WALKING *a* TIGHTROPE

The State of the Safety Net in Ten U.S. Communities

Urgent Matters

The George Washington University Medical Center

School of Public Health and Health Services

Department of Health Policy

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The State of the Safety Net in Ten U.S. Communities

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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 simultaneously attempt to cope with a nursing shortage, escalating labor costs, and the adoption of expensive new technologies.

These forces are felt 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 gauged the "state of the safety net" in ten American communities. This assessment was conducted as part of the *Urgent Matters* project, a national program of the Robert Wood Johnson Foundation designed to spur awareness of safety net issues while finding practical ways to relieve one symptom of distress in a critical access point—overcrowded emergency departments. The project was led by a team of researchers at George Washington University with the direction of Marsha Regenstein, PhD, MCP. In each community this team worked with a Community Partner—a local organization that helped us to identify the key issues and stakeholders. These community partners have also committed to convening opinion leaders and others in their region to discuss the implications of the reports' findings.

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 dialogues 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

Despite years of debate about the availability of health insurance for Americans, and after several attempts to create programs or policies for universal health care coverage, more than 43 million U.S. residents are uninsured.[1] This staggering number is in addition to the millions more who are underinsured for vitally important health services.

Where do these people go for their health care? To whom do they turn for preventive health care, primary and specialty care, inpatient and emergency services, and mental health and dental care?

Many of these individuals receive care from the health care *safety net*—a term that has come to refer broadly to public hospitals, community health centers, public health departments, faith-based clinics, and others who, either by mission or mandate, provide significant amounts of health care to people who are uninsured or underinsured and who cannot cover the costs of care from their own resources.

URGENT MATTERS

The *Urgent Matters* program is a national initiative of The Robert Wood Johnson Foundation. The program is designed to assess the state of America's health care safety net while working to improve access by addressing the crisis in a critical part of the safety net: crowded emergency departments. *Urgent Matters* rests on the assumption that there is an important relationship between emergency department use and the performance of the health care safety net.

The *Urgent Matters* program conducted safety net assessments in 10 communities across the country. Each assessment examines key issues that shape the health care networks available to uninsured and underserved residents. They describe the characteristics of the local populations, and outline the structure and financing of safety net services. Each report includes results from discussions with groups of local residents as well as interviews with key stakeholders and safety net providers. An analysis of data from residents' use of the emergency department at the *Urgent Matters* grantee hospital is also included in the reports. The analysis provides estimates of the use of the emergency department for care that could safely be delivered in a primary care setting.

This report presents the findings from the *Urgent Matters* safety net assessments and identifies common characteristics, opportunities and challenges for communities that wish to better serve the health care needs of uninsured and underserved individuals. It also illustrates differences across many of the communities, especially in terms of the structure and financing of their safety nets. It is a companion report to the individual safety net assessments and provides an overarching perspective of problems that affect safety nets across the country.

KEY FINDINGS AND STRATEGIES FOR IMPROVING CARE FOR UNINSURED AND UNDERSERVED RESIDENTS

After examining key components of the safety net in each of the ten Urgent Matters *communities we offer the following key findings.*

Safety Net Structure and Financing

- Even the most comprehensive and traditionally robust safety nets are facing financial challenges and feeling the effects of the *safety net paradox*: as the need for safety net services grows, the ability and willingness of governments to support these services diminishes.
- Between one-quarter and one-third of residents in the *Urgent Matters* communities are either uninsured or covered by Medicaid or the State Children's Health Insurance Program (SCHIP) and likely to turn to the safety net for their health care needs.

***Urgent Matters* communities:**

Atlanta, Georgia
Boston, Massachusetts
Detroit, Michigan
Fairfax County, Virginia
Lincoln, Nebraska
Memphis, Tennessee
Phoenix, Arizona
Queens, New York
San Antonio, Texas
San Diego, California

- Communities differ substantially in terms of the size and scope of their safety nets. State and local financing for safety net services is considerable in some communities and minimal in others.
- With fewer resources available to support safety net services, all of the communities that are described in this report are being required to do more with less. They are facing cutbacks in payments for direct services and/or decreasing subsidies from state or local governments. All the while, demand for care continues to skyrocket. This is not a strategy that can be sustained over time.

Availability of Safety Net Services

- After conducting assessments of the 10 *Urgent Matters* communities, we have concluded that the availability of primary care is relatively high, specialty care is strained, behavioral health care is generally quite limited, and dental care is virtually non-existent.
- The accessibility of primary care services appears to relate directly to the availability of both dedicated funding streams and substantial systems or networks of providers that serve vulnerable populations.
- The emergency department (ED) was ranked "high" on availability in all 10 communities. Despite long waits for care, patients find the convenience and accessibility of the ED a better alternative to months-long waits for specialty care and multiple visits for diagnostic tests and procedures.
- Important and encouraging initiatives have been implemented by a number of communities to integrate services and patient information across safety net systems. These programs will ultimately improve service delivery and access to care for uninsured and underserved community residents.

Availability of Services and System Integration in *Urgent Matters* Communities

	Primary Care	Specialty Care	Emergency Department	Behavioral Health	Dental Care	Safety Net Integration
Atlanta	●	◑	●	◑	○	○
Boston	●	◑	●	◑	○	◑
Detroit	○	○	●	○	○	◑
Fairfax County	○	○	●	○	○	●
Lincoln	◑	○	●	◑	○	◑
Memphis	●	◑	●	○	○	◑
Phoenix	◑	○	●	◑	○	○
Queens	◑	◑	●	◑	○	●
San Antonio	◑	○	●	○	○	○
San Diego	◑	○	●	○	○	○

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

Focus Group Discussions with Community Residents

- Focus group participants are very appreciative of the care they receive from safety net facilities. Most say that the care is high-quality and they rely heavily on these services for their health care needs.
- Nearly all participants stated that they have difficulties accessing specialty care, behavioral health and dental care.
- Participants lack information about affordable options for health care and are often not aware of the availability of safety net services in their communities.
- Focus group participants complained about long waits at many safety net facilities, although they generally understood that services were in high demand. They were more concerned with poor treatment from providers and staff at safety net hospitals and clinics than they were with long waits for care.
- Lack of adequate interpreters or culturally competent providers creates significant obstacles to accessing services. Transportation also serves as a barrier to care in many of the communities.

Emergency Department Use

- A significant percentage of visits to *Urgent Matters* emergency departments could have been treated in settings other than the ED. Over one-fifth (21.4 percent) of ED visits across the hospitals were non-emergent and another 20.6 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.
- EDs at *Urgent Matters* hospitals see large numbers of uninsured and publicly insured patients. About 60 percent of emergency department visits were for patients who were either uninsured or covered by Medicaid or SCHIP. These hospitals also see a very diverse patient population. About one-fifth (21.2 percent) of visits were for patients who are white, two-fifths (41.8 percent) were for black patients, and one-quarter (24.5 percent) were for Hispanic and Latino patients.
- The rate of use of the ED for primary care treatable visits was higher than the rate for emergent, non-preventable visits. For every visit that was in the emergent, non-preventable category, there were two non-emergent visits and another two emergent but primary care treatable visits. Rates were higher for patients covered by Medicaid and for black and Latino or Hispanic patients.
- Rates of use of the ED for primary care treatable conditions are far higher for children than for adults or elderly patients. For every visit by a child that was emergent and non-preventable, there were 3.74 non-emergent visits and another 3.85 emergent, primary care treatable visits.
- The availability of alternative sources of care does not appear to explain the use of the ED for primary care treatable conditions. Across all sites, patients used the ED for primary care treatable conditions at relatively comparable rates during the hours of 8:00 am to 4:00 pm, when clinics and private practice providers are open, and the hours of 4:00 pm to midnight.

Strategies for Strengthening the Safety Net

The Urgent Matters *Safety Net Assessment Team offers the following key strategies for strengthening the safety net. The strategies recommended here are those most commonly suggested to the* Urgent Matters *communities.*

- Communities need to clearly understand the impact of changes in public financing on safety net services, including the impact on access to care for the most vulnerable populations. Communities that have experienced significant changes in public financing should commission studies to determine what effects these changes have had on the safety net. Studies should include an investigation of any unintended consequences of the changes on the principal safety net institutions in the community. Studies should also examine whether provider payments are sufficient to encourage physicians and other health care providers in the safety net to continue serving the community.

- Safety net providers, community health workers and case managers should work together to measure existing capacity of safety net systems to identify areas needing expansion and better execution. All components of the safety net should be studied. In particular, studies should include a close examination of behavioral health care systems to identify opportunities for re-engineering the delivery of care and making existing capacity more efficient. This process should build on initiatives or discussions that have been undertaken as a result of the dissemination of the individual *Urgent Matters* safety net assessments.
- Collaboration among existing safety net providers should be encouraged and developed as a way of increasing overall capacity and improving quality of care for uninsured and underserved populations. Efforts should focus on a systematic approach to service delivery, recognizing the strengths of individual organizations in the safety net structure and the potential additional capacity that each may offer.
- Safety net providers should implement information systems that follow patients across systems and sites of care, allowing providers to share patient files across various sites of service. Such systems would improve patients' quality of care by streamlining eligibility and registration processes and would enable providers to have more up-to-date information on a patient's clinical profile and history. The development of a formal referral network between the hospitals and other safety net providers could improve access and outcomes for all patients, and especially those who do not have a medical home.
- Hospitals and other safety net providers should develop formal referral networks to improve access and outcomes for patients who present at the ED with primary care treatable conditions but who have no medical homes. Currently in many communities, patients are sent home with written discharge directions, but they frequently fall through the cracks with little or no follow-up care.
- All hospitals in the *Urgent Matters* communities should conduct analyses of the use of their emergency departments for emergent and non-emergent care. These analyses 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 these studies to develop strategies for improving the accessibility of primary, specialty, behavioral health, and dental services in the community.
- Given the increasing diversity of the populations in many of the *Urgent Matters* communities, safety net providers must develop programs to provide language services, health education, and culturally appropriate outreach that effectively meet the needs of the population.
- Public awareness campaigns and outreach efforts should be employed to help uninsured and underserved residents learn how to navigate the health care system. These programs should use community health workers in their outreach efforts to better connect with underserved populations. Such programs can describe options for primary care for uninsured and underserved patients and explain how to apply for services. This is especially important in communities with high numbers of new residents and recent immigrants.
- Key stakeholders should make concerted efforts to include more Latinos, African Americans and members of other racial and ethnic groups in all aspects of the decision making process. Improving representation among traditionally underrepresented groups could result in enhanced awareness of underserved populations and safety net issues in the community.
- The effectiveness of bus routes and the transportation systems serving low-income, underserved populations should be evaluated in communities. Consideration should be given to changing routes to increase their convenience for the underserved. In some communities, a transportation voucher system for low-income populations could be considered.

INTRODUCTION

Despite years of debate about the availability of health insurance for Americans, and after several attempts to create programs or policies for universal health care coverage, more than 43 million U.S. residents are uninsured.[2] This staggering number is in addition to the millions more who are underinsured for vitally important health services.

Where do these people go for their health care? To whom do they turn for preventive health care, primary and specialty care, inpatient and emergency services, and behavioral health and dental care?

Many of these individuals receive care from the health care *safety net*—a term that has come to refer broadly to public hospitals, community health centers, public health departments, faith-based clinics, and others who, either by mission or mandate, provide significant amounts of health care to people who are uninsured or underinsured and who cannot cover the costs of care from their own resources.

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 context 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 in this country, the reduction or elimination of subsidies funding charity care, and the growth of mandated managed care.[3]

Since the time of that report, the state of the safety net has become even more precarious. A combination of forces, often referred to as the "perfect storm," have converged over the past few years, and threaten the ability of our current safety net to continue to stay afloat.[4] These include:

- *Increasing demand for care, primarily from greater numbers of uninsured residents.* Because care for the uninsured is not dispersed evenly throughout communities, rapid and significant increases in demand for safety net services tend to cluster in locations that are known to provide care to the uninsured. This puts added pressure on safety net institutions to meet the needs of a growing patient base.
- *Decreasing revenues.* Safety net providers rely heavily on public sources of financing to provide care for their patient populations. Chief among these are payments from Medicaid for direct services, enhanced Medicaid payments for caring for disproportionately large numbers of uninsured and publicly insured individuals, and state or local subsidies for care for the uninsured. Budget pressures at the federal, state and local levels throughout the country are resulting in lower net revenues to safety net providers.
- *Workforce shortages.* Safety net providers are facing significant difficulties recruiting and retaining a high-quality workforce. The shortage of nurses has been well-documented, with over one in 10 nursing positions currently estimated to be unfilled.[5] Less attention has been focused on shortages in other medical professions, but the impact is significant nonetheless; a scarcity of pharmacists and pharmacy technicians, radiology technicians, and many other hospital and clinic-based health practitioners all strain the ability of the safety net to serve those most in need. Certain specialty physicians, as well as dental and mental health providers are also in very short supply, creating difficulties in meeting the needs of patients. Safety net providers must compete with other health care employers in their markets for these health professionals and may be at a disadvantage when putting together competitive compensation packages.
- *Rising costs of pharmaceuticals and advanced medical technology.* The rise in the cost and use of pharmaceuticals has been among the biggest drivers of medical inflation, with double-digit annual increases over the past several years.[6] Many safety net providers offer free or reduced-cost medications to their uninsured and low-income patients—a practice that,

while extremely important for patients, carries a heavy price tag. Likewise, advances in medical technology have long been associated with increases in the costs of overall health care.[7]

- *Outdated information technology.* Tight revenues offer limited opportunities to invest in capital needs, including emerging information technologies. Such technologies can create safer, better integrated and more efficient systems of care, but require large up-front investments and substantial training for optimal use.

Nowhere have these converging forces been more evident than in our nation's emergency departments (EDs). EDs play a critical role in the safety net of every community, serving residents who have nowhere else to go for timely care. Not only are EDs one of the most accessible safety net providers in a community, available 24 hours a day, seven days a week, but they also provide a full range of services to patients. In addition, federal law ensures that all patients presenting in an ED be screened to determine whether their condition is emergent, regardless of their insurance status or ability to pay for care.[8] If the condition is emergent, federal law requires that the ED provide at least some level of appropriate treatment.

When EDs are too crowded or ambulances cannot deliver patients to the nearest emergency department, however, quality of care and patient safety can be compromised. ED crowding and diversion can be attributed to a number of factors, including those related to the hospital and the health care community at large. Problems with hospital throughput (the process of managing patients in the ED) and output (the process of efficiently moving patients to their next disposition) contribute to crowding and should be addressed by hospital management as ways to reduce crowding.[9] Problems of input (why patients present to the ED initially) are more representative of fractures in the health care system at large and are the major focus of this report.

The Safety Net Paradox

Health care safety nets exist to support the health and well-being of uninsured, underinsured, and otherwise vulnerable residents in their communities. Even the term "safety net" implies a structure or mechanism that offers individuals a soft landing—in this case, an opportunity for vulnerable individuals to get the health care that all of us need throughout our lives.

