REDUCING RELIANCE ON EMERGENCY DEPARTMENTS FOR NON-URGENT CARE
THROUGH PATIENT ASSISTANCE: A PHENOMENOLOGICAL APPROACH TO DIALOGUE THAT LOOKS OUTSIDE HOSPITAL WALLS

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ABSTRACT

America's underserved are turning to emergency departments for non-urgent care at an alarming rate that is attracting national attention in an era of health reform, and prompting hospitals to offer patient assistance programs to help members of this patient population find other affordable care alternatives in the community. This study examined one such program, and the problem it is incurring with patients who continue to return to the emergency department despite receiving assistance. Moving away from the positivistic research norm found in literature, dialogic theory in the phenomenological tradition was used to investigate the lived experiences of patients being assisted by the program to better understand the social factors that lead them to return to the emergency department for non-urgent care. Ten qualitative interviews were held with uninsured and Medi-Cal-insured patients, and a thematic analysis of the data was conducted. Four themes emerged that revealed participants are returning to emergency departments due to the harsh realities of a failing Medi-Cal system, major gaps in community health center capability, a substandard public transit system, and because the emergency department is viewed as one institution where illness is still taken seriously within a health care system that no longer cares. Results of this study were incongruent with existing literature, and emphasize the need for further dialogic research to provide insight and understanding from a holistic patient perspective, which is critical to effectively serving the health care needs of vulnerable populations.
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Chapter 1: Introduction

Introduction

David visited the emergency department 29 times in 2012. Most of these visits were to get refills for various medicines he takes. David has no insurance and cannot afford to see a doctor; thus he has no way to get prescription medications. Cindy admitted to the emergency department 19 times in 2012, mainly seeking treatment for headaches and allergies, even though she is publicly insured through Medicaid and has a doctor (Younts, 2012).

Their names are fictitious, but the stories of David and Cindy are true and all too common today among those who turn to hospital emergency departments for care. Increasingly, America’s emergency departments are balancing the responsibility of providing life-saving treatment for the acutely ill with a new role as safety net provider for the poor and vulnerable (DeLia & Cantor, 2009; Institute of Medicine, 2007). Indeed, 79 percent of Americans who are uninsured and underinsured through Medicaid, like David and Cindy, report that emergency departments are often their only guarantee for any care (Gindi, Cohen, & Kirzinger, 2012).

The growing use of emergency departments by the underserved for care that the more fortunate receive regularly from their family doctor is an issue of nationwide discussion that has intensified in an era of health reform. Discussion centers on concerns over quality and continuity of care, cost of care, and the capacity and financial viability of hospital emergency departments (Cunningham, Felland, & Stark, 2012; DeLia & Cantor, 2009). For instance, the Institute of Medicine (2007) argues that because emergency departments are designed for providing rapid and short-term treatment of acute injuries and illnesses, quality and continuity of care is compromised for individuals who use them as a sole source of non-urgent care on a regular basis. Patients visiting for non-urgent care are given low priority in emergency departments. Emergency department physicians also "do not have a relationship with the patient, often lack complete patient medical records, face constant interruptions and distractions, and have no
means of patient follow-up" (Institute of Medicine, 2007, p. 48). While true cost is hard to estimate, it is generally accepted that cost associated with providing non-urgent care in an emergency department is significantly higher than in a physician's office, or clinic setting; a factor that further contributes to high cost in an already inflated industry (DeLia & Cantor, 2009; Institute of Medicine, 2007). The increasing demand for emergency departments to provide non-urgent care to the underserved, much of which goes uncompensated, often exceeds the capacity of hospital emergency departments (American College of Emergency Physicians, 2009; DeLia & Cantor, 2009; Institute of Medicine, 2007). This has led to the closure of seven percent of America's emergency departments over the past decade, and earned the country a grade of "D-

These concerns have become a priority with the March 2010 passage of the Patient Protection and Affordable Care Act, particularly as they relate to provisions in the new law to provide Medicaid insurance for millions of underserved citizens. An expectation of the law is that Medicaid will open access to care for these citizens, thereby reducing emergency department use for non-urgent care and realizing significant cost savings. In fact, the government anticipates that reduced emergency department visits represent one of the greatest areas for cost-savings (Longworth, 2011). Hospitals and health providers have a compelling reason to rethink emergency department practices and develop new ways to help the underserved find other appropriate means of care (Cunningham, Felland, & Stark, 2012; DeLia & Cantor, 2009; Longworth, 2011). With this aim in mind, four northern California affiliate hospitals piloted the Community Health program in September of 2011. The program uses referral specialists to assist underserved patients who visit the emergency departments of the four affiliate hospitals for non-urgent care. Patients who are uninsured and lack a physician are connected to community health
centers that offer free and low-cost care; Medicaid-insured patients are referred to physicians in the community who accept this insurance. Goals of the Community Health program are to find patients affordable medical homes that provide the access to care they need on a regular basis, thereby decreasing their reliance on the emergency department, and reducing costs (Younts, 2011).

Statement of the Problem and Study Purpose

The Community Health program has successfully assisted 3,000 patients to date, ensuring they have an appointment with a community health center, or physician, for follow-up care when they leave the emergency department. Of the patients assisted, however, 65 percent have continued to return multiple times to the emergency department for non-urgent care (Younts, 2012). Multiple return visits to the emergency department present a problem that counteracts success the program has in finding regular medical homes for patients. It can be argued that simply finding patients other affordable options for care is not a viable solution in and of itself for reducing their reliance on emergency departments. The fact that patients return to the emergency department, even after they receive assistance by the Community Health program, suggests there are underlying challenges facing this patient population that are not being addressed, and raises an important question for communication research: What are the social factors that lead patients currently being assisted by the Community Health program to return to the emergency department for non-urgent care? This question serves as the foundation for this study that seeks to gain insight into the patients being assisted by the Community Health program to better understand why health care alternatives provided are not enough to prevent them from returning to the emergency department for non-urgent care.
Importance of the Study

New insight and understanding that can be gained through this study holds promise for making improvements to the Community Health program to better serve patients. More effectively serving patients can in turn help the Community Health program achieve a reduction in avoidable emergency department visits for non-urgent care, and lower costs; objectives that are shared with the Patient Protection and Affordable Care Act. New insight and understanding can also help inform other developing hospital patient assistance programs for underserved patient populations. On a larger scale, there is a need for increased communication research in health care to address the challenges facing an industry that is undergoing the most dramatic change in its history. Through communication research, new awareness of, and knowledge about, the real-life problems that America's underserved experience when accessing health care can be attained. This is essential if the Patient Protection and Affordable Care Act is to achieve one of its principles aimed at eliminating a layer of health inequity in the Nation. This principle has been made clear by President Barack Obama (2009, June 15):

We are not a nation that accepts nearly 46 million uninsured men, women and children. We are not a nation that lets hardworking families go without coverage, or turns its back on those in need. We are a nation that cares for its citizens.

(Obama, 2009, June 15, para. 61)

Definition of Terms Used

Various terms in this study that are commonly used in health care are defined as follows:

*Community health centers*. Community health centers are also known as Federally Qualified Health Centers, and are considered the safety net mainstay in communities across the country. These centers receive federal funds to operate clinics that provide free, or low-cost,
Comprehensive health care for individuals and families of low-income (National Association of Community Health Centers, 2013).

Comprehensive care. Comprehensive care considers the full spectrum of an individual's health needs, and is care that is provided, or coordinated, by primary care physicians and community health centers. Comprehensive care is defined as “a person-centered system of health care that facilitates access to and coordination of the full array of primary and specialty health services, including behavioral health care and social support services” (Sierra Health Foundation, 2012, p. 6).

Federal Poverty Level. The Federal Poverty Level represents a methodology used by the federal government to define who is poor, and to determine who is eligible for public insurance and other public assistance. Federal Poverty Level is calculated annually, based on the total cash income of an individual, or family. Generally, those with incomes that fall at, or below, 200 percent of the Federal Poverty Level are eligible for public insurance, or other public assistance. For 2013, the 200 percent Federal Poverty Level has been established at $23,550 for a family of four (U.S. Department of Health and Human Services, 2013a).

Geographic managed care. Geographic managed care is the particular system for Medi-Cal selected by some counties in California. Under this system, the California Department of Health Care Services (DHCS) contracts with private insurance plans to manage and ensure health care to eligible low-income individuals. The insurance plans receive a contracted payment amount per month for each insured member from DHCS at a capitated rate, or set fee per patient. In turn, GMC plans contract with physicians who are willing to provide care at a reduced rate to beneficiaries (Klein & Donaldson, 2004).
Medicaid. Medicaid is government-funded health insurance for low-income individuals, including families and children, the elderly, and persons with disabilities. Those eligible for Medicaid generally have incomes at, or below, 200 percent of the Federal Poverty Level. Medicaid is funded by both federal and state governments (U.S. Department of Health and Human Services, 2013b).

Medi-Cal. Medi-Cal is the name for California’s Medicaid health care program, which offers benefits similar to the Medicaid program.

Medical home. A medical home serves as an easily accessible ‘home base’ (physician’s office, or clinic) for individuals and families to receive health care regularly. In a medical home, individuals and families have a relationship with their health care providers, and receive continuous, comprehensive, coordinated, and compassionate care (U.S. Department of Health and Human Services, 2013c).

Non-urgent care. Treatment that has a low level of acuity and can be provided in a physician’s office, or clinic, is commonly referred to as non-urgent care. Other common names for non-urgent care include primary care, and regular care. Examples of non-urgent conditions would include cold and flu, earaches, minor cuts and sprains, rashes, and dental problems (American College of Emergency Physicians, 2013).

Primary care provider. A primary care provider is a family doctor who patients see regularly for comprehensive health care.

Safety net. Safety net is a term that refers to networks of nonprofit providers within communities that deliver health care and health-related services to those who are uninsured, or Medicaid-insured. Providers within safety nets have a mission to serve the most vulnerable, and maintain an open door policy, regardless of a person's ability to pay. Core safety net providers,
like community health centers, are funded by state and federal governments (Institute of Medicine, 2000).

**Underserved.** The term underserved is used to describe individuals, or families, who are uninsured or publicly-insured through Medicaid, and have low-incomes that are at, or below, 200 percent of the Federal Poverty Level.

**Organization of Remaining Chapters**

Four remaining chapters are presented in this study. Chapter 2 begins by examining the current orientation for communication research in the field of health care. The philosophical assumptions and theoretical basis for this study are then presented, followed by a discussion of literature relevant to the study topic. Literature is organized into seven sections: 1) trends in emergency department usage for non-urgent care; 2) impacts on emergency department capacity and viability; 3) quality of non-urgent emergency department care; 4) cost of non-urgent emergency department care; 5) the role of community health centers in offsetting emergency department visits by the underserved for non-urgent care; 6) emerging hospital patient assistance programs with similarities to the Community Health program, and; 7) reasons why the underserved turn to emergency departments for non-urgent care. Chapter 2 concludes with the rationale, purpose and research question for this study. Chapter 3 discusses the scope and methodology for research, including ethical considerations. In Chapter 4, study results are presented, along with a discussion on the implications of the findings. Study limitations, recommendations, and concluding remarks are presented in Chapter 5.
Chapter 2. Review of the Literature

Literature

Research leaves no question that effective communication for health care providers and organizations is critical. The Joint Commission (2010) emphasizes that to "truly meet the needs of patients, families, and communities," hospitals must integrate effective communication into all aspects of their care delivery system (p. 3). The American Medical Association (2006) asserts that ethical, high-quality health care depends on effective communication. The U.S. Department of Health and Human Services (2011) has made communication with patients and local communities a strategic priority for all providers for achieving quality improvement goals under the Patient Protection and Affordable Care Act.

