Building a Healthier Saint Louis:

Recommendations for Improving Safety Net Primary and Specialty Care Services in St. Louis City and County

STRATEGIC PLAN
DETAILED DISCUSSION OF RECOMMENDATIONS

October 2003

Detailed Discussion of Recommendations

The following is a detailed discussion of the St. Louis Regional Health Commission (RHC) recommendations for improving the delivery of safety net primary and specialty care services in ten key areas:

- Improving Integration and Care Coordination in the Health Care Safety Net
- Improving the Financing of the Safety Net System
- Improving Availability of Specialty Care Services
- Improving Safety Net Dental Services
- Improving Safety Net Mental Health Services
- Improving Safety Net Pharmacy Services
- Reducing Financial Barriers to Accessing Care for Individuals
- Reducing Cultural and Informational Barriers to Accessing Health Care
- Reducing Cultural and Linguistic Barriers for New Americans
- Improving Health Measurement and Reporting

For the purposes of detailed discussion, the Recommendations will be discussed as follows:

Section I: Recommendations for Improving the Integration and Financing of the Safety Net Health System (page 9)

Because they are highly interrelated, recommendations for improving safety net integration and recommendations for improving the financing of the safety net system are included in the same discussion.

Recommendations for improving integration of the safety net and improving the financing of the safety net include:

1. Current safety net providers form a permanent regional network or umbrella organization to coordinate and integrate the delivery of primary and specialty health services to the uninsured and underinsured populations in Saint Louis County and the City of St. Louis.

2. Non-FQHC providers (Saint Louis ConnectCare and Saint Louis County Clinics) and Federally Qualified providers seek mutually beneficial relationships to ensure that 100% of primary care visits in our region are eligible for Section 330 funds, including cost-based reimbursement for Medicaid and Medicare.

3. Create a regional health district to coordinate and enhance safety net funds flow.

Section II: Recommendations for Improving Safety Net Care Coordination (page 20)

Standardizing patient entry into safety net system

1. Standardize policies and procedures for establishing safety net eligibility, patient co-pays and required documentation
2. Develop a Universal Application form for registration across safety net institutions

Integrating information systems across providers

3. Develop a Master Patient Index across safety net providers
4. Develop an integrated Clinical Data Repository/Electronic Medical Record across safety net institutions

Improving communication and collaborative decision-making among providers

5. Establish a Joint Medical Advisory Committee across safety net institutions
6. Establish quarterly joint Continuing Medical Education conferences for area safety net providers

Assuring continuity of care and ease of using safety net system

7. Assure continuity of care by linking every safety net patient to a specific primary care physician
8. Implement open access scheduling at all safety net sites
9. Implement automated appointment reminder systems across the safety net

Improving information resources

10. Develop a 24x7 safety net information resource line for people in need of medical services
11. Create a community-wide safety net web site listing available resources
12. Create a community-wide safety net printed resource guide
13. Develop and distribute a community-wide safety net provider directory, including provider photos and contact information

Improving after hours care and urgent care

14. Develop a standardized/integrated after-hours nurse triage service across safety net institutions
15. Provide evening “flex hours” at each safety net primary care site at least one day per week
16. Provide Saturday morning “flex hours” at each safety net primary care site at least one weekend per month
17. Implement a marketing campaign to promote use of current safety net Urgent Care sites for urgent medical problems
18. Provide option of free transportation from hospital Emergency Departments to Urgent Care centers for non-emergent patients
19. Conduct analysis of Urgent Care site geographic locations relative to areas of high need and volume of non-emergent visits to Emergency Departments

Section III: Recommendations for Improving Availability of Specialty Care Services (page 40)

1. Enhance employed safety net specialist recruitment and retention by offering more competitive compensation packages
2. Use volunteer specialty physicians as an interim measure to increase availability of specialist appointment slots
3. Indemnify contracted community specialists
4. Establish a task force to streamline the process for specialty care referrals, communication and follow-up
5. Increase Medicaid physician fee schedule

Section IV: Recommendations for Improving Safety Net Dental Services (page 46)

Improving preventive services

1. Partner with existing efforts to recruit and retain safety net dental health professionals, particularly minority dentists and dental hygienists
2. Partner with existing efforts to develop school initiative that encompasses the provision of preventive dental services, the removal of soda and sugary/high calorie snack foods from school vending machines and offering healthy food choices in school cafeterias
3. Increase integration between primary care providers and dental services, including improving compliance with the Federal Medicaid requirement to perform dental screens as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program
4. Explore the feasibility of expanding the use of mobile dental units to provide access to preventive services and education at schools and nursing homes
5. Advocate for the continuation and expansion of dental hygiene services

Improving integration of physical health and oral health systems

6. Include information on safety net dental health services in coordinated safety net marketing and health literacy campaigns
7. Implement a coordinated awareness campaign for policymakers and lawmakers concerning the importance of dental health
8. Implement a coordinated dental education program for medical providers (e.g., school nurses, safety net physicians)
9. Interface oral health records with integrated safety net data repository/electronic medical record
10. Include medical providers, dental providers and pharmacists in the community-wide safety net provider directory

Improving oral health status measurement and reporting

11. Collaborate with the Missouri Department of Health and Senior Services to develop an oral health status database for St. Louis City and County

Section IV, continued: Recommendations for Improving Safety Net Dental Services

Improving financing of safety net dental services

12. Advocate for the preservation of Medicaid dental coverage
13. Advocate for improved Medicaid reimbursement for dental services

Section V: Recommendations for Improving Safety Net Mental Health Services (page 62)

Improving Coordination between Mental Health and Physical Health Systems

1. Partner existing network of Eastern Region mental health providers with safety net umbrella organization and managed care providers to coordinate and integrate the delivery of safety net mental and physical health services
2. Expand implementation of current best practices in integrating mental health services into existing safety net primary care sites
3. Improve the flow of information between outpatient and inpatient mental health service providers, and across the mental and physical health systems
4. Standardize mental health screening tool(s) to be utilized across systems and points of entry
5. Convene area medical school leadership to identity opportunities to improve medical student/resident education regarding mental health care, management and referral
6. Convene area managed care organization leadership to identify opportunities for improving provision of safety net mental health services

Improving information resources and education

7. Hold Continuing Medical Education conferences on mental health and safety net mental health services
8. Include information on safety net mental health services in coordinated safety net marketing and health literacy campaigns
9. Expand current efforts to train police, social workers, health professionals and teachers in mental health crisis intervention

Maximizing funds into the Mental Health System

10. Develop collaborative proposals and grant applications among mental health network, safety net umbrella organization and other providers
11. Explore feasibility of enhancing public funding streams for mental health service delivery

Improving Children's Mental Health Services

12. Advocate for core principles to improve children's mental health services
13. Conduct an analysis on types of mental health services that should be provided to children and youth
14. Develop a program to improve recruitment and retention of safety net mental health providers, particularly for children

Section V, continued: Recommendations for Improving Safety Net Mental Health Services

Improving Access to Corrections Mental Health Services

15. Explore opportunities to improve access to mental health services for those within and discharged from the corrections system

Section VI: Recommendations for Improving Safety Net Pharmacy Services (page 78)

Improving Patient Utilization of Medications and Provider Education

1. Make comprehensive patient counseling and medication monitoring services available at each safety net pharmacy site
2. Hold Continuing Medical Education conferences focused on safety net pharmacy services

Improving coordination of pharmacy services via centralized system

3. Conduct a feasibility analysis on the development of a centralized medication filling service across safety net pharmacies
4. Develop a common formulary across safety net providers
5. Develop a common Pharmacy and Therapeutics Committee across the safety net
6. Implement coordinated group/bulk purchasing for safety net pharmacies
7. Convene providers to conduct a feasibility analysis on the development of a standardized sliding-scale co-payment system across safety net pharmacies

Improving information resources

8. Include patient medication, allergy and drug interaction information in an integrated safety net data repository/electronic medical record
9. Develop an integrated database of consumers who qualify for reduced-fee prescription medication
10. Include pharmacy services information in safety net information resources
11. Conduct a feasibility analysis on the development of a Pharmacy Information Center
12. Pilot a user-friendly database kiosk for consumers at a safety net pharmacy site

Section VII: Recommendations for Reducing Financial Barriers to Care (page 91)

Reducing Medical Debt

1. Develop a standardized uncompensated care policy across outpatient primary and specialty care safety net providers
2. Identify administrative barriers to Medicaid coverage determinations and conduct staff training sessions on Medicaid eligibility and policies
3. Develop a regional ombudsmen program to help safety net consumers access/navigate the system and to assist with key financial counseling issues
4. Safety net providers conduct a standardized review of eligibility for reduced fees and financial counseling prior to reporting uninsured patients with overdue payments to a collection agency

Reducing the Cost of Catastrophic Hospital Care for Patients

5. Convene area hospital leadership with community representatives to develop effective solutions to medical debt, uncompensated care and billing, and to generate other ideas for reducing financial barriers to care within the boundaries of the law

Reducing Lack of Insurance and Barriers to Care

6. Develop a uniform “no turn-away due to inability to pay” policy across outpatient safety net providers
7. Advocate for maintenance and expansion of Medicaid coverage
8. Coordinate with the State of Missouri and existing entities to examine the development of a statewide or local insurance program for low-income uninsured residents

Section VIII: Recommendations for Reducing Cultural and Informational Barriers to Care (page 103)

1. Regularly assess, report and set goals for reducing cultural and racial barriers to safety net care
2. Institute service quality training programs and cultural sensitivity training programs
3. Integrate cross-cultural education into CME sessions for health care professionals
4. Develop a comprehensive coordinated marketing campaign to raise awareness about the safety net system and how to access care
5. Develop a coordinated health literacy program and campaign
6. Develop a minority health professional recruitment and retention program for the primary and specialty care safety net

Section IX: Recommendations for Reducing Cultural and Linguistic Barriers for New Americans (page 110)

Improving implementation of CLAS standards

1. Form a standing committee across safety net providers to improve implementation of CLAS standards
2. Conduct training on CLAS standards for medical professionals, including reception and frontline staff
3. Include compliance with CLAS standards in recommendation to regularly assess, report and set goals for reducing cultural and racial barriers to safety net care

Improving financing of services for new Americans

4. Safety net providers collaborate to secure increased funding (Federal, State and local) to support interpreter services and document translation

Improving patient entry/system navigation

5. Standardize and expand training programs for medical interpreters
6. Develop a system for providing interpreter services for the 24x7 safety net information resource line (RHC July Care Coordination RECOMMENDATION 10)
7. Develop a patient advocate system to assist new Americans in accessing/navigating the safety net health system
8. Develop a training program to assist medical professionals from other countries in entering a medical profession in the St. Louis area
9. Develop and distribute a list of bilingual medical professionals and safety net clinics

Improving information systems

10. Account for new American consumers in developing the Master Patient Index

Improving Recruitment and Retention of Racial and Ethnic Minority Health Providers

11. Include a focus on both racial and ethnic minorities in the minority health professional recruitment and retention program for the safety net

Section X: Recommendations for Improving Measurement and Reporting (page 122)

1. Link health status measurement and reporting to an ongoing change process.
2. Release an annual health report card for St. Louis City and County for select health status and access indicators.
3. Beginning in 2006, release a comprehensive report every three years assessing progress in improving health outcomes, reducing health disparities and improving access to health care.

Section I: Recommendations for Improving the Integration and Financing of the Safety Net Health System

1. Current safety net providers form a permanent regional network or umbrella organization to coordinate and integrate the delivery of primary and specialty health services to the uninsured and underinsured population in Saint Louis County and the City of St. Louis.

2. Non-FQHC providers (Saint Louis ConnectCare and Saint Louis County Clinics) and Federally Qualified providers seek mutually beneficial relationships to ensure that 100% of primary care visits in our region are eligible for Section 330 funds, including cost-based reimbursement for Medicaid and Medicare.

3. Create a regional health district to coordinate and enhance safety net funds flow.

Section I: Recommendations for Improving the Integration and Financing of the Safety Net Health System

After a consideration of safety net models in other communities and the criteria for developing recommendations, the RHC recommends the following for the integration and financing of St. Louis' health care safety net:

1. **Current safety net providers form a permanent regional network or umbrella organization to coordinate and integrate the delivery of primary and specialty health services to the uninsured and underinsured population in Saint Louis County and the City of St. Louis.**

2. **Non-FQHC providers (Saint Louis ConnectCare and Saint Louis County Clinics) and Federally Qualified providers seek mutually beneficial relationships to ensure that 100% of primary care visits in our region are eligible for Section 330 funds, including cost-based reimbursement for Medicaid and Medicare.**

3. **Create a regional health district to coordinate and enhance safety net funds flow.**

Recommendation 1: Create a permanent network or "umbrella organization"

The RHC recommends the creation of a permanent regional network or umbrella organization to coordinate and integrate the delivery of primary and specialty care services to the uninsured and underinsured population in Saint Louis County and the City of St. Louis.

At a minimum, the members of this body would include those organizations that have as their primary mission the delivery of medical care to the safety net population in the St. Louis region, namely:

1) Family Care Health Centers
2) Grace Hill Neighborhood Health Centers
3) Myrtle Hilliard Davis Comprehensive Health Centers
4) People's Health Centers
5) Saint Louis ConnectCare
6) Saint Louis County Health Centers

Governance of the Umbrella or Network Organization

Member organizations would make contractual agreements regarding the roles of member organizations and the function of the umbrella organization. The contractual agreements could include a three year membership to the umbrella organization. The contract would be reviewed and renegotiated prior to the end of the three year period.

Each member organization would appoint one member to the board of the umbrella organization. A majority vote of the board would bind the organization, except in limited instances where a supermajority may be warranted (i.e. dissolution, removal of umbrella CEO).

The two (2) existing RHC Advisory Boards would provide community input and serve an advisory role for the umbrella organization. Each board would have twenty-five (25) members. The Community Advisory Board would consist of community representatives and safety net patients. The Provider Services Advisory Board would consist of representatives from the safety net provider community.

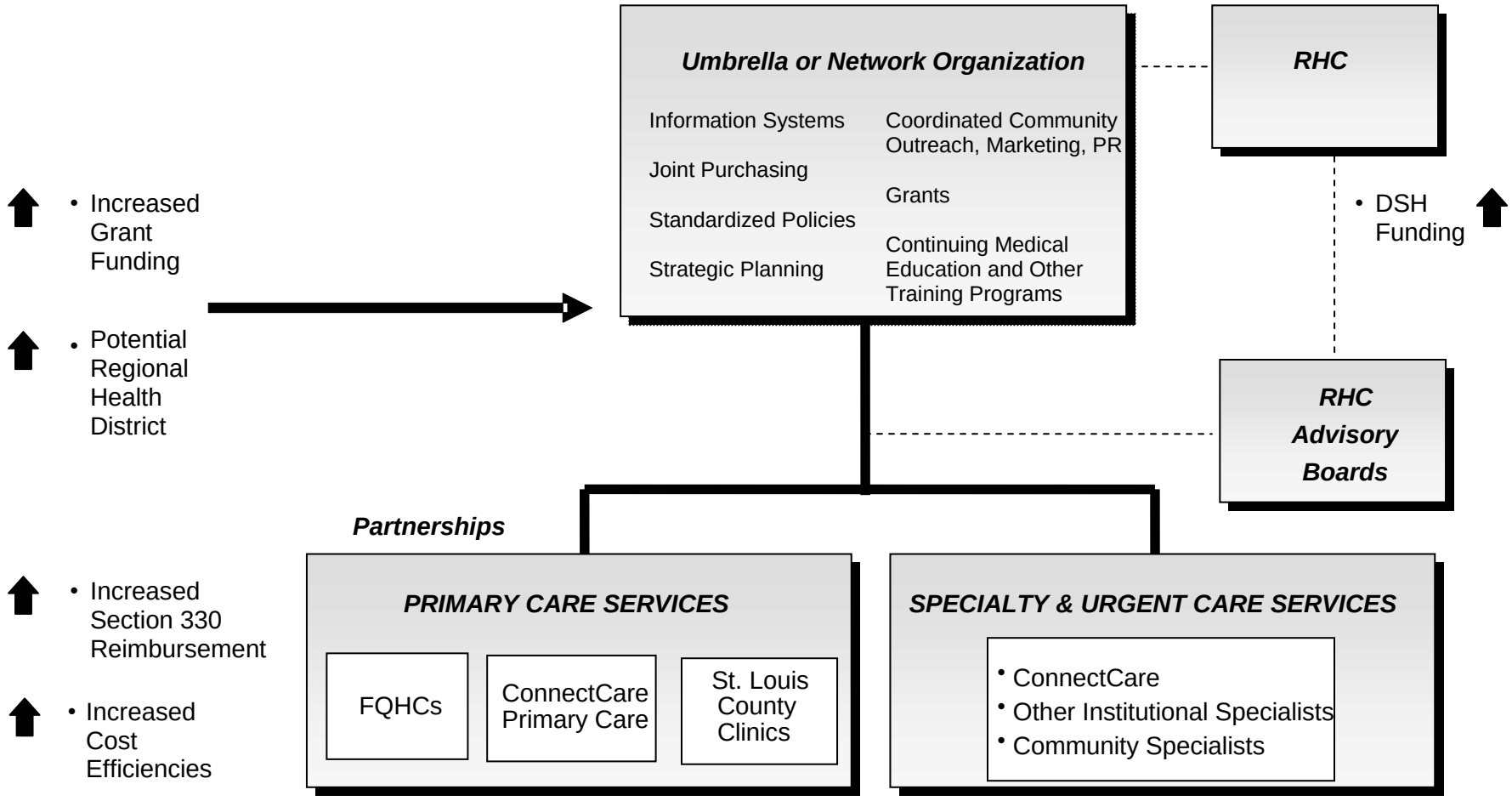
The Advisory Boards would be consulted by the umbrella organization and would support the work of the umbrella organization by:

- Providing direct input to the umbrella organization concerning the work being completed.
- Creating and managing the engagement of the broader community into the work of the umbrella organization.
- Serving as a primary conduit of information from the organization out to the broader community.

Community members and patients would also have a voice by maintaining 51% of the board seats on the Primary Care Services Group (see Organizational Structure diagram below for Primary Care Services Group). In addition, Advisory Board representation on the umbrella organization should be considered and patient representation on the Community Advisory Board should be expanded further.

Organizational Structure

The recommended organizational structure for St. Louis' primary and specialty care safety net is depicted below:



Role of the Umbrella or Network Organization in Relation to the RHC

The roles of the RHC and the umbrella organization would be as follows:

RHC

The RHC would maintain responsibility for strategic direction and broad policies affecting the continuum of health services for St. Louis City and County, particularly as they relate to safety net health care. The RHC's role would include broad policy affecting the interrelationships between:

- Primary and specialty care clinics
- Hospitals
- Medical schools
- Public health departments
- Individual physicians
- Safety net patients

For example the RHC would:

- Serve as the point of contact for DSH waiver dialogue and discussion at the State and Federal levels
- Make recommendations to the Regional DSH Funding Authority (RDFA) as to the distribution of DSH waiver funds
- Develop recommendations around improving the delivery and integration of community health and public health services in St. Louis City and County
- Serve as the voice of the safety net in policy issues, e.g. Medicaid
- Serve as a vehicle for measurement and reporting of health and access outcomes
- Coordinate community health improvement
- Expand funding opportunities for the overall safety net system in St. Louis City and County

Umbrella or Network Organization

The umbrella organization would be responsible for operational issues concerning the integration of the delivery of safety net primary and specialty care services. For example, the umbrella organization would be responsible for the implementation of RHC recommendations such as the creation of uniform policies and procedures across the safety net and the development of a Master Patient Index (MPI). The umbrella organization would also continue to work to improve the coordination and integration of safety net primary and specialty care services beyond the implementation of RHC recommendations.

