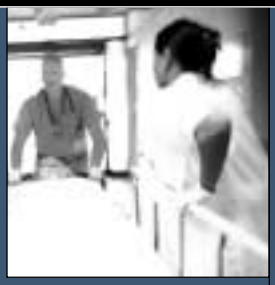
AN ASSESSMENT OF THE

SAFETY NET

in San Antonio, Texas



Urgent Matters

The George Washington University Medical Center

School of Public Health and Health Services

Department of Health Policy

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The mission of GSAHC is to provide leadership in educating, communicating, and coordinating health care providers to improve the health of the San Antonio and Bexar County region. More information on GSAHC can be found at www.gsahc.org.

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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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Foreward

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

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

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

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

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Executive Summary

The *Urgent Matters* program is a new national initiative

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

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

To set the context for this study, the team drew upon secondary data sources to provide demographic information on the populations in San Antonio, 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 University Health System provides care that could safely be provided in a primary care setting.

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

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

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

San Antonio's hospitals, clinics, federally qualified health centers, mental health providers, private sector physicians, public health departments, and community based organizations recognize the need to collaborate on numerous issues to improve access to care for all residents. However, the health care system remains significantly fragmented.

The demand for safety net services in Bexar County is expected to grow due to general increases in the population as well as growth in the number of individuals who are employed but uninsured. Reductions in Medicaid and CHIP eligibility and benefits are likely to adversely affect access to needed services.

Care*Link* is a unique program that provides uninsured residents access to a network of care while reimbursing providers for services rendered. Funding constraints, however, limit the number of residents who benefit from the program. Care*Link* enrolls only about 15 percent of the uninsured in the county, creating a gap in access to care for most of the uninsured. Uninsured residents not covered by Care*Link* face challenges in accessing care because few providers are willing to treat them.

The distribution of primary care providers across the county is uneven, posing access issues for some residents. Few providers are located in neighborhoods where uninsured and underserved residents live.

Data from the University Health System show that a significant percentage of emergency department visits are for patients whose conditions are non-emergent. About 16 percent of all emergency department encounters that did not result in an admission were for patients who presented with non-emergent conditions. Another 17 percent were for patients whose conditions were emergent but could have been treated in a primary care setting.

Access to specialty care is particularly problematic for low-income residents. Many specialists are unwilling to serve low-income residents who cannot afford to pay for care out of pocket. Even those enrolled in Care*Link* must often wait six to nine months for an appointment with a specialist.

Both outpatient and inpatient mental health services are extremely limited and the burden of caring for patients with these issues often falls to the emergency departments. Only a small segment of the Bexar County population qualifies for state-sponsored mental health services.

Many safety net providers struggle to maintain levels of care in the midst of shrinking support from the county for care of the uninsured. Given the gaps that already exist in care for the uninsured and underserved, any additional cuts would further weaken an already fragile and fragmented system of care.

Recent collaborative efforts by the major stakeholders in the health care community have resulted in improved coordination of trauma care services. This same type of collaboration may support future efforts to raise awareness at the local and state levels of the fragility of the safety net in San Antonio and develop solutions to the increasing demand for safety net services.

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

Hospitals, safety net providers and public officials must continue to work together to address the gaps in coverage and health care access for the uninsured and underserved. Similar collaborative efforts have resulted in significant county-wide improvements in ED diversion and in the provision of trauma care. Given the state's fiscal crisis and its overall Medicaid policy, this type of collaboration remains one of the few available resources for addressing the deteriorating mental health system and lack of access to specialty services for uninsured and underserved residents.

The collaboration of safety net providers, community-based organizations, faith-based institutions and other stakeholders is essential for re-enrolling children in CHIP. Given that children must now be re-enrolled in CHIP every six months instead of every year, stakeholders should work together to notify families with children currently enrolled in CHIP of approaching re-enrollment dates. Keeping children enrolled in CHIP will help ensure their continued access to the full range of services, including preventive health care.

San Antonio should consider examining existing bus routes and evaluate the effectiveness of the transportation system in enabling the uninsured and underserved populations to access important services. The lack of a convenient transportation system, particularly south of downtown, makes access to important primary and preventive services more difficult and could contribute to greater emergency room use among neighborhood residents.

San Antonio's safety net providers should consider maintaining and expanding successful programs that have increased access to health care of uninsured and underserved populations. For example, linkages between Care*Link* and health care providers have provided access to a "medical home" for thousands of uninsured families who do not qualify for Medicaid.

San Antonio should consider exploring opportunities for expanding capacity at the two existing federally qualified health centers. With limited state and local resources, health centers should consider pursuing additional federal grants to create or expand the number of service sites. Although the health centers have multiple sites in other underserved communities, the area south of downtown San Antonio continues to suffer from a lack of primary care practices willing to serve neighborhood residents.

San Antonio must monitor changes in the provision of safety net services as health systems convert from nonprofit to for-profit status. Given the concern about possible reductions in the amount of uncompensated charity care provided at those hospitals, a surveillance or reporting mechanism must be in place to help develop realistic remedies for hospitals experiencing an increased burden of uncompensated care.

Public awareness campaigns and outreach efforts to educate patients regarding alternatives to the ED for obtaining health care services care must be employed. Such programs can describe other primary care options for uninsured and underserved patients, such as University Health System clinics, urgent care facilities, and federally qualified health centers. They can also explain how people can apply for services through Care*Link*.

All San Antonio area hospitals should conduct studies examining the use of their emergency departments for emergent and non-emergent care. Such studies would help determine whether area hospitals are experiencing ED-use trends that are similar to those seen in safety net hospitals. Hospitals, community providers and other stakeholders should use the results of these studies to develop strategies for reducing crowding in the 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, the *Urgent Matters* program takes IOM's research a step further and examines the interdependence between the hospital emergency department (ED)—a critical component of the safety net—and other core safety net providers who "organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."[1]

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

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.*

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

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

The safety net assessments were conducted during the summer and fall of 2003. Each assessment draws upon information obtained from multiple sources. The San Antonio assessment team conducted a site visit from August 11 to 13, 2003. The team toured safety net facilities and spoke with numerous contacts identified by the community partner and others. During the site visit, the community partner convened a meeting of key stakeholders who were briefed on the *Urgent Matters* project, the safety net assessment, and the key issues under review. This meeting was held on August 11, 2003, at the Petroleum Club.

Through the site visits and a series of telephone conferences held prior to and following the visit to San Antonio, 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 San Antonio, as well as data on health services utilization and coverage.

While in San Antonio, the team conducted focus groups with residents who use safety net services. The assessment team worked with the community partner and grantee hospital to recruit patients who were likely to use such services. Finally, the assessment included an application of an ED profiling algorithm to emergency department data from University Health System. The algorithm classifies ED encounters as either emergent or non-emergent cases.

