

AN ASSESSMENT OF THE

SAFETY NET

in Lincoln, Nebraska



Urgent Matters

The George Washington University Medical Center

School of Public Health and Health Services

Department of Health Policy

ACKNOWLEDGMENTS

The *Urgent Matters* safety net assessment team would like to thank our community partner, the Community Health Endowment of Lincoln, for its help in identifying key safety net issues in Lincoln and connecting us with stakeholders in the community. At the Community Health Endowment, Lori Seibel and Abby Kuschel were instrumental in coordinating our site visits, interviews and focus groups and essential resources through the course of the project.

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. More information on the Community Health Endowment of Lincoln can be found at www.chelincoln.org.

We would also like to acknowledge Ruth Radenslaben, RN, at the BryanLGH Medical Center, for providing us with important information and resources regarding the emergency department at BryanLGH. The *Urgent Matters* team would also like to recognize the many individuals in the Lincoln health care community who gave generously of their time and provided important and useful insights into the local safety net system. The Lincoln, Nebraska, Safety Net Assessment would not have been possible without their participation.

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

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

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

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MARCH 2004

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FOREWARD

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

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

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

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

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The *Urgent Matters* program is a new national initiative

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

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

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

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

KEY FINDINGS AND ISSUES FOR CONSIDERATION: IMPROVING CARE FOR UNINSURED AND UNDERSERVED RESIDENTS OF LINCOLN

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

The safety net in Lincoln, Nebraska, consists of a patchwork of providers with little or no formal collaboration among them. While there are some instances of cooperation among providers, these efforts are limited and Lincoln providers generally undertake their clinical operations independent of one another.

Limited resources and general physician shortages in Lincoln reduce access to health care for all patients, regardless of their insurance status. Uninsured and Medicaid patients, however, are especially affected by these problems. Uninsured patients experience long wait times for primary care, specialty care, mental health and dental services. Although most physicians in Lincoln and Lancaster County serve Medicaid patients, at least half are not accepting new patients. New Medicaid patients have limited options for seeking health care.

The safety net lacks referral mechanisms for linking patients without medical homes to community providers. These patients often present to emergency departments with non-emergent conditions. BryanLGH West operates a small case management program that focuses on individuals who have multiple emergency department visits; however, the program is limited and reaches only a small portion of the underserved population.

A significant percentage of emergency department visits at BryanLGH Medical Center are for patients whose conditions are non-emergent. About 17 percent of all emergency department encounters that did not result in an admission were for patients who presented with non-emergent conditions. Another 18 percent were for patients whose conditions were emergent but could have been treated in a primary care setting.

Existing interpreter services in the health care community are inadequate. Some interpreter services are available via telephone access lines, but these services may be cumbersome to use and calls may be cut short to conserve resources. Interpreter services are expensive, making it difficult for providers to offer them. The cost of this resource often exceeds the payment providers receive for visits from these patient populations.

Refugees and immigrants need to be educated in a culturally sensitive manner about use of the health care system, available services, and the importance of receiving preventive care. In particular, educational programs should address how cultural traditions and preferences hinder refugees and immigrants from seeking needed services.

Transportation remains a major obstacle for uninsured, low-income populations trying to access health care. Bus routes run primarily in the downtown area and do not run at convenient times. Rides to medical providers can take over an hour. Latino and black residents report that their needs are overshadowed by those of the New Americans—i.e., refugees who account for a much smaller percentage of underserved residents. Latinos, in particular, believe that their concerns are discounted, largely because many are undocumented and do not enjoy the same legal status as the refugees. Latino residents indicated that they were underrepresented in decision-making positions, including boards of hospitals, clinics and foundations.

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

Safety net providers, community health workers and case managers should work together to measure existing capacity and to identify areas needing expansion and better execution. All components of the safety net should be studied. In particular, such a study should include a close examination of the mental health and substance abuse systems to identify opportunities for re-engineering care delivery and making existing capacity more efficient.

Additionally, an inventory of the current safety net system could determine whether services and programs that are particularly important to uninsured and underserved populations are available and adequate. These include transportation, interpreter services, education and information programs, and service coordination.

Collaboration among existing safety net providers should be encouraged and developed as a way of increasing overall capacity. Efforts should focus on a systematic approach to service delivery, recognizing the strengths of each of the organizations in the safety net structure and the potential additional capacity that each may offer. Stakeholders should look to the People's Clinic as a model for successful collaboration in the community.

Hospitals and other safety net providers should develop formal referral networks to improve access and outcomes for patients who present at the ED with non-emergent conditions but who have no medical homes. Opportunities for improving overall care rest with educating patients about the availability of important primary care services in the community.

Key stakeholders should make concerted efforts to include more Latinos, African-Americans and refugees on the boards of major health care providers and funders in the community. Improving representation among traditionally underrepresented groups could result in enhanced awareness of safety net issues in the Lincoln community.

All Lincoln area hospitals should conduct analyses of the use of their emergency departments for emergent and non-emergent care. Such studies would help determine whether area hospitals are experiencing trends in the use of their EDs similar to those seen in safety net hospitals around the country. Hospitals, community providers and other stakeholders should use the results of these studies to develop strategies for reducing crowding in hospital EDs.

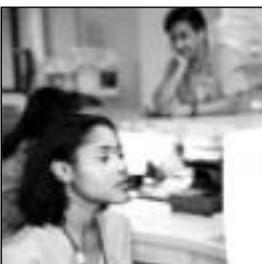


INTRODUCTION

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

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

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



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

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

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

The safety net assessments were conducted over the summer and fall of 2003. Each assessment draws upon information obtained from multiple sources. The Lincoln assessment team conducted a site visit August 25-27, 2003, touring safety net facilities and speaking with numerous contacts identified by the community partner and others. During the site visit, the community partner convened a meeting of key stakeholders who were briefed on *Urgent Matters*, the safety net assessment, and the key issues under review. This meeting was held on August 25, 2003, at the Embassy Suites in Lincoln.

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

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

While in Lincoln, we conducted focus groups with residents who use safety net services. We held three groups with a total of 25 participants; all three focus groups were conducted in English. The assessment team worked with the community partner to recruit patients who were likely to use safety net services. Many of these patients were homeless and/or consumers of mental health services. One focus group was made up of bilingual Latinos who elected to conduct their discussion in English. The assessment included an application of an ED profiling algorithm to emergency department data from BryanLGH Medical Center. The algorithm classifies ED encounters as either emergent or non-emergent cases.

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

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



BACKGROUND

Lincoln, the capital of Nebraska and the seat of Lancaster County, has undergone dramatic changes in population over the past ten years. Over 7 percent of Lincoln's residents are foreign born, and a considerable segment of these residents are new immigrants—mostly Latino populations and refugees from countries such as the Sudan, Bosnia/Herzegovina, Iraq, and Vietnam. Table 1 provides demographic information on Lancaster County residents. Because some Latino residents are undocumented, these numbers may understate their relative proportions within the population.

Table 1 A Snapshot of Lancaster County and Nebraska

	Lancaster County	Nebraska
Population		
Size	245,377	1,677,978
Density: Persons/square mile	292.4	21.8
Race		
White	92.4%	91.6%
Black	2.9%	3.8%
Asian	3.5%	1.5%
Other	1.2%	3.1%
Latino origin and race	3.6%	6.0%
Birthplace/Language		
Foreign born	7.1%	4.4%
Language other than English spoken at home	8.2%	7.7%
Age		
18 years and over	76.2%	74.2%
65 years and over	10.0%	12.8%
Median age (in years)	33.1	35.8

Sources: American Community Survey Profile, 2002, U.S. Census Bureau unless otherwise noted.

Although the majority of both Lancaster County and Nebraska residents are white, racial and ethnic minority populations have grown over the past decade. Since 1990, the general population of Lancaster County has increased 14.8 percent. During that time, the minority population increased 108 percent and the non-minority population grew 9.9 percent (see Table 2).

