California's Emergency Services:

A System In Crisis

January 2001

California Medical Association
Physicians dedicated to the health of Californians

"If my family is in an accident, help will be there."

This is a basic presumption that nearly all Californians make daily. As residents of the wealthiest state in the nation, we assume that emergency medical services will be there when we need them. And for most of us, in years past, this was true. There were hospital emergency departments in every community, and our trauma centers could handle the most complicated injuries. However, as California embarks on a new millennium, the availability of emergency care is in serious question. Emergency departments across the state are closing or reducing services. They are strained beyond their capacity to treat many of the uninsured for ambulatory services. They cannot maintain sufficient on-call specialist capabilities and survive in an era of serious financial crisis.

California's health care system is struggling to adjust to serious under-funding of all services and provide care to more than seven million uninsured Californians. The "safety net" – that part of the system that serves as the first line of defense – has begun to unravel.

Once the envy of the country, California's trauma and emergency services are today in serious jeopardy. In 1998-99 alone, emergency departments reported financial losses of over $315 million while serving 9.3 million patients. Physicians working in these same emergency departments experienced losses exceeding $100 million. For the average patient treated in an emergency room at a cost of $136, hospitals and physicians are only reimbursed $90. That is a loss of $46 per patient. Throughout California, ambulances are being diverted, hospitals are shutting down or scaling back emergency services, and

patients are waiting hours for treatment. Our state faces a very real choice: Act now and save a system on the brink of disaster, or ignore the warning signs and watch the system flat line and die.

The current financing of trauma centers and emergency rooms is a disaster. The state's Medi-Cal program severely under-reimburses the actual cost of emergency care. Many HMOs reduce reimbursement (downcoding), delegate the responsibility for payment to medical groups, or refuse reimbursement entirely because they didn't consider it an "actual emergency" after the service is provided. The flow of red ink has forced hospitals and physicians to function in a perpetual state of crisis. Hospital diversion (sending ambulances from one hospital to another) has spiked dramatically over the past few years. This year, for example, San Francisco General Hospital has been forced to divert emergency patients 31% of the time, a substantial increase over last year.

TABLE 1 – EMERGENCY DEPARTMENT FINANCIAL LOSSES (REPRESENTATIVE COUNTIES)

	1996-97	**1997-98**	**1998-99**
Alameda County	$9,805,952	$16,879,461	$20,802,807
Butte County	$2,049,620	$2,592,243	$4,216,448
Contra Costa County	$8,648,299	$7,909,566	$12,077,437
Humboldt County	$72,376	$798,428	$1,307,618
Los Angeles County	$78,195,890	$77,037,599	$94,944,083
Monterey County	$164,907	$1,512,487	$2,934,341
Sacramento County	$2,039,529	$2,475,795	$5,709,972
San Bernardino County	$16,381,315	$17,142,584	$19,679,307
Santa Clara County	$9,384,158	$9,091,701	$15,538,942
Statewide Total (All Counties)	**$299,690,531**	**$291,986,350**	**$316,576,503**

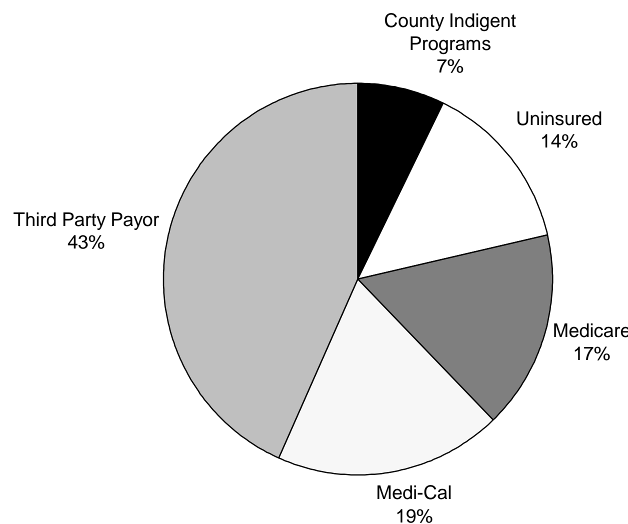
Source: Office of Statewide Health Planning and Development (OSHPD) Hospital Annual Disclosure Reports (1996-99)

As Table 1 demonstrates, the financial problem is not limited to urban areas. In rural areas where emergency service availability is already sparse at best, hospitals are feeling the pinch of maintaining access to emergency care as the availability of many specialists continues to decrease. The emergency department at Redding Medical Center lost over $4 million during 1998-99. How devastating would it be to that community if Redding Medical Center closed the doors to its emergency department? This crisis affects every

county in the state. Hospitals in Alameda, San Diego, and San Bernardino counties lost $20 million in each of those counties in 1998-99. Orange County hospitals lost $16 million and San Francisco $10 million (See Appendix B). No county was spared, whether rural or urban, small or large.

The lack of available care for Medi-Cal patients combined with the rise in the number of uninsured have transformed emergency departments from providers of last resort to providers of first resort for many Californians. Medi-Cal, uninsured patients, and county indigents accounted for 40% of all emergency room visits during 1998-99 (see Figure 1). Among the 40 hospitals reporting the greatest losses, the percentage of Medi-Cal, uninsured, and indigent patients climbed to 53%. For these patients the hospital and physician can expect inadequate or no payment. The Emergency Medical Services Fund (The Maddy Fund) that is used to compensate physicians for care provided to those who are uninsured pays, fifteen cents on the dollar at best. To bill this fund physicians must first bill the patient three times without success and then submit a claim to the county that is responsible for administering the fund. It is a long and cumbersome process that yields little reimbursement for the physician's time and costs.

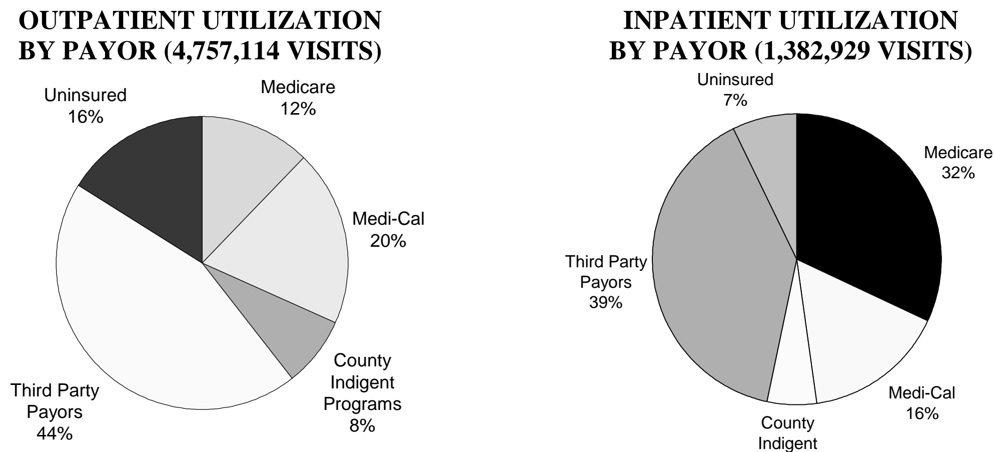
FIGURE 1 – **EMERGENCY ROOM UTILIZATION BY PAYOR (ALL SERVICES)**



Source: Office of Statewide Health Planning and Development (OSHPD) Hospital Annual Disclosure Reports (1996-99)

Over 80 percent of all Medi-Cal and uninsured patient visits to the emergency department were for conditions that could have been treated in a non-emergency care or outpatient environment. These patients seek care for non-emergency conditions because they have no routine source of medical care (see Figure 2). The large percentage of outpatient visits to the emergency room bog down the system.

FIGURE 2 – EMERGENCY ROOM OUTPATIENT & INPATIENT UTILIZATION BY PAYOR



Source: Office of Statewide Health Planning and Development (OSHPD) Hospital Annual Disclosure Reports (1996-99)

Although the growing financial losses represent the greatest problem facing emergency departments and trauma centers, there is also a lack of proper planning. While legislation has created a state and local emergency medical services system, state and local agencies lack authority to plan for and develop a coherent system. For example, local emergency medical service agencies (in conjunction with County Boards of Supervisors) have the authority to designate where trauma centers are located within a county, but not hospital emergency departments, which are regulated by the Department of Health Services as a function of hospital licensure. The state Medical Services Authority approves local trauma center designations but is totally uninvolved in the regulation of emergency departments by the Department of Health Services.

While the basic regulatory functions related to licensure are properly within the jurisdiction of the Department of Health Services, the role of the state and local planning agencies should be strengthened to provide for oversight and funding of those emergency departments that are critical for providing care in each community. This authority would be similar to how the current law treats designation of trauma centers. (See Appendix A for a detailed discussion of recommendations for planning and standards.)

While the trauma and emergency services planning functions must be strengthened, without proper funding these reforms will be meaningless. In the absence of health insurance for millions of uninsured Californians (universal health insurance appears a long way off), the hospital emergency department will remain a primary source for ambulatory services for this segment of the population.

In recognition of this, the Legislature created the county Emergency Medical Services Fund to help address physician reimbursement for low-income persons unable to pay for the cost of care. In spite of the Governor's augmentation of this fund last year by $24.8 million, it simply does not do the job. More money is needed.

A fund should be created (administered by the state and county emergency services agencies) that would provide infrastructure funding for critical trauma and emergency services. Such facilities are as vital to the well being of Californians as police and fire services–and should be funded directly so that their future existence is not dependent on the vagaries of the current fiscal disarray of California's health care system. While such funding will prevent the immediate closure of emergency service departments and trauma centers, other financing reforms must occur as well.

Under managed care, many public and private health care plans delegate responsibility for payment of emergency medical services to contracted medical groups. In other instances, some emergency departments do not have contracts with health plans, even though, by federal and state law, emergency departments must see and treat, when appropriate, every person who walks through the door, regardless of financial status or health care coverage. Thus, in many instances, responsibility for payment is blurred,

adding to the problem of nonpayment for the uninsured. Many emergency departments have indicated that this funding confusion is a major problem in maintaining appropriate on-call physician specialists, who are absolutely vital for a properly staffed emergency department. Public and private health plans should be required to directly reimburse such services unless they can ensure that prompt and proper payments are being made through entities with delegated responsibility.

In December the Los Angeles Times said:

> *"Los Angeles County's emergency and indigent health care system is trapped in a self-destructive cycle – bailout – cutbacks – crisis – bailout – largely because leaders at all levels of government have failed to work together, and with the private sector to identify and implement public health reforms." — Editorial*

While the problems are particularly acute in Los Angeles County, this observation applies throughout California. The legislation that accompanies this brief policy summary would go far in solving many of the current problems with emergency services. If we don't act now, many of these services simply won't exist.

APPENDIX A

Trauma & Emergency Services Background Paper
California Medical Association

November 2000

Trauma and Emergency Services

Background Paper

California Medical Association

Summary

The state Emergency Medical Services Authority (EMSA) was created in 1981 to provide a centralized resource responsible for emergency medical services (EMS) and disaster medical preparedness. However, with an early and continuing emphasis on regulation by local EMS systems, it has been difficult to establish a cohesive, statewide approach to emergency care. Moreover, conspicuously absent from the EMSA jurisdiction is emergency department oversight, which is undertaken by the Department of Health Services through their licensing division. Add to the confusion federal, state and local laws and regulations governing the emergency care environment and you have something that defies the moniker of an "authority."

In the face of alarming press accounts ranging from emergency department closures to adverse outcomes resulting from specialist non-availability, the debate continues over whether or not our current system effectively protects the health of Californians. Are the state and local EMS systems meeting the requirements of their charter? Does the EMS charter need to be amended to meet the realities of the present healthcare crisis? Should physicians who serve on call be paid a stipend? What are the appropriate repercussions for physicians who refuse to show for scheduled call? Do these problems that seem to plague emergency care portend a larger systemic breakdown in health care delivery throughout the state?

Potential provider (physician and hospital) exposure to substantial civil penalties under federal law means real consequences for a failure to address these questions. The potential solutions must address the underlying cause of these problems. As such, it may be time to undertake a realignment of EMS oversight, the establishment of a governmental entity with the charge and appropriation to fully address the realities of the present day emergency services environment, and to recognize the “essential public service” nature of emergency services. The time has come to chart a course for a coherent emergency medical services system in this state.