Section one of the San Antonio safety net assessment provides a context for the report, presenting background demographics on San Antonio and Bexar County, Texas. It further describes the structure of the safety net, identifying the providers and facilities that play key roles in delivering care to the underserved. Section one also outlines the financial mechanisms that support safety net services. Section two discusses the status of the safety net in San Antonio 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 University Health System. This analysis includes demographic information on patients who use the emergency department and examines the extent to which the emergency department at University Health System may be providing care that could safely be provided in a primary care setting. Finally, section five presents key findings and issues that safety net providers and others in the San Antonio area may want to consider as they work together to improve care for uninsured and underserved residents in their community.

Background

San Antonio is located within Bexar (pronounced "bear") County in south central Texas, approximately 140 miles north of the Gulf of Mexico. San Antonio's population is growing faster than the general population of the United States. Between 1990 and 2000, the U.S. population increased 13.1 percent, compared to San Antonio's increase of 22.3 percent and the county's increase of 17.5 percent.[2] During the same time period, two of the fastest growing groups were the Hispanic population and the 45-64 age group.[3]

Table 1 provides a snapshot of the population of Bexar County as compared to the population of the entire state. Like the rest of Texas, the population of Bexar County is relatively young (median age 32.9 years). San Antonio is the first major city in Texas north of the Mexican border and over half of the county's population is Hispanic. Forty-one percent of the residents speak a language other than English at home.

Table 1 A Snapshot of Bexar County and Texas

Select Demographics	Bexar County	Texas
Population		
Population	1,409,834	21,215,494
Size (square miles)*	1,247	261,797
Density: Persons/square mile*	1,117	79.6
Race		
White	71.0%	74.7%
Black	6.8%	11.1%
Asian	1.8%	3.0%
American Indian/Alaska native	0.4%	0.4%
Other	20.0%	10.8%
Hispanic origin and race	56.8%	33.9%
Birthplace/Language		
Foreign born	10.5%	15.2%
Language other than English spoken at home	41.0%	31.5%
Age		
18 years and over	71.1%	71.4%
65 years and over	10.0%	9.6%
Median age (in years)	32.9	32.8

Source: U.S. Census Bureau, American Community Survey Profile, 2002 data, unless otherwise noted.[5]
** State and County QuickFacts, 2000, U.S. Census Bureau.*

Table 2 provides additional information about the income and poverty levels in Bexar County. About one in six county residents (15.6 percent), and 24 percent of the children in the county, live in households with incomes below the federal poverty level (FPL).[6] At $38,756, the median household income is $2,620 less than the median income for the state.

Table 2 also provides information on insurance coverage for residents of the county and the state. Nearly five million residents in Texas are uninsured (nearly 23 percent of the state's population), and the rate of uninsured is even higher in Bexar County. Over one in four individuals in the county (26.4 percent)—approximately 372,000 residents—are uninsured. About 11 percent of residents are covered by public insurance programs such as Medicaid and the Children's Health Insurance Program (CHIP).[7] For those persons living below the poverty level, 45 percent are uninsured and 30 percent are publicly insured.[8]

Table 2 Income, Poverty Levels and Insurance Coverage in Bexar County and Texas

	Bexar County	Texas
Income		
Median household income	$38,756	$41,376
Living below federal poverty level		
All individuals	15.6%	15.6%
Children under age 18	23.7%	21.5%
Insurance coverage*		
Commercial	51.9%	56.2%
Medicare	10.6%	10.4%
Medicaid and CHIP	11.1%	10.8%
Uninsured	26.4%	22.7%

Source: U.S. Census Bureau, American Community Survey Profile, 2002 data, unless otherwise noted.
** 2000 REACH Data, National Association of Community Health Centers.*[9]

One factor contributing to the number of uninsured is the rising unemployment. The unemployment rate in Bexar County has been increasing over the last four years and rose to 5.1 percent in the first quarter of 2003.[10] Even employed residents, however, have high rates of uninsurance. Many of the county's residents are employed in construction or service industries such as tourism or retail. The majority of businesses in San Antonio (93 percent) have fewer than 50 employees and many of these small businesses do not provide group health insurance as a benefit.[11] Consequently, San Antonio has a large number of people who work but who do not have health insurance. It appears that many small businesses in the area are reluctant to provide group health insurance given the cost of such a benefit, believing instead that their employees can receive health care for free at the University Health System, the public hospital system for the county.[12]

Structure of the Safety Net

The safety net in San Antonio consists of hospitals, clinics, federally qualified health centers (FQHCs),[13] mental health providers, private sector physicians, public health departments, and community based organizations. In general, health care in San Antonio is dominated by four large health systems—University Health System (UHS), Christus Health Care System, Baptist Health System, and Methodist Health Care System.[14] While all of these health systems provide some care to uninsured and underserved residents, the majority of care for uninsured and underserved patients is provided by UHS, which includes the county's acute-care public hospital, University Hospital.

UHS' patient demographics reflect its role as the primary safety net provider in the area: two-thirds of UHS patients are either indigent or receive services through Care*Link*, a financial assistance program for low-income county residents.[15] In 2001, University Hospital provided $172.7 million in uncompensated care, which represented more than one-third of gross patient revenues.[16]

UHS sees three times as many unfunded indigent patients as do the rest of the local health systems combined. That does not mean, however, that other systems do not provide services to indigent patients. Christus Santa Rosa, in particular, sees a large number of uninsured and underserved patients in its children's and adult hospitals located in downtown San Antonio. Other facilities in San Antonio also provide services to uninsured and underserved persons, including a Ryan White CARE Act Title III clinic, a small clinic operated by the Daughters of Charity (La Mision Family Health Clinic) on the south side of the city, and Methodist Health Ministries, which provides mental health services.

UHS is comprised of University Hospital and clinics in five separate locations. UHS serves as a teaching facility for physicians, nurses and allied health professionals at the University of Texas Health Science Center at San Antonio (UTHSCSA). The University Physicians Group at UTHSCSA was established in 1994 to serve as a contracting vehicle with UHS and other payers. In 1999, UHS established the Community Medicine Associates, which includes approximately 30-35 primary care physicians, in order to increase primary care services at the University Family Health Centers and at the ExpressMed Clinic. The ExpressMed Clinic, the urgent care center located adjacent to the University Hospital ED, was established to offset the high volume of non-emergent visits in its ED. Patients who use the ExpressMed tend to be younger, more educated, have a primary care physician and have some financial resources.

Community First Health Plans, a subsidiary of UHS, is a locally owned non-profit HMO. The health plan was created in 1994 to participate in the state's Medicaid managed care program, the State of Texas Access Reform (STAR) program. Community First Health Plans has nearly 100,000 enrollees in four product lines—Medicaid STAR, the state's CHIP program, a commercial HMO and a PPO.[17]

Care*Link* is a membership program that reimburses providers who care for residents of Bexar County who have no health insurance and who are not eligible for other programs such as Medicaid and CHIP. While Care*Link* is not a form of health insurance, membership in Care*Link* provides one of the few avenues for the uninsured to access health care services at a reduced cost. Through Care*Link*, families with incomes below 200 percent of the FPL may be eligible for a range of covered services. There is no cost to enroll in the program for participants with incomes under 75 percent of the poverty level. Patients with incomes above 75 percent of the FPL pay a sliding scale premium based on income and family size. Care*Link* is administered by the UHS and is supported primarily by property tax revenue. Patients must be county residents to qualify for the program.

