U.S. Agency for Healthcare Research and Quality

Innovators Exchange: The St. Louis Regional Health Commission

Regional Commission Made Up of Diverse Stakeholders Enhances Access to Coverage and Services for Low-Income Residents, Reducing Readmissions and Emergency Department Visits

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Summary

The St. Louis Regional Health Commission is a diverse consortium of collaborating stakeholders (providers, civic leaders, community activists, and local and State government officials) that provides strategic direction and policy recommendations to improve the quality and efficiency of health care services available to all St. Louis residents regardless of their ability to pay. To that end, the Commission sets up task forces and committees to tackle specific high-priority issues and administers a coverage model for adult residents who do not qualify for Medicare or Medicaid, using Medicaid Disproportionate Share Hospital funds (available through a Medicaid waiver) and local tax money to pay community health centers and other providers for outpatient services. The Commission also created several separate nonprofit membership organizations of providers that collaborate on projects to improve the quality, efficiency, and coordination of physical, mental, and public health services. Through these efforts, the Commission has enhanced access to coverage, medical and dental care, and medical homes for low-income residents, which in turn has led to reductions in readmissions and inefficient use of the emergency department. Based on a retrospective analysis, the Commission believes its efforts also played a role in improvements in selected health outcomes.

Evidence Rating

Suggestive: The evidence consists of post-implementation data on the number of low-income residents gaining access to health coverage; the number of medical and dental visits by low-income residents; the number of individuals connected to a medical home; comparisons of readmission rates among those connected to a medical home with the regional average; comparisons of inappropriate emergency department visits by newly enrolled individuals with the area average; and a 10-year retrospective analysis of health outcomes in the St. Louis region between 2000 and 2010.

Use By Other Organizations

The Detroit Wayne County Health Authority, Mid-America Council in Kansas City, and Healthy San Francisco administer similar programs designed to improve health and bolster the local safety-net system.

Date First Implemented

2001

Problem Addressed

Despite improvements in the last decade, many residents of St. Louis have low incomes, lack health insurance, and struggle with multiple risk factors, making them more likely to be diagnosed with and die from various chronic diseases.

- **Many poor, uninsured residents:** More than a quarter (27 percent) of residents in St. Louis live below the Federal poverty level, a much higher proportion than in Missouri as a whole (15 percent). In addition, in 2011, 31 percent of St. Louis residents did not have health insurance, compared with 23.7 percent for Missouri as a whole.

- **Multiple risk factors:** Over a quarter (25.9 percent) of St. Louis residents do not exercise, while 26.2 percent smoke and 30.6 percent are obese (defined as a body mass index greater than or equal to 30).

- **Increased risk of chronic diseases (and associated deaths):** St. Louis residents are more likely to suffer from one or more chronic diseases than the typical Missouri resident. For example, the incidence of heart disease among St. Louis residents is 297.5 per 100,000 individuals, well above the 245.6 per 100,000 average for the State. The same is true for cancers, with 245.6 out of every 100,000 St. Louis residents having some form of cancer, compared with 197.7 per 100,000 for the State as a whole. St. Louis residents are also more likely to die from chronic disease. For example, the age-adjusted mortality rate for diabetes is 34.9 per 100,000 St. Louis residents, compared with 23.78 per 100,000 for all Missouri residents.

Description of the Innovative Activity

The St. Louis Regional Health Commission is a diverse consortium of collaborating stakeholders that provides strategic direction and policy recommendations to improve the quality and efficiency of health care services available to all residents, regardless of their ability to pay. To that end, the Commission sets up task forces and committees to tackle specific high-priority issues and administers a coverage model for adult residents who do not qualify for Medicare or Medicaid, using Disproportionate Share Hospital (DSH)funds (available through a Medicaid waiver) and local tax dollars to pay community health centers and other providers for outpatient services. It also set up (and works closely with) several independent nonprofit membership organizations made up of providers that collaborate on projects to improve the quality, efficiency, and coordination of physical, mental health, and public health services. Key components of the consortium's structure and activities are outlined below:

- **Collaborative structure that brings together diverse stakeholders:** The Commission is set up to ensure that a diverse group of local stakeholders have input into its activities and policies and that these stakeholders work in a collaborative fashion. Key components of this collaborative structure are detailed below:

    - **Representatives from various stakeholders:** The Commission itself is a diverse body made up of 19 appointed members who meet monthly to provide strategic direction and make recommendations related to the provision of health care services to low-income residents. To foster inclusiveness and consensus-driven decisionmaking, seats are appointed by various important stakeholders, including three by the mayor of St. Louis (usually including the city's public health director), three by the county executive (usually including the county's public health director), two by the Governor (usually including the State Medicaid or Social Services director), two by local hospitals (usually including the chief executive officers of two regional health systems), two by community health centers, one by local medical schools, and three by the community at large (usually civic leaders).

    - **Community and provider advisory boards:** Two 30-member advisory boards—one made up of providers and the other made up of community members—provide input to the Commission and also periodically disseminate information to the public. These advisory bodies meet monthly and have an opportunity to provide formal input during monthly meetings of the Commission. (Receiving reports and input from each advisory board is a formal, standing part of the agenda at these meetings.) In addition, the chairman of each advisory board serves as a voting member of the Commission. The community board includes representatives from patients and consumers, local social service agencies, health advocates, and other community volunteers, while the provider

board includes local physicians, nurses, mental health professionals, dentists, pharmacists, and administrators involved in delivering services to low-income patients.

    - **Active engagement of the community:** To identify potential members for the community advisory board and to collect perspectives on medical, dental, and behavioral health issues from a broad spectrum of the community, Commission staff regularly solicit feedback from patients in emergency department (ED) waiting rooms, host focus groups, conduct surveys, hold community forums (at least once each year), and attend local events hosted by nonprofit agencies and community coalitions.

- **Working committees and task forces to tackle specific issues:** The Commission sets up ad hoc working committees and teams to provide oversight for individual projects targeted at high-priority areas. For example, the Commission created a pilot-program planning team and an outreach and enrollment committee to plan and implement Gateway to Better Health, a coverage program for low-income residents (described in more detail below). The Commission also periodically sets up temporary task forces to collect and analyze information and recommend regional policies and initiatives to enhance access to care and improve the quality of services for uninsured and underinsured individuals. To date, task forces have been set up to assess and improve the behavioral health system, the local and regional public health system, health literacy, dental services, and community-based media research.

- **Administration of coverage model for low-income residents, using DSH funds and local tax revenue:** The Commission serves as the administrative agent for Gateway to Better Health, an outpatient coverage model for low-income adults (ages 19-74, earnings at or below 100 percent of the Federal poverty level) who do not qualify for Medicaid or Medicare. Approved as a Medicaid 1115 waiver demonstration program with DSH funds and local tax revenue, this approach, which is set up as a coverage model, stands in contrast to the traditional approach of paying DSH funds for inpatient care.

    - **Reimbursement of providers based on enrollment and claims:** The plan reimburses a limited network of providers based on enrollment (a per-member per-month payment for primary care) or claims (based on fee-for-service) for specialty providers. Gateway uses a network of five large community health centers that provide primary care, generic prescription medications, and preventive dental services to members through a primary care medical home model. Providers at the community health centers refer patients to specialists as necessary, with physicians from the medical schools at Washington University in St. Louis and St. Louis University providing the bulk (93 percent) of specialty outpatient care. (Medical groups affiliated with three other local systems—SSM Health Care, Mercy, and BJC HealthCare—provide the remainder.) The model covers up to five urgent care visits per year and also covers radiation therapy; radiology and laboratory services; outpatient surgery; limited speech, occupational, and physical therapies; and nonemergency transportation services.