Despite growing attention on communication by these organizations, nowhere in their texts is there a call for research to examine how communication contributes to more meaningful interaction and higher quality outcomes between providers, patients, and communities. As to why not, literature reveals a number of possibilities. Bernhardt (2004) suggests the omission is not uncommon because the discipline continues to operate somewhat on the borders of the health care field. Communication is still perceived by many in health care, particularly within institutions and among clinicians, as more “skill than science,” and as a process of disseminating information that can "speak for itself" (p. 2051). Other scholars suggest that communication research retains a tangential position in health care due to the long-standing domination by, and bias toward biomedical research. This emphasis on the biomedical side of care masks the need to study the human dimension of health care through communication (Branch, Kern, Haidet, Weissmann, Gracey, Mitchell, & Inui, T, 2001; Charon, 2006; Todres, Galvin, & Holloway, 2009).
A related line of thought in literature maintains that while communication research is advancing, studies continue to fall back on the traditional practice of presenting data that comes from institutional records, and from the perspective of organizations and providers, not patients (Adadi-Lari, Tamburini, & Gray, 2004; Ellingson, 2002; Koziol-McLain, Price, Weis, Quinn, & Honigman, 2000). Koziol-McLain et al. (2000) make a point particularly salient to this study. Programs by hospitals designed to assist underserved patients are often “based on the assumptions of administrators and health care providers whose lives of privilege differ extraordinarily from the lives of those they serve” (p. 555). Todres, Galvin, and Holloway (2009) express concern over the emphasis health care research places on large scale representation, or human standardization: “Statistical realities can produce inequalities ... When human beings are forced to fit into the standardized framework they often feel that it makes logical sense, but do not always experience the same practices of standardization ..." (p. 72). In other words, it is hard to normalize and relate to human experiences that are personal and unique.

These perspectives appear to be well-founded when examining literature specifically on the topic of this study. The tendency for research on emergency department usage by underserved patients, and hospital programs to assist these patients is to take a positivist approach that situates health care as a commodity and produces data that looks at people in the form of numbers. In contrast, this study moves away from the more conventional research paradigm and looks outside the walls of hospital institutions to understand what patients assisted by the Community Health program experience in the everyday realities of social life. Situated in the area of interpersonal communication, and specifically within the phenomenological tradition, this study uses dialogic theory.
Philosophical Assumptions and Theoretical Basis

Dialogue, within the phenomenological tradition, is viewed as "authentic communication that is founded on the experience of direct unmediated contact with others" (Craig, 1999, p. 138). While there are many phenomenological perspectives, a common thread among them is the intent to understand through dialogue the meaning of a phenomenon from an individual's lived experience (Anderson, Baxter, & Cissna, 2004; Craig & Muller, 2007; Griffin, 2006; Johannesen, 1971). In particular, this study will draw from the philosophical hermeneutics of Hans-Georg Gadamer, with attention to his concept of genuine dialogue. The more critical approach Stanley Deetz takes to dialogue, specifically as it relates to how organizations communicate with stakeholders, also informs this study. The works of these two philosophers challenge the analytical and individualistic viewpoints of human experience that are grounded in positivism. Their theories involving dialogic communication have a holistic approach that accounts for differences in humans and human experiences within a socially dependent context. Such an approach sits well with this study, which assumes that knowledge and meaning are socially constructed, and understanding is created through interaction with others.

Hermeneutics and genuine dialogue. Gadamer's (2008) representation of philosophical hermeneutics shifts the concept of interpretation from its position as a methodological imperative concerned with understanding to an ontology of understanding. His notion of hermeneutics is not concerned with developing procedures for understanding, but with illuminating "the interpretive conditions in which understanding takes place" (Kinsella, 2006, para. 9). The hermeneutical question for Gadamer (2008) is "not what we do or what we should do, but what happens beyond our willing and doing" (p. xi). Gadamer's (2008) primary intent through hermeneutics is to:
... discover what is common to all modes of understanding and to show that understanding is never a subjective relation to a given 'object' but to the history of its effect; in other words, understanding belongs to the being of that which is understood (p. xxxi).

Central to Gadamer's philosophy of hermeneutics is a focus on language. Far from being just a tool, language shapes the worldviews (and biases within) of humans, defining the way humans think, what they know, and how they understand (McManus-Holroyd, 2007). To Gadamer, “Hermeneutics is an encounter with Being through language” (Palmer, 1969, p. 42). Within this context, language opens the door to meaning, not as an individual and subjective endeavor, but as a “dominant force defining the space that humans share with each other” (McManus-Holroyd, 2007, p. 5).

Strongly connected to this emphasis on language is Gadamer's concept of genuine dialogue as the agency for giving meaning to an experience (Deetz, 1992). Gadamer considers dialogue that involves two people merely exchanging opinions to be unproductive, and limited in that it runs the risk of a dominant opinion overshadowing the conversation (Deetz, 1992). Genuine dialogue on the other hand, engages two people in a conversation in which neither leads; conversation, instead, takes on a "spirit of its own" (Gadamer, 2008, p. 383). The subject matter is what drives a conversation, and while the outcome is unpredictable, the hope is for the discovery of new, shared meaning (Gadamer, 2008). To Gadamer, genuine dialogue “works more to create and recreate a common language and experience as the tensions of difference question the adequacy of current understanding” (Deetz, 1992, p. 166). Thus, genuine dialogue is dynamic, and calls for a "logic of question and answer": a back and forth type of play between people in conversation (Wiercinski, 2011, p. 17). In this "process of question and answer, in
giving and taking, talking at cross purposes and coming to an agreement - dialogical discourse performs that communication of meaning" (Gadamer, 2006, p. 367).

Genuine dialogue must also be entered into with an open mind, and a conscious willingness to be aware that previous assumptions, or what Gadamer calls prejudices, based on past history and knowledge, might be wrong (McManus-Holroyd, 2007). According to Gadamer (2006), being open "includes our situating the other meaning in relation to the whole of our meanings or ourselves in relation to it" (p. 268). This process of situating seems somewhat analogous to experiencing life through the eyes of another, and can shed new light on a subject that challenges traditional understanding and leads to new perspectives.

There are important insights to be gained from Gadamer's work relevant to this study. He helps uncover a fundamental flaw in the Community Health program. The program was developed based on a traditional understanding (assumption) about the kind of assistance patients need, and not upon a mutual understanding that might have been achieved through genuine dialogue with patients. However, from this realization, there is also an opportunity. Genuine dialogue with patients being assisted by the Community Health program may uncover new meaning that offers a chance to get the program right.

**Stakeholder communication.** In basic ways, the philosophies of Deetz and Gadamer align. Deetz (1982) too, argues for the interpretive paradigm over traditional scientific research. He considers language to be the "principle medium through which social reality is created and sustained" (Griffin, 2006, p. 274). A fundamental difference in philosophy, however, lies in Deetz's contention that "the issue of power runs through all language and communication"; thus his approach to communication theory is critical (Griffin, 2006, p. 275). From this position, Deetz (1992) suggests that achieving the level of genuine dialogue or conversation advocated by
Gadamer is difficult because embedded in conversations are ideological structures of power that privilege certain interests.

Deetz's (1996) work is largely centered on communication within organizations, which he maintains is limited by governance structures and decision-making practices that privilege the ideologies of some, while inhibiting and silencing others. Management control is a central issue for Deetz, and he believes it infiltrates every aspect of the workplace, including "language, information, forms, symbols, rituals, and stories" (Griffin, 2006, p. 278). Management control then, is considered built into the communication systems of organizations, and impedes "any real worker voice in structuring their workplace" (Griffin, 2006, p. 276). It is a process characterized by Deetz as "systematically distorted communication" that restricts expressions of ideas and thoughts, and enforces hierarchies in organizations (Griffin, 2006, p. 278). Employees may think they have a say in organizational decision-making processes, when in fact they are merely consenting to taken-for-granted norms, values, and cultures that have already been established and favor the interests of those who are in a dominant position (Griffin, 2006). This type of distorted communication results in "discursive closure" that disempowers employees, prevents them from having their values represented, and leaves them out of the decision-making process (Deetz, 2005, pp. 7, 20).

As an alternative to this organizational form of governance and control, Deetz (2005) offers a model of stakeholder communication. The model differs from the stakeholder governance and participation programs that have gained popularity in modern corporations. Deetz (2005) argues that these programs are primarily focused on finding common ground, or reaching value consensus, and are "underdeveloped and often ineffective" due to their failure to focus on communication concepts and practices (p. 3). These programs overlook the need to
produce "personal meanings in communication," and although they may increase the venues where "representation and debate could occur," they do not increase stakeholder "voice" (p. 19). Here Deetz (2005) departs from Gadamer, when he contends that to more fully develop these programs involves moving "beyond mere mutual understanding to making quality decisions together" (p. 23). Deetz's (2005) model of stakeholder communication "requires a collaborative constitutive view of communication based in conflict rather than consensus" (p. 19).

Deetz (2005) provides a number of insights that are basic to the model of stakeholder communication. Positions of authority should be set aside. Allowing "stakeholders to jointly make decisions" offers more benefit than just giving "stakeholders a say" (p. 23). The diverse interests of stakeholders should be represented, and "emergent solutions" encouraged in discussion (p. 23). Rather than "focusing on problems" or "bargaining over preferred solutions," more is accomplished if the focus is on outcomes that reflect stakeholder interests (p. 23). Finally, more can be achieved if discussion maintains "conflicts and differences as a positive energy toward creativity" (p. 24).

Taken outside of an organizational context, Deetz's model of stakeholder communication, and the insights it provides, are applied to this study. Deetz's definition of stakeholder extends beyond workers to the external community and society (Griffin, 2006). Institutions are socially created and material, and in a broad sense, are "elastic enough to cover buildings and technologies, particular social arrangements, as well as language and various discursive practices" (Deetz, 1992, p. 126). Certainly then, underserved patients, like any other patients, are stakeholders of hospitals, hospital programs intended to serve them like the Community Health program, and the larger system of health care. Deetz (1995) also maintains that questions central to his model, such as "Whose objectives should count?" and "How will they be accounted for?"
are equally relevant beyond commercial enterprises to stakeholders of public agencies, and nonprofit organizations (p. 256). It might be argued that nowhere are these questions more important than in the health care sector, and to nonprofit providers who have both an obligation and a mission to serve patients in need. Lives depend upon how these questions are addressed. So too does the success of the Nation's historical Patient Protection and Affordable Care Act, which is a step at least toward responding to health inequities among the 46 million underserved Americans (U.S. Census Bureau, 2012). It is this patient population, the very same that is being assisted by the Community Health program, that the health care industry has labeled as the marginalized "other." In this state of "otherness," they lose "self-definition, and the game is stacked" (Deetz, 1996, p. 192). If organizations that serve this patient population do not give them a voice and role in making decisions about their health care needs, who will? Moreover, arbitrary decisions made without them risk being ineffective.