Services Provided by Umbrella Organization and by Individual Entities

The functions of the umbrella organization would include:

Strengthening quality of care
- Facilitate development of clinical care guidelines, best practices, innovative medical management programs and collaborative clinical decision making
- Establish quality assurance guidelines
- Coordinate service quality and cultural sensitivity training programs
- Coordinate continuing medical education
- Implement 24x7 nurse telephone information line/triage system

Standardizing patient entry into the safety net system
- Develop clinical information system services including master patient index and clinical data repository/EMR
- Implement uniform policies and procedures for establishing safety net eligibility, patient co-pays and required documentation

Coordinating care with other safety net providers
- Contract with area hospitals for inpatient care and certain outpatient diagnostics/therapies (ex: CT, MRI, cardiac catheterization, radiation oncology, etc)
- Contract with area medical schools for tertiary/quaternary professional services (ex: neurosurgery, cardiac surgery, etc)
- Coordinate care with mental health providers and medical schools
- Coordinate care with hospitals, including children's hospitals
- Coordinate with managed care entities

Enhancing funding opportunities
- Secure additional funding to stabilize and expand specialty care
- Pursue funding opportunities and develop grant applications (private foundations, State grants, Federal grants)

Strengthening community outreach and information resources
- Facilitate coordinated community outreach
- Market and raise public awareness of area safety net services

Improving access to care/services
- Coordinate transportation services
- Coordinate translation/interpreter services
- Provide geographically distributed pharmacy operations

Coordinating purchasing
- Supplies
- Pharmaceuticals
- Contracted support & ancillary services (i.e. housekeeping, laboratory)

Facilitating strategic planning for primary and specialty care
- Facilitate coordinated strategic planning for the safety net primary and specialty care system
- Facilitate clinical program development
- Form a Capital Allocations Committee to approve major capital allocations over a certain threshold (ex: site expansion)

Each individual entity would maintain responsibility for the following functions:

- Human resources
  - Primary care physician and support staff recruiting
  - Benefits Management
  - Performance Management
- Legal Services
- Finance
  - Financial Reporting
  - Treasury Functions
  - Patient Accounting
- Facility Management
- Radiology (plain film x-ray)
- Routine primary care laboratory services
- Employing primary care physicians
- Managed care contracting
- Budgeting, exclusive of capital allocations over a certain threshold
- Case management

Financing

The umbrella organization would receive and distribute funds from the following sources:

- Federal, state and local grants (exclusive of Federal grants under 330 legislation)
- Local public funding, if a regional tax district is created

Each individual entity would receive and retain funds from the following sources:

- Patient services (commercial insurance, Medicare, Medicaid, self-pay patients)
- Federal grants under Section 330 legislation

Financial Reporting

The umbrella organization would report combined financial statements for its member organizations. In addition, each separate entity would maintain its own financial statements.

Recommendation 2: Develop partnerships between FQHC and non-FQHC providers

In order to maximize the substantial financial benefit from Section 330 legislation, the Workgroup also recommends that non-FQHC providers (Saint Louis ConnectCare and Saint Louis County Clinics) and Federally Qualified providers seek mutually beneficial relationships to ensure that 100% of primary care visits in our region are eligible for Section 330 funds, including cost-based reimbursement for Medicaid and Medicare.

Recommendation 3: Create a regional health district

Create a regional health district to coordinate and enhance safety net funds flow. The regional health district could potentially include:

- Development of a local insurance product for low-income uninsured families
- Increased opportunity for local, State and Federal grants to support the safety net
- Creation of a tax district

RATIONALE FOR INTEGRATION AND FINANCING RECOMMENDATIONS

Maximizes safety net funding for the St. Louis region

- Maximization of 330 funds through partnerships
- Increased leverage for federal, national, state, and local funds
- Increased leverage for private foundation funding via collective grant applications
- Increased public support for creating a regional health care tax district

Improves health status of safety net patients

- Coordinated strategic planning and community outreach
- Forum established to allow development of clinical care guidelines, innovative medical management programs and collaborative clinical decision making
- Optimized care via real-time access to patient medical record across the safety net
- More financial resources available to provide critical services for the medically underserved

Enables cost efficiencies

- Reduction in the use of unnecessary medical resources via enhanced care coordination and technology enablers (clinical data repository/EMR)
- Shared nurse call line, purchasing, pharmacy operations and vendor contracting arrangements
- Shared administrative functions

Creates a more user-friendly safety net system

- Coordinated marketing of safety net system enhances public awareness of available resources
- Standardized eligibility, documentation and co-pay policies and procedures

IV. TIMELINE

The Workgroup recommends a two-year timeline for the development of an integrated delivery system:

2004

- Create and staff umbrella organization
- Standardize policies and procedures for establishing eligibility, documentation requirements and patient co-pays
- Develop universal registration form across safety net institutions
- Seek joint grant applications
- Begin migration to a master patient index and integrated clinical data repository/electronic medical record
- Implement 24x7 nurse information/telephone triage system
- Implement coordinated marketing of safety net system
- Begin coordinated community outreach efforts
- Evaluate vendor contracts and begin joint purchasing
- Develop and implement quality assurance standards
- Develop and implement education/training programs and protocols (ex: service quality/cultural sensitivity, etc)
- Streamline specialty care consultation/referral/communication process
- Begin joint primary care/specialist development of coordinated clinical care guidelines, best practices and innovative medical management programs
- Begin capital allocation coordination process
- Develop partnerships between FQHC and non-FQHC providers
- Secure additional funding to expand and stabilize specialty care

2005

- Develop an integrated employed or contracted dental group to provide geographically distributed dental care services at neighborhood community health centers
- Coordinate and contract with inpatient facilities and medical schools
- Create a regional health tax district

Section II: Recommendations for Improving Safety Net Care Coordination

Standardizing patient entry into safety net system

1. Standardize policies and procedures for establishing safety net eligibility, patient co-pays and required documentation
2. Develop a Universal Application form for registration across safety net institutions

Integrating information systems across providers

3. Develop a Master Patient Index across safety net providers
4. Develop an integrated Clinical Data Repository/Electronic Medical Record across safety net institutions

Improving communication and collaborative decision-making among providers

5. Establish a Joint Medical Advisory Committee across safety net institutions
6. Establish quarterly joint Continuing Medical Education conferences for area safety net providers

Assuring continuity of care and ease of using safety net system

7. Assure continuity of care by linking every safety net patient to a specific primary care physician
8. Implement open access scheduling at all safety net sites
9. Implement automated appointment reminder systems across the safety net

Improving information resources

10. Develop a 24x7 safety net information resource line for people in need of medical services
11. Create a community-wide safety net web site listing available resources
12. Create a community-wide safety net printed resource guide
13. Develop and distribute a community-wide safety net provider directory, including provider photos and contact information

Improving after hours care and urgent care

14. Develop a standardized/integrated after-hours nurse triage service across safety net institutions
15. Provide evening “flex hours” at each safety net primary care site at least one day per week
16. Provide Saturday morning “flex hours” at each safety net primary care site at least one weekend per month
17. Implement a marketing campaign to promote use of current safety net Urgent Care sites for urgent medical problems
18. Provide option of free transportation from hospital Emergency Departments to Urgent Care centers for non-emergent patients
19. Conduct analysis of Urgent Care site geographic locations relative to areas of high need and volume of non-emergent visits to Emergency Departments

SECTION II – Care Coordination and Access, Standardizing Patient Entry into Safety Net System

RECOMMENDATION 1: Standardize policies and procedures for establishing safety net eligibility, patient co-pays and required documentation

CRITERIA MET: Encourages collaboration across the safety net. Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net services.

TIMEFRAME: Short-term

DESCRIPTION: Create standardized verification and documentation policies and procedures for determining eligibility and co-pay fees schedules across safety net institutions. Develop uniform requirements for proof of income, social security number and immigration status/proof of residency.

RATIONALE/BENEFITS:

- Unifies the verification process and paves the way for a more efficient data collection system (Jesse Tree – Galveston).
- Encourages collaboration between safety net providers (Jesse Tree; Boston Resource Net).
- Contributes to easier navigation of the safety net for both patients and providers.
- Prerequisite step for electronic sharing of patient registration and eligibility data across safety net institutions.

BARRIERS:

- No identified barriers.

IMPLEMENTATION /NEXT STEPS:

- Conduct interviews of safety net institutions to determine current eligibility criteria, required documentation and sliding scale fee schedules.
- Compile data to assess uniformity of currently gathered information.
- Create a task force to design standardized policies and procedures.

SECTION II – Care Coordination and Access, Standardizing Patient Entry into Safety Net System

RECOMMENDATION 2: Develop a Universal Application form for registration across safety net institutions.

CRITERIA MET: Encourages collaboration across the safety net. Enables cost efficiencies. Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net services.

TIMEFRAME: Short-term

DESCRIPTION: Develop a universal form to standardize patient registration processes across safety net institutions. Form will be available in several languages. Can also be utilized by community organizations that provide services or assistance (food pantries, cash assistance, etc.). Fields collected could include such information as name, residence, social security number, income and expenses.

RATIONALE/BENEFITS:

- Unifies the application process and paves the way for a more efficient data collection system (Jesse Tree – Galveston).
- Encourages collaboration between safety net providers (Jesse Tree; Boston Resource Net).

BARRIERS:

- Potentially affects current provider information systems.

IMPLEMENTATION /NEXT STEPS:

- Conduct interviews of safety net institutions to determine registration forms and processes.
- Conduct interviews of community organizations to determine information required for determination of service eligibility.
- Compile data to assess uniformity in information gathered.
- Create task force to build Universal Application form.

SECTION II – Care Coordination and Access, Integrating Information Systems Across Providers

RECOMMENDATION 3: Develop a Master Patient Index across safety net providers

CRITERIA MET: Creates a more user-friendly safety net system. Enables cost efficiencies. Encourages collaboration across the safety net. Improves quality of care and services delivered

TIMEFRAME: Long-term

DESCRIPTION: Development of a Master Patient Index/Clinical Data Repository (MPI) across all safety net providers to allow tracking of patients within the safety net. Each safety net patient will be given an identification card containing information such as a unique ID number, name of primary care provider and primary care provider contact information. MPI will house in electronic form demographic, encounter, pharmacy and lab data for safety net patients.

RATIONALE/BENEFITS:

- Ensures continuity of care through comprehensive medical information that is accessible at all safety net institutions (Indigent Care Collaboration; Citizens' Council on Health Care).
- Decreases paperwork for providers by maintaining information electronically (Indigent Care Collaboration; Citizens' Council on Health Care).
- Eliminates unnecessary tests/services in that providers are able to review a patient's information to determine what procedures or tests have been conducted (Indigent Care Collaboration; Citizens' Council on Health Care).
- Provides a comprehensive resource for safety net patient information that will aid in budgeting and planning processes (Indigent Care Collaboration).
- Provides accurate and timely information specific to each safety net patient (Golob, R. & Quinn, J. "America's Best Networked Organizations." *Healthcare Informatics* 11, no. 11 (1994): 84).
- Provides safety net providers with realistic unduplicated counts of uninsured patients (Indigent Care Collaboration).

BARRIERS:

- Development and implementation costs and ongoing funding.
- Determining best entity to house and administer the MPI – maintenance, etc.
- Variations in current information systems, data capture and institutional goals and objectives of safety net providers may produce technological hurdles (Golob & Quinn).
- Determining standard process for identifying patients.

IMPLEMENTATION /NEXT STEPS:

- Assess technical feasibility.
- Determine implementation costs.
- Pursue funding sources.

SECTION II – Care Coordination and Access, Integrating Information Systems Across Providers

RECOMMENDATION 4: Develop an integrated Clinical Data Repository/Electronic Medical Record across safety net institutions

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of safety net services. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Enables cost efficiencies. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION:
Develop an integrated clinical data repository/electronic medical record across safety net providers. Provides clinicians with immediate access to patient medical information (including medical history, physical exam findings, comprehensive list of current medical problems and medications, recent treatments, results of diagnostic tests, hospital discharge summaries and emergency room visits). System can also incorporate clinical guidelines and care protocols and track compliance and clinical outcomes.

RATIONALE/BENEFITS:
- Provides treating physician real-time information to assess the patient's medical condition and optimize clinical care
- Reduces risk of medication errors and adverse drug reactions
- Lowers medical costs by eliminating the need for redundant diagnostic studies and assuring compliance with drug formularies
- Enhances physician productivity and communication across safety net providers
- Enhances staff productivity (eliminates phone calls, chart pulls and need to manually copy and send medical records, etc)
- Improves clinical outcomes by tracking compliance with clinical care protocols and the results of clinically important metrics

BARRIERS:
- Need to integrate existing clinical information systems across safety net institutions
- Requires funding.

IMPLEMENTATION /NEXT STEPS:
- Determine interest of safety net institution leadership in building the capability to share patient medical record information electronically
- Assess current information technology capabilities of each safety net institution and develop a plan for seamless communication across these systems
- Secure funding.

SECTION II – Care Coordination and Access, Improving Communication and Collaborative Decision-Making Among Providers

RECOMMENDATION 5: Establish a Joint Medical Advisory Committee across safety net institutions

CRITERIA MET: Encourages collaboration among safety net providers.
Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Enables cost efficiencies.

TIMEFRAME: Immediate

DESCRIPTION: Establish a Joint Medical Advisory Committee composed of medical directors and case managers from area safety net institutions. The Joint Medical Advisory Committee would meet 4 to 6 times per year and focus on operational issues and opportunities to enhance cooperation and coordination of care.

RATIONALE/BENEFITS:

- Creates a forum for regular communication and collaboration among safety net medical leadership
- Improves knowledge-base within safety net institutions
- Fosters rapid problem solving for care coordination issues across safety net institutions.
- Allows for coordination and standardization of policies and procedures
- Improved clinical practice based on adoption of leading practice behaviors

BARRIERS:

- Existing time constraints on safety net medical leadership

IMPLEMENTATION /NEXT STEPS:

- Determine interest of safety net institutions in creating a Joint Medical Advisory Committee
- Determine sponsorship and organizational responsibility for establishing agendas, scheduling meetings, etc.
- Call first meeting

SECTION II – Care Coordination and Access, Improving Communication and Collaborative Decision-Making Among Providers

RECOMMENDATION 6: Establish quarterly joint Continuing Medical Education conferences for area safety net providers

CRITERIA MET: Encourages collaboration among safety net providers. Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Enables cost efficiencies.

TIMEFRAME: Immediate

DESCRIPTION: Hold quarterly continuing medical education conferences with area safety net providers invited, including physicians, nurses and pharmacists. Conferences would encompass a variety of topics including prevention and wellness strategies, evidence-based approaches to improving clinical outcomes, new medical therapies and technologies, care coordination for patients with chronic illnesses, public health, etc.

RATIONALE/BENEFITS:

- Fosters communication and collaboration among front-line safety net caregivers
- Imparts new knowledge that will enhance the quality of care provided to safety net patients

BARRIERS:

- Existing time constraints on participating safety net providers

IMPLEMENTATION /NEXT STEPS:

- Determine interest of safety net providers in establishing this CME forum
- Determine sponsorship and responsibility for organizing and publicizing conferences
- Develop and publicize CME conference schedule

SECTION II – Care Coordination and Access, Assuring Continuity of Care and Ease of Using Safety Net System

RECOMMENDATION 7: Assure continuity of care by linking every safety net patient to a specific primary care physician

CRITERIA MET: Improves health status of safety net patients. Creates a more user-friendly safety net system. Enables cost-efficiencies.

TIMEFRAME: Immediate

DESCRIPTION: Each safety net patient chooses or is assigned a primary care physician, enabling patients to receive ongoing care through a "medical home."

RATIONALE/BENEFITS:

- Improves continuity of care by promoting sustained relationships between physicians and patients (Grumbach and Bodenheimer).
- Reduces non-emergent use of Emergency Departments (District of Columbia Department of Health, Health Care Safety Net Admin.).
- "Promoting a stable physician-patient relationship can improve patients' timely receipt of preventive health care. For certain preventive services, having a regular doctor is more effective than having a regular site" (Sarver JH, Cydulka RK, Barker DW).
- Research indicates that "most people in the United States desire a primary care home to provide for and coordinate their health care needs" (Grumbach and Bodenheimer).

BARRIERS:

- May be increased administrative burden to link patients to a single physician.
- Need to develop means to allocate patients to physicians appropriately and equitably.

IMPLEMENTATION /NEXT STEPS:

- Assess current processes and procedures for physician linkage.
- Develop process for linkage patients to physicians.
- Link current patients to a primary care physician.

SECTION II – Care Coordination and Access, Assuring Continuity of Care and Ease of Using Safety Net System

RECOMMENDATION 8: Implement open access scheduling at all safety net sites

CRITERIA MET: Creates more user-friendly safety net system. Assures timely delivery of medical services. Improves access/reduces barriers to safety net services.

TIMEFRAME: Immediate (3-6 months)

DESCRIPTION: Open access, also known as advanced access or same-day scheduling, is designed to eliminate wait times for primary care appointments. Under this model, patients calling to see their physician are offered an appointment the same day. The model sorts demand by clinician, not by clinical urgency. Each clinician manages on a daily basis his or her own patients' demands for office care.

RATIONALE/BENEFITS:

- Reduces wait times in primary care by doing "today's work today." (JAMA, Murray and Berwick) The RHC Situational Analysis indicates current wait times for safety net primary care appointments are between 14 days and one month.
- Improves continuity of care by enabling patients to see their assigned primary care physician. This is possible because all physicians have appointment slots available each day they work (JAMA, Murray and Berwick).
- May reduce use of Emergency Departments for non-emergent conditions. The RHC Situational Analysis indicates that 37% of ED visits were for non-emergent conditions in CY2001.
- Saves staff time by reducing non-care processes of decision-making, triage and scheduling.
- Reduces the "no-show" rate (currently 10-15% of scheduled appointments).
- In an RHC survey of safety net providers, xx% indicated that they currently use open access scheduling and xx% indicated they would be supportive of implementing open access scheduling.

BARRIERS:

- Open access is not possible if patient demand for appointments is permanently greater than physician capacity to offer appointments. However, open access can still work well if demand exceeds capacity on a given day. The RHC Situational Analysis indicates that demand for safety net primary care appointments in St. Louis City and County does not exceed supply.
- Many primary care physicians do not work everyday. A patient calling to request an appointment with a physician not present that day should be given the choice of seeing another physician that day or scheduling an appointment for another day. (JAMA, Murray and Berwick)
- In order to implement open access, providers must first eliminate their backlog of patients.
- It is sometimes difficult for patients to arrange same-day transportation through MC+ plans.

IMPLEMENTATION /NEXT STEPS:

- Determine willingness of safety net institutions to explore feasibility of open access scheduling.
- Engage a consultant to facilitate implementation at interested safety net institutions.

SECTION II – Care Coordination and Access, Assuring Continuity of Care and Ease of Using Safety Net System

RECOMMENDATION 9: Implement automated appointment reminder systems across the safety net

CRITERIA MET: Assures timely delivery of safety net services. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Enables cost efficiencies. Encourages collaboration among safety net providers.

TIMEFRAME: Short term (requires funding)

DESCRIPTION: Automated call system is programmed to phone patients three days in advance to remind them of scheduled appointments. Recorded message reminds the patient to keep their appointment and asks them to confirm or cancel by touching certain keys on the phone. Patients are also given information on how to reschedule an appointment if they are unable to keep their scheduled visit. Some systems allow automatic deletion of canceled visits from the scheduling database and send the clinic a daily listing of confirmations, cancellations and appointments that need to be rescheduled. May be implemented with consolidated safety net scheduling system, but not necessary.

RATIONALE/BENEFITS:

- Reduces the no-show rate at clinics that do not already make reminder calls. Washington University has seen an 8 to 10 percent decrease in no-shows at clinical sites that had not already had a reminder system in place since implementing an automated appointment reminder system two years ago.
- Enables cost efficiencies by not using a staff person to make reminder calls.
- Opens up appointment slots that otherwise would not have been filled to unanticipated “no shows”

BARRIERS:

- Requires funding but positive ROI. Clinics are charged an initial installation fee and a fee per successful call.