- **Incentive payments based on performance on quality metrics:** Seven percent of claims-based reimbursement to primary health centers is initially withheld and is then paid out based on the centers' ability to meet established quality metrics. Examples of metrics include the following: having at least two office visits within 6 months of initial enrollment or diagnosis of diabetes, chronic obstructive pulmonary disease, hypertension, or congestive heart failure; performing hemoglobin A1c (HbA1c) testing for patients with diabetes within 6 months of enrollment or diagnosis; and maintaining HbA1c levels below 8 percent within 6 months of enrollment or diagnosis for at least 60 percent of patients with diabetes.

- **Consortiums to improve quality, efficiency, and integration of patient care:** To complement its efforts, the Commission created the St. Louis Integrated Health Network, a separate nonprofit membership-based organization of outpatient providers, including the medical schools of Washington University and St. Louis University and six community health centers that collectively have more than 20 locations. A nine-member board meets regularly to direct the network's efforts. The board includes the chief executive officer of the Commission along with executives from the community health centers and the university's multispecialty practices. Task forces oversee individual projects designed to foster integration of care among primary care providers, specialists, EDs, and inpatient units. For example, a task force was set up to oversee the community referral coordinator program, which uses licensed social workers in EDs and inpatient units to connect patients to a primary care medical home at one of the community health centers in the Gateway network. The Commission also works closely with the Behavioral Health Network of Greater St. Louis, which focuses specifically on improving health access and coordination among behavioral health organizations and hospitals in the region.

- **Public reports on access to care:** Each year, the Commission publishes a report providing statistical information on access to care for low-income residents in St. Louis city and county, including visits to primary, specialty, dental, behavioral health, and emergency providers (broken down by provider and payer), and average wait times for appointments to primary and specialty providers. The impetus for establishment of the Commission came in 1997, when the city's only public hospital, the St. Louis Regional Medical Center, closed its doors, leaving St. Louis without a viable health care infrastructure for Medicaid beneficiaries and uninsured residents. In response, Civic Progress, a group of executives from approximately 30 large St. Louis businesses, formed a task force to address the safety-net crisis. One of the issues to be considered was the potential loss of $25 million in annual DSH funds, which had previously been distributed to the public hospital.

Context of the Innovation

The impetus for establishment of the Commission came in 1997, when the city's only public hospital, the St. Louis Regional Medical Center, closed its doors, leaving St. Louis without a viable health care infrastructure for Medicaid beneficiaries and uninsured residents. In response, Civic Progress, a group of executives from approximately 30 large St. Louis businesses, formed a task force to address the safety-

net crisis. One of the issues to be considered was the potential loss of $25 million in annual DSH funds, which had previously been distributed to the public hospital.

Based on the task force's recommendation, the Commission was formed in 2001, with the goal of restructuring the safety-net system to ensure its financial stability and hence its ability to serve uninsured and underinsured individuals. The cornerstone of the restructuring effort involved shifting the locus of care away from inpatient and ED services to outpatient care. To facilitate this transition, the State of Missouri secured a Medicaid 1115 Waiver in 2003 from the Federal Government, allowing the Commission to reallocate DSH funds to outpatient providers, including community health centers and specialty medical practices. Initially these funds were paid on a block-grant basis. With the launch of Gateway to Better Health on July 1, 2012, distribution of these funds changed to the coverage model described previously. Gateway now serves as an important bridge to care for St. Louis' safety-net population until Medicaid expands to cover people in Missouri under 100 percent of the poverty level.

Results

The Commission has enhanced access to coverage, medical/dental care, and medical homes for low-income residents, which in turn has led to reductions in readmissions and inappropriate ED use. The gap between African-American and White residents in selected health outcomes narrowed over time.

- **Enhanced access to coverage:** In its first year of operation (July 1, 2012 through June 30, 2013), Gateway to Better Health provided coverage to more than 28,000 uninsured St. Louis area residents who would not otherwise have had access to coverage. As part of the effort to recruit individuals to Gateway, Commission-sponsored initiatives also identified and enrolled 20,000 other area residents who qualified for Medicaid.

