council and through CHASS. Participants in the English-speaking group, however, were not aware of any resources in the community for mental health care. One participant stated, "*If you go crazy, you go to the hospital and they'll lock you up. That's about all they have to say about mental health if you don't have insurance.*"

Outreach and Information

Participants in the English-speaking group underscored the need for more outreach and information about health care resources for the uninsured in Detroit. The Arabic-speaking and Spanish-speaking groups had developed relationships with community health centers or community based organizations and had a more formal network to tap for accessing health-related services and resources. The English-speaking participants—all of whom had been born and raised in the Detroit area and most of whom were working-age black residents, were essentially on their own. They could not identify any resource to help them navigate the health system and access the health services that could be available to them. They also seemed very interested in learning more about the work of the Voices of Detroit Initiative.

These participants believed that the reason they did not know about affordable health care options for the uninsured in Detroit was because none existed. Participants knew about options for care for Medicaid-covered children and adults, primarily through ads and billboards, and reasoned that if services were available for the uninsured, the state or local authorities would advertise them as well. The Spanish-speaking participants, on the other hand, felt that "everyone" knew about CHASS and Henry Ford Hospital, and that such information was communicated through word of month in the community. Many said how grateful they were to have found CHASS and the REACH program.

Interpreter Services

Arabic-speaking participants appeared to have substantial difficulty finding providers who spoke Arabic and could communicate effectively with them. Many came to the Arab-American and Chaldean Council's primary care center for services, even though the services are limited in scope, because they could be sure to find a provider who spoke their language. The availability of a provider who could communicate effectively was one of the most important considerations to participants in the two Arabic-speaking focus groups. In the words of one of the participants, " *Yes, we go to a doctor who speaks our language, or else how can we communicate with him or her?*" Another woman in the group said, *"I go to a specialist who is from the Arab/Chaldean community… because he can understand me. I don't know how good a doctor he is but I can at least communicate with him.*" Another participant said he chose doctors by watching the ethnic cable television channel and seeing who advertised as speaking his language.

The participants in the CHASS focus group were pleased with their access to Spanish-speaking health providers and felt very comfortable speaking with the clinical and administrative staff at CHASS. They did not find language to be a barrier to specialty or hospital care; they either could find a provider who spoke Spanish or would bring a family member along to interpret.

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 Henry Ford Hospital. Using a profiling algorithm,[58] 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.

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.

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.[59] 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:

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).

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 Henry Ford Hospital

As part of the *Urgent Matters* safety net assessment process, we collected information on ED visits at Henry Ford Hospital for the period July 1 through December 31, 2002. There were 33,285 ED visits for the six-month period that did not result in an inpatient admission. Table 9 provides information on these visits by race, age and gender. Information on visits by coverage is not available for analysis purposes.[60]

Table 9 Demographic Characteristics of ED Visits

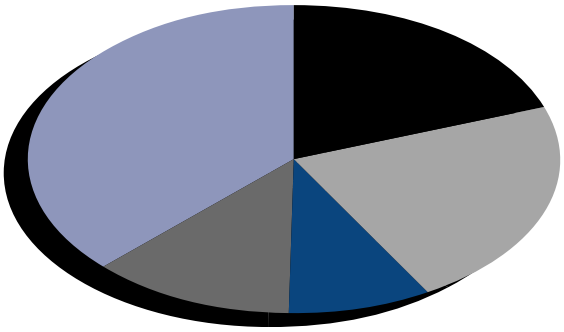
Race		Age		Gender	
Black	82.4%	0-17	18.0%	Female	53.1%
White	11.1%	18-64	70.6%	Male	46.9%
Latino	2.9%	65+	11.4%		
Other/unknown	3.6%				

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

Key Demographic Characteristics of ED Visits

- The majority of ED visits at Henry Ford were for patients who are black (82.4 percent) or white (11.1 percent). Only about 3 percent of visits were made by Latino patients.
- Less than one-fifth of ED visits were for patients under 18 years of age.

Figure 1 Visits by Emergent and Non-Emergent Categories



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 Henry Ford Hospital's emergency department.