IMPLEMENTATION /NEXT STEPS:

- Determine current appointment reminder practices at safety net institutions and determine potential ROI from implementing an automated reminder system

SECTION II – Care Coordination and Access, Improving Information Resources

RECOMMENDATION 10: Develop a 24x7 safety net information resource line for people in need of medical services

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term (requiring funding)

DESCRIPTION:
A telephone help-line providing people in need of safety net medical care, health resources or human services with information on accessing available services. Could be developed as an informational component of the after-hours telephone triage (See Recommendation 10). Draws on the information provided in the community-wide safety net web site (See Recommendation 11). Interpreter services are available for non-English speaking callers.

RATIONALE/BENEFITS:
- Provides a comprehensive resource for health and human service information.
- Accessible to anyone with a telephone. Does not require literacy or computer skills.
- Provides accurate and timely information specific to a user's request.

BARRIERS:
- Complexity of implementation given number of service providers.
- Determining the best entity to house and administer of the information resource line – staffing, etc.
- Information resource line staff must be updated regularly on changes in providers, hours of operation, policies, etc.
- Funding.

IMPLEMENTATION /NEXT STEPS:
- Identify a partner(s) for collaboration in the development and staffing of the information resource line. (Ex: United Way)
- Determine cost and identify funding source.

SECTION II – Care Coordination and Access, Improving Information and Resources

RECOMMENDATION 11: Create a community-wide safety net web site listing available resources

CRITERIA MET: Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net services. Encourages collaboration across the safety net.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Development of a community-wide safety net web site listing available resources. Provides information such as location, programs and hours for health and human service organizations. A user may search by type of organization, service provided, language spoken and/or location or may also search for an agency by alphabetical listing or by key word. Agencies are able to update their information online or through the organization coordinating/maintaining the web site. Offers information on obtaining assistance from a wide variety of local, state and federal programs (e.g., Meals on Wheels, school breakfast and lunch programs, food stamps). Comprehensive website allows for an easily printed document that may be distributed biannually to schools, social service agencies, churches and other organizations. Could be utilized by safety net information resource line (See Section II, Recommendation 10).

RATIONALE/BENEFITS:

- Could allow program participants to fill out a Universal Application form to receive services at community organizations. (Jesse Tree – Galveston) (See Section II, Recommendation II)
- Provides safety net providers and patients with a comprehensive resource for health and human service information. (Jesse Tree – Galveston; Boston Resource Net; Worcester Resources - Massachusetts)
- Reaches a wide audience because information is available at any hour. (Boston Resource Net)
- Provides accurate and timely information specific to a user's request/search. (Boston Resource Net; Worcester Resources – Massachusetts)
- Details documentation required to receive assistance from federal, state and local programs. (Jesse Tree – Galveston; Boston Resource Net; Worcester Resources – Massachusetts)
- Allows for a comprehensive printed document for those who are unable to access the internet. (Boston Resource Net)
- Encourages collaboration between medical care providers, social service agencies and other organizations. (Jesse Tree – Galveston; Boston Resource Net)

BARRIERS:

- Funding
- Complexity of implementation given number of service providers.
- Determining the best entity to house and administer the web site – maintenance, etc.
- "Digital Divide" – low-income people do not necessarily have access to or knowledge of the internet. (Worcester Resources)

IMPLEMENTATION /NEXT STEPS:

- Identify a partner(s) for collaboration in the development and maintenance of a web site. (Ex: United Way Community Service Directory)
- Determine cost and funding source

SECTION II – Care Coordination and Access, Improving Information Resources

RECOMMENDATION 12: Create a community-wide safety net printed resource guide

CRITERIA MET: Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net services. Encourages collaboration across the safety net.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Development of a community-wide printed resource guide listing available resources. Provides information such as location, programs and hours for health and human service organizations. Agencies are able to update their information online through community resource web site (See Section II Recommendation 11) or through the organization coordinating/maintaining the guide or web site. Offers information on obtaining assistance from a wide variety of local, state and federal programs (e.g., Meals on Wheels, school breakfast and lunch programs, and food stamps). May be distributed biannually to schools, social service agencies, churches and other organizations. Could be utilized by safety net information resource line (See Section II Recommendation 10).

RATIONALE/BENEFITS:

- Provides safety net patients and providers with a comprehensive resource for health and human service information. (Jesse Tree – Galveston; Boston Resource Net; Worcester Resources - Massachusetts)
- Can be used by safety net patients who do not have computer access.
- Details documentation required to receive assistance from federal, state and local programs. (Jesse Tree – Galveston; Boston Resource Net; Worcester Resources – Massachusetts)
- Encourages collaboration between medical care providers, social service agencies and other organizations. (Jesse Tree – Galveston; Boston Resource Net)

BARRIERS:

- Complexity of implementation given number of service providers.
- Determining the “owner” of the resource guide.
- Funding.
- Driving usage patterns once built.

IMPLEMENTATION /NEXT STEPS:

- Identify a partner(s) for collaboration in the development and maintenance of the resource guide.
- Determine cost and identify funding source.

SECTION II – Care Coordination and Access, Improving Information Resources

RECOMMENDATION 13: Develop and distribute a community-wide safety net provider directory including provider photos and contact information

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION:
A printed directory of safety net providers, including photos and contact information. Could also be included as a component of the community-wide safety net resource guide or web site (See Section II Initial Recs. 11 and 12).

RATIONALE/BENEFITS:

- Provides a comprehensive listing of safety net providers for patients and providers.
- Helps patients and providers associate names with faces.
- May encourage collaboration in the provider community.

BARRIERS:

- Complexity of implementation given number of service providers.
- Determining the “owner” of the directory.
- Ongoing maintenance of the directory, give frequent changes in provider status.
- Funding.

IMPLEMENTATION /NEXT STEPS:

- Identify a partner(s) for collaboration in the development of the directory.
- Determine cost and identify funding sources.

SECTION II – Care Coordination and Access, Improving After Hours Care and Urgent Care

RECOMMENDATION 14: Develop a standardized/integrated after-hours nurse triage service across safety net institutions

CRITERIA MET: Enables cost efficiencies. Assures timely delivery of medical services. Improves health status of safety net patients. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION:
Patients calling safety net clinics after hours are guided to settings of care by triage program staffed by registered nurses. Depending on patients' descriptions of symptoms, the triage nurses may schedule a doctor's appointment or refer the patient to an after-hours clinic, urgent care center, or Emergency Department. Nurses also give patients the option of scheduling a primary care appointment for the next day as appropriate during the call. Callers in need of information regarding health resources are informed of area providers, clinic hours of operation, and eligibility/documentation requirements for reduced fees. Interpreter services or bilingual nurses are available for non-English speaking callers.

RATIONALE/BENEFITS:
- Reduces non-emergent use of Emergency Departments (AMA H-130.945 Overcrowding and Hospital EMS Diversion).
- Serves as an information resource for patients outside of normal business hours.
- Helps link patients to primary care providers.
- Reduces language barriers for new Americans in need of safety net services.
- Integration enables:
    - Cost-efficiencies through single-vendor contracting.
    - Consistent, user-friendly process for consumers.

BARRIERS:
- Initial implementation costs associated with moving to a standardized/integrated system.
- Requires clinics to have the ability to offer next day primary care appointments.

IMPLEMENTATION /NEXT STEPS:
- Determine interest of safety net institutions in standardizing/integrating current after-hours telephone services.
- Design standardized/integrated after hours triage model.
- Determine cost and identify funding.
- Consider outsourcing telephone triage to a company specializing in this service.
- Options for funding.

SECTION II – Care Coordination and Access, Improving After Hours Care and Urgent Care

RECOMMENDATION 15: Provide evening "flex hours" at each safety net primary care site at least one day per week

CRITERIA MET: Creates more user-friendly safety net system. Assures timely delivery of medical services. Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Enables cost efficiencies.

TIMEFRAME: Short-term

DESCRIPTION: Each safety net primary care site offers care until 9:00 p.m. at least one day per week. Primary care sites offer evening care on different days from one another, in order to cover most days of the week with evening hours. On the day with evening hours, the primary care site opens later (e.g. 11 a.m.) in order to limit associated costs.

RATIONALE/BENEFITS:

- Community members at RHC Townhalls and City of St. Louis focus groups identified a lack of after-hours care as a barrier to accessing care.
- Evening "flex hours" enable patients to see a primary care physician outside of normal work/school hours.
- Increases the use of regular preventive primary care resources by community.
- May reduce strain on hospital Emergency Departments.

BARRIERS:

- Evening hours may be underutilized by patients, particularly when first implemented.

IMPLEMENTATION /NEXT STEPS:

- Umbrella organization surveys current primary care patients to determine days of the week most in need of after-hours care at each site.
- Members of umbrella organization determine which sites will offer evening care on which days.
- Include information regarding after-hours care in safety net marketing campaign (See Section IV Initial Rec. 4). Primary care sites inform their patients of new extended hours.

SECTION II – Care Coordination and Access, Improving After Hours Care and Urgent Care

RECOMMENDATION 16 – Provide Saturday morning "flex hours" at each safety net primary care site at least one weekend per month

CRITERIA MET: Creates more user-friendly safety net system. Assures timely delivery of medical services. Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Enables cost efficiencies.

TIMEFRAME: Short-term

DESCRIPTION: Each safety net primary care site offers care from 9:00 a.m. to noon at least one Saturday per month. Primary care sites offer Saturday hours on different weekends from one another, in order to cover most Saturdays with morning hours. On the weeks with Saturday hours, the site offers several fewer hours of weekday daytime care in order to limit associated costs.

RATIONALE/BENEFITS:

- Community members at RHC Townhalls and City of St. Louis focus groups identified a need for extended hours of care.
- Saturday "flex hours" enable patients to see a primary care physician outside of normal work/school hours.
- Increases the use of regular preventive primary care resources by community.
- May reduce strain on hospital Emergency Departments.

BARRIERS:

- Saturday hours may be underutilized by patients, particularly when first implemented.

IMPLEMENTATION /NEXT STEPS:

- Members of umbrella organization determine which sites will offer care on which Saturdays.
- Include information regarding after-hours care in safety net marketing campaign (See Section IV Initial Rec. 4). Primary care sites inform their patients of new extended hours.
- Consider the use of volunteer medical students to help staff after-hours care.

SECTION II – Care Coordination and Access, Improving After Hours Care and Urgent Care

RECOMMENDATION 17: Implement marketing campaign to promote use of current safety net Urgent Care sites for urgent medical problems

CRITERIA MET: Improves access/reduces barriers to safety net services. Enables cost efficiencies. Improves health status of safety net patients. Creates more user-friendly safety net system. Assures timely delivery of medical services.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Implement marketing campaign to promote the use of current safety net Urgent Care sites for urgent medical problems. Emergency Departments and primary care sites provide information on Urgent Care facilities to patients.

RATIONALE/BENEFITS:

- May enable cost efficiencies by reducing non-emergent use of hospital Emergency Departments.
- Offers more efficient care for non-emergent patients.
- Current safety net Urgent Care sites have capacity to accommodate increased utilization.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Implement in conjunction with safety net marketing campaign (See Section IV Initial Rec. 4).
- Secure funding.

SECTION – II Care Coordination and Access, Improving After Hours Care and Urgent Care

RECOMMENDATION 18: Provide option of free transportation from hospital Emergency Departments to Urgent Care centers for non-emergent patients

CRITERIA MET: Assures timely delivery of medical services. Improves access/reduces barriers to safety net services. Enables cost efficiencies. Encourages collaboration among safety net providers. Improves health status of safety net patients.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Provide option of free transportation from hospital Emergency Departments to Urgent Care sites for ED patients triaged as non-emergent. ED staff informs non-emergent patients of benefits of visiting the Urgent Care center, including likelihood of reduced wait times and lower cost of care.

RATIONALE/BENEFITS:

- May enable cost efficiencies by reducing non-emergent use of hospital Emergency Departments. May encourage urgent (but non-emergent) patients to visit an Urgent Care site rather than a hospital Emergency Department in the future.
- Offers more efficient care for non-emergent patients.
- Current safety net Urgent Care sites have capacity to accommodate increased utilization.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Consider transportation options.
- Secure funding.

SECTION II – Care Coordination and Access, Improving After Hours Care and Urgent Care

RECOMMENDATION 19: Conduct analysis of Urgent Care site geographic locations relative to areas of high need and volume of non-emergent visits to Emergency Departments

CRITERIA MET: Creates more user-friendly safety net system. Assures timely delivery of medical services. Improves access/reduces barriers to safety net services. Enables cost efficiencies. Encourages collaboration among safety net providers. Improves health status of safety net patients.

TIMEFRAME: Short-term

DESCRIPTION: Conduct analysis of Urgent Care site geographic locations relative to areas of high need and volume of non-emergent visits to hospital Emergency Departments. If there is future need for additional UC sites, consider locating them in areas of high need not currently served by UCs or near EDs with high volumes of non-emergent visits.

RATIONALE/BENEFITS:

- Helps determine if there is a need for additional Urgent Care sites.
- Helps determine optimal location for additional Urgent Care site, if another site is warranted.
- May enable cost efficiencies by reducing non-emergent use of hospital Emergency Departments.
- Offers more efficient care for non-emergent patients.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Conduct analysis.

Section III: Recommendations for Improving Availability of Specialty Care Services

1. Enhance employed safety net specialist recruitment and retention by offering more competitive compensation packages
2. Use volunteer specialty physicians as an interim measure to increase availability of specialist appointment slots
3. Indemnify contracted community specialists
4. Establish a task force to streamline the process for specialty care referrals, communication and follow-up
5. Increase Medicaid physician fee schedule

SECTION III – Specialty Care

RECOMMENDATION 1: Enhance employed safety net specialist recruitment and retention by offering more competitive compensation packages

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Assures timely delivery of medical services.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Provide more competitive compensation packages to specialists employed by safety net organizations for services of high shortage.

RATIONALE/BENEFITS:

- May increase number of specialists available to care for safety net patients, which would reduce the excessive wait times for specialty care in the St. Louis market.

BARRIERS:

- Identifying ongoing funding stream for such payments.
- Managing physician productivity to ensure adequate return on investment.

IMPLEMENTATION /NEXT STEPS:

- Determine volume backlog in key specialty areas.
- Determine number of physician FTEs required to service backlog.
- Model gap in existing compensation package vs. average compensation package (MGMA data) vs. premium compensation package.
- Determine cost of expanding employed specialist model to meet current demand for specialty services.

Determine funding streams to provide competitive package on an ongoing basis.

SECTION III – Specialty Care

RECOMMENDATION 2: Use volunteer specialty physicians as an interim measure to increase availability of specialist appointment slots.

CRITERIA MET: Assures timely delivery of medical services. Improves health status of safety net patients. Creates a more user-friendly safety net system.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Increasing availability of specialist appointment slots by utilizing indemnified volunteer physicians. The use of volunteer physicians is an interim strategy in specialties with a critical shortage of providers until a long-term solution is implemented. Providers are asked to make a commitment to a certain number of patients per month. Allows physicians to donate care either within their office or at a safety net clinic. Clinics can be held day or evening, weekday or weekend, etc. Having patients receive services at the physicians' offices allows for non-stigmatizing care and provides access to usual services of physicians. It is also more cost efficient due to different specialty needs and specific equipment. Examine use of retired physicians as volunteer corps in community (St. Charles Salvation Army Clinic)

RATIONALE/BENEFITS:

- The flow of patients is under control of volunteer physician and it is spread among a variety of providers to avoid overburdening one physician or provider.

BARRIERS:

- Recruitment: physician fear s/he will be inundated with patients who need care and cannot afford to pay for it (Project Access – Wichita/Sedgwick County, Kansas; We Care Network – Tallahassee, FL).
- May be difficult to recruit physicians due to professional liability concerns.
- Level of physician commitment varies (Project Access – Wichita/Sedgwick County, Kansas).
- High "No show" rates reduce physician willingness to donate their time.
- Due to geographic distances, transportation may be a barrier for safety net patients receiving care in a community physician's office.

IMPLEMENTATION /NEXT STEPS:

- Determine key specialty areas for initial focus.
- Develop program/process/procedures for building and maintaining "volunteer corps".
- Recruit physicians to volunteer at least 4 hours per month.

SECTION – III Specialty Care

RECOMMENDATION 3: Indemnify contracted community specialists.

CRITERIA MET: Assures timely delivery of medical services. Improves health status of safety net patients. Enables cost efficiencies. Improves access/reduces barriers to safety net services.

TIMEFRAME: Short-term (may require incremental funding)

DESCRIPTION: Provide organizational indemnification of contracted community physicians willing to serve safety net patients. Options include offering liability coverage through existing organizations (i.e. ConnectCare), or utilizing/revising existing Missouri "Good Samaritan" statutes to encourage greater physician participation in service provision.

RATIONALE/BENEFITS:

- Reduces concern that "many community specialists fear that caring for uninsured or Medicaid patients will adversely affect their professional liability insurance premiums" (Building a Healthier St. Louis, St. Louis Regional Health Commission, 2003).
- May increase number of specialists willing to care for safety net patients, which would reduce the excessive wait times for specialty care in the St. Louis market.

BARRIERS:

- Overcoming perception of physicians concerning the cost of professional liability insurance premiums due to serving the safety net population.

IMPLEMENTATION /NEXT STEPS:

- Examine current statues to determine potential means to extend indemnification to community physicians (i.e. Missouri "Good Samaritan" statute for retired physicians).
- Collect data regarding the prevalence of malpractice claims among safety net and privately insured patients.
- Develop program to educate physicians about ability of existing organizations to offer coverage under organizational insurance policies.

SECTION III – Specialty Care

RECOMMENDATION 4: Establish a task force to streamline the process for specialty care referrals, communication and follow-up

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Immediate

DESCRIPTION: Establish a task force with representation from St. Louis ConnectCare, FQHCs, County Clinics and the two medical schools to review the current specialty referral process and modify as appropriate. Task force representatives to include Medical Directors, CMOs, heads of case management. The task force would be charged with:

- Developing recommendations for simplifying the current process for making specialty referral appointments
- Designing a system for primary care physicians to consult with specialists by phone to determine whether a specialist referral may be appropriate
- Developing mechanism(s) to assure that the results of specialist consultations are communicated to the referring primary care physician in a timely manner

RATIONALE/BENEFITS:

Simplifying and clarifying the specialty care referral process will:

- Reduce administrative burden
- Help to assure more timely access to specialty care services
- Improve communication and follow-up between primary care and safety net providers, thereby enhancing quality of care
- Give primary care physicians greater comfort to manage certain medical problems in a primary care setting following phone consultation with a specialist

BARRIERS:

- Time commitment needed from represented entities

IMPLEMENTATION /NEXT STEPS:

- Determine task force membership, deliverables and process
- Call first meeting

SECTION III – Specialty Care

RECOMMENDATION 5: Increase Medicaid Physician Fee Schedule.

CRITERIA MET: Assures timely delivery of medical services. Improves health status of safety net patients. Improves access/reduces barriers to safety net services.

TIMEFRAME: Long-term (requires funding)

DESCRIPTION: Increase current Medicaid payment schedules for specialists to equal Medicare rates for services provided in the St. Louis City and St. Louis County area.

RATIONALE/BENEFITS:

- May increase number of specialists willing to care for safety net patients, which would reduce the excessive wait times for specialty care in the St. Louis market.

BARRIERS:

- Identifying ongoing funding stream for such payments

IMPLEMENTATION /NEXT STEPS:

- Model gap between Medicaid and Medicare rates and determine estimated total cost for increasing Medicaid rates, based upon assumed volume projections.
- Identify funding stream as part of Financing recommendation process.

