

**CRITERIA FOR ASSESSING EFFECTIVE HEALTH CARE DELIVERY
TO CALIFORNIA'S UNDERINSURED**

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CRITERIA FOR ASSESSING EFFECTIVE HEALTH CARE DELIVERY
TO CALIFORNIA'S UNDERINSURED

A Project

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Abstract

of

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Statement of Problem

California's health care delivery system for the underinsured is fragmented. With over 42 percent of Californian's underinsured, we need to refocus the health care safety net models of care to eliminate barriers to care. Currently, there is no formal safety net system in California; care is delivered differently in each county. In addition there is no standard evaluation tool to measure program effectiveness.

Sources of Data

Research and literature on the underinsured and how the underinsured access health care was used from the California HealthCare Foundation, California Healthline, Kaiser Family Foundation, Health Affairs, and other researchers to show the current system of care and challenges and barriers to health care delivery to the underinsured.

Conclusions Reached

Based on the literature on the underinsured, criteria for assessing effective health care delivery to California's underinsured were developed. The criteria include: Availability of Medical Services, Continuum of Care, Accessibility of Care, and Measures of Success at a patient level. Each criterion has multiple health care delivery challenges that will measure a health care delivery models success at providing care to the underinsured. Finally, the criteria were used to evaluate the current health care delivery model in California and the Yolo Health Alliance, Yolo County's safety net system of care. Based on the findings, the Yolo Health Alliance is a best-practice system that provides care to the underinsured that is comparable to care provided to a privately insured patient.

_____, Committee Chair
Robert Waste, Ph.D.

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I hope that this report is useful to Sutter Health and its community partners and adds value to the health care field.

Sincerely,
Keri Thomas Cavner
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TABLE OF CONTENTS

| | |
|---|------|
| Acknowledgement..... | v |
| Listing of Tables and Figures..... | vii |
| Executive Summary..... | viii |
| INTRODUCTION..... | 1 |
| Types of Insurance..... | 3 |
| Health Care Access Points..... | 7 |
| ESTABLISHING CRITERIA FOR EVALUATION..... | 13 |
| Methodology..... | 13 |
| AVAILABILITY OF MEDICAL SERVICES..... | 15 |
| CONTINUUM OF CARE..... | 17 |
| ACCESSIBILITY OF CARE..... | 18 |
| MEASURES OF SUCCESS..... | 21 |
| ASSESSING CALIFORNIA’S SAFETY NET HEALTH CARE DELIVERY SYSTEM..... | 22 |
| Yolo Health Alliance: Background..... | 23 |
| Yolo Health Alliance: Successes..... | 26 |
| Applying the Criteria..... | 30 |
| CONCLUSION..... | 39 |

LISTING OF TABLES AND FIGURES

Tables

| | |
|--|----|
| 1. Health Care Access by Type of Insurance in California..... | 8 |
| 2. The Uninsured and Underinsured in the U.S. and California | 12 |
| 3. Criteria for Assessing Effective Health Care Delivery to California’s Underinsured | 14 |
| 4. Roles of the Yolo Health Alliance Partners..... | 25 |
| 5. Availability of Medical Services..... | 32 |
| 6. Continuum of Care..... | 34 |
| 7. Accessibility of Care..... | 36 |
| 8. Measures Success..... | 38 |

Charts

| | |
|--|----|
| 1. Yolo Health Alliance Number of Eligible Users..... | 26 |
| 2. Yolo Health Alliance Emergency Room Visits..... | 27 |
| 3. Yolo Health Alliance Hospital Inpatient Bed Days Per 1,000 Members..... | 28 |
| 4. Yolo Health Alliance Patient Complaints..... | 29 |

EXECUTIVE SUMMARY

In California, there are two health care delivery systems, one that delivers care to people with private insurance and one that provides care to people without private health insurance, or the poor and working poor. The safety net system for the uninsured and people enrolled in government-sponsored health coverage programs (more commonly referred to as the underinsured) has been created over time and has numerous barriers that make it difficult for a patient to access ongoing preventive care. Because there is no standard safety net system in California, each county delivers care to the uninsured and underinsured differently. The safety net health care system, including government sponsored health coverage programs, community health centers, local county governments, and not-for-profit and public hospitals, operate independent from one another. The result is a fragmented system of care causing episodic medical care for the patient, elevated health care costs for Californian's, and no standard evaluation tool to assess the effectiveness of the system.

The current safety net system categorizes the uninsured and underinsured into multiple categories: people enrolled in publicly funded health coverage programs such as Medi-Cal and Healthy Families, people eligible for County Medically Indigent Services Programs, and people that have no form of health coverage, or the uninsured. The fragmentation causes barriers to health care and the delivery of disrupted health care because the uninsured and underinsured move in and out of health coverage. To develop effective health care programs that increase access to medical services, the systems need to redefine the uninsured and underinsured to be one large category. The underinsured,

as defined in this study, include all people enrolled and eligible for Medi-Cal and Healthy Families, all people eligible for County Medically Indigent Services Program, and all uninsured. With the new definition of the underinsured, over 13.5 million Californian's, or 42 percent, are underinsured and have challenges accessing health care services.

Based on the literature and research on the medical services available to the underinsured and how the uninsured access medical services, this study provides criteria for assessing effective health care delivery to California's underinsured. The criteria include four main categories with specific health care delivery challenges including:

1. Availability of Medical Services

- Access to primary care
- Access to specialty care
- Access to hospital care

2. Continuum of Care

- Single point of entry for all
- Eligibility workers to determine eligibiltiy

3. Accessibility of Care

- Access to ongoing, preventive care
- Cultural and linguistically appropriate services
- Trusted provider
- Convinient location and hours

4. Measures of Success

- Measures success at a patient level

The four criteria were then applied to California's current health care safety net system and the Yolo Health Alliance, the safety net health care delivery system providing care to Yolo County residents. Since there is no formal safety net system of health care in California, the different safety net programs (publicly funded programs, county medically indigent programs, and the uninsured) were assessed on a very high level. The Yolo Health Alliance was evaluated to show that it is a best practice model of health care delivery. The criteria shows that the Yolo Health Alliance delivers care to the underinsured that is comparable to care provided to a privately insured patient.

The established evaluation criteria can be used to assess all health care delivery systems in California and the nation. The criteria provide a measurement standard to compare program effectiveness and efficiency across different counties.

INTRODUCTION

In California, there are two health care delivery systems, one that delivers care to people with private insurance and one that provides care to people without private health insurance, or the poor and working poor. The safety net system for the uninsured and people enrolled in government-sponsored health coverage programs (more commonly referred to as the underinsured) has been created over time and has numerous barriers that make it difficult for a patient to access ongoing preventive care. Because there is no standard safety net system in California, each county delivers care to the uninsured and underinsured differently. The safety net health care system, including government sponsored health coverage programs, community health centers, local county governments, and not-for-profit and public hospitals, operate independent from one another. The result is a fragmented system of care causing episodic medical care for the patient, elevated health care costs for Californian's, and no standard evaluation tool to assess the effectiveness of the system.

The research and literature on health care and the uninsured focus on two solutions: (1) Expand health coverage, and (2) Increase access. The research shows (Cunningham and Hadley, 2004; and Brown, Ponce and Rice, 2001) that health insurance does increase access to ongoing preventive care among the uninsured and underinsured; however, health coverage coupled with a strong community health center system that provides culturally and linguistically appropriate care to the uninsured and underinsured has better outcomes than just health insurance alone. Since the nation and California are

no where close to implementing a universal health insurance program, we need to focus on developing medical care programs that the uninsured and underinsured will use.