Care*Link* currently has approximately 50,000 to 55,000 enrollees. Many more residents could qualify for the program based on income and residence, but funds are limited and unable to meet the demands for services by the uninsured. In part because of limited resources, the program focuses on enrolling the chronically ill.[18] As a consequence of limited resources, Care*Link* supports care for less than 15 percent of the county's uninsured population.

Care*Link* attempts to find each patient a medical home by contracting with physicians associated with UHS as well as with other physicians in the community, such as those working in private practice or in FQHCs. The program was able to be responsive to patient needs by expanding its network of participating primary care physicians through contracts with physicians outside of the University Health System and the University Physicians Group. If a UHS primary care physician cannot see a Care*Link* patient within the two-week period, the patient sees another doctor in the community, such as a physician in private practice or at one of the FQHCs. Physicians treating Care*Link* patients have agreed to accept Medicare rates. Informants indicate some private physicians limit the number of Care*Link* patients that they are willing to see because of the limited reimbursement associated with Care*Link* patients.

San Antonio has two FQHCs, Centro Med and Barrio Comprehensive Health Care, that operate more than a dozen service delivery sites. Both FQHCs have been in existence since the early 1970s and their patients are predominantly Hispanic (87 percent for Centro Med and 83 percent for Barrio Comprehensive Health Care) and poor (92 percent and 87 percent below 150 percent of the FPL, respectively).[19] Centro Med's patient population has increased over the years, but the demographics have stayed fairly constant.[20] The clinics provide services in family practice, internal medicine, obstetrics and gynecology and pediatrics, as well as mental health and dental services.

Over the last ten years, the Texas Department of Health (DOH) has shifted away from providing primary care to being in charge of public health in rural areas.[21] The DOH continues to provide preventive services and to support the local health department, Metro Health, in its mission to promote health and prevent disease. Metro Health provides certain preventive health care services, including immunizations for the uninsured, family planning services, well child clinics, women's wellness clinics, and HIV/AIDS/STD services. It also provides dental services, such as treatment and education, to children, adolescents, and adults. Metro Health is funded by city general funds, state and federal funds, some patient reimbursement, and philanthropy. There is no taxing authority for public health.

The number and distribution of health care providers also affect the functioning of the safety net in Bexar County. Table 3 provides the number of physicians and dentists for every 100,000 people in Bexar County. Bexar County has higher rates of direct patient care providers such as primary and specialty care physicians than does the state (189.8 versus 157.2) and higher proportions of dentists as well (43.8 versus 36.7). Many of the providers, however, do not see patients who are uninsured or covered by public programs such as Medicaid and CHIP.

While Care*Link is not a form of health insurance, membership in* Care*Link provides one of the few avenues for the uninsured to access health care services at a reduced cost.*

Table 3 Supply of Physicians and Dentists for Bexar County and Texas

	Bexar County	Texas
Provider supply 2002 *(per 100,000 population)*		
Direct patient care providers*	189.8	157.2
Primary care providers^	77.4	70.7
Dentists	43.8	36.7

Source: Texas Department of Health as of September 2002.
** Direct patient care physicians include primary care and specialty care physicians actively practicing in Texas but exclude residents and fellows, and physicians in the military.*
^ Primary care providers include general practice, family practice, internal medicine, pediatrics, and OB/Gyn.

Trauma Care: San Antonio has three Level I trauma centers and two Level III trauma centers. The Level I trauma centers are located at University Hospital and at the two military hospitals in the area, Wilford Hall and Brooke Army Medical Center (BAMC). The Level III trauma centers are located within the Christus and Methodist health care systems. The three Level I trauma centers provide trauma care for a 22-county service area.[22]

Crowding in the ED commonly creates a need for hospitals to go on "diversion," a situation that signals that an ED has reached its maximum capacity and new cases must be diverted to other emergency departments in the community. Health care leaders in San Antonio have made a concerted effort to address the problem of ED diversion in the community and to address diversion problems specifically related to trauma care. These leaders have created a Diversion Task Force and a Trauma Care Task Force. The Diversion Task Force, which includes representatives from Emergency Medical Services (EMS) and all area hospitals, has been meeting for three years. As a result of the Diversion Task Force, a system was instituted that tracks trauma level care availability and beds. EMS has a web-based system, which divides the geographic area into zones and ED patients are supposed to be taken to an ED within the zone.

As a result of the various task forces, San Antonio has created a trauma consortium which includes private sector and military trauma centers. UHS provides 50 percent of the area's needed trauma care while the military bases provide the other 50 percent. By accepting private trauma patients, the military bases are able to meet one of their goals, which is to train military trauma staff in order to reach a level of preparedness for dealing with trauma patients in the military. Several informants expressed concern that, without both military bases, UHS would be unable to handle the number of trauma patients generated by the 22-county area. In the event that the military bases would have to address other obligations or be called upon as a result of military actions, the trauma care capacity of the area would be severely compromised. The amount of trauma care that is directed to UHS has an impact on the system's ability to care for other patients presenting at the ED.

The Diversion Task Force, which includes the Greater San Antonio Hospital Council, the Southwest Texas Regional Advisory Council on Trauma, and the Texas Hospital Association, has launched a campaign to educate the public regarding the impact of ED diversion. Part of the campaign helps the public understand the importance of the ED for all community residents—regardless of whether someone has health insurance.

Behavioral Health: The Center for Health Care Services (CHCS) and University Hospital are the two largest providers of mental health services in the Greater San Antonio area. CHCS is the community's mental health and mental retardation authority, which was established under the Texas Health and Safety Code. CHCS

is funded primarily through general revenue from the Texas Department of Mental Health and Mental Retardation and through Medicaid. In addition to state funds, services for the indigent are supported through funds from UHS and from a limited number of grants.

CHCS primarily serves Medicaid patients and operates three clinics for adults, one clinic for adults and children, and one clinic for children. Services are delivered by internal and external providers and include a screening by a licensed mental health professional, intake, and assessment, and referrals to a variety of services at multiple locations throughout the community.

CHCS is implementing a jail diversion program, designed to reduce the number of people who end up in jail due to behavioral problems caused in part by mental illness. The program has involved working with the sheriff's office and training officers to deal with people with severe mental illness. With officers trained to recognize and deal with people acting inappropriately as a result of mental illness, CHCS hopes to direct consumers to more appropriate treatment options than the jail or an ED psychiatric unit.

University Hospital estimates that one in six patients presenting at the University Hospital ED have drug or alcohol problems.[23] University Hospital has 35-40 psychiatric beds and eight beds in a locked unit within the ED. University Hospital also has mental health counselors in the ED. The hospital currently has a protocol for patients with chemical dependency problems who are seen in the ED and need to be admitted; the hospital is developing a protocol for patients with chemical dependency issues who need to be seen on an outpatient basis.

Dental Care: Dental services provided by a dentist or a hygienist are available at seven Centro Med locations. Metro Health has four dental clinics available to uninsured patients and services include screenings for the Head Start program, treatments, emergency services for adults, and dental care for pregnant women. The clinics are used as training sites for pediatric dentists.