Section IV: Recommendations for Improving Safety Net Dental Services

Improving preventive services

1. Partner with existing efforts to recruit and retain safety net dental health professionals, particularly minority dentists and dental hygienists
2. Partner with existing efforts to develop school initiative that encompasses the provision of preventive dental services, the removal of soda and sugary/high calorie snack foods from school vending machines and offering healthy food choices in school cafeterias
3. Increase integration between primary care providers and dental services, including improving compliance with the Federal Medicaid requirement to perform dental screens as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program
4. Explore the feasibility of expanding the use of mobile dental units to provide access to preventive services and education at schools and nursing homes
5. Advocate for the continuation and expansion of dental hygiene services

Improving integration of physical health and oral health systems

6. Include information on safety net dental health services in coordinated safety net marketing and health literacy campaigns
7. Implement a coordinated awareness campaign for policymakers and lawmakers concerning the importance of dental health
8. Implement a coordinated dental education program for medical providers (e.g., school nurses, safety net physicians)
9. Interface oral health records with integrated safety net data repository/electronic medical record
10. Include medical providers, dental providers and pharmacists in the community-wide safety net provider directory

Improving oral health status measurement and reporting

11. Collaborate with the Missouri Department of Health and Senior Services to develop an oral health status database for St. Louis City and County

Improving financing of safety net dental services

12. Advocate for the preservation of Medicaid dental coverage
13. Advocate for improved Medicaid reimbursement for dental services

SECTION IV – Dental Services

RECOMMENDATION 1: Partner with existing efforts to recruit and retain safety net dental health professionals, particularly minority dentists and dental hygienists

CRITERIA MET: Assures timely delivery of services. Improves access/reduces barriers to safety net system.

TIMEFRAME: Long term

DESCRIPTION: Partner with existing efforts to recruit and retain safety net health professionals, with a focus on racial and ethnic minority dentists and dental hygienists. Potential program tactics include:

- Include dental health professional recruitment/retention in the development of the safety net minority health professional recruitment and retention program recommended by the RHC in July 2003.
- Align major non-federally qualified dental providers with Federally Qualified Health Centers in order to implement loan forgiveness programs under 330 legislation. May be implemented in conjunction with RHC's Recommendations for Improving the Integration and Financing of the Safety Net Health System released in July 2003.
- Explore feasibility of expanding the class size of regional dental schools as part of a scholarship/loan forgiveness program.
- Collaborate and partner with local and statewide retention and recruitment effort.
- Explore feasibility of expanding opportunities for regional dental schools with training students to provide care through community-based safety net settings.

RATIONALE/BENEFITS:

- A 2002 report by the Institute of Medicine called for an increase in "the proportion of underrepresented U.S. racial and ethnic minorities among health professionals" as critical to reducing racial health disparities.
- The recruitment and retention of minority dental health providers may help build a workforce of health professionals that more closely mirrors the background of a significant number of safety net patients.
- Areas of St. Louis City and County are impacted by wide disparities in dental health outcomes (*Building a Healthier St. Louis*).
- Addresses low number of students entering dentistry.

BARRIERS:

- Requires funding for recruitment/retention program.
- Identification of safety net dentists to serve as partners.

IMPLEMENTATION/NEXT STEPS:

- Convene a task force to examine current efforts for safety net recruitment and retention of minority health providers (including dental health professionals), identify best practices, examine competitive compensation packages, and develop a plan for improvement.
- Determine the feasibility of aligning major non-federally qualified dental providers with those that are federally qualified, in conjunction with on-going partnership discussions concerning improving the integration of existing safety net providers.
- Determine types of contractual and/or employment relationships that are necessary for dentists to qualify for loan forgiveness.
- Determine cost and identify funding source.
- Identify collaborative partners and opportunities to build on existing recruitment and retention programs.

SECTION IV – Dental Services

RECOMMENDATION 2: Partner with existing efforts to develop school initiative that encompasses the provision of preventive dental services, the removal of soda and sugary/high calorie snack foods from school vending machines and offering healthy food choices in school cafeterias

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers. Enables cost efficiencies.

TIMEFRAME: Short-term

DESCRIPTION: Partner with existing efforts to develop school initiative that encompasses the provision of preventive dental services, the removal of soda and sugary/high calorie snack foods from school vending machines and offering healthy food choices in school cafeterias. Potential strategies include:

- Implement a school-based dental practice that provides diagnostic and preventive services. Ensure that school dental providers communicate with local Medicaid providers for follow-up care.
- Explore feasibility of implementing a school-based Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program at area schools. (The EPSDT program is known as Health Children and Youth [HCY] in Missouri.)
- Schools with vending contracts remove soda and sugary/high calorie snack foods from school vending machines. Replace with healthier choices. Will also eliminate the sale of fundraising candies. (San Francisco area)
- School cafeteria snack bar lunch offerings will meet or exceed the federal government's "food of minimal nutritional value" standard. (San Francisco area)

RATIONALE/BENEFITS:

- Provide dental care to safety-net population, who often lack transportation. Educates patients about the importance of ongoing dental care.
- May provide cost efficiencies through decreased risk and number of caries.
- Encourages proper nutrition and healthy food choices. Reinforces nutrition and health education curricula.
- Targeted marketing and easy access to “junk foods” may lead to increased consumption of these products. May also lead to increased risk of dental caries and negatively influence health (American Academy of Pediatric Dentistry).

BARRIERS:

- Requires pool of available dentists and dental hygienists, which is currently limited.
- Potential decrease in vending machine revenue.
- Changing dietary behavioral patterns.

IMPLEMENTATION /NEXT STEPS:

- Conduct a cost-benefit analysis, including an assessment of the potential economic impact on schools and explore the experience of other communities in removing soda and sugary/high-calorie foods from school vending machines and improving food choices in cafeteria.
- Explore alternative funding opportunities for schools, including the development of a self-sustaining school-based system for delivering oral health prevention services.
- Partner with school district officials, policy makers, Parent Teacher Associations and existing education programs to implement and educate parents, teachers and students about the benefits of healthy food choices for children.

- Collaborate with the Oral Health Network of Missouri to strengthen oral health screenings and follow-up care in St. Louis area head start agencies and elementary schools
- Explore opportunities to collaborate with the Missouri Dental Association on its “Stop the Pop” campaign.

SECTION IV – Dental Services

RECOMMENDATION 3: Increase integration between primary care providers and dental services, including improving compliance with the Federal Medicaid requirement to perform dental screens as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Enables cost efficiencies.

TIMEFRAME: Long-term

DESCRIPTION: Improve coordination between primary care providers and dental services, including:

- Improving coordination of dental care at time of primary care visit within Institutional safety net providers.
- Ensuring compliance with the Federal Medicaid requirement to perform dental screens as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Also increase the provision of parental dental health education as included in the EPSDT program. (The EPSDT program is known as Healthy Children and Youth [HCY] in Missouri.)
- Exploring feasibility of pediatricians providing fluoride varnishes to patients during primary care visits.

RATIONALE/BENEFITS:

- National models encourage the integration of dental services with provision of other primary care services to improve health status.
- Assists parents and children in the development of good oral health habits early in children's lives.
- Inclusion of dental screening in the EPSDT screen is federally mandated and prevents future dental health problems.

BARRIERS:

- Time constraints on providers.

IMPLEMENTATION /NEXT STEPS:

- Identify best practices through umbrella organization.
- Examine other communities' means of implementing and promoting oral health within the primary care setting, including the use of dental hygienists in the primary care setting.
- Determine funding source, as necessary.

SECTION IV – Dental Services

RECOMMENDATION 4: Explore the feasibility of expanding the use of mobile dental units to provide access to preventive services and education at schools, nursing homes and workplaces

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of services. Improves access/reduces barriers to safety net system. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION: Explore the feasibility of expanding the use of mobile dental units to provide access to preventive services and education at schools, nursing homes and workplaces in areas of high need. Utilize dentists and dental hygienists in providing services, including dental screenings, fluoride rinses and sealants. Patients identified as needing further treatment will be referred to other dental facilities in their area. Also incorporate dental education into school health curriculum to coincide with visit by mobile dental units.

RATIONALE/BENEFITS:

- Provides dental care to safety net population.
- Lowers medical costs by reducing the need for costly dental procedures due to lack of preventive care.
- Reduces the number of missed school/work days due to dental problems.
- Educates patients about the importance of ongoing dental care.

BARRIERS:

- Requires funding.
- State law mandates supervision of dental hygienists.
- Requires pool of available dentists and dental hygienists, which is currently limited.

IMPLEMENTATION /NEXT STEPS:

- Define the scope of services a mobile program would ideally provide (does not serve as a dental home for patients)
- Identify opportunities to build on/collaborate with existing mobile dental programs.
- Secure funding.
- Identify program sponsor organization.
- Identify dental professionals to participate.

SECTION IV – Dental Services

RECOMMENDATION 5: Advocate for the continuation and expansion of dental hygiene services

CRITERIA MET: Assures timely delivery of services. Improves access/reduces barriers to safety net system. Creates a more user-friendly safety net system. Enables cost efficiencies.

TIMEFRAME: Long term

DESCRIPTION: Advocate for the continuation and expansion of dental hygiene services, including allowing dental hygienists with three years or more of experience practicing in public health settings to provide fluoride treatment, cleaning and sealants to children who are eligible for medical assistance, without the supervision of a dentist. Advocate for allowing dental hygienists to provide dental hygiene assessments, dental hygiene treatment planning and education, and dental hygiene care for medically underserved children and adults in settings outside of traditional safety net practices, such as nursing homes or schools. Also advocate to provide funding to the hygienist program currently authorized in the State of Missouri.

RATIONALE/BENEFITS:

- Addresses appointment wait times for patients needing routine and preventive dental care (*Building A Healthier St. Louis*).
- Addresses shortage of dental providers in the St. Louis region (*Building A Healthier St. Louis)*.

BARRIERS:

- Requires funding for advocacy campaign.
- Potential need for collaboration with the Missouri Dental Association.

IMPLEMENTATION/NEXT STEPS:

- Discuss potential solutions with Missouri Dental Association, Missouri Dental Hygienist Association and Missouri State Dental Board. Work with Missouri State Dental Board to develop a recommendation for expanding the role of dental hygienists.
- Identify partners and develop advocacy campaign. Partners could include a broad-based coalition consisting of dental societies, dental hygienist associations, medical societies, nursing associations, pharmacy associations, etc.
- Determine cost and identify funding source.
- Establish a coalition of dentists and dental hygienists to advocate at the State level.
- Create legislative strategy to reflect expanded role of dental hygienists in the provision of preventive services.
- Identify legislative sponsorship.

SECTION IV – Dental Services

RECOMMENDATION 6: Include information on safety net dental health services in coordinated safety net marketing and health literacy campaigns

CRITERIA MET: Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Include information on dental health and safety net dental health services in coordinated safety net marketing and health literacy campaigns recommended for development by the RHC in July 2003. Campaigns raise awareness about the availability of safety net health services and provide health education. Consider utilization of media outlets such as television, radio and newspaper, as well as partnerships with community organizations including schools, places of worship and senior centers.

RATIONALE/BENEFITS:

- Increases patient knowledge and use of regular preventive, primary and specialty care resources by community.
- May reduce the stigma sometimes associated with safety net care.
- Integrated campaigns across the safety net enable consistent message and cost-efficiencies through single-vendor contracting.
- Raises health literacy and promotes healthy lifestyles.

BARRIERS:

- Requires funding for campaign development and ongoing marketing expenses.

IMPLEMENTATION /NEXT STEPS:

- Define goals and scope of initiative.
- Secure funding.
- Develop key messages and educational materials regarding prevention and access to dental services.
- Implement under the safety net Network/umbrella organization. Ensure appropriate representation from dental health community in campaign development.

SECTION IV – Dental Services

RECOMMENDATION 7: Implement a coordinated awareness campaign for policymakers and lawmakers concerning the importance of dental health

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of services. Improves access/reduces barriers to safety net system.

TIMEFRAME: Long term

DESCRIPTION: Utilizing existing coalitions and organizations focusing on Oral Health, develop a coordinated and comprehensive regional outreach effort to City, County and State policymakers and legislators to raise awareness concerning the importance of dental health to overall well-being.

RATIONALE/BENEFITS:

- Fosters communication and collaboration among safety net caregivers, oral health professionals and regional policy makers.
- May enhance resources for dental health services long-term.
- Imparts new knowledge that will enhance the quality of care provided to safety net patients.

BARRIERS:

- Time/resource constraints involved with development of appropriate coalitions.
- Legislative focus on budgetary issues over next 24-36 months.
- Requires funding.

IMPLEMENTATION/NEXT STEPS:

- Identify collaborators and party to lead effort.
- Develop legislative strategy/common message.

SECTION IV – Dental Services

RECOMMENDATION 8: Implement a coordinated dental education program for medical providers (e.g., school nurses, safety net physicians)

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net system. Improves quality of care and services delivered. Encourages collaboration across safety net providers.

TIMEFRAME: Long-term

DESCRIPTION: Implement a coordinated dental education program for medical providers (e.g. safety net physicians, other health professionals, school nurses). Ensure providers encourage their patients to visit a dentist regularly, know where to refer their patients and recognize basic dental problems. Encourage primary care providers to ask questions about feeding practices, basic oral health hygiene and implications of poor dental health. May be implemented with the safety net Continuing Medical Education process approved by Commission in July 2003 (See RHC Reducing Cultural Barriers Recommendation 3).

RATIONALE/BENEFITS:

- Fosters communication and collaboration among safety net caregivers, dental health professionals, dental health professionals groups and providers based at senior centers
- Enables patients to be referred to dental health services in early stages of disease process, resulting in enhanced likelihood for better treatment outcomes.
- Increases provider knowledge of dental health prevention, problems and basic treatment.

BARRIERS:

- Time/resource constraints of safety net professionals.

IMPLEMENTATION/NEXT STEPS:

- Coordinate with existing oral health coalitions and organizations for materials.
- Coordinate professional education through umbrella organization.

SECTION IV – Dental Services

RECOMMENDATION 9: Interface oral health records with integrated safety net data repository/electronic medical record

CRITERIA MET: Enables cost efficiencies. Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION:
Interface oral health records with integrated safety net data repository/electronic medical record (See RHC Recommendations). Provides clinicians with immediate access to patient medical, dental and medication records. Meets all Federal HIPAA regulations regarding privacy and electronic systems.

RATIONALE/BENEFITS:
- Provides treating medical/dental provider with real-time information on patient records.
- Improves communication and care coordination across safety net providers.
- Enhances staff productivity (eliminates phone calls, chart pulls and need to manually copy and send medical/dental records, etc.).

BARRIERS:
- Requires integration of existing medical/dental/pharmacy information systems across safety net institutions.
- Requires funding.

IMPLEMENTATION /NEXT STEPS:
- Assess current information technology capabilities of each safety net institution and develop a plan for seamless communication across these systems.
- Assess the Oral Health Record software for interface capabilities.
- Secure funding.

SECTION IV – Dental Services

RECOMMENDATION 10: Include medical providers, dental providers and pharmacists in the community-wide safety net provider directory

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION:
Include medical providers, dental providers and pharmacists in a printed community-wide safety net provider directory with photos and contact information. The directory could also be included as a component of the community-wide safety net resource guide or web site (See Section II Initial Recs. 11 and 12).

RATIONALE/BENEFITS:

- Provides a comprehensive listing of safety net providers for patients and providers.
- Improves referral process by making safety net providers aware of referral options.
- Helps patients and providers associate names with faces.
- May encourage collaboration in the provider community.

BARRIERS:

- Complexity of implementation given number of service providers.
- Determining the “owner” of the directory.
- Ongoing maintenance of the directory, give frequent changes in provider status.
- Funding.

IMPLEMENTATION /NEXT STEPS:

- Identify a partner(s) for collaboration in the development of the directory.
- Determine cost and identify funding sources.

SECTION IV – Dental Services

RECOMMENDATION 11: Collaborate with the Missouri Department of Health and Senior Services to develop an oral health status database for St. Louis City and County

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Assures timely delivery of medical services. Encourages collaboration among safety net providers.

TIMEFRAME: Long-term (requires funding)

DESCRIPTION: Collaborate with the Missouri Department of Health and Senior Services to integrate reporting of select oral health status indicators into the tri-annual comprehensive report assessing progress in improving health outcomes, reducing health disparities and improving access to care in St. Louis City and County (See RHC Measurement and Reporting Recommendation 3).

RATIONALE/BENEFITS:

- There is no ongoing comprehensive source of oral health data in St. Louis City and County.
- The collection and communication of health data can be used to generate an ongoing, solution-focused community dialogue between providers, community organizations, academic institutions, consumers and community members regarding health improvement, system improvement and behavioral change (*Building a Healthier St. Louis, RHC).*
- Oral health data will be used in the development and evaluation of programs and targeting of resources for improving oral health.
- Pain and suffering, multiple tooth loss, gum disease and significant health problems (including possible associations with diabetes, heart and lung diseases, stroke and premature births) are long-term consequences of poor oral health and limited access to oral health care (*Building a Healthier St. Louis, RHC*).

BARRIERS:

- Requires funding.

IMPLEMENTATION/NEXT STEPS

- Consider collaborative opportunities with the State to ensure accurate and comparable data. Also examine collaborative opportunities with associations and local entities.
- Identify sponsor organization to house and administer the database after the RHC 2006 tri-annual report.
- Identify data elements and methods of collection.
- Identify a funding source.

SECTION IV – Dental Services

RECOMMENDATION 12: Advocate for the preservation of Medicaid dental coverage

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system.

TIMEFRAME: Immediate

DESCRIPTION: Pass a resolution and actively advocate for the protection of the Missouri Medicaid budget (including the preservation of existing dental coverage) and the restoration of cuts enacted to the program over the past two years.

RATIONALE/BENEFITS:

- Cuts to the Medicaid budget directly increase the number of uninsured individuals, who then face serious financial barriers to obtaining care, and are deterred from seeking future care until health problems become acute.
- The protection and expansion of Medicaid reduces costs to employers by providing care delivery in the most cost-efficient setting.
- Expanding Medicaid leads to higher economic activity and employment in the health care industry through Federal matching rates.
- Expanding Medicaid provides for a healthier, more competitive workforce for the region.

BARRIERS:

- Projected State budget shortfall.

IMPLEMENTATION/NEXT STEPS:

- Develop RHC resolution for 2004 legislative session.
- Begin developing partnerships across the state to educate key legislators and stakeholders on importance of Medicaid program to all Missouri citizens.
- Support ongoing efforts in the community to promote and effectively utilize existing Medicaid programs, such as the Area Resources for Community & Human Services (ARCHS) Health Task Force.

SECTION IV – Dental Services

RECOMMENDATION 13: Advocate for improved Medicaid reimbursement for dental services

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system.

TIMEFRAME: Immediate

DESCRIPTION: Advocate for improved Medicaid reimbursement for dental services in an effort to increase the number of oral health providers enrolled as Medicaid providers.

RATIONALE/BENEFITS:

- There is a shortage of dentists accepting Medicaid in the St. Louis City and County region. (Building a Healthier St. Louis.)
- Increased reimbursement rates may expand dentist participation in the Medicaid program. (Building a Healthier St. Louis)
- Presently, dentists are reimbursed for approximately two-thirds of the costs incurred in treating Medicaid/MC+ patients. (Citizens for Missouri's Children)

BARRIERS:

- Projected State budget shortfall.

IMPLEMENTATION/NEXT STEPS:

- Develop key messages for advocacy campaign.
- Begin developing partnerships across the state to educate key legislators and stakeholders on importance of increased reimbursement.

Section V: Recommendations for Improving Safety Net Mental Health Services

Improving Coordination between Mental Health and Physical Health Systems

1. Partner existing network of Eastern Region mental health providers with safety net umbrella organization and managed care providers to coordinate and integrate the delivery of safety net mental and physical health services
2. Expand implementation of current best practices in integrating mental health services into existing safety net primary care sites
3. Improve the flow of information between outpatient and inpatient mental health service providers, and across the mental and physical health systems
4. Standardize mental health screening tool(s) to be utilized across systems and points of entry
5. Convene area medical school leadership to identity opportunities to improve medical student/resident education regarding mental health care, management and referral
6. Convene area managed care organization leadership to identify opportunities for improving provision of safety net mental health services

Improving information resources and education

7. Hold Continuing Medical Education conferences on mental health and safety net mental health services
8. Include information on safety net mental health services in coordinated safety net marketing and health literacy campaigns
9. Expand current efforts to train police, social workers, health professionals and teachers in mental health crisis intervention

Maximizing funds into the Mental Health System

10. Develop collaborative proposals and grant applications among mental health network, safety net umbrella organization and other providers
11. Explore feasibility of enhancing public funding streams for mental health service delivery

Improving Children's Mental Health Services

12. Advocate for core principles to improve children's mental health services
13. Conduct an analysis on types of mental health services that should be provided to children and youth
14. Develop a program to improve recruitment and retention of safety net mental health providers, particularly for children

Improving Access to Corrections Mental Health Services

15. Explore opportunities to improve access to mental health services for those within and discharged from the corrections system

SECTION V – Mental Health

RECOMMENDATION 1: Partner existing network of Eastern Region mental health providers with safety net umbrella organization and managed care providers to coordinate and integrate the delivery of safety net mental and physical health services

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of safety net services. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Enables cost efficiencies. Encourages collaboration among safety net providers.

