ST. LOUIS HEALTH CARE "CALL TO ACTION" INITIATIVE

A REPORT TO THE ST. LOUIS REGIONAL HEALTH COMMISSION FROM THE BROAD COMMUNITY

March 26, 2002

TABLE OF CONTENTS

SECTION	PAGE
Executive Summary	3
St. Louis Needs Assessment	5
Success In Other Communities – The Jesse Tree	7
Success In St. Louis – The St. Louis Lead Prevention Coalition	8
Missouri Legislative Initiatives	
• Presumptive Eligibility For Children	10
• Reauthorization of CHIPS/MC+	11
• Access To Physician, Dental & Trauma Care	12
New Partnership Between St. Louis ConnectCare & Federally Qualified Health Centers	16
Assuring Health Care For Immigrants & Refugees	17
Assuring Early & Regular Prenatal Care	19
Assuring Access & Appropriate Use of Medications	20
Improving Oral Health & Access To Dental Care	21
Other Community Input	22
Summary of "Call To Action" Recommendations to the St. Louis Regional Health Commission	23
Appendices	25

ST. LOUIS HEALTH CARE "CALL TO ACTION" INITIATIVE

A REPORT TO THE REGIONAL HEALTH COMMISSION FROM THE BROAD COMMUNITY

EXECUTIVE SUMMARY

While St. Louis has tremendous health care assets, regrettably our community also has some of the worst health statistics in the nation with clinical outcomes in some area neighborhoods approaching those of third world countries.

The "Campaign 100% Access and Zero Health Disparities" was developed by the U.S. Department of Health and Human Services to transform local health care from the "bottom up".

Through the campaign, more than 420 communities across America have demonstrated their resolve to improve access to medical care and eliminate health disparities. Several of these communities have restructured their health delivery systems by developing collaborative partnerships among safety net providers, social service agencies, faith-based organizations, business, and state and local government.

Based on these models of success, 43 local organizations **(Appendix 1)** sponsored a Health Care "Call To Action" meeting on February 22-23, 2002 to establish a meaningful community dialogue on how to best achieve 100% Access & Zero Health Disparities in St. Louis. Specific goals and objectives of the conference were to:

- Heighten public awareness about the magnitude and serious nature of disparities in health status and access to medical care in the St. Louis area

- Identify and implement specific short-term and long-term tactics for removing barriers to care and achieving the 100% Access/Zero Health Disparities goal

- Provide an opportunity for participating organizations to make specific requests for assistance, as well as offers to help, thereby building on existing relationships and establishing new partnerships and initiatives to benefit the medically underserved in our community

- Issue a "blueprint" report from the broad community for the new Regional Health Commission to use in its efforts to craft an area-wide consensus plan for assuring equal access to quality health care for all citizens

The following pages of this report reflect the input of 350 individuals representing all walks of life who attended the February 22-23 “Call To Action” meeting. Participants included consumers, health care providers, the city and county health departments, social service agencies, philanthropic organizations, the faith-based community and elected officials from city, county and state government. The energy, ideas and collaborative spirit generated by this community dialogue are unique in our history and provide a real opportunity to better utilize existing community assets and secure additional resources that will strengthen St. Louis’ health care safety network.

We ask that the St. Louis Regional Health Commission carefully consider the series of recommendations contained in this report. To assure tangible and sustainable progress, the RHC should also take a lead role in:

- Support the development of a coordinating entity in St. Louis to link currently available community resources and enhance coordination of effort across key components of our local health care safety net *(see page 7)*.
- Developing a coordinated business plan for achieving 100% Access and Zero Health Disparities in our community. This plan should have: i) measurable goals and objectives, and ii) a demonstrable return on investment (ROI).
- Tracking and regularly reporting to the public specific metrics documenting progress toward better health care outcomes in St. Louis.
- Creating appropriate communication vehicles and venues to: i) keep the public informed of the Regional Health Commission’s activities, ii) complement these communication efforts by issuing an annual report summarizing the RHC’s progress, and iii) position the broad community for future pace setting events at periodic intervals.

Elimination of long-standing health disparities will require bold new ideas and an unprecedented spirit of cooperation and inclusiveness across all components of the safety net. Energy and commitment are high, the time is right and the vehicles are place. We pledge our full support in helping the St. Louis Regional Health Commission move our community forward.

***Respectfully submitted by the St. Louis Health Care “Call To Action” Initiative Steering Committee* (Appendix 2).**

ST. LOUIS NEEDS ASSESSMENT

The City of St. Louis Department of Health has published zip code-specific data on a variety of health care quality and access indicators including:

- Number of neighborhood clinics
- Avoidable hospitalizations if timely primary care and disease management had been received for certain chronic diseases (heart failure, diabetes, asthma, hypertension)
- Emergency room use rates (a proxy for inadequate primary and specialist doctor office care)
- Lack of early prenatal care
- Teenage pregnancy rates
- Frequency of low birth weight infants
- Prevalence of HIV infection, AIDS and other sexually transmitted diseases
- Lead poisoning rates
- Asthma hospital rates
- Cancer mortality rates
- Diabetes and heart disease death rates

These data show remarkable racial disparities in health status. For example, the infant mortality rate among African Americans is 2.1 times higher than for whites.

Major disparities also exist across various St. Louis neighborhoods with the worst health outcomes occurring in zip codes 63106, 63107 and 63113. For example:

- 42% of mothers in zip code 63113 had no first trimester prenatal care compared to 29% for St. Louis as a whole and 16.6% across the State of Missouri
- The prevalence of low birth weight babies and infant mortality rates in these zip codes are more than twice that for Missouri as a whole
- Age-adjusted death rates among patients with diabetes in zip code 63106 are double that for St. Louis as a whole and more than 3 times the national average
- Cancer death rates in 63106, 63107 and 63113 are equally disturbing – 33% above St. Louis as a whole.

These data can help policy makers and others develop targeted strategies and tactics to build a stronger, healthier St. Louis, neighborhood-by-neighborhood. This will require an unprecedented sense of partnership, coordination and shared responsibility among area safety net providers, social service agencies, neighborhood organizations, schools, churches, businesses and city and state government. To be effective, such efforts must also have clearly defined and measurable goals and objectives.