- **Enhanced access to medical/dental services and medical homes:** During Gateway's first year of operation, the 28,000-plus newly enrolled individuals averaged 3,200 primary care visits and 800 dental visits a month. In the absence of this program, these individuals likely could not have accessed these services. Between 2001 and 2011, the total number of annual primary care visits (adult, pediatric, obstetrical, and dental) to St. Louis area providers (including community health centers and other sites) by Medicaid and uninsured patients grew by over 25 percent, from 437,435 to 561,522. Over the same time period, specialty visits by these groups grew slightly, from 198,073 to 201,897. Since 2008, medical referral coordinators located in hospital EDs and inpatient units have connected more than 8,000 patients to a primary care medical home at a community health center, 46 percent of whom kept the appointments arranged by the coordinators.

- **Fewer readmissions among those connected to medical homes:** Hospital readmission rates among patients connected to a medical home are below 15 percent, less than the regional average of 18 to 25 percent.

- **More appropriate ED use:** In Gateway's first year of operation, less than 5 percent of ED visits by enrollees were for low-severity problems, well below the 22-percent average across all St. Louis EDs.

- **Improvement in selected health outcomes:** While the Commission does not have evidence showing a direct link between its programs and improvements in health outcomes, it believes it has played a positive role in narrowing the gap between African-American and White city and county residents in mortality rates for breast cancer and chronic obstructive pulmonary disease.

Evidence Rating

Suggestive: The evidence consists of post-implementation data on the number of low-income residents gaining access to health coverage; the number of medical and dental visits by low-income residents; the number of individuals connected to a medical home; comparisons of readmission rates among those connected to a medical home with the regional average; comparisons of inappropriate emergency

department visits by newly enrolled individuals with the area average; and a 10-year retrospective analysis of health outcomes in the St. Louis region between 2000 and 2010.

Planning and Development Process

Key steps included the following:

- **Developing and publishing strategic plan:** The Commission formed a communitywide strategic planning task force in 2002. Hundreds of organizations and thousands of individuals provided input on the plan through townhall meetings, focus groups, and other venues. As part of this effort, the task force also reviewed data, surveys, and reports from various sources, such as St. Louis University School of Public Health and local safety-net providers. Published in October 2003, the final plan included 95 recommendations for creating an integrated, financially sustainable, and patient-friendly safety-net system.

- **Forming medical provider network:** Following one recommendation in the strategic plan, the Commission created the aforementioned Integrated Health Network in 2003 as an independent nonprofit membership-based organization that facilitates coordination of care.

- **Launching a coverage model program:** After the Federal Government gave its approval in July 2010, the Commission spent 2 years developing Gateway to Better Health, which launched operations on July 1, 2012.

- **Integrating behavioral health:** In 2006, the Commission launched a major initiative to integrate physical and behavioral health and incorporate behavioral health as a key regional priority in all Commission activities. This innovation led to the formation of the Behavioral Health Network of St. Greater Louis and investments of more than $6 million as of 2014 to improve access to and coordination of behavioral health services in the region.

Resources Used and Skills Needed

- **Staffing:** Three employees (an executive director, a data analyst, and a community engagement expert) run the Commission, while seven other employees coordinate the Gateway model and the multiple vendors necessary to administer a coverage model for 23,000 individuals.

- **Costs:** The annual budget for the Commission totals roughly $500,000, while annual administrative costs for Gateway are approximately 10 percent to 15 percent of the total program, or approximately $3 million to $4 million.

Funding Sources

The city and county of St. Louis jointly fund the operations of the Commission. Funding for Gateway to Better Health comes from the diversion of $25 million of DSH payments, which approximates the amount previously received by St. Louis Regional Hospital in its last year of operation. The city of St. Louis also contributes $5 million annually to Gateway.