Table 2 Lancaster County Population Change by Race 1990-2002

Race	1990	2002	Percent Change
Total	213,641	245,377	14.8
White	203,013	223,313	9.9
Black	4,824	7,144	48.0
Latino	3,418	9,032	164.2
Asian	2,974	8,575	188.3
Indian/Alaska Native	1,259	1,199	-4.7%

Source: 1990 U.S. Census Bureau Data; U.S. Census Bureau Community Survey Profile 2002.

Since 1990, Lincoln has been a resettlement site for approximately 10,000 refugees.² Currently 8 percent of Lancaster County residents speak a language other than English at home. Approximately 4 percent of foreign-born residents of Lancaster County report not being able to speak English “very well.”³ The Lincoln public school system currently provides services to students speaking 42 different languages who represent 53 different nationalities in its English Language Learners program.⁴

Lancaster County’s population is younger than that of the state. The median age is 33.1 versus the state’s average of 35.8. Likewise, Lancaster County has fewer residents over age 65 (10 percent) than does the state (12.8 percent). Accordingly, Medicare pays for a smaller share of hospitalizations of Lancaster County residents (33.5 percent) than for the state overall (40.2 percent).⁵

Table 3 Income, Poverty Levels and Insurance Coverage in Lancaster County and Nebraska

	Lancaster County	Nebraska
Income and Poverty*		
Living below poverty	12.1%	11.0%
Median household income	\$40,150	\$39,904
Insurance Coverage		
Commercial [#]	65.8%	57.2%
Medicare	10.7% ⁼	12.0%
Medicaid and Kids Connection**	13.5% ⁼	18.8% ^o
Uninsured	10.0% ⁼	12.0% ^y

* American Community Survey Profile, 2002, U.S. Census Bureau.

[#] Source: Annual Demographic Survey: March Supplement data, 2003, Current Population Survey.

⁼ Source: REACH Data, 2000, National Association of Community Health Centers.⁶

^o Estimate based on data supplied by the Nebraska Department of Health and Human Services, Office of Finance and Support. Child enrollment in Title XIX and XXI for October 2003 (124,774), adults enrolled in both ADC-related categories and the aged, blind and disabled in July 2003 (191,087), divided by total state population (1,677,978).

^y Governor Mike Johanns. Grant to Assist in Development of Expanded Health Insurance Plan. October, 10, 2003.

<http://gov.nol.org/johanns03/newsroom/oct03/healthInsurance.htm>

** Kids Connection is the Nebraska State Children’s Health Insurance Program.

Many Nebraskans’ insurance status is in flux, in part because of the state’s \$673 million budget deficit and the associated cuts to the Medicaid program. More than 25,000 adults and children are expected to lose Medicaid eligibility due to cuts to the Medicaid program enacted by the state legislature in October 2002.⁷ After holding steady at about 9 percent during the period 1993 to 2000, the percentage of the population in Nebraska who lacked any health insurance increased to 14 percent in 2001.⁸ The current rate is estimated to be 12 percent statewide, which is higher than the rate in Lancaster County (see Table 3).

A steady rise in unemployment in Lincoln and in the state as a whole has already added to rising numbers of uninsured in the area. As of September 2003, the statewide unemployment rate was 4.0 percent, up from 2.9 percent just five years before. Lincoln has experienced an even sharper rise in unemployment, from 2.2 percent to 3.8 percent.⁹

STRUCTURE OF LINCOLN'S HEALTH CARE SAFETY NET

The safety net in Lincoln is comprised of primary care providers, hospitals, and individual practitioners who provide services to uninsured and underserved patients.

Table 4 provides numbers of primary care and specialty physicians in Lancaster County and statewide throughout Nebraska. The proportion of providers is slightly higher in Lancaster County than in Nebraska as a whole, although overall physician supply appears to be relatively low. The entire state has only 895 primary care providers and 154 pediatricians.¹⁰ The county has approximately 49 primary care physicians per 100,000 adults, 12 pediatricians per 100,000 children, and 10 obstetricians/gynecologists per 100,000 adult women.

Table 4 Provider Supply, Lancaster County and Nebraska

Supply (per 100,000 population)	Lancaster County	Nebraska
Primary care providers	49	50
Pediatricians	12	9
OB/GYN	10	7
Psychiatry	10	8
Physician assistant	34	20
Nurse practitioner	20	10
Dentist	81	50
Nurses (LPN, RN)	1550	NA

Source: Data on supply of health professionals in practice from Nebraska Department of Health and Human Services. Area Profile—Lancaster County 2002. www.hhs.state.ne.us/profile1102/lancaster/data.pdf. Rate per 100,000 calculated using 2000 census state and county population data. quickfacts.census.gov/qfd/states/31000.html and quickfacts.census.gov/qfd/states/31/31109.html. Information on medical and surgical specialists is not available.

LINCOLN'S PRINCIPAL SAFETY NET PROVIDERS ARE DESCRIBED BELOW.

The Peoples' Health Center, a Federally Qualified Health Center (FQHC),¹¹ opened its doors on September 30, 2003, and expects to be fully operational within three years. At that point, it will serve 5,000 medical, 2,100 dental and 1,800 behavioral health patients per year, and will provide an estimated 15,000 medical, 4,200 dental, and 3,588 behavioral health encounters. The center estimates that 40 percent of its patients will be uninsured and qualify for reduced fees based on income, another 40 percent will be covered by Medicaid, 10 percent will have Medicare coverage, and 10 percent will be covered by private insurance.¹² The health center is centrally located in Lincoln and is situated within the poorest and most underserved census tracts in the city.

Various providers and organizations have partnered with the Peoples' Health Center. They are helping to recruit physician and dental staff, establish a call center,

and provide physician coverage, imaging services, resident and student placement, prescription assistance, coordinated dental care, in-kind staffing, Medicaid managed care enrollment assistance, and interpreter services. Principal collaborators in creating the center were the Lincoln Lancaster Health Department, local hospitals, the University of Nebraska Dental School, the Lincoln Medical Education Program/Family Practice Residency Program (described below), and community mental health centers.

The Urban Indian Health Center is an FQHC look-alike¹³ which has operated in Lincoln for many years. The health center is staffed with one family practice physician and a nurse practitioner. The center provides approximately 800 visits per month. Nearly two-thirds (62 percent) of the center's patients are covered by Medicaid, 8 percent are on the state's Children's Health Insurance Program,¹⁴ Kids Connection, 9 percent have

private insurance, and 22 percent are uninsured/self pay.¹⁵ The center provides primary care services only. Patients needing specialty and dental care are referred to other providers. Urban Indian owns two mobile vans and employs two drivers to provide transportation for patients to and from appointments. Six case managers trained in medical interpretation work with various populations at the center. Each of the case managers also represents one of the ethnicities or nationalities commonly seen in the patient population. There are case managers who work with Native American, black, Vietnamese, Iraqi, Latino, and Sudanese patients. The clinic has a total of 11 exam rooms and has the capacity to hire additional clinicians.

The Lincoln Medical Education Program/Family Practice Residency Program trains a total of 24 family practice residents each year (eight residents per training year) through seven faculty physicians. The family practice residency program operates a state-of-the-art, stand-alone clinic that offers a wide array of services including primary care, diagnostics, and laboratory. The clinic handles 250 deliveries and provides 30,000 primary care visits per year. The majority of patients have Medicaid (70 percent); the remaining 30 percent are on Medicare (10 percent), have private insurance (10 percent) or are uninsured (10 percent). Half the patients are minorities (20 percent) or refugees (30 percent). The program is subsidized by BryanLGH Medical Center and St. Elizabeth's hospital.

The Lincoln-Lancaster County Health Department serves as a major source of primary care and dental services for the uninsured. The county's medical clinic serves only those without private insurance who do not qualify for Medicaid or Kids Connection. The dental clinic will serve some patients covered by these public programs, however. Primary care patients who become eligible for any insurance program are placed with a physician in the community through the county's referral network. The Primary Care Clinic serves over 2,300 clients each year. Forty-five percent of the medical care services provided to the clients are by volunteer physicians. Many of the clients seen through the Primary Care Clinic have complex health care needs. While individuals with urgent needs are generally seen

right away, many clients requesting appointments wait up to four weeks to be seen by a physician.