Ironically, as pressures increase across sectors of the economy, the safety net also faces economic pressure and often must contract to maintain operations. This is precisely the opposite action that safety nets should take if they are to meet their mission of caring for their communities and, in this case, absorbing additional demand for services. On the contrary, as coverage in the private sector decreases, and as Medicaid programs take steps to cut, limit or slow enrollment, the health care safety net should expand to "catch" these individuals and ensure that they receive the care they need. This is not always happening, however, and this is what we term the "safety net paradox." *As the need for safety net services grows, the ability and willingness of governments to support these services diminishes.*

Safety net systems across the country are feeling the effects of the safety net paradox. As demand for their services increases, they are required to provide greater amounts of care that is uncompensated. They rely heavily on governmental sources of support for this care, but substantial amounts of these sources are discretionary and tend to decrease as government budgets become tight. As the need for the safety net increases in a community, it becomes more and more difficult for safety net providers to fulfill their mission. Most of the communities that are described in this report have been required to do more with less. This is not a strategy that can be sustained over time.

The *Urgent Matters* safety net assessments have found that even the most comprehensive and traditionally robust safety nets are facing considerable financial challenges. If these pressures continue, safety net systems will need to respond with more substantial cuts of their own and the net will become even more fragile and tenuous.

The Urgent Matters Program

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, *Urgent Matters* takes IOM's research a step further and examines the interdependence between the emergency department and core safety net providers who deliver significant levels of health care and other health-related services to uninsured and underserved individuals.

The purpose of *Urgent Matters* is to identify opportunities for relieving crowding in our nation's emergency departments and to improve access to quality care for uninsured and underserved community residents. The program consists of three components: 1) technical assistance to 10 hospitals whose EDs serve as crucial access points for uninsured and underserved patients; 2) demonstration grants to four of these 10 hospitals to support innovative and creative solutions to improve patient flow in the ED;[10] and 3) assessments of the safety nets in each of the communities that are home to the 10 hospitals.

Summary Report: The State of the Safety Net in 10 U.S. Communities

This report presents the findings from the *Urgent Matters* safety net assessments and identifies common characteristics, opportunities and challenges for communities that wish to better serve the health care needs of uninsured and underserved individuals. It is a companion report to the individual safety net assessments and provides an overarching perspective of problems that affect safety nets across the country. Appendix A provides a list of the 10 safety net assessments, as well as information on the *Urgent Matters* hospitals and community partners.

Section one of the report presents information on the general structure of the safety nets in these communities and describes ways that communities finance care for low-income populations. Section two discusses the availability of primary care, specialty care, emergency department, behavioral health and dental services in each of the *Urgent Matters* communities.

Section three presents some of the highlights from focus groups with residents in these communities and brings to life some of the difficulties that uninsured and low-income residents face when trying to find timely and affordable health care. Section four describes demographic characteristics of patients who use the EDs in the 10 *Urgent Matters* hospitals and summarizes the results of an ED use profiling algorithm. The algorithm provides an opportunity to assess the extent to which patients use these emergency departments for primary care treatable conditions. Section five summarizes the key findings of the assessments and identifies issues that safety net providers and others may want to consider as they work to improve care for uninsured and underserved residents in their community.

***Urgent Matters* communities:**

Atlanta, Georgia
(Fulton and DeKalb Counties)

Boston, Massachusetts
(Suffolk County)

Detroit, Michigan
(Wayne County)

Fairfax County, Virginia
(Fairfax County)

Lincoln, Nebraska
(Lancaster County)

Memphis, Tennessee
(Shelby County)

Phoenix, Arizona
(Maricopa County)

Queens, New York
(Queens County)

San Antonio, Texas
(Bexar County)

San Diego, California
(San Diego County)

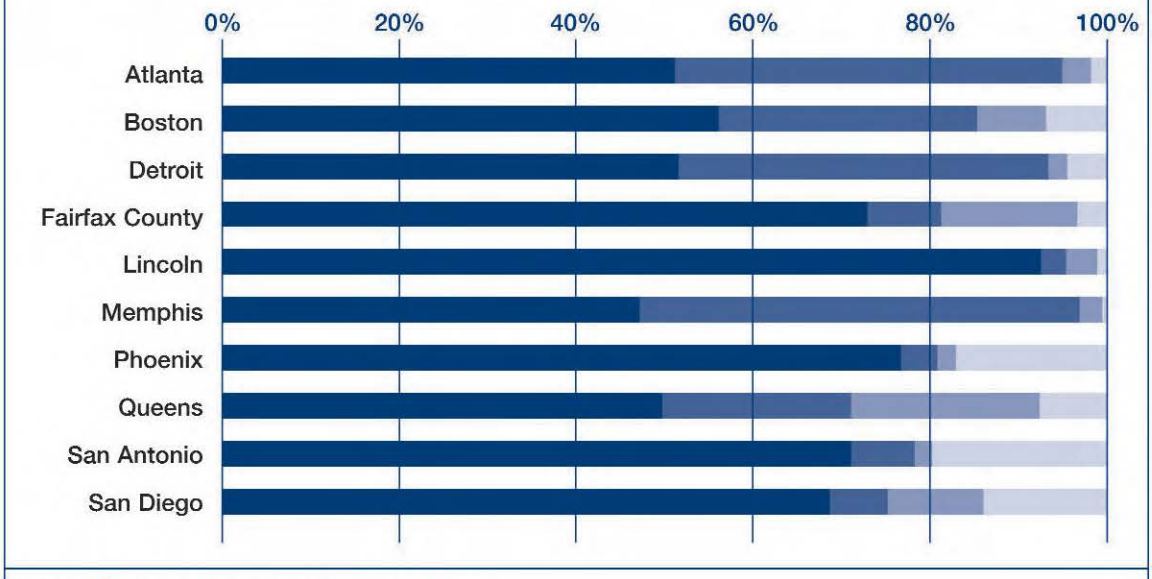
BACKGROUND

The 10 communities that comprise the *Urgent Matters*

project provide extremely interesting examples of the challenges that cities and counties across the country face while attempting to offer and sustain health services for uninsured and underserved residents. All 10 communities house vulnerable populations that are in need of safety net services, though the composition of these populations varies considerably by site. Figures 1 and 2 provide information on the race and ethnicity of the populations who live in these communities and illustrate the substantial variation that exists across these cities and counties.[11]

In terms of race and ethnicity, the communities could not be more different. Lincoln, Nebraska, located in Lancaster County, is the state capitol and the least diverse in terms of the racial composition of the *Urgent Matters* communities. Over 90 percent of Lancaster County residents are white. Atlanta, Detroit and Memphis, on the other hand, have large black populations.[12] Fairfax County and San Diego each have Asian populations that represent over 10 percent of their residents. Queens, which is the most diverse of the ten sites, has a population that is 20 percent black and 20 percent Asian.

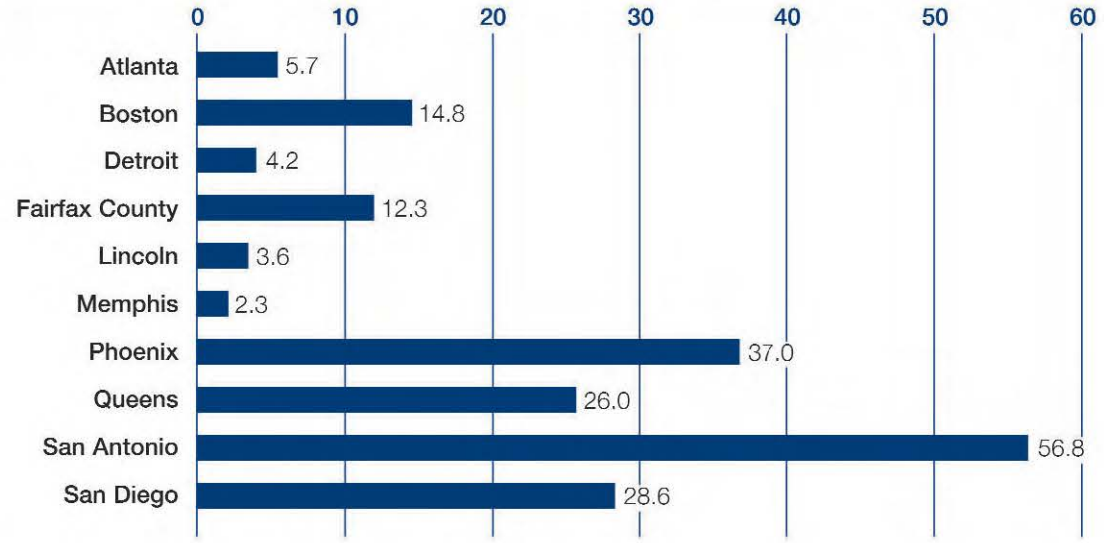
Figure 1 ***Urgent Matters*** **Communities by Race of Population**



Source: American Community Survey Profile, 2002, U.S. Census Bureau.

The communities also differ by the proportions of residents who identify as Latino or Hispanic (see Figure 2). Some communities like Memphis have few Latino residents (2.3 percent) while others have significant Latino presences. In San Antonio, 56.8 percent of residents identify as Hispanic. In some of the communities with lower proportions of Latino or Hispanic residents, growth among these populations has been significant over the past decade and is projected to continue growing in the next decades. For example, the Latino population in Memphis has seen substantial growth in the last several years.[13]

Figure 2 ***Urgent Matters*** **Communities by Percent of Residents Who Identify as Latino or Hispanic**



Source: American Community Survey Profile, 2002, U.S. Census Bureau.

Health care safety net systems exist to serve poor, underserved populations. Like most communities across the country, a considerable proportion of poor people—i.e., individuals whose household incomes are at or below 100 percent of the federal poverty level (FPL)—live in each of the *Urgent Matters* communities.[14] As Table 1 illustrates, Boston has the highest proportion of poor residents at 19.5 percent. As a point of comparison, Boston's proportion of poor residents is more than four times larger than that of Fairfax County, which has the lowest rate of the group. Fairfax County is one of the wealthiest counties in the country with a median income of $85,310 in 2002, nearly twice as high as the median income of residents across the State of Virginia.[15] In Atlanta, Boston, Detroit, Memphis and San Antonio, more than 15 percent of residents are poor.

Furthermore, each of the communities has many other residents who are near-poor, with family incomes that exceed the national poverty level but are nonetheless extremely low. For example, in Wayne County, an additional 16.5 percent of residents have incomes between 100 and 200 percent of the FPL.[16] Thus, one-third of county residents in Wayne County are low-income.

In terms of race and ethnicity, the communities [that comprise the Urgent Matters *safety net assessment project] could not be more different.*

Table 1 **Percent of Residents in *Urgent Matters* Communities Who are Living in Poverty***

	Percent of Residents who are Poor
Atlanta (Fulton County)	15.7
Boston (Suffolk County)	19.5
Detroit (Wayne County)	16.4
Fairfax County	4.5
Lincoln (Lancaster County)	12.1
Memphis (Shelby County)	18.5
Phoenix (Maricopa County)	13.1
Queens (Queens County)	12.2
San Antonio (Bexar County)	15.6
San Diego (San Diego County)	12.4

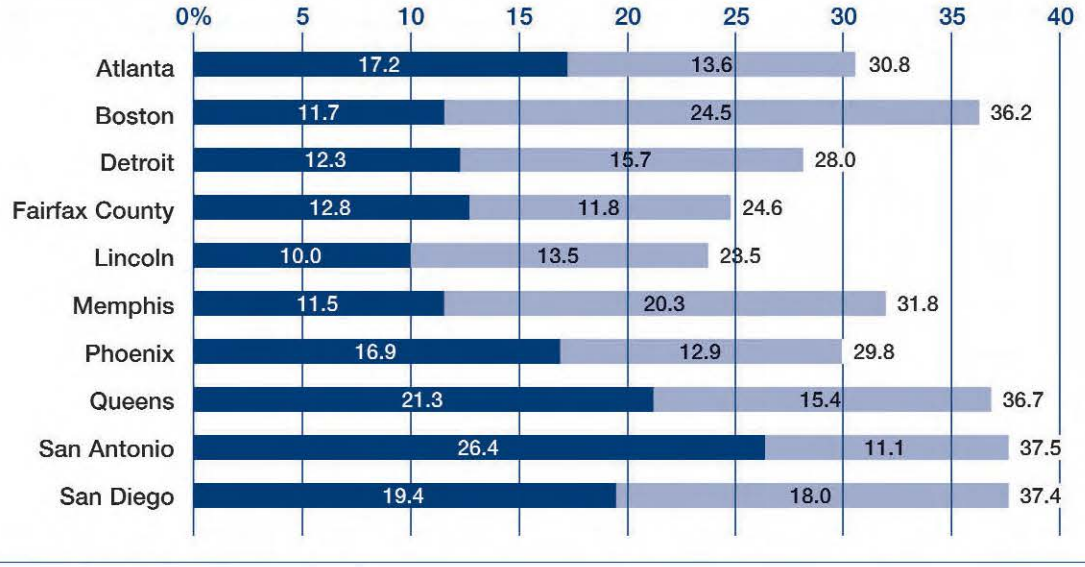
Source: American Community Survey Profile, 2002, U.S. Census Bureau.
**Defined as the percent of residents who live in households with incomes up to 100 percent of the federal poverty level.*

Despite the variation in income levels, each of the communities is home to large groups of residents who are either uninsured or covered by public insurance programs such as Medicaid or the State Children's Health Insurance Program (SCHIP). As can be seen in Figure 3, between 10.0 percent and 26.4 percent of residents in these communities are uninsured, and an additional 11.1 percent to 24.5 percent are covered by Medicaid and SCHIP.

It is these two groups of residents who are most likely to rely on the safety net for their care. Together, these groups of individuals represent between one-quarter and one-third of the people in their communities. Given the proportion of safety net populations across all of the communities, state and local decisions about the stretch and breadth of Medicaid and SCHIP have enormous implications for large numbers of residents.

Boston and San Antonio, for example, have similar proportions of residents who are traditional safety net populations, with 36.2 percent of Boston's residents either uninsured or covered by Medicaid or SCHIP and 37.5 percent of San Antonio's residents in those two categories. Boston residents, however, are more than twice as likely to be covered by Medicaid or SCHIP as San Antonio residents, who are much more likely to be uninsured (see figure 3).

Figure 3 ***Urgent Matters*** **Communities by Percent of Population Uninsured or Covered by Medicaid/SCHIP**



Sources: Data are for the county unless otherwise specified. Resources to Expand Access to Community Health (REACH) Data, 2000, National Association of Community Health Centers.[17]
For Boston, data apply to the City of Boston. Massachusetts Division of Health Care Finance and Policy, 2002.

STRUCTURE OF THE SAFETY NET

Local health care safety nets are often difficult to identify and describe fully because they can be comprised of many different providers. Generally, safety net providers belong to one of the following two categories:

- Publicly supported entities that are mandated, generally as a condition of receiving federal, state or local funding, to provide certain types of health services or care to uninsured, low-income, or otherwise underserved residents.
- Other entities that have assumed a responsibility for providing certain types of health services or care to the same population groups.

Entities that fall into the first category are much more easily identifiable in a community. They include public hospitals, Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes,[18] and, in some communities, public health departments that provide direct services or support service delivery for uninsured and underserved residents. Finally, the safety net in most communities is complemented by private practice physicians and other health care practitioners, who provide free or discounted care to at least some patients in their practices.

The proportion of safety net care that these institutions provide varies tremendously across communities, but generally depends on a complex set of factors, including

the amount of funding available, the demand for safety net services, the total supply of health care in the market, the existence of other local providers who have a safety net mission or mandate, and the history of the entity and the extent to which community residents expect it to serve as a principal safety net provider.