TIMEFRAME: Long-term

DESCRIPTION: Partner existing network of mental health providers from the Department of Mental Health (DMH) Eastern Region with the safety net umbrella organization and managed care providers to:

- Coordinate and integrate the delivery of safety net mental and physical health services in St. Louis City and County.
- Ensure consistent and appropriate utilization of mental health clinical protocols across the safety net.

The mental health network (in collaboration/ coordination with the umbrella organization and managed care providers) will be responsible for improving integration and the delivery of safety net mental health services, including but not limited to the RHC recommendations. Consider expanding membership of Eastern region mental health network to include leadership from additional mental health service providers in region.

RATIONALE/BENEFITS:

- Increases integration between safety net physical and mental health systems.
- Provides a lead entity responsible for the coordination and integration of the mental health system.
- Provides opportunities for collaboration among mental health safety net providers.

BARRIERS:

- None.

IMPLEMENTATION /NEXT STEPS:

- Convene mental health network, safety net umbrella organization and managed care providers to identify opportunities for collaboration/improved integration. Examine models of service integration and consider application in St. Louis.
- Mental health network considers opportunities for expanding its membership and conducts detailed planning and implementation of RHC recommendations and other initiatives in coordination with the safety net umbrella organization

SECTION V – Mental Health

RECOMMENDATION 2: Expand implementation of current best practices in integrating mental health services into existing safety net primary care sites

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Encourages collaboration among safety net providers. Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net services.

TIMEFRAME: Long term

DESCRIPTION: Expand implementation of current best practices in integrating mental health services into safety net primary care sites. Identify best practices both locally and nationally. Consider types and level of mental health/substance abuse services that should be provided at primary care locations.

RATIONALE/BENEFITS:

- Reduces barriers to patient visits to both primary care and/or mental health providers.
- Reinforces connectedness between physical and mental health.
- Enables patient to see primary care provider and mental health provider in same visit.
- Facilitates communication and coordination between primary care and mental health providers.
- Facilitates referral process between physical and mental health providers.

BARRIERS:

- Requires funding.
- Potential space constraints of existing primary care locations.
- Overcoming potential patient resistance to seeking mental health care in community-based locations.

IMPLEMENTATION /NEXT STEPS:

- Identify local and national best practices in integrating mental health services into primary care sites.
- Umbrella organization and Eastern Region mental health network (see Mental Health Recommendation 1) coordinate to identify opportunities for expanded implementation of best practices.

SECTION V – Mental Health

RECOMMENDATION 3: Improve the flow of information between outpatient and inpatient mental health service providers, and across the mental and physical health systems

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of safety net services. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Enables cost efficiencies. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION: Mental health network and safety net umbrella organization collaborate to identify communications barriers and develop processes to improve the flow of information between outpatient and inpatient mental health service providers, and across the mental and physical health systems.

A component of the improved communications processes will be the development of a safety net Electronic Medical Record (see RHC Recommendations, October 2003), which will include mental health information. The EMR will link providers across the safety net, enabling clinicians to have immediate access to patient medical information (including medical history, physical exam findings, comprehensive list of current medical problems and medications, recent treatments, results of diagnostic tests, hospital discharge summaries and emergency room visits). EMR can also incorporate clinical guidelines and care protocols and track compliance and clinical outcomes. EMR will account for new American consumers through identification of primary language, ethnicity and country of origin. Patient identification system will not be solely contingent upon Social Security numbering.

RATIONALE/BENEFITS:

- Enhances communication, productivity and integration between outpatient and inpatient mental health service providers, and across the mental and physical health systems.
- Provides treating provider with information to assess the patient's medical condition and optimize care.
- Reduces risk of medication errors and adverse drug reactions.
- Enhances staff productivity (eliminates phone calls, chart pulls and need to manually copy and send medical records, etc).
- Improves clinical outcomes by improving availability of information regarding compliance with clinical care protocols and the results of clinically important metrics.

BARRIERS:

- Need to integrate existing clinical information systems across safety net institutions.
- Time constraints of health professionals.
- Funding constraints.

IMPLEMENTATION /NEXT STEPS:

- Convene mental health network and umbrella organization to identify communications barriers and develop processes to improve the flow of information.
- Assess current information technology capabilities of each safety net institution and develop a plan for seamless communication across these systems.
- Ensure compliance with HIPAA regulations as they pertain to mental health.

SECTION V – Mental Health

RECOMMENDATION 4: Standardize mental health screening tool(s) to be utilized across systems and points of entry

CRITERIA MET: Encourages collaboration across the safety net. Enables cost efficiencies. Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net services.

TIMEFRAME: Long term

DESCRIPTION: Standardize a mental health screening tool(s) to be utilized across physical and mental health systems and points of entry for adults, children and special populations, such as new Americans. Form will be available in several languages or translator services will be available. May also be used by mental health social service agencies. Fields collected could include such information as name, residence, social security number and specific screening questions for identification of mental health problems, including criteria for qualification for Medicaid disability coverage.

RATIONALE/BENEFITS:

- Provides a standard mental health screening tool that will be utilized across mental and physical health providers.
- Paves the way for a more efficient screening system.
- Encourages collaboration among safety net mental and physical health providers.

BARRIERS:

- Current lack of coordinating body for safety net mental health issues to help implement (see Mental Health Recommendation 1).

IMPLEMENTATION /NEXT STEPS:

- Coordinate under the auspices of the Eastern Region mental health network (see Mental Health Recommendation 1).
- Conduct interviews of mental and physical health providers to determine necessary fields and identify current screening tools.
- Assess current mental health screening tools for possible adaptation/adoption.

SECTION V – Mental Health

RECOMMENDATION 5: Convene area medical school leadership to identity opportunities to improve medical student/resident education regarding mental health care, management and referral

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Encourages collaboration among safety net providers. Assures timely delivery of safety net services.

TIMEFRAME: Long term

DESCRIPTION: Convene area medical school leadership to identify opportunities to improve medical student/resident education regarding mental health care, management and referral, in coordination with the mental health network (see Mental Health Recommendation 1).

RATIONALE/BENEFITS:

- Improves competency of physical health providers in identification, management and appropriate referral for mental health problems.
- Encourages early identification and treatment of mental health problems before issues become acute.
- Improves integration of mental health and physical health systems.

BARRIERS:

- Time and funding constraints on medical school curriculum and residency training programs.

IMPLEMENTATION/NEXT STEPS:

- Convene area medical school leadership and representatives from mental health network.
- Identify best practices for mental health education for medical students/residents. Consider opportunities for incorporation of best practices.

SECTION V – Mental Health

RECOMMENDATION 6: Convene area managed care organization leadership to identify opportunities for improving provision of safety net mental health services

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Encourages collaboration among safety net providers. Assures timely delivery of safety net services.

TIMEFRAME: Short term

DESCRIPTION: Convene area managed care organization leadership to identify opportunities for improving provision and financing of safety net mental health services, in coordination with the mental health network and the St. Louis ISDI Network/primary care clinicians. Issues to be addressed include:

- Exploring options for improving managed care reimbursement of primary care providers for mental health services.
- Identifying options for coordinating/standardizing screening requirements for mental health across managed care organizations.

RATIONALE/BENEFITS:

- Improved reimbursement of primary care providers may encourage providers to identify and manage mental health issues in a primary care setting prior to problems becoming acute.
- Improves integration of mental health and physical health service delivery.
- Review and standardization of screening requirements improves processes for identifying patients in need of safety net mental health services.

BARRIERS:

- Funding difficulties for managed care organizations associated with increasing reimbursement and standardizing screening requirements.

IMPLEMENTATION/NEXT STEPS:

- Convene area managed care organization leadership and representatives from mental health network.
- Explore opportunities for improving service provision, including improving primary care physician reimbursement and coordinating screening requirements.

SECTION V – Mental Health

RECOMMENDATION 7: Hold Continuing Medical Education conferences on mental health and safety net mental health services

CRITERIA MET: Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Hold Continuing Medical Education conferences (for institutional providers and community clinicians) on mental health and safety net mental health services. Include information on identification/management of mental health problems (for adults, children and special populations, such as new Americans) and referral to mental health providers. Also include information on identification of developmental disability and criteria for qualification for Medicaid disability coverage. Emphasize the importance of ongoing communication and coordination between physical and mental health providers. Provide CME credit to participating providers.

RATIONALE/BENEFITS:

- Fosters communication and coordination between physical and mental health providers.
- Imparts knowledge that will enhance the quality of care provided to safety net patients.
- May reduce the stigma sometimes associated with mental illness and safety net care.

BARRIERS:

- Existing time constraints on participating providers.

IMPLEMENTATION /NEXT STEPS:

- Ensure mental health topics are included in CME rotation schedule.
- For the planning of CME sessions dealing with mental health, include Eastern Region mental health network (see Mental Health Recommendation 1) and other organizations (such as the DMH Missouri Institute of Mental Health), as appropriate.
- Develop and publicize CME conference schedule through safety net umbrella organization (see RHC Recommendations, October 2003).

SECTION V – Mental Health

RECOMMENDATION 8: Include information on safety net mental health services in coordinated safety net marketing and health literacy campaigns

CRITERIA MET: Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Include information on mental health and safety net mental health services in coordinated safety net marketing and health literacy campaigns (see RHC Recommendations – October 2003). Raises awareness about the availability of safety net physical and mental health services and educates people about healthful living. Consider utilization of media outlets such as television, radio and newspaper, as well as partnerships with community organizations including schools and places of worship. Ensure that information is provided in appropriate languages for new American populations.

RATIONALE/BENEFITS:

- Increases patient knowledge and use of regular preventive, primary and specialty care resources by community, including mental health resources.
- May reduce the stigma sometimes associated with mental illness and safety net care.
- Optimizes utilization of current resources – optimizes use of current primary care capacity through increased volumes and reduces strain on hospital emergency departments.
- Integrated campaigns across the safety net enable consistent message and cost-efficiencies through single-vendor contracting
- Raises health literacy and promotes healthy lifestyles.

BARRIERS:

- Requires funding for expenses associated with campaign development and ongoing marketing efforts.

IMPLEMENTATION /NEXT STEPS:

- Secure funding for marketing/health literacy campaign through umbrella organization.
- Develop key messages and educational materials regarding prevention and access to mental health services.
- Include Eastern region mental health network/mental health provider community in planning for marketing/health literacy campaign.
- Implement campaign under sponsorship of safety net umbrella organization.

SECTION V – Mental Health

RECOMMENDATION 9: Expand current efforts to train police, social workers, health professionals and teachers in mental health crisis intervention

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers. Enables cost efficiencies.

TIMEFRAME: Short term

DESCRIPTION: Expand current efforts to train police, social workers, health professionals and teachers in mental health issues and crisis intervention. Training includes information on providing assessments and counseling, as well as communication techniques for dealing with adults and children who are experiencing a mental health crisis. This can include people suffering from depression, anxiety, relationship difficulties, stress and family crisis, as well as those who are suicidal or who are family members of trauma victims. Also trains program participants to work with individuals who are having difficulties with addictions and anger management, including providing assessment and referral to appropriate resources in the community.

RATIONALE/BENEFITS:

- Builds on existing programming in the St. Louis community.
- Crisis intervention may reduce hospital service use and shorten inpatient days.
- Police, social workers and health professionals often respond to situations involving people in mental health crisis. Training program provides tools and techniques for responding to these situations in an effective manner.
- Provides for greater efficiency in helping people in mental health crisis receive appropriate care.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Identify opportunities for expansion of existing training efforts.
- Secure funding.

SECTION V – Mental Health

RECOMMENDATION 10: Develop collaborative proposals and grant applications among mental health network, safety net umbrella organization and other providers

CRITERIA MET: Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Increase funding opportunities through collaborative proposals and grant applications among Eastern region mental health network, safety net umbrella organization and other providers, as applicable. Collaborative proposals and grant applications to focus on improving mental health service delivery and increasing integration of the physical and mental health systems. Explore opportunities to maximize federal funding (including reimbursement through Section 330) for mental health services, as well as secure funding through local, state and private foundation sources.

RATIONALE/BENEFITS:

- Coordinated effort may provide greater access to funding from Federal grants, State grants and private foundations.
- May diversify funding streams.
- Provides opportunity for collaboration among safety net mental health providers.

BARRIERS:

- Current lack of staffing to identify and pursue joint funding opportunities.

IMPLEMENTATION /NEXT STEPS:

- Consider opportunities for expanding Eastern Region mental health network membership.
- Convene mental health network, umbrella organization, and other providers as appropriate to identify opportunities for collaborative proposals and grant applications.
- Develop applications under sponsorship of safety net umbrella organization or Eastern region mental health network (see Mental Health Recommendation 1).

SECTION V – Mental Health

RECOMMENDATION 11: Explore feasibility of enhancing public funding streams for mental health service delivery

CRITERIA MET: Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION: Analyze feasibility of enhancing public funding streams for mental health service delivery through:

- Potential creation of a Community Mental Health Fund for the region (St. Louis City currently has a dedicated tax that funds the City of St. Louis Mental Health Board of Trustees).
- Potential collaboration between providers and the St. Louis Mental Health Court to increase funding streams.

Analyze opportunities for use of funding, including support for the provision of mental health services through mental health providers, community organizations and elementary, middle and high schools.

RATIONALE/BENEFITS:

- Diversifies funding opportunities for mental health providers.
- Encourages collaboration between mental health system and Division of Family Services.

BARRIERS:

- Developing broad-based support for safety net mental health funding.
- Competing potential uses of any new tax.
- Identifying a sponsor organization to coordinate campaign/public awareness activities.
- Lack of funding for indirect care activities in the Mental Health arena in the short-term.

IMPLEMENTATION/NEXT STEPS:

- Conduct analyses on creating Community Mental Health Fund and other opportunities for diversifying funding streams.
- Identify lead organization to begin implementation activities.

SECTION V – Mental Health

RECOMMENDATION 12: Advocate for core principles to improve children's mental health services

CRITERIA MET: Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION: Advocate for core principles to improve children's mental health services. Core advocacy principles to include:

- Expansion of the definition of billable Medicaid mental health services to include all required EPSDT services and increased community-based services.
- Commitment to providing children's mental health services in the least restrictive, most appropriate environment that meets the needs of the child.
    - This principle to include identification of children in state custody exclusively due to a need for mental health services. Commitment to providing services to such children in a less restrictive environment, as appropriate.
- Development of a more collaborative, comprehensive and outcome-based children's mental health system to serve children with emotional and behavioral disturbance problems, developmental disabilities and substance abuse problems. System components to include:
    - Increased collaboration between state agencies and family members involved in the lives of children served (i.e., DMH, DSS, Department of Education, Department of Public Safety, Office of State Courts – Juvenile Justice)
    - Involvement of advocates, private and non-profit organizations and other stakeholders
    - Child-centered, family focused and family-driven mental health services
    - Community-based mental health services to children and their families in the context in which the children live and attend school
    - Services delivered in a culturally competent and responsive manner
    - Emphasis on prevention and early identification and intervention
    - Access to a continuum of services through individualized service plans
    - Efforts to address the unique problems of paying for mental health services for children
    - Assurance of a smooth transition from child to adult mental health services when needed
    - Increased collaboration between physical and mental health providers and across the continuum of care
- Increased/protected reimbursement for children's mental health service providers.

RATIONALE/BENEFITS:

- Improves access to mental health services.
- Encourages collaboration and coordination among mental and physical health providers, families and children to improve the delivery of children's mental health services.

BARRIERS:

- Core principles require funding for implementation.
- Potential resistance from mental health institutional providers across the State.

IMPLEMENTATION /NEXT STEPS:

- Identify opportunities for advocacy in core principle areas.
- Educate key audiences on importance of core principles.

SECTION V – Mental Health

RECOMMENDATION 13: Conduct an analysis on types of mental health services that should be provided to children and youth

CRITERIA MET: Enables cost efficiencies. Assures timely delivery of medical services. Improves health status of safety net patients. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Conduct an analysis on the types of mental health services that should be provided to children and youth. Identify gaps in current service provision. Include an assessment of the delivery of mental health screenings through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Also include an analysis of sites where children currently receive mental health services and opportunities for increasing service utilization through alternative delivery locations, such as schools or community centers, for some children's mental health services.

RATIONALE/BENEFITS:

- Provides an evidence-based foundation for improving the delivery of mental health services to children.
- Improves access to mental health services to children.

BARRIERS:

- Requires funding.
- Current lack of coordinating body for safety net mental health issues (see Mental Health Recommendation 1).

IMPLEMENTATION /NEXT STEPS:

- Identify organization to conduct analysis.
- Secure funding.

SECTION V – Mental Health

RECOMMENDATION 14: Develop a program to improve recruitment and retention of safety net mental health providers, particularly for children

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers. Assures timely delivery of medical services.

TIMEFRAME: Long term

DESCRIPTION: Develop a program to improve recruitment and retention of safety net mental health providers, particularly for children. Identify means for providing more competitive compensation packages and for increasing mental health provider enrollment in Medicaid.

RATIONALE/BENEFITS:

- The availability of safety net mental health providers, particularly children's mental health providers, is very limited in the St. Louis region (*Building a Healthier St. Louis* – March 2003*)*.
- Program may increase the number of safety net mental health providers available to care for mental health patients (particularly children), which would reduce the excessive wait times for mental health care.

BARRIERS:

- Identifying ongoing funding stream for increasing compensation packages.

IMPLEMENTATION /NEXT STEPS:

- Examine current efforts for safety net mental health provider recruitment, retention, and compensation. Identify best practices and develop a plan for improvement.
- Program could be implemented under the auspices of the Eastern Region mental health network (See Mental Health Recommendation 1) in coordination with the safety net umbrella organization.

SECTION V – Mental Health

RECOMMENDATION 15: Explore opportunities to improve access to mental health services for those within and discharged from the corrections system

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net system. Assures timely delivery of medical services.

TIMEFRAME: Long term

DESCRIPTION: The Mental Health Network, in coordination with area corrections systems and providers of corrections mental health/substance abuse services, explores opportunities to improve access to and availability of mental health services for those within and discharged from the corrections system. Consider options such as:

- Developing a follow-up system or transition program to assist corrections mental health/substance abuse services recipients in linking to community mental health services upon their release from the corrections system. For example, explore option of assigning a transition person to corrections mental health services recipients to assist in linking to community mental health services upon their release.
- Educating providers about corrections mental health services and the need for more providers.
- Examining resource allocation and opportunities to increase salary/reimbursement for mental health providers serving the corrections system.

RATIONALE/BENEFITS:

- Nationally, more than 16% of adults in jail or prison and 20% of youth in the juvenile justice system have a mental illness (Bureau of Justice Statistics).
- The availability of safety net mental health providers is very limited in the St. Louis region. (*Building a Healthier St. Louis* – March 2003*)*. In particular, there is a need for more providers to serve patients within the corrections system.
- A transition program may assist those transitioning from the corrections system in accessing services and continuing their mental health treatment.
- Provision of ongoing mental health services may reduce recidivism.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Convene Mental Health Network, in coordination with area corrections systems and providers of corrections mental health services.
- Identify local and national best practices in improving access to mental health services for those within and discharged from corrections systems.