Disparities in access to health also exist in St. Louis County. More than 175,000 area residents have no health insurance with 70% of these individuals living in St. Louis County. Contrary to public perception, most of the uninsured are employed but have low-income jobs with companies that do not offer health care benefits. The St. Louis County Department of Health operates 3 geographically dispersed health centers to provide primary care services for these individuals with specialty and inpatient care provided through a partnership with St. Louis ConnectCare and local area hospitals.

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

It is recommended that the RHC work with the St. Louis City and County Public Health Agencies to regularly monitor and publicly report zip code-specific indicators of health care access and quality to determine the effectiveness of planned interventions and initiatives to improve access and eliminate health disparities in our community.

SUCCESS IN OTHER COMMUNITIES – THE JESSE TREE

The Jesse Tree was established in Galveston, Texas to provide a neutral forum for bringing together various components of a fragmented health care safety net. Key components of this safety net included the:

University of Texas Medical Branch	Local Health Clinics
Galveston County Health District	Salvation Army
Social Service Agencies	Catholic Charities
Food Pantries and Nutrition Services	Transportation Services
Shelter and Housing Network	Churches & Synagogues

Specific projects and programs developed by the Jesse Tree include:

- A **"Safety Net" Web Site** containing a comprehensive database of all community resources for assisting the uninsured – social workers, churches, substance abuse counselors, physicians and others utilize this information to meet specific patient needs
- A bilingual **Telephone Help Line** for the uninsured to answer questions regarding local assistance programs and related resources using a single toll-free phone number
- Semi-annual publication of the **Jesse Tree Journal** which lists over 1500 resources available in the Galveston area and is distributed to residents of local public housing, social service agencies and churches
- A **Health Equipment Loan Program (HELP)** for uninsured and low-income individuals who are ill or disabled and in need of durable medical equipment
- A **Universal Application Program** to streamline and coordinate social service applications and referrals, thereby creating a single "port of entry" for anyone seeking assistance with food, clothing, shelter, rent/utilities, medical prescriptions and other needs
- Weekly **Food Fairs** where food distribution for the needy is linked with other activities including health screenings for diabetes and hypertension, disease management education and Medicaid/CHIPS enrollment

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

The RHC should endorse and facilitate the creation of a coordinating entity (i.e. "Jesse Tree-like program") in St. Louis to raise awareness of currently available community resources and enhance coordination of effort across key components of our local safety net.

SUCCESS IN ST. LOUIS – THE ST. LOUIS LEAD PREVENTION COALITION

The St. Louis Lead Prevention Coalition is an excellent model of what can be achieved by bringing people to the table. The Coalition was formed in 1999 and works to reduce and eliminate lead poisoning in the St. Louis metro area.

The lead problem can be summarized as follows:

- 1 in every 4 children in St. Louis has a blood lead level that is too high
- The effects of lead poisoning, many of which are irreversible, include lowered IQ, learning disabilities, behavioral disorders, hyperactivity, diminished eye-hand coordination, kidney problems and anemia

Although not completely curable, lead poisoning is completely preventable through education and environmental interventions.

The Lead Prevention Coalition brought together a diverse group of individuals to address this important public health problem. Those involved included affected families, neighborhood organizations, health care providers, property owners and landlord associations, tenant and housing groups, foundations, schools and universities, health departments and local public agencies, and government officials.

Critical success factors included:

- A willingness to be inclusive
- A sense of partnership and shared responsibility
- Meaningful community participation
- Effective action

The St. Louis Lead Prevention Coalition has significantly raised awareness about the problem of lead poisoning through community workshops, lead screening events, newsletters, press conferences and media coverage.

A comprehensive community-based Action Plan has also been developed to prevent childhood lead poisoning and measurably reduce the blood lead levels of children suffering from lead poisoning. The plan is being implemented by the following 4 committees:

Legislative & Legal Action Committee

Responsible for advocacy through legislative efforts and watchdog activities

Community Involvement/Collaboration Committee

Responsible for lead prevention education and awareness at grassroots level

Prevention Committee

Responsible for environmental interventions, abatement & lead safe housing

Policy Development Committee

Makes recommendations for policy change to address lack of availability or access to lead prevention services

Another measure of the Lead Coalition's success is the passage in 2001 of legislation requiring mandatory screening of children (ages 6 months to 6 years) for lead poisoning and the earmarking of $1.3 million in Missouri tobacco settlement funds to support childhood lead testing.

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

The RHC should promote the St. Louis Lead Prevention Coalition to other health care safety net stakeholders as a model for success.

MISSOURI LEGISLATIVE INITIATIVES

INITIATIVE 1 – PRESUMPTIVE ELIGIBILITY FOR CHILDREN

There are currently more than 90,000 uninsured children in Missouri. Lack of insurance for these children typically translates into delayed access to care, under-use of primary care services, over-reliance on expensive emergency room care and avoidable hospitalizations and medical complications.

Metropolitan Congregations United (MCU), an organization composed of more than 70 area churches and synagogues, has initiated a grass roots effort to assure that every income eligible child in the State of Missouri has immediate access to health care and health insurance via a mechanism known as Presumptive Eligibility.

Under Presumptive Eligibility, the State of Missouri would allow certain agencies like federally qualified Health Centers, other community clinics and hospitals to enroll income-eligible children into the Medicaid program with immediate coverage. Children found presumptively eligible can receive immediate medical care while their Medicaid/MC+ application is being processed.

Implementing Presumptive Eligibility would cost the State of Missouri just under $1 million but would reduce overall Medicaid spending by allowing medical care to be promptly provided in more appropriate and cost-effective outpatient settings as opposed to hospital emergency rooms. This has been validated by experience in 11 other states that have adopted presumptive eligibility.