APPENDIX A

Introduction

In 1999, California's emergency care system treated 9.3 million people at one of the 356 of 567 licensed hospitals with emergency and/or trauma departments[1]. This system has evolved into the principal safety net for health care, providing universal access to emergency and acute medical care for all persons irrespective of their insurance coverage or lack thereof.

The basis for this safety net philosophy is rooted in the ethics of the healing professions and the traditional view that emergency care is an essential public service.

Under state and federal law, everyone who presents at an emergency department must be provided with emergency care, regardless of their ability to pay. These requirements exist without an adequate, dedicated funding stream, and with private, third-party payment marked by slow- and no-payment and inappropriate downcoding of service charges. Consequently, emergency services have become exploited and taken for granted, and California's system, once the envy of the world, has become overcrowded, overwhelmed, and in danger of collapse.

The threat to the emergency system in this state is real. Across the state, patients are enduring long waits, ambulances are being diverted, on-call physicians are withdrawing from hospital backup rosters and facilities are downgrading, closing or are in danger of closing.

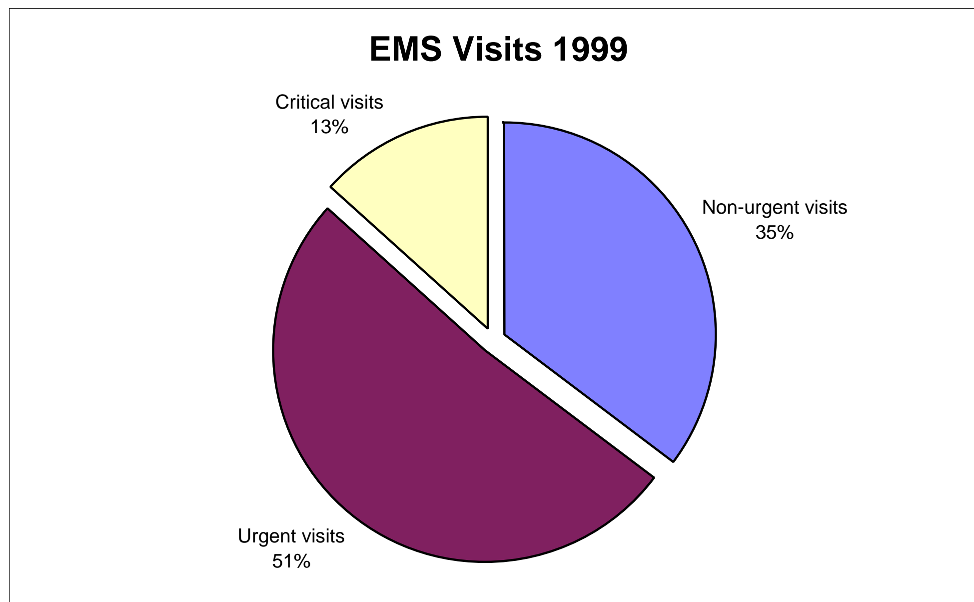
Moreover, the HMO, "make it affordable and they will come," model for reducing the number of uninsured has failed to make an appreciable dent in that number, currently holding around seven million. This means emergency care is and will continue to be the health care service in greatest demand by the public, whether insured or not.

Policymakers, opinion leaders and the general public need to be made aware of the precarious status of the emergency medical care system in California. It is also critical to establish an "Essential Public Service" designation for the system and its participants. Only then can we marshal the effort sufficient to strengthen and consolidate EMS activities at the statewide level and establish a consistent, adequate, dedicated funding stream.

[1] Office of Statewide Health Planning and Development: Hospital Utilization Data for 1999. Of the 356 emergency departments, 297 are Basic; 9 are Comprehensive; and 50 are Standby.

Figure 1 — Emergency Medical Services (EMS) Visits: 1999[2]

EMS Stations	EMS Visits			Admission from EMS
5,071	9,360,456			1,342,566
	Non-urgent Visits	Urgent Visits	Critical Visits	
	3,308,218	4,812,476	1,239,762	



- Emergency medical services (EMS) are hospital services providing immediate initial evaluation and treatment of acutely ill or injured patients on a 24-hour basis. Licensed EMS levels are:

  Standby- the provision of emergency medical care in a specifically designated area of the hospital that is equipped and maintained at all times to receive patients with urgent medical problems, and capable of providing physician services within a reasonable time[3].

  Basic- the provision of emergency medical care in a specifically designated area of the hospital that is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical problems[4].

  Comprehensive- the provision of diagnostic and therapeutic services for unforeseen physical and mental disorders, that if not properly treated, would lead to marked suffering, disability or death. The scope of services is comprehensive, with in-house capability for managing all medical situations on a definitive and continuing basis[5].

- An EMS station is a treatment station that is a specific place within the EMS Department adequate to treat one patient at a time. Holding or observation beds are not included.
- EMS visits are those made during the year to the Emergency Medical Service Department of licensed hospitals. Categories of emergency service are:

  Non-urgent- a patient with a non-emergent injury, illness or condition; sometimes chronic; that can be treated in a non-emergency setting, and not necessarily on the same day they are seen in the ED.

  Urgent- a patient with an acute injury or illness where loss of life or limb is not an immediate threat to their well-being, or a patient who needs a timely evaluation (low or low-to-moderate complexity)

  Critical- a patient presents an acute injury or illness that could result in permanent damage, injury or death.

[2] Office of Statewide Health Planning and Development: Hospital Utilization Data for 1999.
[3] See Title 22, Division 5, §70651-§70657, California Code of Regulations.
[4] Title 22, CCR, §70413-§70419.
[5] Title 22, CCR, §70453-§70459.

APPENDIX A

Background

The Emergency Medical Services Authority (EMSA)

The Emergency Medical Services Authority (EMSA) was created in 1980 in an effort to reduce morbidity and mortality in California through the development of a statewide system of coordinated and integrated emergency medical care and preventive services.

Prior to the formation of EMSA, the responsibility for emergency medical services (EMS) and disaster medical preparedness was shared by a variety of state departments. However, when a more unified approach to emergency and disaster medical services was needed, local administrators, health care providers, consumer groups and legislators worked together to formulate a state lead agency and centralized resource to deal with emergency and disaster medical services.

The Emergency Medical Services System and Prehospital Emergency Care Personnel Act (SB 125, Garamendi) created the Emergency Medical Services Authority[6]. The Authority was charged with providing leadership in developing and implementing EMS systems throughout California and promoting disaster medical preparedness throughout the state, and, when required, managing the state's medical response to major disasters.

The EMS Authority is one of thirteen departments within California's Health and Human Services Agency. Funding for EMS Authority programs comes from the State General Fund, Federal Preventive Health and Health Services Block Grant, fees for paramedic certification testing and registry, and the Office of Traffic Safety. Total appropriation to the EMSA for 2000-01 fiscal year is $13.14 million, with $9.1 million coming from the General Fund.

Table 1 — EMSA Budget[7]

FUND NAME	1998-99	1999-00	2000-01
EMS Authority	9,455,000	13,502,000	13,143,000
General Fund	5,506,000	9,248,000	9,113,000
EMS Training Program Approval Fund	13,000	24,000	26,000
Emergency Medical Services Personnel	762,000	777,000	798,000
Federal Trust Fund	3,174,000	3,342,000	3,206,000
EMSA Personnel	35.5	42.1	41.6

The EMS Authority operates the State Paramedic Licensure Program, which tests and licenses paramedic candidates in California to ensure that they meet the stringent requirements of pre-hospital care. This program also conducts disciplinary investigations. The EMS Authority is also required to develop and implement regulations that set training standards and the scope of

[6] Division 2.5 of the Health and Safety Code Section 1797-1799.
[7] Governor Gray Davis' 2000-01 State Budget, §HHS 4.

practice for emergency medical personnel (EMT-I, EMT-II, EMT-Paramedic, Mobile Intensive Care Nurses, firefighters, peace officers and lifeguards) and first aid training programs for school bus drivers and day care workers[8].

Local Emergency Medical Services Authorities (LEMSA)

California currently has 32 local EMS systems that provide emergency medical services for California's 58 counties. These systems include twenty-five single county agencies and seven regional EMS systems comprised of thirty-three counties. Regional systems are usually comprised of small, more rural, less-populated counties and single-county systems generally exist in the larger and more urban counties.

Day-to-day EMS system management is the responsibility of the local and regional EMS agencies throughout California. It is principally through these agencies that the EMS Authority delegates its authority over EMS services statewide.

They review local and regional EMS plans to ensure compliance with state laws and guidelines, and promulgate Trauma Care System regulations as well as guidelines for the assessment of critical care capabilities of hospitals in order to assure appropriate patient care. However, EMSA does not oversee hospital emergency departments which serve as the receiving facility in the absence of a trauma center, a fact that bears further exploration below.

According to the EMSA, responsibilities for EMS systems planning and development include assessing EMS systems in order to coordinate EMS activity based on community needs for the effective and efficient delivery of EMS services; providing technical assistance to local agencies that are developing, implementing, or evaluating components of an EMS system; developing statewide standards and guidelines for EMS systems as well as guidelines for the assessment of critical care capabilities of hospitals; and reviewing local EMS plans to ensure compliance with the minimum standards set by the EMS Authority.

Table 2 — LEMSA Data[9]

Staffing	Total Revenue	# of EMS Personnel	Total # Transports
343.8	63,358,917	36,210	1,449,403

Trauma Care System Planning and Development

The EMS Authority provides statewide coordination and leadership for the planning, development, and implementation of local trauma care systems. LEMSAs are responsible for planning, implementing, and managing local trauma care systems, including assessing needs, developing the system design, designating trauma care centers, collecting trauma care data, and quality assurance.

[8] This section was derived from the California EMS Authority Web Page: http://www.emsa.cahwnet.gov/
[9] Compiled from individual LEMSA reports to the EMSA.

Responsibilities for trauma care systems planning and development include developing statewide standards for trauma care systems and trauma centers, providing technical assistance to local agencies that are developing, implementing, or evaluating components of the trauma care system, and finally reviewing local trauma care system plans to ensure compliance with the minimum standards set by the EMS Authority.

Emergency Medical Services Commission

The Emergency Medical Services System and Prehospital Emergency Care Personnel Act (SB 125, Garamendi) also created the Emergency Medical Services Commission[10].

The Commission is charged with reviewing and approving regulations, standards, and guidelines to be developed by the authority to implement its emergency medical services responsibilities. The Commission advises the Authority on the development of an emergency medical data collection system. The Commission advises the Director concerning the assessment of emergency facilities and services and with regard to communications, medical equipment, training personnel, facilities and other components of an emergency medical services system.

Based upon evaluations of the EMS systems in the state and their coordination, the Commission makes recommendations for further development and future directions of emergency medical services and reviews and comments upon the emergency medical services portion of the State Health Facilities and Service Plan.

Appeal Functions

Health and Safety Code §1797.105 specifies that the EMS Authority shall receive plans for the implementation of EMS from local EMS agencies. Those local EMS agencies may implement a locally developed plan unless the authority determines that such a plan does not effectively meet the needs of residents and is not consistent with coordinating activities in the geographical area served.

The Health and Safety Code specifies that a local EMS agency may appeal a determination of the Authority to the Commission. In response to that appeal, the Commission may sustain the determination of the Authority or overrule it and permit the implementation the local agency's plan. The decision of the Commission is final.

[10] Division 2.5 of the Health and Safety Code Section 1797-1799.

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA, or the federal "anti-dumping law," was enacted by Congress as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985[11] to assure that patients who come to hospitals for treatment for potential emergency conditions are not turned away or transferred to another facility. EMTALA defines an emergency medical condition as one "manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."

Under EMTALA, hospitals that receive Medicare and Medicaid funding must provide a medical screening examination to determine the presence or absence of an emergency medical condition to all individuals seeking emergency services prior to inquiring about the method of payment. Hospitals are required to stabilize the medical condition of the individual, within the capabilities of the staff and facilities available at the hospital, prior to discharge or transfer.

