Increasing Access to Health Care
for Low-Income Uninsured Residents of Alameda County, California

Baseline Assessment 2007

January 2009

ALAMEDA COUNTY
ACCESS TO CARE
COLLABORATIVE

Expanding Health Coverage
and Increasing Access to
High Quality Care

A JOINT PROJECT OF:

Alameda County
Health Care
Services Agency

Alameda County
Social Services
Agency

Alameda County
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Alameda Alliance
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ALAMEDA COUNTY
MEDICAL CENTER

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Consortium

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INTRODUCTION

Why Should Anyone Care About Access to Health Care?

Access to health care for the uninsured continues to be a public policy problem that is again gaining national attention. Low income people in particular are hit hardest by the consequences of being uninsured: medical debt can limit access to health care, and the risk of bankruptcy is often just one medical bill away. Most unpaid medical bills are sent to collection agencies, resulting in financial ruin for many families.[1,2]

Compounding the financial risk that low-income uninsured families face are barriers due to the way the health care system itself is organized: fragmented services, silos of medical information, low emphasis on preventive and primary care, competing professional philosophies on how care should be delivered, a lack of racial and language diversity in the health care workforce, and insufficient policies and practices that support patient and family involvement in care.

Alameda County is unique in that there are many stakeholders who are committed to addressing these issues. Alameda County benefits from a strong network of federally- and state-funded health care provider organizations that have missions to serve the uninsured, people on Medi-Cal, and other low-income people. Additionally, the Alameda County Board of Supervisors historically commits a large percentage of the county budget to maintain access to free and affordable health care for its lowest-income residents.

Why Conduct a Baseline Assessment on Health Care Services for the Uninsured?

This report provides the results of a 2007 baseline assessment of health care services for Alameda County's lowest income uninsured. The purpose of the assessment is three-fold: (1) to provide a tool for countywide planning and goal-setting, (2) to inform stakeholder discussion to optimize the safety net for Alameda County's diverse population, and (3) to quantify how far Alameda County is from reaching universal coverage and access to care. This report presents 2007 data on:

1. a profile of the low-income uninsured population in Alameda County;
2. the volume of uninsured who accessed primary care through the health care safety net;
3. additional indicators of safety net capacity: primary care wait times,

1 M.M. Doty, J.N. Edwards, and A.L. Holmgren. "Seeing Red: Americans Driven into Debt by Medical Bills." The Commonwealth Fund, August 2005.

2 R.W. Seifert, and M. Rukavina. "Perspective: Bankruptcy is the Tip of the Medical Debt Iceberg." Health Aff (Millwood). 2006 Mar-Apr;25(2):w89-92. Epub 2006 Feb 28.

specialty care wait times, and emergency department use;
4. uninsured populations that are underserved by the safety net.

In the concluding sections, we describe the concept of the patient-centered medical home approach. Additionally, we provide several scenarios that calculate the cost of expanding full health insurance coverage, as well as access to primary care and specialty care services only.

By documenting the current use and capacity of Alameda County's safety net, and by exploring innovative approaches to improving the health care delivery system, Alameda County can determine the best use of limited local resources to increase access to quality health care to its most vulnerable residents.

What Does the Low-Income, Uninsured Population in Alameda County Look Like?

18 PERCENT OF ALAMEDA COUNTY RESIDENTS–APPROXIMATELY 233,000 PEOPLE–WERE UNINSURED DURING THE COURSE OF THE ENTIRE YEAR.

According to the California Health Interview Survey 2005, 18 percent of Alameda County residents—approximately 233,000—were uninsured for part or all of the year. At any given time, 12 percent reported being uninsured, and more than 20 percent were on publicly-funded health insurance programs.[3]

Fifty-two percent (52%) of the uninsured are low-income, living below 200% of the federal poverty level.[4] We focus the rest of this report on the lowest-income uninsured.

Most (78%) of low-income uninsured in Alameda County are adults. Slightly more than half are men. More than half (52%) of low-income uninsured are Latino, followed by Asian (16%), African American (13%), and White (11%). Almost half of low-income uninsured in Alameda County are citizens.

Most (67%) low-income uninsured in Alameda County are limited-English proficient. Of the low-income uninsured reporting that they spoke another language besides English, the largest group was Spanish and English-Spanish speakers (55%).[5]

Most low-income adults and children in Alameda County are not eligible for Medi-Cal or Healthy Families programs, most likely due to the program requirements which are based on income, family composition (i.e. parents with dependent children), and immigration documentation (i.e. must be a citizen, or a legal immigrant residing in the U.S. more than five years).

3 The percentages listed are based on pooled data from the California Health Interview Survey 2003 and 2005.

4 California Health Interview Survey 2005.

5 The percentages listed are based on pooled data from the California Health Interview Survey 2003 and 2005.

Contrary to public perception, most low-income uninsured are employed. They are typically referred to as the "working poor." Approximately 30 percent of Alameda County's working uninsured are employed by small businesses with fewer than 10 workers. Typically, small businesses are less likely to offer health insurance to employees, or if health coverage is offered, the employee's share of cost is unaffordable.[6]

Given that many low-income uninsured are not eligible for public programs, and purchasing individual private health insurance is unaffordable, many turn to Alameda County's safety net for free or low-cost health care.

What is the Health Care Safety Net in Alameda County?

Alameda County's "health care safety net" is comprised of an array of provider organizations. The health care safety net includes: the county public hospital and it affiliated clinics, community clinics (community health centers), two public health departments, school-based health centers, family planning and women's health clinics, community organizations, mobile van programs, private physicians, and private hospitals that serve large numbers of low-income and uninsured people.

Alameda County's safety net provides a fair amount of preventive and primary care to the uninsured.[7] In 2007, more than half of the uninsured in Alameda County (105,000 people) accessed primary care through the largest comprehensive primary care providers: the Alameda County Medical Center, the community health centers, and two pediatric clinics operated by Children's Hospital & Research Center Oakland and St. Rose Hospital. The uninsured served by these providers were mostly low-income.

The uninsured also accessed primary care through many limited-scope medical programs and clinics. In 2007, community organizations reached more than 11,000 people and mobile health vans served more than 6,000 people, mostly uninsured. Family planning and women's clinics (most of which are operated by Planned Parenthood), served more than 18,000 people. The school-based health centers served almost 7,000 students, and the Alameda County and Berkeley Public Health Departments served approximately 13,000 people through public health nurse visits.

Based on the best available data, it appears that more than half of the uninsured accessed primary care services—either comprehensive or limited-scope—at a safety net provider in Alameda County in 2007.[8]

6 The cost to purchase individual or small group coverage is more than $4,000 annually, per individual. "Health Insurance: Can Californians Afford It?" The California Healthcare Foundation, June 2007.

7 Data on private physicians serving the uninsured is not tracked and therefore the numbers served by private physicians are unknown.

8 It was not possible to compute the total number of uninsured patients across the entire safety net, because some accessed services at multiple provider sites.

Who Remains Underserved in Alameda County?

Certain underserved populations experience extraordinary barriers to care, regardless of the perceived availability of services. Social stigma, lack of provider cultural competence, and bureaucracy contribute to poor access for vulnerable populations: foster care youth, the homeless, those "re-entering" society after incarceration, and legal and undocumented immigrants. The following are estimated counts of each group.

There are approximately 2,600 youth under Alameda County foster care supervision.[9] By law, foster youth are entitled to Medi-Cal through age 21, but due to the disruptive nature of foster care placements, insurance coverage is often fragmented. In particular, youth who age out of the foster care system at age 18 often lose their Medi-Cal despite having three more years of eligibility.[10]

There are more than 6,000 homeless in Alameda County on any given night, and as many as 16,000 people experience homelessness over the course of a year. It is estimated that more than two-thirds are uninsured.[11] Because of the transitional nature of being homeless and the prevalence of substance abuse and mental health conditions, most homeless have difficulty with appointment-based services at traditional medical sites. Many services for the homeless are provided "beyond the four clinic walls" via mobile van services and on-site health services to supportive housing sites.

As of 2007, there were 22,250 residents of Alameda County who were under criminal justice supervision (i.e. on parole or probation). It is estimated that within this group approximately 11,000 are uninsured. Challenges that the re-entry population face in accessing health services include: lack of formal identification upon release, lack of access to prison medical records, and difficulty securing employment and affordable housing upon release.[12]

Alameda County has a significant number of low-income immigrants who work in manual labor and low-wage service jobs without health care benefits. The undocumented are particularly vulnerable to poor access to care. Barriers faced by immigrants in Alameda County include: legal restrictions on health services based on immigration status, fear of deportation, and a lack of bilingual providers and language accessible services.

9 "Foster Care in the Bay Area: An Overview from kidsdata.org." Lucile Packard Foundation for Children's Health. Accessed on December 22, 2008 at http://www.kidsdata.org.

10 Y. Leung, C. Burnett, B. Wunsch, S. Geierstanger, and A. Faxio. "Alameda County Health Needs Assessment of Emancipating and Emancipated Foster Youth." Alameda County Health Care Services Agency and Alameda County Social Services Agency, September 2007.

11 R. Speiglman and J Norris. "Alameda Countywide Shelter and Services Survey: County Report." Public Health Institute, May 2004. Accessed on December 22, 2008 at http://www.everyonehome.org.

12 B. Heiser, J. Williams. "Reentry Health Care in Alameda County: Initial Assessment and Recommendations of the Alameda County Reentry Health Taskforce." Urban Strategies Council, May 2008. Accessed on December 22, 2008 at http://urbanstrategies.org.

How Long Does it Take to Access Care through the Safety Net?

Wait times to get a primary care or specialty care appointment provide a glimpse at the capacity of the safety net. Both are inter-related. In 2007, primary care providers cited backlogs in specialty care referrals as a major reason for being unable to take on new primary care patients. Similarly, specialists are overwhelmed with referrals, a percentage of which could be adequately addressed by referring primary care providers.

Wait times to see a primary care provider

In 2007, the greatest disparity in wait times was between established patients (i.e. those making a return visit) and new patients (i.e. those who have never been seen by the provider and therefore are not yet recorded in the clinic system). Established patients—regardless of insurance status—wait up to the next day for urgent care, approximately 3 weeks for follow-up appointments, and approximately 2 months for physical exams. For new patients, however, wait times were significantly longer. In 2007, it was common for new patients to wait as long as 3 months to see a comprehensive primary care provider for a first medical appointment.

What underlies long wait times in Alameda County is a high demand for services. The safety net system simply does not have enough capacity to provide timely access to care for all people in need. Secondly, the largest comprehensive primary care providers are required to screen new patients for eligibility for Medi-Cal, Healthy Families, and County Medical Indigent Service Program (CMSP), a process which may deter transitional and other vulnerable populations from gaining timely access to a medical appointment. Lastly, there is no uniform process for new uninsured patients to get a first medical appointment. Each clinic has its own method of managing high demand, which may involve multiple levels of paperwork and phone calls before a patient is seen. The lack of a uniform process can be confusing for those seeking primary care for the first time.

Wait times for specialty care

Low-income residents who had Medi-Cal access specialty care through a network of private specialists and hospitals that accept Medi-Cal, and through the Alameda County Medical Center (ACMC) and Children's Hospital & Research Center Oakland.

For the uninsured, free and low-cost specialty care is much more limited. Specialty care for uninsured adults is provided almost exclusively by the Alameda County Medical Center (ACMC); demand for specialty care services at ACMC exceeds capacity. Wait times to see a specialist for new patients at ACMC can be as long as six months. The specialties most in demand among the uninsured in 2007 were: gastroenterology, orthopedics, urology, ophthalmology, dermatology, and cardiology. In 2007, more than 9,000 uninsured sought specialty care services at ACMC.

Long wait times for primary and specialty care among the uninsured in Alameda County may contribute in part to increased use of local hospital emergency department services. In 2007, more than 41,000 Alameda County uninsured residents sought care in an emergency room. It is estimated that

a percentage of these visits could have been adequately and more efficiently addressed by early access to primary and specialty care.[13]

What is the Patient-Centered Medical Home, and How Can This Approach Improve Access to Care?

The concept of the "patient-centered medical home" has gained increased national recognition since the term was first coined by the American Academy of Pediatrics in 1967 to address the need for coordinated medical information for children with special needs.[14] Since 1967, the concept has evolved to include other aspects of care for children, youths and adults.[15] The medical home concept is now endorsed by four national medical associations and is the subject of several national initiatives, including a new Medicare demonstration project on primary care payment re-design.[16] Recently, the Commonwealth Fund commissioned a study that concluded that the medical home approach can reduce racial and ethnic disparities in access to care.[17]

There are currently different variations of the medical home definition; what is common among all of the definitions is the characterization of the current health care system as a patchwork of services that must be addressed through increased coordination.

Practical ways that health care providers can implement the medical home approach have been suggested by the National Committee for Quality Assurance (NCQA) and other national organizations. In 2008, NCQA released a medical home assessment survey instrument that examines multiple aspects of care, such as: standardized clinical processes; standardized administrative processes (scheduling, visit with multiple clinicians, triage, same day scheduling capacity, same day triage capacity, clinical advice via telephone, group visits); electronic, searchable, data systems that track language, race, medication, diagnoses, and visit data; and non-physician members involvement in care management.[18]

Large-scale efforts such as the Alameda County Excellence (ACE) program and

13 S. McConville and H. Lee. "Emergency Department Care in California: Who Uses It and Why?" California Counts: Population Trends and Profiles. Public Policy Institute of California.

14 "The Medical Home: Position Statement." Association of American Medical Colleges, March 2008.

15 "Joint Principles of the Patient-Centered Medical Home." American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, March 2007.

16 Payment design for the medical home approach is currently being debated and tested. The Commonwealth Fund has developed a proposal for primary care payment re-design to support the development of "high performance health systems," and the Centers for Medicare and Medicaid Services, in partnership with Mathematica, is proposing a medical home reimbursement structure as part of a Medicare fee-for-service medical home demonstration project, due for roll-out in 2010.

17 Beal, AC; Doty, MM; Hernandez, SE; Shea, KK; Davis, K. "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey," The Commonwealth Fund, June 2007.

18 Physician Practice Connections Tool – Research Version 2007. National Committee for Quality Assurance (NCQA).

the establishment of the Alameda County Specialty Care Task Force are the beginnings of a medical home approach for low-income patient populations in Alameda County.[19] There is room to build on these efforts. A county-wide medical home assessment of all safety net providers would determine the additional steps necessary to ensure that all low-income residents have a medical home.

What is the Current Gap in Access to Health Care for the Uninsured?

In this section, we present several scenarios to close the gap in access to care for the uninsured: insurance coverage expansions, and expanding access to primary and specialty care. Although these scenarios are based on the best available data, they are not scientific and are intended only as a starting point for discussion.

Scenarios #1 and #2: Expanding Full Health Insurance Coverage.

SCENARIO #1
Full Coverage for Children
6,000 children

Alameda County is close to reaching universal coverage for all children. It is estimated that there are 19,000 children in Alameda County who are uninsured, and of those uninsured children 13,000 are eligible for Medi-Cal or Healthy Families. If the systemic problem in public program enrollment can be remedied and those eligible enrolled, Alameda County will only have 6,000 children left to insure. The cost of providing full coverage for these 6,000 children, at $1,200 annually per child, is approximately $7.2 million annually.

SCENARIO #2
Full Coverage for Adults and Children
177,000 people

Though costly, we present a scenario of extending coverage to the adult uninsured population for comparative purposes. We use the upper estimate of 196,000 uninsured. Subtracting those who are eligible for Medi-Cal or Healthy Families, 177,000 uninsured adults and children remain. Multiplying this number by the average annual health coverage premium cost of $4,480 annually, we arrive at a cost of $793 million to provide full coverage for 177,000 adults and children in Alameda County.

19 Alameda County safety net providers are implementing the Coverage Initiative/Alameda County Excellence (ACE) program for the uninsured, tracking chronic disease (i2i Tracks) using a uniform computerized population health management system, convening a Specialty Care Task Force to address access to specialty care for the uninsured, and convening a Health Information Technology Coordinating Committee to address fragmented data systems.

Scenarios #3 and #4: Expanding Outpatient Primary and Specialty Care Only.

SCENARIO #3

Access to Primary and Specialty Care for All Adults and Children

102,120 people

Extending a non-coverage program where care is accessed at the safety net is another option.

We estimate a total of 196,000 total uninsured. We subtract those who are eligible for Medi-Cal or Healthy Families, and those who are currently receiving primary and specialty care services through the county CMSP program. We estimate that similar to the covered population, 87 percent use health services in a given year, resulting in an estimated 102,120 people who will use services but are uninsured. Multiplying this number of people by an annual charge of $500 for outpatient primary and specialty care, we arrive at a cost of $51 million for primary and specialty care for 102,120 people.

SCENARIO #4

Access to Primary and Specialty Care to the Lowest-Income (<200% FPL) Adults and Children

33,389 people

The fourth scenario proposes to increase access to primary and specialty care for only the lowest-income uninsured. We use the upper estimate of 117,000 low-income uninsured. We subtract those who are eligible for Medi-Cal or Healthy Families and those who are currently already receiving primary and specialty care services through the county CMSP program. We estimate that similar to the covered population, 87 percent use health services in a given year, resulting in an estimated 33,389 people who will use services but are uninsured. Multiplying this by an annual charge of $500 for outpatient primary and specialty care, we arrive at a charge of $17 million for 33,389 people.

Workforce Gap in Expanding Access to Primary Care

Expanding access to health services to the uninsured — be it through an insurance model or through expanding access to primary care and specialty care – will require an increase in the health care workforce. Locally, Alameda County experiences difficulties in recruiting licensed providers who are willing to serve uninsured and low-income populations. There are currently 142 full-time equivalent primary care providers in Alameda County's safety net. We estimate that to expand services to reach all uninsured in Alameda County, an additional 95 FTE primary care physicians (PCPs) and 33 FTE specialists are needed. In addition, safety net institutions need more mid-level providers (e.g. nurses, physician assistants), dental providers, mental health providers, other medical personnel and enabling service staff.

Lastly, policymakers and safety net institutions will have to ensure the racial, ethnic, and language diversity of providers, as well as recruitment of enough providers who are comfortable seeing low-income and marginalized patient populations. As noted in a report on the physician workforce by the Center

for Health Professions, "Of California physicians who reported their race or ethnicity in 2000, African Americans and Hispanics/Latinos each comprised less than 5% of California's physicians although they made up about 7% and 31% of the state's population respectively."[20] Efforts to address the local health care workforce shortage will require increased partnerships between safety net providers, colleges and universities, as well as adequate levels of education funding.

Additional Scenarios Clearly, the few scenarios discussed thus far are only a few of many potential scenarios to address the gap in access to care in Alameda County. There are numerous alternative ideas that address the need to increase capacity and improve the quality of care, e.g. streamlining clinic enrollment processes, organizing volunteer physicians to offer care, investment in health information technology, development of a uniform referral system between health, mental health, community organizations, schools, and criminal justice. These and other ideas merit exploration in the effort to improve both access and the quality of care for low-income Alameda County residents.