Legislative action is required to make Presumptive Eligibility a reality in Missouri. There are currently two bills that could effect this:

> **House Bill 1114 (The Rainy Day Fund)** - This bill would fund presumptive eligibility for children and other vital health services including mental health, transportation for the elderly and disabled and home health services
>
> **DSS Appropriations House Bill 1011** - This bill includes $900,000 for presumptive eligibility

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

> *It is requested that the RHC: i) adopt a resolution expressing its unanimous support for Presumptive Eligibility, and ii) interact with elected and appointed state officials to assure implementation of this program.*

MISSOURI LEGISLATIVE INITIATIVES

INITIATIVE 2 – REAUTHORIZATION OF CHIPS/MC+

In 1998, Missouri passed legislation to expand Medicaid to cover children up to 300% of the federal poverty level. Data from the Missouri Department of Health and Senior Services indicate the following impact on the children covered by this expanded program:

- A 38% decrease in preventable hospitalizations among this population
- A 14% decrease in emergency room visits
- A 39% decrease in school absences
- A 12% increase in zero number of days missed at school

If the CHIPS/MC+ program is not re-authorized in the current legislative session, Medicaid eligibility will be reduced to 185% of poverty for children up to age 1, 133% of poverty for children age 1-6, and 100% of poverty for children age 7-18. This means that 77,000 Missouri children, a fourth of whom live in the St. Louis region, will lose access to regular check-ups, prescription drugs and other medical care currently provided under the CHIPS/MC+ program. Loss of Medicaid coverage for this vulnerable population would be a major step backward in assuring 100% Access/Zero Health Disparities.

House Bill 1926 and **Senate Bill 1111** would extend the sunset for the CHIPS/MC+ program to July 2007 and maintain the eligibility level at 300% of the federal poverty level.

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

It is requested that the RHC: i) adopt a resolution expressing unanimous support for Reauthorization of the CHIPS/MC+ Program, and ii) interact with elected and appointed state officials to assure extension of this vital program.

MISSOURI LEGISLATIVE INITIATIVES

INITIATIVE 3 – ACCESS TO PHYSICIAN, DENTAL & TRAUMA CARE

The Missouri Medicaid Program serves over 860,000 adults and children – roughly 1 in every 7 Missouri residents. While Missouri is to be congratulated for reducing the number of uninsured low-income Missourians, enrollment in the Medicaid Program is only one part of the health access equation. Equally important is having a sufficient number of physicians, dentists and other health professionals to care for Medicaid enrollees.

Unfortunately, access to primary and specialty medical care has become increasingly difficult for Missouri's Medicaid population. For example:

- 60 of Missouri's 115 counties have critical shortages in the number of health care professionals
- In urban areas such as St. Louis, specialty care appointment wait times commonly average 3-4 months for Medicaid patients referred from local community health centers
- Appointment wait times for Medicaid patients in need of dental care commonly run as long as 6 months and require families and children to travel several hours to receive care

The major problem to expanding access to physician and dental care is economic:

- Missouri Medicaid payments to physicians are among the lowest in the nation (48th out of 50 states)
- Missouri Medicaid pays physicians about 50% of what other midwestern states pay for the care of Medicaid patients
- Missouri Medicaid payments to physicians do not even cover office overhead costs (staff, medical supplies, rent, utilities, malpractice insurance)

  Average Overhead Costs = $41/patient visit
  Mo Medicaid Payment = $20/patient visit

- With rare exception, Missouri's Medicaid physician fee schedule has remained unchanged since 1995 while office overhead expenses have increased an average of 6.2% per year
- Missouri Medicaid payments to dentists also do not cover clinical practice overhead costs

As a result, the number of physicians and dentists caring for the Medicaid population continues to decline:

- The number of Missouri dentists caring for Medicaid patients dropped from 866 in 1995 to 416 in 2001

- 20% of Missouri's 9,100 physicians do not participate as Medicaid providers and 2/3 of the participating physicians see less than 50 Medicaid patients per year

- Only 347 physicians in Missouri have a significant Medicaid practice – these doctors account for >50% of all outpatient care received by 860,000 Medicaid patients

The medical and economic consequences of inadequate access to physician and dental care are substantial. Readily treatable conditions such as diabetes and hypertension go undetected until patients become acutely ill and debilitating and costly complications occur.

For example, studies have clearly shown that diabetics under the regular care of a physician have better blood sugar control as reflected by lower Hemoglobin A_{1c} levels, and that each 1% decline in their Hemoglobin A_{1c} yields a 17-18% decrease in the risk of stroke, heart attack, kidney failure, cataracts and death.

Approximately 12% of people have one or more chronic diseases such as diabetes, hypertension and heart disease. These individuals account for nearly 50% of all health care costs. Regular physician care and coordinated care management of these individuals can dramatically reduce medical costs. Experience at Washington University School of Medicine in managing 1,100 such patients resulted in:

- Reduction in hospitalization rates by 50%
- Lowering of monthly medical costs by 50%
- Improved health status of participating patients
- $12 in medical cost savings for every dollar invested

Increasing payments to physicians and dentists would: i) substantially increase the number of private sector community providers participating in the Missouri Medicaid Program, ii) improve the health of the population being served, and ii) result in significant medical cost savings by reducing avoidable hospitalizations and expensive use of hospital emergency rooms for care that can be provided more appropriately and cost-effectively in a physician office setting.

The importance of preserving Missouri's trauma care system needs to be recognized. Three Missouri trauma centers have closed in the past 2 years due to mounting financial losses and additional trauma center closures, including the one at DePaul Health Center in North St. Louis County, are likely if action is not taken.

Trauma is defined as any injury caused by physical force. Motor vehicle accidents are the most common single cause, accounting for 42% of cases followed by falls (23%), gunshot wounds (8%), violence (8%), burns (3%) and industrial accidents (3%).

Trauma is one of the most pressing public health problems in Missouri today:

- 3,500 people die in Missouri each year from traumatic injury – as many as perished in the tragic events of last Sept 11

- Trauma is the leading cause of death in children and adults under age 45, claiming more lives than all disease combined

- Nearly 28,000 Missourians are hospitalized each year for severe trauma

- More than 10,000 Missourians suffer permanent debilitating injuries from trauma each year

- The overall death rate from traumatic injury in Missouri is <u>20% higher</u> than for U.S. residents as a whole

- Decreasing Missouri's death rate from trauma to the national average would mean 700 fewer deaths per year and yield $2 billion/year in savings related to medical spending, disability and lost future earnings

The capabilities of specialized trauma centers go far beyond that of a typical hospital emergency room and trauma victims fortunate enough to be treated in one of these facilities have a <u>20-30% greater chance of survival</u>. Trauma centers are, however, expensive to operate:

- Standby costs (cost of being prepared to handle trauma cases) for each Level 1 trauma center are $4.3 million per year (source: Mo Department of Health)

- On a cost basis, Missouri's 32 trauma centers lose $46 million per year

- Medicaid and uninsured patients represent only 23% of the total trauma volume in Missouri but account for a disproportionate share of the operating losses

Given these staggering losses, more Missouri trauma centers will undoubtedly close, shifting the associated financial burden to fewer and fewer institutions. This problem is not unique to Missouri – over the past 5 years more than 90 trauma centers have closed across the nation and several states have taken action to shore up their trauma care systems.