Through the Primary Care Clinic, clients who cannot afford to pay for medications may be eligible to receive prescription drug assistance through the Grapevine Project, a foundation-sponsored program that provides medications and pharmacy supplies to low-income uninsured adults and children. In addition, clinic staff work with clients to enroll them in a medication assistance program that accesses prescription medications through national drug programs. In the first six months of the program, nearly \$100,000 in prescription medications have been obtained for needy clients. Clinic staff also work closely with the state General Assistance program to review medical needs and determine if individuals are eligible for assistance.

The county's dental clinic provides 6,950 visits per year to 3,000 patients. Most dental encounters are for uninsured patients or patients covered by Medicaid. Uninsured patients receive dental services on a sliding scale fee based on income. Between 40 and 50 percent of the clinic's medical patients are members of racial and ethnic minorities, as are 60 percent of the clinic's WIC nutritional program recipients.¹⁶ Among dental clinic patients, 60 percent are racial/ethnic minorities and one-third of the patients have limited English proficiency.

The Health Department also operates a mobile health clinic that provides health screenings (e.g., hypertension, diabetes, cholesterol, skin cancer, heart risk assessment and body mass index), dental health screenings and treatment, immunizations, and health education and outreach. The mobile clinic travels to community centers, churches, agencies serving the homeless and low-income populations, and Community Learning Centers to provide screening and prevention services to neighborhood residents.

The cooperation and collaboration among the city's behavioral services providers is widely praised.



HOSPITALS

BryanLGH West is the primary source of hospital care for uninsured and low-income populations in Lincoln. It is centrally located in Lincoln and closest to the area's low-income population. BryanLGHWest is part of BryanLGH Medical Center, which is the product of a merger between Lincoln General Hospital (LGH), previously owned and operated by the city of Lincoln, and Bryan Memorial Hospital. BryanLGH Medical Center is a 583-bed licensed facility that includes two main hospitals and several outpatient clinics. The BryanLGH West facility is, in fact, the former LGH hospital, and many individuals in the community still refer to it by its previous name. One-quarter of emergency department visits at BryanLGH Medical Center are for patients who are covered by Medicaid and another 14 percent are for patients who are uninsured.¹⁷

St. Elizabeth's Regional Medical Center is also a source of care for uninsured populations. St. Elizabeth's is located outside the center of town, away from the poorest neighborhoods, and is less accessible to low-income populations.

BEHAVIORAL HEALTH SERVICES PROVIDERS

The Community Mental Health Center (CMHC) is a main source of mental health care for adult residents of Lincoln. Services include outpatient care, day rehabilitation, case management, partial hospitalization, and residential support. The CMHC also operates a 15-bed crisis unit available to people in a 16-county area in southeast Nebraska, referred to as Region V. The CMHC provides a total of 5,000 visits each year to 3,000 residents. In August 2003, 100 people were on the community mental health center's waiting list to receive outpatient services;¹⁸ waits for an appointment can be as long as several weeks to two months.¹⁹

Cornhusker Place is another important component of the safety net. It operates a variety of programs including emergency civil protective custody, emergency social detoxification, intermediate residential care, short-term treatment and respite care. During fiscal year 2001-2002, its services included 5,220 admissions to civil protective custody, 2,932 days of intermediate residential care to 17 people, and 383 days of care of short-term residential treatment. BryanLGH's emergency department also provides substance abuse services.

The cooperation and collaboration among the city's behavioral services providers is widely praised. For example, BryanLGH, the Crisis Center, the community mental health center, and Cornhusker Place routinely work together to stretch resources and manage patients' care. Many of these and other organizations meet monthly in workgroups to discuss adult and child emergency services, identify frequent users of the emergency department and identify proper programs in which to place them. To help address the Crisis Center's limited capacity, Cornhusker Place, Community Mental Health Center, and Region V Systems worked together to open additional crisis beds at Cornhusker Place.

DENTAL SERVICES

In addition to the Peoples' Health Center and the Lincoln Lancaster County Health Department, the University of Nebraska Dental School is a source of dental services to uninsured patients. The dental school is currently at capacity and will no longer take new patients, even on an emergency basis. Services are provided by dental students to established patients at discounted rates.

FINANCING THE HEALTH CARE SAFETY NET

The safety net in Lincoln is funded through multiple sources including federal, state and local dollars.

MEDICAID

Medicaid is a major source of funding for many of Lincoln's safety net providers. Statewide, Medicaid expenditures totaled over \$1 billion in fiscal year 2001. The state's general fund portion of the cost was over \$360 million or approximately 15 percent of the state's general fund expenditures. An additional \$7 million was paid from cash funds. The balance was paid from federal funds. Total expenditures for the State's Children's Health Insurance Program, Kids Connection, were over \$11 million in FY 2001; the state's share was nearly \$4 million. As of October 2003, there were 124,774 children, pregnant women and Aid to Dependent Children (ADC) related adults enrolled in Medicaid and Kids Connection. An additional 66,313 residents were enrolled in the aged, blind and disabled and ADC-related caretakers categories, for a total of 191,087 enrollees.²⁰ Pregnant women and children make up the majority of Nebraska's Medicaid enrollment (64 percent). Consistent with other state Medicaid programs, expenditures for aged, blind and disabled enrollees represent 69 percent of total Medicaid costs.²¹

Eligibility for Medicaid follows federal guidelines: pregnant women are eligible with incomes up to 185 percent of the federal poverty level (FPL);²² children age 0-1 are eligible up to 150 percent of the FPL; children 1-5 up to 133 percent of the FPL; and children ages 6-19 up to 100 percent of the FPL. Children up to age 21 can qualify for Kids Connection if their family income is under 185 percent of the FPL.

Nebraska's budget crisis led to the state legislature enacting changes to Medicaid eligibility during a special session in November 2002.²³ The following changes were made to the program:

- Reductions in the period of guaranteed continuous Medicaid eligibility for children in Kids Connection from 12 months to six months from the date of

- initial eligibility, with monthly determinations made after the initial six-month period.

- Termination of Medicaid coverage for caretaker relatives with family incomes equal to or less than 50 percent of the federal poverty level (as of June 30, 2003).

- Implementation of a new method for computing family income that affects each family member's eligibility for Medicaid.

- Changes to the income disregard for work-related expenses from 20 percent of gross income to a \$100 deduction from gross monthly earned income.

- Reductions in transitional Medicaid for families losing eligibility for cash assistance from 24 months to 12 months.

These changes have resulted in the elimination of an estimated 12,600 children and 12,750 adults from Nebraska's Medicaid program.²⁴

DISPROPORTIONATE SHARE HOSPITAL (DSH) FUNDING

Nebraska is one of 15 states categorized as "extremely low-DSH states." These states have Medicaid DSH allotments equal to 1 percent of total Medicaid program expenditures.²⁵ In 1999 total DSH allotments to the state equaled \$3.9 million dollars and were spread across 12 hospitals. BryanLGH did not receive any DSH funding; St. Elizabeth Hospital received \$1,269.²⁶

Nebraska will begin receiving significantly more DSH funding as a result of the passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003. The law requires that in fiscal year 2004 state Medicaid DSH allotments be increased by 16 percent, and that they increase by 16 percent for each of the subsequent five years until fiscal year 2008, adjusted by the consumer price index (CPI) thereafter. As a result of these changes, Nebraska's DSH allotment was over \$12.6 million in 2003.²⁷ Additionally as of April 2004, the Medicare DSH cap will be increased from 5.25 percent to 12 percent for rural hospitals and urban hospitals with fewer than 100 beds.²⁸ This

adjustment is estimated to result in a \$102 million increase over a five-year period (beginning in FY 2004) in the federal DSH allotment for Nebraska.²⁹

OTHER GOVERNMENTAL SOURCES OF FUNDING

The Peoples' Health Center has received \$650,000 in funding from the U.S. Health Resources and Services Administration, Bureau of Primary Health Care. This funding was critical to the opening of the center. The Community Mental Health Center receives 60 percent of its funding from a combination of federal, state, and regional funds.³⁰

Many safety net providers in Lincoln rely on funding from multiple sources to support their programs. The Lincoln Lancaster County Health Department depends on funding from the city and county to support its services to those under 100 percent of the FPL. The Community Mental Health Center receives nearly 20 percent of its funding from Lancaster County and other counties in its region.³¹ Cornhusker Place also relies on a combination of funding sources.³²