Whether by virtue of mission or mandate, safety net providers serve disproportionately high numbers of uninsured, underinsured, and underserved community residents. In some cases, they may assume greater responsibility for certain subpopulations, for example serving proportionally higher numbers of persons with certain diseases (such as HIV, tuberculosis, diabetes, or asthma). In other cases, they may see high numbers of immigrants, children with special health care needs, or other subpopulations that require specialized services in addition to standard health care services.

The safety nets in the *Urgent Matters* communities are as varied as their patient populations. The Atlanta and Queens safety nets have large, public hospital systems, each with extensively developed hospital and community-based clinics for primary and specialty care. In Atlanta's case, FQHCs and faith-based clinics also offer comprehensive preventive and primary care services in many parts of the city. In Northern Queens, an extremely large and diverse population comprised of many immigrant groups receives care from an extensive system of public hospital- and community-based clinics as well as a network of mostly solo practitioners, many of whom are first or second generation immigrants who are well-suited to provide culturally and linguistically appropriate care to their patients.

Phoenix and San Antonio also have public hospitals that provide significant amounts of care to local residents. In the case of Phoenix, however, primary care for the underserved suffers from fragmentation and lack of coordination among safety net hospitals and other primary care providers. In San Antonio, uneven distribution of primary care providers makes it difficult for needy residents to get care.

In Boston, a vast network of FQHCs provides mostly primary and preventive services to the uninsured and underserved. This care supplements the services provided by Boston Medical Center, a non-profit safety net hospital that is a product of a merger between the city's public hospital and a university hospital in the mid-1990s. In Memphis, the Regional Medical Center at Memphis (The Med), a large non-profit safety net health system, provides primary, specialty and tertiary care services. The Med has partnered with the Department of Health to develop a network of community-based clinics to provide services to uninsured and underserved residents.

In Fairfax County, three county-funded and operated clinics provide services exclusively to uninsured patients with incomes under 200 percent of the FPL. About one-third of its low-income uninsured residents (about 11 percent of the total uninsured population in the county) are seen in these clinics and publicly insured individuals are often linked with private providers who agree to take on a small number of Medicaid and SCHIP patients. Fairfax County does not have a public hospital or an FQHC.

The safety net in Detroit is comprised of a relatively small number of FQHCs, as well as collaborations among area hospitals to treat some portion of uninsured and underserved residents. This care is supplemented by services provided by the City and County Departments of Health. These arrangements are similar to the one in place in Lincoln, Nebraska. The Lincoln safety net, however, includes other types of providers that add to the care provided by the hospitals and the FQHC. San Diego's safety net consists of over 70 community clinics and FQHCs, as well as some private physicians who deliver care through managed care contracts. These providers are the main source of primary care for uninsured and underserved residents.

Table 2 provides information on the existence of various safety net providers in each of the *Urgent Matters* communities. Four of the communities have public hospitals and nine have one or more FQHCs or Look-Alikes. 10 of the communities have other types of providers that are part of their local safety nets. These other providers generally include faith-based clinics, public health department clinics, or licensed community clinics that are not FQHCs or Look-Alikes.

Table 2 Safety Net Providers in *Urgent Matters* Communities

	Public Hospital System	FQHCs or FQHC Look-alikes	Other Designated Safety Net Clinics
Atlanta (Fulton and DeKalb County)	✔	✔	✔
Boston (Suffolk County)		✔	✔
Detroit (Wayne County)		✔	✔
Fairfax County			✔
Lincoln (Lancaster County)		✔	✔
Memphis (Shelby County)		✔	✔
Phoenix (Maricopa County)	✔	✔	✔
Queens (Queens County)	✔	✔	✔
San Antonio (Bexar County)	✔	✔	✔
San Diego (San Diego County)*		✔	✔

Source: Urgent Matters *Safety Net Assessments, March 2004. See Appendix A for a list of reports.*
** The University of California San Diego Hospital is part of the University of California state system. It continues to have a public charge but does not operate as a public hospital system.*

Given how very different safety net structures are, it should not be surprising that many are poorly coordinated and form fragmented networks of care. By their very nature, at the community level, health care safety nets are fractured systems of care. Individual providers or safety net systems tend to operate independently. Even in communities in which safety net providers collaborate and try to coordinate care on behalf of uninsured and underserved residents, the systems are rarely integrated, often because of a lack of resources to invest in the information systems and other capital equipment necessary to link sites of care or levels of service.

Despite the challenges involved, some communities have made significant progress in setting the groundwork for a more integrated local safety net. In Fairfax County, for example, the major hospital system, Inova Health System, has partnered with the Fairfax County Health Department's three Community Health Care Networks and other safety net providers to develop an automated eligibility system to streamline the process of patient registration. In Detroit, the Voices of Detroit Initiative (VODI) serves as a broker among key safety net providers in the community, leveraging resources and shepherding expansion grants for new providers and services. VODI also helps uninsured residents obtain health care services with significant outreach programs and case management services.

FINANCING OF LOCAL SAFETY NETS

No single or stable source of financing exists for the health care safety net. Most local safety nets are financed by multiple sources and reflect the political, economic, social and cultural considerations of their communities. Some communities have historically assumed a key role in subsidizing care for their uninsured and underserved residents. Many other communities believe that these roles more appropriately rest with federal and/or state governments, and provide only a small share of support for their residents.

Medicaid and SCHIP: The two largest sources of financing for the safety net are the Medicaid program and the State Children's Health Insurance Program (SCHIP). The Medicaid program funds direct services through reimbursements and administrative payments to safety net and other providers when they care for individuals enrolled in these programs. Both Medicaid and SCHIP are federal/state partnerships and include a federal match, known as the Federal Medical Assistance Percentage (FMAP). States must contribute at least some of the cost of caring for their enrolled populations. The federal match ranges from 50 percent to 77 percent and is based on state and federal income data. States with higher matches contribute proportionally less. For example, Tennessee's FMAP is 64.81 percent and Virginia's is 50 percent. Thus, every additional dollar spent on Medicaid in Tennessee requires a state contribution of 35.19 cents; in Virginia, 50 cents of every dollar spent on Medicaid must come from state funds.

Table 3 lists the FMAPs for the *Urgent Matters* states and shows the enhanced rate that applies for payments under the State Children's Health Insurance Program. States receive at least 65 cents on the dollar for SCHIP expenditures and in all cases these rates exceed the regular Medicaid rates. States with high FMAPs have greater incentives to participate in both programs, but tend to be poorer states and often have the most restrictive Medicaid eligibility criteria and benefits.

Table 3 Medicaid and SCHIP FMAPs for *Urgent Matters* States, FY 2005

State (*Urgent Matters* Community)	Medicaid FMAP	SCHIP FMAP
Arizona (Phoenix)	67.45	77.22
California (San Diego)	50.00	65.00
Georgia (Atlanta)	60.44	72.31
Massachusetts (Boston)	50.00	65.00
Michigan (Detroit)	56.71	69.70
Nebraska (Lincoln)	59.64	71.75
New York (Queens)	50.00	65.00
Tennessee (Memphis)	64.81	75.37
Texas (San Antonio)	60.87	72.61
Virginia (Fairfax County)	50.00	65.00

Source: Federal Medical Assistance Percentages, Fiscal Year 2005 Table, published December 3, 2003. http://aspe.hhs. gov/health/fmap/htm

The state match is only one of many ways that state Medicaid programs differ across the country. The federal government sets eligibility thresholds for the program, but states have wide latitude to create more or less generous eligibility levels or more or less comprehensive benefit packages. These variations can have an enormous impact on safety net providers, who see large numbers of Medicaid, SCHIP and uninsured patients. As Medicaid eligibility and coverage "generosity" improves, overall payment for services improves. Conversely, as states tighten eligibility, cut provider payments, or create obstacles to initial or subsequent program enrollment, safety net providers must cover the costs of caring for these patients through other sources of financing.

DSH: Medicaid also supports safety net care through its Disproportionate Share Hospital (DSH) Program. DSH provides payments to hospitals that serve a disproportionate share of patients who are either enrolled in Medicaid or are uninsured. As such, DSH is a critically important source of funding for safety net hospitals that care for a large segment of these populations and helps to offset the costs of caring for low-income people on Medicaid or without insurance. Aside from Medicaid payments for direct patient care, DSH is the single largest source of support for safety net services.

The federal government also matches a portion of all DSH payments made by each state based on the state's Medicaid matching rate. In 2003, the federal share of DSH payments totaled approximately $8.6 billion.[19] Unlike federal funding for FQHCs that goes directly to providers for care of the uninsured, DSH funds go directly to states, which have considerable discretion in deciding how the funds are distributed. States can develop DSH programs with formulas for allocating the funding based on the amount of uncompensated care and Medicaid services provided by the health care provider. Or, states may elect to use federal DSH funds for health programs that are beyond direct service provision for Medicaid covered and uninsured residents. Consequently, there is no guarantee that all of the DSH funds will go to safety net providers.

DSH is financed largely through intergovernmental transfers that constitute the state's share of the Medicaid payment. This practice has allowed states to free up these revenues for other purposes—a practice that has put the program on precarious political footing at times and one that causes the program to be unpopular among certain policymakers. Nevertheless, DSH remains a vital source of funding for hospitals that serve disproportionate numbers of low-income patients and stands as the sole source of direct support for safety net hospitals.[20]

Federal Grants to FQHCs: Certain safety net providers also receive federal grants to support care for the uninsured. Nine of the *Urgent Matters* communities have FQHCs, which receive federal funding to care for the uninsured as well as enhanced Medicaid and Medicare payments. Unlike the case with other sources of safety net financing, the federal government has made a commitment to expand the number and scope of FQHCs across the country. President Bush has proposed a budget of $1.62 billion for FY2004 and an additional $218 million on top of this funding for FY 2005.[21] Several *Urgent Matters* communities are applying for FQHC expansion grants to either open new community health centers or expand the services available at current sites.

State and local support: In most *Urgent Matters* communities, safety net providers also receive support from state and local governments in the form of direct payments for services or through targeted subsidies. Massachusetts, for example, has a strong tradition of providing health care benefits to the state's neediest residents. In addition to payments from Medicaid, safety net providers in Boston receive funding from the state's Free Care Pool, a financing mechanism that supports care for low-income and uninsured residents of Massachusetts primarily through assessments on hospitals in the state. Table 4 includes information on some of the most significant sources of state and local support for the safety net.[22]

Tax revenues continue to be a critical source of support for local safety net institutions in the *Urgent Matters* communities. For example, in San Antonio, the public hospital (University Health System) is supported through county property taxes. In Atlanta, funding from general revenues in DeKalb and Fulton Counties supports the Grady Health System. In Fairfax County, local property and sales taxes help support county clinics that provide services exclusively to a small percentage of uninsured residents. In Detroit, county tax revenues support indigent care programs for some segments of the working poor who do not qualify for Medicaid or SCHIP. And in Phoenix, voters recently approved a tax referendum that provides funding earmarked for health care services for uninsured and underserved county residents.

A number of state and local governments have elected to designate all or part of tobacco related funds for health care. In Phoenix, Queens, San Antonio, and

San Diego, tobacco tax funds and/or tobacco settlements are used to pay for direct services or to provide subsidies to a variety of safety net providers caring for the uninsured and for Medicaid patients.

Status of funding for the safety net in the late 1990s: During the late 1990s, many states benefited from a strong economy and used budget surpluses to expand public programs such as Medicaid. Medicaid programs expanded eligibility to populations that had not been covered previously and expanded the level of benefits by offering optional services above those required by the federal government. As a result of these expansions, more people were covered under Medicaid and had access to a greater range of services. Safety net providers also benefited from new sources of funding during this period. The State Children's Health Insurance Program (SCHIP), enacted under the Balanced Budget Act of 1997, provided a new source of funds for children who were ineligible for Medicaid and were previously uninsured. The combination of Medicaid expansions, the creation of the SCHIP program and funds from tobacco settlements and taxes resulted in growth in the comprehensiveness of care for low-income populations and increases in both enrollment and costs for state programs. It is estimated that several more million Americans would have been uninsured during this period, had Medicaid and SCHIP enrollment not increased during the late 1990s to the early 2000s.[23]

Table 4 Selected State and County Sources of Support for the Safety Net*#

	Program/Type of Support	Source of Support	Funding on Annual Basis	Number of Uninsured in Program
Atlanta	County support of Grady Health System for care of low-income uninsured	DeKalb and Fulton County general revenues	FY 2004 total estimate = $101.4 million	NA
Boston	Massachusetts Free Care Pool	Combination of provider taxes and state appropriation	Statewide, approximately $472 million in FY 2002. Funds allocated based on formula reflecting amount of free care provided to uninsured	N/A
	CenterCare: Department of Public Health program providing coverage to low-income uninsured state residents.	State general revenues	Not available	5,100 enrollees as of February 2003
	Children's Medical Security Plan: coverage for primary care and preventive services to uninsured children.	State funds and health insurance premiums	Not available	2,611 enrolled from the City of Boston, as of March 2004
Detroit	PlusCare: limited coverage for low-income residents	Wayne County general revenues	$44 million	25,000 residents enrolled/enrollment capped
	HealthChoice: coverage for low-wage workers. County pays one-third of premium	Wayne County general revenues	$16.8 million	15,000 residents enrolled
Fairfax County	County support of Community Health Care Network, clinics providing services to about one-third of County's low-income uninsured residents	Fairfax County general revenues; also some state support	County Health Department operates on $25 million budget, a large percentage of which goes to clinic care.	12,600 residents enrolled as clinic patients/enrollment capped
Lincoln	Community mental health center	70 percent of funding comes from City and County revenues	$8.9 million in FY 2002	N/A

Table 4 Selected State and County Sources of Support for the Safety Net*# *(continued)*

	Program/Type of Support	Source of Support	Funding on Annual Basis	Number of Uninsured in Program
Memphis	County support of The Med for care of low-income uninsured	Shelby County general revenues	$30 million	N/A
Phoenix	Maricopa County Hospital Tax District (approved but not yet implemented)	Property tax increase	$40 million	N/A
	Tobacco Tax funding	Tax on tobacco products	Not available	N/A
Queens	The Healthy New York program expands coverage to uninsured workers in small firms and individual workers	Health Care Reform Act (HCRA), originally passed in 2000	Not available	About 40,000, as of December 2003
	Indigent Care Pools: provides funding for indigent care at hospitals and diagnostic and treatment centers	Combination of provider taxes and state funding	$50.2 million to Elmhurst Hospital Center and $34.7 million to Queens Hospital from hospital pool. Much smaller amounts from diagnostic and treatment pool.	N/A
San Antonio	County support for public hospital	Property taxes	$126 million in 2002	N/A
	Care*Link*: program reimbursing providers who care for low-income uninsured of Bexar County	Property taxes	$106 million of $126 million in county support for the public hospital earmarked for Care*Link* patients	Approximately 55,000/enrollment capped
	State support of trauma care	Fines for alcohol-related driving offenses and other moving traffic violations	$1.8 million to University Health System in 2004 (estimated)	N/A
	Tobacco Settlement	Settlement Funds	$20.9 million to University Health System in FY 2002	N/A
San Diego	County Medical Services Program for low-income uninsured who receive some primary care, specialty, inpatient and mental health services from private practice physicians under contract with county.	San Diego County general revenues	$51 million in FY 2001	About 20,000 patients enrolled in program
	Additional funds from state to support care for uninsured	Dedicated revenues from sales taxes and vehicle license fees	Not available	N/A
	Proposition 99 funding from state for care for uninsured	Revenues from state taxes on tobacco products	Calculated at $8 per uninsured resident	N/A
	Tobacco Settlement	Settlement funds	$52.4 million since 1999	N/A

Source: Urgent Matters *Safety Net Assessments, March 2004.*
N/A indicates that this is not applicable. Some of the funding amounts that apply specifically to safety net services are not available.
** Does not include funding from the disproportionate share hospital (DSH) payment program since a large proportion of that funding comes from federal dollars.*
 # Several county health departments also support the safety nets through primary care clinics operated or funded by the county. This applies to Atlanta, Detroit, and Memphis. The Fairfax County Health Department clinics are listed separately because they constitute the primary care safety net for the population. In other cases, the public health department provides some combination of primary care, dental, and pharmacy services to local residents as a supplement to other safety net services, in addition to core public health functions.