Conclusion

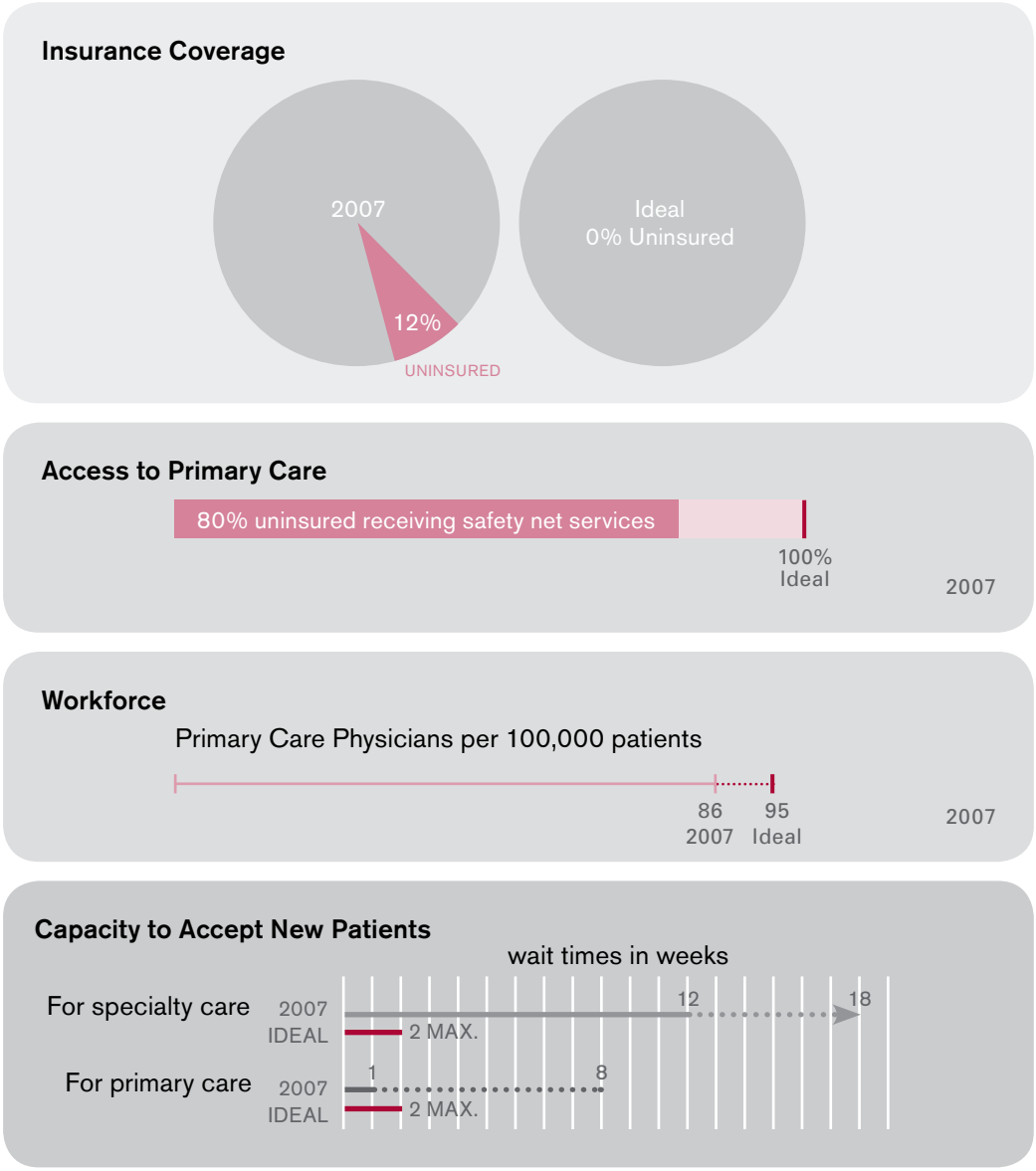
The 2007 data contained in this report provides a baseline for measuring future progress in covering the uninsured and increases in access to health services in Alameda County. In 2007, a tremendous volume of services was provided to more than 100,000 uninsured. Yet demand on the safety net remains high, with limited capacity, as indicated by the long wait times for new patients to access primary and specialty care in a non-emergency department setting. Access to affordable health care remains a top concern and worry for many Alameda County residents. Recent renewed commitment by state and national leaders to address this concern through large-scale health care reform is promising. With state and federal support, Alameda County can make significant advancements in increasing access to care for all Alameda County residents.

20 C. Dower, et al. The Practice of Medicine in California: A Profile of the Physician Workforce. The Center for Health Professions, University of California San Francisco, February 2001.

Alameda County Health Safety Net "Dashboard"

Similar to the dashboard of a car, which tells the driver important performance information like speed, mileage, and gas levels, there can also be performance indicators for the health care safety net.

The indicators used in the following dashboard are not exhaustive and are limited to particular aspects of access to care. Future updates to this dashboard can incorporate additional processes and clinical indicators, such as NCQA's HEDIS Access/Availability of Care Measures.



B. **Introduction**
Why Should Anyone Care About Access to Health Care?

Access to health care for the uninsured continues to be a public policy problem that is again gaining national attention. Low income people in particular are hit hardest by the consequences of being uninsured: medical debt can limit access to health care, and the risk of bankruptcy is often just one medical bill away. Most unpaid medical bills are sent to collection agencies, resulting in financial ruin for many families.[21,22]

Compounding the financial risk that low-income uninsured families face are barriers due to the way the health care system itself is organized: fragmented services, silos of medical information, low emphasis on preventive and primary care, competing professional philosophies on how care should be delivered, a lack of racial and language diversity in the health care workforce, and insufficient policies and practices that support patient and family involvement in care.

Alameda County is unique in that there are many stakeholders who are committed to addressing these issues. Alameda County benefits from a strong network of federally- and state-funded health care provider organizations that have missions to serve the uninsured, people on Medi-Cal, and other low-income people. Additionally, the Alameda County Board of Supervisors historically commits a large percentage of the county budget to maintain access to free and affordable health care for its lowest-income residents.

Why Do a Baseline Assessment on Health Care for the Uninsured in Alameda County?

This report provides the results of a 2007 baseline assessment of health care services for Alameda County's lowest income uninsured. The purpose of the assessment is three-fold: (1) to provide a tool for countywide planning and goal-setting, (2) to inform stakeholder discussion to optimize the safety net for Alameda County's diverse population, and (3) to quantify how far Alameda County is from reaching universal coverage and access to care. This report presents 2007 data on:

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21 M.M. Doty, J.N. Edwards, and A.L. Holmgren. "Seeing Red: Americans Driven into Debt by Medical Bills." The Commonwealth Fund, August 2005.

22 R.W. Seifert, and M. Rukavina. "Perspective: Bankruptcy is the Tip of the Medical Debt Iceberg." Health Aff (Millwood). 2006 Mar-Apr;25(2):w89-92. Epub 2006 Feb 28.

3. indicators of safety net capacity: primary care wait times, specialty care wait times, and emergency department use;
4. uninsured populations that are underserved by the safety net.

We provide an Alameda County health care safety net "dashboard" that summarizes several of the key indicators of access mentioned above (Appendix 2). In the concluding sections, we describe the concept of the patient-centered medical home approach. Additionally, we provide several scenarios that calculate the cost of expanding full health insurance coverage, as well as access to primary care and specialty care services only.

By documenting the current use and capacity of Alameda County's safety net, and by exploring innovative approaches to improving the health care delivery system, Alameda County can determine the best use of limited local resources to increase access to quality health care to its most vulnerable residents.

Why Focus on Primary and Specialty Care?

The definition of "access to care" that is used in this report refers specifically to access to primary and specialty care. We generally exclude acute care services–emergency department and inpatient hospital services–from the overall policy objective of "increasing access to care" for several reasons:

- Alameda County residents should have access to preventive care along with primary and specialty care at earlier stages of disease in order to ensure the best health outcomes.
- Alameda County residents already have access to emergency department services by law, whereas there is no legal mandate to ensure that people have access to primary or specialty care.
- Many Alameda County residents use emergency departments for non-emergency needs because of a lack of timely access to primary and specialty care.

C. What does the **Low-Income, Uninsured Population in Alameda County** Look Like?

Defining Low-Income

We look at the lowest income population in Alameda County, as defined by the federal government. Specifically, we focus on those whose income is equal to or less than 200% of the federal poverty level (FPL). The federal government's definition of poverty is used to determine eligibility for public programs, including Medi-Cal.[23] Federal threshold levels for poverty are listed in Exhibit 1.

For example, a family of three whose total annual household income is less than $17,600 is said to be living in poverty, or "below 100% of the federal poverty level." Similarly, a family of three whose total annual household income is less than $35,200 is "below 200% of the federal poverty level."

According to the U.S. Census, more than 340,000, or almost one-quarter of Alameda County residents are low-income (below 200% FPL).[24] Areas in Alameda County with the highest percentages of residents living below the federal poverty level are: Berkeley, Oakland, Ashland, Emeryville, and Cherryland.[25] According to the California Health Interview Survey 2005, 18 percent of Alameda County residents—approximately 233,000 people—were uninsured for part or all of the year.[26]

IN THIS SECTION

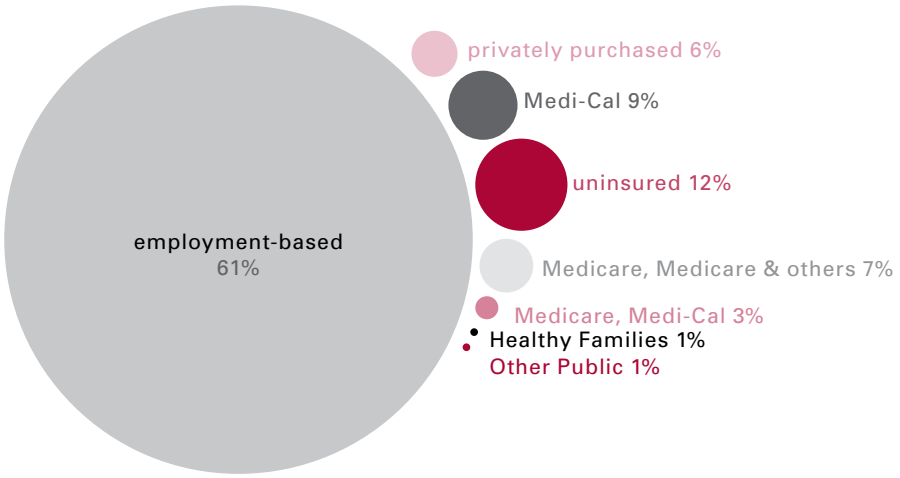
Exhibit 1. Poverty as Defined by the Federal Government

# of persons in family or household	At 100% of the federal poverty level, a family's income would be…			At 200% of the federal poverty level, a family's income would be…		
	annual	monthly	hourly	annual	monthly	hourly
1 person	$10,400	$866	$5.00	$20,800	$1,733	$10.00
family of 2	$14,000	$1,167	$6.73	$28,000	$2,333	$13.46
family of 3	$17,600	$1,467	$8.46	$35,200	$2,933	$16.92
family of 4	$21,200	$1,767	$10.19	$42,400	$3,533	$20.38
family of 5	$24,800	$2,067	$11.92	$49,600	$4,133	$23.85

Source: "The 2008 HHS Poverty Guidelines." United States Dept. of Health & Human Services. Accessed on September 8, 2008 at http://aspe.hhs.gov/poverty/08poverty.shtml.

23 Note that the federal government's definition of poverty does not take into account regional differences in the cost of living, such as the high cost of housing in the San Francisco Bay Area. Household income is counted pre-tax. Cash assistance and federal benefit programs like Medi-Cal are not counted as part of household income.

Exhibit 2. Types of Health Coverage Among Alameda County Residents



Source: California Health Interview Survey, 2003 and 2005. Due to rounding, numbers may not add to 100%. At any given time, 12 percent of Alameda County residents are uninsured. Approximately 18 percent of residents are uninsured during the course of the entire year.

At any given time, 12 percent (more than 166,000) reported being uninsured in Alameda County, and more than 20 percent rely on public programs for their health coverage (Exhibit 2).

Profile of the Low-Income Uninsured Population in Alameda County

18 PERCENT OF ALAMEDA COUNTY RESIDENTS– APPROXIMATELY 233,000 PEOPLE– WERE UNINSURED DURING THE COURSE OF THE ENTIRE YEAR

Of the total uninsured, a little more than half (52 percent) are low-income, living below 200% of the federal poverty level. We focus the rest of this report on this group of the lowest-income uninsured (Exhibit 3).

Most (78 percent) of low-income uninsured in Alameda County are adults. Slightly more than half are men. More than half (52 percent) of low-income uninsured are Latino, followed by Asian (16 percent), African American (13 percent), and White (11 percent). Almost half of low-income uninsured in Alameda County are citizens.

Most (67 percent) low-income uninsured are limited-English proficient, indicating that any future health coverage

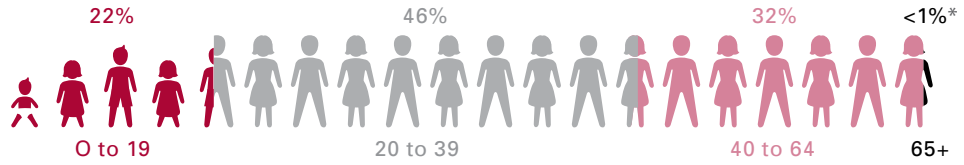
24 U.S. Census Bureau, Census 2000 Summary File 3, Matrices PCT49, PCT50, PCT51, PCT52, PCT53, PCT54, and PCT55.

25 Select Health Indicators for Cities in Alameda County, 2007. Community Planning, Education and Assessment (CAPE) Unit, Alameda County Public Health Department, August 2007.

26 According to the California Health Interview Survey 2005, 233,000 people in Alameda County were uninsured for either part of the year or for the entire year of 2005. At any given time, approximately 166,000 are uninsured in Alameda County. In 2003, the most commonly stated reasons for being uninsured in Alameda County were: (1) Can't afford to purchase coverage/too expensive, (2) Changed employer/lost job, (3) Healthy (no need)/don't believe there is a need, (4) Not eligible because of citizenship status, (5) Not eligible because of working status.

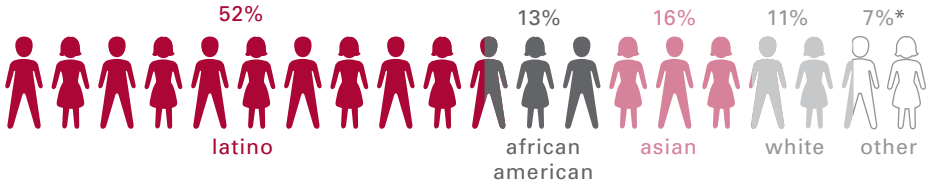
Exhibit 3. Profile of the Uninsured (Low-Income Only)

Alameda County, 2003 and 2005

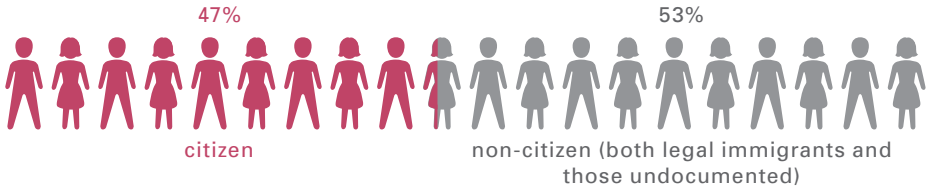


AGE

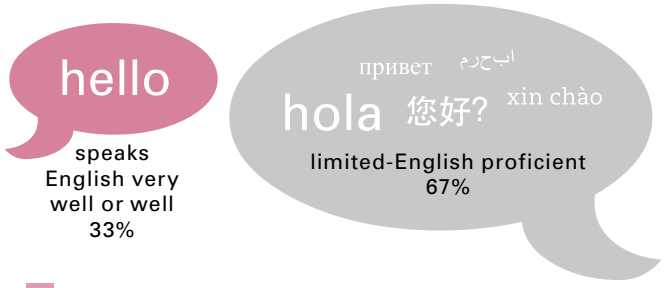
GENDER



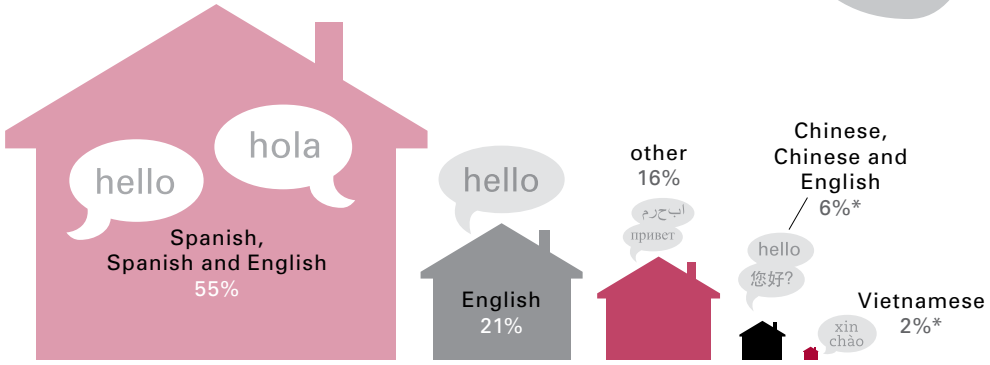
RACE



CITIZENSHIP STATUS



ENGLISH-PROFICIENCY AMONG THOSE ADULTS SPEAKING A LANGUAGE OTHER THAN ENGLISH AT HOME



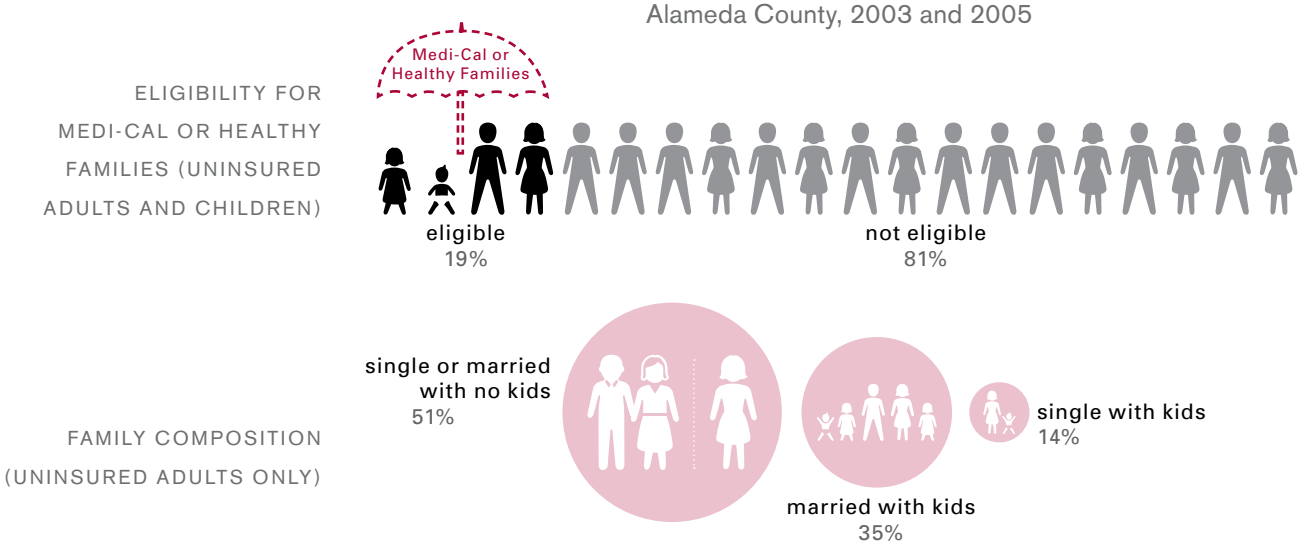
LANGUAGE SPOKEN AT HOME

Source: California Health Interview Survey, 2003 and 2005. Due to rounding, numbers may not add to 100%.

*Statistically unreliable due to a small sample size and/or the percentage has exceeded an acceptable value for coefficient of variance.