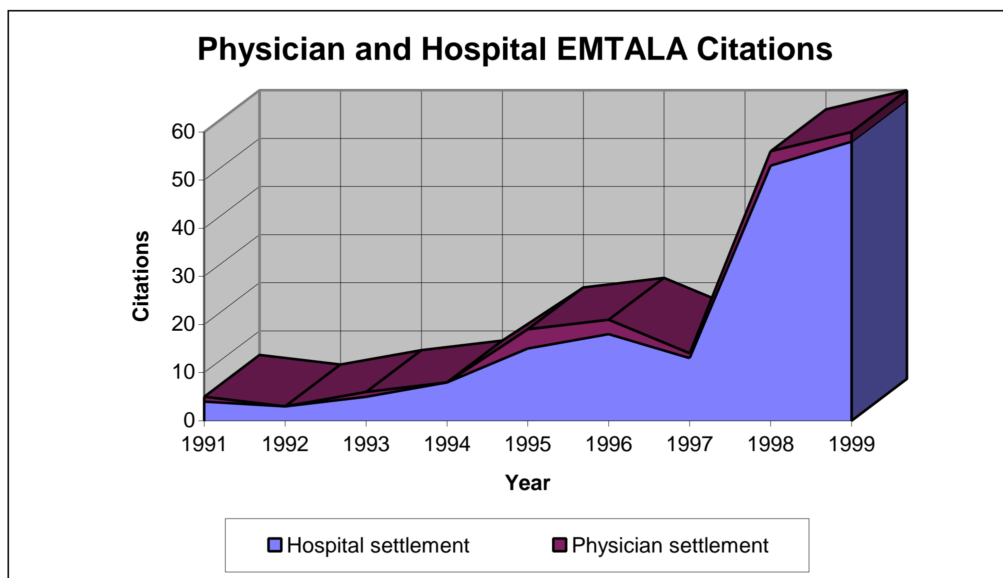
EMTALA is intended to ensure that all patients who come into the emergency department receive appropriate care regardless of their insurance or ability to pay, and such treatment must meet minimum health care quality standards.

Patients who are not stabilized can only be transferred to another facility if the medical benefits of the transfer of the emergent patient prior to stabilization outweigh the risks and is in the best interest of the patient. Hospitals with specialized capabilities are thus required to receive emergency patients in transfer from facilities, which lack these capabilities.

Delays and deficiencies in care constitute EMTALA violations, which can subject hospitals to civil penalties from $25,000 to $50,000 per violation (depending upon the number of beds), as well as potential exclusion from federal health programs, such as Medicare and Medicaid. The following graph presents a history of EMTALA hospital and physician citations from 1991 to 1999:

[11] 42 U.S.C. §1395dd

Figure 2 — EMTALA Citations



Although federal regulators have focused more on hospitals for EMTALA violations, the law states that physicians responsible for inappropriately transferring patients can also face a penalty of up to $50,000 per violation.

Beginning in 1998, the Office of Inspector General (OIG) and HCFA stepped up enforcement of the EMTALA law. For the year 2000, its goal is to push the number of cases to 70. As shown in the above statistics, the number of hospital settlements rose significantly after 1997. HCFA has been empowered with additional financial resources to more aggressively seek compliance and investigate alleged violations.

In fiscal year 1999, the OIG executed 60 settlements and received one default judgment for fines of $1.725 million, which is "equal to about half of all the money collected in the previous life of the statute." Also in 1999, the OIG received two adverse judgments in physician cases, resulting in the reversal of a $100,000 judgment against a physician in fiscal year 1997[12].

Hospital Responsibilities Under EMTALA

Under COBRA/EMTALA, Medicare and Medicaid participating hospitals MUST adhere to the following to be in compliance:

In the case of a hospital that has an emergency department, if any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself or with

[12] Information regarding EMTALA and its enforcement was derived from American Medical Association Organized Medical Staff Section (AMA-OMSS) and the AMA's *EMTALA Quick Reference Guide*. Policies H-130.970, H-130.978, H-130.975, H-130.960, H-130.964, H-240.969, H-285.954, AMA Policy Compendium provided background.

another person to the emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules and regulations), the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

The examinations must be conducted by individuals determined qualified by hospital bylaws or rules and regulations and who meet the requirements concerning emergency services personnel and direction.

Registration Procedures

Patients must not be asked questions about their ability to pay for medical services or insurance coverage *prior to* providing medical care. However, as a general proposition, emergency departments may follow normal registration processes before screening and stabilization, as long as they *do not delay care,* i.e., the patient would be waiting anyway.

Registration may include asking about insurance status. HCFA and the Office of Inspector General (OIG) have determined that *best practice* would be for a hospital *not to give* financial responsibility forms or notices to an individual, or otherwise attempt to obtain the individual's agreement to pay for services.

Patient Transfers

If an individual at a hospital has an emergency medical condition that has not been stabilized, the hospital may not transfer the individual unless:

- The transfer is an appropriate transfer and the individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

- A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual, or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

- If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the

certification. The certification must contain a summary of the risks and benefits upon which it is based.

Transfers to another medical facility are appropriate only in those cases in which:

- The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
- The receiving facility has available space and qualified personnel for the treatment of the individual; and has agreed to accept transfer of the individual and to provide appropriate medical treatment;
- The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and
- The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

A participating hospital may not penalize or take adverse action against a physician or a qualified medical person because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

On-Call Physicians and Rosters

The HCFA *State Operations Manual*[13] states that the purpose of the on-call roster is to ensure that the emergency department is prospectively aware of which physicians, including specialists and sub-specialists, are available to provide treatment necessary to stabilize individuals with emergency medical conditions. The 24 hour/7-day on-call roster must include all specialists and sub-specialists represented on the medical staff. Hospitals may establish a reasonable on-call schedule other than 24 hour/7-day if they are unable to secure agreement by physicians to take call round-the-clock because of the dearth of specialists in the area, the distance from a specialist's home to the hospital, etc.

[13] 42 U.S.C. §1395cc(a)(1)(I)(III).

The on-call list must be immediately updated to reflect any changes in physician staffing. Physicians whose names appear on the on-call list are responsible for finding a suitable replacement if they cannot be available for duty (for any reason that is ***not*** beyond their control) and to update the on-call list with the replacement physician's name and other appropriate information.

The medical staff bylaws or policies and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with emergency medical conditions. The hospital must also have policies and procedures that are followed when a particular specialty is not available or on-call physicians cannot respond because of situations beyond their control (e.g., if the physician is performing another surgery.)

Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time. If the hospital must transfer a patient to another facility because an on-call physician fails or refuses to appear, it must give the on-call physician's name and address to the receiving hospital.

Site of Screening Examination

Emergency services need not be provided in a location specifically identified as an emergency room or an emergency department. Some medical screening examinations or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the emergency department.

Under EMTALA, emergency patients needing a medical screening examination may be directed to a hospital-owned facility that is contiguous or is a part of the hospital "campus" and is owned by the hospital and operated under the hospital's provider number, as long as all persons with the same medical condition are moved to this location, regardless of their ability to pay for the treatment; there is a bona fide medical reason to move the patient; and qualified medical personnel accompany the patient.

When a physician is on-call in an office, it is not acceptable to refer emergency cases to their office for the medical screening examination and stabilization.

On-Call Physicians Responsibilities Under EMTALA

According to the *State Operations Manual*, if the on-call physician fails to respond in a timely fashion when called by the emergency physician to help stabilize an emergency condition, the hospital and the on-call physician are both at risk for an EMTALA violation. The Health Care Financing Administration (HCFA) has not set a specific rule for a response time, but some HCFA officials have mentioned 30 minutes.

On-call physicians, who may be on-call at another hospital simultaneously, may not request that a patient be transferred to a second hospital for the physician's convenience.

Federal regulators focused more often on institutions for EMTALA violations, but on-call physicians responsible for examination, treatment, or transfer of an individual are subject to potential civil fines of up to $50,000 per violation for failing to come to the hospital's emergency unit, and may be excluded from Medicare and Medicaid programs. The editorial, "With Enforcement of EMTALA Heating Up, Hospitals Seek Ways to Avoid Violations, published in the March 20, 2000 issue of, *Perspectives on the Marketplace*, states "a private suit for violation of EMTALA can be hitched to a medical malpractice suit, moving the whole dispute into federal court, where all the records of the peer review of the case – usually not admissible in state court – can be presented to the jury at the trial."

CMA Policy and Recommendations To Date

Table 3 — "CMA ADOPTED POLICIES"

Title	Source	Number	Category
Emergency Room Non-Contracted Physician Service Rendered	House of Delegates	Res. # 409-96	Third Party Payor Coverage
Routine Coverage by Emergency Facilities	House of Delegates	Res. # 137a-79	Third Party Payor Coverage
MediCare Benefits Reduction for E R Payments	Board of Trustees	Rec. # 1-17-86:10	Third Party Payor Coverage
Prudent Layperson for Emergency Services	House of Delegates	Res. # 404-97	Third Party Payor Coverage
Managed Care: Non-Delayed Access To Emergency Services and Care	House of Delegates	Res. # 918a-97	Third Party Payor Coverage
Treatment of Patient Who Presents To the Emergency Department	House of Delegates	Res. # 521-98	Third Party Payor Coverage
Emergency Transfer Responsibilities	Board of Trustees	Rec. # 3-8-91:8	Patient Transfer
Patient Transfer Legislation	House of Delegates	Res. # 210a-87	Patient Transfer
Emergency Transfer Protocols	Board of Trustees	Rec. # 11-11-88:7	Patient Transfer
Managed Care Subscribers Requiring Emergency Care	Board of Trustees	Rec. # 11-11-88:6	Patient Transfer
"Economic" Emergency Room Patient Transfers	House of Delegates	Res. # 918-95	Patient Transfer
Transfers of Managed Care Plan Members	Board of Trustees	Rec. # 7-20-90:5	Patient Transfer

In 1999, a task force comprised of CMA and CAL-ACEP representatives met to discuss the problems some hospitals faced in maintaining adequate specialty back-up to their emergency departments. The CMA and CAL-ACEP Board of Trustees adopted the task force's recommendations.

Discussion

The "System" Condition

The emergence of for-profit managed care entities as the dominant medium for public and employer sponsored health care, coupled with the EMTALA mandate for EDs, has resulted in exploitation of the emergency care safety net.

Despite hard won insurance reforms requiring access and coverage for most emergency services, a combination of very low reimbursement rates, slow payment and inappropriate downgrading of service charges has caused severe economic damage to the emergency care infrastructure. As the safety net for the uninsured and for an ailing health care system in general, California's system is now showing the signs of severe strain with the recent closure of numerous hospitals, and with a serious problem maintaining on-call specialty backup coverage in the majority of community hospital EDs. The following aggravating factors serve to exacerbate the situation:

- Delayed or non-payment by health plans for emergency services is decreasing physicians ability or desire to serve on-call.
- The number of emergency rooms has declined while the number of patients seeking emergency services is on the rise. Eleven trauma centers have closed in Los Angeles in the last 15 years[14].
- Managed care bureaucracy is making it difficult to get appointments with physicians, causing insured patients to delay seeing their physician until their condition becomes emergent.
- Uninsured patients are continuing to increase and use the emergency room for their primary source of medical care.
- Because of low bed availability in intensive care and other units, patients remain in the emergency room for longer periods of time.
- In some cases, EMTALA interferes with the development of regional trauma systems because hospitals are concerned about a potential EMTALA violation.

Recent EMSA Efforts

Recent system reviews include a 1999 assessment of emergency medical services undertaken by the National Highway Traffic Safety Administration which identified key EMS issues or standards, assessed the status, and made recommendations for necessary changes; and a self critical "vision" process undertaken by the EMS Commission beginning in 1997 which identified problems and deficiencies and set out a series of recommendations that constitute a "Vision Plan" for shaping the future of EMS in California.

[14] Riccardi, Nicholas and Karima A. Haynes. "Ailing Trauma Network on the Verge of Collapse." Los Angeles Times, 8 September 2000.

What these two projects found was that multiple, autonomous organizations, both public and private, have high degrees of functional interdependence as they work to provide emergency medical care to individual patients. Managing this interdependence requires planning, standardization and mutual adjustment. The lack of statewide system planning results in conflicts, inefficiencies and a lower level of care to the patient.