Status of the safety net in the early 2000s: As the national economy began to worsen in the early part of the decade, states encountered their own challenges in trying to meet budgets and maintain levels of current services for their populations. Medicaid and SCHIP expenditures typically represent a large percentage of state budgets; both programs have been targeted for reductions as states attempt to balance their budgets.

In FY 2004, 49 states and the District of Columbia are implementing cost containment in their Medicaid programs.[24] According to state Medicaid officials, the top two cost drivers in the program include rising prescription drug use and costs, and growth in enrollment.[25] Medicaid cost containment strategies involve a combination of efforts to curtail benefits, drop coverage for some non-mandatory populations, or cut provider reimbursement, all of which result in lower revenues available to safety net providers for direct care of low-income residents. Cuts in enrollment alone are estimated to result in a loss of coverage for 1.2 to 1.6 million people on Medicaid, SCHIP and other programs.[26] All of these strategies will have a direct and immediate impact on Medicaid-dependent safety net providers.

Most of the *Urgent Matters* states have opted to change the structure of Medicaid and SCHIP benefits; many have also made changes to programs that resulted in reduced enrollment. For example, Georgia, Massachusetts, Michigan and Texas have decreased or completely eliminated funding for certain optional services. Nebraska made administrative changes to its Medicaid program that include reducing the periods of guaranteed eligibility and Transitional Medicaid Assistance; the state also instituted new methods of determining eligibility for Medicaid based on the amount of income or assets that are included in the financial calculations. These changes alone are expected to eliminate 12,600 children and 12,750 adults from Nebraska's Medicaid program.

Along with cutbacks to the size and scope of these programs comes decreasing support from local sources of funding for the safety net. In Detroit, for example, PlusCare, a county-run indigent care program, has frozen enrollment, limited services and cut provider reimbursement rates to remain within budget. In Atlanta, county funding for the Grady Health System has remained flat for the last few years, and in real dollars is now only half the level it was a decade ago.

As funding from federal, state and local sources decreases, safety net providers must go through their own belt-tightening processes while trying to maintain service levels for their patient populations. Safety net systems in Atlanta and Memphis are taking steps to restrict free (or discounted) care that is non-emergent to county or state residents only. Some safety net clinics in Maricopa County (Phoenix) have instituted up-front fees for patients seeking health services. And several of the safety net providers in *Urgent Matters* communities are considering a variety of measures to constrain the growth of pharmaceuticals for uninsured or underserved patients.

In the midst of these challenges, some communities have garnered additional sources of support for their safety nets. In Phoenix, voters recently approved a hospital tax district to raise $40 million for Maricopa Integrated Health System, the principal safety net hospital in the county. The tax has yet to be levied, however, and it will take at least until 2005 for the new funds to become available. As an "extremely low DSH state,"[27] Nebraska had been receiving only $3.9 million in DSH dollars (in 1999), which was spread across 12 hospitals. As a result of federal legislative changes,[28] allotments to Nebraska will be increased each year until 2008 and will result in a $102 million increase in the federal DSH allotment for Nebraska. It remains to be seen how these new monies will be allocated across the hospitals in the state. As welcome as these new sources of financing are, they are insufficient to relieve the increased demands on safety net providers in many of these communities.

SAFETY NET STRUCTURE AND FINANCING KEY FINDINGS:

- Even the most comprehensive and traditionally robust safety nets are facing financial challenges and feeling the effects of the safety net paradox: as the need for safety net services grows, the ability and willingness of governments to support these services diminishes.
- Between one-quarter and one-third of residents in the *Urgent Matters* communities are either uninsured or covered by Medicaid or SCHIP and likely to turn to the safety net for their health care needs.
- Communities differ substantially in terms of the size and scope of their safety nets. State and local financing for safety net services is considerable in some communities and minimal in others.
- With fewer resources available to support safety net services, all of the communities that are described in this report are being required to do more with less. They are facing cutbacks in payments for direct services and/or decreasing subsidies from state or local governments. All the while, demand continues to skyrocket. This is not a strategy that can be sustained over time.

Given these tough economic times, how accessible or available are safety net services for uninsured and underserved residents?

The ten *Urgent Matters* safety net assessments include information on the availability and accessibility of key categories of health care services. These categories are primary care, specialty care, emergency department services, behavioral health services, and dental care. They also include information on a sixth category, system integration, to provide a better understanding of whether patients are able to access a coordinated set of health care services from the local safety net. The findings from the individual community assessments are summarized below.

Availability of Primary Care in *Urgent Matters* Communities

	Primary Care
Atlanta	●
Boston	●
Detroit	○
Fairfax County	○
Lincoln	◑
Memphis	●
Phoenix	◑
Queens	◑
San Antonio	◑
San Diego	◑

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

Using these six categories, we assigned each *Urgent Matters* community's safety net a ranking of high (●), medium (◑), or low (○) to reflect the availability and accessibility of that category of service for uninsured or underserved residents. These rankings are based on the findings presented in the individual community assessments and are clearly subjective in nature. Nevertheless, they reflect information gathered from multiple sources, including interviews with local informants, reports and other relevant documents, discussions with focus group participants and our own observations during site visits.

Primary Care

The accessibility of primary care services appears to relate directly to the availability of both dedicated funding streams for primary care services for the uninsured and underserved, and substantial systems or networks of providers to serve this vulnerable population. We found that the availability of primary care services was the most varied of all service categories across the *Urgent Matters* sites.

Communities were characterized as having high primary care availability if:

1. they contained multiple sites for accessing primary care providers;
2. the sites were relatively well distributed across the community;
3. the sites appeared to have sufficient capacity to accommodate patients currently seeking care as well as additional patients in the community; and
4. the supply of primary care served a high percentage of uninsured and underserved residents in the community.

We found that the availability of primary care services was the most varied of all service categories across the Urgent Matters *sites.*

Three of our sites—Atlanta, Boston, and Memphis—met the criteria for high primary care availability. The safety nets in these cities have large safety net hospital systems that either directly, or in partnership with other entites in their communities, provide primary care services. Atlanta has many primary care clinic sites that are located throughout the city and are considered fairly accessible to uninsured and low-income residents. Many of these providers actively compete for additional patients. Boston also has a large primary care network, with 25 FQHCs offering services to safety net populations. The safety net in Memphis offers many primary care sites located throughout the city, often in or adjacent to low-income neighborhoods. Providers, community groups, local officials and residents indicate that primary care services in these communities are available and accessible to the majority of residents, regardless of coverage or ability to pay.

Sites were ranked as having medium primary care accessibility if:

1) there were mixed opinions among stakeholders about whether there was an adequate supply of primary care sites;
2) the existing sites were unevenly distributed or already at capacity; or
3) the primary care sites served a fair number of the communities' uninsured and underserved patients but there were indications of access problems for many others.

The majority of our sites fell into this ranking, generally because of the third criterion: primary care sites served a fair number of the communities' uninsured and underserved patients but there were indications of access problems for many others. In Lincoln, there are only a few primary care organizations available to the uninsured and underserved and most are at capacity. Similarly, most of the community clinic sites in San Diego are at capacity, causing long waits for appointments and services. Several communities, including the greater Phoenix area and San Antonio, have sites that are unevenly distributed, and many of these are at capacity. In Queens, there is a vast network of primary care sites and providers, but the community is so large and diverse that signficant numbers of residents are unable to access timely primary care services.

Two of the *Urgent Matters* communities were ranked as having low primary care availability because they met none of the criteria for the high or medium ranking. Detroit received this ranking because of its limited supply of primary care providers who care for uninsured and underserved residents. Three FQHCs operate in the community providing services to less than 10 percent of uninsured residents. Even with some recent FQHC expansions and additional services provided by the City and County Health Departments, the Detroit safety net is drastically in need of additional primary care capacity.

Fairfax County was also ranked low on availability of primary care. Although Fairfax County offers comprehensive primary care services through an integrated network of safety net providers, this system is available to only about 11 percent of the county's uninsured population.

Despite their common rankings, Detroit stands out as a community that has extremely limited primary care capacity within its safety net, and very little real opportunity for residents to meet their primary care needs from the private sector. Because Detroit has a relatively high proportion of its residents who are poor, paying for care out-of-pocket is not a viable option for the majority of the uninsured in the community. In addition, primary care providers can be hard to access even for insured residents in Detroit.

Specialty Care Services

When ranking communities for the availability of specialty care for uninsured and underserved populations, we considered three criteria:

1) the degree to which these services were available;
2) whether uninsured patients had access to them via various referral arrangements; and
3) whether the services were available in a timely manner.

Unlike the assessment of primary care, we did not require specialty care to be available from multiple sites, or to be conveniently located in low-income neighborhoods. We assumed that specialty care could be ranked high on accessibility if sufficient specialty providers were available at any site in the community.

The timeliness of the care factored into the ranking. We considered access to specialty care to be timely if appointments with specialty providers could be accessed within several weeks to two months, depending on the specialty. To receive a ranking of high, communities would provide very good access to specialty care for the majority of the uninsured.

None of the *Urgent Matters* communities met this criterion. Therefore, no site received a high ranking.

The criteria for receiving a ranking of medium on specialty care accessibility were quite broad. Sites that ranked medium had either:

1) some access for the majority of the community's uninsured and underserved; or
2) very good access for a subset of the uninsured or underserved.

Four of the sites met one of these criteria. In Boston, some community health center patients have access to specialty services through arrangements with hospitals, and patients at the East Boston health center, one of the largest in the country, have very good access because this center offers specialty care on site. In Queens, many patients have very good access to specialty care at Elmhurst Hospital Center, but the population

Availability of Specialty Care in *Urgent Matters* Communities

	Specialty Care
Atlanta	◑
Boston	◑
Detroit	○
Fairfax County	○
Lincoln	○
Memphis	◑
Phoenix	○
Queens	◑
San Antonio	○
San Diego	○

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

needing care is extremely large and few other providers in the community provide specialty services to patients who are unable to cover the costs of their care out of pocket.

Likewise, in Memphis, patients enrolled at Church Health Center, a faith-based clinic, have access to a variety of specialists through a special program. Enrollment in this center is limited to low-income working poor patients who agree to abide by the clinic's policies concerning missed appointments and co-payment requirements. Other uninsured patients in Memphis can access specialty services through the MedPlex, an ambulatory care center staffed by physicians from the University of Tennessee. However, the MedPlex's provider numbers are declining and waits can be long. Many Atlanta residents have access to specialty care at the Grady Health System, but waits for care tend to be long and patients who access primary care at other sites can have problems with referrals into the system.

The remaining *Urgent Matters* sites received a low ranking for availability of specialty services, indicating that access to these services is poor for the majority of uninsured and underserved in these communities. For example, in Lincoln it is very difficult to find specialty physicians willing to see the uninsured or underserved; as a result, waits for specialty care can exceed several months. In Fairfax County, most of the uninsured do not have any real avenues for accessing timely specialty care outside of the ED. Waits for specialty care in San Antonio often range between six and nine months for selected specialties; in Phoenix waits are as long as 12 months. Such long waits are caused by several factors including shortages of specialty physicians, especially in Phoenix and San Antonio, and a lack of providers willing to serve the underserved, which is the case in Detroit, Lincoln, and San Diego.

Availability of Emergency Department Services in *Urgent Matters* Communities

	Emergency Department
Atlanta	●
Boston	●
Detroit	●
Fairfax County	●
Lincoln	●
Memphis	●
Phoenix	●
Queens	●
San Antonio	●
San Diego	●

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

EMERGENCY DEPARTMENT

All of the *Urgent Matters* sites received a ranking of high for the availability of emergency department services for uninsured and underserved patients. This is due, in large part, to the Emergency Medical Treatment and Active Labor Act (EMTALA),[29] a federal law that prevents all hospitals that receive federal funding from rejecting patients, refusing to treat them, or transferring them to charity or county hospitals due to insurance status. EMTALA requires that patients be screened and then treated and stabilized if necessary. In the ten *Urgent Matters* communities, we heard time and again that patients believe that hospital emergency departments are always open to them, regardless of their coverage or ability to pay.

Despite crowding and long waits that are common to emergency departments across the communities, we did not hear any sentiment that the emergency department was inaccessible to uninsured and underserved individuals. Although waits for care may be long in the ED and some individuals may not immediately seek care at an ED because of the cost, EDs are open seven days a week and offer same-day services that are generally viewed as extremely high quality.

Emergency departments provide a unique and highly specialized set of services to patients in their communities who require emergent services. Many community residents, regardless of whether they are insured, also use the ED for care that could safely be provided in a setting other than the ED. This occurs for a variety of reasons. Many patients value the convenience of the care offered (i.e., open 24 hours), and desire the "one-stop-shopping" aspect of the ED. Patients can access the ED and be assured that they will receive a comprehensive array of services including medical exams, diagnostic tests, and often necessary pharmaceuticals.

Informants in Boston, Fairfax County, Phoenix, and Queens voiced these very sentiments. Although many patients with non-emergent needs face hours-long waits for care in the ED, some accept the wait since they know that will ultimately be seen. In Atlanta, Boston, and Memphis, some residents seek care in the ED to gain access to the hospitals' specialty services. Finally, some uninsured and underserved residents prefer care in the ED because they cannot cover the costs of care out-of-pocket and know that they will be seen, regardless of ability to pay. They are also familiar with some of the hospitals' payment policies related to care delivered in the emergency department and

expect the hospitals to write off the care as bad debt or charity care, reduce the costs of the care, or set up payment plans.

BEHAVIORAL HEALTH CARE

Community rankings for behavioral health care services were based on:

1) the availability of both outpatient care and crisis services for uninsured and underserved patients; and
2) the percentage of patients for whom it was available.

To receive a high ranking, sites would need to provide very good access to both crisis and outpatient care to a good portion of their uninsured and underserved population. No *Urgent Matters* sites received this ranking as none met the criteria.

A community with a medium ranking was determined to either:

1) provide some access to a large number of uninsured or underserved patients; or
2) provide very good services for a subset of uninsured or underserved patients.

We determined that five communities merited a medium ranking for availability of behavioral health services. Lincoln's behavioral health providers deliver a continuum of outpatient, inpatient, crisis and detoxification services; however, resources are strained and providers are at or over capacity. In Boston, outpatient and inpatient services are available; however, budget cuts have eliminated programs and reduced appointment slots for uninsured patients. In the greater Phoenix area, those in crisis generally have access to care. Outpatient care is available but more limited. Behavioral health services are available in Atlanta, but only small numbers of uninsured patients have access to them. Some safety net providers also deliver behavioral health services in Queens, but the demand for care far outstrips the available supply.