Exhibit 4. Public Program Eligibility and Family Composition of Uninsured Residents (Low-Income Only)

Alameda County, 2003 and 2005



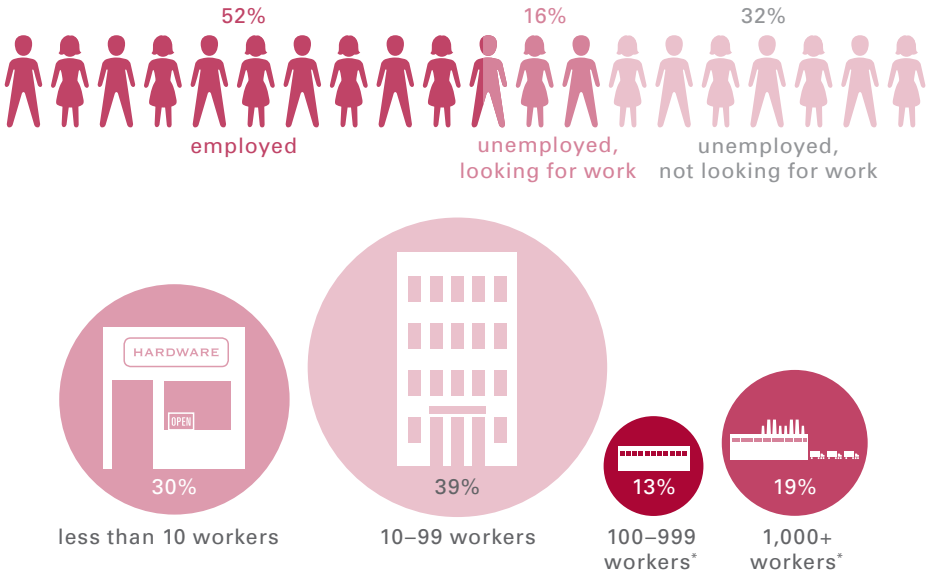
Source: California Health Interview Survey, 2003 and 2005. Due to rounding, numbers may not add to 100%.
*Statistically unreliable due to a small sample size and/or the percentage has exceeded an acceptable value for coefficient of variance.

expansions targeting low-income people would have take into serious consideration language accessibility. Of the low-income uninsured reporting that they spoke another language besides English, the largest groups were Spanish and English-Spanish speakers (55 percent), followed by English-only speakers (21 percent).

Most low-income uninsured adults and children in Alameda County are not eligible for Medi-Cal or Healthy Families programs, most likely due to the Medi-Cal program requirements, which are generally based on income, family composition (i.e. parents with dependent children) (Exhibit 4), and immigration documentation (i.e. must be a citizen or a legal immigrant residing in the U.S. for more than five years).

Exhibit 5. Work Status and Employer Size of the Uninsured

Alameda County, 2003 and 2005[1]



Source: California Health Interview Survey, 2003 and 2005. Due to rounding, numbers may not add to 100%.
*Statistically unreliable due to a small sample size and/or the percentage has exceeded an acceptable value for coefficient of variance.

Contrary to public perception, most low-income uninsured are employed. They are typically referred to as "the working poor." Slightly more than half (52 percent) of low-income uninsured adults are working (Exhibit 5).

Approximately 30 percent of Alameda County's working uninsured are employed by small businesses with fewer than 10 workers (Exhibit 5). Typically, small businesses are less likely to offer health insurance to employees, or if health coverage is offered, the employee's share of cost is unaffordable.[27]

There is also a significant percentage (32 percent) of low-income uninsured that are unemployed and are not looking for work, most likely because they are a student, retired, have family responsibilities, or have disabilities.[28]

Given that many low-income uninsured are not eligible for public programs, and purchasing an individual private health insurance is unaffordable, many turn to Alameda County's safety net for free or low-cost health care.

27 The cost to purchase individual or small group coverage is more than $4,000 annually, per individual. "Health Insurance: Can Californians Afford It?" The California Healthcare Foundation, June 2007.

28 U.S. Department of Labor, Bureau of Labor Statistics, accessed at http://www.bls.gov/cps/faq.htm#Ques5 on 10/24/08.

Health Status and Access to a "Usual Source of Care" Among the Uninsured

ALAMEDA COUNTY'S HEALTH CARE SAFETY NET IS PROVIDING ACCESS TO CARE TO A LARGE VOLUME OF RESIDENTS, DESPITE THE ABSENCE OF INSURANCE COVERAGE. GIVEN DECLINES IN PUBLIC FUNDING AND RISING DEMAND, THE ABILITY OF THE SAFETY NET TO MEET THESE NEEDS WILL DIMINISH.

All people, insured and uninsured, experience problems with access to care, but the uninsured tend to have poorer access to health care and worse health status (Exhibit 6).

Reporting a "usual source of care" is an indicator of good access and is part of having a medical home. Yet 43 percent of uninsured Alameda County residents report that they do not have "usual source of care," compared to only 7 percent of insured who report no "usual source of care." (Exhibit 7).

Furthermore, 38 percent of the uninsured in Alameda County report that they made no doctors' visits in the past year. (Exhibit 8). While it is possible that some uninsured do not see a doctor because they are perfectly healthy, we do not expect the percentage (38 percent) to be more than double than the insured population (14 percent) (Exhibit 8), particularly in light of reports of worse health status among the uninsured.

Conversely, not all uninsured are faring so poorly. We see that 57 percent of the uninsured in Alameda County report having a usual, non-emergency department source of care, and 53 percent has seen a doctor at least once (Exhibits 7 and 8). The data indicate that Alameda County's health care safety net is providing access to care to a large volume of residents, despite the absence of insurance coverage. Given declines in public funding and rising demand, the ability of the safety net to meet these needs will diminish.

Exhibit 6. Health Status, by Insurance Status

Alameda County

Exhibit 7. Usual Source of Care, by Insurance Status

Alameda County

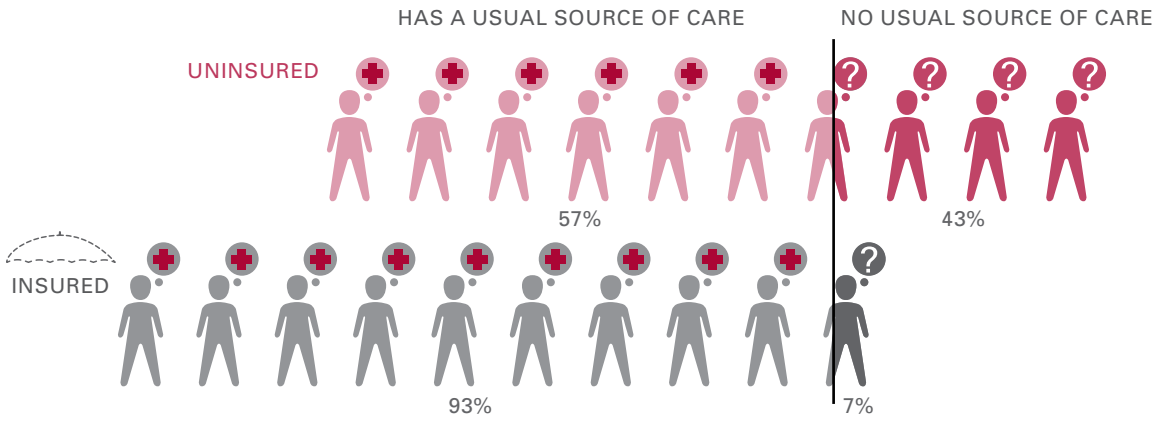
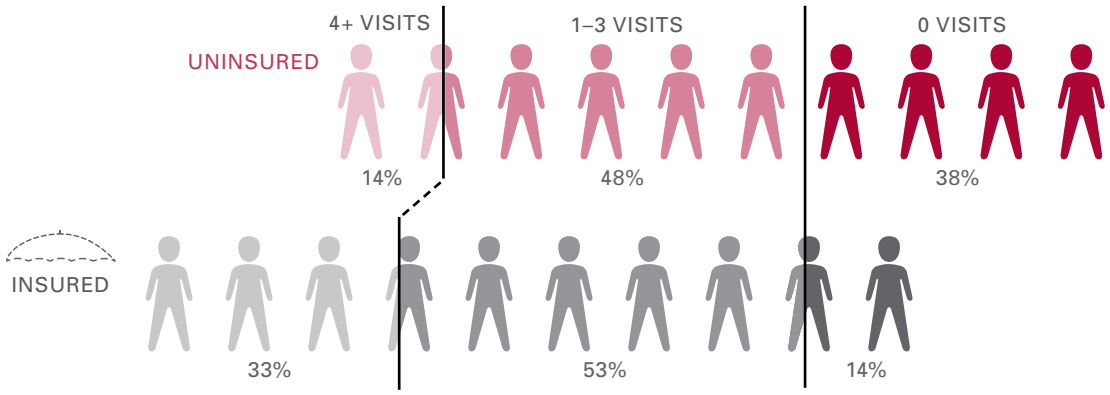


Exhibit 8. # Doctors' Visits, by Insurance Status

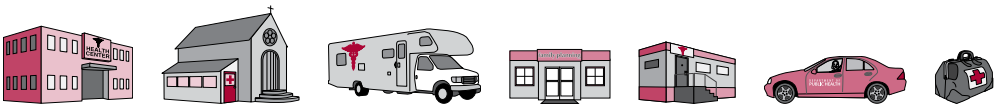
Alameda County



Source: California Health Interview Survey, 2003 and 2005. Due to rounding, numbers may not add to 100%.

D. What is the **Health Care Safety Net** in Alameda County?

Defining the Health Care "Safety Net"



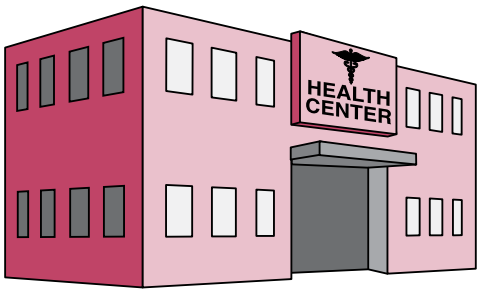
The Institute of Medicine defines the safety net as: "Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients."[29] Core safety net providers are unable to shift uncompensated care costs onto private payers given that they have few patients with private insurance; they rely heavily on federal, state, and local grants and other subsidies to provide care for the poor.

Alameda County's safety net is comprised of an array of provider organizations, including: county public hospitals and clinics, community clinics (community health centers), county public health departments, school-based health centers, family planning and women's health clinics, community organizations, mobile van programs, private physicians, and private hospitals that serve large numbers of low-income and uninsured people. Safety net providers provide a wide range of services based on their organizational structures and missions.

Focus on primary care The following section focuses on primary care providers in the safety net. Data is presented where available. We sub-divided primary care providers in the following way: (1) comprehensive primary care clinics, (2) community organizations with medical service programs or limited-scope clinics, (3) mobile health vans, (4) family planning and women's clinics, (5) school-based health centers, (6) public health departments, and (7) other private providers. With each category, we report baseline numbers of Alameda County residents who received primary care from these providers in 2007.

IN THIS SECTION

29 Lewin, M. E., & Altman, S. (Eds.). 2000. America's Health Care Safety-Net: Intact but Endangered. Institute of Medicine. Washington: National Academy Press.



Comprehensive Primary Care Clinics

IN 2007, THE TWELVE COMPREHENSIVE PRIMARY CARE PROVIDERS (RIGHT) PROVIDED PRIMARY CARE TO MORE THAN 105,000 UNINSURED AND MORE THAN 93,000 PEOPLE ON MEDI-CAL.

Comprehensive primary care clinics are characterized as clinics that offer full-scope primary care services, which includes access to pharmaceuticals, referral to specialty care, and preventive health services. "Enabling" services such as health education, language interpretation, case management, and integrated social services are often offered as well.

As of 2007, there were twelve large provider organizations in Alameda County that offered services at 76 sites, 29 of which were comprehensive primary care sites. The remaining 44 sites offered a wide range of other medical (e.g. optometry, lab), dental, teen clinic, school-based, mental health, substance abuse, enabling, and/or support services.

The Alameda County Medical Center, Alameda County's public hospital system, operated four of the clinic sites.[30] Children's Hospital & Research Center Oakland and St. Rose Silva Pediatric Clinic provided primary care services for children. In addition, there were the following private, non-profit provider organizations that provided primary care: Asian Health Services, Axis Community Health, Berkeley Men and Women's Health Center, La Clínica de La Raza, LifeLong Medical Care, Native American Health Center, Tiburcio Vasquez Health Center, Tri-City Health Center, and West Oakland Health Council.[31]

In 2007, the above-mentioned twelve comprehensive primary care providers provided primary care to more than 105,000 uninsured Alameda County residents, most of whom were low-income, and served more than 93,000 people on Medi-Cal.[32] In total, comprehensive primary care providers provided primary care to more than 233,000 Alameda County residents in 2007 (Exhibit 9). Most of the patients were very low income, with incomes falling at the federal poverty level or below.

Detailed data on patient encounters, demographics, insurance status, and clinic staffing can be found at the end of this report (Appendices 4 through 9).

30 The Alameda County Medical Center (ACMC) is one of 19 public hospitals in California and has a mission to serve low-income and uninsured Alameda County residents. ACMC operates four primary care clinics and three hospitals with a total of 475 beds: Highland Hospital in Oakland, Fairmont Hospital in San Leandro, and John George Psychiatric Pavilion, also in San Leandro. ACMC's Highland Hospital is a level II trauma/emergency center for Northern California.

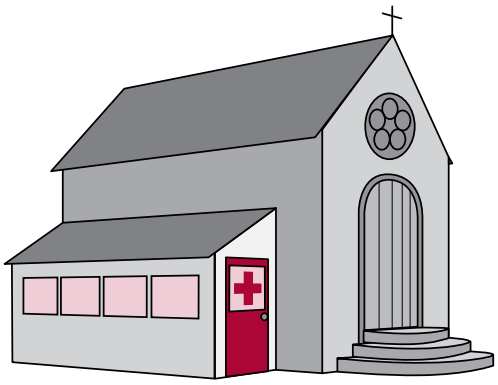
31 Community clinics are also referred to as "community health centers," "federally qualified health centers," "FQHCs," "look-alike FQHCs," and "neighborhood health centers". Most of the community clinics were established in the 1970s, and were a response to unmet medical needs in specific racial and geographic communities. All clinics are located in low-income, federally-designated "medically underserved areas."

32 Primary care data on private physicians were unavailable.

Exhibit 9. Comprehensive Primary Care Clinics in Alameda County

Name	Comprehensive Primary Care Sites / Total sites (e.g. includes dental, social services)	Location of Comprehensive sites	Total Number of Patients	Total Number of Medi-Cal Patients	Total Number of Uninsured Patients	Percent Uninsured
Alameda County Medical Center – Highland	1 site / 1 site	Oakland	47,518	13,784	27,802	59%
Alameda County Medical Center – Eastmont	1 site/1 site	Oakland	19,759	8,349	9,601	49%
Alameda County Medical Center – Newark	1 site/1 site	Newark	5,223	2,650	1,916	37%
Alameda County Medical Center –Winton	1 site/1 site	Hayward	6,694	3,631	1,953	29%
Asian Health Services	2 sites/5 sites	Oakland	18,954	7,085	5,878	31%
Axis Community Health	2 sites/5 sites	Livermore Pleasanton	10,020	4,727	4,849	48%
Berkeley Men and Women's Health Center	1 site/1 site	Berkeley	4,872	1,401	2,938	60%
Children's Hospital & Research Center Oakland – Primary Care Center	1 site/1 site	Oakland	8,633	7,982	61	0.7%
La Clínica de La Raza	3 sites/16 sites	Oakland	34,247	12,793	16,393	37%
Lifelong Medical Care	5 sites/13 sites	Berkeley Oakland	18,259	5,541	6,838	38%
Native American Health Center	1 site/4 sites	Oakland	5,145	2,592	1,317	26%
St Rose Hospital – Silva Pediatric Clinic	1 site/1 site	Hayward	2,801	1,239	680	24%
Tiburcio Vasquez Health Center	2 sites/8 sites	Hayward Union City	11,098	5,269	4,754	39%
Tri-City Health Center	3 sites/9 sites	Fremont	18,930	8,709	9,133	48%
West Oakland Health Council	4 sites/9 sites	Berkeley Oakland	21,751	7,484	11,649	55%
TOTAL	**29 sites/76 sites**		**233,904**	**93,236**	**105,762**	**45%**

Source: The most accurate, available data were used for each provider. The U.S. Dept. of Health & Human Services Uniform Data System (UDS) 2007 data was used for Asian Health Services, La Clínica de la Raza, Lifelong Medical Care, Tiburcio Vasquez Health Center, Tri-City Health Center, and West Oakland Health Council. Because La Clínica de la Raza serves three counties, a percentage of UDS reported numbers were taken to reflect Alameda County patients only. The California Office of Statewide Health Planning & Development (OSHPD) 2007 data was used for Axis Community Health, Berkeley Men and Women's Health Center, and Native American Health Center. Internal self-reported data were used for ACMC, Children's Hospital & Research Center, and the St. Rose Silva Pediatric Clinic.



Community Organizations with Medical Programs or Limited-Scope Clinics

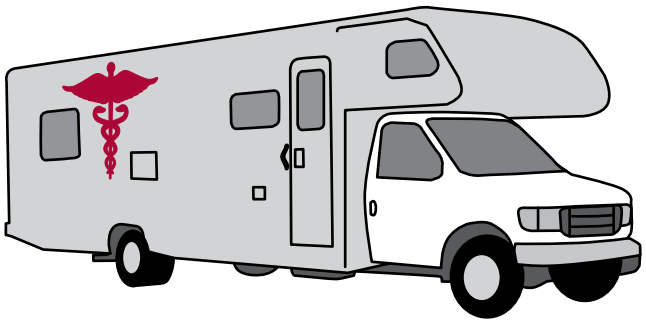
In 2007, there were a number of community-based organizations, civic groups, and churches in Alameda County that provided limited-scope health services (Exhibit 10). These entities are diverse in structure and cannot be easily categorized. Many are free clinics or operate on a volunteer basis. Some offer medical care as part of a larger array of community and social support services: independent living skills training, job training, tax assistance, parenting classes, and substance abuse counseling support groups. Some clinics served a particular demographic and/or diagnosis group (i.e. women with cancer).

What distinguishes these clinics from comprehensive care providers are the limited scope of medical services (e.g. limited access to pharmaceuticals, lab, and/or specialty care referrals) and the integration of limited medical services within the context of a broader range of social support services. Many work in collaboration with comprehensive care providers, and patients are often referred to other clinics for additional health care if needed. Limited-scope clinics are typically volunteer-based, providing medical care on a first-come, first-served drop-in basis. In 2007, community organizations and limited-scope clinics provided medical services to more than 10,000 patients in total, most of whom were uninsured.