Changing the focus from health insurance to health access requires us to redefine the uninsured and underinsured populations. Typically, the uninsured include those individuals without any form of health insurance. However, researchers understand (California Healthcare Foundation, 2004e; Kaiser Family Foundation, 2003; Economic Research Initiative on the Uninsured, 2002) that the poor and working poor move along a health insurance continuum ranging from no health insurance to private health insurance. Table 1 shows how people with different types of health insurance access medical care. Based on research on physician availability (California HealthCare Foundation 2004a) and availability of health care services for the uninsured and the underinsured (The Kaiser Family Foundation, 2003; Medi-Cal Policy Institute, 2001), the scale shows the different levels of access; 1 representing the least access to medical care and 4 representing the most access based on type of health coverage.

TABLE 1. Health Care Access by Type of Insurance in California

| LEVEL OF ACCESS | TYPE OF INSURANCE | HEALTH CARE ACCESS POINTS | | | |
|---------------------|--|---------------------------|-------------------------|---------------|-------------------------|
| | | Primary Care Physician | Community Health Center | County Clinic | Hospital Emergency Room |
| 4 (Most Access) | Private Health Insurance | ✓ | | | ✓ |
| 3 | Medi-Cal or Healthy Families | ✓ | ✓ | | ✓ |
| 2 | County Medically Indigent Services Program | | | ✓ | ✓ |
| 1 (Least Access) | Uninsured | | ✓ | | ✓ |

California HealthCare Foundation, 2005 and Ketch, 2005

Table 1 shows the four types of insurance in the health care continuum that ranges from private health care insurance to no health care insurance. It also examines where people access medical care within the four types of insurance. To better understand the relationship and the interdependence of the health coverage programs and safety net providers, following is a detailed description of the four types of insurance and their relationship to where people access medical care.

Types of Insurance

Private Health Insurance

Baxter and Mechanic define a safety net as “the institutions, programs, and professionals investing substantial resources to serving the uninsured or socially

disadvantaged” (1997). Based on this definition, private health insurance is not considered part of the health safety net system. However, it is included in the table to present the full spectrum of the current health care system. Private health insurance has the most access in the continuum of health care. It is estimated that approximately 52 percent of all California residents have private health insurance, 45 percent is employer-based coverage (California HealthCare Foundation, 2005). Individuals enrolled in private health insurance select their primary care provider; therefore, primary care is typically conveniently located close to their home or office.

Medi-Cal and Healthy Families

Medi-Cal is California’s Medicaid program that provides health care coverage for low-income, documented residents of California who do not have other sources of insurance. The program is jointly funded by federal and state governments and provides care to over six million Californians. Eligibility for the program is based on a family or individuals income. Children ages one to five qualify for Medi-Cal if the family income is at or below 133 percent of Federal Poverty Level (\$23,475 per year for a family of four) and children ages six to 19 qualify for services if the family income is at or below 100 percent of Federal Poverty Level (\$17,650 per year for a family of four). There is no simple way of explaining the Medi-Cal eligibility criteria for adults. Currently, there are 165 categories under which an adult may be eligible for services (Medi-Cal Policy Institute, 2001). Medi-Cal is administered by the State of California through different models; a fee-for-service delivery system and three managed care models: County Organized Health Systems, the Two-Plan Model, and Geographic Managed Care. The

type of Medi-Cal plan affects the local health care delivery model. The delivery model affects the way the local safety net providers deliver care (Medi-Cal Policy Institute, 2001; and California HealthCare Foundation, 2004c, 2005).

Healthy Families is a health coverage program designed to cover the children of working poor families that earn too much to qualify for Medi-Cal, but below 200 percent of Federal Poverty Level (\$35,300 for a family of four). As of January 2005, there were over 600,000 children in California enrolled in the Healthy Families program. This program was developed in response to the high number of employers not offering health benefits to dependents. The program uses commercial insurance programs and is managed by the State of California Medical Risk Managed Care Board (California HealthCare Foundation, 2004b).

Research shows (The California HealthCare Foundation, 2004a and 2004d) that publicly funded health insurance programs improve access to physician services; however, the access to care is still intermittent and the focus of care is on urgent issues not preventive care. Individuals with Medi-Cal or Healthy Families coverage have a medical home just like the privately insured patient, but the medical home can be a primary care physician or community health center depending on the type of Medi-Cal offered in their county. Physicians only accept a certain number of Medi-Cal and Healthy Families patients and as a result beneficiaries may be assigned any physician accepting patients. As a result, a beneficiary's primary care physician could be located in another city, inaccessible to the beneficiary (California HealthCare Foundation, 2004a).

County Medically Indigent Services Program

The Medically Indigent Adult program is a county medical assistance program available in the larger California counties. Medically indigent programs are for the poor residents who do not qualify for government sponsored health coverage programs. The programs are administered by county government and are independent of the Medi-Cal program.

Counties became responsible for providing services to the poor residents of their county in the mid 1800's. The Pauper Act of 1855 mandated counties to provide services to the indigent, or poor residents, but health care was not included in the wording of the mandate. In 1933, the California legislature enacted the Welfare and Institutions Code §17000 that remains in effect today (California HealthCare Foundation, 2005). The code reads:

Every county and every city and county shall relieve and support all incompetent poor, indigent persons, and the incapacitated by age, disease or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means or by state hospitals or other state or private institutions.

Researchers understand (California Healthcare Foundation, 2004e, 2005; Ketch, 2005) that as a result of the broad language used in Government Code section 17000, each county interpreted the mandate differently and developed a unique system of care for the underinsured. Some counties provide care only to the medically indigent population, not providing services to people who qualify for Medi-Cal and Healthy Families. Other counties provide medical services to all underinsured. The counties decide the number of clinics needed to provide an adequate level of health care to the

medically indigent and they develop the definition of adequate. With the increasing numbers of underinsured residents in California and a stagnant or declining revenue base, county governments are forced to reduce the number of services provided to only basic services in order to provide some level of care to all who are eligible. This reduction in services has caused county governments to be known for delivering episodic care, only dealing with the very ill or serious injuries, not providing routine medical care for the underinsured (Fedder, Levitt, O'Brien, and Rowland, 2001). Research found (California HealthCare Foundation, 2005) that county indigent programs provide episodic care and that clients perceive the care to be less than adequate. As a result, underinsured adults would rather visit a hospital emergency department than a county clinic.

Uninsured

The uninsured have the least access to care on the health care continuum. They access care through a community clinic (if they can afford the fee for service) and the hospital emergency room. As a result of the lack of access to care, the uninsured are more likely to require hospitalization for avoidable conditions, are more likely to forgo routine health care services, and are more likely to access the emergency room for routine health care than people with some form of health coverage (The Kaiser Family Foundation, 2000).

Health Care Access Points

Primary Care Physicians

Primary care physicians in California care for the privately insured patient and Medi-Cal and Healthy Families beneficiaries (depending on the Medi-Cal contract the

county has with the State). Patients access care from their primary care physician through private medical offices. Not all primary care physicians in California take Medi-Cal and Healthy Families beneficiaries as patients. The physicians that do accept Medi-Cal and Healthy Families have a cap to the number of beneficiaries they will take as patients. Primary care physicians do play a role in the safety net health care system because they provide care for the underinsured population.