House Bill 1479 sponsored by Representative Lana Baker seeks legislative authority to invoke a 41cent per pack cigarette tax to:

1) Provide funding to preserve Missouri's 32 trauma centers and implement interventions to reduce the prevalence of trauma and associated death rates

2) Expand physician participation in Missouri's Medicaid program by increasing payments to the same level as Medicare

3) Expand access to dental care by improving Medicaid payments to dentists

4) Reduce the prevalence of smoking and tobacco-related diseases via enhanced anti-smoking and smoking cessation programs as recommended by the Center For Disease Control

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

It is requested that the RHC: i) adopt a resolution expressing its unanimous support for the 4 key elements of House Bill 1479, and ii) help assure a successful voter referendum as authorized by either the Missouri General Assembly or an initiative petition.

NEW PARTNERSHIP BETWEEN THE FEDERALLY QUALIFIED COMMUNITY HEALTH CENTERS AND SAINT LOUIS CONNECTCARE

The federally qualified Community Health Centers and Saint Louis ConnectCare recognize one another as essential components of the health care safety net in the St. Louis area.

In preparation for the February 22-23, 2002 Call To Action meeting, the leadership of these organizations met to develop the framework for a new collaborative partnership in support of achieving 100% Access/Zero Health Disparities in St. Louis. Major elements of the agreement are as follows:

- The senior leadership of Saint Louis ConnectCare and the 4 federally qualified Community Health Centers will hold regular meetings to develop strategic opportunities to improve cooperation and coordination of patient care. The city and county health departments and the two area medical schools will also participate in this forum

- Saint Louis ConnectCare and the 4 federally qualified Community Health Centers have also agreed to:

    - Establish a Joint Medical Advisory Committee involving their respective medical directors and case managers to focus on operational issues and processes for improving cooperation and coordination of care

    - Work together collaboratively with Washington University and Saint Louis University Schools of Medicine to expand and improve ConnectCare's specialty care network

    - Establish regular joint Continuing Medical Education venues to: i) enhance familiarity and working relationships among ConnectCare and Community Health Center caregivers, and ii) enhance the quality of care via the development of collaborative medical management initiatives

    - Work together with the St. Louis Regional Health Commission to develop an area-wide consensus plan for assuring equal access to health care and elimination of health disparities

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

The RHC should: i) recognize Saint Louis ConnectCare and the 4 federally qualified Community Health Centers for reaching this new cooperative agreement, ii) encourage additional efforts to enhance communication and care coordination between ConnectCare and the FQHC's, and, iii) ask for periodic progress reports on specific milestones resulting from this new collaborative venture.

ASSURING HEALTH CARE FOR IMMIGRANTS & REFUGEES

St. Louis has become a favored destination for immigrants and refugees, representing more than 10% of St. Louis City's population. St. Louis is perceived as an "immigrant and refugee-friendly" city because of the availability of steady employment, affordable housing, receptive neighborhoods and already established immigrant and refugee communities.

Refugee resettlement is facilitated by two local agencies: Catholic Refugee Services and the International Institute. Due to their success in meeting federal resettlement goals, St. Louis is listed as one of America's top 10 refugee resettlement sites. Relevant statistics include the following:

- 17% of St. Louis City families use a primary language other than English at home
- St. Louis is the top Bosnian resettlement site in the nation with more than 37,000 refugees from the former Yugoslavia
- Spanish speaking immigrants (documented and non-documented) are estimated at 35,000 – a 92% increase since 1990
- Vietnamese refugees are estimated at 16,000+
- Nearly 5,000 Jewish and evangelical Christian refugees from the former Soviet Union reside in the greater metropolitan St. Louis area
- New arrivals from Africa, Afghanistan and Russia

Access to health care for immigrants and refugees varies widely depending upon their INS status as they enter the United States:

- Refugees are eligible for health care via the Missouri Medicaid (MC+) program for a period of 8 months although enrollment is often delayed due to system lags and lack of documentation
- Documented immigrants are sponsored but ineligible for Medicaid for 5 years. Refugees over age 65 are eligible for Medicare.
- Non-documented immigrants are often discouraged from seeking medical services due to probing questions from health care providers, requirements for social security numbers, etc

The Department of Health and Human Services (HHS) Office of Minority Health (OMH) has developed standards for assuring that all people entering the U.S. health care system receive equitable and effective treatment in a culturally and linguistically appropriate

manner (known as CLAS Standards – see **Appendix 4**). These standards are intended for use by policy makers, health care providers, educators, accrediting bodies such as the Joint Commission On Accreditation of Healthcare Organizations (JCAHO), patients and patient advocates.

Recommendations of the "Call To Action" Workgroup on Immigrants & Refugees are as follows:

1) Develop and implement a plan for adoption by community health care providers of the National Standards for Culturally and Linguistically Appropriate Services (CLAS)

2) Hold a community-wide conference in March 2003 on Quality Health Care For Diverse Populations targeted to reach 800 area professionals including health care providers, social workers and teachers

3) Develop a plan in collaboration with Schnuck's pharmacies to provide language access and translated information on prescribed medications

4) Identify and develop a repository of cultural and language-specific providers of medical care

5) Develop a plan to recruit immigrants and refugees into health care careers

6) Clarify state versus provider responsibility for meeting requests for interpreter services at medical appointments under Title VI of the Civil Rights Act of 1964

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

The RHC should actively encourage area health care providers to: i) offer and provide language assistance at no cost to patients with limited English proficiency, and ii) develop collaborative health care and wellness programs with ethnic communities.