Section VI: Recommendations for Improving Safety Net Pharmacy Services

Improving Patient Utilization of Medications and Provider Education

1. Make comprehensive patient counseling and medication monitoring services available at each safety net pharmacy site
2. Hold Continuing Medical Education conferences focused on safety net pharmacy services

Improving coordination of pharmacy services via centralized system

3. Conduct a feasibility analysis on the development of a centralized medication filling service across safety net pharmacies
4. Develop a common formulary across safety net providers
5. Develop a common Pharmacy and Therapeutics Committee across the safety net
6. Implement coordinated group/bulk purchasing for safety net pharmacies
7. Convene providers to conduct a feasibility analysis on the development of a standardized sliding-scale co-payment system across safety net pharmacies

Improving information resources

8. Include patient medication, allergy and drug interaction information in an integrated safety net data repository/electronic medical record
9. Develop an integrated database of consumers who qualify for reduced-fee prescription medication
10. Include pharmacy services information in safety net information resources
11. Conduct a feasibility analysis on the development of a Pharmacy Information Center
12. Pilot a user-friendly database kiosk for consumers at a safety net pharmacy site

SECTION VI – Pharmacy Services

RECOMMENDATION 1: Make comprehensive patient counseling and medication monitoring services available at each safety net pharmacy site

CRITERIA MET: Enables cost efficiencies. Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION: Make comprehensive patient counseling and medication monitoring services available at each safety net pharmacy site. Provide in-person counseling or call consumers (particularly new consumers or those with chronic diseases) to discuss medication compliance, medication changes, etc. Explore opportunities for collaboration with the St. Louis College of Pharmacy to provide such services.

RATIONALE/BENEFITS:

- Patients who have the benefit of discussing their prescriptions with their pharmacist are more likely to comply with directions for use (*The Annals of Pharmacotherapy).*
- Comprehensive patient counseling lowers overall medical costs by reducing the prevalence of adverse events attributable to medication duplication, incorrect dosing, drug interactions and allergic reactions (*Building a Healthier St. Louis*).
- The majority of safety net pharmacies report that comprehensive patient counseling is not routinely provided even though the pharmacists want to provide this needed service.

BARRIERS:

- Requires funding.

IMPLEMENTATION/NEXT STEPS:

- Consider collaborative opportunities with the St. Louis College of Pharmacy.
- Identify funding opportunities.
- Develop plan for implementation.

SECTION VI – Pharmacy Services

RECOMMENDATION 2: Hold Continuing Medical Education (CME) conferences on safety net pharmacy services

CRITERIA MET: Encourages collaboration among safety net providers. Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Enables cost efficiencies.

TIMEFRAME: Immediate

DESCRIPTION: Hold continuing medical education conferences on safety net pharmacy services. Provides pharmacy services information on a variety of topics, including financial assistance and discount pharmacy programs, importance of comprehensive patient counseling, education about the common formulary (when developed), and the sharing of best practices in prescribing medication.

RATIONALE/BENEFITS:

- Fosters communication and collaboration among front-line safety net caregivers.
- Imparts new knowledge that will enhance the quality of care provided to safety net patients and make providers aware of the services available to patients.

BARRIERS:

- Existing time constraints on participating providers.

IMPLEMENTATION /NEXT STEPS:

- Determine sponsorship and responsibility for organizing and publicizing conferences.
- Develop and publicize CME conference schedule.

SECTION VI – Pharmacy Services

RECOMMENDATION 3: Conduct a feasibility analysis on the development of a centralized medication filling service across safety net pharmacies

CRITERIA MET: Enables cost efficiencies. Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION: Conduct a feasibility analysis on the development of a centralized medication filling service across the safety net. Under such a service, prescriptions are filled and inspected per Missouri state law and delivered to safety net pharmacies for consumer pick-up. Patients may order prescription refills by automated phone service or by mail. Patients may check on the status of a prescription or speak with a pharmacy representative. Explore technological innovations to assure product safety and efficacy. Explore utilization of existing services in the community, including commercial services, and investigate if the centralization of the filling service would increase barriers to obtaining medications in any way prior to implementation. Also explore the development of a policy for returned medications as part of the centralized filing service as part of the feasibility analysis.

RATIONALE/BENEFITS:

- Streamlined service across the safety net.
- Economies of scale.
- May standardize co-payments and lower the cost of generic medications and out-of-pocket expenses. (U.S. Medicine Information Central)
- No interruption of current pick-up procedure for consumers.

BARRIERS:

- Need for common pharmacy information system.
- Development of common formulary may require changes to physicians' existing treatment protocols and possible changes to agreements (contractual or otherwise) with pharmaceutical vendors.
- Requires funding.

IMPLEMENTATION/NEXT STEPS:

- Identify party to conduct feasibility analysis and secure associated funding.

SECTION VI – Pharmacy Services

RECOMMENDATION 4: Develop a common formulary across safety net providers

CRITERIA MET: Enables cost efficiencies. Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION: Develop a common formulary across safety net providers. Convene a Pharmacy and Therapeutics Committee of safety net pharmacists, physicians, nurses and clinic representatives to share current formularies and outcomes and collaboratively develop a common formulary (See Pharmacy Recommendation for Pharmacy and Therapeutics Committee). Separately consider both clinical effectiveness and cost. Provide written documentation of formulary standards to safety net providers.

RATIONALE/BENEFITS:

- Improves clinical effectiveness.
- Lowers medical costs through quantity purchasing.
- Enhances pharmacy productivity.
- Consistent medication availability.

BARRIERS:

- Requires changes to physicians' existing treatment protocols.
- May require changes to agreements (contractual or otherwise) with pharmaceutical vendors.

IMPLEMENTATION /NEXT STEPS:

- Establish Pharmacy and Therapeutics Committee.
- Consider 340B guidelines, Missouri Medicaid formulary, patient assistance programs, established clinical treatment guidelines and best practices, clinical effectiveness and cost.

SECTION VI – Pharmacy Services

RECOMMENDATION 5: Develop a common Pharmacy and Therapeutics Committee across the safety net

CRITERIA MET: Enables cost efficiencies. Improves health status of safety net patients. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Develop a Pharmacy and Therapeutics Committee to standardize purchasing criteria and products for medication filling across the safety net, educate providers about medication filling practices, and develop a common formulary (See Pharmacy Recommendation 1 on common formulary). Include pharmacists, physicians, nurses and clinic representatives. The Pharmacy and Therapeutics Committee could utilize Continuing Medical Education sessions to educate about pharmacy services (See RHC Recommendations passed in July 2003.)

RATIONALE/BENEFITS:

- Creates a forum for regular communication and collaboration among safety net health professionals.
- Improves knowledge-base within safety net institutions and pharmacies.
- Fosters rapid problem solving for pharmacy issues across safety net institutions.
- Allows for coordination and standardization of policies and procedures.
- Improves pharmacy medication filling practices based on adoption of standardized purchasing and medication utilization procedures.
- Enhance cost efficiencies through economies of scale.

BARRIERS:

- Existing time constraints on safety net medical professionals.

IMPLEMENTATION /NEXT STEPS:

- Determine membership.
- Determine sponsorship and organizational responsibility for establishing agendas, scheduling meetings, etc.
- Call first meeting.

SECTION VI – Pharmacy Services

RECOMMENDATION 6: Implement coordinated group/bulk purchasing for safety net pharmacies

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety new providers. Enables cost efficiencies.

TIMEFRAME: Short-term

DESCRIPTION: Safety net pharmacies collaborate for quantity purchasing of medications. Could be implemented in conjunction with a common formulary across safety net providers.

RATIONALE/BENEFITS:

- Decreases pharmacy costs to patients.
- Increases economies of scale. By pooling their volumes, providers may be able to negotiate better discounts. (Henry J. Kaiser Family Foundation; Public Hospital Pharmacy Coalition)

BARRIERS:

- Information system coordination.
- Complexity of implementation given number of service providers.
- May require changes to physicians' existing treatment protocols.

IMPLEMENTATION /NEXT STEPS:

- Determine method of tracking purchases and orders.
- Determine ownership and responsibility of purchases/orders.
- Potentially develop a common formulary.

SECTION VI – Pharmacy Services

RECOMMENDATION 7: Convene providers to conduct a feasibility analysis on the development of a standardized sliding-scale co-payment system across safety net pharmacies

CRITERIA MET: Enables cost efficiencies. Encourages collaboration across the safety net.

TIMEFRAME: Long-term

DESCRIPTION: Develop a standardized sliding-scale co-payment system across safety net pharmacies.

RATIONALE/BENEFITS:
- Helps defray safety net pharmacy costs.
- Reduces financial barriers for consumers who qualify for reduced fees.

BARRIERS:
- Education and training of frontline staff.

IMPLEMENTATION /NEXT STEPS:
- Compile and assess uniformity of current co-payment systems.
- Develop task force, potentially the Pharmacy and Therapeutics committee (see Section VI, Recommendation 5) to standardize co-payment system.
- Build consensus on a standardized co-payment system.

SECTION VI – Pharmacy Services

RECOMMENDATION 8: Include patient medication, allergy and drug interaction information in an integrated safety net data repository/electronic medical record

CRITERIA MET: Enables cost efficiencies. Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term

DESCRIPTION:
Include patient drug profiles in an integrated safety net data repository/electronic medical record (See July Recommendations.) Provides clinicians with immediate access to patient medication records (including drug allergies, and drug interaction records). Incorporates pharmacy formulary and medication protocols, along with tracking compliance and medical outcomes. If implemented in conjunction with a common formulary and a centralized medication filling service (See Pharmacy Recommendations X and X), could include electronic medication tracking system. Could also include features that automatically check for drug interactions, allergies and proper dosages. Meets all Federal HIPAA regulations regarding privacy and electronic systems.

RATIONALE/BENEFITS:
- Provides treating physician with real-time information on patient medication records.
- Reduces risk of medication errors and adverse drug reactions.
- Lowers medical costs by reducing the need for diagnostic studies and assuring compliance with drug formularies.
- Enhances pharmacist productivity and communication across safety net providers.
- Enhances staff productivity (eliminates phone calls, chart pulls and need to manually copy and send medical records, etc.).
- Could enhance patient safety through electronic prescribing feature that automatically checks for drug cross-reactions, allergies and proper dosages.

BARRIERS:
- Requires integration of existing clinical/pharmacy information systems across safety net institutions.
- Requires coordination of existing pharmacy systems across safety net institutions.
- Requires funding.

IMPLEMENTATION /NEXT STEPS:
- Assess current information technology capabilities of each safety net institution and commercial pharmacy site and develop a plan for seamless communication across these systems.
- Secure funding.

SECTION VI – Pharmacy Services

RECOMMENDATION 9: Develop an integrated database of consumers who qualify for reduced-fee prescription medication

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers. Enables cost efficiencies.

TIMEFRAME: Long term

DESCRIPTION: Develop a safety net system-wide database of consumers who qualify for reduced-fee prescription medication. Could be implemented as a component of the integrated Clinical Data Repository/EMR (RHC Care Coordination Recommendations). Use 340B pricing as a guideline for reduced pricing.

RATIONALE/BENEFITS:

- Reduces financial barriers to prescription medication for consumers.
- Encourages collaboration among safety net providers.
- Ensures that consumers in need of financial assistance qualify for reduced-fees at any safety net pharmacy.

BARRIERS:

- Updating files to reflect changing consumer financial status.
- Requires funding.
- Standardizing patient eligibility for reduced fees.
- Complexity of implementation given number of service providers.

IMPLEMENTATION /NEXT STEPS:

- Convene group to standardize policies and procedures
- Determine cost and funding source.

SECTION VI – Pharmacy Services

RECOMMENDATION 10: Include pharmacy services information in safety net information resources

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term (requiring funding)

DESCRIPTION:
Include information on pharmacy services in safety net information resources to be developed, including:

- 24x7 safety net information resource line
- Community-wide safety net web site
- Community-wide safety net resource guide

The resource line, web site and resource guide provide people in need of safety net medical care or human services with information on accessing available services (See RHC Care Coordination Recommendations 10-12). Include information on pharmacy services, including comprehensive patient counseling, location of safety net pharmacies and drug financial assistance.

RATIONALE/BENEFITS:

- Provides a comprehensive resource for pharmacy and other health and human service information.
- Information accessible in multiple ways, via telephone, web or written guide.
- Provides accurate and timely information specific to a user's request.

BARRIERS:

- Determining the best entity/entities to develop and administer the information resources
- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Identify a partner(s) for collaboration in the development, staffing and administration of the information resources.
- Develop process for updating the resources on changes in providers, hours of operation, policies, etc.
- Determine cost and identify funding source.

SECTION VI – Pharmacy Services

RECOMMENDATION 11: Conduct a feasibility analysis on the development of a Pharmacy Information Center

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Long term (requiring funding)

DESCRIPTION:
Conduct a feasibility analysis on the development of a centrally-located Pharmacy Information Center to provide comprehensive patient counseling. Center provides patients and providers with information on financial assistance/discount programs for drugs, including available programs, eligibility requirements and required forms. Provides printed information on services. As part of feasibility analysis, consider options for providing similar information and patient education at patients' primary care home, and investigate whether patients would make a special trip to a central, separate location for pharmacy information.

RATIONALE/BENEFITS:
- Provides a forum for comprehensive patient counseling, thereby improving patient compliance/understanding of treatment program.
- Provides a comprehensive resource for pharmacy services information and financial assistance programs, which are often complex.
- Provides in-person information specific to a user's request.

BARRIERS:
- Determining the best entity to house and administer the Pharmacy Information Center.
- Requires funding.

IMPLEMENTATION /NEXT STEPS:
- Identify party to conduct feasibility analysis and secure associated funding.

SECTION VI – Pharmacy Services

RECOMMENDATION 12: Pilot a user-friendly database kiosk for consumers at a safety net pharmacy site

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety new providers.

TIMEFRAME: Short term (requires funding)

DESCRIPTION: Develop a user-friendly database kiosk to provide comprehensive drug information to consumers. Pilot and monitor usage patterns at one or more safety net pharmacies. Includes education/compliance information on medications and information on safety net pharmacy services. Allows identification of drug interactions, precautions and target populations. Information is available in different languages. Provides patients and providers with information on financial assistance/discount programs for drugs, including available programs, eligibility requirements and required forms. Permits navigation to more specific and more generic medical conditions and pharmaceuticals.

RATIONALE/BENEFITS:

- Provides a comprehensive resource for health and human service information.
- Provides accurate and timely information specific to a user's request.
- Accessible to anyone who visits the safety net pharmacy sites.

BARRIERS:

- Funding.
- Information system coordination if implemented across the safety net system.
- Complexity of system-wide implementation given number of service providers.

IMPLEMENTATION /NEXT STEPS:

- Determine cost and identify funding source.
- Determine data for inclusion in the database.
- Determine the best entity to house and administer the database.

Section VII: Recommendations for Reducing Financial Barriers to Care

Reducing Medical Debt

1. Develop a standardized uncompensated care policy across outpatient primary and specialty care safety net providers
2. Identify administrative barriers to Medicaid coverage determinations and conduct staff training sessions on Medicaid eligibility and policies
3. Develop a regional ombudsmen program to help safety net consumers access/navigate the system and to assist with key financial counseling issues
4. Safety net providers conduct a standardized review of eligibility for reduced fees and financial counseling prior to reporting uninsured patients with overdue payments to a collection agency

Reducing the Cost of Catastrophic Hospital Care for Patients

5. Convene area hospital leadership with community representatives to develop effective solutions to medical debt, uncompensated care and billing, and to generate other ideas for reducing financial barriers to care within the boundaries of the law

Reducing Lack of Insurance and Barriers to Care

6. Develop a uniform “no turn-away due to inability to pay” policy across outpatient safety net providers
7. Advocate for maintenance and expansion of Medicaid coverage
8. Coordinate with the State of Missouri and existing entities to examine the development of a statewide or local insurance program for low-income uninsured residents

SECTION VII – Reducing Financial Barriers

RECOMMENDATION 1: Develop a standardized uncompensated care policy across outpatient primary and specialty care safety net providers

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Develop a standardized uncompensated care policy across outpatient primary and specialty care providers to include:

- Common sliding fee scale, which slides to zero per Federal Section 330 guidelines and includes a "no turn-away" policy
- Common application and verification process. In addition to common processes, it is important for safety net providers to be able to share patient eligibility information. This would allow the patient to make a single application for assistance, rather than duplicating the application for each safety net provider.
- Screening of all patients for eligibility for reduced-fee care.
- Uniform policy on treatment and billing for those that do not have payment at time of treatment.
- Uniform policy on the frequency and procedures for verifying an individual's eligibility for reduced fees.
- Uniform policy on maximum out-of-pocket liability across the system for the uninsured and underinsured.
- Written materials in appropriate languages about uncompensated care policy.
- Conspicuous signs in patient areas and notices on bills informing patients of the availability of free and reduced-fee care.
- Continuing education for safety net health care employees so that information is available in key areas at safety net sites.

Feasibility analysis and policy development should include community input.

RATIONALE/BENEFITS:

- The St. Louis Regional Health Commission estimates the number of uninsured in St. Louis City and County to be 129,000 (conservative, point-in-time estimate).
- "Uninsured people face serious financial barriers to obtaining care, even at safety net facilities, and are often burdened with debts as a result of obtaining care. Moreover, these debts may deter them from seeking future care." (*Paying for Health Care When You're Uninsured,* Access Project. Report used survey findings on the experiences of 6,884 uninsured individuals in trying to pay for medical care at safety net hospitals and health centers).
- Unifies the uncompensated care process and creates a more efficient system.
- Reduces medical debt and financial barriers by raising awareness among patients regarding eligibility for reduced-fee or free care.
- Reduces administrative costs of safety net providers through reduced billing and follow-up on uncollectible accounts.

BARRIERS:

- Potentially affects current provider information systems.
- Obtaining consensus from safety net providers on criteria for eligibility and extent of patient discounts.

IMPLEMENTATION/NEXT STEPS:

- Convene safety net providers with consumer/community representatives, such as RHC Advisory Board members, to compare current uncompensated care policies and develop a standardized policy.

SECTION VII – Reducing Financial Barriers

RECOMMENDATION 2: Identify administrative barriers to Medicaid coverage determinations and conduct staff training sessions on Medicaid eligibility and policies

CRITERIA MET: Enables cost efficiencies. Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net system.

TIMEFRAME: Short term

DESCRIPTION: Convene safety net provider (hospitals, health centers) leadership and patient registration staff, community providers, consumer/community representatives and State Department of Medical Services representatives to (1) identify barriers to determination of Medicaid eligibility/coverage and appropriate billing by providers, and (2) develop solutions. Issues addressed to include:

- System complexity in determining whether an individual has Medicaid coverage (or any insurance).
- Systems improvements and training to correct errors that lead to improper billing, including ensuring that providers/physicians bill the proper Medicaid source (e.g., the correct health plan or Medicaid fee-for-service).

Based on the identified barriers and solutions, conduct training sessions for the staffs of safety net providers (health centers, hospitals, etc.) and the staffs of community physicians on Medicaid eligibility and policies. Training to include, in particular:

- Proper identification and classification of Medicaid patients for billing purposes to ensure that Medicaid patients are not directly billed by providers for services. This should include ensuring that providers bill the proper Medicaid source (e.g., the correct health plan or Medicaid fee-for-service).
- Medicaid policies and procedures (fee-for-service and MC+).

Training sessions may be implemented with safety net CME training sessions. Explore use of State trainers in Medicaid eligibility, policies and procedures.

RATIONALE/BENEFITS:

- Improves identification of Medicaid patients and reduces improper billing. In some cases under current system, Medicaid patients are improperly classified, resulting in billing to the patient.
- Improper billing of patients may result in confusion or patient avoidance of needed medical services.
- Improves efficiency in billing system.

BARRIERS:

- Limited staff time.

IMPLEMENTATION/NEXT STEPS:

- Convene safety net providers' (hospitals, health centers) leadership and patient registration staff, community providers, consumer/community representatives (such as RHC Advisory Board members), and State Department of Medical Services representatives to identify barriers and develop solutions.
- Determine key identification and classification issues to include in training.
- Develop standardized training materials.