A significant percentage of visits to the Henry Ford Hospital ED could have been treated in settings other than the ED. As Figure 1 demonstrates, 19.5 percent of ED visits at Henry Ford were non-emergent and another 22.1 percent 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 10 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 in the emergent, not preventable category, there were about one and one-half non-emergent visits and nearly another two emergent, but primary care treatable visits.

Table 10 Relative Rates for ED Visits at Henry Ford Hospital

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**1.57**	**1.79**	**0.70**	**1.00**
Age				
0-17	3.49	3.69	1.46	1.00
18-64	1.45	1.67	0.66	1.00
65+	1.05	1.26	0.47	1.00
Race				
Black	1.66	1.87	0.77	1.00
Latino	1.37	1.72	0.35	1.00
White	1.20	1.36	0.44	1.00
Sex				
Female	1.63	1.85	0.65	1.00
Male	1.50	1.70	0.78	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 Henry Ford Hospital's emergency department.

Visits varied only slightly by the race/ethnicity of the patient: black patients were marginally more likely than patients of other races to have used the ED for non-emergent care. Rates varied much more widely by the age of the patient, with children using the ED for non-emergent care at triple the rate of elderly patients. This difference was equally pronounced in the use of the ED for emergent, primary care treatable visits. Similar patterns involving the age of the patient were seen in analyses of ED data from other *Urgent Matters* sites.

These data support the assertion that patients are using the ED at Henry Ford Hospital for conditions that could be treated by primary care providers. The data show that children are especially likely to use the ED for primary care treatable emergent and non-emergent conditions. This suggests that there are opportunities to improve care for patients in Detroit while also addressing crowding in the ED at Henry Ford Hospital. While this analysis does not address ED utilization at other area 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 Detroit safety net, the assessment team identified the following key findings:

- The Detroit safety net is in a fragile state following a steady decline in health care resources previously available to some low-income and uninsured residents. Any further hospital closures within the Detroit Medical Center system could cause the safety net to collapse, leaving low-income and uninsured residents virtually "on their own" in terms of their access to vital health care services.
- There is a severe undersupply of primary care services for low-income and uninsured residents of Detroit and Wayne County. Most primary care for these populations is provided by a handful of community health centers and clinics that offer services at no- or low-cost. Access for individuals who are covered by Medicaid is hampered by a very limited supply of private physicians who are willing to accept Medicaid rates.
- Access to timely specialty care is largely dependent on an individual's access to primary care. Community Health Centers have partnered with the three major health systems in Detroit to provide specialty care for that center's patient population; however, access is uneven across these arrangements. Some of these patients have very good access to primary care, specialty care, inpatient services and prescription drugs, all at deeply discounted prices. Others, however, are less likely to receive these services in a timely or coordinated fashion, if at all.
- Funding for behavioral health care services is inadequate, affecting the infrastructure of delivery of care. As a result, patients report that they do not know where to go for care, and providers report that they have few options for follow-up care. The emergency departments of the health systems appear to be the default provider for patients with either acute or chronic behavioral health needs.
- A significant percentage of emergency department visits at Henry Ford Hospital are for patients whose conditions are non-emergent. Nearly one-fifth (19.5 percent) of all emergency department encounters that did not result in an admission were for patients who presented with non-emergent conditions. More than one-fifth (22.1 percent) were for patients whose conditions were emergent but could have been treated in a primary care setting.
- Pressures on the Detroit safety net can only be alleviated with an infusion of additional dollars targeted toward the expansion of primary care, specialty care, behavioral health and other health service capacity for low-income and uninsured residents. After decades of sustained neglect and retrenchment, the safety net needs more significant and stable financing to have the capacity to serve the populations in need of care.
- Two important initiatives have created the potential for a reorganized and rejuvenated safety net. The proposed creation of a Health Authority promises to consolidate safety net financing and coordinate health care delivery for low-income Detroit residents. At the same time, the Voices of Detroit Initiative (VODI) can serve as a model for other communities wishing to leverage scarce resources on behalf of the underserved. VODI has worked closely with safety net providers in the community and has helped to establish a coordinated strategy for strengthening the safety net.