FOUNDATION SUPPORT

Support from the Community Health Endowment (CHE) of Lincoln, a municipal endowment created by the sale of the city hospital in 1997, is an important source of support for safety net providers and their patients. CHE supports the Grapevine Project, which provided over 7,000 prescriptions to people in need during a three-year period.³³ Another CHE-funded initiative is the Peer Employment Medical Transportation Program. Consumers of mental health services at a day rehabilitation program provide transportation to medical, dental, and psychiatric appointments for individuals in community-based services. In the past six months, the project has provided 232 roundtrip medical transports. CHE previously provided partial funding for the Communities Helping Immigrants and Refugees Progress (CHIRP) Project, which provides interpreter services via telephone for patients with limited English proficiency. Between July 2001 and June 2003, the CHIRP line received a total of 1,240 calls and provided interpreting in Spanish, Arabic, Vietnamese, Russian and Bosnian.³⁴ CHE funded 79 projects totaling more than \$4 million between 2000 and 2003.³⁵

National foundations also have an important impact on funding for local programs in Lincoln. In particular, the Robert Wood Johnson Foundation has co-sponsored, along with the Community Health Endowment, the Black Bag Project, a physician-led mobile chronic care team that provides home-based medical care to homebound elderly with chronic health conditions. To assure long-term sustainability, operation of the Black Bag Project has been transitioned to the People's Health Center.



The safety net assessment team conducted interviews with key stakeholders in the Metropolitan Lincoln health care community and visited safety net facilities between August 25 and 27, 2003. This analysis of the Lincoln safety net was greatly informed by the interviews with safety net providers and other local stakeholders. Informants discussed important changes in local health policy and programs, emergency department use and crowding, issues relating to access to care, and significant barriers that patients face in seeking health care services.

OVERVIEW

The safety net in Lincoln, Nebraska, consists of a patchwork of providers that offer primary care, inpatient and emergency services, mental health care and substance abuse treatment. Although there are significant examples of collaboration, Lincoln's providers generally operate independently, with little formal collaboration on clinical issues occurring among them. Services delivered by Lincoln's providers are not coordinated or integrated into one cohesive system of care. The inception and development of the People's Health Center represents the first major, community-wide collaborative effort by many of Lincoln's safety net providers, agencies, funders, and community based organizations.

NEED FOR ADDITIONAL PRIMARY CARE SERVICES

In a recent series of studies conducted by the Community Health Endowment, low-income and uninsured populations reported a lack of access to primary health care, dental services, and mental health care.³⁶ Many informants reported that the emergency department was their most frequently utilized source of care. To address these problems, many organizations in the community came together in an unprecedented effort to create the Peoples' Health Center. Although the center will provide a sorely needed source of primary care for thousands of patients when fully operational, the demand and need in the community will likely continue to outstrip the supply of safety net services.

There is limited capacity in Lincoln's health care safety net. Currently most primary care providers have reported waits of up to one month or longer for routine appointments. Urgent or acute care can generally be accommodated more quickly, usually within a few days. Few providers have evening hours. Nearly all providers seemed to be operating at capacity, with the exception of the Urban Indian Health Center.

Many of the exam rooms at Urban Indian remain empty while patients wait for a provider.³⁷

NEED FOR ADDITIONAL SPECIALTY CARE SERVICES

Specialty care is very difficult for uninsured and low-income populations to access in Lincoln. Very few primary care providers have the capacity to provide specialty services in-house. The Peoples' Health Center anticipates adding mental health and substance abuse specialists to its staff by 2005 (i.e., its third year of operation). Until then, its patients must rely on an already overburdened network of community services.

Some providers in Lincoln have developed lists of specialists in the community willing to accept referrals for Medicaid enrollees or uninsured patients. Some providers reported that they are able to use personal relationships with specialists to obtain appointments for patients. When a specialty appointment is obtained, it can require a wait of several months.³⁸ Shortages of orthopedists are especially severe. The medical society also has a list of providers to whom they refer on a rotating basis; however, Peoples' Health Center or the Lincoln-Lancaster County Health Department is usually the first choice when referring an uninsured patient.

LACK OF ADEQUATE FOLLOW UP FOR EMERGENCY DEPARTMENT PATIENTS

Hospitals and primary care providers generally do not communicate when a patient has been seen in



Services delivered by Lincoln's providers are not coordinated or integrated into one cohesive system of care.

the emergency department. Patients are sent home with discharge papers and instructions for follow-up, but the system has no formal mechanisms for coordinating the care of these patients with other safety net providers. Under state law, patients who present at the emergency department without a physician of record are each permitted one follow-up visit with the on-call physician who treated them at the ED. That follow-up is only for the condition treated at the ED, and is not intended to create a permanent relationship between that patient and physician. However, uninsured patients who have no physician of record are often confused by this arrangement and wish to continue seeing the physician, though they are frequently unable to pay the full cost of care.³⁹

NEED FOR BEHAVIORAL HEALTH SERVICES

Mental health and substance abuse services are stretched to the limit and are often closed to new patients because they are at capacity. Waits for services can be weeks or months long, depending on the severity of the problem. Only those in crisis can receive prompt treatment, and then the level of care may be inappropriate for the condition. The strain on mental health services in Lincoln was exacerbated by the closure of one-third of the free-standing mental health beds in Omaha, Nebraska, located about 50 miles away. When excess demand cannot be met in Omaha, patients are sent to Lincoln for treatment.

The Community Mental Health Center's Crisis Center is at capacity nine months of the year. During these times, patients in crisis are referred to BryanLGH Medical Center. When the hospital's 69 mental health beds and three observation beds are full, people are transferred to medical floors for care.⁴⁰ All too often, patients at the Crisis Center who have undergone a full committal hearing and require stepped-down care cannot be transferred since there are no open slots in short-term rehabilitation and outpatient care programs. Likewise, patients who require inpatient or residential treatment may not find such treatment and instead end up staying in the Crisis Center. A three-day stay in the Crisis Center can easily become a six-day stay or longer if a vacancy does not become available. Cornhusker

Place, Community Mental Health Center, and Region V Systems have worked to increase capacity at the Crisis Center by providing crisis mental health care to a limited number of individuals at Cornhusker Place.

Nebraska's governor has recognized that the state is facing a mental health services crisis and has proposed legislation to reform the state's system. The "Road to Recovery" legislation would create community-based mental health services across the state to better serve people currently served at the state's Regional Centers.⁴¹ The plan will be implemented over the next two years. Nebraska's two academic health centers, University of Nebraska Medical Center and Creighton University, will play key roles in partnership with governmental and private organizations. The governor will also seek potential Medicaid funding for community-based mental health services; currently Nebraska's Regional Centers are not eligible for federal funding through Medicaid. Additionally a behavioral health division would be created in the state's Department of Health and Human Services, and an Office of Consumer Affairs would be established.⁴²

Cornhusker Place, a major substance abuse treatment center in Lincoln, is similarly stretched to capacity. The facility's Civil Protective Custody unit (i.e., involuntary detoxification) averages over 400 admissions per month. In a 12-month period in 2001-2002, the Civil Protective Custody unit was closed 120 times, with each closure averaging 8 to 10 hours.⁴³ When the facility is at capacity, law enforcement must find another level of care with which to respond to individuals under the influence of alcohol or drugs. Other Cornhusker Place programs face similar capacity issues: the voluntary detoxification program is only open to six women and 20 men at a time; intermediate residential care has a 14-bed program for men over age 19; and short-term residential is open to four men at a time. The facility is focusing on increasing women's treatment services, which are particularly important since the percentage of women using Cornhusker Place's services has nearly doubled over a five-year period.⁴⁴

NEED FOR ADDITIONAL DENTAL SERVICES

Dental services are limited, with only a few providers serving the uninsured. Residents covered by Medicaid also find it difficult to find a dentist willing to treat them.⁴⁵ Wait times for appointments with the few dental providers who see uninsured patients can be months long. Likewise, finding treatment for emergency services can be very difficult for individuals without an established relationship with a dentist.