Exhibit 10. Community Organizations with Medical Programs or Limited-Scope Clinics

Name	Number of Clinic Sites	Location	Total Number of Patients	Total Number of Medi-Cal Patients	Total Number of Uninsured Patients	Percent Uninsured
AIDS Project of the East Bay	1 site	Oakland	115	46	60	52%
Ashland Free Medical Clinic	1 site	San Lorenzo	341	not available	not available	not available
Berkeley Free Clinic	1 site	Berkeley	6,708	not available	not available	not available
Beyond Emancipation Teen Health Center	1 site	Oakland	246	178	68	28%
Charlotte Maxwell Complementary Clinic	1 site	Oakland	600	not available	not available	not available
City Team Ministries	1 site	Oakland	not available	not available	not available	not available
Davis Street Family Resource Center RotaCare Free Clinic	1 site	San Leandro	1,000	not available	not available	not available
Healthy Oakland - Save a Life Clinic	1 site	Oakland	696	not available	not available	not available
Order of Malta Oakland Clinic	1 site	Oakland	not yet opened	not yet opened	not yet opened	not yet opened
Street Level Health Project	2 sites	Oakland Hayward	750	not available	not available	not available
St. Vincent De Paul's Medical Clinic	1 sites	Oakland	207	not available	not available	not available
Suitcase Clinic (Lifelong Medical Care)	3 sites	Berkeley	60	not available	not available	not available
Total	**15 sites**		**10,723**	**not available**	**not available**	**not available**

Source: The most accurate, available data were used for each provider. The California Office of Statewide Health Planning & Development (OSHPD) 2007 data was used for AIDS Project East Bay, Ashland Free Medical Clinic, Beyond Emancipation Teen Health Center, and Charlotte Maxwell Complimentary Clinic. OSHPD 2007 data was not available for Berkeley Free Clinic; 2006 data was used. Self-reported data was used for Davis Street Family Resource Center RotaCare Free Clinic, Healthy Oakland – Save a Life Clinic, Street Level Health Project, Suitcase Clinic, and St. Vincent de Paul's Medical Clinic. Order of Malta Oakland Clinic opened in October 2008, thus does not have 2007 data to report.



Mobile Health Van Programs

Like the community organizations with medical programs, mobile health vans provide limited-scope medical services to vulnerable populations in Alameda County. There are seven mobile health van programs that served 6,200 people in 2007 (Exhibit 11). The mobile health vans serve a variety of purposes. Some mobile vans provide services to the homeless population and the uninsured population; other mobile vans provide disease-specific services (e.g. asthma, HIV testing), while others travel only as needed to health fairs and other community events.

There are three mobile health vans that exclusively serve the homeless population in Alameda County: the Alameda County Public Health Department's federally-funded Health Care for the Homeless program, Kerry's Kids, and the HOPE Project mobile health clinic.

The Health Care for the Homeless van travels to 28 sites in the county, from parks to shelters. Kerry's Kids is a non-profit volunteer-driven organization that collaborates with the Health Care for the Homeless van to serve children at 5 shelter sites in Alameda County. The HOPE Project mobile health clinic is operated collaboratively by the Tri-City Homeless Coalition, Tri-City Health Center, and the Tri-Valley Haven and travels to seven different sites in Eastern and Southern Alameda County. The mobile health van programs provide limited primary medical and dental care, eye care, tuberculosis testing, alcohol and drug services, and other support services which include: case management, financial benefits, housing, employment and food assistance, public health nursing, mental health services, legal referrals, and transportation assistance.

Two mobile van programs are run by two private hospital systems and provide off-site services. The Washington on Wheels van is operated by Washington Hospital Healthcare System and the ValleyCare Mobile Van is operated by ValleyCare Health System. Both mobile van programs provide medical services (e.g. physicals, TB screening, immunizations, skincare, foot care) at senior centers, churches, schools, and other community centers. Patients needing social support services are referred to a community clinic. The ValleyCare Mobile Van program began in 2008.

Two mobile health van programs in Alameda County target specific disease conditions. The California Prevention Education Project (CAL-PEP) provides rapid HIV testing and HIV counseling four days a week as well as every other Saturday. The times and location CAL-PEP provides this service changes on a weekly basis. Prescott-Joseph Center for

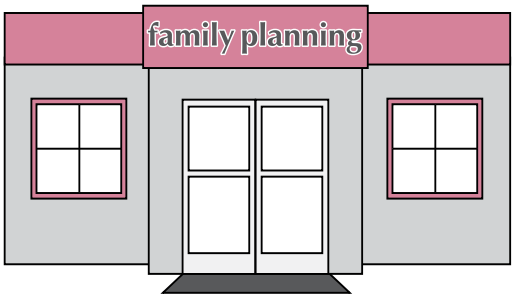
Exhibit 11. Mobile Health Van Programs

Name	Number of Van Sites	Location	Total Number of Patients	Total Number of Medi-Cal Patients	Total Number of Uninsured Patients	Percent Uninsured
Breathmobile (Prescott-Joseph Center for Community Enhancement, Inc.)	not open in 2007	not open in 2007	not open in 2007	not open in 2007	not open in 2007	not open in 2007
CAL-PEP- California Prevention Education Project	Varies on weekly basis	n/a	2,417	not available	not available	not available
Health Care for the Homeless Mobile Van (Alameda County Department of Public Health)	28 van sites	County-wide	1,341	not available	not available	not available
Healthy Oakland Save a Life Mobile Health Services (Healthy Oakland)	Services at health fairs	Oakland	179	not available	not available	not available
Hope Project Mobile Van (Tri-City Health Center & Tri-City Homeless Coalition)	7 van sites	Fremont Livermore	500	not available	not available	not available
Kerry's Kids	5 van sites	Alameda Oakland San Leandro	250	not available	not available	not available
Washington on Wheels Mobile Van (Washington Hospital Heatlhcare System)	4 van sites	Fremont	1,513	not available	not available	not available
ValleyCare Mobile Van--Livermore Rotarian Foundation (ValleyCare Health System)	5 van sites	Livermore Pleasanton	n/a	not open in 2007	not open in 2007	not open in 2007
Total	**49 van sites**		**6,200**	**not available**	**not available**	**not available**

Source: The most accurate, available data were used for each provider. The California Office of Statewide Health Planning & Development (OSHPD) 2007 data was used for Washington on Wheels. Self-reported data was used for CAL-PEP, Health Care for the Homeless Mobile Van, Healthy Oakland Save a Life Mobile Health Services, HOPE Project Mobile Van, and Kerry's Kids. ValleyCare Mobile Van opened in 2008 and Breathmobile in 2009, and thus does not have 2007 data to report.

Community Enhancement, Inc., a community organization in West Oakland, operates a Breathmobile van that will provide asthma clinics at schools sites and other locations beginning in 2009.

Many health vans, in addition to having regular site visits, also provide services at health fairs, community events, or upon request by community organizations. Healthy Oakland, another nonprofit in West Oakland, operates the Save a Life mobile health clinic that provides such services, as does Kerry's Kids, HOPE Project, and the Health Care for the Homeless mobile vans.



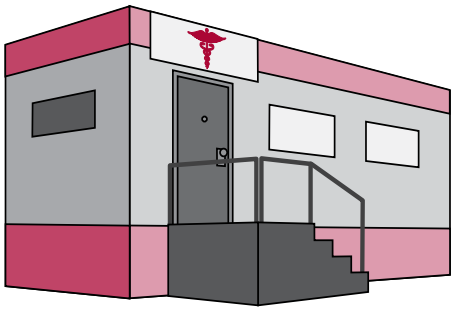
Family Planning and Women's Clinics

In mission, these clinics focus on women's health and family planning services. These clinics also provide a range of primary care services and, for some patients, serve as the main source of primary care. Planned Parenthood is the largest reproductive health and family planning provider in the county, and served more than 17,000 people at two sites, in Oakland and Hayward (Exhibit 12). Services offered include: confidential family planning services, gynecological services, male services, screenings for sexually-transmitted diseases, immunizations, asthma screenings, and domestic violence referrals. The majority of patients seen by Planned Parenthood were uninsured or on Medi-Cal. Women's Choice Clinic is a smaller clinic located in Oakland. Similar to Planned Parenthood, most of the patients at Women's Choice Clinic were also uninsured or had Medi-Cal.

Exhibit 12. Women and Family Planning Clinics in Alameda County

Name	Number of Clinic Sites	Location	Total Number of Patients	Total Number of Medi-Cal Patients	Total Number of Uninsured Patients	Percent Uninsured
Planned Parenthood Golden Gate	3 sites	Oakland Hayward	17,074	3,524	3,912	23%
Women's Choice Clinic	1 site	Oakland	1,556	451	701	45%
Total	**4 sites**		**18,630**	**3,975**	**4,613**	**25%**

Source: The most accurate, available data were used for each provider. The U.S. Dept. of Health & Human Services Uniform Data System (UDS) 2007 data was used for Planned Parenthood Golden Gate. The California Office of Statewide Health Planning & Development (OSHPD) 2007 data was not available for Women's Choice Clinic; 2006 data was used.



School-Based Health Centers

Schools play an important role in addressing the physical and mental health of youth, and school-based health centers serve many low-income youth who are on Medi-Cal or uninsured. The unique service mix in school-based health centers requires complex partnerships between school districts, community-based organizations, medical and mental health providers, funders, and with some school sites, city administration. The Alameda County Health Care Services Agency is the lead in the countywide effort to expand school-based health center services for students.

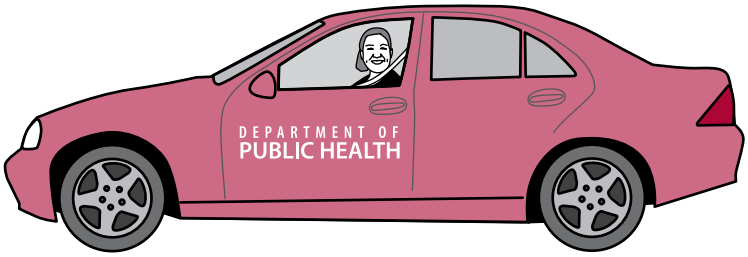
In 2007, Alameda County had twelve school-based health centers located in one elementary school, one middle school, and ten high schools (Exhibit 13). School-based health centers provide a unique mix of medical and mental health services: limited-scope primary care, with large volumes of counseling, mental health, and support services for students. Medical care provided at school-based clinics typically consist of immunizations (elementary age), sports physicals, reproductive health services, and health education services such as tobacco education. School-based health centers frequently work with the larger comprehensive primary care clinics to refer students needing a wider range of medical services.

In 2006-2007, school-based health centers in Alameda County served more than 6,800 children and adolescents. The number of school-based health centers and students served are expected to double in upcoming years, as considerable private grant money will support the opening of new clinics. The percentages and numbers of low-income K-12 students in Alameda County schools can be found at the end of this report (Appendix 10).

Exhibit 13. School Based Health Centers in Alameda County

School/Name (Medical Provider)	Total Clinic Sites	Location	Total Number of Patients	Total Number on Medi-Cal	Total Number of uninsured	Percent Uninsured
Hawthorne Elementary School-based Clinic (La Clínica de La Raza)	1 Site	Oakland	233	143	76	33%
Roosevelt Health Center (La Clínica de La Raza)	1 Site	Oakland	746	2	587	79%
Alameda High School (Alameda Family Services SBHC) (Native American Health Center)	1 Site	Alameda	257	25	76	30%
Berkeley High School Health Center (City of Berkeley Public Health)	1 Site	Berkeley	1,621	189	105	7%
Chappell R. Hayes Health Center (McClymonds High School) (Children's Hospital & Research Center Oakland)	1 Site	Oakland	263	104	54	21%
James Logan Health Center (Tiburcio Vasquez)	1 Site	Union City	880	87	104	12%
San Lorenzo High Health Center (La Clínica de La Raza)	1 Site	San Lorenzo	339	12	112	33%
TechniClinic (Oakland Technical High School) (La Clínica de La Raza)	1 Site	Oakland	488	6	443*	91%
Tennyson Health Center (Tiburcio Vasquez Health Center)	1 Site	Hayward	605	49	148	25%
Tiger Clinic (Fremont High School) (La Clínica de La Raza)	1 Site	Oakland	351	85	37	11%
Encinal High School (Tri-High Health Services) (Native American Health Center)	1 Site	Alameda	348	59	123	35%
Youth UpRising Health Center (Castlemont High School) (Children's Hospital & Research Center Oakland)	1 Site	Oakland	726	147	528	73%
Total	**12 sites**		**6,857**	**908**	**2,393**	**40%**

Source: Alameda County School Health Services Coalition & University of California, San Francisco Philip R. Lee Institute for Health Policy Studies, 2006-07.



Public Health Departments

There are two public health departments in Alameda County: the Alameda County Public Health Department, which covers all of Alameda County; and the Berkeley Public Health Department which covers the City of Berkeley (Exhibit 14).[33] Public Health Department services are typically provided "in the field" outside of clinic walls, with some public health services subcontracted out to community organizations.

The Alameda County Public Health Department is charged with providing the following services to all Alameda County residents: public education, disease diagnosis and investigation, enforcement of health and safety laws, and health assessment and evaluation. It oversees programs that address: tuberculosis control, Black infant health and high-risk pregnancies, asthma case management, diabetes education, and dental care for children. The Alameda County Public Health Department also operates the federally-funded Health Care for the Homeless program.

In 2007, The Alameda County Health Department employed more than 60 public health nurses that served more than 11,000 residents in the field in 2007. Alameda County public health nurses worked with community health outreach workers as part of ten Community Health Teams throughout the county. The Community Health Teams provided assessment, counseling, education and case management services to individuals and populations; partnered with public health staff and other agencies on issues related to maternal child health, tuberculosis, lead poisoning, Sudden Infant Death Syndrome, acute communicable disease, aging and adult health; and provided clinical services such as immunizations, flu shots, TB testing, and pregnancy testing to high-risk target populations.

In 2007, the Berkeley Public Health Department employed 12 public health nurses who provided a similar set of services to residents of the City of Berkeley, including: home visits to: Medi-Cal mothers, WIC program, and those with communicable diseases such as chicken pox and tuberculosis. The Berkeley public health nurses took referrals from Berkeley Public School, the Department of Social Services, senior centers, and

33 Most public health departments are operated by county government; Berkeley is one of three cities in California that has its own public health department. Other cities that have health departments are Long Beach and Pasadena.

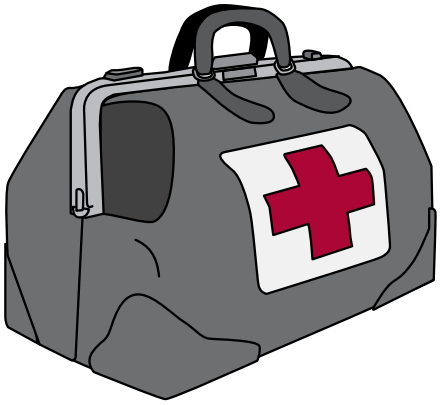
Exhibit 14. Public Health Departments

Name	Number of Clinic Sites	Location	Total Number of Patients	Total Number of Medi-Cal Patients	Total Number of Uninsured Patients	Percent Uninsured
Alameda County Public Health Department	home visits by public health nurses	Throughout Alameda County	11,000	not available	not available	not available
Berkeley City Health Department	home visits by public health nurses	Berkeley	2,392	not available	not available	not available
	Berkeley Public Health Clinic	Berkeley	4,727	not available	not available	not available

Source: Alameda County Public Health Department and Berkeley Public Health Department, 2007.

other self-referrals. In 2007, City of Berkeley public health nurses saw more than 2,000 Berkeley residents.

The Berkeley Public Health Department also operates a public health clinic that provides family planning services, immunizations, STD appointments and testing, TB testing, and other diagnostic services. In the 2007-08 year, the Berkeley Public Health clinic saw over 4,700 patients.



Private Physicians

Data on private providers in Alameda County who served the low-income and uninsured population in 2007 was unavailable. According to the Alameda-Contra Costa Medical Association, physicians seeing uninsured patients rarely track the numbers served; due to the cost of billing, they often do not charge uninsured patients and therefore payer source data is not easily available. Operating more or less as small businesses, they lack the resources and infrastructure of the larger clinic practices.

Private physicians seeing Medi-Cal patients are the most likely to also see uninsured patients, especially uninsured family members of Medi-Cal patients. Those interested in taking a closer look at private providers who are likely seeing uninsured patients can look at the Alameda Alliance for Health's Medi-Cal managed care provider network, more than half of which is comprised of small private physician practices.

The Difference in Provider Networks for the Medi-Cal Population vs. Uninsured

Insurance status is a major determinant of access to care. For those fortunate enough to have insurance, the type of insurance payment arrangement (i.e. fee-for-service, managed care, grant-funded) can also shape how one accesses services and the selection of providers.

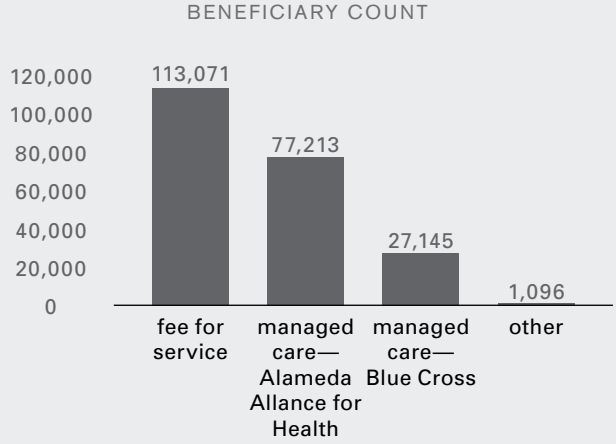
Medi-Cal Provider Network

In Alameda County, residents who are covered by the Medi-Cal program generally access benefits in one of two ways: (1) through a fee-for-service arrangement or (2) by enrolling in one of two managed care plans that have been approved by the State of California, which in Alameda County are the Alameda Alliance for Health and Anthem (Blue Cross).

Generally, the Medi-Cal program pays providers poorly.[34] These rates are set by the State of California. As a result, many people on Medi-Cal experience difficulties in finding providers who are willing to accept them, particularly specialists. Virtually all providers in Alameda County who do accept Medi-Cal are signed up as providers through the Alameda Alliance for Health and/or Anthem. Many also continue to see patients on a fee-for-service basis.

Slightly more than half of people on Medi-Cal in Alameda County (more than 113,000 people) see their health care provider on a fee-for-service basis (Exhibit 15).

Exhibit 15. Medi-Cal Beneficiaries in Alameda County, 2008



Source: California Department of Health Services, Medi-Cal-Beneficiaries-Profiles-by-County File, Medi-Cal statistics section, January 2008.

Among those enrolled in a health plan, most chose the Alameda Alliance for Health. In 2007, the Alameda Alliance for Health had more than 77,000 Medi-Cal members and Anthem (Blue Cross) had more than 27,000 members.

Most Medi-Cal providers in Alameda County have contracts with both health plans. However of the two plans, the Alameda Alliance for Health has a larger provider network (Exhibit 16).[35] The provider network for the Alameda Alliance for Health is comprised of more than 1,500 primary care providers and specialists, 29 community health centers, and more than 15 hospitals that are geographically distributed throughout Alameda County. In addition, Medi-Cal beneficiaries have access to mental health services through Alameda County Behavioral Health Care Services.

34 California ranks last in the nation in Medicaid reimbursement rates to providers. "Medicaid Payments Per Enrollee, FY 2005." Statehealthfacts.org, The Henry J. Kaiser Family Foundation. Accessed at: http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4&sub=47&yr=28&typ=4&o=d&sort=218 on June 2, 2008. Cuts to Medi-Cal provider rates will further erode the network of private physician practices willing to accept Medi-Cal.

35 A very small number of health care providers in Alameda County see Medi-Cal patients on a fee-for service basis (i.e. they do not have contracts with Alameda Alliance for Health or Anthem). Currently, there are fewer than 35 solo physicians and fewer than 10 physician groups who are not contracted with a Medi-Cal managed care plan.

Exhibit 16. Medi-Cal Managed Care Provider Network in Alameda County

TYPE OF PROVIDER
448 primary care providers
224 mid-level providers
899 specialists
15 hospitals

Source: Alameda Alliance for Health, 2008.