The 2002 Community Needs Assessment and Health Profiles indicates that 33 percent of the preschool children screened had dental decay during a visit to a WIC clinic.[24,25] The prevalence of tooth decay was twice as high in San Antonio as in other cities in Texas. The water supply for San Antonio was fluoridated for the first time in 2002.

Financing the Safety Net

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

Medicaid and CHIP

In 2002, the Texas Comptroller's office projected that the State of Texas would spend a total of $12.6 billion of federal and state funds on Medicaid with the state's share representing approximately 22 percent of the total state budget.[26] An estimated $638 million would be spent on the CHIP program including federal and state funds.[27]

Eligibility for Medicaid is 158 percent of the FPL for pregnant women,[28] 185 percent of the FPL for newborns up to one year, 133 percent of the FPL for children 1-6, and 100 percent of the FPL for children 6-19.[29] CHIP covers children not eligible for Medicaid up to 200 percent FPL and has a sliding scale of monthly premiums and copayments for services based on family income as a percentage of the FPL.[30]

Table 4 provides information regarding enrollment in Medicaid and CHIP. As of October 2003, 192,095 individuals were enrolled in Medicaid in Bexar County;

Table 4 Medicaid and CHIP Enrollment for Bexar County and Texas

	Bexar County	Texas
Medicaid enrollment*		
All ages	192,095	2,502,068
Ages 0-18	127,243	1,659,184
CHIP program^		
Enrolled	28,545	464,191
To be determined	32,420	486,407

** Source: Texas Medicaid Enrollment. Texas Health and Human Services Commission.*
^ Source: CHIP Application and Enrollment Activity by County. Texas Health and Human Services Commission.
Data are current as of October 2003.

two-thirds of these enrollees were 18 years old or younger. At this same time, 28,545 children were enrolled in CHIP, and another 32,420 children had their applications under review.[31]

This past fiscal year, Texas was faced with a budget shortfall of nearly $10 billion. Like many other states, Texas made changes to its Medicaid and CHIP programs designed to help balance the budget. These changes affect the number of eligible enrollees, covered benefits, and provider reimbursement. Hospital, physician, and HMO reimbursement for Medicaid and CHIP has been reduced by 2.5 percent.[32]

Changes in the Medicaid program include:

- Elimination of optional services for adults over age 21 including mental health services, eyeglasses, hearing aids, podiatry services, and chiropractic services;
- A reduction in maternity coverage eligibility from 185 percent of the FPL to 158 percent of the FPL; and
- A reduction in coverage for the adult medically needy from 24 percent of the FPL to 17 percent of the FPL.

Changes in the CHIP program include:

- Switching the re-enrollment requirement from every year to every six months;
- Establishing a 90-day waiting period between eligibility determination and coverage;[33]
- Eliminating covered benefits for dental services; vision care and eyeglasses, and chiropractic services;
- Reducing the number of days and visits allowable under the mental health and substance abuse benefits;
- Establishing maximum levels of cost-sharing based on the federal guidelines; and
- Increasing monthly premiums per family.

Bexar County will lose an estimated $153.2 million in funding from the Medicaid and CHIP cuts in the 2004-2005 budgets.[34] As many as 20,000 children may lose Medicaid and CHIP coverage in Bexar County. The overall changes in the Medicaid and CHIP programs will reduce the number of residents eligible for these programs and eliminate many of the needed services for remaining enrollees.

Additional Funding for the Safety Net

The Texas Indigent Health Care and Treatment Act of 1985 requires counties to have programs to provide services to the indigent.[35] A number of counties, such as Bexar County, have elected to fulfill this requirement by funding a public hospital with local property taxes. These hospitals serve as the foundation of the safety net in their respective counties and are required to provide a minimum level of services for indigent clients. This effectively shifts caring for the uninsured from the state to the local level.

UHS (which includes University Hospital, the public hospital for Bexar County) relies on multiple sources of revenue to meet this obligation. Sources include patients with some source of payment such as commercial insurance or Medicaid, local property taxes, disproportionate share hospital payments,[36] Upper Payment Limit (UPL) payments,[37] tobacco settlement funds, and other miscellaneous sources. UHS reports that its largest source of funding is from insured patients, accounting for 57 percent of gross revenues. UHS also received $126 million from property taxes in 2002 representing approximately 25 percent of the total budget.[38] Approximately 85 percent of these funds were used to support direct patient care for county residents enrolled in Care*Link*, while the remainder funded care provided to other indigent patients.

In fiscal year 2002-2003, the state appropriated over $1 billion in tobacco settlement receipts; $982.1 million (91.2 percent) of these funds went to the state Department of Health and Human Services with the largest single amount, $419.2 million, funding the CHIP program. Tobacco funds were also designated to support programs that target diabetes and obesity. UHS used its $20.9 million tobacco settlement allocation from 1999 to help fund the Community Health Initiative Fund, which supports projects that address prevention efforts in areas of tobacco cessation, risk reduction for type 2 diabetes, mental health and substance abuse, and women's health issues.

A new source of funding for trauma care will be provided by recent state legislation that increases fines for alcohol-related driving offenses and other moving traffic violations. A portion of the revenue generated by the fines will be used to fund Texas trauma centers. UHS anticipates receiving $1.8 million in 2004 from these new revenues. UHS loses approximately $12 million annually in trauma care provided to unfunded patients; approximately $5.8 million of this amount is accounted for by people who reside outside of Bexar County.[39]

The Texas Tertiary Care Fund, which comes from unclaimed lottery winnings, has historically been used to fund trauma services at University Hospital for residents who live outside of Bexar County. These funds are no longer available in light of the state's budget crisis. Consequently, UHS is unable to include this source of funding in revenue projections after 2002. UHS will be required to provide an increasing amount of unfunded care as a result of losing these funds.

Another source of funding for the safety net is federal funds. Both of the FQHCs located in San Antonio receive funding through federal grants to Section 330 community health centers. By law, these funds must cover the costs of caring for the uninsured. Centro Med estimates that 65 percent of its patient population is uninsured, while Barrio Comprehensive Health Care estimates that 76 percent of its patient population is uninsured.[40] In 2002, Centro Med and Barrio Comprehensive Health Care received $4.0 million and $4.1 million, respectively, in federal grant funds.[41]

The safety net assessment team conducted interviews with key stakeholders in the San Antonio health care community and visited safety net facilities between August 11 and 13, 2003. Our analysis of the San Antonio safety net was greatly informed by the interviews with safety net providers and local stakeholders. Informants discussed important changes in local health policy and programs, emergency department use and crowding, issues relating to access to care, and significant barriers that patients face in seeking health care services.[42]

Overview

Access to care remains a major issue in San Antonio and Bexar County, despite the existence of a public hospital, several other hospitals, outpatient clinics and community health centers. The uninsured and underserved face many difficulties accessing health care services, particularly specialty care, mental health, and dental services. Many individuals described the safety net as being "fragmented;" patients have to seek care from multiple providers, if care can be found at all.