Issues for Consideration

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

- The Detroit Health Care Stabilization Workgroup should continue its efforts to strengthen the safety net through the creation of a Health Authority. Such a move will consolidate and leverage resources to maximize revenues earmarked for care for uninsured and underserved residents.
- The Health Authority can play an important role in providing a coordinating function across safety net providers and other key health leaders. This function would build on collaborative work already undertaken by VODI. Such coordination could help support growth that is efficient and appropriately targeted to existing needs. The Health Authority should ensure that any new safety net funding goes directly to care for uninsured and underserved residents of Detroit.
- Stakeholders involved in the Detroit safety net must work to attract sufficient numbers of clinicians to the city. Shortages of primary care physicians in Wayne County and the City of Detroit jeopardize private sector health care delivery as well as safety net services. A revitalized safety net will never be possible without an influx of talented and committed primary care providers and specialists interested in working with both insured and uninsured Detroit residents. Even with additional funding available for services, more work will need to be done to attract sufficient numbers of clinicians to the city.
- The Detroit and Wayne County Health Departments should have clear roles within the Health Authority and contribute significantly to the health and well being of residents in the community. At present, the services provided by city and county health departments are too limited to meet even basic public health needs.
- All hospitals in the Wayne County safety net area should conduct analyses of the use of their emergency departments for emergent and non-emergent care. These studies would help determine whether area hospitals are experiencing trends in ED use similar to those seen in safety net hospitals. Hospitals, community providers and other stakeholders should use the results of these studies to develop strategies for reducing crowding in hospital EDs.

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

2 Charter County of Wayne, Michigan, 2002 Annual Report.

3 Ranking based on population estimates for Michigan cities found at the Census and Statistical Data for Michigan, www. Michigan.gov/census/0,1607,7-162—71812—,00.html.

4 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: Detroit City, Wayne County, 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

5 In 2003, the FPL 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).

6 Median income levels for Macomb County ($50,134), Oakland County ($62,402) and the city of Detroit ($30,461) taken from 2002 American Community Survey, U.S. Census Bureau, 2003.

7 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.

8 Michigan Department of Community Health, "Strengthening the Safety Net in Detroit and Wayne County: Report of the Detroit Health Care Stabilization Workgroup," August 2003, www.michigan.gov/mdch/0,1607,7-132—72692—,00.html (as of November 2003).

9 Before the sale to DMC, the public hospital was known as Detroit General Hospital. For information about the transition from public to nonprofit status, see M. Legnini, S. Anthony, E. Wicks, J. Meyer, L. Rybowski, L. Stepnick, *Privatization of Public Hospitals* (Washington, DC: Prepared by Economic and Social Research Institute for the Henry J. Kaiser Family Foundation, January 1999).

10 Staff Writers, "Burden from Uninsured People is Heaviest on DMC," *Detroit Free Press*, 3 July 2003.

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

12 M. Taylor, "Bad Days in Detroit," *Modern Healthcare*, (4 August 2003).

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

14 Michigan Department of Community Health, "Strengthening the Safety Net in Detroit and Wayne County: Report of the Detroit Health Care Stabilization Workgroup," August 2003.

15 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.

16 Federally Qualified Health Centers (FQHCs) are designated to serve medically underserved populations. FQHCs are eligible for Section 330 grants from the Health Resources and Services Administration to offset the costs of care to uninsured patients. They also are eligible for enhanced Medicaid reimbursements.

17 These data come from the Uniform Data System, a national database of patient and health center characteristics managed by the Health Resources and Services Administration. Data are from 2002.

18 Encounters include medical services as well as enabling services such as transportation, interpreter services, case management, etc.

19 Percentages do not add to 100 because missing values or other races are not included in the estimates.

20 Michigan Primary Care Association, *Primary Health Care Profile of Michigan*, (Okemos, MI: MCPA, 2002).

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

22 Michigan Primary Care Association, *Primary Health Care Profile of Michigan*, (2002).

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

24 State Medicaid representatives noted that some residents are "excluded" or can voluntarily "opt-out" of a health plan and receive services on a fee-for-service basis.