The Literature

When examining literature with specific relevance to the Community Health program, and the patient population being served, several themes emerge that provide a contextual framework for this study. There is considerable scholarly literature that points to linkages between increases in emergency department use for non-urgent care and medically underserved populations, and the implications thereof (DeLia & Cantor, 2009; Institute of Medicine, 2007; Tang, Stein, Hsia, Maselli, & Gonzales, 2010). Related literature discusses the potential effects that using the emergency department for non-urgent needs can have on quality and cost of care (Koziol-McLain, Price, Weiss, Quinn, & Honigman, 2000; McCue-Horwitz, Busch, Balestracci, Ellingson, & Rawlings, 2005; McWilliams, Tapp, Barker, & Dulin, 2011). Literature also takes a look at the expectations the Patient Protection and Affordable Care Act establishes for
community health centers and hospitals to collaborate on patient assistance initiatives. Along this same line, studies investigate the potential community health centers have to reduce non-urgent emergency department visits (Derlet & Richards, 2008; Falik, Neddleman, Herbert, Wells, Politzer, & Benedict, 2006; Okada & Wan, 1980). While somewhat limited, literature provides an evaluation of evolving partnership programs between hospitals and community health centers that offer assistance similar to the Community Health program (Cunningham, Felland, & Stark, 2012; Kyriacou, Handel, Stein, & Nelson, 2005). Critical to this study is literature that investigates the reasons why underserved patients rely on emergency departments for non-urgent care (Andrulis, 1998; Cunningham, 2006; DeVoe, Baez, Angier, Krois, Edlund, & Carney, 2007; Gindi, Cohen, & Kirzinger, 2012).

**Increasing trends in emergency department utilization.** Since the mid-1990s, emergency department visits have increased at a significant pace. An analysis by Tang, Stein, Hsia, Maselli, and Gonzales (2010) of National Hospital Ambulatory Medical Care Surveys (NHAMCS), showed a rise in annual visits from 94 million to nearly 117 million between 1997 and 2007; double the rate of population growth. By 2009, annual visits had grown to over 136 million (Centers for Disease and Prevention, 2012).

Visits for non-urgent care by underserved individuals who are uninsured or Medicaid-insured account for a large percentage of this increase (DeLia & Cantor, 2009; Institute of Medicine, 2007; Tang, Stein, Hsia, Maselli, & Gonzales, 2010). In a meta-analysis of published studies on emergency department utilization, DeLia and Cantor (2009) found that in contrast to privately insured patients, visits for non-urgent care were almost four times higher among Medicaid patients, and over twice as high among uninsured patients. Tang, Stein, Hsia, Maselli, and Gonzales (2010) determined from their NHAMSC study that 30 to 40 percent of all visits by
uninsured and Medicaid-insured patients were diagnosed as non-urgent in 63 percent of the Nation's emergency departments. Research by Tang et al. (2010) is consistent with what the four affiliate hospitals in this study experience; over 35 percent of all visits by those who are uninsured or Medicaid-insured are identified as non-urgent (Younts, 2012).

**Impact on emergency department capacity and viability.** It is speculated that the use of emergency departments for non-urgent care by the underserved has been influenced by the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) (DeLia & Cantor, 2009; Institute of Medicine, 2007; Tang, Stein, Hsia, Maselli, & Gonzales, 2010). Enacted in 1986, the act requires emergency departments to see all patients, regardless of their condition or ability to pay (DeLia & Cantor, 2009). Whether due to EMTALA, or not, the trend of increasing visits by underserved patients for non-urgent care has moved emergency departments toward what some call a breaking point (DeLia & Cantor, 2009; Institute of Medicine, 2007; Tang, Stein, Hsia, Maselli, & Gonzales, 2010). Capacity has not kept up with demand, and the financial viability of emergency departments is said to be threatened due to the burden of excessive charity care for the uninsured and lower rates of government reimbursement for Medicaid patients (DeLia & Cantor, 2009; Institute of Medicine, 2007). According to DeLia and Cantor (2009), more than 1,000 emergency departments have closed their doors in the last two decades.

**Issues with quality of care.** For those using emergency departments regularly for non-urgent care there are also implications. A consistent assumption is made in literature that quality of care is compromised when emergency departments are used as the only source for all medical care (DeLia & Cantor, 2009; Institute of Medicine, 2007; Koziol-McLain, Price, Weiss, Quinn, & Honigman, 2000; McCue-Horwitz, Busch, Balestracci, Ellingson, & Rawlings, 2005; McWilliams, Tapp, Barker, & Dulin, 2011). The assumption is tied to a number of factors. High
volumes in emergency departments result in a process that "is all about getting patients in and out quickly" (Koziol-McLain, Price, Weiss, Quinn, & Honigman, 2000, p. 555). The episodic treatment patients receive in emergency departments is considered suboptimal because it fails to focus on prevention, offers no means for follow-up care, and lacks the continuity of care a family doctor can provide (McCue-Horwitz, Busch, Balestracci, Ellingson, & Rawlings, 2005; McWilliams, Tapp, Barker, & Dulin, 2011). Non-urgent patients may also face long delays due to overcrowded conditions, and the fact that the acutely ill take priority (DeLia & Cantor, 2009; Institute of Medicine, 2007).

**Cost impact for non-urgent care.** Costs for treating non-urgent care in an emergency department is another concerning factor. Simply put, emergency departments that are equipped with expensive advanced medical technology, and staffed by specialty physicians around the clock, are more expensive (Cunningham, 2006; DeLia & Cantor, 2009; McWilliams, Tapp, Barker, & Dulin, 2011). In a random study that compared the costs to treat uninsured patients in an emergency department to costs for the same treatment in a community health center, McCue-Horwitz, Busch, Balestacci, Ellingson, and Rawlings (2005) reported that emergency department costs were 31 percent higher. A similar study by McWilliams, Tapp, Barker, and Dublin (2011) found that emergency department costs for non-urgent care were 320 to 728 percent higher than health centers. The Institute of Medicine (2007) estimates that the cost for an emergency department to provide non-urgent treatment is as much as five times higher than the cost for treatment at a health center. This estimate is consistent with findings by the four affiliate hospitals in this study that the average emergency department cost for non-urgent care is four times higher than the same treatment in a health center (Younts, 2012). While cost estimates differ across studies, likely because hospital systems have different methods of charging, there is
agreement in research that non-urgent care could be treated more cost effectively in community health centers.

**Increasing role for community health centers.** Considered a vital safety net asset, community health centers (also known as Federally Qualified Health Centers) have served the medically vulnerable for decades, and are known for providing comprehensive primary care (Falik, Neddleman, Herbert, Wells, Politzer, & Benedict, 2006; Okada & Wan, 1980). Of late, these federally funded health centers are receiving increased attention as a priority under the Patient Protection and Affordable Care Act. The federal government is depending on these centers to provide medical homes for the millions of individuals who will receive Medicaid insurance under the act in 2014, and providing significant new funding to build capacity in preparation for this influx (Cunningham, Felland, & Stark, 2012; Derlet & Richards, 2008; Natale-Pereira, Enard, Nevarez, & Jones, 2011; U.S. Department of Health and Human Services, 2011). There are also provisions in the act that set expectations for community health centers to save costs by reducing the use of emergency departments for non-urgent care (U.S. Department of Health and Human Services, 2011). To help ensure this happens, community health centers and hospitals are being strongly encouraged to work together to assist patients by coordinating their care (U.S. Department of Health and Human Services, 2011).

Research suggests partnering with community health centers offers good potential to reduce non-urgent emergency department visits (Falik, Neddleman, Herbert, Wells, Politzer, & Benedict, 2006; Okada & Wan, 1980). In an earlier survey study, Okada and Wan (1980) reported that emergency department visits decreased by 20 percent in 10 urban and two rural communities after the establishment of new health centers. More recent studies continue to reflect positive findings. For example, a retrospective analysis of claims data for one million
Medicaid patients in four states found that patients preferred community health centers over other providers, including emergency departments (Falik, Neddleman, Herbert, Wells, Politzer, & Benedict, 2006). In addition, Falik et al. (2006) reported that patients who used community health centers visited emergency departments for non-urgent care less often.

**Emerging patient assistance programs.** With implementation of the Patient Protection and Affordable Care Act on the horizon, a sense of urgency is building to contain costs by redirecting patients away from emergency departments. The concept of hospitals and community health centers partnering to provide patient assistance is gaining momentum (Crane, Collins, Hall, & Rochester, 2012; Cunningham, Felland, & Stark, 2012; DeLia, Cantor, Brownlee, Nova, & Gaboda, 2012; Ferrante, Cohen, & Crossen, 2010). These types of programs are viewed as being "uniquely positioned to play an integral role in the changing environment of health care delivery by facilitating access to care" (Natale-Pereira, Enard, Nevarez, & Jones, 2011, p. 3551). However, while marketing collateral abounds, there appears to be limited research that specifically examines hospital-community health center patient assistant programs similar to the Community Health program.

One study by Cunningham, Felland, and Stark (2012) analyzed data from the Community Tracking Study, which monitors health system changes in 12 major metropolitan areas across the country. Measuring the growth and success of patient assistance programs in these areas, Cunningham et al. (2012) reported that new patient assistance programs grew from two in 2000, to six in 2010. The researchers noted that the six new programs were partnerships between multiple safety net providers, including hospitals and community health centers, provided referral services, and focused on reducing non-urgent emergency department visits (Cunningham et al., 2012). These programs all have the same characteristics as the Community Health
program. To what extent they were achieving their goals, however, remains unknown. According to Cunningham et al., (2012) while several claimed to have significantly reduced emergency department visits and costs, formal evaluations had not been conducted; nor was data made public.

In a second study relative to the Community Health program, Kyriacou, Handel, Stein, and Nelson (2005) assessed the level of compliance by patients who received follow-up appointments at community health centers before leaving the emergency department. Kyriacou et al. (2005) reported that 59 percent of the patients showed up for their health center appointments. What the study did not do was look to see whether or not these patients continued to return to the emergency department. A different perspective comes from Crane, Collins, Hall, and Rochester (2012) who evaluated a hospital-based assistance program that offered both group medical visits in community health centers, and case management support to connect patients with social services. Crane et al. (2012) found that emergency department visits by patients who received assistance were reduced by half over a 12-month period. Aside from the positive results reported, what makes this study stand out from the others is the fact that the patient assistance program incorporates support to link patients to social services.