The recent changes to Medicaid and CHIP will put increasing pressure on the hospital EDs in the area, especially on the University Health System ED, as more uninsured and underinsured residents either forgo primary care completely or seek such care in the ED. UHS estimates that changes to Medicaid and CHIP will result in a $15.6 million loss in direct funding for the health system.[43] Reductions in state funds for Medicaid and CHIP will force more of the cost of caring for the uninsured and underserved down to the county level.

In addition to funding uncertainties, a number of factors are expected to affect the future demand for safety net services in the San Antonio community including:

- The growing population within San Antonio, Bexar County, and the surrounding region.
- The increased use of Bexar County health facilities by residents of other counties.
- Increasing numbers of uninsured resulting from cuts in the Medicaid and CHIP programs.
- Continuing high numbers of residents who work but have no insurance.
- Increasing demand for trauma services.
- Increasing numbers of people in the 45-64 year old age group who will require care for chronic conditions, such as diabetes or cardiovascular disease.

While the population of San Antonio has been growing, no new capacity has been created in any of the hospital emergency departments.

UHS and other safety net providers are struggling to find new sources of funding in light of increasing demand for services and reductions in reimbursement. Even with new potential sources of funding,[44] Bexar County and San Antonio will continue to face challenges in meeting ever increasing demand for care.

Limitations on Access to Primary Care

Opinions varied about the adequacy of primary care capacity and, more specifically, about whether there were sufficient numbers of primary care physicians to meet the needs of the uninsured and underserved populations. Some individuals believed that capacity is adequate, especially in the more urban areas of the county, but that the uneven distribution of providers throughout the county creates barriers to accessing timely and appropriate care. Others reported an overall shortage of primary care providers in the county, particularly in the rural areas.

Access to primary care services is closely related to an individual's insurance status. Patients with Medicaid or enrolled in Care*Link* have better access to primary care services than do uninsured patients. Care*Link* patients, for example, are able to see a primary care physician within two weeks. Uninsured patients, on the other hand, may have difficulty finding a primary care provider willing to see them.

Cuts to the Medicaid program are likely to affect access to primary care providers. While Medicaid has been considered a reasonably good payer in Texas, some physicians have already limited the number of Medicaid patients they see, in light of the lower reimbursement they receive from Medicaid as compared with payments made by commercial insurers. As Medicaid reimbursement drops, physicians may be more reluctant to see Medicaid patients, and even less willing to treat uninsured patients who cannot cover the costs of their care out-of-pocket.

Lack of Access to Specialty Care

Difficulties in accessing specialty care services result from the limited number of physicians within certain specialties (particularly cardiologists, neurologists and rheumatologists) as well as from the small number of physicians across all specialties willing to see uninsured patients. While access to specialists is difficult for Medicaid patients, it is nearly impossible for uninsured patients. Even if a specialist is willing to see a patient, there is often a long waiting time for an appointment. While Care*Link* patients only have a two-week wait to see a primary care physician, they often have to wait six to nine months to see a specialist. Physicians complain about not only the limited reimbursement they receive for treating Care*Link* patients, but also about the high no-show rate among patients in this program.

Potential Adverse Impacts of Mergers and Conversions

Historically, health care providers within San Antonio have relied on the large number of local faith-based health care organizations to care for the uninsured and underserved populations in the community. However, two of the faith-based health care systems have converted to for-profit status. In 1994, the Methodist Health Care System became co-owned by HCA and Vanguard Health acquired the Baptist Health System at the beginning of 2003. The results of these conversions have not yet fully played out, but other safety net providers have expressed concern that the amount of charity care provided by these institutions will certainly decline. Along with these mergers and conversions, new specialty hospitals are being developed in San Antonio, creating concern on the part of existing hospitals that these new hospitals will care for the healthiest patients with insurance, leaving the current safety net with an even sicker and poorer patient mix.

Emergency Department Crowding and Stresses on the Trauma Care System

Several trends contribute to the problem of crowding in hospital emergency departments. First, the population is growing while ED capacity has remained unchanged. Second, many of the uninsured and underserved continue to use EDs either as their main source of primary care or as an alternative to existing sites in the community offering primary care services. Many of these individuals seem to be unaware of other options they may have. Third, hospitals are often unable to find physicians from selected specialties willing to take call and to see patients in their EDs.

While the population of San Antonio has been growing, no new capacity has been created in any of the hospital emergency departments. Consequently, EDs in San Antonio are operating well above capacity, causing long waiting times for care. Some EDs are operating at 200 percent capacity.[45] Backlogs in the ED also create bottlenecks in hospital inpatient operations, posing challenges to treating patients safely and effectively. University Hospital is limited, at this time, in its ability to move patients from the ED into available inpatient beds. Licensed for 466 beds, it staffs only 343 of those beds, in part due to a particularly severe nursing shortage.

The most frequent users of the ED are patients with chronic illnesses, the homeless, and patients with mental health problems. These patients tend to show up in the ED fairly often and are less likely to have a medical home in the community where they can receive ongoing care. UHS reports that two groups of patients most often seen in its ED are 18-24 year old adults who either get sick or experience a trauma and 45-64

year old uninsured patients who are developing a chronic condition. Patients seen in the ED are generally referred to a community provider, but finding a primary care provider can be a challenge if the patient is uninsured and is not enrolled in Care*Link*.

The problem of ED crowding is exacerbated by the difficulties that many hospitals have in finding and retaining physicians willing to take call and to see patients in the ED. Certain surgical specialists, such as neurosurgeons, are particularly scarce, creating difficulties for the EDs, which must cover the call schedule adequately. Hospital administrators reported having to pay physicians additional amounts in order to take call. Hospital administrators also reported problems with on-call physicians being reluctant to come in to take care of publicly insured or uninsured patients.

As was mentioned earlier, University Hospital created an urgent care facility, the ExpressMed, near the hospital ED in an effort to reduce the high volume of non-emergent visits in the ED. Another hospital operates a "fast track" within its ED during 12 peak hours of operation. Approximately one-third of the patients presenting at the ED go through the fast track at this hospital. The long-term effects of various efforts to reduce ED crowding remain uncertain.

Other efforts designed to reduce use of the ED for primary care treatable conditions have included increased patient education. More specifically, some have suggested that patient education targeted to parents of young children for problems, such as common illnesses, fevers, stomach aches and the like, might be especially fruitful.

Funding from the state for trauma care is limited as allocations from the Tertiary Medical Care Fund[46] dwindle or are diverted to the state's general funds. Informants expressed concern that the ED and trauma care do not get the same financial support as other public services such as the Fire and Police Departments, yet the public expects that trauma care should always be available. Property taxes from Bexar County cover only a small portion of the indigent care provided for trauma services within UHS. Trauma centers within Bexar County are particularly stressed by having to provide care for many patients from outside of the county. In 2001, 15.5 percent of the total trauma patients were not residents of Bexar County and 37 percent of these out-of-county patients were uninsured and had no means of covering their health care costs. As a result, in 2001, UHS reported that its trauma center lost $5.8 million.