NEED FOR FURTHER COLLABORATION AND COORDINATION

The creation of the People's Health Center serves as a model for successful collaboration in the community. Many organizations and agencies demonstrated their ability to coalesce around the development of the clinic, and this collaboration is likely to continue as the new center evolves. Several agencies plan to contribute in-kind assistance, personnel and diagnostics and laboratory services.

Many individuals in the community are hoping to extend this same collaborative spirit to the Urban Indian Health Center. Urban Indian has a long history in Lincoln, and its relationship with some other area providers has sometimes been strained. Some providers expressed a reluctance to work with Urban Indian and an unwillingness to send residents, nurses or other trainees to the site for professional development. However, recent changes at Urban Indian may create new opportunities for collaboration between the Center and the community's other safety net providers.

The safety net in Lincoln lacks appropriate referral mechanisms for linking patients without medical homes to community providers. These patients often present at emergency departments with non-emergent conditions. Uninsured patients who present at emergency departments without primary care providers of record do not receive information on available primary care providers in the community. There is no mechanism for tracking patients seen by multiple safety net providers in the community. BryanLGH West operates a small case management program that focuses on individuals with five or more emergency

department visits over a 12-month period; in some of these cases, primary care providers are identified for these patients.

GENERAL PROVIDER SHORTAGES

Nebraska is a large state with vast areas that are underserved by the health care system. Shortages of providers have plagued the state for many years. These shortages are quite common in Lancaster County as well. Physicians are not the only health care providers who are in short supply. The state (and local markets within the state) experience shortages of dentists, nurse practitioners, physician assistants and other health practitioners.

New Medicaid and Medicare enrollees face particular challenges in locating physicians willing to accept their coverage. As many as one half of all providers who participate in the Medicaid program have closed their practices to new Medicaid patients.⁴⁶ Medicare enrollees also face difficulty locating new physicians; only 17 of 115 primary care (family practice and internal medicine) physicians are accepting new Medicare patients.⁴⁷

These shortages make it all the more difficult for uninsured or underinsured patients to find doctors who may be willing to serve them. While many private physicians in Lincoln are willing to accept patients who are uninsured, they tend to limit the number of uninsured patients in their practice. Several physicians reported that they limit the percentage of uninsured in their practices to mirror the overall percentage of uninsured in Lincoln.

BARRIERS TO CARE

Inadequate Interpreter Services

Given the large influx of immigrants and refugees to Lincoln, interpreter services are critical to assuring access to health care. According to recently published surveys, between 26 and 35 percent of residents living in the poorest sections of Lincoln reported needing an interpreter to obtain health care, depending on the type of service sought (e.g., medical, dental, mental health).⁴⁸ Currently, interpreter services are inadequate

to address these needs, as there are too few interpreters with command of all the necessary languages.

Some providers have in-house staff who are fluent in one of the more common languages in the community such as Spanish, Arabic, Vietnamese, Russian, and Bosnian. Often, these staff members are not certified medical interpreters and providers sometimes rely on administrative, clerical, or janitorial staff to interpret during encounters with patients.⁴⁹ Other providers contract with local community organizations to provide interpreters, but these encounters are infrequent, and interpreters cannot always be reached when they are needed.⁵⁰ The CHIRP line, which provides telephone-based interpreter services, is also an important resource for interpreter services. However, some providers have complained that it is cumbersome to use, and that the 15-minute time period allotted for each call is too short for patients with multiple health needs.⁵¹

Many providers admit to using family members to interpret for patients. Although this is not desirable, providers often find this the most convenient and least expensive option. The cost of professional interpreter services is commonly higher than providers' reimbursement rates for Medicaid or payments that are discounted based on the patient's income. Costs for interpreter services range between \$50 and \$75 per hour.⁵² Since office visit fees range from \$40 to \$65, providers may not feel that they can afford to provide professional interpreter services for their patients. This is even more problematic for Medicaid encounters, which typically reimburse physicians approximately \$25 for standard visits.

Some of the potential resources for interpreters remain untapped in Lincoln. Organizations such as the Hispanic Community Center and Urban Indian Health Center have personnel trained in medical interpretation who remain underutilized in the community. Many providers do not know that such capacity exists.

Lack of Knowledge

Refugees and immigrants need information about Lincoln's health care system, the services available, and the importance of receiving preventive care. These

new residents are often overwhelmed with language barriers, cultural change, and bureaucratic systems. They often do not seek care until they are very ill. This is due in part to a lack of knowledge of where to go for health care services. More than a fifth of respondents to a survey of low-income Lincoln residents reported that they did not know where to go for a medical problem (21 percent); 17 percent did not know where to seek dental care; and 23 percent did not know where to go to obtain free or reduced-cost pharmaceuticals. Lack of knowledge of available options leads to an increase in emergency department use. One study of the poorest census tracts in Lincoln revealed that a quarter of those surveyed indicated that they used the emergency department more frequently than any other source of medical care.⁵³

Survey respondents' lack of knowledge about where to seek mental health and substance abuse services was even more striking. Forty-four percent of respondents said that they did not know where to seek or find mental health services, and 49 percent were similarly unaware of available substance abuse services.⁵⁴ This lack of knowledge regarding the behavioral health system may reflect, in part, cultural norms and the stigma associated with behavioral health services.

Transportation Barriers

Transportation remains a major barrier for uninsured, low-income populations trying to access health care. While most bus routes run through downtown Lincoln, buses do not run at convenient times, and rides to medical providers can take over an hour due to necessary transfers.⁵⁵ The \$1.00 cost per bus ride is considered by some to be too high for low-income residents. A local program that allows low-income riders to purchase reduced or free bus passes may not be well known among low-income populations. Also, buses stop running at 7:00 p.m., which discourages some providers from extending office hours. Transportation may be less of a barrier for individuals covered by Medicaid, who can receive vouchers to cover the costs of taxis to and from appointments with health care providers. However, long wait times and unavailability of taxi service can present problems for this population.

The safety net assessment team conducted focus groups

with residents who receive their care from safety net providers in the Lincoln area. The focus groups were held on August 25 and 26, 2003, at the Community Mental Health Center, Matt Talbot Soup Kitchen, and the Hispanic Community Center. Focus group participation was voluntary. Participants were recruited with the help of the local community partner, the Community Health Endowment of Lincoln. 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 25 individuals participated in the focus groups. One group, comprised of Latino participants who were bilingual, elected to conduct their discussion in English rather than Spanish. Two additional focus groups were conducted in English as well.

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

LATINO RESIDENTS

Latino participants reported that their health care needs were being overshadowed by those of smaller numbers of underserved refugees, to whom they referred as ‘the New Americans.’ Latino participants voiced concerns that their health care needs were second to those of these refugee groups, in large part because they did not enjoy the same legal status as the refugees. These participants indicated that they were underrepresented in decision-making positions, including boards of hospitals, clinics, and foundations.⁵⁶

Latino participants had mixed reactions to their interactions with clinics and hospitals in the area. They were pleased with the care they received at the Urban Indian Health Center and had concerns about whether they would feel welcome at the new Peoples’ Health Center, which has strong relationships with the refugee communities. Some participants felt that they had been mistreated or treated unprofessionally by hospital staff, perhaps because they could not speak English well. Participants were uniform in their frustration with the lack of interpreter services in the community and told stories of having hospital janitors or kitchen staff interpreting during encounters with physicians or other health care providers.

Latino participants were eager to learn more about the health care system and the value of various preventive services. They appeared to be well-aware that they are at higher-than-average risk for certain chronic disease and appreciated the association between better understanding and improved health status. Several called for more community and lay health care workers to carry out health education efforts.

HOMELESS RESIDENTS

Access to primary care was a concern of homeless focus group participants, who discussed their difficulties finding primary care physicians willing to see new patients. They also reported long waiting times (up to one month) when seeking care with their regular doctor. Some reported waits of up to four months for care at the health department’s clinics.⁵⁷ Many reported that, when faced with such long waits, that they would instead choose to go to the emergency department.

