

APPENDICES TABLE OF CONTENTS

1. ST. LOUIS REGIONAL HEALTH COMMISSION'S SURVEY METHODOLOGY AND RESPONDENT LIST	240
2. ST. LOUIS REGIONAL HEALTH COMMISSION WORKPLAN	244
3. ST. LOUIS REGIONAL HEALTH COMMISSION ROSTERS AS OF MARCH 2003	261
4. CALL TO ACTION UPDATE: THE ST. LOUIS REGIONAL HEALTH COMMISSION RESPONSE TO COMMUNITY RECOMMENDATIONS	264
5. SAFETY NET AFTER-HOURS RESOURCES	270
6. RESOLUTION TO RECOMMEND THE PROTECTION OF STATE FUNDS TO MISSOURI MEDICAID PROGRAM	272
7. 330 LEGISLATION	274
8. METHODOLOGIES USED TO ESTIMATE SOURCES AND USES OF FUNDS FOR PRIMARY AND SPECIALTY CARE – ST. LOUIS CITY AND COUNTY	275
9. ESTIMATE OF NUMBER OF NON-ELDERLY, UNINSURED PERSONS IN ST. LOUIS CITY AND COUNTY	286
10. CULTURAL AND LINGUISTIC BARRIERS FOR NEW AMERICANS	294
11. MEASUREMENT IN OTHER COMMUNITIES	304

APPENDIX I: REGIONAL HEALTH COMMISSION’S SURVEY METHODOLOGY AND RESPONDENT LIST

The St. Louis Regional Health Commission defines “safety net provider” as a provider that serves a significant number of people who are uninsured or covered under Missouri Medicaid.

In order to gather data on access and availability of safety net services, the RHC conducted a survey of 140 safety net medical providers in St. Louis City and County. Much of the data reported in Section IV of this report was gathered through this survey process. The RHC surveyed providers in seven different categories including Institutional Primary Care Safety Net Providers, Community Practitioner Primary Care Safety Net Providers, Institutional Specialty Care Safety Net Providers, Community Specialist Safety Net Providers, Oral Health/Dentistry Safety Net Providers, Mental Health Safety Net Providers, and Hospital Emergency Departments. In addition, the St. Louis College of Pharmacy conducted a survey that the RHC utilized for the pharmacy survey data cited in Section IV of the report.

The survey questions were developed by RHC Workgroups, with significant input from Commissioners and Advisory Board members. Individuals from community organizations with expertise in the different types of health care services that were being examined also provided input into the survey design.

The providers that responded to the survey are listed in the following tables. A survey was collected for each site providing safety net care within each organization surveyed. A total of 115 surveys were returned. Respondents were asked to reply either by mail or via an online survey. Of the providers that were surveyed, 82% responded.

Response Rate by Category

CATEGORY	RESPONSE RATE
INSTITUTIONAL PRIMARY CARE SAFETY NET PROVIDERS	100%
INSTITUTIONAL SPECIALTY SAFETY NET PROVIDERS	100%
HOSPITAL EMERGENCY DEPARTMENTS	100%
MENTAL HEALTH SAFETY NET PROVIDERS	66%
COMMUNITY PRACTITIONER SAFETY NET PROVIDERS	50%
COMMUNITY SPECIALIST SAFETY NET PROVIDERS	12%
ORAL HEALTH/DENTISTRY SAFETY NET PROVIDERS	44%

Results were aggregated using Microsoft Access database software, with the final outputs exported into Microsoft Excel.

Respondent List – Separated by Category

INSTITUTIONAL PRIMARY CARE SAFETY NET PROVIDERS (N=33)	
ORGANIZATION	HEALTH CENTER NAME
1. SAINT LOUIS CONNECTCARE	DELMAR
2. SAINT LOUIS CONNECTCARE	FLORENCE HILL CENTER – RIVERVIEW
3. SAINT LOUIS CONNECTCARE	HOMER G. PHILLIPS HEALTH CENTER
4. SAINT LOUIS CONNECTCARE	MAX C. STARKLOFF HEALTH CENTER
5. SAINT LOUIS CONNECTCARE	LILLIAN E. COURTNEY
6. SAINT LOUIS COUNTY HEALTH CENTERS	NORTH CENTRAL COMMUNITY HEALTH CENTER (PINE LAWN)
7. SAINT LOUIS COUNTY HEALTH CENTERS	JOHN C. MURPHY
8. SAINT LOUIS COUNTY HEALTH CENTERS	SOUTH COUNTY
9. PEOPLES HEALTH CENTERS	DELMAR
10. PEOPLES HEALTH CENTERS	FLORISSANT
11. PEOPLES HEALTH CENTERS	MAPLEWOOD
12. FAMILY CARE HEALTH CENTER	CARONDOLET
13. FAMILY CARE HEALTH CENTERS	FOREST PARK SOUTHEAST
14. MYRTLE DAVIS COMPREHENSIVE	MARTIN LUTHER KING/NEWSTEAD
15. GRACE HILL HEALTH CENTERS	HADLEY
16. GRACE HILL HEALTH CENTERS	SOULARD NEIGHBORHOOD HEALTH CENTER
17. GRACE HILL HEALTH CENTERS	GRACE HILL SOUTH HEALTH CENTER
18. GRACE HILL HEALTH CENTERS	GRACE HILL @ ST. PATRICK HEALTH SERVICES
19. GRACE HILL HEALTH CENTERS	GRACE HILL ST. STEPHENS HEALTH SERVICES
20. GRACE HILL HEALTH CENTERS	WATER TOWER HEALTH CENTER