**Reasons for using emergency departments for non-urgent care.** There is a profusion of research that examines the reasons why patients use emergency departments for non-urgent care, but conclusions reported can be easily synthesized into three main findings: 1) no health insurance; 2) poor access to other care; and, 3) unaffordable cost (Andrulis, 1998; Cunningham, 2006; DeVoe, Baez, Angier, Krois, Edlund, & Carney, 2007; Gindi, Cohen, & Kirzinger, 2012). When studying data from the 2011 National Health Interview Survey, Gindi, Cohen, and Kirzinger (2012) found that over 61 percent of uninsured adult respondents used emergency
departments because they had no where else to go. In another analysis of data from household surveys, Cunningham, Felland, and Stark (2012) reported that respondents' main reasons for visiting emergency departments centered on lack of insurance, and the inability to access affordable care. The same findings have been cited in other similar research (Andrulis, 1998; DeVoe, Baez, Angier, Krois, Edlund, & Carney, 2007). In particular, two studies reported that in addition to lack of insurance, lack of access to care, and unaffordable cost, some patients said it was more convenient to visit the emergency department, or thought their medical conditions were serious (DeLia, Cantor, Brownlee, Nova, & Gaboda, 2012; Rocovich & Patel, 2012).

From a holistic point of view, there are many who argue through discourse in literature that the way in which, and the reasons why, individuals seek care is intrinsically related to social factors and community needs (Adler & Newman, 2002; Hillemeier, Lynch, Harper, & Casper, 2003; Koh, Piotrowski, Kumanyika, & Fielding, 2011; Natale-Pereira, Enard, Nevarez, & Jones, 2011; World Health Organization, 2008; Wuest & Merritt-Gray, 2002). Relevant to this study, however, empirical research in support of this argument appears to be missing in literature. Hillemeier, Lynch, Harper, and Casper (2003) suggest using a model that considers contextual dimensions of communities, such as education, housing, environment, and transportation, to examine health patterns in communities, but offer no application of the model.

**Study Rationale**

Research concurs that increasing numbers of visits by underserved patient populations for non-urgent care are placing a strain on the capacity and financial viability of America's emergency departments. Literature also suggests that quality of care may suffer for patients who use emergency departments consistently for non-urgent care. Studies demonstrate that community health centers provide an appropriate and more cost efficient alternative to care, and
have the ability to reduce non-urgent emergency department visits. The need is evident in literature for hospitals and community health centers to work together to assist patients through programs like the Community Health program. However, while similar programs exist, research reflecting either problems or successes these programs are having is limited; thus it does not provide sufficient insight for this study.

Research into the reasons why patients use emergency departments is not much more helpful. Studies take a cursory approach that does not go beyond the generic and obvious reasons of no insurance, no access, and no way to pay. By finding medical homes for patients in community health centers that offer free care, the Community Health program is essentially eliminating these reasons why individuals seek care in emergency departments for non-urgent care. Yet, patients continue to return to the emergency department for non-urgent care. Therefore, research offers no new perspectives on the problem the Community Health program is experiencing.

What is missing altogether in literature surrounding the topic of this study is the presence of communication research, particularly focused on dialogic theory, which places a high value on the social aspects of human experience, meaning, and engagement. The construct of genuine conversation prescribed by Gadamer (2008), and voice so strongly advocated by Deetz (2005), that could provide new ways of thinking, and lead to more effective practices in health care are not to be found.

**Purpose of Study and Research Question**

This study began under the assumption that literature would likely offer abundant guidance and potential solutions for addressing the problem being experienced with the Community Health program. Instead, another problem arises in literature itself that is
characterized by Adler and Newman (2002) as a visible absence of empirical study that might lead to positive action needed to address social conditions affecting the health of underserved populations. Natale-Pereira, Enard, Nevarez and Jones (2011) express the same sentiment:

Despite all that is known about the nation's health, how health is perceived, how it is intricately related to socioeconomic status, and how it is deeply affected by cultural influences and personal choices, the gap between knowledge and effective action to address this national crisis remains widely open and a challenge for the 21st Century. (p. 3543)

Research must begin to build upon existing knowledge in the health care field to better address the monumental challenges concerning the health of the Nation and its communities. Communication research could go a long way in filling this gap. This study hopes to make a contribution.

Specifically, this study investigates why underserved patients who have been assisted by the Community Health program in finding other affordable care options continue to visit emergency departments of the four affiliate hospitals for non-urgent care. Dialogic theory is used to give voice to patients who are silent in existing literature on this topic, and silenced by the historical practices of a daunting health care system. The objective is to use the voice of these stakeholders to discover why health care alternatives offered by the Community Health program are not enough to prevent them from returning to the emergency department for non-urgent care, and together, determine how the program might be improved to better meet their needs.

Research aims to answer the following:

RQ1: What are the social factors that lead patients currently being assisted by the Community Health program to return to the emergency department for non-urgent care?
Chapter 3. Scope and Methodology

Scope of Study

The scope of this study was dictated by two key factors: 1) the research question, which seeks to determine what social factors lead patients to return to the emergency departments of four affiliate hospitals for non-urgent care after they are given other care options by the Community Health program; and 2) the research purpose to find answers to this question, and opportunities to improve the program through the voice of patients. Therefore, the scope of this study was narrowly focused on ten patients who have continued to return to the hospitals' emergency departments despite assistance by the Community Health program. A narrow approach provided the advantage of coming as close as possible to the "concrete daily life" of the target population (Neuman, 2006, p. 57).

Assessing the social setting. This study was conducted in a geographically disperse county in northern California, home to four hospitals that are affiliated with one of the largest health systems in the U.S. An assessment of the health care landscape of the County - the social setting - is important to the overall scope of this study. Of the County’s 1.4 million residents, one in four are uninsured or insured through Medi-Cal, which is California's version of the federal Medicaid program (Sierra Health Foundation, 2012). The safety net system designed to care for these residents is characterized as weak and fragmented, with little communication among clinics and providers who have historically operated in silos (Sierra Health Foundation, 2012). The County lacks a method of coordinating care for its most vulnerable residents, and providers offer minimal patient outreach (Sierra Health Foundation, 2012). The recent recession created the perfect storm for these conditions. Between 2008 and 2010, 65,000 additional residents, due to job losses and economic strife, joined the ranks of the underserved (Calvan, 2010). Emergency
department visits during this same three year period more than tripled at each of the four hospitals; an alarming trend that served as the impetus for developing the Community Health program (Younts, 2011).

**Inclusion criteria.** The selection of patients for interviews was dependent upon primary inclusion criteria to ensure data collected remained within the context of the study purpose. Inclusion criteria included: 1) participant was uninsured or Medi-Cal-insured; 2) participant was a resident of the County; 3) participant was 18 years of age or older (adult consent is required for assistance by the Community Health program); 4) participant visited the emergency department four or more times within the last 12 months for non-urgent care, and; 5) participant had been assisted by the Community Health program in obtaining an appointment with a physician, or at a community health center. To understand how socio-demographic differences might affect the experiences of participants, secondary criteria were also obtained, including gender, age, ethnicity/race, employment status, marriage status (married, single, married with children, single with children), and geographic location within the County.

**Methodology**

**Research design.** This study used the qualitative method of inquiry. Qualitative inquiry was a natural choice based on this study's philosophical assumptions, and the respective theoretical frameworks that Gadamer and Deetz provide for this study’s attempt through dialogue to create meaning about patient experiences, and give patients a voice in decision-making processes. Qualitative research is foundational to the phenomenological tradition and the theoretical perspectives of these two philosophers. Qualitative methods are concerned with social life, social systems and social practices, and endeavor to understand the lived experiences of people, and the social meanings attached to their experiences (Alvesson & Deetz, 2000;
Anderson, Baxter, & Cissna, 2004; Eriksson & Kovalainen, 2008; Merriam, 2009; Moustakas, 1994; Neuman, 2006). Qualitative inquiry then, precisely supports what this study purports to accomplish. In fact, for any dialogic communication in which "meanings are fluid and emergent," qualitative studies are essential (Anderson, Baxter, & Cissna, 2004, p. 10).

Deetz (1982) considers the qualitative method of inquiry, as opposed to the positivistic model of study, synonymous with the "holistic, meaning-centered" interpretive paradigm, which he credits Gadamer's work in philosophical hermeneutics for advancing (p. 131). As literature demonstrates, this holistic, meaning-centered tradition of study is visibly absent in health care research. The use of the qualitative, or interpretive method of inquiry is necessary in this study for a deeper understanding of problems associated with the human dimension of health care that are left ambiguous in quantitative studies.

**Sampling method.** A purposive sampling method was used in order to select participants who specifically met the criteria needed for this study; in other words, to identify those patients returning to the emergency department for non-urgent care after being assisted by the Community Health program. The selective strategies involved in this nonrandom case sampling method increase clarity when studying human experiences, and provide deeper insight into research questions (Neuman, 2006). Purposive sampling is consistent with research in the phenomenological tradition, and for dialogic study, and produces greater rigor (Ajjawi & Higgs, 2007; Englander, 2012; McManus-Holroyd, 2007).

**Sample size.** Ten participants were recruited from the target population for interviews, anticipating that this number could provide adequate empirical data needed for analysis. While a larger number of participant interviews would provide more diversity in data, an average sample size is typically considered to be ten because of the voluminous amount of data produced from
each interview (Ajjawi & Higgs, 2007; Creswell, 1998; Englander, 2012; Starks & Brown-Trinidad, 2007).

**Participant selection criteria.** Participants were selected from the Community Health program database of 3,000 patients. The database includes pertinent data on all patients who are assisted by the program, including demographic and contact information, and medical diagnosis and treatment histories. An authorization form must be signed by patients in order to include them in the database; an important consideration in health care and required by the Health Insurance, Portability and Accountability Act (HIPAA). Patient authorization allows the Community Health program to outreach to patients, monitor their progress, and share their health data with partner clinics and providers.

**Instrumentation.** Face-to-face interviews provided the dialogical forum for this study as a means to involve, give voice to, and explore experiences and ideas with participants. Interviews were informal and unstructured in an attempt to allow participants to speak freely, and describe their own experiences in their own words. This was in keeping with the objective of the phenomenological interview to be conversational and narrative in nature in order to explore experiences with participants, and enable them to tell their stories (Ajjawi & Higgs, 2007; Eriksson & Kovalainen, 2008; Finlay, 2009; Johannesen, 1971; McManus-Holroyd, 2007; Neuman, 2006). One of the advantages of the interview as an instrument in qualitative research is that it is "highly individualized, contextualized, and relevant to the participant," and can lead to insights that were not expected (Eriksson & Kovalainen, 2008, p. 83).

**Interview questions.** Seven open-ended questions, and subsets of these questions, were developed to facilitate conversation, or to use for elaboration and clarification if needed. However, as McManus-Holroyd (2007) notes, questions often arise during the course of dialogue
that may be "very different from what the researcher envisioned prior to the encounter" (p. 7).

Therefore, questions developed for interviews in this study were used primarily as a starting point for dialogue. These questions were developed independently from research, and included:

1. Can you describe your main health issues, and how you go about finding care?

2. If you are comfortable talking about it, please share what the number one health issue is that you and your family deal with the most? How do you deal with it?

3. What are the biggest challenges or barriers you face when trying to stay healthy or improve your health? When seeking health care? Has it always been this way for you?

4. What is it like when you get sick and need care? What are your choices for getting care? How long do you deal with a health problem before coming to the emergency department?