Provider Network Serving the Uninsured

Not surprisingly, uninsured Alameda County residents have the most difficulty finding health care providers outside of the local emergency department who will see them. Few health care providers are willing and can afford to provide services to the uninsured on an ongoing basis for free. Specialty care in particular is the most difficult to come by for the uninsured.

Alameda County local government provides funds to providers to subsidize health care for the uninsured, and some state and federal funds also subsidize select services for the uninsured.[36] Though the funds are not enough for full health coverage, they do allow core safety net providers—primarily community health centers, the public hospital system, the county health department, emergency department physicians—to maintain access to care for the uninsured (Exhibit 17).

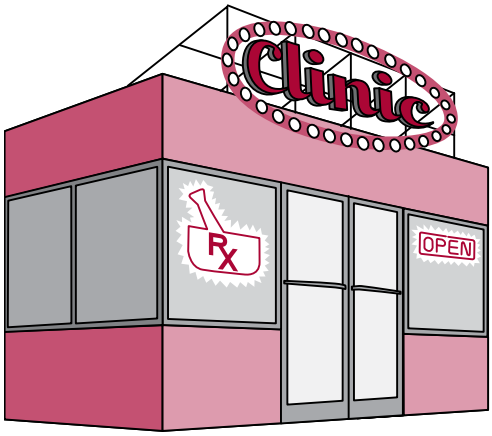
Exhibit 17. Provider Network for the Uninsured

TYPE OF PRIMARY CARE PROVIDER	142 full-time equivalent (FTE) physicians
	90 FTE mid-levels
OTHER SERVICE PROVIDERS	72 public health nurses

Source: California Office of Statewide Planning & Development (OSHPD) 2007;
Internal self-reported data from the Alameda County Public Health Department, and City of Berkeley Public Health Department, 2008.

36 Health care services for the uninsured in Alameda County are subsidized largely by local county funds through the Alameda County Health Care Services Agency' County Medical Services Plan (CMSP), Alameda County Excellence (ACE), and Measure A sales tax revenue. Other funds that pay for services for the uninsured are: higher Medi-Cal rates for federally qualified health centers, state funds such as the Early Access to Primary Care (EAPC) and Family PACT; federal funds such as disproportionate share (DSH); and local hospital community benefits plans, and philanthropic grants.

Retail Clinics: A Role in the Safety Net?



Retail clinics are growing on a national level, yet their relationship to the traditional safety net is undefined.

Currently, there are two physician-run retail clinics in Alameda County, located at Wal-Mart in Fremont and at Farmacia Remedios, a pharmacy in the Fruitvale district of Oakland.[37] Both clinics in Alameda County currently accept only cash or credit card, although most retail clinics in other parts of the country now accept insurance and are increasingly being included in health plan provider networks. At the Fruitvale clinic in Oakland, 70 percent of the patients are uninsured.[38]

The limited services that are offered at retail locations can also be obtained from community health centers, public hospitals, or public health departments for free or at a low cost for people whose income falls below 200 percent of the federal poverty level. Moreover, because the services at retail locations are limited, low-income uninsured patients who pay the visit fee may still end up being referred to a county hospital or community health centers for follow-up or for additional needed services. The linkage between retail clinics and traditional safety net providers—referral processes, exchange of medical information—is still undeveloped.

Still, some patients may choose to go to a retail clinic based on convenience factors. Retail clinics are typically located inside drugstores, retail chain stores and grocery stores that serve large numbers of low-income people. A limited set of basic medical services are provided, such as evaluation of strep throat or the provision of immunizations. These clinics provide a level of convenience in that patients do not need appointments and the payment structure is transparent.

The California HealthCare Foundation predicts that retail clinics will proliferate in California as a result of recent partnerships between retail clinic companies and Walmart.[39] In many parts of the country, retail-based clinics are already accepting Medi-Cal and private insurance; in some areas, they are part of health plans' provider networks.

37 Both are owned by QuickHealth, a for-profit corporation with clinic sites throughout California. The cost to see a doctor is $49 for a fifteen minute consultation.

38 Brevetti, Francine. "Oakland Health Clinic Serves Uninsured, Spanish-speaking," Oakland Tribune 16 Sept 2006.

39 Scott, MK. "Health Care in the Express Lane: The Emergence of Retail Clinics." Scott & Company, California Health Care Foundation, July 2006.

E. Who Remains **Underserved** in Alameda County?

IN THIS SECTION

Certain underserved populations experience extraordinary barriers to care, regardless of the perceived availability of services. Social stigma, lack of provider cultural competence, and bureaucracy contribute to poor access for vulnerable populations. The following section is not exhaustive, but focuses on several groups of vulnerable residents: foster care youth, the homeless, those "re-entering" society after incarceration, and undocumented and other immigrant populations.

Foster Care Youth

Youth who are in the Alameda County foster care system are children who are 18 years and younger who have been removed from their families by order of the court due to safety concerns, or who are voluntarily placed in foster care by a parent who is unable to care for them. Already a highly vulnerable population, youth who "age out" of the foster care system at 19 years old are considered "at-risk" because they may lose access to benefits and social support services. They are a population with little income and are highly dependent on public transportation. Involvement in the foster care system is considered a strong predictor of future homelessness.[40]

By law, foster youth are entitled to Medi-Cal coverage, and after aging out of foster care they can re-apply for Medi-Cal through age 21. However due to the disruptive nature of foster care—a child may be placed many times with multiple families during their childhood—Medi-Cal coverage is typically inconsistent, and many may be uninsured for extended periods of time. Furthermore, it is estimated that one in every two children in foster care has chronic medical problems that are unrelated to behavioral concerns.[41]

There are more than 2,600 youth under Alameda County foster care supervision.[42] One health center, the Beyond Emancipation Teen Health Center, located in the Fruitvale district of Oakland and opened in 2004, specifically serves teens currently in foster care and teens aging out of foster care. The health center provides limited-scope primary care and is open Monday through Friday. In 2007 it provided services to 246 youth. However, this clinic is closing doors in 2009.

40 "Alameda County Health Needs Assessment of Emancipating and Emancipated Foster Youth." Alameda County School Health Services Coalition, Pacific Health Consulting Group and the Institute for Health Policy Studies, UCSF, September 2007.

41 Ibid.

42 "Foster Care in the Bay Area: An Overview from kidsdata.org." Lucile Packard Foundation for Children's Health. Accessed on December 22, 2008 at http://www.kidsdata.org.

Homeless Population

According to a 2004 survey sponsored by the Alameda Countywide Homeless Continuum of Care Council, there are more than 6,000 homeless in Alameda County on any given night, and as many as 16,000 people experience homelessness over the course of a year.[43]

According to the survey, over two-thirds of the homeless population is uninsured.[44] Twenty-nine (29) percent reported having Medi-Cal, and 16 percent reported having Medicare. Emergency departments are a large source of care for the homeless population. The average number of emergency room visits for the surveyed population was 3.5 per year, with 37 percent going to the emergency room more than three times in a year. The homeless population averaged nearly one hospitalization over the year, which is more than double that of those housed persons with extremely low-incomes. About one-third of the homeless reported using the emergency room as the location of their most recent medical care, and 36 percent reported delaying or not receiving medical care even if they thought they needed it.[45]

The homeless population is served by Alameda County's safety net providers, many of which are funded through the Alameda County Public Health Department's federal grant-funded program, Health Care for the Homeless. The Health Care for the Homeless program sub-contracts with 8 community clinic sites and 2 substance abuse recovery programs to provide comprehensive primary care and substance abuse services. In addition, the Alameda County Public Health Department operates a Health Care for the Homeless mobile van that provides on-site services at 28 sites in the county.[46] In addition, LifeLong Medical Care provides medical, mental health, and case management services on-site at six supportive housing buildings in Oakland and Berkeley where formerly chronically homeless residents now live. Other homeless health care services are offered through other community-based and private organizations, including the HOPE Project that is operated by Tri-City Health Center in the Tri-City region, the Washington Hospital's Washington Mobile Van and the Healthy Oakland Save a Life Mobile Van.

Re-entry (formerly incarcerated) population

The process of being released from incarceration and returning to the community is referred to as "re-entry." In 2001, Alameda County had the ninth

43 R. Speiglman and J Norris. "Alameda Countywide Shelter and Services Survey: County Report." Public Health Institute, May 2004. Accessed on December 22, 2008 at http://www.everyonehome.org The definition of homeless used in the report was the community definition of homelessness: staying in emergency shelters or transitional housing, living on the street or in a car, and losing housing within a month and with nowhere to go.

44 Ibid. Uninsured is defined as reporting having "no insurance," an Alameda County Health Card, Indigent care/County Plan, or receive care at a free clinic, community clinic, or county hospital.

45 Ibid.

46 In 2007, the Alameda County Public Health Department's Health Care for the Homeless program saw nearly 13,000 patients, with over 28,000 encounters.

largest number of people released from prisons in the U.S.[47] As of 2007, there were 22,250 residents of Alameda County who were under criminal justice supervision (i.e. on parole or probation).[48] Forty-six (46) percent of probationers reside in Oakland, and 13 percent reside in Hayward.[49]

It is estimated that within the re-entry population, approximately 57 percent—11,000 people—are uninsured.[50] Challenges that the re-entry population face in accessing health services include: lack of formal identification upon release, lack of access to prison medical records, and difficulty securing employment and affordable housing upon release.[51]

Prisoners and soon to be released inmates have higher rates of communicable disease, mental illness, and chronic disease than the general population.[52] For example, in 1997, nearly 25 percent of all people living with HIV or AIDS, nearly 33 percent of people with Hepatitis C, and more than 33 percent of those with tuberculosis were released from a prison or jail that year.[53] Studies indicate that three-quarters of the re-entry population have substance abuse issues and more than a third of inmates report having a mental or physical disability, with rates of serious mental illness being two to four times that of the general population.[54]

Accessing health services can be difficult for the low-income and uninsured. Navigating the system can be further complicated for a person who has been removed from society for extended periods of time. The Alameda County Health Care for the Homeless program provides onsite medical care to the re-entry population county-wide, and in West Oakland, the Healthy Oakland "Save a Life" clinic is specifically seeing re-entry program clients and offers wrap-around services specifically for the population. Healthy Oakland is piloting a program to enroll soon-to-be-released inmates at Santa Rita Jail into health coverage programs through Alameda County's computerized enrollment system, One-e-App. Through this effort, inmates can be connected with Healthy Oakland, Lifelong Medical Care, or West Oakland Health Council as their medical home, prior to being released.

47 U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Releases by county of jurisdiction for participating National Correctional Reporting Program States, 2001, Revised April 2004, in http://www.urbanstrategies.org/documents/ReentryHealthTaskForceFinalReportFINAL_000.pdf

48 B. Heiser, J. Williams. "Reentry Health Care in Alameda County: Initial Assessment and Recommendations of the Alameda County Reentry Health Taskforce." Urban Strategies Council, May 2008. Accessed on December 22, 2008 at http://urbanstrategies.org.

49 Ibid.

50 Ibid.

51 Ibid.

52 NCCHC, "Prevalence of Communicable Disease, Chronic Disease, and Mental Illness Among the Inmate Population," The Health Status of Soon-To-Be Released Prisoners, A Report to Congress, 2002: BJS Special Report: Substance Abuse and Treatment, State and Federal Prisoners, NCJ 1999.

53 Outside the Walls: A National Snapshot of Community Based Prisoner Reentry Programs, Amy L. Solomon, Michelle Waul, Asheley Van Ness, Jeremy Travis, January 2004, in http://www.urbanstrategies.org/documents/ReentryHealthTaskForceFinalReportFINAL_000.pdf

54 Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community. Council of State Governments. Reentry Policy Council. New York: Council of State Governments. January 2005. Accessed on August 18, 2008 at http://www.reentrypolicy.org

Legal and Undocumented Immigrants

Exhibit 18. Alameda County Population, by Income and Citizenship Status

	All Alameda County Residents		Alameda County Residents Below 100% of the Federal Poverty Line	
	#	#	#	%
Citizen	1,241,753	85%	121,345	77%
Non-Citizen (includes both lawfully present and undocumented)	222,449	15%	36,582	23%
	1,464,202	**100%**	**157,927**	**100%**

Source: American Community Survey, 2007.

Immigrants face multiple barriers to accessing health care, namely the use of citizenship and immigration status to restrict eligibility for public programs. For undocumented immigrants in particular, the potential threat of being reported, arrested and deported from the country is a deterrent to accessing needed medical care—even when the medical provider attempts to allay community fears that they do not participate in the reporting.

The American Community Survey estimates that approximately 85 percent of Alameda County residents are citizens (Exhibit 18). Of the residents who are not citizens (i.e. immigrants who are either legal or undocumented) approximately 36,000 live in poverty.

Approximately half of Alameda County's uninsured is non-citizen.[55] Non-citizens are eligible for Medi-Cal if they meet the program requirements and have been lawfully present in the U.S. for more than five years. However, Alameda County has a significant number of recent legal immigrants, and undocumented immigrants (e.g. day laborers, domestic workers, restaurant and janitorial workers) who are barred from public programs and are working without benefits.

For many Alameda County residents—naturalized citizens, legal immigrants, the undocumented—the lack of language accessible health services compounds the problem of accessing care. The patient-provider interaction, and therefore the *quality of care*, is also often compromised due to a lack of bilingual staffing or trained interpreters. As discussed in Section C, the majority of low-income uninsured (67 percent) are limited-English proficient.[56]

55 California Health Interview Survey 2003 and 2005.
56 Ibid.

F. How Long Does it Take to **Access Care** Through the Safety Net?

The following section looks at a specific set of indicators of safety net capacity: wait times for primary care, wait times for specialty care, and emergency department use.

Wait times to get a primary care or specialty care appointment provide a glimpse at the capacity of the safety net. Both are inter-related. In 2007, primary care providers cited backlogs in specialty care referrals as a major reason for being unable to take on new primary care patients. Similarly, specialists are overwhelmed with referrals, a percentage of which could be adequately addressed by referring primary care providers.

IN THIS SECTION

Wait times for Primary Care

In 2007, the greatest disparity in wait times was not between the insured and uninsured, but between established patients (i.e. those making a return visit) and new patients (i.e. those who have never been seen by the provider and therefore are not yet recorded in the clinic system).

Established patients—regardless of insurance status—wait up to the next day for urgent care, approximately 3 weeks for follow-up appointments, and approximately 2 months for physical exams (Exhibit 19). The type of visit generally determines the length of wait time, with urgent/acute care cases being seen more quickly and physical exams taking the longest.

For new patients, wait times were significantly longer. In 2007, it was common for new patients to wait as long as 3 months to see a comprehensive primary care provider for a first medical appointment.

What underlies long wait times for primary care in Alameda County is a

Exhibit 19. Established Patients – Insured and Uninsured

Type of care	Wait time	Factors considered
Urgent/acute care	All responded: same or next day	• acuity
Follow up appointments	Most responded: 2 days to 3 weeks. Some responded: 6-8 weeks.	• Acuity • what the provider specified • how much the provider is in demand.
Physical exams	Most responded: 1-8 weeks. One responded: 3-4 months.	• Depends on provider specifications

Exhibit 20. Processes for New Patients to Get a Primary Care Appointment Vary by Clinic

Wait time	Clinic 1 process	Clinic 2 Process	Clinic 3 Process	Clinic 4 Process	Clinic 5 Process
				call to get on wait list	go in-person at designated time to get on wait list
enrollment/ eligibility screening 1day – 3 months; 1 year			schedule eligibility/enrollment appointment	schedule eligibility/enrollment appointment	schedule eligibility/enrollment appointment
first primary care visit 1 day – 2 months	drop-in hours to get medical services	schedule combined eligibility/enrollment and medical appointment	schedule medical appointment	schedule medical appointment	schedule medical appointment

Source: Calls to clinic sample, 2008.

high demand for services. The safety net system simply does not have enough capacity to provide timely access to care for all people who need them. Clinics reported that the greatest barriers to serving more new patients quickly were: enrollment and eligibility verification and restrictions, lack of providers, lack of specialty care access, language barriers, facilities/space, patient no-shows, the high burden of disease among patients, and cost.

Secondly, the largest comprehensive primary care providers are required to screen new patients for eligibility for Medi-Cal, Healthy Families, and the County Medical Indigent Service Program (CMSP), a process which may deter transitional and other vulnerable populations from gaining timely access to a medical appointment. New patients can face long wait times before enrollment and eligibility screening, thus taking longer to see a doctor.[57]

Lastly, there is no uniform process for new uninsured patients to get a first medical appointment. Calls to clinics in Alameda County in 2007 revealed that the process of enrolling and eligibility screening differed widely by clinic system (Exhibit 20). Some clinics combined eligibility enrollment with the first visit with a provider, while other clinics had separate systems for eligibility/enrollment and scheduling a visit with a provider.

Each provider had its own internal process for accepting new patients, with each process intended to manage a high demand for services in an organized manner.[58] Most of the large safety net providers in Alameda County asked patients to

57 New patients enrolled in a Medi-Cal managed care plan tended to have shorter wait times because of contractual requirements of managed care health plans with clinic systems.

58 These processes range from one step to three steps.

provide financial and residency documentation to determine eligibility for Medi-Cal, Healthy Families, CMSP, and other public programs.[59] Smaller providers were unlikely to screen patients for insurance due to the limited scope and a lack of reimbursement systems.

In short, each clinic has its own method of managing high demand, which may involve multiple levels of paperwork and phone calls before a patient is seen. The lack of a uniform process can be confusing for those seeking primary care for the first time.

Wait Times for Specialty Care

Low-income residents who have Medi-Cal access specialty care through a network of private specialists and hospitals that accept Medi-Cal, and through the Alameda County Medical Center (ACMC) and Children's Hospital & Research Center Oakland.

For the uninsured, free and low-cost specialty care is much more limited. Specialty care for uninsured adults is provided almost exclusively by ACMC; demand for specialty care services at ACMC exceeds capacity. In 2007, more than 9,000 uninsured patients sought specialty care services at ACMC.[60]

In 2007, ophthalmology topped the list of the top ten specialties in demand at ACMC (Exhibit 21). Ophthalmology is a critical specialty service for patients with diabetic retinopathy.

Wait times to see a specialist for new patients at ACMC can be as long as six months. The average wait time was up to more than 6 months for dermatology, orthopedics, ortho hand, and renal. For

Exhibit 21. Top 10 Specialties in Demand Among the Uninsured at ACMC, 2007

Number	Total # Referrals	Number	Total # Referrals
Ophthalmology	1,225	Gastroenterology	605
General Surgery	1,127	Urology	553
Orthopedics	1,088	Dermatology	550
Podiatry	764	Cardiology	514
Ear Nose Throat	683		

Sources: Alameda County Medical Center, Central Appointments and Referral Unit. Referral data is from the period of July 1, 2007 – December 31, 2007 and the average wait times reported this period are the 3rd Next Available appointment.

59 A computerized enrollment system, One-e-App, requires clinic and hospital workers in Alameda County to enter a group application for each family. For example, each person applying for health coverage is asked to also submit documentation for their entire family. The result is that more people are being enrolled into health programs; however the process of applying is longer because applications are processed as a group (family). Alameda County is one of 10 counties that use One-e-App.

60 Alameda County Medical Center, Central Appointments and Referral Unit. Referral data is from the period of July 1, 2007 – December 31, 2007.