The Need for a Systems Approach to EMS

In an article published by Richard Narad in 1990, he indicated that the Federal EMS Act defined an EMS system as "a system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery in an appropriate geographic area of health care services under emergency conditions (occurring either as a result of the patient's condition or of natural disasters or similar conditions) and which is administered by a public or nonprofit private entity which has the *authority and the resources* to provide effective administration of the system"[15] (emphasis added). The target populations for the EMS system include patients suffering from behavioral emergencies, burns, cardiac emergencies, neonatal emergencies, poisonings, spinal cord injuries and trauma.

The delivery of emergency health care requires the participation of numerous independent individuals and organizations, including public safety agencies, ambulance services, physicians, and hospitals. Despite their autonomy, these organizations have high degrees of functional interdependence as they work to provide care, sometimes simultaneously, to individual patients. Managing interdependence requires planning, standardization, and mutual adjustment.

Of the various approaches a community can take to address system oversight for what amounts to an "essential public service," placing the entire EMS system under the solid direction of a single agency is necessary to garner the public trust and support as well as to demonstrate the mission critical status of and designation of emergency medical services as an essential public service. Perhaps it is time to bolster the authority and funding of the EMSA to plan for the entire EMS system in order to provide the optimal response to the emergency patient. In doing so, it must consider all patient needs and all resources required to meet these needs. [16]

Service Areas: Regionalization

The National Academy of Sciences defined regionalization in EMS as "the process of identifying and developing resources on an area-wide basis to meet the needs of all the acutely ill and injured for prompt, efficient, and effective medical care" which is "achieved by area-wide

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[15] Section 1201(1), U.S. Public Health Service Act. Quoted in the "California EMS System Standards and Guidelines" (EMSA Publication #103, June 1993). Richard Narad, Consultant.

[16] Narad, Richard. 1990. "Emergency Medical Services System Design", Emergency Medicine Clinics of North America, Vol. 8, No. 1 (February 1990)

organization, coordination, and integration" of system components[17]. The American Society for Testing and Material's Committee on EMS defined a region as "the geographic or demographic area that is a natural catchment area for EMS provision for most, if not all, patients in the designated area."[18]

A regional EMS system then is a natural system, based on day-to-day response patterns and hospital catchment areas. Where possible, the boundaries of the responsible EMS council or lead agency should match the natural system. Within that area, providers should be coordinated to ensure that the closest appropriate responders are sent to a medical emergency, regardless of geopolitical boundaries, and to ensure that patients are taken to the closest appropriate facility for their condition. The system must include suburban and rural areas along with metropolitan areas in order to ensure availability of tertiary services. In remote areas, access to specialized services must be ensured through transfer agreements.[19]

EMS System Organization

Legal requirements for emergency medical care, communication, transportation, assessment of facilities, disaster response, and other EMS services are addressed in five California Codes and several titles of the California Code of Regulations. In addition to each local jurisdiction and various private, professional, and voluntary associations, numerous State and Federal agencies have defined EMS roles or responsibilities. Integration of these entities into a statewide EMS system requires centralized planning, coordination, and administration.

Recommendations

RECOMMENDATION 1: THAT CMA AND CAL/ACEP JOINTLY SPONSOR "EMSA LEGISLATION" TO SIGNIFICANTLY REFORM THE CURRENT EMERGENCY MEDICAL SERVICES SYSTEM IN CALIFORNIA WHICH WOULD CHARGE THE STATE MEDICAL SERVICES AUTHORITY FOR DEVELOPING A STATEWIDE EMERGENCY SERVICES PLAN WHICH CREATES UNIFORM STANDARDS FOR LOCAL EMS AUTHORITIES, DEFINES THE OVERSIGHT RELATIONSHIP OF THE STATE AUTHORITY AND ESTABLISHES AN EXPANDED ROLE FOR THE STATEWIDE ADVISORY COMMITTEE.

[17] Emergency Medical Services at Midpassage; Washington, DC: National Academy of Sciences, 1978, p. 46. Quoted in Richard Narad. "Emergency Medical Services System Design." Emergency Medicine Clinics of North America, Vol. 8, No. 1 (February 1990) pp. 1-15.

[18] "Standard Guide for Structures and Responsibilities of Emergency Medical Services System Organizations (Standard F 1086-87)" (Philadelphia: ASTM, 1988) Section 3.2.1. Quoted in Richard Narad. "Emergency Medical Services System Design." Emergency Medicine Clinics of North America, Vol. 8, No. 1 (February 1990) pp. 1-15.

[19] Narad, Richard. 1990. "Emergency Medical Services System Design." Emergency Medicine Clinics of North America, Vol. 8, No. 1 (February 1990) pp. 1-15.

EXPLANATION: THE WORK GROUP ACKNOWLEDGED THE PROBLEMS PRESENTED BY THE VARIABLE APPROACHES USED BY LOCAL EMSAS AND FELT THAT UNIFORM STANDARDS WOULD FACILITATE IMPROVED COORDINATION AND OVERSIGHT.

RECOMMENDATION 2: THAT THE "EMSA LEGISLATION" SPECIFY THAT EMERGENCY SERVICES, INCLUDING BACKUP SPECIALISTS, ARE AN ESSENTIAL PUBLIC SERVICE THAT REQUIRES ADEQUATE LEVELS OF FUNDING TO MEET COMMUNITY SERVICE NEEDS.

EXPLANATION: THE WORK GROUP DETERMINED THAT PUBLIC ADVOCACY AND ACCEPTANCE OF THIS OVERARCHING PRINCIPLE WAS ESSENTIAL IN ORDER TO IMPROVE THE DELIVERY OF EMERGENCY SERVICES TO CALIFORNIA RESIDENTS. FURTHER, NO SYSTEM CAN BE EXPECTED TO BE SUCCESSFUL IF NOT ADEQUATELY FUNDED.

RECOMMENDATION 3: THAT THE "EMSA LEGISLATION" INCLUDE IDENTIFICATION OF SUFFICIENT FUNDING SOURCES, AND THAT THE AMOUNT BE DETERMINED USING ACTUARIALLY SOUND METHODOLOGY TO INCREASE PAYMENTS FOR EMERGENCY SERVICES FOR UNCOMPENSATED CARE IN ORDER TO ASSURE ACCESS TO CARE.

EXPLANATION: UNCOMPENSATED CARE WAS IDENTIFIED AS A MAJOR CAUSE OF DIFFICULTY IN ASSURING ON-GOING ACCESS TO EMERGENCY SERVICES. THE WORK GROUP ELECTED TO SEPARATELY CONSIDER THE CHALLENGES RELEVANT TO PATIENTS WITH DIFFERENT SOURCES OF FUNDING.

RECOMMENDATION 4: THAT THE "EMSA LEGISLATION" INCLUDE A REQUIREMENT THAT MEDI-CAL DIRECTLY REIMBURSE EMERGENCY AND ON-CALL PHYSICIAN SERVICES.

EXPLANATION: THE PROVISION OF EMERGENCY SERVICES VERY FREQUENTLY OCCURS IN A SETTING WHERE THE PATIENT HAS NOT HAD THE OPPORTUNITY TO SELECT THEIR PREFERRED TREATING PHYSICIAN IN ACCORDANCE WITH THE EXPECTATIONS OF THE

MANAGED CARE PLAN. THIS SITUATION CREATES INTOLERABLE PAPERWORK BURDENS AND HASSLE FACTORS WHICH SHOULD BE ELIMINATED.

RECOMMENDATION 5: **THAT INSURANCE COMPANIES AND LICENSED HEALTH CARE SERVICE PLANS DIRECTLY REIMBURSE SUCH SERVICES (EXCEPT FOR KAISER AND OTHER IPAS OR MEDICAL GROUPS THAT HAVE APPROPRIATELY CONTRACTED FOR THESE SERVICES.) HEALTH PLANS MAY NOT DELEGATE RESPONSIBILITY FOR PAYMENT FOR EMERGENCY AND BACK UP PHYSICIANS.**

EXPLANATION: THERE WAS CONSIDERABLE DISCUSSION ABOUT THIS RECOMMENDATION. THE WORK GROUP WIDELY SUPPORTED TRANSFER OF THE RESPONSIBILITY FOR PAYMENT FOR EMERGENCY SERVICES TO THE HEALTH PLAN IN MOST INSTANCES. THIS WOULD PROVIDE FOR A DRAMATIC REDUCTION IN BILLING AND PAYMENT HASSLES. HOWEVER, THE WORK GROUP FOUND IT REASONABLE TO PERMIT DELEGATION FROM KAISER FOUNDATION HEALTH PLAN TO ITS MEDICAL GROUP AS THE CURRENT ARRANGEMENTS HAVE WORKED WELL FOR OUT-OF-PLAN CARE. ADDITIONALLY, A MAJORITY OF WORK GROUP MEMBERS FELT THAT THERE ARE MANY EXAMPLES OF EFFECTIVE COLLABORATIVE RELATIONSHIPS BETWEEN IPAS AND THEIR DOCTORS WHO RENDER EMERGENCY SERVICES AND FELT THAT DISRUPTION OF THESE RELATIONSHIPS WAS NOT WARRANTED AT THIS TIME.

RECOMMENDATION 6: **THAT A COMMITTEE BE FORMED TO STUDY AND REPORT ON THE FOLLOWING ISSUES:**

- **THAT CMA PURSUE PLACEMENT OF EMERGENCY DEPARTMENT OVERSIGHT UNDER THE JURISDICTION OF THE EMSA;**

- **THE ROLE OF THE STATE ADVISORY COMMITTEE, AND THE POTENTIAL FOR EXPANSION OF THE STATE ACTION IMMUNITY CONTAINED IN HEALTH AND SAFETY CODE SECTION 1797.6 WHICH ALLOWS FOR JOINT NEGOTIATIONS BY EMS PROVIDERS WITH INSURERS, AND TO BE**

OVERSEEN BY THE STATE MEDICAL SERVICES AUTHORITY.

EXPLANATION: WHILE THERE WAS GENERAL SUPPORT FOR THESE RECOMMENDATIONS, SEVERAL WORK GROUP MEMBERS WERE CONCERNED ABOUT THE POSSIBILITY OF INCREASED REGULATORY BURDENS AND FELT THAT THE FIRST ISSUE ABOVE WARRANTED FURTHER STUDY. IN REGARD TO THE SECOND RECOMMENDATION, THE WORK GROUP FELT THAT ANY REQUEST FOR GOVERNMENTAL OVERSIGHT SHOULD BE VERY CAREFULLY CONSIDERED, IN ORDER TO ASSURE THAT APPROPRIATE SAFEGUARDS ARE IN PLACE.

RECOMMENDATION 7: **THAT CMA SUPPORT CHANGES IN STATE LAW, TO MAKE IT CONFORM TO FEDERAL TRANSFER LAW, ON THE SUBJECT OF CUSTOMARY EMERGENCY ROOM REGISTRATION PROCEDURES, SO AS TO PROMOTE CONTINUITY OF CARE BY PERMITTING INQUIRY ABOUT NAMES OF PHYSICIANS WHO SHOULD TREAT THE PATIENT.**

EXPLANATION: WHILE EMTALA (FEDERAL) LAW PERMITS OBTAINING INFORMATION RELEVANT TO TYPICAL REGISTRATION PROCESSES (E.G., NAME OF PERSONAL PHYSICIAN, IDENTIFICATION OF WHICH PANEL OF SPECIALISTS MAY BE APPROPRIATE), CALIFORNIA LAW MAY PREVENT SUCH ROUTINE INQUIRY. IF THE INQUIRY IS PERFORMED IN A SENSITIVE MANNER, WHICH DOES NOT DELAY A PATIENT'S CARE, IT IS LIKELY TO BE IN THE PATIENT'S BEST INTEREST IN THE CONTEXT OF ASSURING CONTINUITY OF CARE.