SECTION VII – Reducing Financial Barriers

RECOMMENDATION 3: Develop a regional ombudsmen program to help safety net consumers access/navigate the system and to assist with key financial counseling issues

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system.

TIMEFRAME: Long term

DESCRIPTION: Develop a regional ombudsmen program to help safety net consumers access/navigate the system and to assist with key financial counseling issues at health centers and hospitals. Financial counseling may include assistance with correction of improper billing and administrative errors/barriers, appropriate determination of Medicaid eligibility, and development of payment plans.

Screen and identify patients for ombudsmen services based on criteria. Also develop a mechanism by which ombudsmen may report recurring administrative/systemic problems at a regional level and recommend solutions to facilitate system improvement.

RATIONALE/BENEFITS:

- Assists patients in rectifying problems regarding improper billing and determination of insurance status/Medicaid eligibility.
- Staff assistance in providing information on payment options helps patients avoid medical debt (*Paying for Health Care When You're Uninsured*, The Access Project).
- Reduces financial barriers by assisting patients in developing payment plans.
- Creates efficiencies by identifying patients likely to need assistance with payment plans early in the process.
- Patients with medical debt are less likely to seek needed medical services (The Access Project).

BARRIERS:

- Requires funding.

IMPLEMENTATION/NEXT STEPS:

- Determine which safety net providers currently offer ombudsmen services.
- Identify opportunities to utilize existing ombudsmen programs.
- Determine key components of regional ombudsmen program.
- Secure funding.
- Establish patient identification criteria for ombudsmen services.

SECTION VII – Reducing Financial Barriers

RECOMMENDATION 4: Safety net providers conduct a standardized review of eligibility for Medicaid, reduced fees and financial counseling prior to reporting uninsured patients with overdue payments to a collection agency

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Safety net providers (health centers, hospitals, etc.) conduct a standardized review of eligibility for Medicaid, reduced fees and financial counseling prior to reporting uninsured patients with overdue payments to a collection agency. Required payment and patient counseling is provided as appropriate. Information is shared electronically throughout safety net to reduce redundant financial screenings (long-term).

RATIONALE/BENEFITS:

- Assists patients in avoiding long-term medical debt, which may have severe consequences on a patient's financial future long term.
- Reduces financial barriers to care by assisting patients in developing payment plans.
- Patients with medical debt are less likely to seek needed medical services (The Access Project).
- Reduces administrative costs through sharing of financial screening information.

BARRIERS:

- Additional labor needed to conduct standardized review.

IMPLEMENTATION/NEXT STEPS:

- Develop a standardized uncompensated care policy across outpatient primary and specialty care safety net providers, including eligibility for reduced-fee care.
- Establish a standardized review process across safety net providers.
- Develop a regional ombudsmen program to help safety net consumers access/navigate the system and to assist with key financial counseling issues.
- Ensure adequate training of staff on eligibility when implementing standardized review of eligibility.
- Coordinate financial information requirements with EMR/technology development team.

SECTION VII – Reducing Financial Barriers

RECOMMENDATION 5: Convene area hospital leadership with community representatives to develop effective solutions to medical debt, uncompensated care and billing, and to generate other ideas for reducing financial barriers to care within the boundaries of the law

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term

DESCRIPTION: Convene area hospital leadership with community representatives to develop publicly available effective solutions to medical debt, uncompensated care and billing, and to generate other ideas for reducing financial barriers to care within the boundaries of the law. Solution areas to include:

A. Sliding fee scales, which slide to zero and include a "no turn-away" policy
B. Application and verification process coordinated with outpatient providers. (It is important for safety net providers to be able to share patient eligibility information. This would allow the patient to make a single application for assistance, rather than duplicating the application for each safety net provider.)
C. Screening of all patients for eligibility for reduced-fee care.
D. Policy on treatment and billing for those that do not have payment at time of treatment.
E. Policy on the frequency and procedures for verifying an individual's eligibility for reduced fees, including proper identification and classification of Medicaid patients.
F. Policy on maximum out-of-pocket liability across the system for the uninsured and underinsured. (A discounted rate may be inadequate when catastrophic charges are incurred.)
G. Reduced-fee policy on physician billing for emergency care and unplanned admissions for eligible patients.
H. Assurance that each hospital has a sufficient number of physicians who accept Medicaid (both fee-for-service and MC+)
I. Written materials in appropriate languages about uncompensated care policy.
J. Conspicuous signs in patient areas and notices on bills informing patients of the availability of free and reduced-fee care.
K. Continuing education for safety net health care employees so that information is available in key areas at safety net sites.

Conduct research on solution models from other communities and explore feasibility of implementing. Also generate other solutions for reducing financial barriers to care, including strengthening of hospital financial counseling/ombudsmen programs.

RATIONALE/BENEFITS:

- Assists patients in eliminating medical debt, which may have severe long-term consequences on a patient's financial future.
- Reduces the number of patients impacted by medical debt accrued prior to the implementation of standardized uncompensated care policy across the safety net; for example, a patient may qualify for a 75% discount; however, this discount is rather meaningless if you are looking at several hundred thousand in outstanding medical bills.
- Enables hospital providers to collaboratively develop solutions for reducing financial barriers.

BARRIERS:

- Financial impact on safety net providers.

IMPLEMENTATION/NEXT STEPS:

- Conduct an analysis of the financial impact (on providers and consumers) of various common approaches to medical debt, uncompensated care and billing. Convene hospital leadership with consumer/community representatives (such as RHC Advisory Board members) to reach consensus on a common approach.

SECTION VII – Reducing Financial Barriers for Individuals

RECOMMENDATION 6: Develop a uniform "no turn-away due to inability to pay" policy across outpatient safety net providers

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system.

TIMEFRAME: Short term

DESCRIPTION: Develop a policy across outpatient primary and specialty care providers that no patient will be denied health services due to an inability to pay.

RATIONALE/BENEFITS:

- Eliminates a barrier to care for individuals who can not afford services.
- Decreases the number of individuals deterred from seeking care until medical problems become acute.
- Reduces the use of Emergency Departments for non-emergent care.
- Lowers acute care costs by improving the health status of consumers by removing barriers to primary and preventive services.

BARRIERS:

- Financial impact on providers.
- Potential abuse of the policy by some consumers.

IMPLEMENTATION/NEXT STEPS:

- Conduct analysis on financial impact of no turn-away policy.
- Convene safety net providers to establish consensus on policy.

SECTION VII – Reducing Financial Barriers for Individuals

RECOMMENDATION 7: Advocate for maintenance and expansion of Medicaid coverage

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system.

TIMEFRAME: Immediate

DESCRIPTION: Pass a resolution and actively advocate for the protection of the Missouri Medicaid budget and the restoration of cuts enacted to the program over the past two years, including:

- Restoration of parental coverage up to 100% of the Federal Poverty Level
- Support for the elderly and people with disabilities up to 100% of the Federal Poverty Level
- Reduction in wait time for enrollment in MC+ plans after signing up for the plan. (Ensure appropriate implementation of presumptive eligibility and advocate for the restoration/expansion of presumptive eligibility coverage.)

RATIONALE/BENEFITS:

- Cuts to the Medicaid budget directly increase the number of uninsured individuals, who then face serious financial barriers to obtaining care, and are deterred from seeking future care until medical problems become acute.
- By expanding Medicaid, costs to employers are reduced through delivery of care in the most cost-efficient setting.
- Expanding Medicaid leads to higher economic activity and employment in the health care industry through Federal matching rates.
- Expanding Medicaid provides for a healthier, more competitive workforce for the region.

BARRIERS:

- State budgetary constraints.

IMPLEMENTATION/NEXT STEPS:

- Develop RHC resolution for 2004 legislative session.
- Begin developing partnerships across the state to educate key legislators and stakeholders on importance of Medicaid program to all Missouri citizens.

SECTION VII – Reducing Financial Barriers for Individuals

RECOMMENDATION 8: Coordinate with the State of Missouri and existing entities to examine the feasibility of developing a statewide or local insurance program for low-income uninsured residents

CRITERIA MET: Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Assures timely delivery of safety net services. Creates a more user-friendly safety net system.

TIMEFRAME: Long term

DESCRIPTION: Coordinate with the State of Missouri and existing entities to examine the feasibility of developing a statewide or local insurance program for low-income uninsured residents. Potential components of the program could include:

- Assign or allow uninsured residents to choose a network of safety net providers.
- Patients receive an insurance card and contribute to the cost of their care using a sliding fee scale based on personal income.
- Coordinating entity administers enrollment functions and serves as payer, linking clients with health care provider network.
- Catastrophic insurance coverage product that caps maximum payments for individuals.

RATIONALE/BENEFITS:

- Eliminates a critical barrier to care for low-income persons without health insurance.
- Reduces the use of Emergency Departments for non-emergent care. (Hillsborough County saved $10 million in Emergency Department care).
- Reduces health disparities by providing uninsured patients with timely access to primary and preventive care services.
- Lowers acute care costs by improving the health status of this population.

BARRIERS:

- Identifying a funding stream.
- Identification of an administrative partner willing and able to take on the administrative components of this program.
- Enrollment of members into the insurance program.

IMPLEMENTATION /NEXT STEPS:

- Identify partners to conduct feasibility analysis, including the State and other entities.
- Examine other communities that have implemented insurance programs for low-income uninsured residents.
- Develop business plan.
- Explore potential funding sources.
- Potentially identify organization to advocate for implementation.

Section VIII: Recommendations for Reducing Cultural and Informational Barriers to Care

1. Regularly assess, report and set goals for reducing cultural and racial barriers to safety net care
2. Institute service quality training programs and cultural sensitivity training programs
3. Integrate cross-cultural education into CME sessions for health care professionals
4. Develop a comprehensive coordinated marketing campaign to raise awareness about the safety net system and how to access care
5. Develop a coordinated health literacy program and campaign
6. Develop a minority health professional recruitment and retention program for the primary and specialty care safety net

SECTION VIII – Reducing Cultural and Informational Barriers

RECOMMENDATION 1: Regularly assess, report and set goals for reducing cultural and racial barriers to safety net care

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Improves health status of safety net patients.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Publish a report assessing progress in reducing cultural and racial barriers to safety net care. Include survey/focus group data on patient satisfaction with safety net system.

RATIONALE/BENEFITS:

- Could serve as a basis for an ongoing, solution-focused community dialogue between providers, community organizations, academic institutions, patients and community members regarding reducing cultural barriers to care.
- Provides a means for evaluating initiatives and setting goals.
- Provides another opportunity to gather patient feedback about the safety net system.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Develop indicators and key questions for assessing progress in reducing cultural barriers.
- Convene focus groups or develop surveys of safety net patients and community members regarding cultural barriers and satisfaction with the safety net system.
- Could be included in the RHC's measurement and reporting process.

SECTION VIII – Reducing Cultural and Informational Barriers

RECOMMENDATION 2: Institute service quality training programs and cultural sensitivity training programs

CRITERIA MET: Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net services.

TIMEFRAME: Short-term (requiring funding)

DESCRIPTION: Institute service quality training programs and cultural sensitivity training programs. Develop or utilize existing service quality training program that will educate personnel about customer service (i.e. exceeding patient expectations) and cultural sensitivity. Cultural sensitivity training focuses on valuing workforce and patient diversity, improving communication skills, exploring the effects of one's behavior on others as well as defining culture and how it impacts perception, behavior and values. The effectiveness of the training programs would be measured and evaluated through pre- and post-assessment of the participant groups' knowledge of effective service quality and cultural sensitivity.

RATIONALE/BENEFITS:

- Treating patients with compassion, courtesy and respect enhances patient loyalty and willingness to return for future medical care needs
- Understanding other cultures and cultural impact on perception and behavior allows caregivers to be provide better medical care to the patients they serve
- Service quality and cultural sensitivity training fosters a team-oriented work environment and enhances staff morale and productivity

BARRIERS:

- Requires funding.
- Provider and staff time constraints

IMPLEMENTATION /NEXT STEPS:

- Identify/develop training program options and determine best fit
- Determine interest of safety net institutions in enrolling their staff in service quality/cultural sensitivity training
- Secure funding.

SECTION VIII – Reducing Cultural and Informational Barriers

RECOMMENDATION 3: Integrate cross-cultural education into CME sessions for health care professionals.

CRITERIA MET: Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Provide structured educational sessions for physicians, nurses and other health care professionals on topics to improve cultural sensitivity and communication with patients in care delivery. Can be integrated into the quarterly Continuing Medical Education Conferences involving all safety net institutions. May be implemented by the permanent regional body ("umbrella organization") established to coordinate and integrate the delivery of primary and specialty health services to the uninsured and underinsured. The effectiveness of the cross-cultural CME sessions would be measured and evaluated through pre- and post-assessment of the participant groups' cultural sensitivity.

RATIONALE/BENEFITS:

- Improves care delivery through increased cultural sensitivity and improved communication with patients.
- Develops coordinated, "best practice" methods of delivery across the safety net.
- Improves customer perception of service quality – increases customer satisfaction.
- Reduces cultural barriers to effective medical treatment.

BARRIERS:

- Development of educational curriculum.

IMPLEMENTATION /NEXT STEPS:

- Implement under sponsorship of safety net umbrella organization when CME Conferences initiate.

SECTION VIII – Reducing Cultural and Informational Barriers

RECOMMENDATION 4: Develop a comprehensive coordinated marketing campaign to raise awareness about the safety net system and how to access care

CRITERIA MET: Improves access/reduces barriers to safety net services. Improves health status of safety net patients. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Develop a comprehensive coordinated marketing campaign to raise awareness about the safety net system. May use media outlets like television channels, radio stations and newspapers to help educate people, as well as community-based outlets such as schools, churches, and community-service organizations.

RATIONALE/BENEFITS:

- Increases the use of regular preventive, primary and specialty care resources by community.
- Optimizes utilization of current resources – optimizes use of current primary capacity through increased volumes and reduces strain on hospital emergency departments.
- Integration of campaign enables:
    - Cost-efficiencies through single-vendor contracting
    - Consistent, user-friendly message to consumers

BARRIERS:

- Development of campaign and ongoing marketing expenses

IMPLEMENTATION /NEXT STEPS:

- Determine interest of safety net institutions in jointly promoting safety net system awareness in the community.
- Define goals and scope of initiative and issue RFP to potential vendors
- Obtain funding support
- Implement campaign under sponsorship of safety net umbrella organization

SECTION VIII – Reducing Cultural and Informational Barriers

RECOMMENDATION 5: Develop a coordinated health literacy program and campaign

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Encourages collaboration among safety net providers. Creates a more user-friendly safety net system. Improves access/reduces barriers to safety net services.

TIMEFRAME: Short-term (requiring funding)

DESCRIPTION:
Develop a coordinated health literacy program and campaign across the safety net system to include:

- Public service announcements promoting wellness, disease prevention and how to access to primary care safety net clinics
- Partnerships with school systems to provide comprehensive education and prevention programs (examples: smoking, nutrition, substance abuse, mental illness, sexually transmitted diseases, etc)
- Partnerships with community based organizations to provide education and prevention programs
- Development and distribution of health education materials written at a 6^{th} to 8^{th} grade reading level
- Health fairs

RATIONALE/BENEFITS:

- Raises health literacy and promotes healthy lifestyles
- Improves patient knowledge of safety net system and how to access
- May reduce the stigma sometimes associated with safety net care

BARRIERS:

- Requires funding

IMPLEMENTATION /NEXT STEPS:

- Develop key messages regarding prevention and primary care access
- Develop educational materials
- Identify funding source(s)
- Pursue partnerships with school systems
- Implement campaign under sponsorship of safety net umbrella organization

SECTION VIII – Reducing Cultural and Informational Barriers

RECOMMENDATION 6: Develop a minority health professional recruitment and retention program for the primary and specialty care safety net

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Improves health status of safety net patients. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term (requires funding)

DESCRIPTION: Develop a minority health professional recruitment and retention program for the primary and specialty care safety net. Program effectiveness would be measured and evaluated on a regular basis.

RATIONALE/BENEFITS:

- Areas of St. Louis City and County are impacted by wide disparities in health outcomes (*Building a Healthier St. Louis*).
- A 2002 report by the Institute of Medicine called for an increase in "the proportion of underrepresented U.S. racial and ethnic minorities among health professionals" as critical to reducing racial health disparities.
- The recruitment and retention of minority health providers may help build a workforce of health professionals that more closely mirrors the background of a significant number of safety net patients.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Convene a task force to examine current efforts for safety net recruitment and retention of minority health providers, identify best practices, examine competitive compensation packages and develop a plan for improvement.
- Program could be implemented under the umbrella organization.

Section IX: Recommendations for Reducing Cultural and Linguistic Barriers for New Americans

Improving implementation of CLAS standards

1. Form a standing committee across safety net providers to improve implementation of CLAS standards
2. Conduct training on CLAS standards for medical professionals, including reception and frontline staff
3. Include compliance with CLAS standards in recommendation to regularly assess, report and set goals for reducing cultural and racial barriers to safety net care

Improving financing of services for new Americans

4. Safety net providers collaborate to secure increased funding (Federal, State and local) to support interpreter services and document translation

Improving patient entry/system navigation

5. Standardize and expand training programs for medical interpreters
6. Develop a system for providing interpreter services for the 24x7 safety net information resource line
7. Develop a patient advocate system to assist new Americans in accessing/navigating the safety net health system
8. Develop a training program to assist medical professionals from other countries in entering a medical profession in the St. Louis area
9. Develop and distribute a list of bilingual medical professionals and safety net clinics

Improving information systems

10. Account for new American consumers in developing the Master Patient Index

Improving Recruitment and Retention of Racial and Ethnic Minority Health Providers

11. Include a focus on both racial and ethnic minorities in the minority health professional recruitment and retention program for the safety net

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 1: Form a standing committee across safety net providers to improve implementation of CLAS standards

CRITERIA MET: Enables cost efficiencies. Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term

DESCRIPTION: Form a standing committee of physicians, nurses, staff and administrators from across the safety net to improve implementation of Culturally and Linguistically Appropriate Services (CLAS) standards. Assess current strengths/weaknesses of safety net implementation of CLAS standards. Identify current difficulties in implementation. Hold focus group with reception/gatekeeper safety net clinic staff to gather information on improving CLAS standard implementation in the reception/registration process. Research best practices (local and national). Develop solutions and a timeline for improvements

RATIONALE/BENEFITS:

- CLAS Standards set forth Federal mandates, guidelines and recommendations for culturally and linguistically appropriate services by health care providers. They also offer a basis for evaluation and quality assurance.
- Task Force provides opportunity to identify and implement best practices in implementation of and adherence to CLAS standards.
- Successful implementation of CLAS standards enables cost efficiencies and greater consumer satisfaction,

BARRIERS:

- Time constraints on safety net medical professionals.
- Difficulty in evaluating implementation of standards.

IMPLEMENTATION/NEXT STEPS:

- Determine sponsorship and organizational responsibility for establishing agendas, scheduling meetings, etc.
- Identify participants.

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 2: Conduct training on CLAS standards for medical professionals, including reception and frontline staff

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term

DESCRIPTION: In conjunction with training activities sponsored by safety net Umbrella (or Network) organization. Provide training on CLAS standards to professionals across the safety net, including front-line staff. Will reduce confusion and lack of knowledge about standards throughout safety net providers.

RATIONALE/BENEFITS:

- CLAS Standards set forth Federal mandates, guidelines and recommendations for culturally and linguistically appropriate services by health care providers. They also offer a basis for evaluation and quality assurance.
- Successful implementation of CLAS standards enables cost efficiencies and greater consumer satisfaction. Such implementation will not be effective without sustained training of safety net personnel.
- Standardized training allows efficient and consistent delivery and implementation across safety net.

BARRIERS:

- Time constraints on safety net medical professionals.

IMPLEMENTATION/NEXT STEPS:

- Integrate CLAS standards training into curriculum of Network once formed.

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 3: Include compliance with CLAS standards in recommendation to regularly assess, report and set goals for reducing cultural and racial barriers to safety net care

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term

DESCRIPTION: Include compliance with CLAS standards in recommendation to regularly assess, report and set goals for reducing cultural and racial barriers to safety net care. This recommendation to assess, report, and set goals for reducing cultural barriers was approved by the RHC on July 17, 2003. Information collected by the RHC for its March 2003 Building a Healthier St. Louis report can be used as potential baseline data for such reporting.