Additional Resources

More information on the Commission, including reports on past and current programs, is available at: http://www.stlrhc.org

More information on the St. Louis Integrated Health Network is available at: http://www.stlouisihn.org

Getting Started with This Innovation

- **Create organizational structure that unifies stakeholders:** To ensure equal standing in the decision making process, program developers should create a structure that involves representatives from a diverse group of stakeholders, including hospitals, community health centers, public health departments, community advocacy organizations, civic leaders, and State and local government agencies.

- **Solicit community feedback:** Before launching the program, it is helpful to use a variety of methods to elicit information and opinions on medical, dental, and behavioral health issues facing the target population. Potential ways to collect this information include visiting ED waiting rooms to talk to patients, hosting focus groups, conducting surveys, sponsoring community forums, and attending community functions. Such feedback can be quite important; for example, without it, the Commission might not have included two very important services in Gateway's coverage package: preventive dental services and nonemergency transportation.

Sustaining This Innovation

- **Encourage active participation from executives:** Chief executive officers of major health systems and large community health centers need to play an active, ongoing role. Their participation at monthly meetings and on key committees helps maintain legitimacy and support for the program among key stakeholders, including their employees.

- **Maintain culture free of partisan politics and organizational agendas:** It is important to develop and continually reinforce the need for a collaborative culture in which organizational agendas and partisan politics do not cloud the decision-making process.

Use By Other Organizations

The Detroit Wayne County Health Authority, Mid-America Council in Kansas City, and Healthy San Francisco administer similar programs designed to improve health and bolster the local safety-net system.

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Innovator Disclosures

Mr. Fruend reported having no financial interests or business/professional affiliations relevant to the work described in this profile, other than the funders listed in the Funding section.

Recognition

In 2014, the St. Louis Regional Health Commission and the St. Louis Integrated Health Network received the "What's Right With the Region!" award. An annual award sponsored by Focus St. Louis (a nonprofit organization that promotes the development of civic leaders), this award recognizes programs that improve work or community life in St. Louis. More information is available at: http://www.focus-stl.org/news/162393/Introducing-the-2014-Whats-Right-with-the-Region-Honorees.htm.

In 2012, the St. Louis Regional Health Commission as well as both the city and county of St. Louis received the Outstanding Local Government Achievement Award for the Gateway to Better Health coverage model from the East-West Gateway Council of Governments (a nonprofit organization that facilitates cooperation among local governments in the St. Louis region to solve problems that cross jurisdictional boundaries). This award recognizes local government accomplishments, including those that are a result of public/private collaborations. More information is available at: http://www.ewgateway.org/amtg12/2012-AwardWinners.pdf.

In 2010, the St. Louis Regional Health Commission received the Silver Key award from Mental Health America of Eastern Missouri for the Commission's efforts to reduce the stigma associated with seeking treatment for mental illness. More information is available at: https://www.blacktie-missouri.com/photos/photoevent.cfm?id=4916.

Footnotes

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2. Missouri Department of Health and Senior Services. Community data profiles, St. Louis. [Web site]. Available at: http://health.mo.gov/data/CommunityDataProfiles/index.html.

3. St. Louis Regional Health Commission. Gateway to better health pilot program—year 1 outcomes (July 1, 2012–June 30, 2013). Available at: http://www.stlrhc.org/wp-content/uploads/2013/07/Gateway-Year-1-Outcomes.pdf(link is external).

4. St. Louis Regional Health Commission. Progress toward building a healthier St. Louis: 2008 access to care report. Available at: http://www.stlrhc.org/wp-content/uploads/2013/07/RHC-2008-Access-to-Care-Report.pdf(link is external).

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6. St. Louis Integrated Health Network. Figures at a glance [Web site]. Available at: http://www.stlouisihn.org/figures-glance(link is external).

7. St. Louis Regional Health Commission. Decade review of health status for St. Louis city and county, 2000-2010. Available at: http://www.stlrhc.org/wp-content/uploads/2013/07/Decade-Review-of-Health-Status.pdf (link is external)