RECOMMENDATION 8: **AMEND RELEVENT CMA POLICY TO SAY THAT "HOSPITALS, MEDICAL STAFFS AND THE COMMUNITY HAVE A SHARED ETHICAL RESPONSIBILITY."**

RECOMMENDATION 9: **THAT CMA CONVENE DISCUSSION AMONG INTERESTED AND AFFECTED SPECIALTIES TO DEVELOP AN INTERNAL DEFINITION OF "EMERGENCY SERVICES" TO GUIDE CMA ACTION AND POLICY IN THIS AREA.**

APPENDIX B

Summary of Hospital Emergency Room Utilization & Financial Condition For Hospitals Reporting ER Losses 1998-99

(Sorted by County)

Data Source:

Office of Statewide Health Planning and Development

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
ALAMEDA COUNTY									
ALAMEDA CO MED CTR - HIGHLAND CAMPUS	OAKLAND	B	3,249	8,526	10,481	22,189	2,338	-$157.41	-$7,364,112
CHILDREN'S HOSPITAL MED CENTER OF NO. CALIFORNIA	OAKLAND	B	14	5,889	10	17,961	2,700	-$157.87	-$4,195,237
KAISER FOUNDATION HOSPITAL - OAKLAND CAMPUS	OAKLAND		1,186	133		4,363		-$307.32	-$1,746,192
KAISER FOUNDATION HOSPITAL - HAYWARD	HAYWARD	B	676	26		5,286		-$232.88	-$1,394,485
ST. ROSE HOSPITAL	HAYWARD	B	5,497	5,927		12,997	6,058	-$40.40	-$1,231,352
ALTA BATES MEDICAL CENTER - ASHBY CAMPUS	BERKELEY	B	8,773	7,060		16,698	8,793	-$27.48	-$1,135,584
VALLEY MEMORIAL HOSPITAL - LIVERMORE	LIVERMORE		3,225	692	31	12,508	2,648	-$52.03	-$993,981
SAN LEANDRO HOSPITAL	SAN LEANDRO	B	7,315	2,556		8,132	2,300	-$48.64	-$987,538
ALAMEDA HOSPITAL	ALAMEDA	B	4,562	5,186		15,316	5,026	-$31.10	-$935,799
SUMMIT MEDICAL CENTER - NORTH PAVILION	OAKLAND	B	12,962	7,209		14,997	3,906	-$11.30	-$441,536
WASHINGTON HOSPITAL - FREMONT	FREMONT	B	5,889	4,700		22,504	9,218	-$8.91	-$376,991
								Alameda County Total Losses:	**-$20,802,807**
AMADOR COUNTY									
SUTTER AMADOR HOSPITAL	JACKSON	B	3,825	1,688	256	5,208	1,135	-$21.43	-$259,560
								Amador County Total Losses:	**-$259,560**
BUTTE COUNTY									
ENLOE MEDICAL CENTER- ESPLANADE CAMPUS	CHICO	B	4,602	7,855	958	9,659	5,442	-$65.06	-$1,855,251
OROVILLE HOSPITAL	OROVILLE	B	7,779	18,455	1,959	10,315	3,140	-$44.17	-$1,839,592
FEATHER RIVER HOSPITAL	PARADISE	B	4,835	4,383	680	5,518	1,060	-$30.55	-$503,342
BIGGS GRIDLEY MEMORIAL HOSPITAL	GRIDLEY	S	666	1,962	225	1,086	3,425	-$2.48	-$18,263
								Butte County Total Losses:	**-$4,216,448**
COLUSA COUNTY									
COLUSA COMMUNITY HOSPITAL	COLUSA	S	1,375	1,811	167	2,579	1,061	-$73.01	-$510,559
								Colusa County Total Losses:	**-$510,559**

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
CONTRA COSTA COUNTY									
CONTRA COSTA REGIONAL MEDICAL CENTER	MARTINEZ	B	2,616	11,943	12,970	1,852	2,766	-$118.98	-$3,824,850
MT. DIABLO MEDICAL CENTER	CONCORD	B	8,972	2,722	140	30,173	4,676	-$71.07	-$3,317,761
JOHN MUIR MEDICAL CENTER	WALNUT CREEK	B	7,201	1,565	439	18,609	3,177	-$46.12	-$1,429,305
SUTTER DELTA MEDICAL CENTER	ANTIOCH	B	6,197	9,052		17,221	5,713	-$32.61	-$1,245,148
KAISER FOUNDATION HOSPITAL-MARTINEZ/WALNUT CREEK	WALNUT CREEK	B	917	137		4,924		-$165.64	-$990,196
SAN RAMON REGIONAL MEDICAL CENTER	SAN RAMON	B	2,006	155		11,548	2,590	-$55.23	-$900,194
DOCTORS MEDICAL CENTER - PINOLE CAMPUS	PINOLE	B	2,844	1,049	5	9,765	437	-$26.24	-$369,984
								Contra Costa County Total Losses:	**-$12,077,437**
DEL NORTE COUNTY									
SUTTER COAST HOSPITAL	CRESCENT CITY	B	4,884	3,158	352	4,466	2,107	-$35.18	-$526,539
								Del Norte County Total Losses:	**-$526,539**
EL DORADO COUNTY									
MARSHALL HOSPITAL	PLACERVILLE	B	4,767	4,223	1,191	10,575	1,768	-$33.52	-$755,004
BARTON MEMORIAL HOSPITAL	SOUTH LAKE TAHOE	B	6,077	3,528	622	15,036	5,500	-$21.03	-$646,946
								El Dorado County Total Losses:	**-$1,401,950**
FRESNO COUNTY									
CLOVIS COMMUNITY HOSPITAL	CLOVIS	B	2,510	1,728	48	9,413	1,947	-$70.16	-$1,097,723
KAISER FOUNDATION HOSPITAL - FRESNO	FRESNO	B	303			2,378		-$294.24	-$788,857
COALINGA REGIONAL MEDICAL CENTER	COALINGA	S	1,246	1,550		2,880	1,594	-$96.29	-$700,028
SELMA DISTRICT HOSPITAL	SELMA	S	3,236	2,192		5,010	4,864	-$19.72	-$301,755
SIERRA KINGS DISTRICT HOSPITAL	REEDLEY	S	1,727	2,794		2,356	1,737	-$20.77	-$178,913
								Fresno County Total Losses:	**-$3,067,277**
GLENN COUNTY									
GLENN MEDICAL CENTER	WILLOWS	S	740	875	76	1,485	697	-$92.33	-$357,594

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
								Glenn County Total Losses:	**-$357,594**
HUMBOLDT COUNTY									
"GENERAL HOSPITAL, THE"	EUREKA	B	2,268	3,723	704	2,532	1,300	-$66.70	-$702,151
REDWOOD MEMORIAL HOSPITAL	FORTUNA	B	2,625	2,344	304	3,310	1,453	-$59.82	-$600,354
ST. JOSEPH HOSPITAL - EUREKA	EUREKA	B	6,592	4,777	910	5,310	2,864	-$0.25	-$5,113
								Humboldt County Total Losses:	**-$1,307,618**
IMPERIAL COUNTY									
EL CENTRO REGIONAL MEDICAL CENTER	EL CENTRO	B	6,271	7,725	1,772	6,340	3,013	-$5.99	-$150,475
								Imperial County Total Losses:	**-$150,475**
INYO COUNTY									
NORTHERN INYO HOSPITAL	BISHOP	B	1,404	1,415	318	3,191	768	-$78.80	-$559,165
SOUTHERN INYO HOSPITAL	LONE PINE	S	263	208		299	361	-$230.18	-$260,334
								Inyo County Total Losses:	**-$819,498**
KERN COUNTY									
BAKERSFIELD MEMORIAL HOSPITAL- 34TH STREET	BAKERSFIELD	B	6,618	1,129		14,298	1,620	-$72.92	-$1,725,652
SAN JOAQUIN COMMUNITY HOSPITAL	BAKERSFIELD	B	4,274	3,402		14,968	1,623	-$64.33	-$1,561,096
RIDGECREST REGIONAL HOSPITAL	RIDGECREST	B	1,875	2,651		5,833	1,216	-$73.78	-$854,004
DELANO REGIONAL MEDICAL CENTER	DELANO	B	1,867	3,032	115	5,740	2,545	-$52.24	-$694,740
MERCY WESTSIDE HOSPITAL	TAFT	S	1,343	2,001	378	2,552	855	-$78.05	-$556,418
MERCY HOSPITAL - BAKERSFIELD	BAKERSFIELD	B	5,875	872	172	12,310	1,023	-$3.86	-$78,173
KERN VALLEY HEALTHCARE DISTRICT	LAKE ISABELLA	S	2,146	1,099	368	2,623	516	-$0.18	-$1,215
								Kern County Total Losses:	**-$5,471,298**
KINGS COUNTY									
HANFORD COMMUNITY MEDICAL CENTER	HANFORD	B	4,535	4,653	840	7,333	3,994	-$69.90	-$1,492,715
CORCORAN DISTRICT HOSPITAL	CORCORAN	S	744	1,708	130	1,067	703	-$66.25	-$288,320

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
CENTRAL VALLEY GENERAL HOSPITAL	HANFORD	B	1,127	2,060	214	1,256	1,067	-$34.18	-$195,646
								Kings County Total Losses:	**-$1,976,681**

LAKE COUNTY

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
SUTTER LAKESIDE HOSPITAL	LAKEPORT	B	3,521	2,322	194	1,989	1,879	-$79.81	-$790,518
REDBUD COMMUNITY HOSPITAL	CLEARLAKE	B	4,381	5,780	643	3,397	696	-$28.34	-$422,181
								Lake County Total Losses:	**-$1,212,699**

LOS ANGELES COUNTY

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
LOS ANGELES CO MARTIN LUTHER KING JR/DREW MED CTR	LOS ANGELES	B	1,894	16,405	28,719	3,710	200	-$182.97	-$9,318,296
LOS ANGELES CO USC MEDICAL CENTER	LOS ANGELES	C	9,278	41,130	132,06	15,525	2,831	-$43.25	-$8,685,941
POMONA VALLEY HOSPITAL MEDICAL CENTER	POMONA	B	4,338	10,531	15	22,419	9,422	-$93.36	-$4,362,246
LOS ANGELES CO HARBOR-UCLA MEDICAL CENTER	TORRANCE		2,731	21,521	41,599	8,641	1,846	-$57.09	-$4,358,136
NORTHRIDGE HOSPITAL MEDICAL CENTER	NORTHRIDGE	B	8,183	12,555	32	27,851	6,475	-$75.79	-$4,175,726
ST. FRANCIS MEDICAL CENTER	LYNWOOD	B	11,045	27,595		23,415	23,887	-$42.75	-$3,674,021
CITRUS VALLEY MEDICAL CENTER - QV CAMPUS	WEST COVINA		7,864	7,478		32,911	5,414	-$62.53	-$3,355,798
CALIFORNIA HOSPITAL MEDICAL CENTER - LOS ANGELES	LOS ANGELES	B	7,841	13,458	796	18,777	13,707	-$58.53	-$3,194,509
LOS ANGELES CO OLIVE VIEW MEDICAL CENTER	SYLMAR	B	514	15,429	26,155	1,754	873	-$67.24	-$3,007,309
CHILDREN'S HOSPITAL OF LOS ANGELES	LOS ANGELES	B	35	18,936	152	5,212	4,422	-$93.31	-$2,683,316
ST. MARY MEDICAL CENTER	LONG BEACH	B	6,315	10,591		7,198	9,325	-$79.89	-$2,670,643
SANTA MONICA - UCLA MEDICAL CENTER	SANTA MONICA	B	3,136	2,524	282	12,316	7,853	-$91.45	-$2,387,851
GOOD SAMARITAN HOSPITAL	LOS ANGELES	B	5,302	2,673		4,451	6,471	-$104.79	-$1,980,217
ROBERT F. KENNEDY MEDICAL CENTER	HAWTHORNE	B	3,587	5,278		5,951	7,279	-$85.86	-$1,897,077
PRESBYTERIAN INTERCOMMUNITY HOSPITAL	WHITTIER	B	5,421	5,751	492	17,048	6,112	-$52.88	-$1,841,493
ST. LUKE MEDICAL CENTER	PASADENA	B	2,204	2,069		8,374	885	-$134.83	-$1,824,520
LAKEWOOD REGIONAL MEDICAL CENTER - SOUTH STREET	LAKEWOOD	B	3,209	2,000	9	20,057	1,789	-$57.95	-$1,568,359
NORTHRIDGE HOSPITAL MEDICAL CENTER - SHERMAN WAY	VAN NUYS		3,169	4,774	997	6,299	3,931	-$76.22	-$1,461,137
VALLEY PRESBYTERIAN HOSPITAL	VAN NUYS	B	5,256	9,056		14,514	2,134	-$45.44	-$1,406,822
MIDWAY HOSPITAL MEDICAL CENTER	LOS ANGELES	B	4,034	1,880		6,636	1,745	-$96.72	-$1,382,612