RATIONALE/BENEFITS:

- CLAS Standards set forth Federal mandates, guidelines and recommendations for culturally and linguistically appropriate services by health care providers. They also offer a basis for evaluation and quality assurance.
- Successful implementation of CLAS standards enables cost efficiencies and greater consumer satisfaction. The regular measurement and reporting of adherence to such standards will promote the implementation of CLAS standards across safety net providers.

BARRIERS:

- Time constraints on safety net medical professionals.
- Difficulty in evaluating adherence to standards, and the difficulty/cost of obtaining data from safety net providers on a regular basis.

IMPLEMENTATION/NEXT STEPS:

- Determine sponsorship and organizational responsibility for reporting.

SECTION IX – Improving patient entry/navigation of the system

RECOMMENDATION 4: Safety net providers collaborate to secure increased funding (Federal, State and local) to support interpreter services and document translation

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers. Enables cost efficiencies.

TIMEFRAME: Long term

DESCRIPTION: Safety net providers collaborate to secure increased funding (Federal, State and local) for interpretation, translation, and medical professional training across the safety net. Use funds to recruit more interpreters, build on existing interpreter training programs and train medical professionals to work across cultures.

RATIONALE/BENEFITS:

- Enhances collaboration among safety net providers.
- Builds on existing resources for new Americans in the community.
- Improves availability of interpreter and translation services.
- Enhances provider effectiveness.

BARRIERS:

- Limited availability of funds.

IMPLEMENTATION /NEXT STEPS:

- Identify funding sources.
- Organize collaborators.
- Determine funding priorities.

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 5: Standardize and expand training programs for medical interpreters

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system.

TIMEFRAME: Long term

DESCRIPTION: Standardize and expand training programs for medical interpreters, for both "on call" interpreters and for bilingual staff employed in the safety net. Establish standard certification requirements for medical interpreters across safety net providers. Increase the number of trained medical interpreters to serve the safety net by increasing recruitment to training programs and by providing certification.

RATIONALE/BENEFITS:

- Improves availability and quality of interpreter services.
- Builds on existing resources in the community.
- Enhances provider effectiveness.

BARRIERS:

- May require funding.

IMPLEMENTATION/NEXT STEPS:

- Identify an organization to lead the effort. Discuss this effort with organization already involved in providing interpreter services.
- Existing interpreter training program, providers, advocates and new American community discuss standardization of certification requirements and opportunities to increase capacity of existing program.
- Potentially secure funding.

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 6: Develop a system for providing interpreter services for the 24x7 safety net information resource line

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Encourages collaboration among safety net providers.

TIMEFRAME: Short term (requires funding)

DESCRIPTION: Develop a system for providing interpreter services, including assistance in scheduling appointments, for non-English speaking callers to the 24x7 safety net information resource line (see RHC Recommendations for Improving Care Coordination). The resource line is a telephone help-line providing people in need of safety net medical care, health resources or human services with information on accessing available services. Draws on the information provided in the community-wide safety net web site (See Section II, Recommendation 11).

RATIONALE/BENEFITS:

- Provides non-English speaking consumers with accessible information on safety net services and assistance in scheduling appointments.
- Currently medical interpreters are being diverted into a case management function to schedule patient appointments.
- The resource line is accessible to anyone with a telephone. Does not require literacy or computer skills.
- The resource line provides accurate and timely information specific to a user's request.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Consider various options for providing these services, including building on existing interpreter services.
- Identify an organization to guide the implementation process.

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 7: Develop a patient advocate system to assist new Americans in accessing/navigating the safety net health system

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Assures timely delivery of medical services. Creates a more user-friendly safety net system.

TIMEFRAME: Long term

DESCRIPTION:
Develop a patient advocate system to assist new Americans in accessing/navigating the safety net health system. Consider options for implementing such a system including:

- Utilizing new Americans to assist less experienced new Americans in accessing/navigating the safety net health system. This could include assigning new American consumers to more experienced "partners" to answer questions, assist in setting up appointments, and help them understand and utilize safety net services.
- Building on existing case management systems to provide patients with a case manager who speaks their language, as necessary.

RATIONALE/BENEFITS:

- Could draw on the experience of new Americans to assist others in accessing/navigating the system.
- Provides new Americans with accessible, individually-focused information.
- Does not require access to a computer or proficiency in English for new American patients to obtain information.

BARRIERS:

- Requires funding.
- Limited availability of case managers.

IMPLEMENTATION /NEXT STEPS:

- Consider options for system implementation.
- Identify a sponsor organization to develop and implement the system.
- Determine cost and identify funding source.
- Potentially identify new Americans familiar with the safety net system to serve as partners.

SECTION IX – Improving patient entry/navigation of the system

RECOMMENDATION 8: Develop a training program to assist medical professionals from other countries in entering a medical profession in the St. Louis area

CRITERIA MET: Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system. Encourages collaboration among safety net providers. Enables cost efficiencies.

TIMEFRAME: Long term

DESCRIPTION: Develop and implement a training program that will assist medical professionals from other countries in entering a medical profession or applying for the education or certification necessary to work in a medical profession in the region. Training program will include information on U.S. requirements to serve in the medical profession (Board certifications, etc.) and available resources (including funding) for education and training.

RATIONALE/BENEFITS:

- Utilizes medical professionals from other countries in their chosen (or a related) profession.
- May help reduce cultural and linguistic barriers to care for new Americans by increasing the number of providers serving new Americans in the community.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Determine organization to establish and implement program.
- Determine cost and identify funding source.

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 9: Develop and distribute a list of bilingual medical professionals and safety net clinics

CRITERIA MET: Improves health status of safety net patients. Improves access/reduces barriers to safety net services. Assures timely delivery of medical services. Creates a more user-friendly safety net system.

TIMEFRAME: Short term

DESCRIPTION: Develop and distribute a document listing bilingual medical professionals (including specialists) serving safety net consumers, safety net clinics, and information on after-hours resources. Distribute to providers for use in referrals and to new Americans case managers/advocates. Include in the information available through the 24x7 safety net information resource line, guide and web site (RHC Care Coordination Recommendations). Translate into multiple languages for safety net consumers and distribute through International Institute, places, of worship, ethnic food stores, foreign language newspapers and other media, schools, workplaces, etc. Also indicate bilingual professionals in the safety net provider directory.

RATIONALE/BENEFITS:

- Reduces cultural, linguistic and informational barriers to care. Provides new American safety net consumers with translated information on safety net resources, including providers that speak their language.
- Provides resource for providers and advocates when making referrals.

BARRIERS:

- Difficulty of maintaining an updated list.

IMPLEMENTATION /NEXT STEPS:

- Identify organization to develop and maintain the list.
- Develop and distribute document.

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 10: Account for new American consumers in developing the Master Patient Index

CRITERIA MET: Enables cost efficiencies. Improves health status of safety net patients. Assures timely delivery of medical services. Improves access/reduces barriers to safety net system.

TIMEFRAME: Long term

DESCRIPTION: Account for new American consumers in the construction of the Master Patient Index across the safety net (RHC Care Coordination Recommendation 3). Note each patient's primary language, ethnicity and country of origin. Ensure patient identification system is not contingent upon Social Security numbering.

RATIONALE/BENEFITS:

- Numerous safety net user s do not have social security numbers due to immigration status. Coordinating the transfer of medical information about these patients will be important to ensure timely delivery of medical services.
- Improves efficiency and coordination in securing interpreter services.

BARRIERS:

- Difficulties associated with ensuring patient identification system is not contingent upon Social Security numbering.

IMPLEMENTATION/NEXT STEPS:

- Ensure Network IT staff considers recommendation as IS planning is initiated.

SECTION IX – Reducing Cultural and Linguistic Barriers for New Americans

RECOMMENDATION 11: Include a focus on both racial and ethnic minorities in the minority health professional recruitment and retention program for the safety net

CRITERIA MET: Improves access/reduces barriers to safety net services. Creates a more user-friendly safety net system. Improves health status of safety net patients. Encourages collaboration among safety net providers.

TIMEFRAME: Short-term

DESCRIPTION: Include a focus on both racial and ethnic minorities in the minority health professional recruitment and retention program for the safety net recommended by the RHC for development (see RHC Recommendations, October 2003). Program effectiveness would be measured and evaluated on a regular basis.

RATIONALE/BENEFITS:

- Areas of St. Louis City and County are impacted by wide disparities in health outcomes (*Building a Healthier St. Louis*).
- A 2002 report by the Institute of Medicine called for an increase in "the proportion of underrepresented U.S. racial and ethnic minorities among health professionals" as critical to reducing racial health disparities.
- The recruitment and retention of minority health providers may help build a workforce of health professionals that more closely mirrors the background of a significant number of safety net patients.

BARRIERS:

- Requires funding.

IMPLEMENTATION /NEXT STEPS:

- Convene a task force to examine current efforts for safety net recruitment and retention of minority health providers, identify best practices, examine competitive compensation packages and develop a plan for improvement.
- Program could be implemented under the umbrella organization.

Section X: Improving Health Measurement and Reporting

1. Link health status measurement and reporting to an ongoing health improvement process.

2. Release an annual health report card for St. Louis City and County for select health status and access indicators.

3. Beginning in 2006, release a comprehensive report every three years assessing progress in improving health outcomes, reducing health disparities and improving access to health care.

Section X: Recommendations for Improving Measurement and Reporting

The RHC envisions a broad goal for measurement and reporting in the St. Louis community: **to encourage collaborative, long-term improvement in the health and health care of the region's citizens, based on accurate data.**

In order to accomplish this goal, the RHC makes the following Recommendations for measurement and reporting:

4. Link health status measurement and reporting to an ongoing health improvement process.

5. Release an annual health report card for St. Louis City and County for select health status and access indicators.

6. Beginning in 2006, release a comprehensive report every three years assessing progress in improving health outcomes, reducing health disparities and improving access to health care.

The RHC views the communication of health status information to the community as an engagement process – an opportunity to generate energy and foster the development of solutions around increasing access to care, improving health outcomes and reducing health disparities. The communication of health data will be used to generate an ongoing, solution-focused community dialogue between providers, community organizations, academic institutions, patients and community members regarding health improvement, system improvement, and behavioral change.

The communication of health data is not an end in itself, but a means for generating action and evaluating initiatives. The reporting of data should include structured and organized action.

Current RHC Measurement and Reporting Process

The RHC Situational Analysis provides a comprehensive overview of the health status of St. Louis City and County in three areas:

- Access to safety net primary and specialty care services

- Health outcomes (reported on over 60 health and socioeconomic status indicators in maps and tables)

- Health disparities (reported by race and zip code in maps and comparative tables on over 60 health and socioeconomic status indicators; reported by neighborhood or municipality where significant)

The RHC is using this data as baseline information for informed, collaborative decision-making. In 2003 and 2004, the Commission will release strategic plans for strengthening the integrity of the safety net system, improving health outcomes, and reducing health disparities in the region. The RHC will then work with responsible organizations and individuals in the community to implement the plan over the next several years.

The process for developing the strategic plan involves engaging the health community and the broader community around the data in order to generate, evaluate, and reach consensus on solutions. The current and planned RHC engagement process includes:

- *Determining the problem:* Involving safety net institutions, academic institutions, health departments, community organizations and safety net patients in the determination of the integrity of the safety net and health status of the community (Development of March 2003 report; Development of community health report).

- *Generating solutions:* Communicating the data in a series of town hall meetings, and engaging citizens in generating solution ideas. Meeting with community, safety net and governmental leaders to gather solution ideas. Seeking out existing resources and collaborations to work with and strengthen.

- *Gathering feedback on potential solutions:* Holding a series of "listening posts" to gather feedback on potential solutions. Meeting with community, safety net and governmental leaders to determine solution feasibility.

- *Implementing solutions:* Working with community members and organizations, safety net providers, and governmental representatives to take action around solutions.

Recommendations for Measurement and Reporting

The RHC will report back to the community with an evaluation of its progress and continue to engage the community in the development and implementation of solutions. Because change in health outcomes and access to care takes time, the RHC recommends that this information be reported in a comprehensive manner **every three years**. The RHC proposes that in 2006, the Commission release a follow-up report on the community's progress in the three areas the Commission seeks to improve:

- Access to safety net primary and specialty care services (See attached recommended Access and Availability Indicators)
- Health outcomes (See attached Health Status Indicators from Section VII of *Building a Healthier Saint Louis*)
- Health disparities (Same as Health Status Indicators)

The 2006 data will be compared to the 2003 baseline data. The resulting analysis will be used as a basis for engaging citizens, providers, patients, and community and governmental leaders in considering the effectiveness of current initiatives, setting new community health priorities, revising action plans and implementing new solutions, as needed. The RHC will finance the ongoing engagement process and 2006 report out of its budget.

Between now and 2006, the RHC will also develop an **annual report card of key indicators**. This report card will not be a comprehensive report, but rather an overview of the community's progress in key areas using available data sources.

Beyond 2006, the RHC recommends that the community:

- Continue to assess its progress with a comprehensive report every three years and an annual report card of several key indicators.
- Use a collaborative, inclusive process to generate solutions and take action around the data on an ongoing basis.

The process of tracking, reporting, and engaging the public around the community's health status may continue as an RHC function or be adopted by another organization following the 2006 report. In its 2006 report, the Commission will make a recommendation for an organization or organizations to carry on this function, and for an ongoing funding stream to support these efforts.

Indicators for Measurement and Reporting

The following are tables of indicators to be measured and reported to the community. Key Indicators will be reported on an annual basis. Comprehensive Indicators and Access and Availability Indicators will be reported every three years beginning in 2006.

KEY INDICATORS TO BE REPORTED ON AN ANNUAL BASIS

	Disparities and Outcomes
1	Infant Mortality
2	Breast cancer – ratio of early stage to late stage diagnosis
3	Heart Disease Mortality
4	Diabetes mortality
5	HIV Infection Incidence
6	Lead poisoning screened prevalence rate – age 0-5
7	Adult smoking rate (BRFSS – 7-County Region only)
8	Suicide
9	Obesity (BMI)* (BRFSS – 7-County Region only)

	Access to Care
1	Preventable hospitalizations
2	1st trimester prenatal care

COMPREHENSIVE INDICATORS TO BE REPORTED EVERY THREE YEARS

Demographic Indicators	
1	Population change (1990-2000)
2	Age 0-4
3	Age 5-14
4	Age 15-44 female
5	Age 15-44 male
6	Age 65+
7	Racial distribution/racial polarization
8	Overall population
9	Crude birth rate
10	Crude death rate
11	Fertility rate

Socioeconomic Indicators	
12	Average household income
13	Persons below poverty
14	Female head of household
15	High school graduation or GED
16	Unemployed

Health Status Indicators	
17	Breast cancer – ratio of early state to late stage diagnosis
18	Hospital admission rates
Maternal and Child Health Indicators	
19	Infant mortality
20	1st trimester prenatal care
21	Teen births (ages 10-17)
22	Teen births (ages 10-14)
23	Births to women over age 35
24	Very low birth weight (less than 1500 g or 3.3 pounds)
25	Low birth weight (less than 2500 g or 5.5 pounds)
26	Lead poisoning percent tested (age 0-5)
27	Lead poisoning screened prevalence rate (age 0-5)
28	Asthma hospitalizations
29	Birth – Medicaid
30	Birth – WIC
31	Birth – Food stamps
32	Birth – Smoking
33	Birth – Alcohol
34	Birth – Education

Health Status Indicators, cont.	
Mortality Indicators	
35	Leading causes of death
36	Overall mortality
37	Life expectancy
38	Heart disease mortality
39	Stroke mortality
40	COPD mortality
41	Overall cancer mortality
42	Breast cancer mortality
43	Prostate cancer mortality
44	Lung cancer mortality
45	Diabetes mortality
46	Homicide
47	Suicide
48	Motor vehicle accident mortality
49	Non-motor vehicle accident mortality
50	Overall accident mortality
51	Influenza and pneumonia mortality
Infectious Disease Indicators	
52	HIV infection incidence
53	AIDS incidence
54	Gonorrhea rates (NA by race)
55	Syphilis rates
56	Tuberculosis rates
57	AIDS mortality
58	Chlamydia (NA by race)
59	Hepatitis A
60	Hepatitis B
61	Hepatitis C

Environmental Indicators	
62	Possible environmental indicators (e.g. air quality)

Additional Comprehensive Indicators for Subsequent Years

The RHC proposes that these indicators be tracked if and as the data become more readily available.

1	Adolescent heavy and binge drinking in past 30 days
2	Adult heavy and binge drinking in past 30 days
3	Adult illicit drug use in past 30 days
4	Obesity (BMI)
5	Rate of physical activity
6	Rate of 5 or more servings of fruit and vegetables

ACCESS AND AVAILABILITY INDICATORS

The following metrics illustrate access and availability of safety net primary and specialty care services. Baseline metrics are included from the RHC Situational Analysis released in March 2003.

Primary Care

The metrics in the table below will be graphically illustrated:

Metric	Baseline from Situational Analysis
Primary care physical plant capacity	915,840
Primary care physician capacity	
Expected visits	552,600
Actual visits	437,022
Difference between number of expected and number of actual visits	115,578

Primary Care, cont.

The indicators in the table below will also be reported:

Metric	**Baseline from Situational Analysis**
Number of unduplicated individuals served/size of safety net population	252,919/307,000
Percentage of safety net population seen in primary care setting in year	74%
Areas of need within 20 min of primary care site	XX Square miles of xx total square miles
Percentage of sites < 15 days appointment wait time	86%
Number of patients seen per exam room per day/number seen in a typical physician's office	3.8 patients per exam room per day/8
% primary care seen in ED setting	17%
% ED visits that are non-emergent	37%

Specialty care

The indicators in the table below will be graphically illustrated:

Metric	Baseline from Situational Analysis
Specialty care physician capacity	
Expected visits	368,400
Actual visits	145,784
Difference between number of expected visits and number of actual visits	246,400

The indicators in the table below will also be reported:

Metric	Baseline from Situational Analysis
Percentage of sites < 30 days appointment wait time, as reported by primary care safety net sites	List by specialty – ranges from 28% (Urology) to 74% (Eye care)

Dental Care

The indicators in the table below will be graphically illustrated:

Metric	Baseline from Situational Analysis
Expected visits	307,000
Actual visits	56,344
Difference between number of expected visits and number of actual visits	250,656

The indicators in the table below will also be reported:

Metric	Baseline from Situational Analysis
Number of patients seen per chair per day/typical number	3.8 patients per chair per day/X
Average wait time	2 months

Mental Health

Psychiatric Services

The indicators in the table below will be graphically illustrated:

Metric	Baseline from Situational Analysis
Estimated number of persons in need of psychiatric services	22,718
Number of unduplicated clients served by Administrative Agents	10,549
Difference between number of clients served by Administrative Agents and number estimated to be in need	12,169
Total population in need served	46%

The indicator in the table below will also be reported:

Metric	Baseline from Situational Analysis
Number of providers with wait times over 4 weeks	65%

Mental Health, cont.

Substance Abuse

The indicators in the table below will be graphically illustrated:

Metric	Baseline from Situational Analysis
Estimated number of persons in need of substance abuse services	29,165
Number of clients admitted to ADA programs	11,210
Difference between number of clients served by ADA and number estimated to be in need	12,169
Total population in need served	38%

Pharmacy Services

The indicators in the table below will be reported:

Number of prescriptions filled	325,000 new, 3000 refill
Amount of uncompensated prescription drugs provided	$7 Million

ADDITIONAL ACCESS INDICATORS

The indicators in the table below will also be reported:

17	Preventable hospitalizations
18	Emergency room visits
Uninsured Population	
19	Number of uninsured persons (estimate)
Medicaid Population (MC+)	
20	MC+ eligibility (enrolled) as percent of total population
Medicaid Population (Traditional)	
21	Medicaid eligibility (enrolled) as percent of total population