Community Health Centers

Community health centers provide medical services to the underinsured populations. Community health centers are not-for-profit agencies that provide care for the underinsured, including Medi-Cal and Healthy Families beneficiaries. Community health centers typically have a sliding scale payment structures for people without any form of health insurance where the fee for service is determined by family income. These clinics are self-sufficient through fees for service, reimbursements from public programs, grants, and private fundraising (Baxter and Mechanic, 1997). Not-for-profit community health centers do not exist in all communities; therefore, this system of health care is not a reliable source of care for the underinsured.

County Clinics

Government code section 1700 requires county governments to provide health care services to the poor. To meet the expectations of the mandate, majority of large local county governments developed a health care system for the medically indigent residents that included independent health care clinics. The level of services provided at a county clinic varies by county. Some counties provide care to all of the underinsured

and others provide care to only patients deemed eligible for the County Medically Indigent Services Program. This inconsistency of care from county to county adds to the fragmented safety net health care system available to California's underinsured.

Public and Not-for-Profit Hospitals

Public and not-for-profit hospitals are part of the safety net system. Public hospitals are operated by a government entity and therefore are required to care for the underinsured. A recent study found that the number of public hospitals has declined over the past ten years. Between the years of 1996 to 2003, the number of public hospitals declined by 43 percent, from 217 hospitals to 168 hospitals (California Healthline, 2005). California currently has 26 public hospitals, 24 of which are located in large metropolitan areas (California Healthline, 2003). A report by California Healthline (2003) listed maintenance costs and lack of a strong payer mix as the two major challenges that face California's public hospitals. In California, public hospitals absorb 55 percent of the cost of treating the more than six million uninsured state residents, care that cost a total of \$1.6 billion in 2001. The report also found that hospital expenses have risen 53 percent since 1995, but revenue has not increased equivalently. As a result, public hospitals are unable to earn enough revenue to provide top-level care for patients and provide the necessary facility maintenance.

Not-for-profit health care systems in California are becoming an increasingly important part of the safety net health care delivery system. Not-for-profit hospitals are required by the State Legislature to provide care to anyone regardless of their ability to pay and to have an emergency department open 24 hours per day-seven days per week.

Research shows (Baxter and Mechanic, 1997; California HealthCare Foundation, 2005; Strunk and Cunningham, 2002) that the point of entry for the underinsured is typically through the emergency department. Using the emergency room for primary care services strains a system that was not established for providing primary care and therefore is a threat to the quality of care for the patients that need emergency treatment. Further, the emergency department is the most expensive form of health care and is not designed to provide the follow-up care of a primary physician (Cunningham and Hadley, 2004).

The different levels of access shown in Table 1, demonstrates that access to health care services is a continuum and that the type of health coverage impacts the level of access. Defining the current health care delivery model in California as a continuum of care changes the way we define the uninsured and underinsured. In order to increase access and decrease fragmentation, we need to group all populations that have barriers to accessing ongoing medical care. Based on the findings of research (California HealthCare Foundation, 2004a, 2004b, 2004c, 2004e; Kaiser Family Foundation, 2000) the uninsured, the medically indigent, and the beneficiaries of public health insurance programs access health care similarly and have comparable problems in accessing ongoing medical care. In addition, these populations move along the health care continuum, moving in and out of health coverage programs over time. Therefore, an effective health care delivery model needs to provide services to Medi-Cal and Healthy Families beneficiaries, medically indigent adults, and the uninsured. Based on the many similarities among these populations, and to simplify the terminology these three populations, for the purpose of this paper, will be referred to as the underinsured.

Table 2 shows the total number of underinsured for both the nation and California. Combining the number of uninsured and the number of people enrolled in public health insurance programs significantly increases the number of underinsured. Utilizing this new model, 42 percent of California's population requires some level of public support for health care. This percentage is fourteen percent higher than the national average of 28 percent. Giving this alarming trend, California is faced with a health care crisis that, if not addressed properly, will impact the cost of health care and the State's economy. The number of underinsured is higher in California due to a higher cost of living, large population of undocumented immigrants not eligible for publicly funded programs, and fewer employers offering health coverage for dependents as compared to other states (Economic Research Initiative on the Uninsured, 2002).

TABLE 2. The Uninsured and Underinsured in the U.S. and California

| Health Coverage Status | U.S. Estimate Number | U.S. Percent of Total Population | California Estimate Number | California Percent of Total Population |
|---|-----------------------------|---|-----------------------------------|---|
| Population, 2003 | 293,655,404 | | 35,893,799 | |
| Number of people without health coverage for one year, 2004 | 45.8 million | 15.5% | 6.5 million | 20% |
| Number of people enrolled in publicly sponsored health coverage programs, 2004 | 37.9 million | 12.9% | 7 million | 22% |
| Total number of people without health coverage and eligible for publicly sponsored health coverage programs, 2004 | 83.7 million | 28.4% | 13.5 million | 42% |

Developed from: U.S. Census Bureau; California HealthCare Foundation

This table only reflects the underinsured populations. It does not reflect the number of people enrolled in private health insurance and the Medicare Program.

ESTABLISHING CRITERIA FOR ASSESSING EFFECTIVE HEALTH CARE DELIVERY TO CALIFORNIA'S UNDERINSURED

There is no formal safety net system of health care in California; therefore, each county has developed their own way of delivering care to the underinsured. As a result, there are large discrepancies in the safety net health care systems serving the underinsured. The lack of a standard system of care makes it difficult to measure success. Consequently, there are no standard evaluation criteria to measure long term effectiveness of primary care service delivery for the underinsured population. The next section explains a methodology for evaluating health care delivery systems to the underinsured. The evaluation criteria are a tool for health care safety net providers to use to measure program effectiveness. Later in this study, these criteria will be used to evaluate current health service delivery models serving the underinsured population of California and the Yolo Health Alliance, a collaborative program providing seamless health care to the underinsured.

Methodology

Table 3 summarizes research on the health care delivery challenges for the underinsured. Based on the information from the literature review, each of the challenges falls under one of four larger categories: Availability of Services, Continuum of Care, Accessibility of Care, and Measures of Success. These four categories will serve as the evaluation criteria. The criteria are broad measures that together evaluate the health care delivery system in a specific community or the effectiveness of a specific program. Following is a more detailed description of each category with information from the appropriate research that shows the relevance of the criteria.

TABLE 3. Criteria for Assessing Effective Health Care Delivery to California's Underinsured

| CATEGORY | HEALTH CARE DELIVERY CHALLENGES |
|----------------------------------|--|
| Availability of Medical Services | Physician capacity |
| | Access to primary care |
| | Access to specialty care |
| | Access to hospital care |
| Continuum of Care | Single point of entry for all |
| | Eligibility workers to determine eligibility |
| Accessibility of Care | Access to ongoing, preventive care |
| | Cultural and linguistically appropriate services |
| | Trusted provider |
| | Convenient location |
| | Convenient hours |
| Measures of Success | Measures success at patient level |

Developed from multiple research on the uninsured and underinsured

AVAILABILITY OF MEDICAL SERVICES

The first criterion for program evaluation assesses whether medical services are available to the underinsured. The four criteria to evaluate the availability of medical services to the underinsured measure whether there is: (1) Physician Capacity, (2) Access to Primary Care, (3) Access to Specialty Care, and (4) Access to Hospital Care. All of the criteria will be used to evaluate program availability except physician capacity. Most communities in California are facing a shortage of physicians (California HealthCare Foundation, 2004a); therefore, it is not a fair unit of measure.