ASSURING EARLY & REGULAR PRENATAL CARE

Early and regular prenatal care is key to improving newborn and maternal health. Unfortunately, 29% of St. Louis mothers receive no first trimester prenatal care compared to 16.6% across the State of Missouri.

Lack of prenatal care is even more problematic in certain St. Louis neighborhoods such as zip codes 63106, 63107, 63113 and 63120 where 39-43% of pregnant women fail to seek medical care during the first trimester. Not surprisingly, the prevalence of low birth weight babies and infant mortality in these same zip codes is 30-40% higher than the average for St. Louis and more than twice that seen across the State of Missouri.

The "Call To Action" Workgroup on Early & Regular Prenatal Care recommends a neighborhood-by-neighborhood approach to improving early enrollment in prenatal care, targeting those zip codes with the worst infant outcomes. Achieving this goal will require broad community involvement and highly focused coordination of effort among neighborhood health care providers, social service agencies, churches and other organizations. Efforts should also be coordinated with the Maternal Child and Family Health Coalition's Healthy Start project.

The Workgroup plans to focus its particular efforts on zip code 63106 and has developed the following tactics under the banner of the "Friends of 106 Campaign":

- Catholic Community Services will facilitate a home-by-home neighborhood effort to identify all pregnant women living in zip code 63106
- Grace Hill Health Centers and Mercy Health Plans will work together to hold "block parties" in zip code 63106 to engage local residents and community leaders in identifying and enrolling all pregnant women in early and regular prenatal care. Local political leaders will be invited to participate in these events.
- Nurses For Newborns will enlist churches in zip code 63106 to support and participate in the prenatal care campaign
- Male partners and parents of pregnant women will be educated about the importance of prenatal care and encouraged to take an active role in assuring that prospective mothers seek early and regular medical care.

The Workgroup will also explore the feasibility of using a mobile van to provide pregnancy testing and education. Corporate sponsors will also be sought to support the "Friends of 106 Campaign".

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

T he RHC is requested to endorse the "Friends of 106 Campaign" and assist this Work Group's efforts to identify corporate sponsors and other necessary resources to assure 100% access to early and regular prenatal care in St. Louis zip code 106

ACCESS TO & APPROPRIATE USE OF MEDICATIONS

Uniform access and appropriate use of medications are essential if health disparities are to be eliminated in our community. Major barriers include:

- Low-income uninsured families often don't have the economic means to pay for prescriptions

- Safety need provider organizations have experienced difficulty in operating their on-site pharmacy services due to a general shortage of pharmacists and increasingly competitive market place for these health professionals

- Patient education regarding appropriate dosage and use of medications needs to be improved to assure optimal benefit and reduce drug-related complications and illness

The "Call To Action" Medication Work Group has developed the following strategies and tactics to address the above issues:

1) Create a central group to serve as a resource for pharmacy and related issues

2) Develop a database of Low-Cost Medication Access Programs and distribute this information to all St. Louis safety net providers / Organize a group of individuals to assist patients in filling out the application forms for these programs

3) Develop a Pharmacy Resource Guide to identify pharmacists who are willing to provide clinical pharmacy services on a volunteer basis to St. Louis safety net providers

4) Develop a Medication Education Program at the patient level for distribution and/or presentation to all St. Louis safety net providers

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

The RHC is requested to: 1) endorse the pharmacy community's effort to provide pharmacy services to the underserved of St. Louis, 2) seek ways to assure that appropriate resources are provided to meet these needs, and 3) provide assistance in soliciting community support and funding for these efforts.

ORAL HEALTH & ACCESS TO DENTAL CARE

Access and disparities in dental health are major problems in Missouri as illustrated by the following facts:

- Fewer than 30% of Medicaid eligible children have an annual dental visit
- 80% of tooth decay in children occurs in Medicaid and uninsured populations.
- Medicaid families often must travel to other communities to access dental care for their children
- Dental appointment wait times for Medicaid eligible children run as long as 6 months
- The number of dentists accepting Medicaid fell from 886 in 1995 to 416 in 2001 – at present, only 1 in 5 dentists is a Medicaid provider

The Workgroup on Dental Health proposes the following steps for improving dental health and access to dental care:

- Expand the number of dentists willing to provide care to Medicaid enrollees by raising payments to 75% of the UCR charge, thereby covering clinical practice overhead expenses
- Identify state funding for the Student Loan Forgiveness Program for graduating dentists who serve in Missouri counties with health care professional shortages
- Provide dental services at all 15 federally qualified health centers in Missouri
- Develop dental health education programs in partnership with local schools and Head Start programs
- Launch a Crusade for Children's Dental Health program aimed at educating parents on proper care of the oral cavity for infants and children under age 3
- Provide case management and transportation services to assure that Medicaid enrollees keep scheduled dental appointments
- Consider the use of mobile dental clinics in underserved, indigent communities

RECOMMENDATION TO ST. LOUIS REGIONAL HEALTH COMMISSION

The RHC is requested to: 1) endorse the dental community's effort to improve dental health and access to dental care, and 2) add a member of the dental community to the RHC Provider Services Advisory Board.

OTHER COMMUNITY INPUT

Several other workgroups convened during the February 22-23 “Call To Action” meeting to discuss specific health care issues and needs. These included:

- The importance of providing low-income uninsured individuals with equal access to quality health care
- The value of coordinated case management programs in improving health status and reducing medical costs for specific high-risk populations who suffer from chronic medical diseases
- The need to reduce the prevalence of obesity and AIDS among our teenagers
- Ideas for assuring: i) immunization of all children, and ii) comprehensive health screening (EPSDT, lead poisoning, etc) of all children along with the availability of appropriate follow-up care for screen-positive individuals
- The critical importance of: i) preserving State funding for existing community mental health services , and ii) better education and advocacy for mental health and its impact on the family
- The need to educate safety net organizations about effective legislative advocacy strategies and tactics in support of 100% Access and Zero Health Disparities

SUMMARY OF "CALL TO ACTION" RECOMMENDATIONS TO THE ST. LOUIS REGIONAL HEALTH COMMISSION

The following recommendations are made by the community to the St. Louis Regional Health Commission. The RHC should:

1) Support the development of a coordinating entity in St. Louis to link currently available community resources and enhance coordination of effort across key components of our local health care safety net *(see page 7)*.