5. Do you feel you have health care choices available when you make the decision to go to the emergency department? If so, what are your choices? Why do you choose the emergency department over other choices?

6. You have participated in the Community Health program. How has it worked or not worked for you? What would it take to make it work better?

7. What would you like to talk about that we might have missed?

**Interview procedure.** Phone calls were initially made to extend the invitation to patients to participate in interviews. Participants were given their choice of location for the interviews. Four were held at local neighborhood coffee shops; the reminder were held in a conference room at a regional office of the four hospitals, which is centrally located in the County. Interviews lasted approximately 70 minutes in length on average. Interviews were audio-taped and a journal
was kept of notes and reflections. Following the interviews, participants were given a $25 gift voucher to a local farmers market (budgeted through the Community Health program) to thank them for participating.

**Data Analysis**

To organize and analyze empirical data from participant interviews, this study employed thematic analysis. This method of analysis is dependent upon text; thus the first step in the process was to transcribe each of the interviews conducted. Thematic analysis involves close, ongoing examination of detailed texts to uncover embedded common themes and subthemes that can lead to new meaning about the lived experiences of participants and the reality of the phenomenon studied (Braun & Clarke, 2006; Eriksson & Kovalainen, 2008; Neuman, 2006; Rubin, J. & Rubin, S., 2012). Common themes, or what Deetz (1982) refers to as inner relationships, are what provide clarity about an issue, increase awareness, and result in new insight. Insight is crucial in that it allows for the reshaping of knowledge and can lead to new choices, or opportunities that may not have been previously discernible. According to Deetz (1982), "The importance of insight is clear in the phenomenological demonstration that a more essential level of knowing underlies all everyday knowledge and scientific research" (p. 138).

Interpretation is core to thematic analysis and involves a dynamic and ongoing examination of parts of the text, in relation to the whole of the text. Gadamer perceives the act of interpretation as being circular in nature, or occurring within the hermeneutic circle. In the hermeneutic circle, “understanding moves beyond the usual stance of subjective or objective interpretations; instead, what is offered is the interplay of movement between tradition and interpretation” (McManus-Holroyd, 2007, p. 4). Similarly, Deetz (1982) maintains that interpretation and understanding are not cumulative, but “transactive” (p. 145). All knowledge is
accumulated through a process that is dialectic, and basic to this process “is the tension between whole and part; the part has meaning only in terms of the whole, and the meaning of the whole is understood only from the meaning of the parts” (p. 145). What is also core to interpretation during analysis is having a great degree of familiarity with the text, and setting aside preconceptions while still acknowledging them so they can be questioned by the text (Deetz, 1982).

**Process of coding.** A process of coding, or labeling, that is common for thematic analysis was applied to this study, and involved the following phases:

- initial, or open coding as themes are recognized to organize and condense data into meaningful groupings;
- second level, or axial coding, which focuses more on the analysis of coded themes than on data to begin uncovering relationships that might exist between them; and
- a final stage of selective coding once themes appear to form coherent patterns, which requires 1) revisiting the entire data set for the purpose of coding any additional data within themes that might have been overlooked; and 2) selecting data to illustrate major themes (Braun & Clarke, 2006; Neuman, 2006).

Coding was conducted manually through note writing and highlighting. Data extracts were also coded to correlate with codes. Codes and correlating data extracts were kept together in individual files.

**Validity**

Unlike positivistic research, qualitative research is not intended to produce “one definite truth about something that is 'out there,'” but to offer one version of it” from the perspective of participants being studied (Eriksson & Kovalainen, 2008, p. 223). Therefore, the same evaluation
criteria for validity used in quantitative research are not applicable to qualitative research. However, key principles should be followed for evaluating the validity of qualitative research. One core principle is to be trustworthy; to avoid results that are "subjective, spurious and ideologically based" (Deetz, 1982, p. 146). Interpretations should be both reasonable and coherent (Deetz, 1982; Eriksson & Kovalainen, 2008). Research results should be applicable to the participants studied (Deetz, 1982; Eriksson & Kovalainen, 2008; Neuman, 2006). Deetz (1982) also argues for studies to have “rhetorical force” (p. 148). By this he means that not only should research be defendable, but it should also lead to consensus that there is a need for further dialogue and study. From a critical perspective, validity for Deetz (1982) is closely associated with ethical responsibility. Research should provide the opportunity for “exposing conditions of closure” and “the means for responsible choice” (p. 148). Thus, research serves as a platform for positive change.

**Ethical Considerations**

Health and health care are highly sensitive and personal issues. As such, the priority for this research was to ensure the anonymity, privacy and confidentiality of participants. Conjointly, ethical principles were followed that apply to all research, including "informed consent, the avoidance of deception, harm or risk, and Kant's universal principle of respect, treating others always as ends and never as means" (Eriksson & Kovalainen, 2008, p. 62). When interview invitations were initially extended, and again at the beginning of each interview, introductions were made, and context was provided to explain the purpose of the interview and intended use of the data. Participants were asked to read and sign a consent form before the start of the interview, and any questions they had were addressed. Ground rules were also provided so that participants understood that the interviews were voluntary, that their names and information
would be kept confidential, and that interviews would be recorded. Participants were informed that they were free to leave at any time (Eriksson & Kovalainen, 2008). This study was also undertaken with approval from the four affiliate hospitals.
Chapter 4. The Study

Introduction

According to van Manen (1990), phenomenological research "encourages a certain attentive awareness to the details and seemingly trivial dimensions of our everyday lives. It makes us thoughtfully aware of the consequential in the inconsequential; the significant in the taken-for-granted" (p. 8). Certainly, the lived experiences participants in this study are far from trivial or inconsequential. Their voices speak loudly to the trials they face daily when dealing with both routine and complex health issues.

Of the ten participants interviewed, five were female and five were male. Ages of participants ranged from 24 to 61 years. Five participants were uninsured; five were insured through Medi-Cal. All participants had returned to the emergency department for non-urgent care five to 13 times in the past 12-months, after being assisted in finding other health care options by the Community Health program. Ethnicity of participants was mixed, and included Caucasian, African American, Hispanic, and Asian. Marital and employment status, and geographic location of residence within the County varied among participants. Participant socio-demographic characteristics are shown in Table 1.

Two characteristics that had a significant bearing on the experiences of participants were insurance status (whether participant was insured through Medi-Cal, or uninsured), and geographic location of residence within the County. Other characteristics did not appear to have an impact on participant experiences relevant to this study. One exception must be noted. Specific income levels were not demarcated in this study since all patients who are assisted by the Community Health program are underserved, with incomes at, or below, 200 percent of the Federal Poverty Level. While the effects of being underserved, or poor, were never directly
expressed by participants, the presence of this shared characteristic - an underlying sense that social or class status weighed heavily on the experiences of all participants - could be felt in every interview.

Table 1

Socio-demographic Characteristics of Participants

<table>
<thead>
<tr>
<th>Participant Code</th>
<th>Gender</th>
<th>Age</th>
<th>Insurance Status</th>
<th>Non-Urgent Emergency Department Visits Past 12 Months</th>
<th>Race/ Ethnicity</th>
<th>Married/ Children</th>
<th>Employment Status</th>
<th>Geographic Location of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Male</td>
<td>46</td>
<td>Medi-Cal-insured</td>
<td>11</td>
<td>African American</td>
<td>Married; 2 children</td>
<td>Unemployed (Disabled)</td>
<td>South</td>
</tr>
<tr>
<td>P2</td>
<td>Female</td>
<td>24</td>
<td>Uninsured</td>
<td>7</td>
<td>Asian</td>
<td>Single; no children</td>
<td>Employed</td>
<td>East</td>
</tr>
<tr>
<td>P3</td>
<td>Female</td>
<td>45</td>
<td>Medi-Cal-insured</td>
<td>13</td>
<td>Caucasian</td>
<td>Single; 2 children</td>
<td>Unemployed</td>
<td>North</td>
</tr>
<tr>
<td>P4</td>
<td>Female</td>
<td>61</td>
<td>Uninsured</td>
<td>6</td>
<td>Caucasian</td>
<td>Single, no children</td>
<td>Unemployed</td>
<td>North</td>
</tr>
<tr>
<td>P5</td>
<td>Male</td>
<td>48</td>
<td>Uninsured</td>
<td>8</td>
<td>Hispanic</td>
<td>Married; 3 children</td>
<td>Employed Part-time</td>
<td>South</td>
</tr>
<tr>
<td>P6</td>
<td>Female</td>
<td>55</td>
<td>Medi-Cal-insured</td>
<td>5</td>
<td>African American</td>
<td>Married; 2 children</td>
<td>Employed Part-time</td>
<td>Central Downtown</td>
</tr>
<tr>
<td>P7</td>
<td>Male</td>
<td>38</td>
<td>Uninsured</td>
<td>10</td>
<td>Caucasian</td>
<td>Married; 2 children</td>
<td>Unemployed</td>
<td>West</td>
</tr>
<tr>
<td>P8</td>
<td>Female</td>
<td>31</td>
<td>Medi-Cal-insured</td>
<td>5</td>
<td>Caucasian</td>
<td>Married; 2 children</td>
<td>Unemployed</td>
<td>Central Downtown</td>
</tr>
<tr>
<td>P9</td>
<td>Male</td>
<td>27</td>
<td>Uninsured</td>
<td>6</td>
<td>Caucasian</td>
<td>Single; no children</td>
<td>Employed</td>
<td>South</td>
</tr>
<tr>
<td>P10</td>
<td>Male</td>
<td>38</td>
<td>Medi-Cal-insured</td>
<td>4</td>
<td>Asian</td>
<td>Married; 2 children</td>
<td>Unemployed</td>
<td>East</td>
</tr>
</tbody>
</table>

Results of the Study

Four major themes were developed from the analysis of data that provide insight into the social factors that lead the target population to return to the emergency department for non-urgent care despite assistance by the Community Health program. Not all themes were applicable
to all participants. Two themes differed by insurance status, while remaining themes emerged from all data regardless of insurance status.