Exhibit 22. Average Wait Times for New and Return Specialty Care Appointments for the Uninsured at ACMC, 2007

Specialty	New Appointment	Return Appointment
Gastroenterology[1]	monthly scheduling*	> 1 month
Ophthalmology[2]	monthly scheduling*	3 weeks
Dermatology[2]	> 6 months	1 month
Orthopedics[1]	> 6 months	3 weeks
Ortho Hand	> 6 months	1 month
Renal	> 6 months	1 month
Endocrinologist	> 4 months	> 4 months
Allergy/Asthma	> 2 to 4 months	> 1 month
Urology[1]	4 months	> 1 month
Cardiology[2]	> 3 months	2 months

* Because appointments are not scheduled more than one month out and patients are not placed on waiting lists, the exact wait times cannot be determined.

[1] identified by CHCN clinics as top 3 most needed.

[2] identified by CHCN clinics as second 3 most needed.

Sources: Alameda County Medical Center, Central Appointments and Referral Unit. Referral data is from the period of July 1, 2007 – December 31, 2007 and the average wait times reported this period are the 3rd Next Available appointment. Community Health Center Network.[61] Clinic interviews were conducted in 2006.

returning patients, the wait time ranged from 3 weeks to more than four months (Exhibit 22).

Reducing wait times for primary care and specialty care are inter-related. In the late 1990s, private-public expansions in primary care in the Los Angeles area led to an unexpected rise in specialty care demand that rapidly exceeded capacity of the safety net at the time. Balancing a growth in primary care with growth in specialty care will be an important consideration in future efforts to increase access to care in Alameda County.

61 The Community Health Center Network (CHCN) is a managed care organization in Alameda County representing seven community health centers.

Emergency Department Use

Long wait times for primary and specialty care among the uninsured in Alameda County may contribute in part to increased use of local hospital emergency department services. In 2007, more than 41,000 Alameda County uninsured residents sought care in an emergency room (Exhibit 23). Though the uninsured use emergency departments at a much lower rate than the insured, it is estimated that a percentage of these visits could have been adequately and more efficiently addressed by early access to primary and specialty care. Studies show that approximately one-third of emergency room visitors could be more appropriately served in a non-emergency department setting.[62]

Even with an extensive safety net in Alameda County, many used local emergency departments for conditions that may be better addressed in a primary or specialty care setting.

Exhibit 23. Number of Alameda County Residents Who Visited an Emergency Department in 2007, by Hospital and Insurance Status

Hospital	Insured	Uninsured	Total	% Uninsured
Alameda County Medical Center – Highland Campus	6,881	14,480	21,361	68%
Alameda Hospital	5,302	2,288	7,590	30%
St. Rose Hospital[1]	17,578	5,638	23,216	24%
Washington Hospital Healthcare System	13,033	3,423	16,456	21%
San Leandro Hospital	7,062	1,717	8,779	20%
Alta Bates Summit Medical Center – Summit Campus	11,433	2,303	13,736	17%
Eden Medical Center	8,970	1,789	10,759	17%
Alta Bates Summit Medical Center – Alta Bates Campus	12,083	2,065	14,148	15%
Valleycare Health System	8,084	1,139	9,223	12%
Children's Hospital & Research Center Oakland	12,516	1,733	14,249	12%
Kaiser Permanente Medical Center - Oakland	11,751	883	12,634	7%
Kaiser Permanente Medical Center - Hayward	9,694	572	10,266	6%
Kaiser Permanente Medical Center - Fremont	6,822	329	7,151	5%
Hospitals outside of Alameda County	15,532	2,865	18,397	–
Total Emergency Department Visitors	**146,741**	**41,224**	**187,965**	**22%**

Source: Community Assessment Planning & Education (CAPE) Unit, Alameda County Public Health Department. Data Source: Data for all hospitals except St. Rose Hospital was taken from the California Office of Statewide Health Planning Department (OSHPD) 2007. St. Rose Hospital data is internal self-reported data. Note: The OSHPD data excludes records of patients who did not have a social security number. Including these records would have resulted in an overestimate in ED visitors. Therefore the data presents the most conservative estimate of ED visitors. The estimated range of ED visitors is 35,000 to 55,000.

62 S. McConville and H. Lee. "Emergency Department Care in California: Who Uses It and Why?" California Counts: Population Trends and Profiles. Public Policy Institute of California. August 2008.

G. What is the **Patient-Centered Medical Home Approach**, and How Can this Approach Improve Access to Care?

There has been interest among health care providers in Alameda County in the concept of the "patient-centered medical home" (Appendix 11). The following section outlines this concept, practical strategies for implementation, and current initiatives in Alameda County that address the medical home approach. We recommend that local safety net providers work collaboratively to conduct a countywide medical home assessment in order to determine next steps in fully implementing the medical home approach to care.

The concept of the "patient-centered medical home" has gained increased national recognition since the term was first coined by the American Academy of Pediatrics in 1967 to address the need for coordinated medical information for children with special needs.[63] Since 1967, the concept has evolved to include other aspects of care for children, youth, and adults.[64] The medical home concept is now endorsed by four national medical associations, and is the focus of several national initiatives, including a new Medicare demonstration project on primary care payment re-design.[65] Recently, the Commonwealth Fund commissioned a study that concluded that the medical home approach can reduce racial and ethnic disparities in access to care.[66]

There are currently different variations of the medical home definition. Some definitions emphasize cultural competency and "patient- and family-centeredness"; others emphasize the physician role in coordinating care; still others emphasize the structural aspects of care, such as health information systems.[67] What is common among all of the definitions is the characterization of the existing health care system as an uncoordinated patchwork of services that falls short of the patient-centered medical home ideal.

SOME DEFINITIONS EMPHASIZE CULTURAL COMPETENCY AND "PATIENT- AND FAMILY-CENTEREDNESS"; OTHERS EMPHASIZE THE PHYSICIAN ROLE IN COORDINATING CARE; STILL OTHERS EMPHASIZE THE STRUCTURAL ASPECTS OF CARE, SUCH AS HEALTH INFORMATION SYSTEMS

63 The Medical Home: Position Statement, March 2008, Association of American Medical Colleges.

64 Joint Principles of the Patient-Centered Medical Home. March 2007. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association.

65 Payment design for the medical home approach is currently being debated and tested. The Commonwealth Fund has developed a proposal for primary care payment re-design to support the development of "high performance health systems," and the Centers for Medicare and Medicaid Services, in partnership with Mathematica, is proposing a medical home reimbursement structure as part of a Medicare fee-for-service medical home demonstration project, due for roll-out in 2010. This year, NCQA developed a medical home assessment tool for primary care providers to determine what medical home characteristics are in place in their practices.

66 Beal, AC; Doty, MM; Hernandez, SE; Shea, KK; Davis, K. "Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey," Commonwealth Fund, June 2007.

67 Ibid.

Practical ways that health care providers can implement the medical home approach have been suggested by the National Committee for Quality Assurance (NCQA) and other national organizations. NCQA has developed a medical home assessment tool (see Exhibit 24). [68]

Large-scale efforts are underway in Alameda County to implement many of the above components of the medical home approach for uninsured, Medi-Cal, and other low-income patient populations.[69] Recent local work includes:

- **Widespread adaption of the medical home framework** through provider trainings on the medical home concept;
- **Implementation of uniform clinical guidelines** for diabetes, hypertension, congestive heart disease, and asthma across provider practices;
- **Increased panel management** by non-physician staff;
- **Increased coaching of patients on disease self-management** by non-physician staff;
- **Increased communication and coordination between specialists and primary care providers to improve access to specialty care** through cross-agency planning;
- **Enhancements in a web-based referral system** for primary care providers referring patients to the Alameda County Medical Center (ACMC) for specialty care;[70]
- **Increased uniformity of chronic disease data management** through the adoption of a common chronic disease software;[71]
- **Increased ability of primary care providers to access specialists notes, lab, and radiology results** on patients who are referred to ACMC;
- **Increased attention to reducing avoidable emergency department use** through coordination between hospital emergency departments, primary care providers, community organizations, and county government.[72]

There is room to build on these efforts; were Alameda County to conduct a county-wide medical home assessment, a clearer picture of next steps for Alameda County medical home efforts would emerge. Full implementation of the medical home approach can happen in concert with the potential benefits expansions that are being discussed on the national and state levels.

68 S; Merrell, K; Underwood, WS; Williams, AF. A House is not a home: keeping patients at the center of practice redesign. Health Affairs, Vol 27, Number 5, 1219-1221. September/October 2008.

69 Alameda County's Coverage Initiative/Alameda County Excellence (ACE) program, i2i Tracks disease registry implementation, the Alameda County Specialty Care Task Force, and the Health Information Technology (HIT) coordinating committee are examples of incremental efforts to implement a medical home concept.

70 In 2007, the Alameda County Medical Center (ACMC), which operates as the main provider of specialty care for the uninsured, began convening a Specialty Care Task Force to increase coordination between specialists and primary care providers. In 2008, the Alameda County Medical Center implemented major enhancements in RefTrak, and online referral system for primary care providers to refer patients to ACMC for specialty care.

71 In 2008, several community clinics in Alameda County's safety net adopted i2i, a population health management software system; all of Alameda County's large health care safety net providers are now using the same system to track and manage patient populations with chronic disease.

72 Alta Bates Summit Medical Center, ACMC, LifeLong Medical Care, East Oakland Community Project, Alameda County Behavioral Health Care

Exhibit 24. Major Features of a Medical Home

A. **Clinic Characteristics**
   - ☐ % Patients with Insurance, Panel size, # patients with at least one visit, # full-time equivalent providers

B. **Access & Communication**
   - ☐ Standardized processes (scheduling, visit with multiple clinicians, triage, same day scheduling capacity, same day triage capacity, clinical advice via telephone, group visits)

C. **Patient Tracking & Registry Functions**
   - ☐ Electronic, searchable, data systems with: language, race, medications, diagnoses, dates of visits, billing codes, immunizations, allergies, blood pressure, height, weight, BMI
   - ☐ Charting tools to record: problem list, over-the-counter medicines, risk factors, preventive services
   - ☐ Reminders of: preventive, testing, follow up care

D. **Management of Preventive & Chronic Care**
   - ☐ Clinical protocols, i.e. diabetes, cardiovascular disease, depression, asthma, screenings, immunizations, counseling (e.g. smoking cessation)
   - ☐ Guideline based physician reminders, i.e. flow sheets, checklists
   - ☐ Routine practice of care management, e.g. reminding patients of appointments, reviewing care management plans with patients
   - ☐ Involvement of non-physician members of staff in care management
   - ☐ Supporting patient self-management of disease
   - ☐ Transition planning, i.e. discharge planning
   - ☐ Systemic process to assess patients' communication needs

E. **Patient-Practice Interaction**
   - ☐ Accommodations for limited-English proficient patients
   - ☐ Ability of patients to view their medical records
   - ☐ Easily understandable reports for patients (e.g. lab results, medication lists, allergy lists)

F. **Test & Referral Tracking**
   - ☐ System outside of the paper medical chart
   - ☐ Electronic system, i.e. ordering lab tests, ordering imaging tests, receiving lab results, flagging orders for duplicate or inappropriate tests

G. **Performance Monitoring & Quality Improvement**
   - ☐ Clinical processes (e.g. % women 50+ with mammogram)
   - ☐ Clinical outcomes (e.g. HbAIc levels for diabetics)
   - ☐ Service data (e.g. wait times)
   - ☐ Patient experience of care
   - ☐ Patient safety issues
   - ☐ Stratification of data (e.g. race, language)
   - ☐ Patient ratings on the quality of language assistance
   - ☐ Report back of performance data to physicians
   - ☐ Participation in formal quality improvement activities
   - ☐ Sharing of data (e.g. lab, imaging) with other health care organizations

Source: Physician Practice Connections Tool – Research Version 2007. National Committee for Quality Assurance (NCQA).

H. What is the **Current Gap** in Access to Health Care for the Uninsured?

In the previous section, we discussed transforming the health care safety net to incorporate a patient-centered medical home approach. The following section assumes no major re-design of services.

We present five scenarios that quantify the cost of expanding the current health care safety net as currently operated. Although these scenarios are based on the best available data, they are not scientific. The scenarios are intended only as starting points to inform the current discussion on health care reform.

IN THIS SECTION:

Scenarios #1 and #2: Covering the Uninsured

SCENARIO #1
Full Coverage for Children
6,000 people

Alameda County is close to reaching universal coverage for all children. It is estimated that there are 19,000 children in Alameda County who are uninsured, and of those uninsured children 13,000 are eligible for Medi-Cal or Healthy Families. If the systemic problem in public program enrollment can be remedied and those eligible enrolled, Alameda County will only have 6,000 children left to insure. The cost of providing full coverage for these 6,000 children, at $1,200 annually per child, is approximately $7.2 million annually (Exhibit 25).

SCENARIO #2
Full Coverage for Adults and Children
177,000 people

Though costly, we present a scenario of extending coverage to the adult uninsured population for comparative purposes. There are up to 196,000 uninsured in Alameda County, the overwhelming majority of whom are adults.

We use the upper estimate of 196,000 uninsured and will continue to use the upper estimate for the remaining scenarios. Subtracting those who are eligible for Medi-Cal or Healthy Families, 177,000 uninsured adults and children remain. Multiplying this number by the average annual health coverage premium cost of $4,480 annually per person, we arrive at a cost of $793 million to provide full coverage for 177,000 adults and children in Alameda County (Exhibit 25).

Exhibit 25. Scenario 1 & 2: Ballpark Calculation of Gap in Health Insurance Coverage

		Full Coverage Scenario #1	Scenario #2	
	Numbers of Uninsured and Cost to Expand Coverage/ Access	**Children Only (0-18 years)**	**Children & Adults**	**Notes**
begin with	Lower estimate of the uninsured	19,000	166,000	Based on 2005 CHIS, a household telephone survey.
add +	Additional estimate of uninsured populations to account for potential CHIS undercount[1]	n/a	30,000[1]	This estimate accounts for groups typically not included in household telephone surveys, i.e. homeless, formerly incarcerated population, undocumented immigrants. Presumably, the majority are adults.
equals =	Total # uninsured	19,000	196,000	
subtract –	# uninsured, eligible for Medi-Cal or Healthy Families but not enrolled[2]	13,000[2]	19,000[2]	Based on CHIS estimate of uninsured who are eligible
equals =	Gap in # uninsured	6,000	177,000	
multiply x	Cost, annually per person	$1,200	$4,480[3]	Insurance cost is based on average annual premium for single coverage (group rate).
equals =	**Gap in annual funding**	**$7.2 million**	**~$793 million**	

[1] 30,000 is a conservative estimate of uninsured special populations that may not have been counted in CHIS 2005. The Alameda County re-entry Health Care Task Force estimated in 2008 that there are 11,452 uninsured, formerly incarcerated people in Alameda County. In addition, the Alameda County-wide Homeless Continuum of Care Council estimated in 2004 that there are at least 4,288 uninsured chronically homeless in Alameda County. No data is available on the undocumented immigrant population, although the Urban Institute estimates that there are more than 2.5 million undocumented immigrants in California. Alameda County represents approximately four percent of California's total population; four percent of the total number of undocumented immigrants in California results in hundreds of thousands of undocumented who are estimated to reside in Alameda County. Lastly, households that have cell phones and no land lines were not included in CHIS 2005; they will be included in the next CHIS.

[2] Studies have shown that the population eligible for public programs but not enrolled are not enrolled due to the undue burden of bureaucracy and a cumbersome re-application process on the applicant.

[3] The children's coverage cost is based on the average cost of covering a child through Medi-Cal/Healthy Families. The adult coverage cost is based on figures taken from: "Employer Health Benefits: Summary of 2007 Findings." The Kaiser Family Foundation, and Health Research and Educational Trust.

Challenges in Retention and Renewal in Medi-Cal and Healthy Families

Efforts to cover the uninsured through public programs should not only include outreach to new people, but retention and renewal strategies for those currently enrolled. In Alameda County there are 19,000 people who are eligible for, but not enrolled in Medi-Cal or Healthy Families. It is likely that many in this group have at some point been enrolled in Medi-Cal or Healthy Families but dropped out.

The administrative complexity of enrollment (and re-enrollment) in public programs is what causes many eligible people to lose their insurance coverage. A study sponsored by The California Endowment that followed a group of children who had Medi-Cal and Healthy Families showed low retention in both Medi-Cal and Healthy Families: after 13 months of enrollment, only 62 percent kept their insurance; and after 21 months of enrollment, only 50 percent kept their health insurance coverage. Of the Medi-Cal population that was dis-enrolled, 35 percent was re-enrolled in the following year.[73]

Similarly, a large proportion of current Medi-Cal enrollees in Alameda County tend to dis-enroll in the course of a year.[74] As a result, Alameda County may be spending limited local funds to subsidize health care for the 19,000 uninsured who should be enrolled in federally- and state-funded programs like Medi-Cal and Healthy Families.

73 Fairbrother, G and Schuchter, J. "Stability and Churning in Medi-Cal and Healthy Families." Child Policy Research Center, Cincinnati Children's Hospital Medical Center, The California Endowment, March 2008.

74 Experiences in Alameda County reinforce the findings of Fairbrother and Schuchter study. The Community Health Center Network reports that from July 2006 to June 2007, it had 53,225 Medi-Cal enrollees at any one point in time; however, only 17,361 were enrolled for the entirety of the 12 months.

Scenarios #3 and #4: Expanding Access to Primary and Specialty Care (non-insurance program)

SCENARIO #3

Access to Primary and Specialty Outpatient Care to All Adults and Children

102,120 people

We estimate a total of 196,000 total uninsured. We subtract those who are eligible for Medi-Cal or Healthy Families, and those who are currently receiving primary and specialty care services through the county CMSP program. We estimate that similar to the covered population, 87 percent use health services in a given year, resulting in an estimated 102,120 people who will use services but are uninsured. Multiplying 102,120 people by an annual charge of $500 for outpatient primary and specialty care, we arrive at a cost of $51 million for primary and specialty care for 102,120 people (Exhibit 26).

SCENARIO #4

Access to Primary and Specialty Care to the Lowest-Income (<200% FPL) Adults and Children

33,389 people

The fourth scenario proposes to increase access to primary and specialty care for only the lowest-income uninsured.

We use the upper estimate of 117,000 uninsured low-income residents. We subtract those who are eligible for Medi-Cal or Healthy Families, and those who are currently receiving primary and specialty care services through the county CMSP program. We estimate that similar to the covered population, 87 percent use health services in a given year, resulting in an estimated 33,389 people who will use services, but are uninsured. Multiplying this by an annual charge of $500 for outpatient primary and specialty care, we arrive at a charge of $17 million for 33,389 people (Exhibit 26).