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	ARCADIA		5,685	1,959		16,991	3,608	-$48.19	-$1,361,030
CENTINELA HOSPITAL MEDICAL CENTER	INGLEWOOD	B	3,932	4,700		14,542	7,292	-$44.34	-$1,350,862
CENTURY CITY HOSPITAL	LOS ANGELES	B	2,453	266		5,914	1,257	-$128.42	-$1,270,074
BEVERLY HOSPITAL	MONTEBELLO	B	3,260	5,883	4	9,450	4,825	-$53.01	-$1,241,600
COMMUNITY & MISSION HOSPITAL OF HUNTINGTON PARK	HUNTINGTON PARK	S	857	1,428		2,328	1,639	-$189.52	-$1,184,879
WHITE MEMORIAL MEDICAL CENTER	LOS ANGELES	B	5,516	6,915		12,462	8,010	-$35.87	-$1,180,231
WEST HILLS HOSPITAL & MEDICAL CENTER	CANOGA PARK		5,754	1,332		18,765	4,207	-$38.64	-$1,161,441
BROTMAN MEDICAL CENTER	CULVER CITY	B	4,274	3,342		6,354	5,401	-$57.99	-$1,123,324
MONTEREY PARK HOSPITAL	MONTEREY PARK	B	1,424	1,293		4,063	183	-$156.24	-$1,087,899
SANTA MARTA HOSPITAL	LOS ANGELES	B	2,205	2,955		2,371	2,153	-$109.92	-$1,064,465
GREATER EL MONTE COMMUNITY HOSPITAL	SOUTH EL MONTE		1,099	2,164		6,417	1,802	-$91.24	-$1,047,618
PROVIDENCE HOLY CROSS MEDICAL CENTER	MISSION HILLS	B	2,950	2,683	1,567	14,755	4,392	-$37.18	-$979,581
DANIEL FREEMAN MEMORIAL HOSPITAL	INGLEWOOD	B	7,747	10,098	12	13,300	6,419	-$25.51	-$958,564
HUNTINGTON MEMORIAL HOSPITAL	PASADENA	B	5,736	6,256	1,312	15,187	10,384	-$22.52	-$875,465
ALHAMBRA HOSPITAL	ALHAMBRA	B	1,188	1,156		1,737	871	-$174.35	-$863,381
SUBURBAN MEDICAL CENTER	PARAMOUNT	B	1,443	3,044		10,247	597	-$54.69	-$838,452
SHERMAN OAKS HOSPITAL AND HEALTH CENTER	SHERMAN OAKS		2,427	778		4,375	1,684	-$88.94	-$823,940
PROVIDENCE SAINT JOSEPH MEDICAL CENTER	BURBANK	B	15,747	4,448		18,349	4,263	-$18.46	-$790,217
SAN GABRIEL VALLEY MEDICAL CENTER	SAN GABRIEL	B	3,906	2,825	161	9,783	3,523	-$38.89	-$785,500
CEDARS SINAI MEDICAL CENTER	LOS ANGELES	B	16,472	7,323	205	25,042	11,877	-$12.71	-$774,280
GLENDALE MEMORIAL HOSPITAL & HEALTH CENTER	GLENDALE		6,459	5,366		13,396	5,496	-$24.06	-$739,051
TRI-CITY REGIONAL MEDICAL CENTER	HAWAIIAN GARDENS	S	1,028	869		1,305	751	-$158.16	-$625,206
ORTHOPAEDIC HOSPITAL	LOS ANGELES	S	549	3,298		3,264	1,814	-$70.05	-$625,196
LOS ANGELES COMMUNITY HOSPITAL	LOS ANGELES	S	192	1,343		463	380	-$250.24	-$595,071
HUNTINGTON EAST VALLEY HOSPITAL	GLENDORA	B	2,785	2,419		5,164	1,986	-$46.56	-$575,202
PACIFICA HOSPITAL OF THE VALLEY	SUN VALLEY	B	1,701	3,302	125	6,854	4,312	-$34.69	-$565,239
GRANADA HILLS COMMUNITY HOSPITAL	GRANADA HILLS	B	2,834	1,129		3,516	4,040	-$46.80	-$539,089
VERDUGO HILLS HOSPITAL	GLENDALE	B	3,665	988		9,240	1,860	-$34.22	-$539,068
COAST PLAZA DOCTORS HOSPITAL	NORWALK	B	3,715	4,213		8,289	3,619	-$26.10	-$517,720
EAST LOS ANGELES DOCTORS HOSPITAL	LOS ANGELES	B	836	1,558		3,475	1,920	-$64.02	-$498,652
GARFIELD MEDICAL CENTER	MONTEREY PARK	B	3,507	3,003	5	12,604	389	-$24.09	-$469,948
ENCINO-TARZANA REGIONAL MEDICAL CENTER	ENCINO	B	2,158	327		4,518	226	-$63.74	-$460,776

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
UCLA MEDICAL CENTER	LOS ANGELES	C	10,449	4,457	36	13,764	7,497	-$8.68	-$314,242
LONG BEACH COMMUNITY MEDICAL CENTER	LONG BEACH	B	6,828	4,920	121	26,139	5,909	-$6.92	-$303,906
MONROVIA COMMUNITY HOSPITAL	MONROVIA	S	298	154		43	43	-$550.71	-$296,282
MISSION COMMUNITY HOSPITAL - PANORAMA CAMPUS	PANORAMA CITY	B	1,329	2,471		3,809	1,050	-$30.64	-$265,312
HENRY MAYO NEWHALL MEMORIAL HOSPITAL	VALENCIA	B	4,699	1,552	624	10,977	8,435	-$8.09	-$212,662
LANCASTER COMMUNITY HOSPITAL	LANCASTER	B	3,588	1,316		9,334	1,745	-$12.66	-$202,345
SANTA TERESITA HOSPITAL	DUARTE	B	1,451	2,390		5,177	1,944	-$12.53	-$137,354
WHITTIER HOSPITAL MEDICAL CENTER	WHITTIER	B	2,037	1,884		12,632	8,287	-$5.52	-$137,117
AVALON MUNICIPAL HOSPITAL	AVALON	S	187	145			36	-$261.57	-$96,258
MEMORIAL HOSPITAL OF GARDENA	GARDENA	B	2,628	4,424		5,926	3,861	-$4.84	-$81,501
PACIFIC HOSPITAL OF LONG BEACH	LONG BEACH	B	2,611	4,118		3,782	2,495	-$6.25	-$81,288
FOOTHILL PRESBYTERIAN HOSPITAL-JOHNSTON MEMORIAL	GLENDORA	B	2,092	1,255		10,988	2,483	-$3.97	-$66,767
								Los Angeles County Total Losses:	**-$94,944,083**

MADERA COUNTY

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
CHOWCHILLA DISTRICT MEMORIAL HOSPITAL	CHOWCHILLA	S	670	1,454			1,128	-$32.82	-$106,731
								Madera County Total Losses:	**-$106,731**

MARIN COUNTY

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
NOVATO COMMUNITY HOSPITAL	NOVATO	B	1,778	1,345	273	5,240	1,454	-$109.48	-$1,104,653
KAISER FOUNDATION HOSPITAL - SAN RAFAEL	SAN RAFAEL	B	441	42		2,237		-$218.86	-$595,299
								Marin County Total Losses:	**-$1,699,952**

MARIPOSA COUNTY

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
JOHN C FREMONT HEALTHCARE DISTRICT	MARIPOSA	S	1,109	829		1,238	605	-$86.08	-$325,468
								Mariposa County Total Losses:	**-$325,468**

MENDOCINO COUNTY

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
FRANK R HOWARD MEMORIAL HOSPITAL	WILLITS	S	1,913	2,571	659	2,866	1,345	-$7.34	-$68,658

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
								Mendocino County Total Losses:	**-$68,658**
MERCED COUNTY									
SUTTER MERCED MEDICAL CENTER	MERCED	B	2,273	10,450	1,312	4,319	5,740	-$28.40	-$684,270
MERCY HOSPITAL & HEALTH SERVICES	MERCED	B	3,943	5,111		6,001	1,620	-$30.35	-$506,086
DOS PALOS MEMORIAL HOSPITAL	DOS PALOS	S	449	2,085	12	57	1,540	-$41.38	-$171,437
								Merced County Total Losses:	**-$1,361,793**
MODOC COUNTY									
MODOC MEDICAL CENTER	ALTURAS	S	403	342	12	308	126	-$114.68	-$136,584
								Modoc County Total Losses:	**-$136,584**
MONO COUNTY									
MAMMOTH HOSPITAL	MAMMOTH LAKES	S	573	266	78	4,506	1,416	-$35.07	-$239,844
								Mono County Total Losses:	**-$239,844**
MONTEREY COUNTY									
SALINAS VALLEY MEMORIAL HOSPITAL	SALINAS	B	7,329	9,840	5	13,144	6,813	-$38.79	-$1,440,311
COMMUNITY HOSPITAL MONTEREY PENINSULA	MONTEREY	B	11,014	5,640	2	16,986	5,390	-$15.01	-$585,870
GEORGE L MEE MEMORIAL HOSPITAL	KING CITY	B	1,199	4,134	66	3,695	1,864	-$44.06	-$482,809
NATIVIDAD MEDICAL CENTER	SALINAS	B	1,191	4,051	1,652	1,648	2,831	-$37.40	-$425,350
								Monterey County Total Losses:	**-$2,934,341**
NAPA COUNTY									
ST. HELENA HOSPITAL	DEER PARK	B	2,492	942	101	6,254	1,074	-$118.35	-$1,285,636
QUEEN OF THE VALLEY HOSPITAL - NAPA	NAPA	B	6,614	2,431	745	6,889	1,397	-$25.88	-$467,807
								Napa County Total Losses:	**-$1,753,443**

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
NEVADA COUNTY									
TAHOE FOREST HOSPITAL	TRUCKEE	B	2,121	921	160	10,473	4,241	-$87.19	-$1,562,096
SIERRA NEVADA MEMORIAL HOSPITAL	GRASS VALLEY	B	7,486	4,006	905	9,352	2,402	-$43.17	-$1,042,599
								Nevada County Total Losses:	**-$2,604,695**
ORANGE COUNTY									
CHILDREN'S HOSPITAL OF ORANGE COUNTY	ORANGE	B	56	8,081		24,382	1,438	-$48.03	-$1,630,955
HUNTINGTON BEACH HOSPITAL	HUNTINGTON BEACH	B	2,801	453	2,433	11,280	578	-$88.47	-$1,552,206
WEST ANAHEIM MEDICAL CENTER	ANAHEIM	B	2,806	661	655	12,282	3,626	-$64.88	-$1,299,546
LA PALMA INTERCOMMUNITY HOSPITAL	LA PALMA	B	1,911	1,762	220	10,624	2,705	-$66.70	-$1,148,707
ANAHEIM MEMORIAL MEDICAL CENTER WEST	ANAHEIM	B	1,476	2,248	1,690	10,246	2,977	-$59.34	-$1,105,920
ORANGE COAST MEMORIAL MEDICAL CENTER	FOUNTAIN VALLEY	B	354	54		14,706	602	-$69.07	-$1,085,504
COASTAL COMMUNITIES HOSPITAL	SANTA ANA	B	1,243	3,671	127	6,226	1,780	-$72.71	-$948,647
LOS ALAMITOS MEDICAL CENTER	LOS ALAMITOS	B	3,070	579	93	15,762	769	-$42.10	-$853,493
BREA COMMUNITY HOSPITAL	BREA	B	2,124	519	111	8,723	1,443	-$65.29	-$843,547
ANAHEIM GENERAL HOSPITAL	ANAHEIM	B	1,023	253		2,801		-$184.25	-$751,187
PACIFICA HOSPITAL	HUNTINGTON BEACH	B	1,293	322	265	2,185	957	-$144.61	-$726,231
ORANGE CO COMMUNITY HOSP - BUENA PARK	BUENA PARK		1,701	1,301		1,036	409	-$121.25	-$539,199
HOAG MEMORIAL HOSPITAL PRESBYTERIAN	NEWPORT BEACH	B	9,882	724	748	32,665	9,943	-$9.73	-$525,050
PLACENTIA LINDA HOSPITAL	PLACENTIA	B	1,604	522	78	12,002	1,068	-$34.25	-$523,135
ANAHEIM MEMORIAL MEDICAL CENTER	ANAHEIM	B	3,233	1,816	565	8,690	4,843	-$27.15	-$519,841
SADDLEBACK MEMORIAL MEDICAL CENTER	LAGUNA HILLS	B	12,104	288		22,847	4,386	-$11.20	-$443,800
WESTERN MEDICAL CENTER HOSPITAL - ANAHEIM	ANAHEIM	B	1,191	3,856	265	6,048	3,548	-$24.88	-$370,911
FOUNTAIN VALLEY RGNL HOSP & MED CTR - EUCLID	FOUNTAIN VALLEY		7,127	2,053	1,306	16,981	1,081	-$9.83	-$280,627
SAN CLEMENTE HOSPITAL & MEDICAL CENTER	SAN CLEMENTE	B	2,007	231		3,099	1,324	-$39.50	-$263,110
IRVINE MEDICAL CENTER	IRVINE	B	2,209	198	216	13,320	2,807	-$13.73	-$257,438
SANTA ANA HOSPITAL MEDICAL CENTER INC	SANTA ANA		553	1,134	7	60	261	-$114.46	-$230,637
GARDEN GROVE HOSPITAL & MEDICAL CENTER	GARDEN GROVE	B	2,334	1,448	227	13,885	2,490	-$6.87	-$140,038
CHAPMAN MEDICAL CENTER	ORANGE	B	1,806	696	117	6,169	1,201	-$13.02	-$130,057
SOUTH COAST MEDICAL CENTER	LAGUNA BEACH	B	2,502	137		7,553	1,189	-$8.09	-$92,072
								Orange County Total Losses:	**-$16,261,858**