**Theme 1. Red tape hell.**

For the five Medi-Cal-insured participants, it became clear through analysis that the County’s Medi-Cal system does not guarantee regular health care. In reality, the bureaucracy and inefficiencies in the County’s Medi-Cal system are driving the population that it is designed to serve back to the emergency department in order to receive adequate and timely treatment. Seven reoccurring codes were initially formed into subthemes and consolidated to develop this major theme. The subthemes leading to this theme were prevalent in the data sets of all Medi-Cal-insured participants, and included: 1) arbitrary changes made by Medi-Cal to participant plans; 2) no understanding by participants as to why plans were changed; 3) no communication by Med-Cal that provided explanations; 4) difficulties involved in finding a doctor who would accept a Medi-Cal plan; 5) long waits to get a doctor's appointment; 6) trouble retaining the same doctor, and; 7) overall confusion and frustration with the Medi-Cal system. For example, Participant 3 described how the Medi-Cal system itself represents the greatest health challenge for her and her family:

They [Medi-Cal] make it so hard. It took me six months to even get Medi-Cal coverage for my family. I still don't know who my doctor is. I got all this paperwork, but every time I try to call, the line is busy, or I get a recording, or I get transferred to someone who can't help me. When I ask questions they say, no you can't do this and no you can't do that. I don't know what me or my family is covered for. It is red-tape hell that has you going around in circles (Participant 3).
Participant 1 described the Medi-Cal system as being "crazy stressful." Participant 1 is the wife of a patient assisted by the Community Health program. She arrived for the interview asking to speak on behalf of her husband who suffers from liver disease, and at the time of the interview, was going through a "bad spell." She had come, she said, because she "had a lot to say":

I appreciate what you're trying to do with this program [Community Health program], I really do. It worked just fine when you got us an appointment that first time. But then we got switched by Medi-Cal to another plan, and this plan, they told us we had to go to a different doctor. Only when I called the new doctor's office, they didn't know anything about it and weren't taking new patients, so I couldn't get my husband in. I called back to Medi-Cal and they gave me another doctor. I got an appointment, but when we got there, I kid you not, the doctor wouldn't see my husband. The office told us he wasn't taking this plan anymore. I had to call Medi-Cal back, and this time they sent me a list of doctors and told me we could go to one of them. I've called over 20 on the list and I'm waiting to hear back. It's been four weeks now ... So, my husband, he just keeps getting sick, and I have to watch him get sick over and over again. That's the worst, the hardest thing. And there's nothing I can do. The Medi-Cal people tell you they'll find you a doctor, and then you never hear back from them. I'm starting to think they just make it all up. I can't tell you how stressful it is. We really, really, really just need primary care. All we need is a doctor so my husband can be stable on his medicines, and be monitored so he doesn't get sick all the time ... (Participant 1).
Participant 8 also experienced changes in her Medi-Cal plan after she was assisted by the Community Health program, which in her case, resulted in losing a doctor she had come to trust:

For some reason, and they didn't tell me why, Medi-Cal came in and changed the plan on me, so my family couldn't keep going to the same doctor. I don't know why they did that. I called to find out, and after being transferred about ten times, I finally reached this woman who was really rude. She said making changes to plans happens and it's just the way it works. She acted all put out that I was even calling, like I was wasting her time. I don't know if it's because it's Medi-Cal or not, but that's how they treat you. When I called the doctor they gave me under this new plan to make an appointment, his office tells me I can't get in for six weeks. My kid has a high fever and has to wait six weeks - that's a joke, right? It's like I keep going backwards with health problems, and ending up in the emergency department. My other doctor knew us, knew our problems you know ...

( Participant 8).

About the County's Medi-Cal system. In need of context and clarity for these participant experiences, this study turned to existing literature about the Medi-Cal program. Managed by the California State Department of Health Care Services (DHCS), Medi-Cal was first adopted by California in 1966. Today it is the largest source of health insurance in the state. By law, Medi-Cal must cover low-income families with children, seniors and individuals with disabilities, and pregnant women whose income is at or below 200 percent of the Federal Poverty Level (California HealthCare Foundation, 2010). In 2013, California began expanding Medi-Cal to childless adults with incomes at, or below, 138 percent of the Federal Poverty Level through a Low Income Health Plan (Lucia, Jacobs, Watson, Dietz, & Roby, 2013).
In the early years, Medi-Cal in California operated under a fee-for-service system. Physicians who accepted Medi-Cal beneficiaries billed the state directly for patient care and were paid a state-approved rate (Klein & Donaldson, 2004). In the mid-1990s, California began the process of converting its fee-for-service Medi-Cal program to a Medi-Cal managed care system. It was determined that the managed care system would be a more comprehensive and effective approach resulting in timelier access to physicians, better care for beneficiaries, and reduced use of the emergency department for non-urgent care (Klein & Donaldson, 2004). The specific managed care system selected by the County in which this study was conducted is called Geographic Managed Care (GMC). Under the GMC system, the DHCS contracts with private health care insurance plans to provide Medi-Cal coverage to low-income residents. The insurance plans receive a contracted payment amount per month for each insured member at a capitated rate, or set fee per patient, regardless of the type of treatment provided; be it primary, or specialty care. In turn, GMC plans contract with physicians who are willing to provide care at a reduced rate to Medi-Cal patients (Klein & Donaldson, 2004). On average, there are 2000 beneficiaries contracted to one physician (Bindman & Schneider, 2011).

There are several large for-profit GMC insurance plans that operate in the County of this study. Eligible beneficiaries can either select one of these plans, or are automatically assigned to one of these plans by the DHCS. GMC plans may refuse to accept assignments made by DHCS (California Department of Health Care Services, 2011b). Decisions by the DHCS about automatically assigning beneficiaries to competing plans are based on each plan's performance. Performance is measured by the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool developed by the National Committee for Quality Assurance, and measures quality performance for multiple aspects of care and service. HEDIS measures are captured
through random sampling of administrative and clinical data (California HealthCare Foundation, 2006). What is not included in the methods used by the DHCS to evaluate GMC plan performance is communication with beneficiaries. The performance process "fails to make use of any consumer-focused performance measures. This results not from an explicit decision to exclude them, but rather from the failure to identify any valid measures" (California HealthCare Foundation, 2006, p. 19).

There is, however, one statewide consumer-focused survey measure available, called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey is administered by the Health Services Advisory Group, an external quality review organization, under contract with the Medi-Cal Managed Care Division of the DHCS (California Department of Health Care Services, 2011b). The survey assesses beneficiaries' satisfaction with care received by managed plans, but is not used by the DHCS to assess the performance of these plans. The DHCS "considered and rejected the CAHPS due to the fact that data are collected only biannually, and health plans felt the results were not meaningful ..." (California HealthCare Foundation, 2006, p. 19). Although not recognized by the DHCS, nor meaningful to the insurance companies that offer the managed care plans, the most recent 2010 CAHPS survey results reveal that on a scale of one (poor) to five (excellent), the near 39,000 consumer respondents gave most all managed care plans - including the County's GMC plans - a ranking of one. This poor ranking was consistent across numerous categories, including getting needed care, getting timely care, communication with members, customer service, and shared decision-making (California Department of Health Care Services, 2011b).

Because of the CAHPS results, oversight of the managed care plans by DHCS has come into question in recent years. An investigation by the California Bureau of State Audits (2011)
found that the DHCS has an ineffective process to monitor managed care plans. Further, the California Bureau of State Audits (2011) cited the DHCS for failing to conduct medical audits of the managed care plans, being chronically late in completing financial reviews, not analyzing financial reports on all plans, and failing to follow-up with corrective action plans. The Public Policy Institute of California has also expressed concerns about California's overall Medi-Cal managed care system: "Problems with provider participation, implementation, lack of patient and provider education, and certain aspects of the Medi-Cal program itself make seamless integration of Medi-Cal enrollees into private plans and provider networks difficult" (Adams, Bronstein, & Becker, 2000, p. v).

Certainly, the experiences of Participants 1, 3 and 8 in this study provide real life examples that reflect these concerns; as do the experiences shared by the other Medi-Cal-insured participants interviewed:

Your program [Community Health program] was nice to refer me back to my doctor, but honestly, it didn't do much good because they [Medi-Cal] put me in this new plan, and so now I have to go to a different doctor. I guess I didn't fill out some paperwork or something I was supposed to do, or whatever. Anyway, I can't get in to see him for three months, which would be okay except I get really bad migraines a lot and my prescriptions have run out ... (Participant 6).

It is the "waiting" that frustrates Participant 10 more than anything else; to the point where he is "fed-up and ready to give-up":

I was riding my bike and got sideswiped and hurt my knee pretty bad. It was a while ago, but I'm still in a lot of pain, and I need physical therapy. My Med-Cal plan told me it was covered and they would get it for me. That was six months
ago, and I'm still waiting. At this rate, I'll be waiting forever. At least when I go to the emergency department, I only have to wait a couple of hours. This Medi-Cal coverage, I just don't see how it's supposed to work ... (Participant 10).

**Theme 2. Health centers not capable.**

Uninsured participants find it necessary to return to the emergency department to manage chronic illnesses that have gone neglected too long, and are beyond the scope of care community health centers in the County are capable of providing. This main theme emerged from coded subthemes that were identified in the data of all five uninsured participants: 1) delayed periods of time endured before getting treatment; 2) complications to health that developed/worsened during that period, and; 3) inability by community health centers to provide needed care. Excerpts of conversations with Participant 4 perhaps best capture the essence of this theme:

My health's been going downhill for a few years now. I've had to make do you know, take care of my health problems the best I can without any health care ... I have a lot of health problems; are you ready for this? I have high blood pressure and bad cholesterol. I have thyroid problems. I have trouble with heartburn. I have an old back and leg injury that happened when I fell off a loading dock. And, I have diabetes. That's enough, isn't it? What's really bad with the diabetes is that if you don't take care of it, other things happen. Like it's made my teeth soft, they are breaking off and keep getting infected ... Oh, I've been to the health centers a few times, and they refill my medicine, but other than that they can't deal with my issues. They are trying to find some doctors who can, but with me not having insurance, that's pretty tough. When something starts to flare up, like my diabetes, or my teeth, I'm pretty much out of options ... (Participant 4).
Participant 5 also struggles with chronic conditions that cannot be addressed by community health centers in the County:

I've had heart problems for several years now. I had a heart attack a while back. It wasn't a bad one, but I know I should be doing things, or taking medicine, so I don't have another one. I also have a lot of back pain, but without insurance, it's kind of hard to do anything about it ... You just deal with it. You have to make choices you know, and I have to make sure my family gets taken care of first ...

We do go to the clinic, but they don't have the special doctors there for heart or pain problems ... (Participant 5)

Other uninsured participants spoke of chronic illnesses that either they, or their family members, had been suffering from for some time, like cancer, migraines, back pain, stomach pain, asthma, acid reflux, and respiratory problems. While the community health centers they were referred to by the Community Health program could treat for some of these illnesses by prescribing medicine, they were unable to identify, and address, the root cause of problems without the need for further testing and specialty care that was simply not available. This left the participants at the mercy of either private physicians in the community that the health centers could find who were gracious enough to provide charity care, or emergency departments.

**Understanding the state of community health centers.** As literature examined in Chapter 2 points out, community health centers are recognized for serving as a medical home and providing comprehensive care to the underserved and vulnerable. Comprehensive care is defined as "a person-centered system of health care that facilitates access to and coordination of the full array of primary and specialty health services, including behavioral health care and social support services" (Sierra Health Foundation, 2012, p. 6). Based on the experiences of
participants interviewed, community health centers in the County of this study appear to fall short of meeting the expectations of this definition. Several factors may explain this shortcoming. Although they receive federal funds, community health centers in the County are "financially challenged, with expenses consistently exceeding revenues" (Sierra Health Foundation, 2012, p. 7). The number of community health centers in the County is limited and well below other similar size regions in the state. The network for the centers is not integrated and lacks coordinated leadership (Sierra Health Foundation, 2012). It is a network described by Rubenstein (2013, May 8) as "fragmented, frayed and two to three decades behind the times" (para. 3). These shortcomings may likely be why this major theme did not surface in the data sets of Medi-Cal-insured participants in this study. GMC plans are hesitant to contract with community health centers in the County because they are concerned that the centers "are relatively new and small, with no track record of being able to manage risk" (California HealthCare Foundation, 2012, p. 9). In total, the GMC plans contract with community health centers in the County for only 0.6 percent of all Medi-Cal beneficiaries, which reflects the lowest rate for health center contracting in all of California (California Department of Health Care Services, 2011a).