Applying the Criterion

In order for the underinsured to access health care, medical services need to be available. Researchers understand (California HealthCare Foundation, 2004a, 2004d, 2004e; Fedder, Levitt, O'Brien and Rowland, 2001) that access to health care includes access to preventive services, access to specialty care, and access to hospital care. All three of these access points are necessary to deliver continuous care over time.

Research shows (California HealthCare Foundation, 2004a) that there is a shortage of primary care providers giving medical care to the underinsured. Currently, private practitioners have a limit on the number of underinsured (specifically Medi-Cal and Healthy Families patients) patients they will take as patients. This patient cap implemented by physicians and medical groups creates an even greater shortage of primary care providers available to the underinsured community.

In California, there is currently a shortage of specialty care physicians (California HealthCare Foundation, 2004a). The shortage of specialty care physicians impacts both

the commercially insured population as well as the underinsured population; however, research shows that the shortage has a greater impact on the underinsured population. Researchers estimate that Medi-Cal and Healthy Families beneficiaries receive 47 percent less referrals to specialty care services than the privately insured patient (California HealthCare Foundation, 2004a, 2004f). It is estimated that the underinsured are more than twice as likely to not receive needed specialty care as a privately insured patient (California HealthCare Foundation, 2004e) and that the underinsured are more than 39 percent more likely to need specialty care due to an elevated condition.

The underinsured have equal access to hospital care assuming there is a public or not-for-profit hospital located in their community. To access the hospital, most underinsured use the emergency room as the point of entry. The underinsured present to the emergency room with an elevated condition and are admitted to the hospital for care showing that the safety net providers are not able to admit patients to the hospital directly (California HealthCare Foundation, 2005).

The Availability of Medical Services criterion is intended to measure whether adequate health services are available to the underinsured. To provide a baseline measure, the medical services available to the underinsured patient will be measured against the medical services available to the privately insured patient. The availability of medical services criterion is not intended to measure whether medical services are accessible to the underinsured. The goal of this measure is to measure whether services exist.

CONTINUUM OF CARE

The second criterion evaluates whether a continuum of care exists for the underinsured within a program or a community. The research suggests (Cunningham and Hadley, 2004) that community clinics are more effective when: (1) The clinic is a single point of entry for all underinsured and (2) The clinic has eligibility workers onsite to determine eligibility. The current safety net health care delivery system has specific programs focusing care to a particular underinsured population rather than the underinsured population as a whole. Researchers understand (California HealthCare Foundation, 2004a and 2004e; Kaiser Family Foundation, 2000; Economic Research Initiative on the Uninsured, 2002) that this fragmented safety net system is not effective because the underinsured move along the health coverage continuum.

Table 1 demonstrates that the underinsured access health care services differently based on type of insurance. For example Mr. Jones who has Medi-Cal coverage and accesses care through a primary care provider. He then begins working a construction job and earns too much money to qualify for Medi-Cal but does not have employee sponsored coverage. As a result, he is now uninsured and must find other sources of health care services. If the health care safety net offered a continuum of care, he would be able to access care in the same location regardless of his insurance status.

Applying the Criterion

It is important to understand how the underinsured access medical services to understand the value of having one continuum of care. Researchers understand (California HealthCare Foundation, 2004d; and 2004e; Strunk and Cunningham, 2002)

that the underinsured are more likely to postpone and forgo care than a privately insured patient due to access issues. Consequently, the underinsured are more likely to access care with elevated cases of preventable conditions. In fact, underinsured are 2.5 times as likely as the insured to access care through the emergency room for elevated cases of preventable conditions (Strunk and Cunningham, 2002). Research has found (Webber, Showstack, Hunt, Colby, and Callahan, 2004) that the three top reasons that the underinsured access primary care via a hospital emergency room is because there are no health centers that provide care to the underinsured in their community, they do not know about other available options in their community, and they think they cannot afford primary care services in an outpatient clinic.

One single point of entry for the underinsured will improve access to primary care services and streamline health care services to the underinsured. As a result, the underinsured will know where to access care reducing emergency room usage for non-urgent conditions. Eligibility workers are another important piece to providing a continuum of care to the underinsured. Currently, there are different applications for health coverage programs that a person must complete in order to receive benefits. Eligibility workers onsite will assist the underinsured client with the application and be able to identify program eligibility, removing any confusion for the client.

ACCESSIBILITY OF CARE

The third criterion for program evaluation assesses the accessibility of care to the underinsured. The three criteria to measure the accessibility of care for the underinsured measure whether: (1) Cultural and linguistically appropriate services provided, (2) Care is

delivered from a trusted provider, and (3) Care is offered in a convenient location with convenient hours of operation. Researchers understand (Cunningham and Hadley, 2004; and Strunk and Cunningham, 2002; California HealthCare Foundation, 2004d; Kaiser Family Foundation, 2003) that improving access to medical services and preventive care will not only improve the health of the underinsured population, but also reduce emergency room utilization for non-routine health care services and decrease the amount of spending on health care.

Applying the Criterion

Researchers report (Cunningham and Hadley, 2004; California HealthCare Foundation, 2004d) that delivering culturally and linguistically appropriate services to the underinsured increases their access to medical care. One study (Kaiser Family Foundation, 2000) found that community health centers have a higher patient satisfaction scores when they hired multilingual staff reflective of the community. In addition to patient satisfaction scores, clinics that provide culturally and linguistically appropriate services have a sixty percent return rate for follow-up services. Research shows (California HealthCare Foundation, 2003a) that clients' with diabetes that access cultural and linguistically appropriate services are two times more likely to comply with physician orders and necessary medication routines than clients accessing care through the emergency department or private primary care physician.

Researchers understand (Cunningham and Hadley, 2004; Webber, Showstack, Hunt, Colby and Callahan, 2004) that provider trust is an important to the underinsured. People will comply with physician orders if they trust the physician. In addition, the

underinsured are as likely as a privately insured patient to return to a trusted physician for routine health care. The California HealthCare Foundation (2004d) found that hospitalizations were fewer among Medi-Cal beneficiaries that received routine health care from a community health center that was self-selected than Medi-Cal beneficiaries that were assigned a physician. This shows that if a client has a say in their health care provider and believes they are receiving quality care, they are more likely to receive and comply with routine, preventive care.

Finally, convenience impacts whether the underinsured access medical services. Research shows (Cunningham and Hadley, 2004) that the underinsured are more likely to visit a neighborhood community health center than a hospital emergency room for treatment assuming the health center is within a perceived accessible distance. For the purpose of this study, “accessible distance” is defined as more than twenty minutes travel time from the client’s home. The underinsured are more than twice as likely to forgo necessary medical care if the provider is outside the defined accessible distance. There was little research on the importance of keeping hours that are conducive to working families; however, medical groups and physicians offer after-hour urgent care clinics to meet the needs of privately insured patients. Recent studies show that 75 percent (approximately 5.3 million Californians) of Medi-Cal and Healthy Families beneficiaries are workers and their families (Medi-Cal Policy Institute, 2001), and that eight out of ten (approximately 5.8 million Californians) uninsured people in California are workers and their families (California HealthCare Foundation, 2004e). Majority of the underinsured are employed

and therefore it is safe to assume that the need for after-hour clinics among the underinsured is the same as the need among people with private insurance.