The remaining *Urgent Matters* communities received a low ranking for availability of behavioral health care services. We based these rankings on:

1) the lack of service availability in a community; or
2) the extremely limited percentage of uninsured or underserved patients who are served by the system.

We found that behavioral health services have been under-funded in some of these communities for many years. For example, in Detroit the behavioral health system has been substantially under-funded and was described as being in "complete disarray." In that community, some mental health services are available to very small numbers of uninsured and underserved patients who have particularly severe mental health needs. Similarly, in San Antonio, only those with severe mental health needs that meet state criteria can qualify for state-funded care; limited services are also available through the county. Substance abuse services are even more limited than mental health services in San Antonio. In Memphis, community mental health services have been seriously under-funded and available providers are overwhelmed with patients. Uninsured patients are forced to pay for services out of pocket or to forgo care completely.

In several communities, the behavioral health care system was described as fragmented. This description applies to Fairfax County, where the supply of providers and services is inadequate to meet the need. In San Diego, the behavioral health system has been characterized as difficult to navigate and lacking adequate resources and providers. Medi-Cal patients face long waits for appointments and have difficulty selecting providers with specific expertise. Uninsured patients have little more than the ED for behavioral health care.

All of the *Urgent Matters* communities are facing significant challenges to delivering behavioral health care services to their uninsured and underserved residents. Virtually all of the behavioral health providers in these communities have survived on flat budgets or are sustaining budget cuts, which are further straining their ability to provide the already limited services they offer. Throughout the assessment process, informants reported

Availability of Behavioral Health Services in *Urgent Matters* Communities

	Behavioral Health
Atlanta	◑
Boston	◑
Detroit	○
Fairfax County	○
Lincoln	◑
Memphis	○
Phoenix	◑
Queens	◑
San Antonio	○
San Diego	○

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

Availability of Dental Care in *Urgent Matters* Communities

	Dental Care
Atlanta	○
Boston	○
Detroit	○
Fairfax County	○
Lincoln	○
Memphis	○
Phoenix	○
Queens	○
San Antonio	○
San Diego	○

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

substantial unmet need in their communities, with little chance of funding increases given state budget crises. Further funding cuts will reduce or eliminate services for the uninsured and underserved, and will likely result in increased ED use for these populations.

DENTAL CARE

Criteria for a high ranking for dental service availability required that:

1) comminities had very good access to dental care; and
2) services were accessible to the majority of uninsured or underserved patients.

A medium ranking required that either:

1) some access was available to the majority of the uninsured or underserved; or
2) very good access was available to a subset of uninsured or underserved patients.

None of the *Urgent Matters* sites met any of these criteria. All of the *Urgent Matters* sites received a low ranking, which signifies that few uninsured or underserved patients have access to dental services.

In all 10 sites we heard that access to dental care is extremely limited for uninsured and underserved patients. In Boston, the issue of dental care access was described as a serious problem as the demand far exceeds the supply. In Detroit and Fairfax County, as in other communities, lack of dental care was a primary unmet need for uninsured adults. Although a few communities do have some safety net providers who deliver dental care, services are limited and waits for appointments can be very long. This was the case in Atlanta, Fairfax County, Lincoln, Memphis, and San Diego. A general lack of dental providers, as well the availability of few providers willing to treat uninsured and underserved patients for free or at discounted costs, were factors limiting access to dental services in Lincoln, Queens, Phoenix, and San Antonio.

System Integration in *Urgent Matters* Communities

	Safety Net Integration
Atlanta	○
Boston	◑
Detroit	◑
Fairfax County	●
Lincoln	◑
Memphis	◑
Phoenix	○
Queens	●
San Antonio	○
San Diego	○

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

SAFETY NET INTEGRATION

System integration is essential for a safety net to operate efficiently. Integration can reduce duplication of services and more efficiently allocate scarce resources on behalf of uninsured and underserved patients. We characterized the extent to which safety net providers in the *Urgent Matters* communities have been able to develop system integration across sites of care. This included integration across sites within a system, such as a large safety net hospital system with multiple on-site and community-based clinic sites, as well as integration across separate safety net entities, such as networks of FQHCs or other safety net providers. To earn a high ranking on integration, a community must have:

1) created an integrated system that includes health care networks with a variety of health care provider types; or
2) built an information system allowing providers to share patient information.

An information system enables providers to schedule appointments for patients across various sites of care, track the services they receive, and identify the health professionals they have seen. Such a system can also keep track of financial information for program eligibility determinations.

Fairfax County and Queens were the only communities to receive a high ranking on safety net integration. Fairfax County has developed a program to better integrate service delivery that, in time, should serve as a model for other communities. Created under a Community Access Program (CAP) grant, safety net providers in Fairfax County developed an automated eligibility system to provide patients with more efficient, patient-friendly access to care from community safety net providers. Participating providers at 27 sites share access to patient records. This allows low-income uninsured patients to access care from multiple providers without continually repeating the application process for services from the county's Community Health Care Network.

Queens has also implemented a number of systems designed to improve integration and provider coordination. The Queens Health Network (QHN), the major safety net provider in the community, has established a referral network designed to facilitate physician referrals, improve patient tracking and share consultation reports. Over 550 community providers are linked to QHN resources. The Queens Health Network has also implemented an e-record system that integrates clinical information, lab results, radiology records and medication orders, and links the hospitals in the network to their satellite facilities. Finally, QHN is piloting an electronic patient identification program that promises to improve efficiency and reduce redundancy in enrollment and admission processes. Patients in the program are given an identification card with a computer chip that contains relevant medical information and insurance status. Upon arrival at a facility, providers and staff can download demographic and clinical information from the card.

Other *Urgent Matters* communities have begun to coordinate patient care, but have not developed an integrated system. Four communities received medium rankings, indicating strong efforts in this area. This is the case among the safety net providers in Boston, Detroit, Lincoln, and Memphis. In Detroit, the Voices of Detroit Initiative (VODI) has served as a broker across Detroit's principal safety net providers and other key stakeholders in the community. In large measure because of relationships across safety net providers, Detroit's safety net, though extremely limited, does not experience the duplication of effort that exists in some safety net systems.

In Lincoln, safety net providers came together in an unprecedented effort to create the People's Health Center, a new FQHC. Various providers have partnered with the People's Health Center, helping to recruit physician and dental staff, establishing a call center, and providing physician coverage, imaging services, resident and student placement, prescription assistance, and translation and interpretation services.

The remaining four sites received a low ranking for safety net integration because the providers in the community generally work independently with little clinical or programmatic coordination among them. In Phoenix, the safety net is a loose configuration of independent providers with no clear coordination among them. No one system provides the underserved with a comprehensive set of services. In San Diego, coordination is strong around outreach and enrollment for public programs, but this coordination does not extend to direct safety net service delivery or integration. A similar situation exists in San Antonio. In Atlanta, although services exist, patients often have difficulties accessing care because of a lack of coordination across key safety net providers.

Overview of Availability of Services and System Integration

Table 5 summarizes the rankings for each of the categories of services for the *Urgent Matters* communities and clearly identifies certain gaps in care for uninsured and underserved residents. The availability of primary care across the sites is relatively high, while specialty care is strained, behavioral health care is generally quite limited, and dental care is virtually nonexistent. Standing in stark contrast to the rest of the safety net is the emergency department, which is extremely accessible to individuals in each of the communities and is clearly struggling to develop strategies to better meet the demands of residents who require these critically important services.

Efforts to better integrate care across safety net providers could help stretch resources to fill some of the gaps in the safety net. The assessments demonstrate that there are important and encouraging initiatives in this area that will ultimately improve service delivery and access to care for uninsured and underserved community residents.

Table 5 Availability of Services and System Integration in *Urgent Matters* Communities

	Primary Care	Specialty Care	Emergency Department	Behavioral Health	Dental Care	Safety Net Integration
Atlanta	●	◑	●	◑	○	○
Boston	●	◑	●	◑	○	◑
Detroit	○	○	●	○	○	◑
Fairfax County	○	○	●	○	○	●
Lincoln	◑	○	●	◑	○	◑
Memphis	●	◑	●	○	○	◑
Phoenix	◑	○	●	◑	○	○
Queens	◑	◑	●	◑	○	●
San Antonio	◑	○	●	○	○	○
San Diego	◑	○	●	○	○	○

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

AVAILABILITY OF SAFETY NET SERVICES KEY FINDINGS:

- After conducting assessments of the 10 *Urgent Matters* communities, we have concluded that the availability of primary care is relatively high, specialty care is strained, behavioral health care is generally quite limited, and dental care is virtually non-existent.
- The accessibility of primary care services appears to relate directly to the availability of both dedicated funding streams and substantial systems or networks of providers that serve vulnerable populations.
- The emergency department was ranked "high" on availability in all 10 communities. Despite long waits for care, patients find the convenience and accessibility of the ED a better alternative to months-long waits for specialty care and multiple visits for diagnostic tests and procedures.
- Important and encouraging initiatives have been implemented by a number of communities to integrate services and patient information across safety net systems. These programs will ultimately improve service delivery and access to care for uninsured and underserved community residents.

The safety net assessment team conducted focus groups

with residents who receive their care from safety net providers in the *Urgent Matters* communities. The focus groups were held during the summer and fall of 2003 at a variety of locations, including safety net providers and community based organizations. Focus group participation was voluntary. Participants were recruited with the help of the local community partners in each site. Recruitment efforts involved displaying flyers announcing the sessions and their schedules. Participants received $25 each in appreciation of their time and candor. A total of 266 individuals participated in 28 focus groups. Most groups (14) were conducted in English; nine were in Spanish, two were in Arabic, and one each was in Cantonese, Haitian Creole, and Vietnamese.

The focus group discussions highlighted difficulties that many uninsured and underserved residents have in accessing timely and affordable health services. Participants addressed issues such as primary care and prevention, access to specialty and inpatient services, use of the ED for emergent as well as non-emergent care, their understanding of the health care system and the resources that are available to them, and their feelings about the provider community.

Access to Health Care Services

Focus group participants are very appreciative of the care they receive from safety net providers. Most say that the care is high-quality and they rely heavily on these services for their health care needs.

Primary Care: Many focus group participants reported that they rely almost exclusively on safety net providers for their care. For some, obtaining primary care is fairly easy. In Atlanta, participants said they generally do not have problems accessing care, especially once they are familiar with the resources in the area, especially Grady Health System and local community health centers. One participant from Queens noted that health care at Elmhurst Hospital Center is "like heaven" compared to care from his home country.

Of the three focus groups we conducted in Lincoln, only those who were homeless faced difficulties accessing care. In Memphis, all our participants could name a source of primary care; most use either the community health centers in the area or a faith-based clinic. In Phoenix, patients expressed their deep appreciation for area safety net providers, without whom they would have few if any sources of care. Similarly, participants in our focus groups in Fairfax County reported that the Community Health Care Network clinics were their only option for services. Participants in all of these sites noted that when they can get care, they are very satisfied with the quality of care they get.

Despite the fact that care is available from safety net providers, many focus group participants complained about long waits for services at the facilities. Participants in the Boston and Queens groups emphasized that this prevents people from seeking care and often causes people to seek care in the emergency department. A Boston participant noted that safety net providers are often difficult to find. She stated, *"You have to have a lot of patience even though they will treat you and it will be affordable."* Other participants noted that limited hours of availability often create problems trying to get timely care from a primary care provider.

"I feel fortunate and lucky. What would I do if I didn't have this?"

—Boston focus group participant

The focus group discussions highlighted difficulties that many uninsured and underserved residents have in accessing timely and affordable health services.

"I have a problem right now and I was supposed to have a referral to see a GI but when I called to get a referral they told me I had 500 patients ahead of me."

—Memphis focus group participant

A number of participants described their reluctance or inability to seek preventive health care services. For some, this reluctance stems from financial problems, while for others it stems from cultural issues. In San Antonio, participants said that their access to care is based largely on insurance status. The uninsured have little access to care; Medicaid and SCHIP patients have somewhat better access. In San Diego and Detroit, uninsured patients reported delaying care for as long as possible. In the meantime, many admitted to self-medicating or using home remedies. Similarly, in Queens, some of the participants prefer seeing private physicians in their community; however, lack of insurance or resources to pay out-of-pocket pose the biggest barrier to accessing that care. Instead, many forgo care or use traditional medicine or home remedies. In Boston, participants reported that they were less likely to get routine preventive care, and only sought care when they were sick. Immigration status causes some focus group participants in Phoenix to delay or forgo care.

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

—San Diego focus group participant

Specialty Care: Participants' perspectives on access to specialty care were mixed, with some people indicating timely access to services and others saying that these services were well beyond their reach. Complaints focused on a lack of providers willing to treat uninsured and underserved patients. Where specialists could be identified, participants reported they are often overwhelmed with patients, resulting in long waits for services. This experience was shared by some focus group participants in Fairfax County, Memphis, Phoenix, and San Diego. In Queens, some participants said it was relatively easy to access specialty care through the public hospital's network, while others complained about the difficulties in finding a specialist in a convenient location and the long waits for appointments.

"If it's after hours, you can't come to [the clinic], so you go to the emergency room."

—Fairfax County focus group participant

Behavioral Health Services: Obtaining behavioral health services was a challenge for most focus group participants. Only in Boston did we find focus group participants who felt that behavioral health services were available and accessible. In contrast, participants in Detroit were unaware of the existence of any community mental health care.

In Lincoln, although inpatient and crisis care is available, it is limited because the system is at capacity. Mental health clients discussed their difficulties finding outpatient behavioral health services in Lincoln. They also emphasized the important role such services play in reducing emergency department and hospital admissions. In Phoenix and San Diego, other participants perceived the mental health system as cumbersome and difficult to navigate.

Dental Care: Dental care remains a major unmet need for many of the participants in our focus groups. In Boston, for example, participants felt that dental cleanings and dentures were a luxury. In Memphis and Phoenix, focus group participants reported that there were few dental care providers willing to treat the uninsured. In a few instances, participants were aware of individual providers willing to treat some uninsured patients for reduced fees. This was true in San Antonio and in Fairfax County.

Customer Service

Some focus group participants voiced strong dissatisfaction with the service they received at the local hospital or emergency department. In Atlanta participants expressed their belief that their hospital stays are shorter because they are uninsured. Participants in Fairfax County suggested that the county's major safety net hospital system has been reluctant to provide them with the charity care for which they have previously qualified. This results in some patients receiving bills that eventually are referred to collections agencies. Other patients must reapply to receive services at the emergency department. Several participants in the Queens focus group expressed their frustrations with their experiences at some hospitals due to long waits and uneven treatment.

A number of other focus group participants' complained of hospital and emergency department staffs' rudeness. Some attributed this treatment to their lack of insurance, race/ethnicity, or inability to speak English well. In Lincoln, Latino focus group participants reported being mistreated at hospitals and said they thought it was due to their lack of English proficiency. This was

also the case among some Spanish-speaking participants in Atlanta and San Diego. Memphis focus group participants felt they were mistreated by area hospitals because they are uninsured. Participants in the Boston group stated that poor treatment in the emergency room depends upon on the staff on duty. They also stated their belief that all area hospitals are understaffed.