2) Develop a coordinated business plan for achieving 100% Access and Zero Health Disparities in our community. This plan should have: i) measurable goals and objectives, and ii) a demonstrable return on investment (ROI).

3) Work with the city and county public health departments to regularly monitor and publicly report zip code-specific metrics documenting progress toward better health care outcomes in St. Louis.

4) Create appropriate communication vehicles and venues to: i) keep the public informed of the Regional Health Commission's activities, ii) complement these communication efforts by issuing an annual written report summarizing the RHC's progress, and iii) position the broad community for future pacesetting events at periodic intervals.

5) Promote the St. Louis Lead Prevention Coalition to other health care safety net stakeholders as a model for success.

6) Adopt a resolution expressing its unanimous support for Presumptive Eligibility For Children, and interact with elected and appointed state officials to assure implementation of this program.

7) Adopt a resolution expressing unanimous support for Reauthorization of the CHIPS/MC+ Program, and interact with elected and appointed state officials to assure extension of this vital program.

8) Adopt a resolution expressing its unanimous support for the 4 key elements of House Bill 1479, and help assure a successful voter referendum as authorized by either the Missouri General Assembly or an initiative petition.

9) Recognize Saint Louis ConnectCare and the 4 federally qualified Community Health Centers for reaching a new cooperative agreement, encourage additional efforts to enhance communication and care coordination between ConnectCare and the FQHC's, and ask for periodic progress reports on specific milestones resulting from this new collaborative venture.

10) Actively encourage area health care providers to: i) offer and provide language assistance at no cost to patients with limited English proficiency, and ii) develop collaborative health care and wellness programs with ethnic communities.

11) Endorse the "Friends of 106 Campaign" and assist this Work Group's efforts to identify corporate sponsors and other necessary resources to assure 100% access to early and regular prenatal care in St. Louis zip code 106.

12) Endorse the pharmacy community's efforts to provide medication services to the underserved of St. Louis and provide assistance in soliciting community support and funding.

13) Endorse the dental community's effort to improve dental health and access to dental care and add a member of the dental community to the RHC Provider Services Advisory Board.

APPENDICES

Appendix 1 - Listing of "Call To Action" Sponsoring Organizations

Appendix 2 - Listing of "Call To Action" Steering Committee

Appendix 3 - "Call To Action" Program and Speakers

Appendix 4 - Immigrant & Refugee CLAS Standards

APPENDIX 1

St. Louis Health Access Community Call to Action

Organization	Contact
Sponsors	
ARCHS	Mary Bell
Behavioral Health Response	Lesley Levin
BJC HealthCare	Steven Lipstein
Care Partners	Shirley Rosenberg/David Heitmar
Catholic Charities	Sister Betty Brucker
Central Reform Congregation	Rabbi Susan Talve
Civic Progress	John Roberts
Community Care Plus	Jerry Linder
Deaconess Foundation	Rev. Jerry Paul
Family Care Health Centers	Robert Massie, D.D.S.
GHP	Charlie Stark
Grace Hill Neighborhood Health Centers	Richard Gram
HealthCare USA	Davina Lane
Incarnate Word Foundation	Bridget Flood
Lutheran Charities Foundation	Sherry Winkelman
Missouri Primary Care Association	Joe Pierle
State of Missouri- Governor's Office	Quentin Wilson/Patrick Lynn
Mercy Health Plans	Tom Kelly
Missouri Hospital Association	Marc Smith/Leslie Porth
Mound City Medical Society	Will Ross, M.D.
Myrtle Davis Comprehensive Health Center	Deborah Cooper
Peoples Health Centers	Betty Jean Kerr
Regional Center for Non-Profit Adm.	Clarence Hauer/Bette Welch
Saint Louis University School of Public Health	Richard Kurz, Ph.D
Sisters of Mercy Health System	Ron Ashworth
SSM Health Care	Ron Levy
St. Anthony's Medical Center	Kathleen Fischer/David Seifert
St. John's Mercy Health Care	Mike Morgan
St. Louis 2004	Peter Sortino
City of St. Louis	Melba Moore
St. Louis Black Leadership Roundtable	James Whittico, M.D.
St. Louis College of Pharmacy	Mary Patton
St. Louis ConnectCare	Larry Fields, M.D.
St. Louis County Health Dept.	Dr. Jaquelynne Meeks/Rick Wolf
St. Louis Lead Prevention Coalition	Judith Riehl
St. Louis Metropolitan Medical Society	Ron Garrett
St. Louis Regional Chamber & Growth Assoc	Richard Fleming/Eric Schneider
St. Louis Regional Health Commission	Peter Sortino/Dan Body
St. Lukes Hospital	Dorothy Barnard/Gary Olson
Tenet Healthcare Foundation	Suzanne Gales/Jo Curran
United Way of Greater St. Louis	Lottie Wade
Urban League of Metropolitan St. Louis	Jim Buford
Washington University School of Medicine	James Crane, M.D.

APPENDIX 2

CALL TO ACTION STEERING COMMITTEE

RON ASHWORTH, CHAIR
President & Chief Executive Officer
Sisters of Mercy Health System

SISTER BETTY BRUCKER, F.S.M.
Executive Director
Catholic Community Services & The Archbishop's
Commission on Community Health

DEBORAH COOPER
Chief Executive Officer
Myrtle Davis Comprehensive Health Center

JAMES CRANE, MD
Associate Vice Chancellor
Washington University School of Medicine

LARRY FIELDS, M.D.
President & Chief Executive Officer
St. Louis ConnectCare

PATRICK LYNN
Senior Policy Advisor
Office of the Governor
State of Missouri

CAROLYN PRYOR, M.D.
Private Practice Physician
Serenity Women's Health Care

RABBI SUSAN TALVE
Central Reform Congregation

LOTTIE WADE
Vice-President
United Way of Greater St. Louis

RICK WOLF
Executive Assistant
St. Louis County Health Department

DAN BODY – STAFF
Interim Executive Director
St. Louis Regional Health Commission

APPENDIX 3

A CALL TO ACTION

"Moving Toward 100% Healthcare Access and Zero Health Disparities"