These participants also found the costs of medication for chronic conditions to be well beyond their means. Some were aware of, and had used, the Grapevine Project to secure medications, while others reported that they were not eligible for the program. Several reported rationing their medications, in some cases taking half doses of insulin, to stretch their supplies until they could afford more.

“If you have depression and they’re chasing after you to get bills paid, it makes you even more depressed.”



Some homeless participants reported good experiences at BryanLGH hospital emergency department, having experienced relatively short waits for care and few questions about their ability to pay. Others were not as enthusiastic, however, and felt pressured to pay up-front for services. When unable to pay the bills, they were contacted by collection agencies. Participants also had mixed experiences with Lincoln's mental health and substance abuse providers. Several had received care involuntarily at the detoxification center or at the crisis center or hospital. Many felt that they were not treated with dignity and respect.

Dental care is a significant unmet need among the homeless clients with whom we spoke. Many reported that there are few places available to them because of their lack of insurance. Some receive care through a mobile van that conducts dental assessments. Others seek care at the health department or the dental college, although there are often long waits for service.

Transportation is a major barrier to care for homeless individuals, as well as other focus group participants. While downtown travel appears to be relatively convenient using public transportation, that is not the case when traveling in other areas, such as south of the city. Waiting times between buses can be long, and buses do not run after 7:00 p.m. or on Sunday. Many participants said that they cannot afford the \$1 cost of a bus ride. Individuals on Medicaid reported that they sometimes use taxis to get to and from doctors' visits and some others can arrange for transportation 24 hours in advance of their appointment through their provider. Several participants wished it were easier to get bus passes.

CONSUMERS OF MENTAL HEALTH SERVICES

Many of the mental health clients in the focus group received their primary health care from the Lincoln Medical Education Program (family practice residency program). They reported that they can usually obtain care the same day for an urgent problem. Routine appointments are usually scheduled a month in advance.

All the participants had experience seeking emergency mental health care at the emergency department. Some complained that they had experienced waits of up to five hours while in a state of severe anxiety, paranoia, or crisis. A few reported that they had been turned away from the emergency department; these individuals appear to have had frequent visits to the emergency department and were well known to staff.

Seeking outpatient mental health services has been challenging for several of the focus group participants. Several participants described difficulties in finding a psychiatrist for care. The scarcity of outpatient services can have a real impact on clients' lives. One patient stated, *"Activities and groups keep me focused and stable. It's healthy for me and keeps me out of the hospital."*

Participants had experienced, first-hand, the shortage of mental health care beds for patients with serious conditions. When one woman sought inpatient care for her mental health problems, she found it difficult to find a facility that would take Medicaid, and many required some payment up front. Some participants felt they were discharged too soon because other patients were waiting for the beds. Two participants expressed concern for their safety when, as mentally ill patients in the Crisis Center, they shared space with people who were under arrest for violent crimes.

Many described the challenges of being uninsured and trying to pay mounting hospital and doctor's bills. Several had bills go to collection agencies and more than one filed for bankruptcy. One participant stated, *"If you have depression and they're chasing after you to get bills paid, it makes you even more depressed."* The high cost of prescription medications was also a challenge for some of the focus group participants.

OVERVIEW

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

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

In this section of the report, we provide an analysis of ED use at BryanLGH Medical Center. Using a profiling algorithm,⁵⁸ we were able to classify visits as either emergent or non-emergent. We were able to further identify what portion of these visits were primary care treatable, preventable/avoidable or non-preventable/non-avoidable. Communities should use this information to further understand the dynamics of health care delivery. These data, however, do not tell the whole story and should not be viewed as a comprehensive analysis of emergency department use in the community.

THE ED USE PROFILING ALGORITHM

In 1999, John Billings and his colleagues at New York University developed an *emergency department use profiling algorithm* that creates an opportunity to analyze ED visits according to several important categories.⁵⁹ The algorithm was developed after reviewing thousands of ED records and uses a patient’s primary diagnosis at the time of discharge from the ED to apportion visits to five distinct categories. These categories are:

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

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

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



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

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

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

The data from the ED utilization category must be interpreted cautiously and are best viewed as an indication of utilization rather than a definitive assessment. This is because the algorithm categorizes only a portion of visits and does not include any visits that result in an inpatient admission. For many hospitals, visits that result in an inpatient admission are not available in ED electronic databases. Presumably, since these visits

warrant inpatient treatment, none would fall into the non-emergent category. Excluding these visits may inflate the primary care treatable (both emergent and non-emergent) categories. However, ED visits that result in an inpatient admission generally do not comprise more than 10-20 percent of total ED visits and would likely have a relatively small effect on the overall findings. A larger effect could occur if more visits were categorized by the algorithm. Since a sizeable percentage of ED visits remain unclassified, percentages or visits that are classified as falling into one of the four emergent or non-emergent categories should be interpreted as a conservative estimate and may understate the true values in the population.

ED USE AT BRYANLGH MEDICAL CENTER

As part of the *Urgent Matters* safety net assessment process, we collected information on ED visits at BryanLGH for the period July 1 through December 31, 2002. There were 23,294 ED visits for the six-month period that did not result in an inpatient admission.⁶⁰ Table 5 provides information on these visits by race, coverage, age and gender.

Table 5 Demographic Characteristics of ED Visits

Race		Coverage		Age		Gender	
White	47.2%	Commercial	42.6%	0-17	20.2%	Female	52.4%
Unknown	52.8% ⁶¹	Medicaid	23.5%	18-64	67.9%	Male	47.6%
		Medicare	14.3%	65+	11.9%		
		Uninsured	13.8%				
		Other	5.8%				

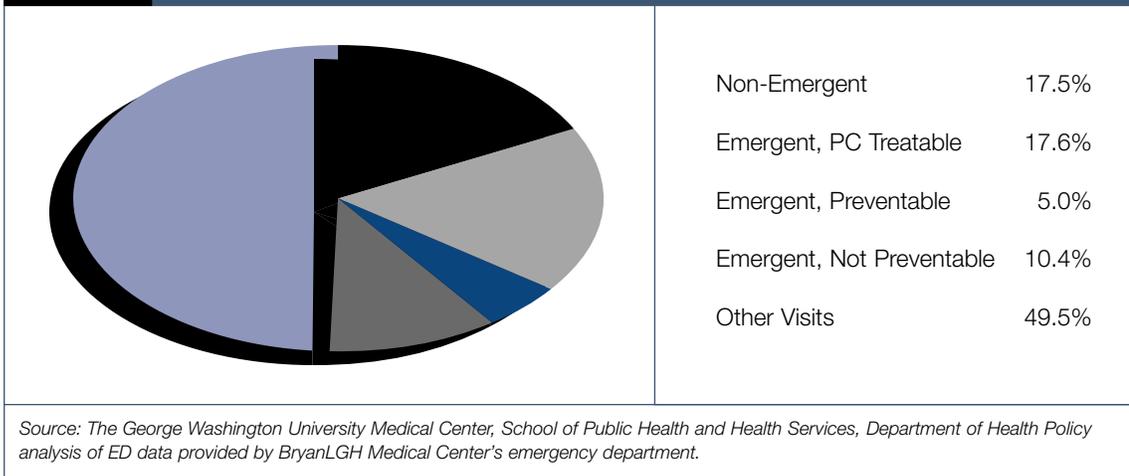
Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy analysis of ED data provided by BryanLGH Medical Center's emergency department.

KEY DEMOGRAPHIC CHARACTERISTICS OF ED VISITS

Approximately half of ED visits at BryanLGH were for patients who were white. This may understate the number of visits to patients who were white because of high rates of missing data on the race/ethnicity of the patient population.

More than four out of ten patients were commercially insured. Nearly one-quarter of ED visits were for Medicaid patients. About one of seven visits was for a patient who was uninsured.

One-fifth of all ED visits were for children.

Figure 1 Visits by Emergent and Non-Emergent Categories

A significant percentage of visits to BryanLGH's ED could have been treated in settings other than the ED. As Figure 1 demonstrates, 17.5 percent of ED visits at BryanLGH were non-emergent and another 17.6

percent were emergent but primary care treatable. Thus, one-third of all ED visits that did not result in an inpatient admission could have been safely treated outside of the ED.⁶²

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

These findings differ across various categories. Medicaid patients and the uninsured used the ED for non-emergent conditions at higher rates (2.04 and 1.96) than did commercially insured and Medicare patients (1.53 and 1.33 respectively).⁶³ Contrary to the results of similar analyses conducted at many other hospitals, these results indicate that commercially insured patients were not using the BryanLGH ED at rates equal to uninsured or publicly insured patients.