Although they consider the hospitals and local emergency departments to be providers of last resort, San Diego participants expressed overall high satisfaction with the quality of care they received at hospitals. They asserted that they were treated well and equally by health care providers, regardless of their insurance status.

Knowledge of Programs

In nearly every community we found that participants lacked information about available health care services and providers, as well as information about how to access services from the local safety net. In many sites, at least some focus group participants were unaware of available primary care resources. For example, in Atlanta participants who received care from Grady's outpatient clinics were generally unaware of the existence of Grady's community clinics or the FQHCs that provide care across many Atlanta neighborhoods. Participants in San Antonio also stated that they were unaware of all their options for care. In Detroit, participants who were not already patients at area FQHCs did not have information about any FQHCs in their community. Thus, they had no idea where they could receive care that was either free or on a sliding fee scale. Arab participants were familiar with Arabic-speaking providers but were unaware of any other options other than local hospitals and emergency departments. Knowledge of available primary care sources was also mixed among Phoenix area participants.

Spanish-speaking participants at a focus group in Lincoln stated a real need for education about the importance of health prevention. They understood that as a group they are at greater risk for diabetes, hypertension, cardiovascular disease, and stroke, and felt that a comprehensive community education and awareness campaign focused at the Latino population should be undertaken.

Participants in some focus groups wanted to be educated about how the local health care system works. In Queens, some participants requested information on how the health care system is structured and where to obtain services from available safety net providers. In Phoenix, Spanish-speaking focus group participants described a general lack of knowledge of the difference between an emergency condition, an urgent problem or a condition that can be safely treated in a primary care setting. They said that misunderstanding these differences often results in people seeking immediate care at an emergency department.

Many focus group participants discussed the difficulties of finding adequate care without health insurance coverage. In the absence of information about affordable choices, residents without insurance have very few options in their communities. Several participants spoke about their reluctance to be a burden, stating that they would wait until their conditions deteriorated or their pain became so substantial that they could no longer delay care.

Barriers to Care

Language and Culture: The availability of culturally and linguistically appropriate services was described as an important factor in participants' ability to obtain care in most of the communities. In Phoenix and San Diego, Spanish-speaking participants reported that they generally have access to at least some bilingual health care providers or staff. This is likely due to the high concentration of Spanish-speaking residents in these cities.

"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."

—Detroit focus group participant

"[Outpatient] activities and groups keep me focused and stable. It's healthy for me and keeps me out of the hospital."

—Lincoln focus group participant

"Dental care is non-existent."

—Phoenix focus group participant

"We are poor and broke so they treat us like nothing."

—Atlanta focus group participant

In nearly every other site, we learned that available interpreter services are inadequate to meet the needs of non-English speakers. In Fairfax County and Detroit, Spanish-speaking participants said they repeatedly went to certain health care providers because they could communicate with them in their preferred language. Patients who speak languages other than English or Spanish often have more difficulties obtaining interpreter services. This was the sentiment echoed in the Cantonese-speaking focus group in Queens. Arabic-speaking participants in Detroit also face significant challenges finding providers with adequate interpreter services.

"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."

—Detroit focus group participant

Transportation: In most communities we learned that transportation can be a major barrier for focus group participants without their own vehicles. Often health care facilities are not located on public transportation routes, transportation is unreliable, or patients must travel on several buses to get to a provider. The cost of public transportation was also cited as a barrier for low-income patients.

Focus Group Key Findings:

- Focus group participants are very appreciative of the care they receive from safety net providers. Most say that the care is high-quality and they rely heavily on these services for their health care needs.
- Nearly all participants stated that they have difficulties accessing specialty care, behavioral health and dental care.
- Participants lack information about affordable options for health care and are often not aware of the availability of safety net services in their communities.
- Focus group participants complained about long waits at many safety net facilities, but generally understood that services were in high demand. They were more concerned with poor treatment from providers and staff at safety net hospitals and clinics than they were with long waits for care.
- Lack of adequate interpreters or culturally competent providers creates significant obstacles to accessing services. Transportation also serves as a barrier to care in many of the communities.

"When you're uninsured, you're basically walking a tightrope. You deal with things on your own for as long as you can, and then you just hope that somebody will take care of you."

—San Antonio focus group participant

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 individuals who have nowhere else to go for timely care. In addition to relying on emergency departments for a unique set of specialized emergency services and critical burn and trauma care, community residents often choose the ED as their primary source of care, knowing they will receive comprehensive, high-quality care in a single visit.

When and why residents use the emergency department for care that is treatable in a primary care setting depends on a complex set of factors. Clearly, these decisions involve 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.

In some communities, residents believe that the emergency department is the only health care provider available to them. While safety net programs and funding contract across the country, emergency rooms continue to serve as an open resource to community residents who, for a variety of reasons, are unable or unwilling to access adequate primary care services. Emergency departments also serve as a resource for specialty services and behavioral health care when long waits or cuts to these systems reduce availability. A number of communities have seen mental health programs cut services, limit enrollment, or shut down completely. In all of these cases, emergency departments have experienced abrupt upswings in their patient volumes.

Throughout our discussions with community residents, we learned that the ED is commonly considered the premier health care provider in a community. Despite long waits, residents know that if they go to the emergency department, they will receive high-quality care at a single location. If they are uninsured, they generally understand that they will be able to receive the same care that all other community residents receive, regardless of their ability to pay.

Yet EDs are not the best venues for providing high-quality primary care. They are not designed or staffed to provide on-going patient management. Effective primary care relationships build across time and rely on strong relationships with providers who are trained to monitor acute and chronic needs over the life cycle.

The results of this analysis should not be considered a judgment on the performance of, or appropriateness of, care in the ED. It instead may be indicative of the performance of the broader safety net and its capability of serving all in need.

Demographic Characteristics of Patients who Use the ED at Urgent Matters Hospitals

As part of the *Urgent Matters* project, we obtained information on patients at each of the 10 *Urgent Matters* hospitals over a six-month period in 2002.[30] This information applies to patients who used the ED but were not admitted to the hospital. Information on patients admitted to the hospital from the ED is often unavailable in ED records.

Tables 6, 7, and 8 provide information on the age, race/ethnicity, and insurance coverage of emergency department visits at each of the *Urgent Matters* hospitals. During the period July 1, 2002 through December 31, 2002, there were a total of 329,102 patient visits that did not result in an inpatient admission. Not surprisingly, the characteristics of the patients varied considerably across communities, reflecting the demographics of the area as well as the services provided by the emergency department.

About one quarter (26.0 percent) of visits were for children under the age of 18 and 67.7 percent were for adults aged 18-64. Only 6.4 percent of visits were

When and why residents use the emergency department for care that is treatable in a primary care setting depends on a complex set of factors.

for patients who were 65 or older. There was significant variation across the hospitals in terms of the age of the patient. The percentage of visits by children, for example, ranged from a high of over 45 percent at Elmhurst Hospital Center in Queens, to less than 4 percent at The Regional Medical Center at Memphis (The Med). As a group, these EDs had relatively few visits (that did not result in an inpatient admission) by patients aged 65 and above.

Table 6 Percent of ED Encounters at *Urgent Matters* Hospitals by Age of Patients

	Hospital	Total Encounters (Non-Admits)[31] Six Months	Percent < age 18	Percent ages 18-64	Percent age 65 and above
Atlanta	Grady Health System	60,876	41.0	54.9	4.1
Boston	Boston Medical Center	41,682	21.2	73.3	5.5
Detroit	Henry Ford Health System	33,285	18.0	70.6	11.4
Fairfax County	Inova Fairfax Hospital	25,199	26.6	63.3	10.1
Lincoln	BryanLGH Medical Center	23,294	20.2	67.9	11.9
Memphis	Regional Medical Center at Memphis	30,528	3.9	91.4	4.7
Phoenix	St. Joseph's Hospital and Medical Center	19,924	30.6	63.2	6.2
Queens	Elmhurst Hospital Center	50,894	45.2	50.5	4.3
San Antonio	University Health System	32,060	9.6	85.5	4.9
San Diego	UC San Diego	11,360	8.4	84.5	7.1
Total Encounters		329,102	26.0	67.7	6.4

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Urgent Matters *hospitals' emergency departments.*

Nine of the 10 EDs were able to classify the majority of the encounters by the race/ethnicity of the patient. BryanLGH Medical Center in Lincoln did not identify a race for more than 50 percent of its visits. Information on the hospitals that provided such data indicates that the EDs generally provide care to a diverse patient population or treat large percentages of patients who identify as belonging to racial and ethnic minorities.

Overall, one-fifth (21.1 percent) of visits were for patients who are white, over two-fifths (41.8 percent) were for black patients, and one-quarter (24.5 percent) were for Latino and Hispanic patients. An additional 12.6 percent of visits were for patients who either identified with other racial or ethnic groups, or whose race/ethnicity was unknown.

At the Grady Health System, Boston Medical Center, the Henry Ford Hospital and The Med, at least half of patient encounters are for patients who are black. Two thirds of visits at the University Health System in San Antonio and Elmhurst Hospital Center were for Hispanic patients (67.4 and 62.6 percent, respectively). As a group, only about 2.7 percent of visits were for patients who are Asian.[32]

Table 7 **Percent of ED Encounters at *Urgent Matters* Hospitals by Race of Patients**

Site	Hospital	White	Black	Latino/ Hispanic	Other/ Unknown
Atlanta	Grady Health System	6.1	87.4	4.4	2.1
Boston	Boston Medical Center	22.2	50.7	17.4	9.6
Detroit	Henry Ford Health System	11.1	82.4	2.9	3.6
Fairfax County	Inova Fairfax Hospital	42.1	9.3	15.8	32.8
Lincoln	BryanLGH Medical Center	47.2			52.8
Memphis	Regional Medical Center at Memphis	17.8	76.5	3.1	2.7
Phoenix	St. Joseph's Hospital and Medical Center	41.6	9.3	44.8	4.3
Queens	Elmhurst Hospital Center	8.8	7.8	62.6	20.8
San Antonio	University Health System	23.0	6.9	67.4	2.7
San Diego	UC San Diego	53.0	19.0	20.7	7.3
Total Encounters		21.1	41.8	24.5	12.6

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Urgent Matters *hospitals' emergency departments.*

EDs at *Urgent Matters* hospitals see large numbers of uninsured and low-income patients. Nearly one of three visits (29.2 percent) were for patients who were covered by Medicaid or SCHIP and an additional 30.9 percent were for patients who were uninsured at the time of the encounter. Less than one-fifth of all encounters (17.5 percent) were for patients who were covered by commercial insurance, and only 8.8 percent of visits were for patients covered by Medicare.

Again, the payer mix varied quite a bit across the group. Over half (58.3 percent) of the patients at San Antonio's University Health System were uninsured—about one quarter of these are enrolled in Care*Link*, indicating that they have access to primary care and other services in the community. Comparatively high percentages of uninsured patients were also seen at the Grady Health System, Boston Medical Center, Elmhurst Hospital Center, and The Med.

Perhaps the biggest variation is seen in terms of visits for commercially insured patients. More than three-fifths (61.5 percent) of Inova Fairfax Hospital's visits are for commercially insured patients, compared to only 1.9 percent of Grady's visits. Very low commercial coverage is also seen at Boston Medical Center, The Med, Elmhurst Hospital Center, and University Health System.

Table 8 Percent of ED Encounters at Urgent Matters Hospitals, by Insurance Coverage of Patients

Site	Hospital	Commercial	Medicaid/ SCHIP	Medicare	Uninsured	Other
Atlanta	Grady Health System	1.9	41.2	7.2	41.7	8.0
Boston	Boston Medical Center	7.4	17.5	8.9	39.3	26.9[33]
Detroit	Henry Ford Health System	32.5	4.3	14.3	17.5	31.3[34]
Fairfax County	Inova Fairfax Hospital	61.5	8.6	9.4	19.0	1.5
Lincoln	BryanLGH Medical Center	42.6	23.5	14.2	13.8	5.8
Memphis	Regional Medical Center at Memphis	8.2	48.1	9.9	33.7	—
Phoenix	St. Joseph's Hospital and Medical Center	25.5	42.8	9.5	17.9	4.3
Queens	Elmhurst Hospital Center	8.3	43.3	3.7	32.5	12.1
San Antonio	University Health System	9.8	20.8	7.5	58.3[35]	3.6
San Diego	UC San Diego	18.8	24.6	11.2	18.9	26.5
Total Encounters		17.5	29.2	8.8	30.9	13.6

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Urgent Matters *hospitals' emergency departments.*

The ED Use Profiling Algorithm

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.[36] 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. These include visits with a primary ED discharge diagnosis of injury, mental health and substance abuse, certain pregnancy-related visits and other smaller incidence categories.

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. 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 of 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.

The ED use profiling algorithm is best used as a tool to develop an understanding of the extent to which communities turn to the emergency department for care that could be delivered in a primary care setting. Because EDs are not designed to provide ongoing care and follow-up, when patients receive care in the ED, even if that care is outstanding, they may not develop meaningful relationships with primary care providers who are trained to help patients effectively manage their care over the long-term.

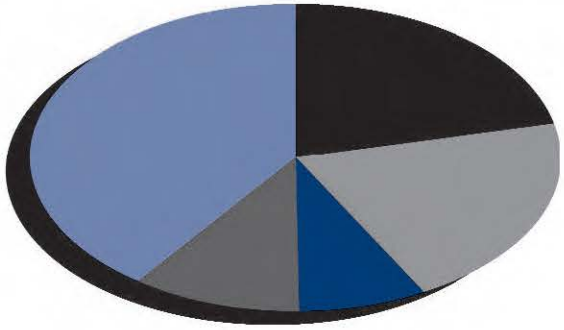
Numerous communities have used the ED profiling algorithm to study primary care availability and accessibility. Optimally, all EDs in the community participate in the exercise and the need for primary care capacity or improved accessibility can be identified and addressed across several different providers and systems of care.

The *Urgent Matters* analysis involves only the grantee hospital in each of the communities. Thus, it provides only preliminary indications of the use of the emergency department for primary care treatable conditions from the community's perspective. Communities should use the information on ED use in each of the assessments to further understand the dynamics of health care delivery, but they tell only a part of the story.

Use of the ED for Non-Emergent and Emergent Care

A significant percentage of visits to *Urgent Matters* emergency departments could have been treated in settings other than the ED. As Figure 4 demonstrates, 21.4 percent of ED visits across the hospitals were non-emergent and another 20.6 percent were emergent but primary care treatable. Thus, four of 10 ED visits that did not result in an inpatient admission could have been safely treated outside of the ED.

Figure 4 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 Urgent Matters *hospitals' emergency departments.*

Relative Rates: Billings and colleagues suggest analyzing the ED data by comparing the rates of use to visits for cases that were non-preventable emergencies.[37] Table 9 displays the analysis of relative rates. Rates for non-preventable emergencies are set at a value of 1.00. Rates for non-emergent visits, for emergent primary care treatable visits, and for emergent preventable visits are compared to this value and may be higher or lower values. Higher values indicate that patients are using the ED more frequently for conditions in the other categories.

As Table 9 illustrates, across all of the *Urgent Matters* hospitals, for every visit that was in the emergent, non-preventable category, there were two non-emergent visits and another two emergent but primary care treatable visits. These rates varied by the coverage, race/ethnicity, and age of the patients.