February 22-23, 2002

Marriott Pavilion Hotel

St. Louis, MO

Day 1 - Friday, February 22, 2002

7:30 - 8:30 a.m. **Registration and Continental Breakfast**

PLENARY SESSION - *Moderated by* Phyllis Busansky*, President & CEO Community Health Leadership Network & Senior Fellow, The Hudson Institute*

8:30 - 8:35 a.m. **Introductory Remarks -** Ron Ashworth*, President & CEO, Sisters of Mercy Health System, St. Louis*

8:35 – 8:45 a.m. **100% Access and Zero Health Disparities - A National Movement (videotape presentation)**

8:45 - 9:45 a.m. **Achieving 100% Access and Zero Health Disparities In St. Louis – How Do We Get There?**

- Strengths of The Current Safety Net System
- Opportunities To Improve
- Critical Success Factors

Panel Discussion **Moderated By** *Phyllis Busansky*

Panel Members:

Rick Wilk, MPH, MBA, *Director of Business Development, HRSA*
James Kimmey, M.D., M.P.H., *CEO, Missouri Foundation For Health*
Louise Quesada, M.P.H, *Planning Executive, City of St. Louis Health Department*
Jacquelynn Meeks, Dr.PH, *Director, St. Louis County Department of Health*
Rabbi Susan Talve, *Central Reform Congregation*

APPENDIX 3

A CALL TO ACTION

"Moving Toward 100% Healthcare Access and Zero Health Disparities"

9:45 - 10:30 a.m. **Communities In Action**

- **The Jesse Tree**
  Ted Hanley, M.Ed.*, Executive Director, The Jesse Tree, Galveston, Texas*
- **Mobilizing Public Will**
  Phyllis Busansky*, Former County Commissioner, Hillsborough County, Florida*

10:30 - 10:45 a.m. **Break**

10:45 - 11:15 a.m. **St. Louis Lead Prevention Coalition – A Model For Success**
Mari Kay Rogers, MSW*, Action Plan Manager St. Louis Lead Prevention Coalition*

11:15 -11:45 a.m. ***Presumptive Eligibility For Missouri's Children – A Grass-Roots Effort***
Katie Plax, M.D., Metropolitan Congregations United

11:45 -12:10 p.m. **Key Issues For St. Louis – Identification of Break Out Topics**
(facilitated by John Scanlon, Ph.D*, Partner, JSEA, Inc. and* Eric Baumgartner, M..D., M.P.H.*, President, Baumgartner Health)*

12:30 -1:30 p.m. **Luncheon & Presentation – 100% Access/Zero Health Disparities –** Donald Weaver, M.D.*, Assistant Surgeon General, U.S. Public Health Service & Director, National Health Services Corp, Health Resources Services Administration*

1:30 -2:30 p.m. **1st Round of Breakout Sessions – Improving Health Care For Specific Populations**

- **Developing A Business Plan To Transform Your Community Health System - *Hawthorne 3***
  Rick Wilk, MPH, MBA*, HRSA Consultant*
- **Preventive Health For Children – *Pavilion Suites I, II, III***
  ***Bill Keenan, M.D.*, SLU School of Medicine**
  Robert W. Wilmott, M.D., *Chairman, Department of Pediatrics, SLU School of Medicine*
- **Assuring Health Care For Immigrants and Refugees - *Salons E-G***
  Kym Hemley, M.P.H., M.S.W., *LAMP*

APPENDIX 3

A CALL TO ACTION

"Moving Toward 100% Healthcare Access and Zero Health Disparities"

1st Round of Breakout Sessions – Continued:

- **Assuring Health Care For The Uninsured –** ***Hawthorne 2***
  Sponsored by St. Louis Black Leadership Roundtable & Mound City Medical Forum
  James Whittico, M.D., *Chair*
  Betty Kerr, *President, Peoples Health Centers*
  James Kimmey, M.D., M.P.H, *CEO, Missouri Foundation For Health*
  John Anstey, M.D., *Past President, St. Louis Metropolitan Medical Society*
  Larry Fields, M.D., *CEO, St. Louis ConnectCare*
  William Siedhoff, *Director, Department of Human Services, City of St. Louis*
  Joy Williams, *Director, Office of Minority Health Missouri Department of Health*

Other breakouts based on topics identified in morning plenary session

2:30 - 2:45 p.m.	**Break**
2:45 - 3:45 p.m.	**2nd Round of Breakout Sessions – Improving Health Care For Specific Populations**

- **Improving Access, Affordability and Appropriate Use of Medications For Needy Populations –** ***Pavilion Suites I, II, III***
  Mary Patton, R.Ph., *St. Louis College of Pharmacy*

- **Mental Health & Substance Abuse Services –** ***Salons E-G***
  Leslie Levin, LCSW, ACSW**,** *Behavioral Health Response*

- **Assuring Early & Regular Prenatal Care –** ***Hawthorne 2***
  Corrine Walentik. M.D., *SLU School of Medicine &* Ricky LaGrange,BSN, MA, *Mercy Health Plans*

- **Case Management For High-Risk Populations – The Key To Improving Health & Saving Money –** ***Hawthorne 3***
  John Lynch, M.D., *Washington University School of Medicine*
  Eloise Crayton, B.S.N., M.A., *Grace Hill Neighborhood Health Centers*

Other breakouts based on topics identified in morning plenary session

APPENDIX 3

A CALL TO ACTION

"Moving Toward 100% Healthcare Access and Zero Health Disparities"

3:50 - 4:50 p.m. **Closing Session**

- Recommendations From Breakout Groups
- Next Steps

Facilitated by Phyllis Busansky, John Scanlon *and* Eric Baumgartner, M.D.

4:50 - 6:00 p.m. **Reception / Informal Networking**

APPENDIX 3

A CALL TO ACTION

"Moving Toward 100% Healthcare Access and Zero Health Disparities"

Day 2 - Saturday, Feb 23, 2002 (moderated by Eric Baumgartner, M.D.)