Gaps in Mental Health/Substance Abuse Services

State funds for mental health services may only be used to provide care to two groups in need—adults with severe and persistent mental illness or other severely disabling mental disorders which require crisis resolution and ongoing support, and children and adolescents who meet certain criteria. Thus, many individuals with mental health needs are not eligible for services from one of the largest providers of mental health services, the Center for Health Care Services, because they do not fall within these priority populations. It appears that some mental health services are available through other Bexar County organizations, but these are quite limited. Mental health services for patients in rural areas are even less accessible.

Public funding for substance abuse services is limited as well. The county does not have any beds designated for patients needing detoxification or rehabilitation services. The state hospital for patients with mental health problems has inpatient beds but does not offer any ED services. The sources of mental health services are not integrated with systems for medical care, which means that patients must have a different set of providers for medical and mental health needs. This reduces the chances that the patient's care is being coordinated among all the different providers.

The safety net assessment team conducted two focus groups

with residents who receive their care from safety net providers in the San Antonio area. The focus groups were held on August 11, 2003, at the University Health Center-Downtown. Focus group participation was voluntary; participants were recruited with the help of the grantee hospital, the University Health System, which involved displaying flyers announcing the sessions and their schedules. Participants received $25 each in appreciation of their time and candor. A total of twelve individuals participated in the focus groups, most of whom were patients of the University Health System primary care system. Both focus groups were conducted in English.

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

Barriers to Care

As has already been noted, the ability of people in Bexar County to access health care services is largely a function of whether or not they have health insurance. In general, comments by the focus group participants about their ability to access health care services reflected their insurance status. The participants had various experiences with Medicaid coverage, eligibility for services via Care*Link*, and being uninsured. Patients with Medicaid or those patients who were able to access services through Care*Link* reported fewer difficulties finding a primary care physician than did patients without any type of coverage. All groups, even those with Medicaid or access to Care*Link,* experienced difficulties accessing specialists, and complained of long waits for appointments. Patients often waited several months to actually see a specialist physician even after receiving a referral.

Focus group participants without Medicaid or Care*Link* generally reported having no usual source of primary care. Uninsured participants said they often delayed seeking health care until it was absolutely necessary. When they finally sought care, they often turned to the ED. In one participant's words, "*Where else can we go? We try and wait so we're not a burden on the system since we can't pay. But after a certain point, what choice is there but the hospital?*" Another participant had the following comment: "*When you're uninsured, you're basically walking a tightrope. You deal with things on your own for as long as you can, and then you just hope that somebody will take care of you. We do have good hospitals here.*"

Participants expected long waits at any of the hospital EDs and attributed those waits to understaffing at the hospitals and to the uninsured not being aware of other places where they could go in the community for primary care. Despite the anticipated long waits, participants felt that the overall quality of hospitals in San Antonio was generally high. The quality at University Hospital was seen as excellent and was a preferred hospital because of its strong trauma center.

Care*Link* was viewed as an invaluable program that provides important access to much needed services for county residents. According to its users, the strengths of Care*Link* include the ease of making primary care appointments, the friendliness of the office staff and practitioners, and the availability of low-cost prescription drugs. According to one participant, "*The older you get, the more complicated your health gets…so I rely a lot on* Care*Link.*"

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

Transportation was another barrier to care cited by focus group participants. While primary care providers appear to be relatively accessible for patients, patients often have to travel a long time to see a specialist. A number of people rely on public transportation to get to their doctors appointments or to the hospital, which can often be inconvenient.

Focus group participants had limited experience with mental health or substance abuse problems and were unable to talk about the ease or difficulty in accessing these types of services. Participants felt that they did have some options for accessing dental services as there are a number of low-cost dental providers in different San Antonio neighborhoods as well as the dental school at the University of Texas, which provides services on a sliding-scale fee basis.

In general, lack of knowledge about options for care was a problem echoed by the focus group participants. Patients felt they did not have sufficient information about the resources available to them in the San Antonio area.

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 accessibility of timely care outside of the ED. Whether it serves as a first choice or last chance source of care, the ED provides a valuable and irreplaceable service for all community residents, including low-income underserved populations.

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

In this section of the report, we provide an analysis of ED use at the University Health System. Using a profiling algorithm,[47] we were able to classify visits as either emergent or non-emergent. We were able to further identify what portion of those visits was 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.[48] 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 distinct categories. These categories are:

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

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

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

Visits that are classified as needing ED care are classified as either non-preventable/non-avoidable or preventable/avoidable. The ability to identify visits that

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 accessibility of timely care outside of the ED.

would fall in the latter category may offer opportunities to reduce costs and improve health outcomes: patients who present with emergent but preventable/avoidable conditions should be treated earlier and in settings other than the ED.

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

The data from the ED utilization category must be interpreted cautiously and are best viewed as an indication of utilization rather than a definitive assessment. This is because the algorithm categorizes only a portion of visits and does not include any visits that result in an inpatient admission. For many hospitals, visits that result in an inpatient admission are not available in ED electronic databases. Presumably, since these visits warrant inpatient treatment, none would fall into the non-emergent category. Excluding these visits may inflate the primary care treatable (both emergent and non-emergent) categories. However, ED visits that result in an inpatient admission generally do not comprise more then 10-20 percent of total ED visits and would likely have a relatively small effect on the overall findings. A larger effect could occur if more visits were categorized by the algorithm. Since a sizeable percentage of ED visits remain unclassified, percentages or visits that are classified as falling into one of the four emergent or non-emergent categories should be interpreted as a conservative estimate and may understate the true values in the population.

ED Use at University Health System (UHS)

As part of the *Urgent Matters* safety net assessment process, we collected information on ED visits at the University Health System (UHS) for the period July 1 through December 31, 2002. There were 32,060 ED visits over the six-month period that did not result in an inpatient admission. Table 5 provides information on these visits by race, coverage, age and gender.

Table 5 Demographic Characteristics of ED Visits

Race		Coverage		Age		Gender	
Black	6.8%	Care*Link*	16.5%	0-17	9.6%	Female	56.2%
Hispanic	67.4%	Commercial	9.8%	18-64	85.5%	Male	43.8%
White	23.0%	Medicaid	20.8%	65+	4.9%		
Other/Unknown	2.7%	Medicare	7.5%				
		Other	3.6%				
		Uninsured	41.8%				

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

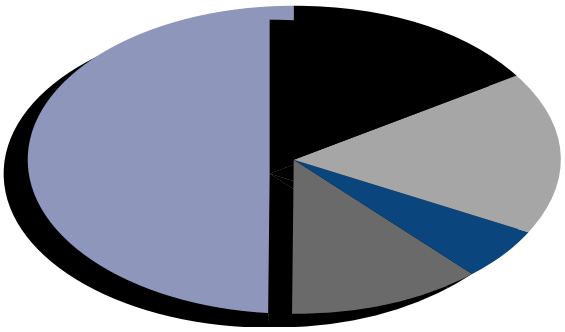
Key Demographic Characteristics of ED Visits

About two-thirds of ED visits at UHS were for patients who were Hispanic. Nearly one-quarter of visits were for patients who were white.

More than four out of ten visits were for patients who were uninsured. Another 16.5 percent were for uninsured patients enrolled in Care*Link*. Medicaid covered about one-fifth of all ED visits.