Patients covered by Medicaid and uninsured patients used the ED for non-emergent conditions at higher rates (2.52 and 2.22, respectively) than patients covered by commercial insurance (1.66) and patients on Medicare (1.35).[38] These rates varied quite a bit across the different hospitals. Uninsured patients at UC San Diego used the ED for non-emergent conditions at rates that were lower than those seen with commercially insured patients (1.81 versus 1.91, respectively). At University Hospital in San Antonio, patients covered by Medicaid used the ED for non-emergent care at rates lower than those seen with uninsured patients (1.25 versus 1.60, respectively). And at The Med, commercially insured patients had the highest rates of use of the ED for non-emergent conditions: 1.77, versus 1.30 for Medicaid, 0.89 for Medicare, and 1.49 for uninsured patients.

Rates of use for emergent, primary care treatable conditions were similar to those for non-emergent conditions. Patients covered by Medicaid had higher rates of use, compared to other coverage groups.

The comparisons across coverage categories should also be interpreted cautiously. Some of the hospitals have very low percentages of commercially insured patients and their samples may not be a true representation of that population.

Rates of Use by Race/Ethnicity: Black and Hispanic patients had higher rates of ED use for non-emergent conditions (2.23) in comparison to white patients (1.70). They also had higher rates for emergent but primary care treatable conditions compared to white patients. These rates also varied across the different *Urgent Matters* hospitals. At St. Joseph's Hospital and Medical Center in Phoenix, white patients had higher rates of ED use for non-emergent conditions (1.89) than did black patients (1.69); Hispanic patients had

Table 9 Relative Rates for ED Visits at *Urgent Matters* Hospitals

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**2.08**	**2.01**	**0.76**	**1.00**
Insurance Status				
Commercial	1.66	1.63	0.48	1.00
Medicaid	2.52	2.53	0.92	1.00
Medicare	1.35	1.42	0.76	1.00
Uninsured	2.22	1.98	0.76	1.00
Age				
0-17	3.74	3.85	1.27	1.00
18-64	1.79	1.65	0.66	1.00
65+	1.28	1.33	0.61	1.00
Race				
Black	2.23	2.13	1.02	1.00
White	1.70	1.58	0.56	1.00
Hispanic	2.23	2.21	0.62	1.00
Gender				
Female	2.07	1.97	0.67	1.00
Male	2.09	2.05	0.86	1.00

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Urgent Matters *hospitals' emergency departments.*

slightly higher rates (1.93) and much higher rates for use of the ED for emergent, primary care treatable conditions (2.23 compared to 1.88 for black patients and 1.66 for white patients).

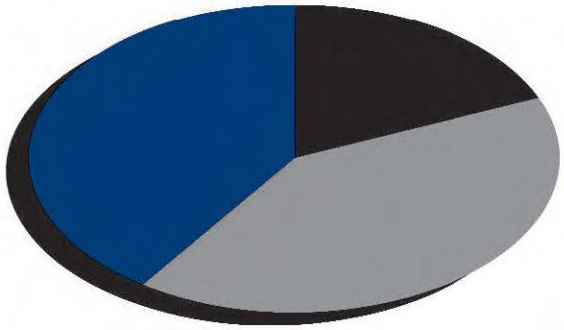
Rates of Use by Age: The largest differences in use of the ED occur when comparing children's rates of use to adult and elderly patients rates. For every visit by a child that was emergent and non-preventable, there were 3.74 non-emergent visits and another 3.85 emergent, primary care treatable visits. Some of the *Urgent Matters* hospitals that had high proportions of children among their ED patients had relatively high rates of ED use for conditions that could be treated in another setting.

High Medicaid rates are also a result, at least in part, of the influence of children's use of the ED. Still, some EDs with relatively high proportions of Medicaid patients did not have higher-than-average rates of use by children for non-emergent use of the ED.

Because of the influence of children's use of the ED, we conducted the same analysis on ED encounters for adult patients only. As can be seen in Figure 5, removing children from the analysis results in a relatively small change in the proportions of visits that fall into each of the algorithm categories. Nearly one-fifth of visits by adults seeking care at *Urgent Matters* hospitals were non-emergent and 18.6 percent were emergent but primary care treatable. Use of the ED across these two categories drops from 42 percent to 38.5 percent when the analysis applies only to adults.

Most visits in the ED occurred between the hours of 8:00 am and midnight. As Figure 5 illustrates, 41 percent of visits that did not result in an inpatient admission occurred between the hours of 8:00 am and 4:00 pm. Only about 18.6 percent occurred between midnight and 8:00 am.

Figure 5 ED Visits by Admit Time



Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by Urgent Matters *hospitals' emergency departments.*

Table 10 illustrates the rates of use of the ED for emergent and non-emergent conditions according to three time periods—8:00 am to 4:00 pm; 4:00 pm to midnight; and midnight to 8:00 am. Many visits to the ED for primary care treatable conditions occurred during business hours that commonly coincide with physician and clinic availability. In fact, patients used the ED for primary care treatable conditions at relatively comparable rates during "regular business hours" and the hours of 4:00 pm to midnight. This finding was consistent across the *Urgent Matters* hospitals.

Table 10 Relative Rates for ED Visits at *Urgent Matters* Hospitals by Admit Time to the ED*

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**2.08**	**2.01**	**0.76**	**1.00**
Admit Time				
8 am – 4 pm	2.10	1.96	0.80	1.00
4 pm – midnight	2.01	1.92	0.76	1.00
Midnight – 8 am	1.72	1.71	0.70	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 Urgent Matters *hospitals' emergency departments.*
* *Eight* Urgent Matters *hospitals provided information on the time of admission to the ED. Elmhurst Hospital Center and Henry Ford Hospital did not provide this information.*

These data support the assertion that at hospitals across the country, patients are using the ED for conditions that could be treated by primary care providers, at times during the day when primary care providers are likely to be available. The analysis suggests that there are opportunities for improving care for patients in *Urgent Matters* communities while also addressing crowding in the ED at the individual hospital.

The aggregate analysis presented here has only limited relevance to local conditions in the *Urgent Matters* communities. It illustrates that a significant percentage of ED visits are for care that could be treated in settings other than the ED—a finding that was uncovered in each of the *Urgent Matters* hospital analyses. We strongly encourage communities to conduct their own analyses of ED visits to identify opportunities for better understanding the scope and dynamics of the use of the ED for primary care treatable conditions in their own communities.

ED Use Key Findings:

- A significant percentage of visits to *Urgent Matters* emergency departments could have been treated in settings other than the ED. Over one fifth (21.4 percent) of ED visits across the hospitals were non-emergent and another 20.6 percent were emergent but primary care treatable. Thus, four of 10 ED visits that did not result in an inpatient admission could have been safely treated outside of the ED.
- EDs at *Urgent Matters* hospitals see large numbers of uninsured and publicly insured patients. About 60 percent of emergency department visits were for patients who were either uninsured or covered by Medicaid or SCHIP. These hospitals also see a very diverse patient population. About one-fifth (21.2 percent) of visits were for patients who are white, two-fifths (41.8 percent) were for black patients, and one-quarter (24.5 percent) were for Hispanic and Latino patients.
- The rate of use for the ED for primary care treatable visits was higher than the rate for emergent, non-preventable visits. For every visit that was in the emergent, non-preventable category, there were two non-emergent visits and another two emergent but primary care treatable visits. Rates were higher for patients covered by Medicaid and for black and Hispanic patients.
- Rates of use of the ED for primary care treatable conditions are far higher for children than for adults or elderly patients. For every visit by a child that was emergent and non-preventable, there were nearly four non-emergent visits and another four emergent, primary care treatable visits.
- The availability of alternative sources of care does not appear to explain the use of the ED for primary care treatable conditions. Across all sites, patients used the ED for primary care treatable conditions at relatively comparable rates during the hours of 8:00 am to 4:00 pm, when clinics and private practice providers are open, and the hours of 4:00 pm to midnight.

KEY FINDINGS

After examining key components of the safety net in each of the ten *Urgent Matters* communities we offer the following key findings.

SAFETY NET STRUCTURE AND FINANCING

- Even the most comprehensive and traditionally robust safety nets are facing financial challenges and feeling the effects of the *safety net paradox*: as the need for safety net services grows, the ability and willingness of governments to support these services diminishes.
- Between one-quarter and one-third of residents in the *Urgent Matters* communities are either uninsured or covered by Medicaid or SCHIP and likely to turn to the safety net for their health care needs.
- Communities differ substantially in terms of the size and scope of their safety nets. State and local financing for safety net services is considerable in some communities and minimal in others.
- With fewer resources available to support safety net services, all of the communities that are described in this report are being required to do more with less. They are facing cutbacks in payments for direct services and/or decreasing subsidies from state or local governments. All the while, demand for care continues to skyrocket. This is not a strategy that can be sustained over time.

AVAILABILITY OF SAFETY NET SERVICES

- After conducting assessments of the 10 *Urgent Matters* communities, we have concluded that the availability of primary care is relatively high, specialty care is strained, behavioral health care is generally quite limited, and dental care is virtually non-existent.
- The accessibility of primary care services appears to relate directly to the availability of both dedicated funding streams and substantial systems or networks of providers that serve vulnerable populations.

Availability of Services and System Integration in *Urgent Matters* Communities

	Primary Care	Specialty Care	Emergency Department	Behavioral Health	Dental Care	Safety Net Integration
Atlanta	●	◑	●	◑	○	○
Boston	●	◑	●	◑	○	◑
Detroit	○	○	●	○	○	◑
Fairfax County	○	○	●	○	○	●
Lincoln	◑	○	●	◑	○	◑
Memphis	●	◑	●	○	○	◑
Phoenix	◑	○	●	◑	○	○
Queens	◑	◑	●	◑	○	●
San Antonio	◑	○	●	○	○	○
San Diego	◑	○	●	○	○	○

High ● Medium ◑ Low ○

Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, Urgent Matters *Safety Net Assessments, March 2004.*

- The emergency department (ED) was ranked "high" on availability in all ten communities. Despite long waits for care, patients find the convenience and accessibility of the ED a better alternative to months-long waits for specialty care and multiple visits for diagnostic tests and procedures.
- Important and encouraging initiatives have been implemented by a number of communities to integrate services and patient information across safety net systems. These programs will ultimately improve service delivery and access to care for uninsured and underserved community residents.

Focus Group Discussions with Community Residents

- Focus group participants are very appreciative of the care they receive from safety net facilities. Most say that the care is high-quality and they rely heavily on these services for their health care needs.
- Nearly all participants stated that they have difficulties accessing specialty care, behavioral health and dental care.
- Participants lack information about affordable options for health care and are often not aware of the availability of safety net services in their communities.
- Focus group participants complained about long waits at many safety net facilities, although they generally understood that services were in high demand. They were more concerned with poor treatment from providers and staff at safety net hospitals and clinics than they were with long waits for care.
- Lack of adequate interpreters or culturally competent providers creates significant obstacles to accessing services. Transportation also serves as a barrier to care in many of the communities.

Emergency Department Use

- A significant percentage of visits to *Urgent Matters* emergency departments could have been treated in settings other than the ED. Over one-fifth (21.4 percent) of ED visits across the hospitals were non-emergent and another 20.6 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.
- EDs at *Urgent Matters* hospitals see large numbers of uninsured and publicly insured patients. About 60 percent of emergency department visits were for patients who were either uninsured or covered by Medicaid or SCHIP. These hospitals also see a very diverse patient population. About one-fifth (21.2 percent) of visits were for patients who are white, two-fifths (41.8 percent) were for black patients, and one-quarter (24.5 percent) were for Hispanic and Latino patients.
- The rate of use of the ED for primary care treatable visits was higher than the rate for emergent, non-preventable visits. For every visit that was in the emergent, non-preventable category, there were two non-emergent visits and another two emergent but primary care treatable visits. Rates were higher for patients covered by Medicaid and for black and Latino or Hispanic patients.
- Rates of use of the ED for primary care treatable conditions are far higher for children than for adults or elderly patients. For every visit by a child that was emergent and non-preventable, there were 3.74 non-emergent visits and another 3.85 emergent, primary care treatable visits.
- The availability of alternative sources of care does not appear to explain the use of the ED for primary care treatable conditions. Across all sites, patients used the ED for primary care treatable conditions at relatively comparable rates during the hours of 8:00 am to 4:00 pm, when clinics and private practice providers are open, and the hours of 4:00 pm to midnight.

Most Common Barriers to Accessing Health Care

The following were most often cited by a variety of stakeholders as barriers to obtaining health care in the *Urgent Matters* communities. While some of these barriers are significant enough to impede access on their own, many act in concert with others to create far-reaching and complex limits to accessing health care for uninsured and underserved patients.

Language: Lack of adequate interpretation and translation services pose significant access barriers for non-English speakers. The high cost of interpreters often impedes providers from hiring such staff. Spanish-speaking patients are most likely to access an interpreter while patients who speak other languages face significant challenges.

Patients' Lack of Knowledge: Uninsured and underserved patients often lack information on how to use and navigate the health care system in the *Urgent Matters* communities. This is especially prevalent among immigrants and those with limited formal education. Uninsured and underserved patients also do not understand the importance of accessing preventive care. Stakeholders identified the need for culturally competent outreach and education programs to inform patients how to use the system and why preventive care is so important.

Lack of Insurance: Patients' lack of insurance presents a major barrier to accessing health care. Low-income uninsured and underserved patients often can not afford the high cost of health care and must rely on providers who provide sliding fee scale prices or payment plans. Even the relatively low up-front fees (e.g., $20-$30) charged by some safety net providers can impose significant barriers, especially for seeking preventive care.

Transportation: Uninsured and underserved patients in communities with limited or no public transportation face significant barriers to accessing health care. Where public transportation is available, stakeholders reported it is often unreliable, and patients must spend several hours taking several buses to reach their destination. Sometimes safety net providers are not located at predetermined public transportation stops.

Hours of Operation: Many uninsured and underserved patients are unable to miss work and must rely on providers with after-hours care or weekend appointments. Many FQHCs and clinics in the *Urgent Matters* communities are open only on weekdays between 8 a.m. and 5 p.m. Restricted hours of operation encourage patients to seek health care from emergency departments which are always open and available.

Provider Shortages: Shortages of medical, dental and other health care providers who are willing to serve the uninsured and underserved pose a significant barrier to accessing care. These shortages create long wait times for appointments and likely increase non-emergent use of emergency departments. General provider shortages also played a role in some *Urgent Matters* communities.

Wait Times for Appointments: Long wait times for appointments, especially for specialty care, create significant barriers to care. In some communities waits ranged between several months and a year for specialty care. Such long waits likely lead to non-emergent use of emergency departments. In addition, some conditions that go untreated for long periods evolve to emergent conditions and warrant care at the emergency department and admission to the hospital.

STRATEGIES FOR STRENGTHENING THE SAFETY NET

The *Urgent Matters* Safety Net Assessment Team offers the following key strategies for strengthening the safety net. The strategies recommended here are those most commonly suggested to the *Urgent Matters* communities.