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

26 K. Norris, "4 Medicaid HMOs Mired in Insolvency," *Detroit Free Press*, 12 September 2003.

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

28 Michigan Department of Community Health, "Health Care Programs Eligibility," http://www.michigan.gov/mdch (as of 22 November 2003).

29 Michigan Primary Care Association, *Primary Health Care Profile of Michigan*, (2002).

30 Michigan Department of Community Health, "MIChild Brochure," 2003, http://www.michigan.gov/mdch (as of 22 November 2003).

31 Access to Health Care Coalition, "Closing the Gap: Improving Access to Health Care in Michigan," (March 2003).

32 Greater Detroit Area Health Council, Inc., *Health and Health Care in Southeast Michigan: A Chart Book*, (Detroit, MI: Greater Detroit Area Health Council, Inc., September 2003).

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

34 Citizens Research Council of Michigan, "Wayne County Medical Program," 27 March 2002, http://www.crcmich.org/HCOutline/Purchase/ohcp-w1.html (as of 4 December 2003).

35 D. Andrulis and M. Gusmano, "Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?" *The New York Academy of Medicine* (August 2000).

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

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

38 Wayne County's Health and Community Services Department, "County card," www.waynecounty.com/hcs/countycard.htm (as of 22 November 2003).

39 These include all activities related to public and mental health, solid waste disposal, headstart, job training, and housing and urban development. See Charter County of Wayne, Michigan, 2002 Annual Report.

40 The availability of Medicaid matching funds engenders strong debate among informants in Detroit. Several interviewees believe that the county has not been effective in maximizing Medicaid dollars and believe that significant monies are available from better Medicaid maximizations strategies.

41 Andrulis and Gusmano, "Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?"

42 Michigan Department of Community Health, "FY 02 Boilerplate Report," February 2002, www.michigan.gov/documents/blrplt_1695,_Feb,_2002_34661_7.pdf (as of 22 November 2003).

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

44 Grant funds may support activities that have benefits for publicly or commercially insured patients as well. For example, education programs targeted toward patients with chronic conditions such as asthma, diabetes, and heart disease would also create resources for insured patients.

45 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

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

47 Governor Granholm has identified mental health as one of her top priorities. See G. Kuppa and J. Brooks, "Granholm Vows to Fix Mental Health System," *The Detroit News Special Report,* 22 July 2003.

48 G. Kuppa and J. Brooks, "Mental Care System Shows Web of Despair," *The Detroit News Special Report,* 20 July 2003.

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

50 Recent budget cuts will also eliminate Medicaid coverage for chiropractic and podiatry services and hearing aids for adult recipients. See P. Montemurri, "600,000 to lose state dental care: Medicaid cuts effective Oct. 1," *Detroit Free Press*, 3 September 2003.

51 Michigan Department of Community Health, "MIChild Brochure," 2003.

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

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

54 Michigan Department of Community Health, "Strengthening the Safety Net in Detroit and Wayne County: Report of the Detroit Health Care Stabilization Workgroup," August 2003.

55 Ibid.

56 Ibid.

57 REACH, or Racial and Ethnic Approaches to Community Health 2010, is a project funded by the Centers for Disease Control and Prevention that provides assistance and health care services to minorities with diabetes, high blood pressure, and other health problems. The purpose of the national CDC program is to combat disparities among minorities with special conditions like diabetes. REACH provides funding to the center to cover the costs of some patients' regular doctor's visits, testing and medical supplies, and certain prescription medicines.

58 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* (Volume 8, no. 11, 2001) 1030-1036.

59 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).

60 Only about 4 percent of visits were categorized as being covered by Medicaid. This number refers to visits covered by Medicaid fee-for-service. An additional 30 percent of visits were paid by HMOs. This category includes a larger number of visits that were covered by Medicaid managed care plans, although they cannot easily be identified separately from visits covered by commercial managed care plans. For this reason, we do not include an analysis of visits by coverage.

Urgent Matters Grantee Hospitals and Community Partners

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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

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Project Director: Theodore C. Chan, MD