Access to care does impact not-for-profit hospitals in the Sacramento Sierra Region, including El Dorado, Placer, Sacramento, and Yolo counties. The number of underinsured utilizing the emergency room for routine health care have increased by more than fifty percent between the years 2002 and 2004. (Healthy Communities Forum, 2005).

MEASURES OF SUCCESS

The final criterion for program evaluation assesses whether success can be measured at the patient level. Currently, program evaluation is conducted by each individual health delivery system. Each agency provides outcome measurements on the number of visits provided and the number of clients served. The system does not let the safety net providers to share client information to improve the level of medical care provided to the underinsured. Therefore, the current system does not provide success outcomes at a patient level. In addition, there are no standards defining success.

Applying the Criteria

Finding information that defines success for health care delivery to the underinsured population is difficult. Research exists on quality measures and programs that are effective at treating a single population and a single condition. For example, there are studies on how to manage chronic conditions among the underinsured (California HealthCare Foundation, 2003a). Also, there is research (Cunningham and Hadley, 2004; and Kaiser Family Foundation, 2003) that identified ways to increase and

measure the availability of medical services to the uninsured. There was no research on ways to measure the effectiveness of medical care provided to the underinsured population. The current research focuses on single populations or single conditions. Having access to data at a patient level would allow agencies and communities to demonstrate that health services are available and accessible to the underinsured.

Because the current safety net system was created over time with programs that were implemented to serve only one population within the underinsured category, agencies serving the underinsured are unable to measure success at a patient level. For example, the current system in California allows hospitals to track the number of underinsured patients served, including number of emergency room visits for non-urgent conditions. The current system also allows community health centers to track the number of primary care visits per patient. The safety net health care system does not share information between the different medical care providers. Sharing data would let providers' measure success at the patient level and show outcomes that demonstrate success. A coordinated approach to program evaluation would provide data to show that ongoing primary care reduces the number emergency room visits for non-urgent conditions and decreases the hospitalizations from treatable conditions. Communities would be able to report on the health of the underinsured.

ASSESSING CALIFORNIA'S HEALTH CARE DELIVERY SYSTEM

The established criteria provide a comprehensive system to evaluate safety net health care delivery systems to the underinsured. This section of this report will apply the criteria to the current safety net systems in California against the Yolo Health

Alliance model of care to demonstrate that the Yolo Health Alliance is a best-practice approach to health care delivery. Below is detailed information on the Yolo Health Alliance and the assessment of California's health care safety net.

Yolo Health Alliance: Background

The Yolo Health Alliance is a unique, integrated approach to delivering health care services to the underinsured residents of Yolo County. In 1992 the County of Yolo sought help in strengthening its safety net for the medically indigent population. The County issued a Request for Proposal to health care providers interested in contracting with the County to deliver care to the underinsured residents. The County Board of Supervisors decided to approach the safety net health care delivery model differently for four reasons: (1) the County was facing a projected budget shortfall of \$1.1 million dollars; (2) the County hospital closed causing higher payment rates to Sutter Davis Hospital and Methodist Hospital for hospitalization care for the medically indigent; (3) the two County operated clinics were old causing expensive maintenance costs, and (4) the County operated clinics had a high number of patient complaints at 360 complaints per year. Yolo County offered a contract for \$2.5 million annually to a private health care provider to manage and care for the medically indigent. The contract with the County required the contract agency to maintain two existing county clinics, establish a third clinic site, and provide medical care to all patients deemed eligible by the Yolo County Department of Indigent Healthcare.

The contract with the County, which was awarded to Sutter Davis Hospital and in 1993, and was renewed in 2004, requires the Alliance to provide care specifically for the

medically indigent population. Counties across the nation are required to provide medical care to the medically indigent population; however, by contracting with CommuniCare Health Centers all of the community health centers in Yolo County provide care to medically indigent, Medi-Cal and Healthy Families beneficiaries, uninsured residents, and undocumented residents. Providing care to all of the underinsured provides a continuum of health care for Yolo County's residents.

The collaborative partner agencies shared the goal to delivery comprehensive, accessible primary health care to the underinsured to decrease the emergency room utilization rates and inpatient hospital bed days. Emergency room visits for non-urgent conditions was at 873 visits for the 1993-1994 years. Further, inpatient hospitalization was at an average of 38.8 bed days per 1,000 members for preventable chronic conditions (please see Charts 1 through 4 below for project outcomes). Sutter Davis Hospital, CommuniCare Health Center, and Sutter West Medical Group all benefited if the underinsured had access to effective primary care. By participating in the Alliance, Sutter Davis Hospital and Sutter West Medical Group decreased the amount of free care provided in the emergency room, increasing the emergency room availability to the community for real emergencies. CommuniCare Health Center, an independent not-for-profit benefited from a sustainable revenue source from subcontracting with Sutter Davis Hospital to be the primary care system for the underinsured.

Table 8 shows the collaborative roles and annual contributions to the Yolo Health Alliance. The program is successful and sustainable because a diverse group of agencies have agreed to share program responsibilities and costs. The cost varies based upon the

agencies ability to pay. It is with this understanding of partners participating at a level they can afford that allows the program to be sustainable and effective.

TABLE 4. Roles of Yolo Health Alliance Collaborative Partners

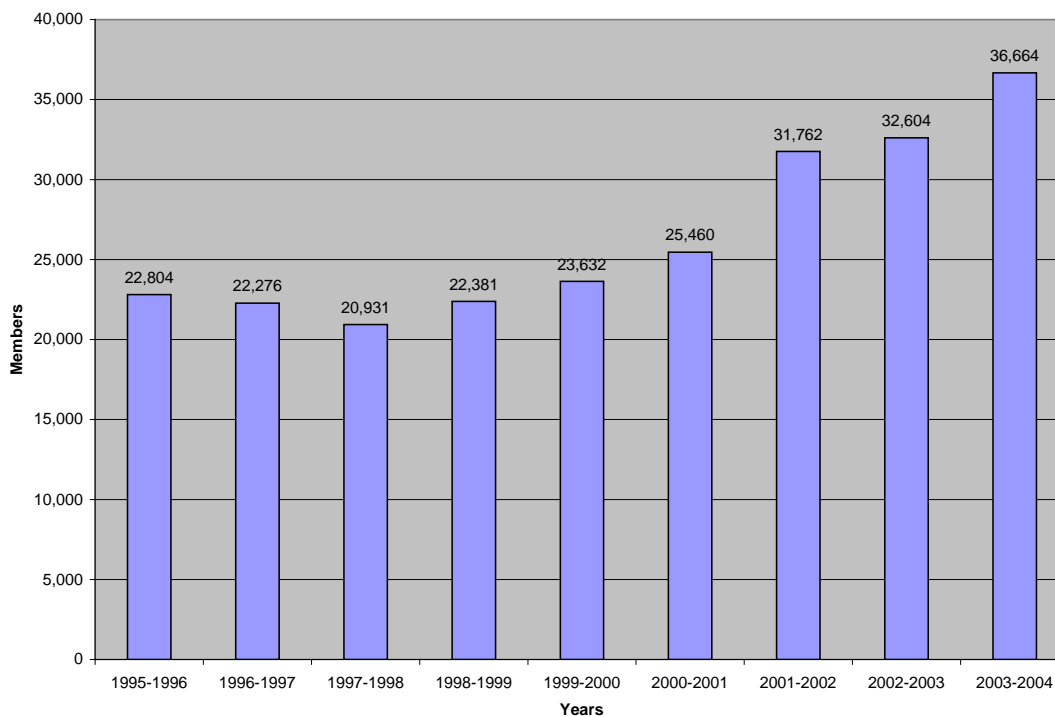
| AGENCY | TYPE OF AGENCY | COLLABORATIVE ROLE | ANNUAL COST OF CARE |
|---|--------------------------|---|--|
| Sutter Davis Hospital | Not-for-Profit Hospital | Contract with County Licenses two sites as outpatient departments of hospital Administrative Oversight (case management, medical records, and financial management) | \$500,000/year average |
| Sutter West Medical Group | For-profit corporation | Primary Care M.D. in two of the clinics Link to specialty care Staff after-hours clinic Staff 24-hour call coverage | Physicians are reimbursed at Medi-Cal rates for their services. |
| CommuniCare Health Centers | Not-for-Profit | Subcontracts w/SDH to operate community clinics Provides cultural and linguistically appropriate care (staff speak 10 languages) Outreach to impacted neighborhoods | \$10 million per year to operate clinics CommuniCare receives \$1.2 million for MIA |
| County of Yolo, Department of Indigent Care | Public Government Entity | Eligibility workers at clinic sites Insures compliance with all state codes and regulations | \$3 million/year |