Exhibit 26. Scenario 3 & 4: Ballpark Calculation of Gap in Access to Primary and Specialty Care for the Uninsured

	Numbers of Uninsured and Cost to Expand Coverage/Access	Scenario #3: Children & Adults	Scenario #4: Children & Adults, Lowest Income (<200% FPL)	Notes
begin with	Lower estimate of the uninsured	166,000	87,000	Based on the point-in-time, single year estimate of the uninsured in the 2005 CHIS, a household telephone survey. An alternate method of measuring the gap in coverage would be to use the larger number of people reported in the 2005 CHIS that they were uninsured for all or part of the year.
add +	Additional estimate of special uninsured populations to account for potential CHIS undercount[1]	30,000[1]	30,000[1]	This estimate accounts for groups not included in household telephone surveys, i.e. homeless, re-entry population, undocumented immigrants.
equals =	Total # uninsured	196,000	117,000	
subtract –	# uninsured, eligible for Medi-Cal or Healthy Families but not enrolled[2]	19,000	19,000	Based on 2005 CHIS estimate of eligible uninsured. Studies have shown that the population that is eligible for public programs but not enrolled are not enrolled due to a cumbersome re-application process and the undue burden of bureaucracy on the applicant, rather than a lack of information about the program.
equals =	Subtotal # uninsured	177,000	98,000	
subtract –	# uninsured getting county-subsidized primary and specialty care	59,621[3]	59,621[3]	CMSP outpatient data is being used as a proxy for use of primary and specialty care. Based on CMSP patients who received *outpatient care* in FY 2006-07. CMSP outpatient data broken down by primary care or specialty care only are not available.
equals =	*Subtotal # uninsured not getting* county-subsidized primary and specialty care	117,379	38,379	
multiply x	Estimated percentage who will use services	87%	87%	Based on 2005 CHIS estimate of the insured that made at least one doctor visit in a year.
equals =	Estimated # uninsured who will use services	102,120	33,389	
multiply x	Ave. charge, annually per person for primary and specialty care only	$500	$500	Based on the average charges to the CMSP program for primary and specialty care
equals =	**Gap in annual funding**	**$51 million**	**$17 million**	

[1] 30,000 is a conservative estimate of uninsured special populations that may not have been counted in CHIS 2005. The Alameda County re-entry Health Care Task Force estimated in 2008 that there are 11,452 uninsured, formerly incarcerated people in Alameda County. In addition, the Alameda County-wide Homeless Continuum of Care Council estimated in 2004 that there are at least 4,288 uninsured chronically homeless in Alameda County. No data is available on the undocumented immigrant population, although the Urban Institute estimates that there are more than 2.5 million undocumented immigrants in California. Alameda County represents approximately four percent of California's total population; four percent of the total number of undocumented immigrants in California results in hundreds of thousands of undocumented who are estimated to reside in Alameda County. Lastly, households that have cell phones and no land lines were not included in CHIS 2005; they will be included in the next CHIS.

[2] Studies have shown that the population who is eligible for public programs but are not enrolled are not enrolled due to the undue burden of bureaucracy and a cumbersome re-application process on the applicant, rather than a lack of information.

[3] MICRS July 1, 2006 – June 30, 2007. Note: Use of CMSP outpatient care is used as a rough proxy for receipt of primary or specialty care. Patients who only used emergency department and inpatient services were not included. 59,621 is the number of unduplicated patients who received an outpatient service in FY06-07. CMSP data is not broken down by primary care or specialty care service only.

[4] California Health Interview Survey 2005. The number of uninsured who will not need any doctor visits was derived by taking the percentage (16.9%) of insured people who reported to CHIS that they do not need any doctor visits. In other words, we expect that once the uninsured are covered or given access to care, their service utilization pattern would be the same as an insured population. There is still likely an undercount, as the uninsured report worse health status than the insured, indicating a higher need for services.

SCENARIO #5

Workforce Gap in Expanding Access to Primary Care

Expanding access to health services to the uninsured – be it through an insurance model or through expanding access to primary care and specialty care – will require an increase in the health care workforce. There are severe shortages of primary care physicians and nurses on a national level, and these shortages are exacerbated in the safety net.[75] Locally, Alameda County experiences difficulties in recruiting licensed providers who are willing to serve uninsured and low-income populations. The following calculation is one measure of the shortage in Alameda County, with a focus on primary care physician shortages. (Exhibit 27).

There are currently 142 full-time equivalent primary care providers in Alameda County's safety net (counts of specialists were not available). We estimate that to expand services to reach all uninsured in Alameda County, an additional 95 full-time equivalent (FTE) primary care physicians (PCPs) and 33 FTE specialists are needed. In addition, safety net institutions need more mid-level providers (e.g. nurses, physician assistants), dental providers, mental health providers, other medical personnel and enabling service staff. In light of the fact that Alameda County's safety net already has a workforce shortage, the challenges in recruitment for future coverage or service expansions will be great (see Appendix 9 for current staffing in Alameda County's safety net).

Lastly, policymakers and safety net institutions will have to ensure the racial, ethnic, and language diversity of providers, as well as recruitment of enough providers who are comfortable seeing low-income and marginalized patient populations. As noted in a report on the physician workforce by the Center for Health Professions, "Of California physicians who reported their race or ethnicity in 2000, African Americans and Hispanics/Latinos each comprised less than 5% of California's physicians although they made up about 7% and 31% of the state's population respectively."[76] Efforts to address the local health care workforce shortage will require increased partnerships between safety net providers, colleges and universities, as well as adequate levels of education funding.

75 *Access Denied: A Look at America's Medically Disenfranchised.* The Robert Graham Center Policy Studies in Family Medicine and Primary Care, National Association of Community Health Centers, 2007.

76 C. Dower, et al. The Practice of Medicine in California: A Profile of the Physician Workforce. The Center for Health Professions, University of California San Francisco, February 2001.

Exhibit 27. Scenario 5: Workforce Gap in Expanding Access to Primary Care

	Numbers of Uninsured and Cost to Expand Coverage/Access	Children & Adults	Notes
begin with	Lower estimate of the uninsured	166,000	Based on the point-in-time, single year estimate of the uninsured in the 2005 CHIS, a household telephone survey. An alternate method of measuring the gap in coverage would be to use the larger number of people reported in the 2005 CHIS that they were uninsured for all or part of the year.
add +	Additional estimate of special uninsured populations to account for potential CHIS undercount[1]	30,000	This estimate accounts for groups not included in household telephone surveys, i.e. homeless, re-entry population, undocumented immigrants.
equals =	Total # uninsured	196,000	Based on 2005 CHIS and estimate of groups not included in CHIS.[1]
subtract –	Total # uninsured receiving comprehensive primary care services in the safety net	105,779	The total number served as reported in section D in this report.
equals =	**Gap of uninsured not receiving services**	**90,221**	**The number 90,221 is rounded up to 100,000 to more easily apply the Physician Requirements Model (see below).**
	Number of primary care physicians needed	**95 (full-time equivalent) PCPs**	**Based on HRSA estimates of the number of physicians needed per 100,000 patients.[77]**
	Number of specialists needed	**33 (full-time equivalent) specialists**	**Based on HRSA estimates of the number of physicians needed per 100,000 patients.[78]**

[1] See footnote on CHIS in previous table.

77 The Physician Requirements Model (PRM) developed by the Health Resources and Service Administration (HRSA) indicates that per 100,000 population, 95 FTE primary care providers and 33 FTE specialists are needed. "Physician Supply and Demand: Projections to 2020." Bureau of Health Professions, Heath Resources and Service Administration, U.S. Department of Health and Human Services, October 2006.

78 Ibid.

I. Conclusion

The 2007 data contained in this report provides a baseline for measuring future progress in covering the uninsured and increases in access to health services in Alameda County. Data collected from safety net providers illustrates that in 2007 a tremendous volume of services was already being provided to the uninsured. The ability to serve more than 100,000 uninsured in 2007 is largely due to Alameda County's unique network of safety net providers—public and private hospitals, community health centers, limited-scope clinics, mobile van programs, family planning clinics, school-based health centers, and public health departments.

Yet despite the tremendous volume of care delivered to the uninsured, demand on the safety net remains high, with limited capacity. Wait times for a primary care visit with a comprehensive primary care provider for new patients can be as long as 3 months, and wait times for specialty care for new patients can take as long as 6 months. Certain underserved populations such as foster care youth, the homeless, those who were formerly incarcerated, and immigrant groups in particular may face challenges in accessing care from a system with limited capacity.

Lack of access is not only about a lack of health insurance. The fragmentation of services and the way in which health care services are organized for low-income residents in Alameda County deserves equal attention. This report provided a brief overview of the medical home approach to care, which emphasizes increased service coordination and integration, cultural competency, and increased involvement of patients and families in their own care. Alameda County safety net providers are currently taking steps to implement this approach through several local initiatives.

Numerical estimates of the gap in access to care in Alameda County were also provided. The estimations of the numbers of remaining uninsured to be served and the associated costs offer starting points for stakeholders to discuss and plan future expansions in health coverage, services, and to address the health care workforce shortage.

As a first attempt at establishing a countywide baseline of access to care for the uninsured, there were limitations, mainly due to the heterogeneity of health care providers in Alameda County and the availability of comparable data. Future updates and additions to this report should incorporate other additional critical components of access to care, such as dental care and behavioral health care. Participation from all providers in future updates can also inform the development of an analysis of the racial disparities in care, as well as gaps in the geographic distribution of clinic sites in relation to where patients live.

Access to affordable health care remains a top concern and worry for many Alameda County residents. Recent

renewed commitment by state and national leaders to address this concern through large-scale health care reform is promising. With state and federal support, Alameda County can make significant advancements in increasing access to care for all Alameda County residents.

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K. Appendices

Appendix 1. Methodology

This report is based on a baseline assessment of free and low-cost primary and specialty care services, as well as emergency department services that were used by residents of Alameda County who were either uninsured or covered by the Medi-Cal program in 2007.

In the analysis, we describe the uninsured population, the safety net, the populations served, and the total need for services. We subtract total need from the total supply of services in order to arrive at the "gap" in services. In other words, Alameda County's unmet need, or the gap in health services for low-income people is calculated in the following manner:

Total demand for services on the safety net by low-income uninsured
– Supply of services that are currently available through safety net providers
= Gap in services (i.e. unmet need)

To determine the demand for services, we use the single-year estimate as provided by the California Health Interview Survey 2005. For more demographic detail of the uninsured, we use pooled two-year data from the California Health Interview Survey 2003 and 2005.

To determine the supply of health services, we used several sources: (1) U.S. Dept. of Health and Human Services' uniform data system (UDS) for health centers, (2) the Office of State Health Planning and Development (OSHPD) clinic and hospital data sets, and (3) interviews with providers and self-reported data from providers who do not report through the UDS and OSHPD systems.

Due to the limited scope of this assessment, we do not incorporate a thorough analysis of access to dental care and behavioral health care services. For those primary and specialty care providers who also offer mental health and substance abuse services, we include information on their services.

We use the most recent available data for all providers, most of which covers the period of January through December 2007. Data from the Alameda County Medical Center (ACMC) and the school-based health centers covers July 2006 through June 2007. In order to create a baseline with multiple data sets that span a diverse set of health care providers, several assumptions were made.

For ACMC, we requested that they report patients who had at least one primary care visits (i.e. exclude patients who had no primary care visits even though they may have received other services through specialists, the emergency department, or the inpatient department).

For the rest of the providers, the reported patient numbers largely refer to the provision of primary medical care, even though some providers may have

the capacity to provide other services (i.e. limited specialty care, health education, case management, substance abuse counseling). Presumably, patients at these clinics have made at least one primary care visit, even if they receive other services.

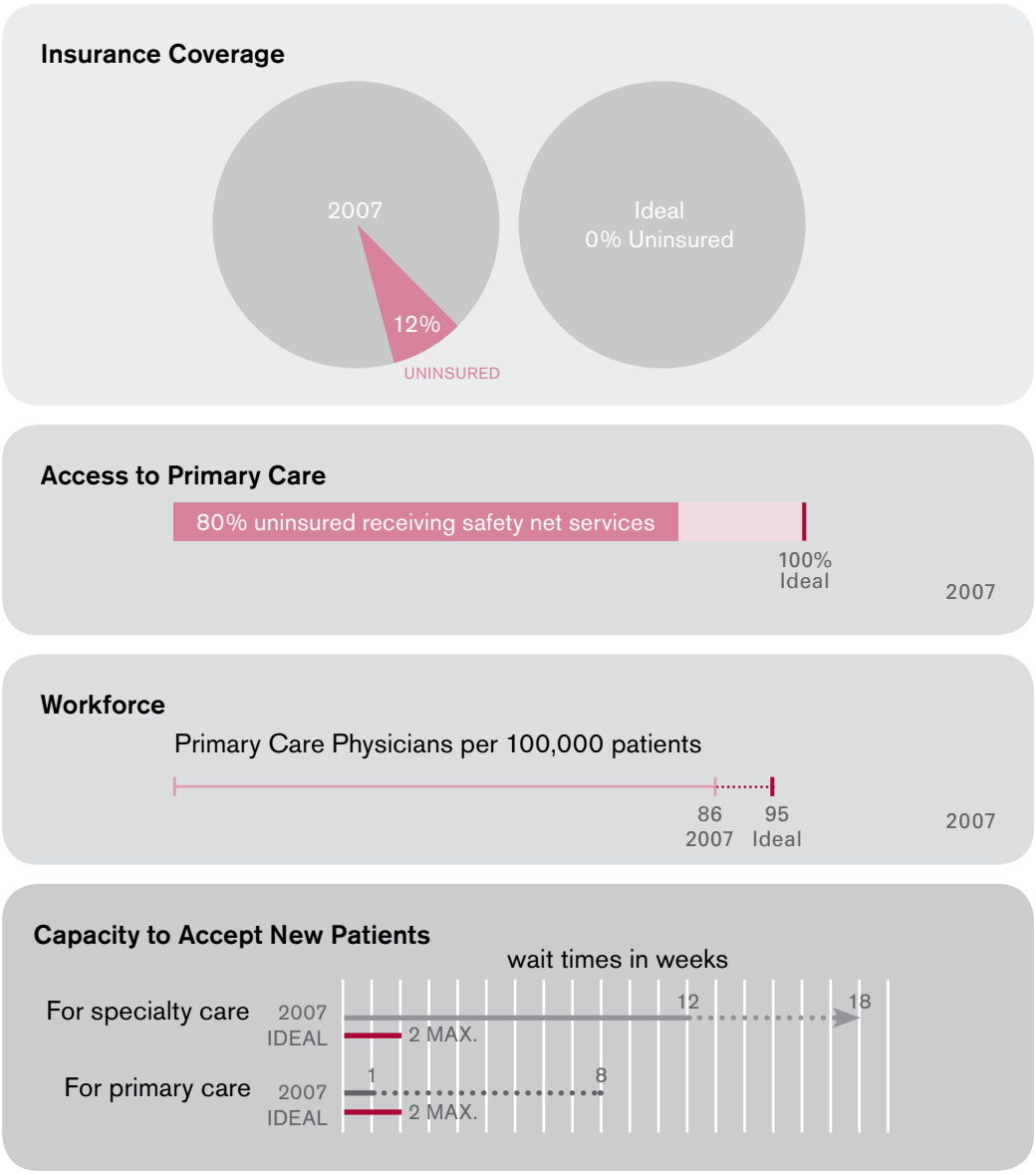
Lastly, as this report reflects, more detailed data was available from the larger, more established providers that are accustomed to collecting and reporting patient statistics to UDS and OSHPD as a part of clinic operations. In contrast, solo physicians and small physician group practices have limited staffing and infrastructure to collect and report patient statistics. Though they are an important part of the safety net, particularly in regards to accepting Medi-Cal patients, no data on solo physicians were available for inclusion in this report.

The calculations contained in this report are intended to provide an approximate baseline by which Alameda County stakeholders can measure future increases in access to care and coverage for the uninsured. The data should be interpreted carefully, with all of their limitations.

Appendix 2. Alameda County Health Care Safety Net "Dashboard"

Similar to the dashboard of a car, which tells the driver important performance information like speed, mileage, and gas levels, there can also be performance indicators for the health care safety net.

The indicators used in the following dashboard are not exhaustive and are limited to particular aspects of access to care. Future updates to this dashboard can incorporate additional process and clinical indicators, such as NCQA's HEDIS Access/Availability of Care Measures (Appendix 3).



Appendix 3. National Committee for Quality Assurance Health Plan Employer and Information Set (HEDIS) 2007

Specific Guidelines for Access/Availability of Care Measure

Measure 1 **Adults' Access to Preventive/Ambulatory Health Services (AAP)**
The percentage of enrollees 20-44, 45-64, and 65 years and older who had an ambulatory or preventive care visit.

Measure 2 **Children and Adolescents' Access to Primary Care Practitioners (CAP)**
The percentage of enrollees 12-24 months, 25 months – 6 years, 7-11 years and 12-19 years who had a visit with an MCO primary care provider.

Measure 3 **Prenatal and Postpartum Care (PPC)**
The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of prenatal care.* The percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester or within 42 days of enrollment in the MCO.
- *Postpartum care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Measure 4 **Annual Dental Visit (ADV)**
The percentage of enrolled members 2-21 years of age who had at least one dental visit during the measurement year.

Measure 5 **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**
This measure calculates two rates for adult members and two rates for adolescent members with Alcohol and Other Drug (AOD) dependence.

- Initiation of AOD Dependence Treatment. The percentage of adolescent members with AOD dependence who initiate treatment through either:
  - inpatient AOD admission, or
  - an outpatient service, for AOD dependence *and* an additional AOD service within 14 days
- Engagement of AOD Treatment. An intermediate step between initially accessing care (initiation treatment) and completing a full course of treatment. This measure is designed to assess the degree to which members engage in treatment with two additional AOD services within 30 days after initiation.

Measure 6 **Call Answer Timeliness (CAT)**

The percentage of calls received by the MCO's Member Services call centers (during Member Services operating hours) during the measurement year that were answered by a live voice within 30 seconds.

Measure 7 **Call Abandonment (CAB)**

The percentage of calls received by the MCO's Member Services call centers (during Member services operating hours) during the measurement year that were abandoned by the caller before being answered by a live voice.