Less than 15 percent of visits were for children or seniors.

Figure 1 Visits by Emergent and Non-Emergent Categories



Non-Emergent	15.8%
Emergent, PC Treatable	17.0%
Emergent, Preventable	5.5%
Emergent, Not Preventable	11.8%
Other Visits	49.9%

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 University Hospital's emergency department.

A significant percentage of visits to UHS's ED could have been treated in other settings. As Figure 1 demonstrates, 15.8 percent of ED visits at UHS that did not result in an inpatient admission were non-emergent and another 17.0 percent were emergent but primary care treatable. Thus, one-third of all ED visits could have been safely treated outside of the ED.[49]

Table 6 compares the rate of visits that were emergent, that required ED care, and that were not preventable or avoidable against rates for other categories of visits. For every visit that was in the emergent, not preventable category, there were nearly three visits that were either non-emergent (1.34) or emergent, but primary care treatable (1.44).

Patients on Medicare were less likely to seek treatment in the ED for non-emergent conditions than were the uninsured or patients with other forms of insurance coverage. While uninsured patients are slightly more likely to use the ED for primary care treatable conditions (both emergent and non-emergent) than were other patients, the rates for uninsured patients were very similar to those rates seen among commercially insured patients.[50] Patients in Care*Link* were less likely than uninsured patients to use the ED for primary care treatable conditions.[51]

Table 6 Relative Rates for ED Visits at UHS

	Non-Emergent	Emergent, Primary Care Treatable	Emergent, ED Care Needed Preventable/ Avoidable	Emergent, ED Care Needed Not Preventable/ Not Avoidable
Total	**1.34**	**1.44**	**0.47**	**1.00**
Insurance status				
Care*Link*	1.16	1.44	0.46	1.00
Commercial	1.40	1.32	0.36	1.00
Medicaid	1.25	1.25	0.46	1.00
Medicare	0.78	1.15	0.62	1.00
Uninsured	1.60	1.64	0.39	1.00
Age				
0-17	2.02	2.26	0.85	1.00
18-64	1.35	1.41	0.43	1.00
65+	0.68	1.03	0.57	1.00
Race				
Black	1.56	1.51	0.62	1.00
Hispanic	1.33	1.46	0.45	1.00
White	1.27	1.36	0.50	1.00
Sex				
Female	1.51	1.48	0.43	1.00
Male	1.12	1.39	0.52	1.00

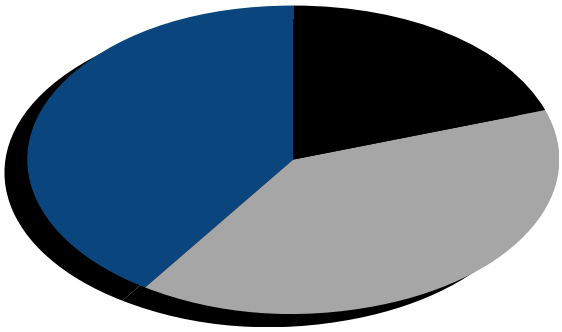
Source: The George Washington University Medical Center, School of Public Health and Health Services, Department of Health Policy application of the ED use profiling algorithm to data provided by University Hospital's emergency department.

Children used the ED for emergent and non-emergent primary care treatable conditions at higher rates than did older patients.[52] Females also were more likely than males to use the ED for non-emergent conditions, but this difference faded in terms of use of the ED for emergent, primary care treatable conditions. Only minimal differences were seen in utilization across categories of race or ethnicity.

Relatively few visits were classified as emergent but preventable or avoidable. The algorithm does not provide sufficient detail to determine why there were fewer of those visits than those categorized as emergent, non-preventable category.

Most ED visits at UHS occurred during the hours of 8:00 am to midnight. As Figure 2 illustrates, only about one-fifth percent of visits that did not result in an inpatient admission occurred between midnight and 8:00 am. Interestingly, many visits to the ED for primary care treatable conditions occurred during business hours during which other physicians and clinics are available.

Figure 2 ED Visits by Admit Time to the ED



Midnight – 8 am	19.8%
8 am – 4 pm	39.6%
4 pm – midnight	40.6%

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

Table 7 Relative Rates for ED Visits at UHS, 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	**1.34**	**1.44**	**0.47**	**1.00**
Admit time				
8 am – 4 pm	1.46	1.52	0.45	1.00
4 pm – midnight	1.31	1.42	0.49	1.00
Midnight – 8 am	1.17	1.33	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 University Hospital's emergency department.

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 roughly the same rates during "regular business hours" and the hours of 4:00 pm to midnight.

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

KEY FINDINGS

After examining important components of the San Antonio safety net, the assessment team identified the following key findings:

San Antonio's hospitals, clinics, federally qualified health centers, mental health providers, private sector physicians, public health departments, and community based organizations recognize the need to collaborate on numerous issues to improve access to care for all residents. However, the health care system remains significantly fragmented.

The demand for safety net services in Bexar County is expected to grow due to general increases in the population as well as growth in the number of individuals who are employed but uninsured. Reductions in Medicaid and CHIP eligibility and benefits are likely to adversely affect access to needed services.

Care*Link* is a unique program that provides uninsured residents access to a network of care while reimbursing providers for services rendered. Funding constraints, however, limit the number of residents who benefit from the program. Care*Link* enrolls only about 15 percent of the uninsured in the county, creating a gap in access to care for most of the uninsured. Uninsured residents not covered by Care*Link* face challenges in accessing care because few providers are willing to treat them.

The distribution of primary care providers across the county is uneven, posing access issues for some residents. Few providers are located in neighborhoods where uninsured and underserved residents live.

Data from the University Health System at San Antonio show that a significant percentage of emergency department visits are for patients whose conditions are non-emergent. About 16 percent of all emergency department encounters that did not result in an admission were for patients who presented with non-emergent conditions. Another 17 percent were for patients whose conditions were emergent but could have been treated in a primary care setting.

Access to specialty care is particularly problematic for low-income residents. Not only are some types of specialists in short supply, but many specialists are unwilling to serve low-income residents who cannot afford to pay for care out of pocket. Even those enrolled in Care*Link* must often wait six to nine months for an appointment with a specialist.

Both outpatient and inpatient mental health services are extremely limited and the burden of caring for patients with these issues often falls to the emergency departments. Only a small segment of the Bexar County population qualifies for state-sponsored mental health services.

Many safety net providers struggle to maintain levels of care in the midst of shrinking support from the county for care of the uninsured. Given the gaps that already exist in care for the uninsured and underserved, any additional cuts would further weaken an already fragile and fragmented system of care.

Recent collaborative efforts by the major stakeholders in the health care community have resulted in improved coordination of trauma care services. This same type of collaboration may support future efforts to raise awareness at the local and state levels of the fragility of the safety net in San Antonio and develop solutions to the increasing demand for safety net services.

ISSUES FOR CONSIDERATION

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

Hospitals, safety net providers and public officials must continue to work together to address the gaps in coverage and health care access for the uninsured and underserved. Similar collaborative efforts have resulted in significant county-wide improvements in ED diversion and in the provision of trauma care. Given the state's fiscal crisis and its overall Medicaid policy, this type of collaboration remains one of the few available resources for addressing the deteriorating mental health system and lack of access to specialty services for uninsured and underserved residents.