Table created from Yolo Health Alliance planning documents and reports.

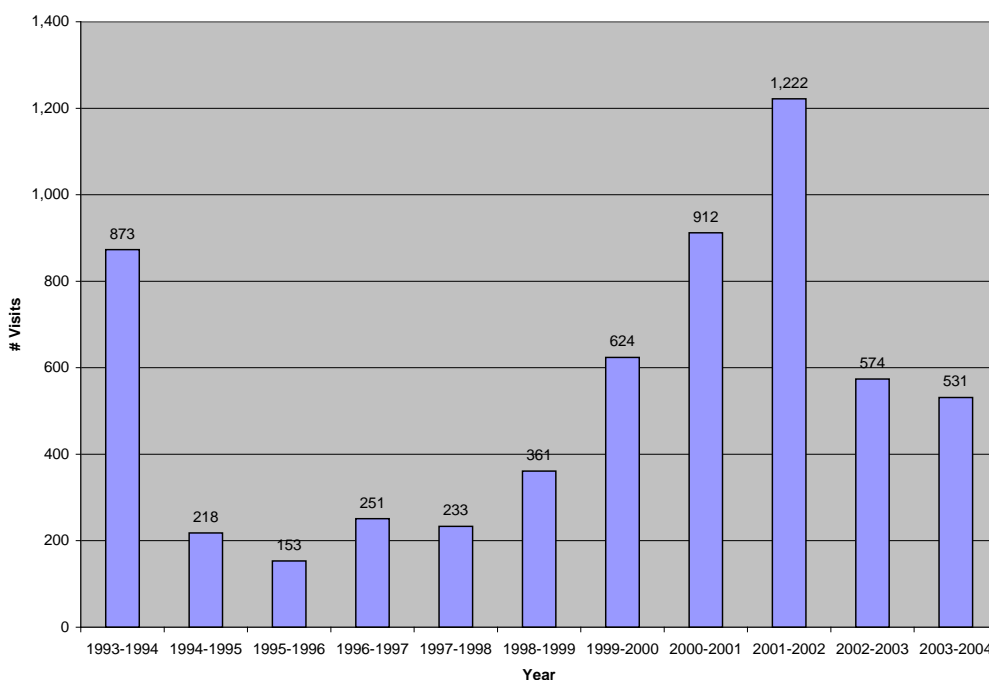
Yolo Health Alliance Successes

Since the projects inception, the Yolo Health Alliance has achieved many successes. Below are a series of graphs showing the projects outcomes over time. The data below reflects only the medically indigent population, not all of the underinsured clients of CommuniCare Health Centers.

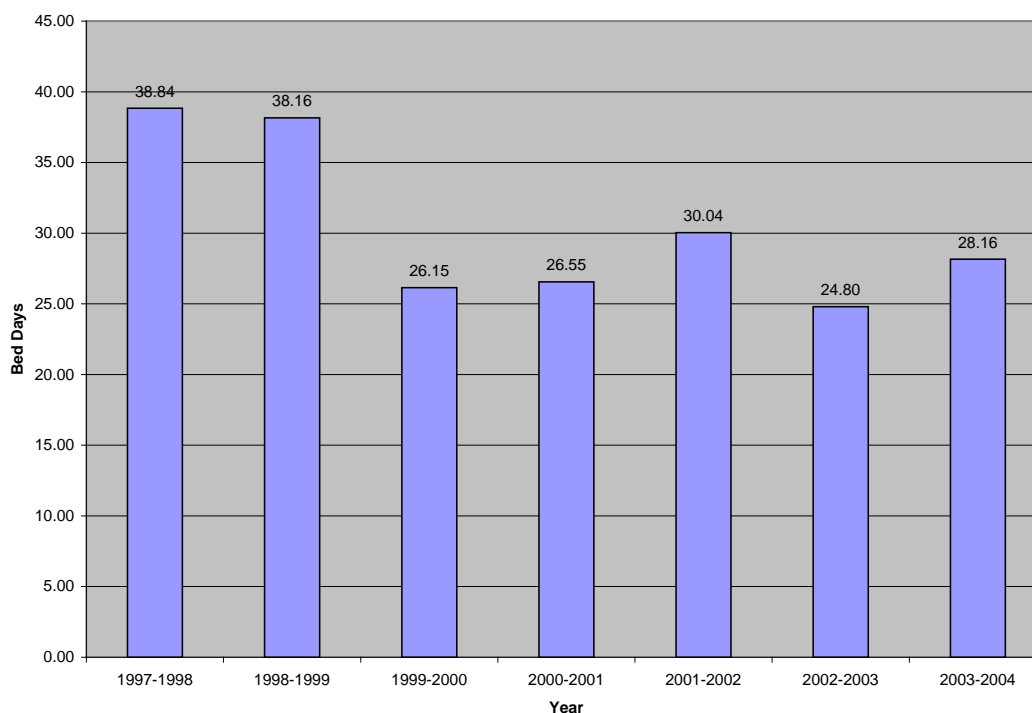
CHART 1. Yolo Health Alliance Number of Eligible Users