8:30 - 9:15 a.m. **Enlightened Leadership – Getting To The Heart Of Change**
Doug Krug*, Author and Nationally Recognized Leader in the Field of Change Implementation*

9:15 – 10:00 a.m. **Assuring Access To Physician & Dental Care For All Missourians**
Jim Crane, M.D.*, Associate Vice Chancellor for Clinical Affairs, Washington University School of Medicine*

Presentation followed by interactive audience dialogue

10:00 - 10:20 a.m. **Break**

10:20 – 11:00 a.m. **Communication/Coordination Across Primary Care, Specialty Care and Acute Care Providers – How Can We Improve?** *(Panel Discussion)*

Panel Members:
Joan Bialczak, *Director, Division of Health Services, St. Louis County Health Department*
Deborah Cooper, *CEO, Myrtle Davis Comprehensive Health Center*
Larry Fields, M.D., *CEO, St. Louis ConnectCare*
Richard Gram, *CEO, Grace Hill Community Health Centers*
Betty Kerr, *CEO, Peoples Health Centers*
Bob Massie, DDS, *CEO, Family Health Care Center*

11:00 – 12:00 noon **The Role of the St. Louis Regional Health Commission In Assuring 100% Access/Zero Health Disparities** *(Panel Discussion)*

Panel Members*:*
Francis Slay*, St. Louis City Mayor*
Jacquelynn Meeks, DrPH, *Director, St. Louis County Health Department and Vice Chair, St. Louis Regional Health Commission*
Peter Sortino*, Chair, St. Louis Regional Health Commission*
Lana Ladd Baker, *Representative, District 76, Missouri House of Representatives*

12:00 – 12:10 noon **Closing Remarks – A Call To Action** – Ron Ashworth

APPENDIX 4

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE (CLAS)

National Standards for Culturally and Linguistically Appropriate Services in Health Care

Preamble

The following national standards issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

- CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).
- CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).
- CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

The standards are also intended for use by:

- Policymakers, to draft consistent and comprehensive laws, regulations, and contract language. This audience would include Federal, State and local legislators, administrative and oversight staff, and program managers
- Accreditation and credentialing agencies, to assess and compare providers who say they offer culturally competent services and to assure quality for diverse populations. This audience would include the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, professional organizations such as the American Medical Association and American Nurses Association, and quality review organizations such as peer review organizations
- Purchasers, to advocate for the needs of ethnic consumers of health benefits, and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions
- Patients, to understand their right to receive accessible and appropriate health care services, and to evaluate whether providers can offer them
- Advocates, to promote quality health care for diverse populations and to assess and monitor care being delivered by providers. The potential audience is wide, including legal services and consumer education/protection agencies; local and national ethnic, immigrant, and other community-focused organizations; and local and national nonprofit organizations that address health care issues.
- Educators, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include educators from health care professions and training institutions, as well as educators from legal and social services professions
- The health care community in general, to debate and assess the applicability and adoption of culturally and linguistically appropriate health services into standard health care practice

APPENDIX 4

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE (CLAS)

1. *Health Care Organizations Should Ensure That Patients/Consumers Receive From All Staff Members Effective, Understandable, and Respectful Care That Is Provided in a Manner Compatible With Their Cultural Health Beliefs and Practices and Preferred Language*

2. *Health Care Organizations Should Implement Strategies To Recruit, Retain, and Promote at All Levels of the Organization a Diverse Staff and Leadership That Are Representative of the Demographic Characteristics of the Service Area*

3. *Health Care Organizations Should Ensure That Staff at All Levels and Across All Disciplines Receive Ongoing Education and Training in Culturally and Linguistically Appropriate Service Delivery*

4. *Health Care Organizations Must Offer and Provide Language Assistance Services, Including Bilingual Staff and Interpreter Services, at No Cost to Each Patient/Consumer With Limited English Proficiency at All Points of Contact, in a Timely Manner During All Hours of Operation*

5. *Health Care Organizations Must Provide to Patients/Consumers in Their Preferred Language Both Verbal Offers and Written Notices Informing Them of Their Right To Receive Language Assistance Services*

6. *Health Care Organizations Must Assure the Competence of Language Assistance Provided to Limited English Proficient Patients/Consumers by Interpreters and Bilingual Staff. Family and Friends Should Not Be Used To Provide Interpretation Services (Except on Request by the Patient/Consumer)*

7. *Health Care Organizations Must Make Available Easily Understood Patient-Related Materials and Post Signage in the Languages of the Commonly Encountered Groups and/or Groups Represented in the Service Area*

8. *Health Care Organizations Should Develop, Implement, and Promote a Written Strategic Plan That Outlines Clear Goals, Policies, Operational Plans, and Management Accountability/Oversight Mechanisms To Provide Culturally and Linguistically Appropriate Services*

9. *Health Care Organizations Should Conduct Initial and Ongoing Organizational Self-Assessments of CLAS-Related Activities and Are Encouraged To Integrate Cultural and Linguistic Competence-Related Measures Into Their Internal Audits, Performance Improvement Programs, Patient Satisfaction Assessments, and Outcomes-Based Evaluations*

10. *Health Care Organizations Should Ensure That Data on the Individual Patient's/Consumer's Race, Ethnicity, and Spoken and Written Language Are Collected in Health Records, Integrated Into the Organization's Management Information Systems, and Periodically Updated*

11. *Health Care Organizations Should Maintain a Current Demographic, Cultural, and Epidemiological Profile of the Community as Well as a Needs Assessment to Accurately Plan for and Implement Services That Respond to the Cultural and Linguistic Characteristics of the Service Area*

12. *Health Care Organizations Should Develop Participatory, Collaborative Partnerships With Communities and Utilize a Variety of Formal and Informal Mechanisms to Facilitate Community and Patient/Consumer Involvement in Designing and Implementing CLAS--Related Activities*

13. *Health Care Organizations Should Ensure That Conflict and Grievance Resolution Processes Are Culturally and Linguistically Sensitive and Capable of Identifying, Preventing, and Resolving Cross-Cultural Conflicts or Complaints by Patients/Consumers*

14. *Health Care Organizations Are Encouraged to Regularly Make Available to the Public Information About Their Progress and Successful Innovations in Implementing the CLAS Standards and To Provide Public Notice in Their Communities About the Availability of This Information*

The complete report, along with supporting material, is available online at www.OMHRC.gov/CLAS.