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
PLACER COUNTY									
SUTTER AUBURN FAITH HOSPITAL	AUBURN	B	3,597	1,730	343	10,466	1,944	-$34.04	-$615,443
SUTTER ROSEVILLE MEDICAL CENTER	ROSEVILLE	B	11,950	4,187	393	11,748	6,153	-$6.93	-$238,607
								Placer County Total Losses:	**-$854,050**
PLUMAS COUNTY									
PLUMAS DISTRICT HOSPITAL	QUINCY	S	1,021	853	74	1,655	569	-$72.74	-$303,471
SENECA HOSPITAL	CHESTER	S	845	757	90	1,748	264	-$58.68	-$217,351
EASTERN PLUMAS HEALTH CARE	PORTOLA	S	1,084	1,621	81	2,906	1,015	-$12.19	-$81,758
								Plumas County Total Losses:	**-$602,580**
RIVERSIDE COUNTY									
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	MORENO VALLEY	B	1,117	8,156	17,610	8,571	4,107	-$59.22	-$2,342,802
JOHN F KENNEDY MEMORIAL HOSPITAL	INDIO	B	2,751	5,010	305	16,029	630	-$75.07	-$1,856,106
CORONA REGIONAL MEDICAL CENTER-MAGNOLIA	CORONA		2,954	4,815	180	15,655	4,226	-$55.92	-$1,556,254
INLAND VALLEY REGIONAL MEDICAL CENTER	WILDOMAR	B	2,271	2,918	262	12,532	4,741	-$68.27	-$1,551,367
RIVERSIDE COMMUNITY HOSPITAL	RIVERSIDE	B	2,457	3,350	1,085	17,640	8,778	-$38.77	-$1,291,429
PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER	RIVERSIDE	B	4,405	17,582	236	19,825	9,740	-$23.84	-$1,234,626
EISENHOWER MEMORIAL HOSPITAL	RANCHO MIRAGE	B	11,202	2,268	170	15,001	2,351	-$36.48	-$1,130,588
MENIFEE VALLEY MEDICAL CENTER	SUN CITY	B	2,838	1,792	110	6,863	2,237	-$32.38	-$448,139
SAN GORGONIO MEMORIAL HOSPITAL	BANNING	B	2,558	4,619	525	6,614	2,254	-$24.84	-$411,599
PALO VERDE HOSPITAL	BLYTHE	S	2,337	1,522	168	2,671	1,568	-$13.23	-$109,359
RANCHO SPRINGS MEDICAL CENTER	MURRIETA	B	863	756	35	5,826	748	-$9.61	-$79,071
								Riverside County Total Losses:	**-$12,011,340**
SACRAMENTO COUNTY									
KAISER FOUNDATION HOSPITAL - SACRAMENTO	SACRAMENTO	B	1,682	104		9,103		-$309.80	-$3,373,412
KAISER FOUNDATION HOSPITAL SOUTH SACRAMENTO	SACRAMENTO		24	101		4,378		-$282.61	-$1,272,593
MERCY HOSPITAL - FOLSOM	FOLSOM	B	1,803	1,291	48	10,164	636	-$37.88	-$528,123

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
SUTTER MEMORIAL HOSPITAL	SACRAMENTO	B	2,709	4,328	237	9,054	794	-$26.74	-$457,842
MERCY GENERAL HOSPITAL	SACRAMENTO	B	4,731	4,540	30	13,187	1,439	-$3.26	-$78,002
								Sacramento County Total Losses:	**-$5,709,972**
SAN BENITO COUNTY									
HAZEL HAWKINS MEMORIAL HOSPITAL	HOLLISTER	B	1,530	2,699	210	7,428	2,397	-$11.99	-$171,025
								San Benito County Total Losses:	**-$171,025**
SAN BERNARDINO COUNTY									
LOMA LINDA UNIVERSITY MEDICAL CENTER	LOMA LINDA	B	10,213	15,910	589	42,171	8,440	-$78.84	-$6,096,145
SAN BERNARDINO COUNTY MEDICAL CENTER	SAN BERNARDINO		1,740	10,302	24,244	7,235	2,715	-$57.93	-$2,678,451
ST. BERNARDINE MEDICAL CENTER	SAN BERNARDINO		4,753	7,459		17,048		-$67.14	-$1,964,516
SAN ANTONIO COMMUNITY HOSPITAL	UPLAND	B	7,816	10,142		37,833	13,822	-$23.77	-$1,654,701
CHINO VALLEY MEDICAL CENTER	CHINO	B	2,643	2,511		10,511	2,829	-$74.92	-$1,385,570
REDLANDS COMMUNITY HOSPITAL	REDLANDS	B	3,752	2,830	107	15,145	4,090	-$51.50	-$1,335,086
ST. MARY REGIONAL MEDICAL CENTER	APPLE VALLEY	B	4,714	3,318		13,604	2,928	-$41.53	-$1,020,143
VICTOR VALLEY COMMUNITY HOSPITAL	VICTORVILLE	B	2,273	2,903	47	6,360	3,683	-$59.87	-$913,975
KPC GLOBAL MEDICAL CENTER	MONTCLAIR	B	775	2,079		6,598	2,506	-$59.62	-$712,936
MOUNTAINS COMMUNITY HOSPITAL	LAKE ARROWHEAD	S	559	1,019		3,087	1,312	-$96.91	-$579,231
BEAR VALLEY COMMUNITY HOSPITAL	BIG BEAR LAKE	S	580	1,538		4,400	1,572	-$58.55	-$473,670
COMMUNITY HOSPITAL OF SAN BERNARDINO	SAN BERNARDINO	B	3,952	9,543	184	7,076	4,345	-$17.51	-$439,501
HI-DESERT MEDICAL CENTER	JOSHUA TREE	B	2,174	3,980		3,809	2,209	-$32.40	-$394,373
DESERT VALLEY HOSPITAL	VICTORVILLE	B	2,350	3,890		14,638	4,748	-$1.21	-$31,007
								San Bernardino County Total Losses:	**-$19,679,307**
SAN DIEGO COUNTY									
SCRIPPS MERCY HOSPITAL	SAN DIEGO	B	7,209	7,493	5,464	17,970	7,347	-$64.45	-$2,931,379
UNIVERSITY OF CALIF-SAN DIEGO MEDICAL CENTER	SAN DIEGO	C	7,948	12,816	5,430	13,061	10,176	-$58.02	-$2,867,987
GROSSMONT HOSPITAL	LA MESA	B	13,223	14,325	5,923	44,976	10,418	-$28.84	-$2,562,867
CHILDREN'S HOSPITAL - SAN DIEGO	SAN DIEGO	B	8	9,056		20,117	3,958	-$65.01	-$2,154,366

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SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
TRI-CITY MEDICAL CENTER	OCEANSIDE	B	7,740	6,041	378	29,722	7,215	-$33.90	-$1,732,154
SCRIPPS HOSPITAL - EAST COUNTY	EL CAJON	B	3,127	5,321	1,836	7,942	3,989	-$57.09	-$1,268,254
SHARP CHULA VISTA MEDICAL CENTER	CHULA VISTA	B	4,219	3,559	882	13,060	2,276	-$45.49	-$1,091,578
SCRIPPS MEMORIAL HOSPITAL - ENCINITAS	ENCINITAS	B	3,844	1,166	1,264	12,251	3,716	-$43.73	-$972,599
"VILLA VIEW COMMUNITY HOSPITAL, INC."	SAN DIEGO	B	847	4,118	221	427	2,421	-$101.30	-$813,844
PARADISE VALLEY HOSPITAL	NATIONAL CITY	B	5,230	7,081	2,877	7,828	4,826	-$27.66	-$770,110
SHARP MEMORIAL HOSPITAL	SAN DIEGO	B	6,094	7,594	3,893	35,086	5,702	-$12.73	-$743,037
SHARP CABRILLO HOSPITAL	SAN DIEGO	B	1,702	913	722	5,404	1,601	-$68.29	-$706,255
MISSION BAY HOSPITAL	SAN DIEGO	B	2,206	743		4,866	3,263	-$47.36	-$524,654
FALLBROOK HOSPITAL DISTRICT	FALLBROOK	B	2,103	1,203	21	4,729	1,779	-$48.16	-$473,654
PALOMAR MEDICAL CENTER	ESCONDIDO	B	4,591	4,308	1	17,949	8,257	-$8.40	-$294,890
SHARP MARY BIRCH HOSPITAL FOR WOMEN	SAN DIEGO			646	4	319	20	-$118.57	-$117,266
SHARP CORONADO HOSPITAL AND HEALTHCARE CENTER	CORONADO	B	2,336	501		3,306	868	-$4.56	-$31,970
								San Diego County Total Losses:	**-$20,056,865**

SAN FRANCISCO COUNTY

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
"ST. MARY'S MEDICAL CENTER, SAN FRANCISCO"	SAN FRANCISCO		11,150	3,739		8,370	4,004	-$56.18	-$1,531,635
SAN FRANCISCO GENERAL HOSPITAL	SAN FRANCISCO	C	9,391	19,850	32,125	9,553	421	-$20.24	-$1,443,922
UCSF/MOUNT ZION	SAN FRANCISCO	B	3,545	2,270	2	5,232	1,319	-$115.84	-$1,432,709
CHINESE HOSPITAL	SAN FRANCISCO	S	2,048	609		1,676	476	-$224.05	-$1,077,456
KAISER FOUNDATION HOSPITAL - GEARY S F	SAN FRANCISCO		575	6		3,043		-$248.09	-$899,078
ST. FRANCIS MEMORIAL HOSPITAL	SAN FRANCISCO	B	3,748	2,278		6,827	5,468	-$31.42	-$575,646
MEDICAL CTR AT THE U.C.S.F.	SAN FRANCISCO	B	4,959	3,406	38	10,013	2,613	-$22.69	-$477,148
DAVIES CAMPUS HOSPITAL	SAN FRANCISCO	B	1,262	460		2,317	930	-$78.94	-$392,253
								San Francisco County Total Losses:	**-$7,829,847**

SAN JOAQUIN COUNTY

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
SAN JOAQUIN GENERAL HOSPITAL	FRENCH CAMP	B	4,115	8,230	11,788	8,423	9,283	-$92.45	-$3,868,016
ST. JOSEPH'S MEDICAL CENTER OF STOCKTON	STOCKTON		9,576	9,243	130	10,871	3,569	-$34.28	-$1,144,575
LODI MEMORIAL HOSPITAL	LODI	B	3,690	2,701		4,308	3,641	-$70.78	-$1,014,985
SUTTER TRACY COMMUNITY HOSPITAL	TRACY	B	2,372	2,792		9,283	2,418	-$51.78	-$873,270