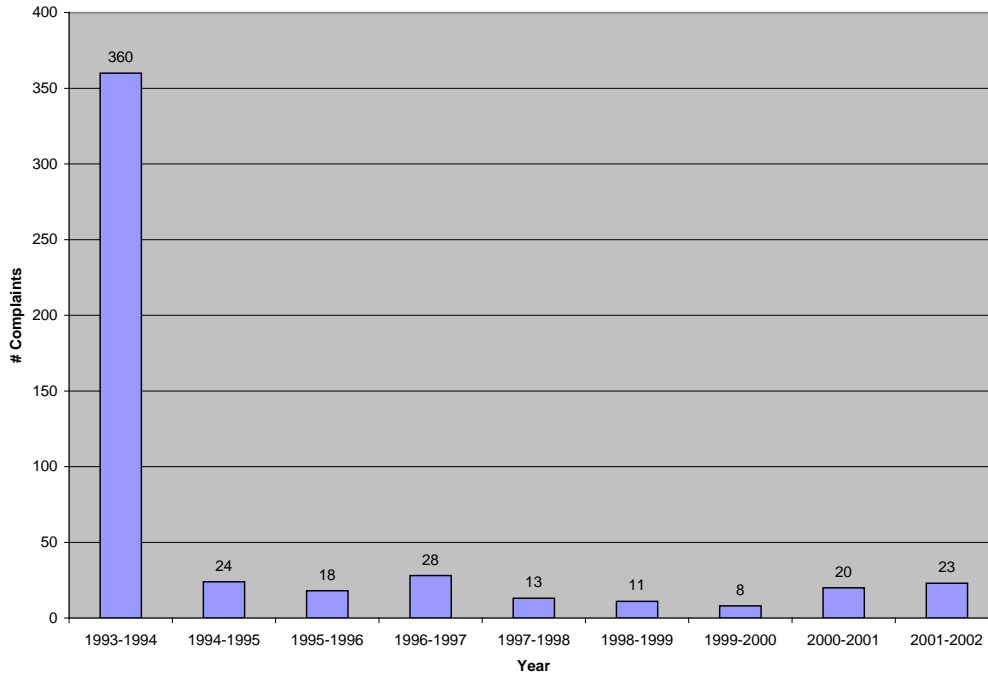
The number of Yolo Health Alliance eligible users has increased by approximately sixty percent over ten years, from 22,804 members in 1995 to 36,664 members in 2004.

CHART 2. Yolo Health Alliance Emergency Room Visits

The medically indigent population had 873 visits to the emergency room for non-urgent conditions in 1993 (when the County still managed and provided services to the medically indigent). A decrease in the number of emergency room visits for non-urgent conditions significantly decreased the first year of the Alliance. There was an increase in the number of emergency room visits during the years 2000-2002; however, this increase was primarily due to the addition of approximately 8,000 medically indigent adults. In 2002-2003 the emergency room visits decreased because the Yolo Health Alliance had time to restructure the service delivery system to meet the increased demand for services.

CHART 3. Yolo Health Alliance Hospital Inpatient Bed Days Per 1,000 Members

Length of stay during hospitalizations is a way to measure the effectiveness of ongoing, preventive care. People without access to routine health care, when admitted to the hospital, have elevated conditions that take longer to treat than a person who has access to primary care services (California HealthCare Foundation, 2004e). Over the ten-year history of the Alliance, hospital inpatient bed days per 1,000 members have decreased by approximately ten days. This significant decrease in hospital length of stay provides clear evidence that access to medical care provides an overall savings to the health care system.

CHART 4. Yolo Health Alliance Patient Complaints

One of the reasons the County decided to identify a new way of providing health care to the underinsured residents of Yolo County was because of the large number of patient complaints from patients accessing care through the county system of care. The Yolo Health Alliance model of care significantly decreased the number of patient complaints over time. In fact, the patient complaints have remained low over the ten year history of the Yolo Health Alliance.

Applying the Criteria

The purpose of the established evaluation criteria is to assess whether programs and services providing care to the underinsured is available and accessible. The criteria are a new, systematic evaluation tool that will assess effectiveness across a broad range of programs and services. I will apply the criteria to the different types of insurance (Table 1) and the Yolo Health Alliance to demonstrate that the Yolo Health Alliance effectively delivers care to the underinsured population.

Availability of Care

The Underinsured

Table 5 evaluates the availability of medical services to the underinsured in California as compared to Yolo County. The table shows that Medi-Cal and Healthy Families beneficiaries have access to primary care and hospital services. Currently, there are not enough physicians accepting Medi-Cal and Healthy Families beneficiaries to meet demand (California HealthCare Foundation, 2004a); however, Medi-Cal and Healthy Families beneficiaries have a greater access to primary care physicians than someone without any form of health insurance. Medi-Cal and Healthy Families beneficiaries' primary point of access to hospital care is through the hospital emergency room.

County Medically Indigent Services Programs that are operated by county government offers services to the poor residents of the county. The programs do have physicians available to provide primary care because they employ physicians to work in their clinics. Specialty care is not readily available to medically indigent clients, but they

do have access to hospital care accessed primarily through the hospital emergency room (Baxter and Mechanic, 1997).

The uninsured have the least amount of medical services available. Access to primary care depends on the number of not-for-profit community health centers providing care to people without health insurance. The uninsured access preventive care via a hospital emergency room; in California the uninsured are 76 percent more likely to present to a hospital emergency room with an elevated case of a preventable condition due to a lack of ongoing, preventive care (California HealthCare Foundation, 2004e).

The Yolo Health Alliance

The Yolo Health Alliance provides medical services comparable to the privately insured patients. By contracting with CommuniCare Health Centers to deliver care to the medically indigent population, Yolo County has a seamless system of care for all underinsured residents. Yolo County has a single community health center system CommuniCare Health Centers, which operates seven community health centers located throughout the County. The health centers have the capacity to provide ongoing primary care to all of the underinsured population, have access to specialty care through the Alliance partnership with Sutter West Medical Group, and have the ability to access necessary hospital care through the partnership with Sutter Davis Hospital. The underinsured residents of Yolo County have quality health care services available, regardless of income level and health insurance status.

TABLE 5. Availability of Medical Services

| LEVEL OF ACCESS | TYPE OF INSURANCE | ACCESS TO PRIMARY CARE | ACCESS TO SPECIALTY CARE | ACCESS TO HOSPITAL CARE |
|-----------------|--|------------------------|--------------------------|-------------------------|
| 4 | Private Health Insurance | ✓ | ✓ | ✓ |
| 4 | The Yolo Health Alliance | ✓ | ✓ | ✓ |
| 3 | Medi-Cal or Healthy Families | ✓ | | ✓ |
| 2 | County Medically Indigent Services Program | ✓ | | ✓ |
| 1 | Uninsured | | | ✓ |

Continuum of Care

The Underinsured

Table 6 evaluates the continuum of care available to the underinsured population in California as compared to Yolo County. Currently in California, there is no standard single point of entry for the underinsured population. As a result, Medi-Cal and Healthy Families beneficiaries, medically indigent adults, and the uninsured all have different points of access. Access to eligibility workers for the underinsured depends on where they access care. The medically indigent population has access to eligibility workers at county operated clinic sites. Medi-Cal and Healthy Families beneficiaries with a primary care physician do not have access to eligibility workers and the uninsured only have access to eligibility workers if they access care through a community clinic. State law prohibits not-for-profit hospital emergency rooms to ask health insurance status, so most

hospitals do not determine eligibility for health coverage programs in the emergency room. These criteria show that California does not have a continuum of health care services for the underinsured population.

The Yolo Health Alliance

Yolo County has seven community clinics operated by CommuniCare Health Centers. Each health center is available to people regardless of their health coverage status, citizenship status or age. The clinics are a single point of entry for all underinsured. Because CommuniCare is one agency, clients can visit any clinic and their medical chart will be available to staff. Further, the County places onsite eligibility workers in the clinics. The eligibility workers assist the underinsured clients with applications for health coverage programs and acts as the intermediary between the client and the different government agencies. The fact that the Yolo Health Alliance provides a single point of entry for all underinsured and equal access to eligibility workers provides the underinsured residents of Yolo County a continuum of health care comparable to a private insured patient.