Questions have been raised as to whether health leaders in the County have knowledge about, or a "real appreciation" for, the dire need that exists to strengthen community health centers (Sierra Health Foundation, 2012, p. 10). According to Boyle (2009), the need is certainly well recognized by community health centers, but stepping up to meet the need is no easy task. Community health centers attempting to expand and integrate specialty medical services and other care into their operations "face significant legal and regulatory barriers" (p. 2). The process involves meeting both state and federal requirements and regulations that are onerous, and if not
followed precisely, put health centers at risk of losing funding. Expensive liability protection must also be provided to physicians providing services at the health centers. The application and approval process for adding services is complicated and lengthy and government payments for specialty services are typically delayed, which for small nonprofit health centers makes it hard to sustain (Boyle, 2009). Any community health center "seeking to expand clinical services to include medical specialties must understand where such services might fit within controlling regulatory schemes" (Boyle, 2009, p. 5).

**Theme 3. Public transit pretty useless.**

The fact that the underserved face significant transportation barriers in the County that lead them to head to the nearest emergency department in their neighborhood was a theme found common to half of the participants interviewed (three uninsured participants and two Medi-Cal participants). On one level, this theme was easily discernable, considering the County encompasses a geographically dispersed population living within a sprawling urban-suburban metropolitan region that is nearly one million square miles in size, and made up of 67 Zip Codes (U.S. Census Bureau, 2013). Even for those who have their own vehicle, getting around the County is not easy. Out of 101 urban areas, the County is ranked at 47 for having the worst traffic congestion; the mean travel time to work for all residents is 30 minutes or longer (Wiese, 2013, February 5). The primary cause for congestion is attributed to an inadequate public transportation system; only one percent of all daily trips in the County are via public transit (Sacramento Transportation and Air Quality Collaborative, 2005). For those without a means to travel who must rely on public transit, it becomes difficult at best to get to somewhere as seemingly easy as the store, school, work, doctor, or clinic appointment. According to the Sacramento Transportation and Air Quality Collaborative (2005), there is a great deal of social
inequity in the County's system of transportation, and transit planning is not based on special
needs of the population. Comments from participants interviewed illustrate these needs:

One of the problems is that the light rail is pretty useless, unless you live
downtown. I get rides with my friends when I can, but I usually take the bus
places. It doesn't stop near any clinic though, so for me to get there means I end
up walking part of the way (Participant 9).

We have no car, and my husband is mobility impaired. That's a big challenge. If
my daughter is around, I ask her for a ride, other than that I either have to ask my
neighbor, or be able to walk with my husband in a wheelchair to get anywhere ...
( Participant 1).

I'm saving to get my truck fixed. It broke down, so I had no way to get to my
clinic appointment. I'm hoping you can make me another appointment, and this
time I'll figure out a way to get there, even if I have to walk. I really want
someone to help me get my health back in order so I can finish my GED and get
things together ... (Participant 7).

On another level, the problem with transportation brings the GMC Medi-Cal system in
the County back into play with the way in which doctors are matched to beneficiaries; it appears
that the importance of proximity is not a main consideration when assigning beneficiaries to
providers. In most parts of the County, matching beneficiaries to physicians is done randomly,
although the likelihood of beneficiaries being assigned to a physician closer to home is greater in
urban areas where there is a larger concentration of available physicians (California Department
of Health Care Services, 2011a). A random assignment process presents a problem for
participants: "This new doctor they [Medi-Cal] assigned to me is over an hour away from where I live, which is gonna be a real problem" (Participant 6).

Community health centers are also more highly concentrated in urban areas of the County, which again, makes it particularly hard for those participants who live in outlying areas with no transportation to get to an appointment. This problem was raised by Participant 2:

I live out east, but the clinics are downtown. To get there and back means I take the bus, then light rail, then another bus, and then walk. It's like an all day trip.

The one clinic I went to, it took me four hours (Participant 2).

**Theme 4. No one cares.**

Underscoring the experiences shared by participants in this study were references tied to the loss of caring in an industry that is supposed to be centered on the wellbeing of people. Several participants expressed a sense of security in emergency departments as a place, when other places failed, where time and attention would be devoted to their care, and where their health issues would be taken seriously.

They [doctor's office] said for me not to come in so much. All I ever have is about five minutes with my doctor anyway, so I don't see why it really matters. It's not like he's all that interested anyway ... The one thing about the emergency department is that you know they're going to spend time with you, and check you out completely (Participant 6).

What's so frustrating is that you can't get anyone to answer your medical questions. Things are sure different today than they used to be. People used to care, but now they just have blinders on. They don't want to know you're sick ...

In the emergency department you get to talk about your health problems, and they
ask all kinds of questions, like they actually want to get to the bottom of things ...

(Participant 4).
When I end up in the emergency department, everyone is real nice and helpful.
That sure is a lot different than a lot of other places. No one has treated me very nice about my health in a long time. It's kind of sad ... (Participant 5).
Sad indeed. Comments by participants bring to mind disturbing words by Rothman (1993) related to health care:

Americans do not think of themselves as callous and cruel, yet in their readiness to forgo and withhold this most elemental social service, they have been so. This question arises: How did the middle class, its elected representatives, and its doctors accommodate themselves to such neglect? (273)
Comments by participants, perhaps, come far too close to truth in these words.

**Participant thoughts on improving the Community Health program.** In conversations with participants about how to make the Community Health program work better, only a handful of suggestions were made. Participants seemed surprised they were being asked for their perspective; an observation that might be expected given their apparent lack of voice within the County’s existing system of care. In addition to wondering if there were ways the Community Health program might help in addressing the issues of red tape, transportation, and timeliness in getting appointments, three participants inquired about the possibility of getting health education. For instance:

I need to start making sure I’m doing the right things, taking care of myself better … Do you have programs that teach you things like that? … I’m still young, and I already have health problems. Just imagine when I get older (Participant 2).
Mainly, participants hoped for assistance in navigating the complex system:

I can’t be the only one having trouble understanding how this whole Medi-Cal thing works. Could your program help explain it to people? (Participant 6).

Discussion

Research conducted sought to determine what social factors lead patients currently being assisted by the Community Health program to return to the emergency department for non-urgent care. To this end, dialogue with participants brings to light several findings that are both enlightening and sobering. Of all themes developed, Theme 3, which highlights lack of transportation as a factor causing participants to return to the emergency department seeking non-urgent care, is the most straightforward, and perhaps the easiest to be accommodated when considering improvements to the Community Health program. Findings that become more complex in Theme 2 are not so easily accommodated.

Participant experiences captured within Theme 2 point to the inability of community health centers in the County to provide comprehensive care as a factor that results in their return to the emergency department to manage chronic conditions. This finding offers a different perspective than literature in Chapter 2 that implies quality and continuity of care suffer when patients depend solely on emergency departments to meet their regular health care needs. While continuity of care, perhaps, may not be attainable when patients receive only episodic care in an emergency department, it becomes hard to judge the quality of care when, as in the case of this study, there is no other care available to make comparisons. Findings in Theme 2 also conflict with literature in Chapter 2 relative to the assumptions made by the federal government that community health centers are the solution to filling the gaps in care for the underserved, and reducing non-urgent visits to the emergency department. Certainly, in the County of this study,
community health centers are ill-prepared to provide this solution today, not to mention in 2014, when the Patient Protection and Affordable Care Act takes effect. Whether community health centers in the County will eventually be capable of meeting this expectation is a question that remains unanswered, particularly considering that the system that set this expectation may be working against them by creating what Boyle (2009) has described as "controlling regulatory schemes" (p. 2).

Theme 1 carries with it convoluted implications that demand more in-depth scrutiny. The experiences expressed by Medi-Cal-insured participants in this study reveal major flaws existing in the County’s GMC Medi-Cal system that negatively impact their health, including unexpected and unexplained changes to their insurance plans, difficulty in finding, seeing, and retaining doctors, and a complete absence of communication. Theme 1 findings are inconsistent with literature examined in Chapter 2, which cites having no insurance as being a primary reason underserved populations visit emergency departments for non-urgent care. The reality for participants in this study is that difficulties experienced with their insurance coverage through the County's system of Medi-Cal are actually impeding access to care, and resulting in return visits to the emergency department. In their attempts to make the system work for them, it is as though participants are fighting an uphill battle.

Literature in Chapter 2 also names poor access to care as the reason that underserved individuals utilize the emergency department for non-urgent care, which on the surface aligns with the findings of Theme 1. What literature fails to do, however, is examine what underlies the problem of poor access. For the Medi-Cal-insured participants in this study, it is the insurance system itself that contributes to poor access. What is more, research findings of Theme 1 are asymmetrical to broad assumptions made that the Medi-Cal managed care system provides
timely and appropriate access to care for underserved populations, and reduces use of the
emergency department for non-urgent care. A case in point:

Managed care is a planned, comprehensive approach to the provision of health
care combining clinical services and administrative procedures within an
integrated, coordinated system to provide timely access to primary care and other
necessary services in an effective manner … Managed care’s emphasis on access
to primary care is intended to increase utilization of clinical preventative services
and thus reduce both preventable hospitalizations and the unnecessary use of
emergency rooms. It turn, this enables the plan to reallocate its resources to
promote preventative and primary care for its members. (Klein, & Donaldson,
2003, p. 2)

Literature can be found that, like this study, disagrees with the assumption made above,
and argues that breakdowns in California's Medi-Cal managed care system are negatively
impacting the health of those it is intended to serve. For example, Rodwin (1996) argues that the
way in which managed care plans are reimbursed "creates incentives to skimp on services.
Because plans receive a fixed payment per member, any expenditure for providing services
reduces net profits" (p. 111). Bindman and Schneider (2011) posit that the low rate at which
physicians are reimbursed raises concerns about being able to attract enough physicians who are
willing to participate in the managed care system. The physician reimbursement rate in
California is among the lowest in the U.S., and only 25 percent of all primary care physicians
provide care for over 80 percent of all beneficiaries (Bindman & Schneider, 2011). For the Medi-
Cal-insured population, too few physicians equates to limited appointment availability
(California HealthCare Foundation, 2009). Beneficiaries have "little chance of realizing the ideal
physician-patient relationship, since they lack the choice of practice setting and physician, and receive care in a rushed atmosphere" (Ezekiel & Neveloff-Dubler, 1995).

Whether any, or all, of these issues raised are relevant specifically to the GMC Medi-Cal system within the County of this study is unknown. An important question to ask, however, is if anyone is looking into how the County's GMC system operates and taking note. Certainly, research findings from this study indicate that no one has bothered to solicit firsthand knowledge from GMC plan beneficiaries, like those who participated in this study. The problems they are experiencing warrant immediate attention, and there are frightening future implications as well. The County continues to move full-speed ahead with plans to expand the current 227,629 GMC plan beneficiaries today by an additional 167,000 enrollees who are eligible for public insurance in 2014 under the Patient Protection and Affordable Care Act (California Department of Health and Human Services, 2012; Sierra Health Foundation, 2012). If flaws in the system continue to go unrecognized and are not addressed, the County's underserved can expect the status quo to grow more chaotic.