Table 6 Relative Rates for ED Visits at BryanLGH Medical Center

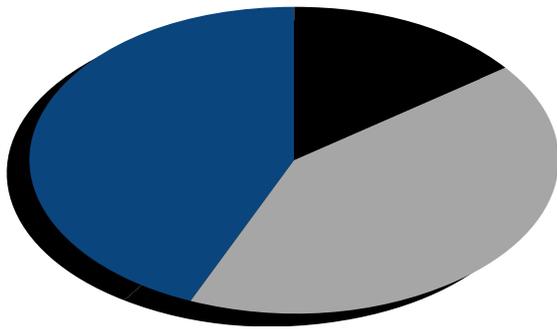
	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/Avoidable	Emergent, ED Care Needed Not Preventable/Not Avoidable
Total	1.68	1.69	0.48	1.00
Insurance status				
Commercial	1.53	1.60	0.42	1.00
Medicaid	2.04	2.00	0.62	1.00
Medicare	1.33	1.47	0.41	1.00
Uninsured	1.96	1.96	0.59	1.00
Age				
0-17	1.93	1.89	0.58	1.00
18-64	1.73	1.71	0.49	1.00
65+	1.24	1.44	0.37	1.00
Race				
White	1.88	1.79	0.54	1.00
Other/unknown	1.50	1.62	0.43	1.00
Sex				
Female	1.78	1.72	0.48	1.00
Male	1.57	1.66	0.50	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 BryanLGH Medical Center's emergency department.

Age appears to be a factor in ED use, although its effect does not appear to be as strong as is seen in analyses of ED data from other hospitals.⁶⁴ Children were somewhat more likely than other patients to use the ED for non-emergent and emergent primary care treatable conditions. The data do not allow comparisons in utilization by the race of the patient.

Most ED visits at BryanLGH occurred during the hours of 8:00 am to midnight. As Figure 2 illustrates, only about 17 percent of visits that did not result in an inpatient admission occurred between midnight and 8:00 am.

Figure 2 ED Visits by Admit Time



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

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

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

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/Avoidable	Emergent, ED Care Needed Not Preventable/Not Avoidable
Total	1.68	1.69	0.48	1.00
Admit time				
8 am – 4 pm	1.62	1.67	0.47	1.00
4 pm – midnight	1.75	1.75	0.52	1.00
Midnight – 8 am	1.56	1.65	0.46	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 BryanLGH Medical Center’s emergency department.

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

KEY FINDINGS

After examining key components of the Lincoln safety net, the assessment team identified the following key findings:

The safety net in Lincoln, Nebraska, consists of a patchwork of providers with little or no formal collaboration among them. While there are some instances of cooperation among providers, these efforts are limited and Lincoln providers generally undertake their clinical operations independent of one another.

Limited resources and general physician shortages in Lincoln reduce access to health care for all patients, regardless of their insurance status. Uninsured and Medicaid patients, however, are especially affected by these problems. Uninsured patients experience long wait times for primary care, subspecialty care, mental health and dental services. Although most physicians in Lincoln and Lancaster County serve Medicaid patients, at least half are not accepting new patients. New Medicaid patients have limited options for seeking health care.

The safety net lacks referral mechanisms for linking patients who lack medical homes to community providers. These patients often present to emergency departments with non-emergent conditions. BryanLGH West operates a small case management program that focuses on individuals who have multiple emergency department visits; however, the program is limited and reaches only a small portion of the underserved population.

A significant percentage of emergency department visits at BryanLGH Medical Center are for patients whose conditions are non-emergent. About 17 percent of all emergency department encounters that did not result in an admission were for patients who presented with non-emergent conditions. Another 18 percent were for patients whose conditions were emergent but could have been treated in a primary care setting.

Existing interpreter services in the health care community are inadequate. Some interpreter services are available via telephone access lines, but these services may be cumbersome to use and calls may be cut short to conserve resources. Interpreter services are expensive, making it difficult for providers to offer them. The cost of this resource often exceeds the payment providers receive for visits from these patient populations.

Refugees and immigrants need to be educated in a culturally sensitive manner about use of the health care system, available services, and the importance of receiving preventive care. In particular, educational programs should address how cultural traditions and preferences hinder refugees and immigrants from seeking needed services.

Transportation remains a major obstacle for uninsured, low-income populations trying to access health care. Bus routes run primarily in the downtown area and do not run at convenient times.

Rides to medical providers can take over an hour.

Latino and black residents report that their needs are overshadowed by those of the New Americans—i.e., refugees who account for a much smaller percentage of underserved residents. Latinos, in particular, believe that their concerns are discounted, largely because many are undocumented and do not enjoy the same legal status as the refugees.

Latino residents indicated that they were underrepresented in decision-making positions, including board of hospitals, clinics and foundations.

ISSUES FOR CONSIDERATION

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

Safety net providers, community health workers and case managers should work together to measure existing capacity and to identify areas needing expansion and better execution. All components of the safety net should be studied. In particular, such a study should include a close examination of the mental health and substance abuse systems to identify opportunities for re-engineering care delivery and making existing capacity more efficient. Additionally, an inventory of the current safety net system could determine whether services and programs that are particularly important to uninsured and underserved populations are available and adequate. These include transportation, interpreter services, education and information programs, and service coordination.

Collaboration among existing safety net providers should be encouraged and developed as a way of increasing overall capacity. Efforts should focus on a systematic approach to service delivery, recognizing the strengths of each of the organizations in the safety net structure and the potential additional capacity that each may offer. Stakeholders should look to the People's Clinic as a model for successful collaboration in the community.

Hospitals and other safety net providers should develop formal referral networks to improve access and outcomes for patients who present at the ED with non-emergent conditions but who have no medical homes. Opportunities for improving overall care rest with educating patients about the availability of important primary care services in the community.

Key stakeholders should make concerted efforts to include more Latinos, African-Americans and refugees on the boards of major health care providers and funders in the community. Improving representation among traditionally underrepresented groups could result in enhanced awareness of safety net issues in the Lincoln community.

All Lincoln area hospitals should conduct analyses of the use of their emergency departments for emergent and non-emergent care. Such studies would help determine whether area hospitals are experiencing trends in the use of their EDs similar to those seen in safety net hospitals around the country. Hospitals, community providers and other stakeholders should use the results of these studies to develop strategies for reducing crowding in hospital EDs.