- Communities need to formally and clearly understand the impact of changes in public financing on safety net services, including the impact on access to care for the most vulnerable populations. Communities that have experienced significant changes in public financing should commission studies to determine what effects these changes have had on the safety net. Studies should include an investigation of any unintended consequences of the changes on the principal safety net institutions in the community. Studies should also examine whether provider payments are sufficient to encourage physicians and other health care providers in the safety net to continue serving the community.
- Safety net providers, community health workers and case managers should work together to measure existing capacity of safety net systems to identify areas needing expansion and better execution. All components of the safety net should be studied. In particular, studies should include a close examination of behavioral health care systems to identify opportunities for re-engineering the delivery of care and making existing capacity more efficient. This process should build on initiatives or discussions that have been undertaken as a result of the dissemination of the individual *Urgent Matters* safety net assessments.
- Collaboration among existing safety net providers should be encouraged and developed as a way of increasing overall capacity and improving quality of care for uninsured and underserved populations. Efforts should focus on a systematic approach to service delivery, recognizing the strengths of individual organizations in the safety net structure and the potential additional capacity that each may offer.
- Safety net providers should implement information systems that follow patients across systems and sites of care, allowing providers to share patient files across various sites of service. Such systems would improve patients' quality of care by streamlining eligibility and registration processes and would enable providers to have more up-to-date information on a patient's clinical profile and history. The development of a formal referral network between the hospitals and other safety net providers could improve access and outcomes for all patients, and especially those who do not have a medical home.
- Hospitals and other safety net providers should develop formal referral networks to improve access and outcomes for patients who present at the ED with primary care treatable conditions but who have no medical homes. Currently in many communities, patients are sent home with written discharge directions, but they frequently fall through the cracks with little or no follow-up care.
- All hospitals in the *Urgent Matters* communities should conduct analyses of the use of their emergency departments for emergent and non-emergent care. These analyses 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 these studies to develop strategies for improving the accessibility of primary, specialty, behavioral health, and dental services in the community.

- Given the increasing diversity of the populations in many of the *Urgent Matters* communities, safety net providers must develop programs to provide language services, health education, and culturally appropriate outreach that effectively meet the needs of the population.
- Public awareness campaigns and outreach efforts should be employed to help uninsured and underserved residents learn how to navigate the health care system. These programs should use community health workers in their outreach efforts to better connect with underserved populations. Such programs can describe options for primary care for uninsured and underserved patients and explain how to apply for services. This is especially important in communities with high numbers of new residents and recent immigrants.
- Key stakeholders should make concerted efforts to include more Latinos, African Americans and members of other racial and ethnic groups in all aspects of the decision making process. Improving representation among traditionally underrepresented groups could result in enhanced awareness of underserved populations and safety net issues in the community.
- The effectiveness of bus routes and the transportation systems serving low-income, underserved populations should be evaluated in communities. Consideration should be given to changing routes to increase their convenience for the underserved. In some communities, a transportation voucher system for low-income populations could be considered.

1 U.S. Census Bureau, Health Insurance Coverage in the United States: 2002 (Washington, DC: U.S. Department of Commerce, September 2003).

2 Ibid.

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

4 Many of these issues were included in a presentation entitled *Tough Times, Tough Choice*, by Patricia A. Gabow, MD, CEO and Medical Director of Denver Health, on April 15, 2004, at a conference of the National Association of Public Hospitals and Health Systems.

5 The Bureau of Health Professions of the U.S. Department of Health and Human Services estimated a national shortfall of 110,700 full-time registered nurses in 2000, the most recent year for which data are available. A number of colliding factors have contributed to this shortfall including the rise in retirement of nurses, a low rate of growth in the nursing work force in the past decade and declining enrollment in nursing schools. J. Sochalski, "Nursing shortage redux: Turning the corner on an enduring problem," *Health Affairs* 21, no. 11 (2002): 157.

6 Prescription drug costs represent the fastest growing component of the health care industry. The cost of prescription drug coverage is expected to jump 18 percent in 2004, continuing the trend of large price increases of the past several years. The Segal Group, *2004 Segal Health Plan Cost Trend Survey.* (New York City: The Segal Group). 2003.

7 D. Cutler, M. McClellan, J. Newhouse, "What Has Increased Medical-Care Spending Bought?" The American Economic Review 88, no.2 (1998):132. See also: B.A. Weisbrod, "America's Health Care Dilemma," Challenge 28, no. 4 (1985):30.

8 Emergency Medical Treatment and Active Labor Act (EMTALA), 42 US C Sec. 1395dd (1990). Full text and regulations of EMTALA may be found at http://www.emtala.com/#stat

9 J. Gordon, J. Billings, B. Asplin, K. Rhodes, "Safety Net Research in Emergency Medicine: Proceedings of the *Academic Emergency Medicine* Consensus Conference on 'The Unraveling Safety Net,'" *Academic Emergency Medicine* 8, no. 11 (2001): 1024-1029.

10 The results of these first two activities will be available shortly at the program website, www.urgentmatters.org

11 In most cases, the safety net assessments represent findings for a specific county or counties that surround the *Urgent Matters* city location. Demographic data, insurance coverage statistics and funding information refer to these counties unless otherwise specified.

12 Race and ethnicity data apply to county statistics. For a few of the communities, the demographics of the community at the city level are quite different. For example, Atlanta and Detroit have relatively larger proportions of residents identifying as racial minorities, compared to estimates at the county level.

13 L. Nolan, J. Harvey, K. Jones, M. Regenstein. *An Assessment of the Safety Net in Memphis, Tennessee.* (Washington, DC: George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy, May 2004.)

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

15 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: Fairfax County, Virginia, Profile of General Demographic, Social and Economic Characteristics* (Washington, DC: U.S. Census Bureau, 2003), www.census.gov/acs

16 Ibid.

17 The REACH data are based on Census Bureau data and provide estimates on the number of persons by poverty level, age, sex, race and primary source of health insurance for each county in the U.S. for 2000. Estimates are based on the 2000-2002 pooled data from the Current Population Survey and the 2000 Census of the United Sates, which are provided by the Bureau of the Census.

18 FQHCs are federally funded health centers that 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 and Medicare reimbursements.

19 J. Tolbert, ed. Safety Net Financing: A Source Book for Healthcare Executives, (Washington, DC: National Association of Public Hospitals and Health Systems, 2003).

20 Many other federal programs are available to provide support to safety net populations. For example, Ryan White funding provides support for persons with HIV/AIDs and many health care institutions receive such support. Still, DSH is the only source of funding that is designed to provide enhanced funding to safety net hospitals in support of their mission to provide care to uninsured and publicly insured individuals.

21 For information on federal policies concerning FQHCs, see http://www.hrsa.gov/budget.htm

22 With the exception of the Free Care Pool in Massachusetts, these programs and funding sources do not include Medicaid or DSH.

23 L. Ku, S. Nimalendran. "Losing Out: States are Cutting 1.2 to 1.6 Million Low-Income People from the Medicaid, SCHIP and Other State Health Insurance Programs." Washington, DC: Center on Budget and Policy Priorities, December 2003.

24 V. Smith, et al. *States Respond to Fiscal Pressure: A Fifty State Update of State Medicaid Spending Growth and Cost Containment Actions.* (Menlo Park: Kaiser Family Foundation). January 2004.

25 Health Management Associates. *Factors Sates Reported as Among the Top Three Increasing Medicaid Spending.* (Washington: Kaiser Commission on Medicaid and the Uninsured) June 2002.

26 Ku and Nimalendran.

27 Extremely low DSH states receive allotments equal to one percent of Medicaid expenditures.

28 Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108-173).

29 EMTALA—The Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd et seq.

30 Most hospitals provided data on all encounters that did not result in an inpatient admission for the period July 1 through December 31, 2002. One hospital had a slightly shorter reporting period.

31 These numbers reflect one-half year's utilization. The annual number of visits is likely to be twice this amount.

32 Two hospitals had much higher percentages of visits by Asian patients; these are Inova Fairfax Hospital (nearly 5 percent) and Elmhurst Hospital Center (11.3 percent). Other hospitals with larger-than-average Asian populations may have reported ED data only according to the following categories: white, black, Latino/Hispanic, and other.

33 Most of these patients are coded as HMO patients and may be part of a commercial or Medicaid managed care plan.

34 The majority of these visits are for patients covered by HMOs. Some of these patients are in commercial plans and others are enrolled in Medicaid plans.

35 Approximately 16.5 percent of patients at University Health System are uninsured and enrolled in Care*Link*, a program that provides access to health services for some uninsured county residents. The program does not provide coverage. Rather, it reimburses providers for some portion of the cost of caring for patients enrolled in the program.

36 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).

37 Billings, et al.

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

METHODOLOGY

The safety net assessments were 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. Information about the *Urgent Matters* hospitals and community partners is listed on the following pages.

The assessments were 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 obtained through multiple sources. The assessments began with three- to four-day site visits that included tours of hospitals, clinics, public health department facilities, and other sites where uninsured and underserved residents were likely to receive health care services. During each of the site visits, the community partner convened a meeting of key stakeholders who were briefed on *Urgent Matters*, the safety net assessment, and the key issues under review.

Through the site visits and a series of telephone conferences held prior to and following the visit, 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. In all, the teams spoke to over 300 local informants across the ten communities. The safety net assessment teams also drew upon secondary data sources to provide demographic information on the populations in each of the *Urgent Matters* communities as well as data on health services utilization and coverage.

We also conducted focus groups with residents in each of the ten communities. A total of 266 residents participated in 28 focus groups across the sites. Focus groups were conducted in Arabic, Cantonese, English, Haitian Creole, Spanish and Vietnamese. The assessment team worked with the community partners to identify local organizations willing to assist with organizing and hosting focus groups, and recruiting patients who were likely to use safety net services.

Because of the role that the ED plays in providing services to safety net populations, we collected data on ED encounters from each of the ten *Urgent Matters* hospitals. The data provide an opportunity to determine whether these EDs are providing care to patients who could safely be treated in other settings. Using an ED use profiling algorithm, we were able to classify ED encounters as either emergent or non-emergent cases.

The assessments were developed to provide information to communities about the residents who are most likely to rely on safety net services.

Urgent Matters Hospitals and Community Partners

The *Urgent Matters* Safety Net Assessments are the products of collaborations among researchers from The George Washington University, emergency department staff from the hospital, and a community partner from each site. Below is the list of *Urgent Matters* project staff by city. We appreciate the time and effort put in by all who participated in the project.

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

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

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

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

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

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

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

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

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

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

COMMUNITY PARTNERS AND CONTACT INFORMATION

Atlanta, GA—National Center for Primary Care
(www.msm.edu/NCPC2003/index.htm)
The National Center for Primary Care at the Morehouse School of Medicine promotes excellence in primary care practices and community health programs in an effort to eliminate health disparities in underserved populations. For more information on the Atlanta, Georgia, safety net assessment and the National Center for Primary Care, please contact George Rust, MD, MPH, FAAFP, at (404) 756-5740.

Boston, MA—Health Care for All
(www.hcfama.org)
Health Care for All is a non-profit, consumer health advocacy organization that works with organizations and consumers to identify the current health system's failures and to design solutions for the existing health care crisis. For more information on the Boston, Massachusetts, safety net assessment and Health Care for All, please contact Marcia Hams at (617) 350-7279.

Detroit, MI—Voices of Detroit Initiative
The Voices of Detroit Initiative, a partnership between the leading health system providers in Detroit, federally qualified health centers and the Detroit Health Department, focuses on bringing all segments of the community together to address the issues of access to cost-effective health care for the uninsured. For more information on the Detroit, Michigan, safety net assessment and the Voice of Detroit Initiative, please contact Lucille Smith at (313) 832-4246.

Falls Church, VA—Fairfax County Community Access Program
The Fairfax County Community Access Program is charged with the development of a culturally competent integrated delivery system in Fairfax County, Fairfax City and Falls Church through community partnerships with over 50 organizations. For more information on the Fairfax County, Virginia, safety net assessment and the Fairfax County Community Access Program, please contact Elita Christiansen at (703) 289-2033.

Lincoln, NE—Community Health Endowment of Lincoln
(www.chelincoln.org)
The Community Health Endowment of Lincoln focuses on the creation of collaborative partnerships to improve the health status of persons at the highest risk for the poorest outcomes. For more information on the Lincoln, Nebraska, safety net assessment and the Community Health Endowment of Lincoln, please contact Lori Seibel at (402) 436-5516.

Memphis, TN—University of Tennessee Health Sciences Center
(www.utmem.edu)
The mission of the University of Tennessee Health Sciences Center is to reduce disparities in the overall health, quality of care and length of survival among minorities through student and public education, health services and research into the causes of disparities. For more information on the Memphis, Tennessee, safety net assessment and the University of Tennessee Health Sciences Center, please contact Alicia McClary, EdD, at (901) 448-8502.

Phoenix, AZ—St Luke's Health Initiative
(www.slhi.org)
St Luke's Health Initiative, an Arizona public foundation, uses its extensive experience in health policy analysis, public education and advocacy to convene community and professional groups around issues of health care access, quality and cost. For more information on the Phoenix, Arizona, safety net assessment and the St. Luke's Health Initiative, please contact Jill Rissi at (602) 385-6500.

Queens, NY—Northern Queens Health Coalition
The Northern Queens Health Coalition is a 60 member coalition of health services providers whose mission is to help providers and consumers identify gaps and inefficiencies in the health services delivery system. For more information on the Queens, New York, safety net assessment and the Northern Queens Health Coalition, please contact Mala Desai at (718) 661-9313.

San Antonio, TX—Greater San Antonio Hospital Council
(www.gsahc.org)
The mission of the Greater San Antonio Hospital Council (GSAHC) is to provide leadership in educating, communicating, and coordinating health care providers to improve the region's health. For more information on the San Antonia, Texas, safety net assessment and the Greater San Antonio Hospital Council, please contact Bill Rasco at (210) 820-3500.

San Diego, CA—Community Health Improvement Partners
(www.sdchip.org)
The Community Health Improvement Partners is a voluntary collaboration of San Diego health care systems, hospitals, community clinics, insurers, physicians, universities and community benefit organizations, who are committed to improving the health of the community through collaboration and assessment. For more information on the San Diego, California, safety net assessment and the Community Health Improvement Partners, please contact Kristin Garrett, MPH, at (619) 515-2854.

URGENT MATTERS SAFETY NET ASSESSMENTS

An Assessment of the Safety Net in Atlanta, Georgia, by J. Harvey, M. Regenstein, K. Jones. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in Boston, Massachusetts, by K.H. Mead, P. Shin, M. Regenstein, K. Jones, and K. Kenney. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in Detroit, Michigan, by M. Regenstein, K. Nguyen, K. Jones, K. Kenney. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in Fairfax County, Virginia, by L. Nolan, L. Vaquerano, K. Jones, M. Regenstein. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in Lincoln, Nebraska, by L. Nolan, L. Vaquerano, K. Jones, M. Regenstein. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in Memphis, Tennessee, by L. Nolan, J. Harvey, K. Jones, M. Regenstein. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in Phoenix, Arizona, by L. Nolan, L. Vaquerano, M. Regenstein, K. Jones. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in Queens, New York, by K.H. Mead, M. Regenstein, K. Jones. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in San Antonio, Texas, by M. Wilson, P. Shin. M. Regenstein, K. Jones. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

An Assessment of the Safety Net in San Diego, California, by K. Nguyen, P. Shin, M. Regenstein, M. Wilson, K. Kenney, K. Jones. *Urgent Matters*, The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy. March 2004.

For more information or to request copies of the *Urgent Matters* safety net assessments please contact *Urgent Matters* at info@urgentmatters.org or call (202) 530-2335.