Appendix 4. Comprehensive Primary Care Providers, by Encounters and Patients

	ENCOUNTERS							PATIENTS	
Comprehensive Primary Care Provider	Medical	Dental	Mental Health	Substance Abuse	Other Profes-sional	Enabling	Total Encounters	Total Patients	Annual Encounters per Patient
ACMC – Eastmont	37,894	2,822	n/a	n/a	1,997	1,378	44,091	19,759	2.2
ACMC – Highland Primary Care Clinics	51,607	8,819	n/a	n/a	1,948	1,798	64,172	47,518	1.4
ACMC – Newark	11,628	n/a	n/a	n/a	1,054	931	13,613	5,223	2.6
ACMC – Winton	17,335	n/a	n/a	n/a	1,609	1,161	20,105	6,694	3.0
Asian Health Services	78,939	10,010	1,244	n/a	629	920	91,742	18,954	4.8
Axis Community Health	not available	not available	not available	not available	not available	not available	21,470	10,020	2.1
Berkeley Men and Women's Health Center	not available	not available	not available	not available	not available	not available	5,321	4,872	1.1
Children's Hospital & Research Center Oakland – Primary Care Center	not available	not available	not available	not available	not available	not available	39,919	8,633	4.6
La Clínica de La Raza	105,184	33,505	10,593	7,434	7,434	11,399	168,115	34,247	4.9
LifeLong Medical Care	86,662	10,730	11,357	454	5,415	1,673	116,291	18,259	6.4
Native American Health Center	not available	not available	not available	not available	not available	not available	15,760	5,145	3.1
St. Rose – Silva Pediatric Clinic	not available	not available	not available	not available	not available	not available	not available	2,801	not available
Tiburcio Vasquez Health Center	36,591	6,505	4,005	n/a	n/a	7,209	54,310	11,098	4.9
Tri-City Health Center	60,960	3,150	872	n/a	1,302	4,472	70,756	18,930	3.7
West Oakland Health Council	47,110	4,225	8,654	38,549	10,117	9,633	118,288	21,751	5.4
TOTAL	**533,910**	**79,766**	**36,725**	**46,437**	**31,505**	**40,574**	**843,953**	**233,904**	**3.7 overall ave.**

Appendix 5. Comprehensive Primary Care Providers, by Patients in Poverty

	Federal Poverty Level (FPL)				
	# Patients, 100% and Below FPL	**# Patients 101–200% FPL**	**# Patients Over 200% FPL**	**# Patients Unknown FPL**	**# Patients Total**
ACMC – Eastmont	12,601	6,912	246	–	19,759
ACMC – Highland Primary Care Clinics	37,202	9,400	916	–	47,518
ACMC – Newark	2,949	2,200	74	–	5,223
ACMC – Winton	3,556	2,991	147	–	6,694
Asian Health Services	9,688	3,693	353	5,220	18,954
Axis Community Health	7,415	2,405	200	–	10,020
Berkeley Men and Women's Health Center	3,819	777	276	–	4,872
Children's Hospital & Research Center Oakland – Primary Care Center	n/a	n/a	n/a	n/a	8,633
La Clínica de La Raza	21,715	10,330	2,483	–	34,247
LifeLong Medical Care	10,614	2,599	1,175	3,871	18,259
Native American Health Center	4,926	112	46	61	5,145
St. Rose – Silva Pediatric Clinic	n/a	n/a	n/a	n/a	2,801
Tiburcio Vasquez Health Center	7,113	3,528	457	–	11,098
Tri-City Health Center	14,598	3,912	420	–	18,930
West Oakland Health Council	18,413	1,667	224	1,447	21,751
TOTAL	**154,609**	**50,526**	**7,017**	**10,599**	**233,904**

Appendix 6. Comprehensive Primary Care Providers, by Patient Ethnicity, Race, and Language

	Ethnicity (U.S. Census definition)			Race (U.S. Census Definition)							
	Hispanic or Latino	All others (including unreport-ed)	Total Patients	Asian/ Hawaiian/ Pacific Islander	Black/ African American	American Indian/ Alaska Native	White	More than one race	Other/ Unknown	Total Patients	# Limited English Patients
ACMC – Eastmont	7,805	12,330	19,759	2,490	4,257	738	6,241	5,164	869	19,759	8,378
ACMC – Highland Primary Care Clinics	17,776	29,746	47,518	9,232	13,842	1,106	12,012	9,157	2,169	47,518	21,763
ACMC – Newark	1,713	3,510	5,223	832	1,208	469	1,512	1,140	62	5,223	2,194
ACMC – Winton	2,457	4,237	6,694	1,325	1,878	544	1,521	1,279	147	6,694	2,765
Asian Health Services	59	18,895	18,954	18,336	112	6	108	–	392	18,954	16,452
Axis Community Health	5,710	4,310	10,020	1,002	301	301	8,316	–	100	10,020	6,375
Berkeley Men and Women's Health Center	1,315	3,557	4,872	630	1,754	25	2,338	–	27	4,872	1,315
Children's Hospital & Research Center Oakland	n/a	n/a	8,633	436	4,687	8	389	n/a	176	8,633	n/a
La Clínica de La Raza	26,064	8,001	34,247	2,368	2,105	115	15,688	181	13,646	34,247	25,920
LifeLong Medical Care	3,247	15,012	18,259	1,800	6,700	120	4,128	–	5,511	18,259	3,777
Native American Health Center	1,114	4,031	5,145	619	1,126	1,684	1,643	–	30	5,145	1,682
St. Rose – Silva Pediatric Clinic	n/a	n/a	2,801	n/a	n/a	n/a	n/a	n/a	n/a	2,801	n/a
Tiburcio Vasquez Health Center	8,764	2,334	11,098	756	589	51	546	9,156		11,098	7,890
Tri-City Health Center	7,775	11,155	18,930	5,087	1,826	89	2,704	–	9,224	18,930	8,063
West Oakland Health Council	3,776	17,975	21,751	372	15,388	83	4,821	–	1,087	21,751	1,305
TOTAL #	**87,575**	**135,093**	**233,904**	**45,285**	**55,773**	**5,339**	**61,967**	**26,077**	**33,440**	**233,904**	**107,879**
%	**39%**	**61%**	**100%**	**19%**	**24%**	**2%**	**26%**	**11%**	**14%**	**100%**	**46%**

Appendix 7. Comprehensive Primary Care Providers, by Patient Age and Gender

Comprehensive Primary Care Provider	0–19			20–64			65+			Total		
ACMC – Eastmont	n/a	n/a	5,844	n/a	n/a	12,986	n/a	n/a	929	7,644	12,115	19,759
ACMC – Highland Primary Care Clinics	n/a	n/a	4,947	n/a	n/a	40,447	n/a	n/a	2,124	25,769	21,749	47,518
ACMC – Newark	n/a	n/a	1,730	n/a	n/a	3,185	n/a	n/a	308	2,013	3,210	5,223
ACMC – Winton	n/a	n/a	2,121	n/a	n/a	4,083	n/a	n/a	490	2,578	4,116	6,694
Asian Health Services	2,532	2,741	5,273	3,103	6,447	9,550	1,725	2,406	4,131	7,360	11,594	18,954
Axis Community Health	1,216	2,506	3,722	1,840	4,103	5,943	108	247	355	3,164	6,856	10,020
Berkeley Men and Women's Health Center	32	93	125	1,054	3,449	4,503	90	154	244	1,176	3,696	4,872
Children's Hospital & Research Center Oakland	4112	4187	8,299	104	230	334	0	0	0	4,216	4,417	8,633
La Clínica de La Raza	8,444	8,817	17,267	4,837	10,412	15,247	650	1,074	1,724	13,941	20,312	34,247
LifeLong Medical Care	908	1,018	1,926	4,938	7,583	12,521	1,259	2,553	3,812	7,105	11,154	18,259
Native American Health Center	745	1,226	1,971	995	1,982	2,977	55	142	197	1,795	3,350	5,145
St. Rose – Silva Pediatric Clinic	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2,801
Tiburcio Vasquez Health Center	2,540	3,078	5,618	1,074	3,873	4,947	169	364	533	3,783	7,315	11,098
Tri-City Health Center	3,133	4,647	7,780	2,858	7,621	10,479	252	419	671	6,243	12,687	18,930
West Oakland Health Council	2,506	3,028	5,534	6,024	9,145	15,169	414	634	1,048	8,944	12,807	21,751
TOTAL	**26,168**	**31,341**	**72,157**	**26,827**	**54,845**	**142,371**	**4,722**	**7,993**	**16,566**	**95,731**	**135,378**	**233,904**

Appendix 8. Comprehensive Primary Care Providers, by Patient Insurance Status

	Total Patients	None/ Uninsured	Total Medicaid (Regular + SCHIP)	Medicare (Title XVIII)	Other Public Insurance	Private Insurance
ACMC – Eastmont	19,759	9,601	8,349	1,630	n/a	179
ACMC – Newark	5,223	1,916	2,650	509	n/a	148
ACMC – Winton	6,694	1,953	3,631	965	n/a	145
ACMC – Highland Primary Care Clinics	47,518	27,802	13,784	5,395	n/a	537
Asian Health Services	18,954	5,878	7,085	3,156	1,955	880
Axis Community Health	10,020	4,849	4,727	343	99	2
Berkeley Men and Women's Health Center	4,872	2,938	1,401	452	0	81
Children's Hospital & Research Center Oakland – Primary Care Center	8,633	61	7,982	2	53	537
La Clínica de La Raza	34,247	16,393	12,793	944	1,900	2,371
LifeLong Medical Care	18,259	6,838	5,541	3,844	98	1,938
Native American Health Center	5,145	1,317	2,592	1,027	10	199
St. Rose – Silva Pediatric Clinic	2,801	680	1,239	not available	882	not available
Tiburcio Vasquez Health Center	11,098	4,754	5,269	443	638	61
Tri-City Health Center	18,930	9,133	8,709	412	652	23
West Oakland Health Council	21,751	11,649	7,484	1,566	675	377
TOTAL	**233,904**	**105.762**	**93,236**	**20,688**	**6,962**	**7,478**

Appendix 9. Comprehensive Primary Care Providers, by Full-Time Equivalent (FTE) Staffing

	Subtotal of Physicians	Nurse Practitioners	Physician Assistants	Certified Nurse Midwives	Total Midlevel Practitioners	Nurses	Other Medical Personnel	Lab and X-Ray Personnel	Total Medical Care Services
ACMC – Eastmont	14.8	2	5.1	0	7.1	10	11	0	42.9
ACMC – Highland Primary Care Clinics	30	9	11	0	20	12.5	7	0	69.5
ACMC – Newark	8.8	1	1.5	0	2.5	6	4	0	21.3
ACMC– Winton	6.9	1	2	0	3	8	5	0	22.9
Asian Health Services	18.2	0.36	0.74	0	1.1	10.87	22.28	1.05	53.5
Axis Community Health	5.98	1	0	0	1	4	0	0	10.98
Berkeley Men and Women's Health Center	2.1	0	0	0	0	1	0	0	3.1
Children's Hospital & Research Center Oakland – Primary Care Center	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
La Clínica de La Raza	21.26	12.38	1.89	n/a	15.78	10.12	52.61	0	110.08
LifeLong Medical Care	16.24	3.52	5.42	2.15	11.09	11.5	26.99	0	65.82
Native American Health Center	2.1	3.15	0.7	0.5	4.35	2.5	0	0	8.95
St. Rose – Silva Pediatric Clinic	1.25	n/a	n/a	n/a	3.04	n/a	n/a	n/a	7.71
Tiburcio Vasquez Health Center	3.48	4.33	2.55	0.6	7.48	3.76	23.17	2	39.89
Tri-City Health Center	5.73	10.4	3.1	0	13.5	1	32.69	0	52.92
West Oakland Health Council	6.6	2.06	0.25	0.8	3.11	3.2	17.55	11	41.46
TOTAL	**142.19**	**50.20**	**34.25**	**4.05**	**90.01**	**84.45**	**202.29**	**14.05**	**543.30**

Appendix 9. Comprehensive Primary Care Providers, by Full-Time Equivalent (FTE) Staffing (continued)

	Dentists	Dental Hygienists	Dental Assistants, Aides and Technicians	Total Dental Services	Psychiatrists	Other Licensed Mental Health Providers	Other Mental Health Staff	Total Mental Health Services	Substance Abuse Services	Total Enabling Services	Total Employees
ACMC – Eastmont	2.5	0	2	4.5	0	0	0	0	0	26	82.4
ACMC – Highland Primary Care Clinics	3.1	0	9	12.1	0	0	0	0	0	2	99.1
ACMC – Newark	0	0	0	0	0	0	0	0	0	7	32.3
ACMC– Winton	0	0	0	0	0	0	0	0	0	11	39.9
Asian Health Services	3.78	0	5.97	9.75	0	0.95	0.76	1.71	0	37.15	177.56
Axis Community Health	0	0	0	0	0	0	0	0	0	0	40.62
Berkeley Men and Women's Health Center	0	0	0	0	0	0.1	0	0.1	0	0	8.2
Children's Hospital & Research Center Oakland – Primary Care Center	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
La Clínica de La Raza	9.99	0.56	26.37	37.58	0.68	16.73	n/a	21.67	n/a	44.82	395.83
LifeLong Medical Care	4.64	0	2.88	7.52	0.63	8.47	5.89	14.99	1.48	39.67	238.76
Native American Health Center	3.8	0	4	7.8	0.5	0	0	0.5	1	8.5	32.25
St. Rose – Silva Pediatric Clinic	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Tiburcio Vasquez Health Center	3	0	8.82	11.82	0	0	10.5	10.5	0	28.33	172.49
Tri-City Health Center	0.75	0	0	0.75	0	1	0	1	0	29.5	137.93
West Oakland Health Council	2.4	0	4	6.4	0.9	2	9.1	12	18.33	14.87	162.49
TOTAL	**33.96**	**0.56**	**63.04**	**98.22**	**2.71**	**29.25**	**26.25**	**62.47**	**20.81**	**248.84**	**1619.83**

Appendix 10. Low-Income K-12 Student Population in Alameda County

Using enrollment in the free and reduced school lunch program as a proxy for low-income status, it is estimated that more than 80,000 students K-12 in Alameda County are low-income. Many of students may access services through multiple safety net providers.

Low-Income[1] K-12 Students in Alameda County, by School District, 2007

School District	# schools[2]	Total # School District Enrollment[3]	% Low-Income[1] Students	# Low-Income Students
Piedmont City Unified	6	2,552	0.3%	8
Mountain House Elementary	1	37	50%	19
Dublin Unified	10	5,556	8%	444
Pleasanton Unified	16	14,864	4%	595
Albany City Unified	6	3,810	16%	610
Emery Unified	2	817	78%	637
Alameda County Office of Education	5	2,007	39%	783
Castro Valley Unified	14	8,827	15%	1,324
Livermore Valley Joint Unified	19	13,213	20%	2,643
Newark Unified	14	7,142	38%	2,714
Alameda City Unified	19	10,323	33%	3,407
Berkeley Unified	16	8,959	40%	3,584
New Haven Unified	14	13,006	34%	4,422
San Leandro Unified	12	8,725	51%	4,450
San Lorenzo Unified	18	11,821	45%	5,319
Fremont Unified	41	31,948	18%	5,751
Hayward Unified	33	21,619	53%	11,458
Oakland Unified	143	46,447	70%	32,513
SBE – Leadership Public Schools – Hayward School District	1	313	not available	not available
SBE – Livermore Valley Charter School District	1	855	not available	not available
Sunol Glen Unified	1	215	0.3%	not available
California School for the Blind	1	81	not available	not available
California School for the Deaf	1	406	not available	not available
Total	**391**	**213,543**		**80,678**

[1] Enrollment in the Free or Reduced Price Meal Program is used here as a proxy for low-income. A child's family income must fall below 185% of the Federal Poverty Level (or $37,000 for a family of four in 2006) to qualify for reduced-cost meals, or below 130% of the Federal Poverty Level ($26,000 for a family of four in 2006) to qualify for free meals. Not all eligible children are enrolled in the program, so these numbers do not reflect all low-income school-age children. Source: www.kidsdata.org, a program of the Lucile Packard Foundation for Children's Health as accessed on 10/14/08. Data source: California Department of Education, Educational Demographics Unit. Retrieved 01/07/08. http://data1.cde.ca.gov/dataquest/

[2] Source: Education, Data, Partnership (Ed-Data). Accessed on 10/24/08 at http://www.ed-data.k12.ca.us .

[3] Source: California Department of Education, Educational Demographics Unit, 7/7/08.

Appendix 11. Alameda County Access to Care Collaborative Summary of October 2007 Strategic Planning Session

Goal

Universal access to primary care and specialty care through a countywide system

Outcome and Target Population

Medical home for the lowest-income uninsured residents, under 200% FPL.

Characteristics of the Countywide System

- Easy, timely, convenient access to services when the client wants services.
- Public health and prevention principles are central to primary care.
- Community and county clinics serve as medical homes.
- Other entities (e.g. ERs, urgent care centers, school-based health centers, smaller clinics, pharmacies, mobile health vans) serve as entry points to, and partner with, the clinics that have the capacity to serve as medical homes
- Promote public understanding of the value of a medical home.

Principles

- Balance the growth of primary care with a growth in specialty care in order to meet patients' needs.
- Manage risks to the safety net as we implement new initiatives (e.g. hospital waiver, enrollment of more seniors and people who are blind or disabled into managed care).
- Support safety net institutions to emphasize primary care
- System changes should support seamlessness in services, regardless of a person's insurance status
- Include evaluation/research to measure the outcomes

Priority Areas

#1. Baseline assessment of services for the uninsured: Identify what services currently exist; identify gaps in timely, convenient access, identify locations for expanded services.

#2. Create New Sites and Expand Access at Current Sites: Coverage Initiative, provider training, redesign primary care, integration of behavioral health, role of urgent care, identify players, financing, role of prevention, role of specialty care, linkages to school health centers and single childless adult efforts.

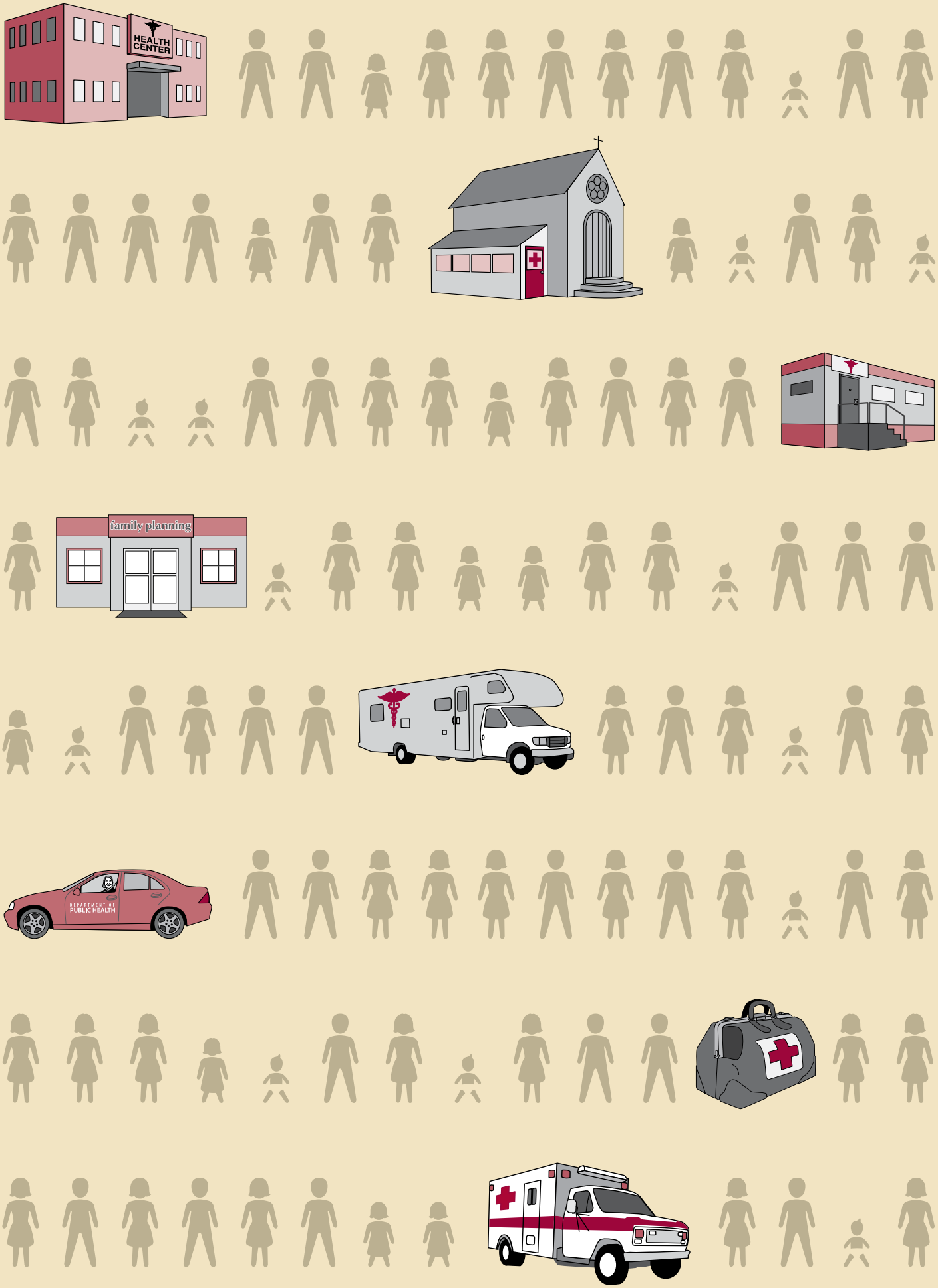
#3. Branding and Communications with Target Population: Catchy name for the countywide system, 800# for access, identification card.

#4. Technology Tools: One-e-App, E-Referrals, communication between providers.

#5. Policy Agenda.

Timeline

2008-2010


HEALTH CENTER
family planning
DEPARTMENT OF PUBLIC HEALTH