- 1 Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered*, (Washington, DC: National Academy Press, 2000): 21.
- 2 Peoples' Health Center Application for Federal Assistance, 18 April 2003.
- 3 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. The data can be found at www.census.gov/acs/www/Products/Profiles/Single/2002/ACS/index.htm. U.S. Census Bureau, 2003. *American Community Survey Profile 2002: Lancaster County, Nebraska, Profile of General Demographic, Social and Economic Characteristics*. Washington, DC: U.S. Census Bureau.
- 4 Peoples' Health Center Application for Federal Assistance, 18 April 2003.
- 5 Nebraska Department of Health and Human Services, "County Profile Highlights—2002 Lancaster County," www.hhs.state.ne.us/profile1102/lancaster/highlight.pdf (as of December 2003).
- 6 National Association of Community Health Centers, *Resources to Expand Access to Community Health (REACH) Data 2002*, (Bethesda, MD: NACHC, 2002). The REACH data are based on Census Bureau data and provide estimates on the number of persons by poverty level, age, gender, race, and primary sources of health insurance for each county in the U.S. in 2000. Estimates are based on the 2000-2002 pooled data from the Census Population Survey and the 2000 Census of the United States which are provided by the Bureau of Census.
- 7 Nebraska Health and Human Services, "Reminder to Verify Medicaid Eligibility before Providing Services due to Changes in Eligibility for Kids Connection and Nebraska Medicaid Clients," *Provider Bulletin*, 15 October 2002.
- 8 Governor Mike Johanns, "Grant to Assist in Development of Expanded Health Insurance Plan (News Release)," 10 October 2003, gov.nol.org/johanns03/newsroom/oct03/healthInsurance.htm (as of November 2003).
- 9 September 2003 is the last month for which data are available for both the state of Nebraska and the Lincoln Metropolitan Statistical Area. Rates are not seasonally adjusted. See U.S. Department of Labor, Bureau of Labor Statistics, www.bls.gov
- 10 Nebraska Department of Health and Human Services, "Area Profile—Lancaster County 2002," www.hhs.state.ne.us/profile1102/lancaster/data.pdf (as of November 2003).
- 11 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 reimbursements.
- 12 People's Health Center Application for Federal Assistance, 18 April 2003.
- 13 An FQHC look-alike, based on a determination made by the Health Resources and Services Administration, meets the requirements of the Section 330 (migrant and community health center) grant program but does not receive the grant. FQHC Look-Alikes receive no Section 330 Federal funding but are eligible for cost-based reimbursement under Medicaid and Medicare and participate in the 340(b) Federal Drug Pricing program. See www.bphc.hrsa.gov/CHC/CHCInitiatives/fqhc_lookalike.asp
- 14 The State Children's Health Insurance Program (SCHIP), also known as Title XXI, was passed as part of the Balanced Budget Act of 1997. SCHIP provides \$40 billion in Federal matching funds over 10 years to help states expand health care coverage to uninsured children.
- 15 Unpublished data from Urban Indian Health Center, August 2003.
- 16 Special Supplemental Nutrition Program for Women, Infants, and Children, better known as WIC.
- 17 Emergency Department Data for BryanLGH Medical Center provided to *Urgent Matters* for analysis purposes. Data apply to 2002.
- 18 Unpublished data from Community Mental Health Center of Lancaster County, August 2003.
- 19 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 20 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 21 E. Kruska, "Legislator's Guide to The Nebraska Medicaid Program and Children's Health Insurance Program," March 2002, www.nabho.org/new_page_1.htm
- 22 In 2003, the FPL was \$8,980 for an individual and \$18,400 for a family of four (US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2003).
- 23 Nebraska Health and Human Services, "Reminder to Verify Medicaid Eligibility before Providing Services due to Changes in Eligibility for Kids Connection and Nebraska Medicaid Clients," *Provider Bulletin*, 15 October 2002.
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- 25 Disproportionate Share Hospital payments provides additional funding to hospitals that provide a disproportionate amount of care to Medicaid and uninsured populations.
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- 27 J. Tolbert, ed. *Safety Net Financing: A Source Book for Healthcare Executives*, (Washington, DC: National Association of Public Hospitals and Health Systems, 2003).
- 28 Nebraska Hospital Association, "Details of House-Senate Medicare Agreement," 21 November 2003, www.nhanet.org/advocacy/advocacy_news.htm?topic=details&news_id=321 (as of December 2003).
- 29 National Republican Legislators Association, "21st Century Medicare: More Choices—Better Benefits: What the Bipartisan Agreement Means for Nebraska," 23 November 2003, www.nrla.net/policypapers/nebraska.pdf

- 30 Community Mental Health Center of Lancaster County, *Annual Report 2001, Fiscal Year 2000 Annual Statistics covering the period July 1999 through June 2000*, (Lincoln, NE: CMHC, 2002).
- 31 Ibid.
- 32 Funding includes federal/state and county dollars and accounts for nearly two-thirds of funding, while the city of Lincoln provides 13 percent of Cornhusker Place's revenue. See Cornhusker Place, *2001-2002 Annual Report*, (Lincoln, NE: Cornhusker Place, 2002).
- 33 Community Health Endowment of Lincoln, *Annual Report to the Community 2002-2003*, (Lincoln, NE: Community Health Endowment of Lincoln, June 2003).
- 34 Ibid.
- 35 Community Health Endowment, unpublished data, 2003.
- 36 Community Health Endowment, *40 Solutions: Improving the Health Status of Lincoln Census Tracts 4, 17, and 18. Results of the Blueprint Project*, (Lincoln, NE: Community Health Endowment of Lincoln, November 2002).
- 37 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 38 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 39 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 40 BryanLGH hospital will expand its facilities to include 77 mental health beds and six observation beds by April 2004.
- 41 Nebraska's Department of Health and Human Services (HHS) directly operates three Regional Centers (public psychiatric hospitals) in Lincoln, Hastings, and Norfolk, Nebraska. They provide acute inpatient, secure residential and intermediate residential services and coordinate services with available community resources.
- 42 Governor Mike Johanns, "Gov. Johanns Unveils Plan for Mental Health Reform," 19 November 2003, <http://gov.nol.org/johanns03/newsroom/nov03/mentalhealthreform.html> see also, Governor Mike Johanns, "Gov. Johanns Unveils Plan for Excellence in Behavioral Health," 15 December 2003, <http://gov.nol.org/johanns03/newsroom/dec03/behavioralhealth.html> (as of December 2003).
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- 44 Ibid.
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- 46 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 47 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 48 Planning and Connecting (PAC), *Blueprint Project Coalition: An Evaluation and Survey Report of 1220 Men and Women Regarding Access to Health Care and Barriers to Health Services*, 16 September 2002.
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- 51 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 52 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 53 Community Health Endowment, *40 Solutions: Improving the Health Status of Lincoln Census Tracts 4, 17, and 18*, November 2002.
- 54 Planning and Connecting (PAC), *Blueprint Project Coalition*, 16 September 2002.
- 55 Personal communication with interviewees. Interviews were held between summer 2003 and winter 2004.
- 56 Similarly the Blueprint Project found that, "the people who are most adversely affected by public policy health problems have little voice in policy-making or service delivery, yet these same people have important insights into creating workable solutions." Community Health Endowment, *40 Solutions: Improving the Health Status of Lincoln Census Tracts 4, 17, and 18*, November 2002.
- 57 Lincoln-Lancaster County Health Department reports wait times are actually between six and eight weeks.
- 58 The algorithm presented here uses a methodology that has been replicated in numerous communities in the country to categorize emergency department visits data. The algorithm does not address the issue of appropriate use of the ED for non-emergent and/or primary care treatable conditions. This issue has been discussed extensively in the peer-reviewed literature. For a summary of these discussions see: L. Richardson and U. Hwang, "Access to Care: A Review of the Emergency Medicine Literature," *Academic Emergency Medicine* (Volume 8, no. 11, 2001) 1030-1036.
- 59 For a discussion of the development of the algorithm and the potential implications of its findings, see: J. Billings, N. Parikh and T. Mijanovich, *Emergency Room Use: The New York Story*, (New York, NY: The Commonwealth Fund, November 2000).
- 60 There were an additional 5,107 ED encounters that resulted in an inpatient admission.
- 61 Includes patient visits classified as other or unknown.
- 62 These figures are relatively low compared to findings from analyses of other *Urgent Matters* grantee hospitals' data. BryanLGH has a high percent of visits that are not included in the algorithm. Thus, the findings may indicate that there is lower use of the ED for non-emergent or primary care treatable conditions; in the alternative, the data could reflect the limitations of the method of analysis and understate the amount of primary care conditions that are being treated in the ED.
- 63 It is important to note that these findings refer to the allocation of visits across emergent and non-emergent categories and do not address whether uninsured patients use the ED, per se, in greater numbers than insured patients. This assessment would not be possible in the absence of better data on ED use across many more hospitals in the Lincoln area to determine whether uninsured patients were using ED care at higher rates than insured patients.
- 64 Children often use the ED for non-emergent care at higher rates than patients in other age categories. These findings are seen in several of the *Urgent Matters* ED use profiling analyses.

URGENT MATTERS GRANTEE HOSPITALS AND COMMUNITY PARTNERS

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Community Partner: Health Care for All

Project Director: Marcia Hams

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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

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Project Director: Rhonda Nelson, RN

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Project Director: Jill Rissi

Grantee Hospital: St. Joseph's Hospital and Medical Center

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Grantee Hospital: Elmhurst Hospital Center

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Project Director: William Rasco

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