Theme 4, which encompasses participant experiences in the real world that cause them to believe that no one cares, and turn them toward the emergency department where attention is guaranteed, is not so much complex as it is a sad reflection of a flaw in society. It is indicative of the treatment in America of health care as a market commodity, rather than a human right. Woven within this theme is an ethical dilemma that has been raging for decades, and an ongoing failure in this country to move past the political forces at play and focus on traditional values that should form the basis of meaningful dialogue and decisions about health care. Salient to this theme are words that were written over 50 years ago:
The poor are politically invisible. It is one of the cruelest ironies of social life in advanced countries that the dispossessed at the bottom of society are unable to speak for themselves. They are without lobbies of their own; they put forward no legislative program. As a group, they are atomized. They have no face; they have no voice. (Harrington, 1962, p. 6)

Harrington's (1962) words underscore the research findings of this study. What is crystal clear, particularly with Theme 1, is that the target population lacks any representation whatsoever within the County's system of care. More blatantly evident is the total absence of meaningful communication between the system and the target population. Rather, the County's system of care undermines communication. In such a system, which might be described as one where "norms or rules of conduct are entirely static and exempt from further interpretation," there is no room for Gadamer's concept of genuine conversation through dialogue (Dallmayr, 2009, p. 29). To achieve an understanding of how the system truly works for the target population through genuine conversation prescribed by Gadamer "presupposes a dialogical give and take" (Dallmayr, 2009, p. 29). There is no give and take within the County's system of care.

As Deetz (1992) argues in Chapter 2, the ability to achieve a level of genuine conversation, or dialogue, is rare due to ideological structures of power that privilege certain interests, which are hidden in conversations. This argument is supported by research findings in this study that reveal the power privileging certain interests lies in the hands of the County's system of care, and attempts by the target population to engage in genuine dialogue with the system are futile. An absence of genuine dialogue within the County’s system of care has resulted in systematically distorted communication, where one-sided meanings are misconstrued and reproduced rather than produced through an inclusive participatory process (Deetz, 1992).
As such, communication processes are closed and static, lack checks and balances, and provide little opportunity to understand people and situations as they really are. As Deetz (1992) explains:

To the extent that the communication system precludes responsiveness to an exterior, adaptation is limited; to the extent that the ideal speech situation is denied, freely shared normative standards are violated; and to the extent that the self and experience are reproduced, concept formation cannot occur in regard to otherness. (Deetz, 1992, p. 177)

In the County’s system of care, there is no regard to otherness. The system offers the target population no window of opportunity for voice to understand, or question the system, and no role in decision-making processes related to their own health. Nor does the system have effective mechanisms in place to make managed care plans responsible and accountable to the target population they serve. The situation leaves the target population in a very weak position indeed.

Research findings of this study make it evident that the social factors affecting the health care of the target population, and leading them to return to the emergency department despite assistance, have unintended implications that are much larger than the Community Health program. While changes, such as those that have been suggested by participants, can be made to enhance the program, no one improvement, or even a combination of improvements to the program, can fix the broken system in which the participants in this study must struggle to survive.
Chapter 5. Summaries and Conclusions

Limitations of the Study

This study was qualitative in nature, and conducted in one county within California, focusing only on a specific target population being assisted by the Community Health program at four hospitals. As such, this study was limited by a small sample size, demographic constraints, and qualitative research design, which restrict the potential to generalize the understanding and knowledge gained from findings that are unique to the target population of this study to other settings (Neuman, 2006). The goal of this study, however, was not to develop findings that could be generalized. As literature examined in Chapter 2 reflects, existing research that provides generalizations on the topic of this study is already extensive. The intent of this study rather, was to move away from generalizations in order to gain deeper insight, and a more holistic understanding about the meaning of a phenomenon through the lived experiences of others. In this instance, qualitative inquiry into a focused target population provided the ideal type of research design necessary to understand what Deetz (1996) describes as "differences that matter and that are hard to see in the traditional positivistic vein of research that dominates literature" (p. 199).

Time constraints presented another limitation for this study. Participant interviews were conducted, and data analyzed, over a two week period. Expanding the number of patient interviews over an extended period of time could produce a more robust analysis. Participant triangulation, through what Neuman (2006) describes as extreme case sampling, would have also strengthened this study. Interviewing patients who have not returned to the emergency department after being successfully assisted by the Community Health program may have
offered different experiences and perspectives that could have been compared to those of the target population.

**Recommendations**

**Community Health program improvements.** In keeping with Deetz's (2005) stakeholder model of communication, whether in research or in practice, dialogue should strive to go a step further than understanding and lead to positive action and change through mutual decision-making processes. The Community Health program should consider making a number of improvements recommended by participants in the study. The program might extend services to help patients understand, and navigate within, the County’s Medi-Cal system, and going one step further, break down communication barriers and open doors for patients. Like Participant 3 said, “You’re a pretty big hospital. Maybe you can help us get through all the red tape.” Being a major health provider in the region does offer some leverage that patients do not have in gaining access to system administrators, and physicians. The program could incorporate a bus and taxi voucher system to help resolve the transportation barriers that patients face when they need to travel to doctor and clinic appointments. Patients could also be enrolled in the health education and chronic disease management programs the four affiliate hospitals offer. While participants did not make the suggestion, this study has shown that one of the greatest needs for the County’s underserved is an effective forum for voice. The Community Health program could serve in an advocacy role, and in partnership with others in the community, create an active consumer group strong enough to ensure patient voices are heard, and that they receive attention that reflects and supports their interests.

**The need for further study.** A population cannot be served effectively, or even ethically, if their health care needs are not understood. A full understanding is not possible by
only continuing to go down the same path of positivistic research, which literature has shown to be dominant in health care. This study reflects the value of what can be learned by shifting the paradigm. Phenomenological research using dialogic theory has enabled this study to receive a first-hand account of the everyday realities that constitute the lives of patients, and uncover new meaning about the social factors and institutional practices and processes that serve as major barriers to their care. The positivistic tradition of research would have limited the potential to obtain this type of holistic meaning. Gadamer's construct of genuine conversation provided a framework for this study to get beyond positivistic categorizations and classifications and see a phenomenon in a truer light through the eyes of another. This to Gadamer is a learning experience that can lead to a "radical shift in consciousness" (McManus-Holroyd, 2007, p. 8). Further dialogic research to create a radical shift in consciousness is desperately needed in health care. Deetz's stakeholder model of communication added a critical component to Gadamer's framework, and offered a way for this study to scrutinize equality in representation, uncover conditions that block or overshadow the interests of patients, and reframe previous taken-for-granted assumptions about the system of care for the underserved. Failure to conduct further research in this vein would be "a failure to attend carefully to the otherness around us, which limits our perspective, produces incomplete and inadequate decision-relevant information, and does violence to those 'others' whose positions are often already institutionalized and marginalized" (Deetz & Simpson, 2004, p. 157).

**Conclusion**

True to Deetz's (1992) claim that, "whether in science or in everyday life, there is no route to the world or other persons except through the experience of them," the use of dialogic theory in the phenomenological tradition proved to be a valuable approach for communication
research conducted in this study (p. 116). Such an approach enabled this study to give voice to underserved patients that resulted in new insight and understanding about the social factors that lead them to return to the emergency department for non-urgent care after being assisted by the Community Health program in finding other health care options. Through the analysis of rich data obtained from personal experiences shared by ten study participants, four themes were discovered that reflect non-urgent use of the emergency department by underserved patients in a context quite different than findings presented in existing research examined on this topic. Themes revealed that 1) Medi-Cal-insured participants are victims of the County's broken system of managed care, which appears hardly better than no care at all; 2) uninsured participants suffer from the failure of the County's community health centers to meet assumed, or taken-for-granted, standards of care; 3) the County's meager public transit system, combined with Medi-Cal’s random process of assigning physicians that does not taken location to patients into consideration make it next to impossible for patients to travel to appointments, and; 4) participants consider the emergency department as the one institution where the need for medical care is still taken seriously within a County where health care has lost its sense of caring.

Findings of this study leave little wonder as to why underserved patients in the County return to the emergency department for non-urgent care despite assistance by the Community Health program. While these findings may not be representative of the larger population, it is frighteningly possible they are indicative of a more far-reaching problem. It is said that emergency departments are often a benchmark for how well health care systems are performing (American College of Emergency Physicians, 2009; DeLia & Cantor, 2009; Institute of Medicine, 2000). What is known from literature examined in Chapter 2 is that emergency departments across the Nation today are nearing a breaking point largely because they are
inundated with underserved patients seeking care for non-urgent medical needs. If viewed as a benchmark, the state of America's emergency departments then, surely does not speak well to the performance of systems designed to provide health care for the underserved. Findings from this study substantiate this correlation, and open up questions about a larger, more systemic problem.

Theme 3 in this study, which reveals flaws in the County's Medi-Cal managed care system as a main reason why underserved patients visit the emergency department for non-urgent care, can be used as an example to further illustrate this point. Consider first, that the Medi-Cal managed care system is not unique to the County of this study, or to California. Thirty-six other states contract with insurance companies to provide managed care to underserved individuals and families who are eligible for this public health insurance; in fact, two-thirds of all individuals in the U.S. who are enrolled in Medicaid, or 26 million individuals, receive their benefits from managed care systems (Henry J. Kaiser Family Foundation, 2012). In less than a year, millions more uninsured individuals and families will be receiving Medicaid insurance through the Patient Protection and Affordable Care Act, and will be entering these managed care systems.

Consider next, that the reality of how well these other managed care systems perform in comparison to the system in the County of this study is not well known, for as literature has also shown, the tendency for research in health care disregards the patient perspective. There is certainly enough speculation found in literature on the Medicaid managed care system, however, to raise red flags. Hurley and Somers (2003) for instance, argue that the Nation’s dependence on managed care counteracts the goals of the Medicaid program. The authors maintain that managed care problems "continue to snowball and have created huge challenges," and they liken a Medicaid insurance card to nothing more than "a license to hunt for providers who might accept
it" (pp. 77, 78). Rodwin (1996) characterizes the Medicaid managed care system as market driven "creative destruction" (p. 111). Given these red flags, now consider the larger implications if the problems being incurred by patients in managed care systems across the Nation are the same or similar to the experiences shared by participants in this study. The negative impacts to the health and wellbeing of participants in this study are already bad enough. The potential stakes for America's Medicaid-insured are monumental.

One final point comes from Rodwin (1996) that hits close to the heart of this study. Health organizations, health care insurers and health care providers have the financial resources, incentives, power, and voice to lobby on their own behalf. As this study has shown, the underserved patients of the County have none of these advantages. They are silenced and powerless. Neither the County's system of care, nor the health inequalities within it, can be reformed until patient voices are heard.
References