The collaboration of safety net providers, community-based organizations, faith-based institutions and other stakeholders is essential for re-enrolling children in CHIP. Given that children must now be re-enrolled in CHIP every six months instead of every year, stakeholders should work together to notify families with children currently enrolled in CHIP of approaching re-enrollment dates. Keeping children enrolled in CHIP will help ensure their continued access to the full range of services, including preventive health care.

San Antonio should consider examining existing bus routes and evaluate the effectiveness of the transportation system in enabling the uninsured and underserved populations to access important services. The lack of a convenient transportation system, particularly south of downtown, makes access to important primary and preventive services more difficult and could contribute to greater emergency room use among neighborhood residents.

San Antonio's safety net providers should consider maintaining and expanding successful programs that have increased access to health care of uninsured and underserved populations. For example, linkages between Care*Link* and health care providers have provided access to a "medical home" for thousands of uninsured families who do not qualify for Medicaid.

San Antonio should consider exploring opportunities for expanding capacity at the two existing federally qualified health centers. With limited state and local resources, health centers should consider pursuing additional federal grants to create or expand the number of service sites. Although the health centers have multiple sites in other underserved communities, the area south of downtown San Antonio continues to suffer from a lack of primary care practices willing to serve neighborhood residents.

San Antonio must monitor changes in the provision of safety net services as health systems convert from nonprofit to for-profit status. Given the concern about possible reductions in the amount of uncompensated charity care provided at those hospitals, a surveillance or reporting mechanism must be in place to help develop realistic remedies for hospitals experiencing an increased burden of uncompensated care.

Public awareness campaigns and outreach efforts to educate patients regarding alternatives to the ED for obtaining health care services must be employed. Such programs can describe other primary care options for uninsured and underserved patients, such as UHS clinics, urgent care facilities, and federally qualified health centers. They can also explain how people can apply for services through Care*Link*.

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

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

2 The Chamber, *San Antonio Facts*, (San Antonio, TX: The Greater San Antonio Chamber Chamber of Commerce, March 2003).

3 University Health System, *University Health System Operational and Financial Plan 2002-2006*, (San Antonio, TX: University Health System, 21 August 2002).

4 Includes persons reporting more than one race.

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

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

7 The Texas State Children's Health Insurance Program is referred to as CHIP.

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

9 Ibid.

10 The Chamber, *2003 First Quarter Economic Report*, (San Antonio, TX: The Greater San Antonio Chamber of Commerce, 2003).

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

12 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

13 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.

14 The area also has two military hospitals.

15 University Health System, "University Health System Operational and Financial Plan 2002-2006," (San Antonio, TX: University Health System, 21 August 2002).

16 Uncompensated care represented 34.9 percent of gross revenues. See *Charity Charges and Selected Financial Data for Acute Care Texas Hospitals*, (TX: Texas Department of Health and Center for Health Statistics, DDM, TDH, 2001).

17 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

18 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

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

20 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

21 The Texas Department of Health continues to operate the Texas Center for Infectious Diseases in San Antonio, which provides inpatient and acute medical care for patients with tuberculosis and other infectious diseases.

22 The primary catchment area includes 22 counties in south/central Texas; the secondary catchment area includes an additional 15 counties in south Texas.

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

24 Bexar County Community Health Collaborative, *2002 Community Health Assessment and Health Profiles*, (San Antonio, TX: Bexar County Community Health Collaborative and Metro Health, 2002).

25 The Special Supplemental Program for Women, Infants and Children (WIC) is a program administered by the U.S. Department of Agriculture's Food and Nutrition Service that provides nutritious foods to supplement diets, information on healthy eating and referrals to health care providers to low-income women, infants and children up to age five. See www.fns.usda.gov/wic/

26 Actual Medicaid expenses for FY 2002 are not available. See C.K. Rylander, *Health Care Spending in the Texas State Budget*, (TX: Office of the Comptroller, August 2002), www.window.state.tx.us/taxbud/healthcare/96-957.pdf

27 Ibid.

28 This figure reflects a decrease in eligibility from 185 percent of the FPL, effective September 1, 2003.

29 Texas Health and Human Services Commission, "Texas Medicaid in Perspective Fourth Edition" (TX:Texas Health and Human Services Commission, April 2002), http://www.hhsc.state.tx.us/medicaid/reports/pb/2002pinkbook.html

30 TexCare Children's Health Insurance, see www.texcarepartnership.com

31 Another 33,768 children were in an "other" category, which generally indicates that they are temporarily ineligible due to the program's 90-day waiting period or are ineligible due to age or current insurance.

32 The original reduction proposed was 5 percent. The 2.5 percent reduction is effective for 2004 with no guarantee that the reduction will not be higher during the second year of the biennium, 2005. See Center for Public Policy Priorities, *How does new $167 million change impact of Medicaid and CHIP budget cuts?*, (Austin, TX: CPPP, 11 August 2003), http://www.cppp.org/products/policypages/191-210/html/pp201.html

33 This also applies to families who fail to re-enroll.

34 Center for Public Policy Priorities, *Estimated caseload and total dollar losses due to Medicaid and CHIP cuts by county?*, (Austin, TX: CPPP, 2003).

35 Texas Institute for Health Policy Research, "The Health Care Safety Net in Texas," (Austin, TX: Texas Institute for Health Policy Research, 12 December 2002).

36 Disproportionate Share Hospital payments provide additional funding to hospitals that provide a disproportionate amount of care to Medicaid and uninsured populations. See www.naph.org/Content/NavigationMenu/About_Our_Members/Frequently_Asked_Questions1/FAQpdf2.pdf

37 While states have considerable flexibility in setting payment rates within the Medicaid program, the maximum rates that can be paid are constrained by an upper payment limit determined by the federal government. Since the states receive federal matching dollars for Medicaid expenditures, increasing Medicaid expenditures up to the UPL will maximize the federal dollars coming to the states (State Medicaid Director Letter, July 26, 2000, Centers for Medicare & Medicaid Services).

38 University Health System, *Operational and Financial Plan 2002-2006*, (San Antonio, TX: University Health System, 21 August 2002).

39 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

40 Uniform Data System, 2002.

41 Ibid.

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

43 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

44 These new sources of funding are from the Upper Payment Limit (UPL) program and Population Based Initiatives. UPL funds will come from a federal match to dollars spent on selected Medicaid services. Due to efforts by University Health System's Medicaid products, the Population Based Initiative funds will come from Medicaid HMO profits being kept in Bexar County instead of being returned to the state.

45 Personal communications with interviewees. Interviews were held between summer 2003 and winter 2004.

46 These funds come from unclaimed lottery winnings.

47 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.

48 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).

49 These figures are relatively low compared to findings from analyses of other *Urgent Matters* grantee hospitals' data. UHS 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.

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

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

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

Urgent Matters Grantee Hospitals and Community Partners

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

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

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

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

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

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

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

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

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

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