TABLE 6. Continuum of Care

| LEVEL OF ACCESS | TYPE OF INSURANCE | SINGLE POINT OF ENTRY | ELIGIBILITY WORKERS ONSITE |
|-----------------|--|-----------------------|----------------------------|
| 4 | Private Health Insurance | ✓ | N/A |
| 4 | The Yolo Health Alliance | ✓ | ✓ |
| 3 | Medi-Cal or Healthy Families | | |
| 2 | County Medically Indigent Services Program | | ✓ |
| 1 | Uninsured | | |

Accessibility of Care

The Underinsured

Table 7 evaluates the accessibility of medical care to the underinsured population in California as compared to Yolo County. The private insured and Yolo Health Alliance patients have the most access compared to the underinsured population in California. Medi-Cal and Healthy Families beneficiaries do have access to preventive care, but there is no guarantee that the care will be delivered by a trusted provider, in a cultural and linguistically appropriate manner, and in a convenient location with extended hours of services. County operated clinics likely provide cultural and linguistically appropriate care because they employ physicians to work in their clinics and therefore can hire according to patient ethnicity and culture. However, the providers are not always trusted among the underinsured communities and the county clinics often do not offer consistent extended hours of operation. The uninsured have the least amount of access to services.

The current safety net system of care does not provide any consistent services to the uninsured across the State.

The Yolo Health Alliance

CommuniCare Health Centers have a longstanding history of delivering culturally and linguistically appropriate services to the underinsured residents of Yolo County. CommuniCare hires staff that is reflective of the population served. Currently, CommuniCare staff speaks more than ten languages. The agency uses community health outreach workers to visit communities with large numbers of underinsured to build trust and provide public health services such as immunizations and Tuberculosis treatments to show the underinsured that medical care is available. CommuniCare has strategically placed the clinics in areas with a high number of underinsured and immigrant populations and address the transportation issues for individuals and families living in very rural areas to improve access. As a result, the Yolo Health Alliance has experienced a large decrease in hospital bed days related to chronic conditions among the medically indigent population.

TABLE 7. Accessibility of Care

| LEVEL OF ACCESS | TYPE OF INSURANCE | ACCESS TO PREVENTIVE CARE | CULTURAL AND LINGUISTICALLY APPROPRIATE SERVICES | TRUSTED PROVIDER | CONVENIENT LOCATION; CONVENIENT HOURS |
|------------------------|--|----------------------------------|---|-------------------------|--|
| 4 | Private Health Insurance | ✓ | ✓ | ✓ | ✓ |
| 4 | The Yolo Health Alliance | ✓ | ✓ | ✓ | ✓ |
| 3 | Medi-Cal or Healthy Families | ✓ | | | |
| 2 | County Medically Indigent Services Program | ✓ | ✓ | | |
| 1 | Uninsured | | | | |

Measures Success*The Underinsured*

Table 8 evaluates the safety net systems ability to measure success at a patient level in California as compared to Yolo County. The current safety net system for the underinsured was created over time with programs that focused on a single underinsured population. As a result, agencies serving the underinsured population are unable to measure success at a patient level. For example, the current system in California allows hospitals to track the number of underinsured patients served, including number of emergency room visits for non-urgent conditions. The current system also allows community health centers to track the number of primary care visits per patient. The

safety net health care system does not share important health information between the different medical care providers. Sharing data would let providers' measure success at the patient level and show outcomes that demonstrate success. A coordinated approach to health care delivery service evaluation would allow community health centers and government health coverage programs to show that routine preventive care does reduce the number emergency room visits for non-urgent conditions and hospitalizations for treatable conditions.

The Yolo Health Alliance

Currently, the Yolo Health Alliance only tracks patient success for the medically indigent population; however, the collaborative model is conducive for evaluating the health indicators of all underinsured clients accessing care through Sutter Davis Hospital and CommuniCare Health Centers. The collaborative nature of the program and the contract between the different partner agencies allow the Alliance partners to share client information to further health care delivery. This means that when a client presents to the hospital emergency department for non-urgent care, hospital staff can notify CommuniCare staff of the client's condition and discharge orders. If the client presents during clinic hours, a CommuniCare case manager will escort the client to the clinic for care. The sharing of patient information allows the safety net, or the Yolo Health Alliance, measure the success of the primary care provided at the clinics.

TABLE 8. Measure Success

| LEVEL OF ACCESS | TYPE OF INSURANCE | MEASURES SUCCESS AT PATIENT LEVEL |
|------------------------|--|--|
| 4 | Private Health Insurance | ✓ |
| 4 | The Yolo Health Alliance | ✓ |
| 3 | Medi-Cal or Healthy Families | |
| 2 | County Medically Indigent Services Program | |
| 1 | Uninsured | |

CONCLUSION

Health care is a topic of ongoing debate in California. With almost half of all Californian's underinsured (approximately 13.5 million Californian's or 42 percent of the total population) we are approaching a health care crisis; a crisis that will affect health care premiums and potentially have a negative impact on the State economy. The current safety net health care system is fragmented and does not deal with the underinsured population as a comprehensive group. This problem is further compounded in California by the discrepancies in health care delivery systems across counties. Therefore, as a result no standard criteria exist to measure the success of a program or health care delivery system's ability to provide comprehensive care to the underinsured.

Based on the research, there are four natural themes to assess the effectiveness of a health care delivery system for the underinsured: (1) Availability of Medical Care, (2) Continuum of Care, (3) Accessibility of Care, and (4) Measures of Success at a patient level. Availability of medical care evaluates whether medical services are available to the underinsured by measuring access to primary care, specialty care, and hospital care. The continuum of care criterion evaluates whether a continuum of care exists for the underinsured by determining whether a program has a single point of entry for all underinsured and onsite eligibility workers. Accessibility of care evaluates whether the underinsured will utilize the available medical services. Three factors that impact access include the delivery of cultural and linguistically appropriate services, delivery of care from a trusted provider, and delivery of care in a convenient manner. The final criterion is whether health outcomes can be measured at a patient level.

The developed criteria provide a standard approach to measuring whether a health care delivery model is effective to the patient. In order to show how the criteria works, the developed criteria was used to evaluate the availability, continuum of care, accessibility, and ability to measure success at a patient level for the programs currently serving the underinsured in California as compared to the safety net system, the Yolo Health Alliance, that provides care to the underinsured in Yolo County. Based on the evaluation criteria, the Yolo Health Alliance has access to primary care, specialty care, and hospital care services equal to that of a private health insurance plan. The Yolo Health Alliance provides a continuum of care to all underinsured by offering a single point of access and onsite eligibility workers. In general, a continuum of care for all underinsured does not exist in California. The underinsured who participate in the Yolo Health Alliance access services and give strong patient satisfaction scores. This access is comparable to the services available to the privately insured patient. Access to services for the underinsured in California is determined based on the type of insurance. Finally, the structure of the Yolo Health Alliance allows partners to measure success at a patient level. Most health care delivery systems in California do not have the capacity to track a patient's use pattern between health care providers.

Based upon the evaluation tool presented in this study, the underinsured in Yolo County have access to medical care that is comparable to individuals with private health insurance. The Yolo Health Alliance outcomes demonstrate project success through decreased emergency room utilizations for non-urgent care, decreased hospital bed days, and decreased patient complaints. These successes have occurred over a ten year period,

during which time there was a sixty percent increase in eligible users. These statistics coupled with the ongoing collaborative nature of the program demonstrate that the Alliance model is sustainable and effective at providing care for the underinsured and a best-practice, safety net health care delivery system that other counties should consider.

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