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
DOCTORS HOSPITAL OF MANTECA	MANTECA	B	1,656	986	51	8,346	633	-$69.80	-$814,706
ST. DOMINIC'S HOSPITAL	MANTECA	B	1,519	4,166		5,488	3,439	-$12.25	-$178,997
								San Joaquin County Total Losses:	**-$7,894,548**
SAN LUIS OBISPO COUNTY									
FRENCH HOSPITAL	SAN LUIS OBISPO	B	3,046	1,045	69	6,113	518	-$116.85	-$1,260,928
SIERRA VISTA REGIONAL MEDICAL CENTER	SAN LUIS OBISPO		4,622	3,060	262	7,577	855	-$48.52	-$794,564
SAN LUIS OBISPO GENERAL HOSPITAL	SAN LUIS OBISPO	B	912	4,026	1,859	1,265	4,125	-$62.41	-$760,591
TWIN CITIES COMMUNITY HOSPITAL	TEMPLETON	B	5,272	4,734	287	15,603	1,111	-$24.50	-$661,672
ARROYO GRANDE COMMUNITY HOSPITAL	ARROYO GRANDE	B	3,717	3,713	302	7,946	1,979	-$34.89	-$616,053
								San Luis Obispo County Total Losses:	**-$4,093,807**
SAN MATEO COUNTY									
SAN MATEO CO. GENERAL HOSPITAL	SAN MATEO	B	4,319	7,447	6,235	5,411	2,418	-$132.04	-$3,410,593
KAISER FOUNDATION HOSPITAL - SO SAN FRANCISCO	SOUTH SAN	B	473	13		3,013		-$259.26	-$907,151
KAISER FOUNDATION HOSPITAL - REDWOOD CITY	REDWOOD CITY		404	2		2,140		-$189.34	-$482,060
SETON MEDICAL CENTER - COASTSIDE	MOSS BEACH	S	376	3		2,471	543	-$77.67	-$263,534
SEQUOIA HOSPITAL	REDWOOD CITY	B	3,910	276		14,625	2,650	-$0.22	-$4,721
								San Mateo County Total Losses:	**-$5,068,059**
SANTA BARBARA COUNTY									
SANTA BARBARA COTTAGE HOSPITAL	SANTA BARBARA	B	4,575	2,731	296	11,931	5,217	-$35.48	-$878,130
VALLEY COMMUNITY HOSPITAL	SANTA MARIA	B	1,277	1,900		4,627	1,639	-$63.58	-$600,386
ST. FRANCIS MEDICAL CENTER OF SANTA BARBARA	SANTA BARBARA	B	2,078	905	41	3,844	1,696	-$68.05	-$582,780
MARIAN MEDICAL CENTER	SANTA MARIA	B	9,686	5,841	210	7,386	1,370	-$19.91	-$487,656
LOMPOC HEALTHCARE DISTRICT	LOMPOC	B	1,734	4,720		4,018	3,321	-$34.23	-$472,134
SANTA YNEZ VALLEY COTTAGE HOSPITAL	SOLVANG	S	821	225		2,860	711	-$74.45	-$343,736
GOLETA VALLEY COTTAGE HOSPITAL	SANTA BARBARA	B	1,732	665	3	6,379	1,851	-$31.54	-$335,270
								Santa Barbara County Total Losses:	**-$3,700,092**

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
SANTA CLARA COUNTY									
REGIONAL MEDICAL OF SAN JOSE	SAN JOSE	B	8,519	21,668	25	27,353	10,337	-$69.70	-$4,732,769
STANFORD UNIVERSITY HOSPITAL	STANFORD	B	5,696	2,268	2,757	15,033	5,830	-$90.98	-$2,873,512
KAISER FOUNDATION HOSPITAL - SANTA CLARA	SANTA CLARA	B	804	314		4,492		-$420.83	-$2,360,856
GOOD SAMARITAN HOSPITAL	SAN JOSE	B	4,243	1,167		30,915	2,236	-$54.65	-$2,107,359
EL CAMINO HOSPITAL	MOUNTAIN VIEW	B	5,904	2,070		25,252	4,673	-$43.08	-$1,632,689
ST. LOUISE REGIONAL HOSPITAL	GILROY	B	928	1,621		5,583	2,196	-$70.47	-$727,814
SANTA TERESA COMMUNITY HOSPITAL	SAN JOSE	B	489	12		3,355		-$144.95	-$558,927
COMMUNITY HOSPITAL OF LOS GATOS	LOS GATOS	B	2,718	389	5	8,396	490	-$44.05	-$528,512
ST. LOUISE REGIONAL HOSPITAL (GILROY CAMPUS)	GILROY	B	1,979	3,974		7,985	2,732	-$0.99	-$16,503
								Santa Clara County Total Losses:	**-$15,538,942**
SANTA CRUZ COUNTY									
DOMINICAN SANTA CRUZ HOSPITAL/SOQUEL	SANTA CRUZ	B	6,421	1,682	892	20,655	6,660	-$51.77	-$1,879,769
WATSONVILLE COMMUNITY HOSPITAL	WATSONVILLE	B	1,367	535	267	3,320	1,298	-$53.18	-$360,933
								Santa Cruz County Total Losses:	**-$2,240,701**
SHASTA COUNTY									
REDDING MEDICAL CENTER	REDDING	B	8,623	9,406	2,664	9,211	1,308	-$134.84	-$4,208,626
MERCY MEDICAL CENTER	REDDING	B	9,447	13,484	1,909	9,022	9,020	-$29.27	-$1,255,156
								Shasta County Total Losses:	**-$5,463,782**
SIERRA COUNTY									
SIERRA VALLEY DISTRICT HOSPITAL	LOYALTON	S	150	88	6	263	74	-$75.09	-$43,627
								Sierra County Total Losses:	**-$43,627**
SISKIYOU COUNTY									
FAIRCHILD MEDICAL CENTER	YREKA	B	3,101	2,372	262	3,153	1,456	-$74.98	-$775,593
MERCY MEDICAL CENTER MT. SHASTA	MOUNT SHASTA	S	2,055	1,459	300	2,592	743	-$78.86	-$563,770

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
								Siskiyou County Total Losses:	**-$1,339,363**
SOLANO COUNTY									
KAISER FOUNDATION HOSPITAL & REHABILITATION CENTER	VALLEJO	B	1,003	94		6,828		-$345.31	-$2,736,582
SUTTER SOLANO MEDICAL CENTER	VALLEJO	B	3,440	5,219	3,010	6,692	3,104	-$50.78	-$1,089,993
								Solano County Total Losses:	**-$3,826,574**
SONOMA COUNTY									
SUTTER MEDICAL CENTER OF SANTA ROSA	SANTA ROSA	B	2,495	6,280	2,182	4,751	5,439	-$122.83	-$2,597,486
SANTA ROSA MEMORIAL HOSPITAL	SANTA ROSA	B	5,001	4,071	1,514	14,068	3,542	-$79.41	-$2,239,044
PALM DRIVE HOSPITAL	SEBASTOPOL	B	1,904	1,537	358	4,534	1,889	-$70.88	-$724,535
KAISER FOUNDATION HOSPITAL - SANTA ROSA	SANTA ROSA	B	441	223		2,254		-$188.33	-$549,547
SONOMA VALLEY HOSPITAL	SONOMA	B	2,150	1,143	217	3,910	919	-$58.90	-$491,167
WARRACK MEDICAL CENTER HOSPITAL	SANTA ROSA	S	2,428	453		2,042	1,312	-$60.01	-$374,162
								Sonoma County Total Losses:	**-$6,975,942**
STANISLAUS COUNTY									
DOCTORS MEDICAL CENTER	MODESTO	B	6,038	6,736	1,662	28,209	1,591	-$119.28	-$5,276,470
MEMORIAL HOSPITAL MEDICAL CENTER - MODESTO	MODESTO	B	7,329	9,278		27,737	4,340	-$20.65	-$1,005,325
"EMANUEL MEDICAL CENTER, INC"	TURLOCK	B	4,273	12,375		10,423	5,133	-$16.43	-$529,112
OAK VALLEY DISTRICT HOSPITAL (2-RH)	OAKDALE	B	2,261	2,595		4,696	1,920	-$25.06	-$287,488
								Stanislaus County Total Losses:	**-$7,098,395**
TEHAMA COUNTY									
ST. ELIZABETH COMMUNITY HOSPITAL	RED BLUFF	B	7,413	5,343	1,047	5,619	1,900	-$24.81	-$528,999
								Tehama County Total Losses:	**-$528,999**
TRINITY COUNTY									
TRINITY HOSPITAL	WEAVERVILLE	S	1,444	957	116	1,040	577	-$87.32	-$360,981

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
								Trinity County Total Losses:	**-$360,981**
TULARE COUNTY									
SIERRA VIEW DISTRICT HOSPITAL	PORTERVILLE	B	5,452	12,722	494	6,665	7,465	-$35.10	-$1,151,210
KAWEAH DELTA DISTRICT HOSPITAL	VISALIA	B	9,455	17,633	467	17,098	8,272	-$15.49	-$819,808
MEMORIAL HOSPITAL AT EXETER	EXETER	S	856	1,385		683	730	-$220.89	-$807,132
ALTA HOSPITAL DISTRICT	DINUBA	S	1,444	1,867	125	1,020	1,647	-$88.53	-$540,299
LINDSAY DISTRICT HOSPITAL	LINDSAY	B	1,432	3,327	212	1,368	1,081	-$23.28	-$172,738
								Tulare County Total Losses:	**-$3,491,186**
TUOLUMNE COUNTY									
TUOLUMNE GENERAL HOSPITAL	SONORA	B	2,301	3,827	978	2,524	1,989	-$7.71	-$89,582
								Tuolumne County Total Losses:	**-$89,582**
VENTURA COUNTY									
COMMUNITY MEMORIAL HOSPITAL-SAN BUENAVENTURA	VENTURA		6,893	2,116		12,918	4,152	-$47.50	-$1,238,753
OJAI VALLEY COMMUNITY HOSPITAL	OJAI	S	918	861		3,669	908	-$102.63	-$652,316
SIMI VALLEY HOSPITAL & HEALTH CARE SERVICES-SYCAMO	SIMI VALLEY	B	2,401	1,691		11,302	3,617	-$19.02	-$361,589
ST. JOHN'S PLEASANT VALLEY HOSPITAL	CAMARILLO	B	4,036	1,518	11	10,938	1,381	-$5.51	-$98,541
SANTA PAULA MEMORIAL HOSPITAL	SANTA PAULA	B	1,889	2,482		6,207	2,235	-$6.60	-$84,566
								Ventura County Total Losses:	**-$2,435,765**
YOLO COUNTY									
WOODLAND MEMORIAL HOSPITAL	WOODLAND	B	3,044	2,227	145	6,505	2,096	-$43.37	-$607,917
								Yolo County Total Losses:	**-$607,917**
YUBA COUNTY									
RIDEOUT MEMORIAL HOSPITAL	MARYSVILLE	B	6,016	6,899	2,591	7,047	1,715	-$93.43	-$2,267,359

Source: OSHPD Hospital Financial Data Disclosure Report (98-99)

SUMMARY OF HOSPITAL EMERGENCY ROOM UTILIZATION & FINANCIAL CONDITION FOR HOSPITALS REPORTING EMERGENCY ROOM LOSSES (1998-99)

Hospital	Location	ER Type	Medicare Visits	Medi-Cal Visits	County Indigent Visits	Third Party Payor Visits	Uninsured Visits	Average Loss Per Visit	ER Total Annual Loss
								Yuba County Total Losses:	**-$2,267,359**
								Statewide Losses:	-$316,576,503

EXPLANATION OF ER TYPE:

(S)tandby - The provision of emergency medical care in a specifically designated area of the hospital that is equipped and maintained at all times to receive patients with urgent medical problems, and capable of providing physician services within a reasonable time.

(B)asic - The provision of emergency medical care in a specifically designated area of the hospital that is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical problems .

(C)omprehensive - The provision of diagnostic and therapeutic services for unforeseen physical and mental disorders, that if not properly treated, would lead to marked suffering, disability or death. The scope of services is comprehensive, with in-house capability for managing all medical situations on a definitive and continuing basis.