21. GRACE HILL HEALTH CENTERS	"MOBILE" SITE
22. HEALTH CARE FOR KIDS	LINDELL AVE
23. ACCION SOCIAL COMMUNITARIA/ LA CLINICA HEALTH CENTER	LA CLINICA
24. CHIPS	2431 N. GRAND
25. BARNES JEWISH HOSPITAL	BJH MEDICINE CLINIC/ WOMEN'S WELLNESS CENTER (OB-GYN CLINIC)
26. TENET FOREST PARK HOSPITAL	AMBULATORY CARE CENTER (INTERNAL MEDICINE)/ WOMEN'S HEALTH CENTER/ FAMILY MEDICINE OF ST. LOUIS
27. ST. JOHN'S MERCY MEDICAL CENTER	MERCY NEIGHBORHOOD HEALTH CENTER (SOUTH CITY)
28. ST. JOHN'S MERCY MEDICAL CENTER	JOHN F. KENNEDY CLINIC (ST. JOHN'S CAMPUS)
29. ST. JOHN'S MERCY MEDICAL CENTER	MEACHAM PARK CLINIC
30. DEPAUL HEALTH CENTER	ADULT CLINIC/OB CLINIC
31. ST. MARY'S HOSPITAL	CLAYTON ROAD
32. ST. LUKE'S HOSPITAL	PEDIATRIC CENTER – ST. CHARLES ROCK ROAD
33. CARDINAL GLENNON HOSPITAL	CARDINAL GLENNON

COMMUNITY PRACTITIONER PRIMARY CARE SAFETY NET PROVIDERS (N=13)

1. ST. LUKE'S PEDIATRIC CARE
2. HINES FAMILY CARE CENTER, INC.
3. FAMILY HEALTH CARE CENTER
4. MECCA T. MCDONALD, MD, LLC
5. NATHANIEL MURDOCK
6. ALISON C. NASH
7. HOMER NASH
8. SERENITY WOMEN'S HEALTHCARE
9. HILLARD SCOTT
10. WEST END INTERNAL MEDICINE
11. MARY A.T. TILLMAN, MD, PC
12. MIDWEST MEDICAL SPECIALISTS
13. JEROME WILLIAMS, JR.

COMMUNITY SPECIALIST SAFETY NET PROVIDER (N=2)

1. JACQUELINE GARRETT, M.D.
2. JULIAN MOSLEY, M.D.

ORAL HEALTH/DENTISTRY SAFETY NET PROVIDERS (N=8)

1. DONALD V. COLEMAN
2. BYRON DUVAL
3. JOSEPH O. ERONDU
4. BEN QUAYNOR
5. CHARLES QUIGLESS
6. DENTAL CARE FOR KIDS
7. MYRTLE DAVIS COMP. HEALTH CENTER
8. PEOPLE'S HEALTH CLINIC – E. FOWLER

INSTITUTIONAL SPECIALTY CARE SAFETY NET PROVIDERS (N=9)

1. BARNES JEWISH HOSPITAL
2. WASHINGTON UNIVERSITY
3. CARDINAL GLENNON
4. ST. JOHN'S MERCY
5. ST. LOUIS CONNECT CARE – DELMAR
6. ST. LOUIS CONNECT CARE – MAX C. STARKLOFF HEALTH CENTER
7. ST. LOUIS CONNECT CARE – HOMER G. PHILLIPS HEALTH CENTER
8. ST. LOUIS CONNECT CARE – LILLIAN E. COURTNEY
9. SAINT LOUIS UNIVERSITY
10. TENET

MENTAL HEALTH SAFETY NET PROVIDERS (N=21)	
PROVIDER	HEALTH CENTER
1. ADAPT OF MISSOURI	HAMPTON CLUB
2. ADAPT OF MISSOURI	COMMUNITY SUPPORT
3. ADAPT OF MISSOURI	NORTHVIEW
4. ADAPT OF MISSOURI	BERNARD CARE CENTER
5. ADAPT OF MISSOURI	SUNSET
6. BJC BEHAVIORAL HEALTH	BJC SOUTH
7. BJC BEHAVIORAL HEALTH	BJC NORTH
8. BJC BEHAVIORAL HEALTH	BJC CENTRAL
9. BRIDGEWAY COUNSELING SERVICES	119 CHURCH STREET
10. BRIDGEWAY COUNSELING SERVICES	1011 EAST CHERRY STREET
11. BRIDGEWAY COUNSELING SERVICES	1601 OLD SOUTH RIVER ROAD
12. BRIDGEWAY COUNSELING SERVICES	UNION CENTER 113 LIBERTY PLAZA
13. HOPEWELL CENTER	SOUTH GRAND
14. HOPEWELL CENTER	NORTH NEWSTEAD
15. INDEPENDENCE CENTER	COMMUNITY CARE PARTIAL HOSPITAL
16. INDEPENDENCE CENTER	MIDWEST PSYCHIATRY
17. INDEPENDENCE CENTER	CLUB HOUSES (COMBINED, WEST PINE HOUSE, MIDLAND HOUSE)
18. INDEPENDENCE CENTER	STREPP APTS
19. INDEPENDENCE CENTER	NEWSTEAD PLACE RCFII
20. PREFERRED FAMILY HEALTHCARE, INC.	3800 S. BROADWAY
21. PREFERRED FAMILY HEALTHCARE, INC.	5652 PERSHING AVE

HOSPITAL EMERGENCY DEPARTMENTS (N=15)
BJC
1. BARNES/JEWISH HOSPITAL
2. CHILDREN'S HOSPITAL
3. CHRISTIAN HOSPITAL NORTHEAST/NORTHWEST
4. MISSOURI BAPTIST MEDICAL CENTER

SSM
5. ST. MARY'S HOSPITAL
6. ST. JOSEPH'S HOSPITAL KIRKWOOD
7. DEPAUL HOSPITAL
8. CARDINAL GLENNON

TENET
9. FOREST PARK HOSPITAL
10. ST. ALEXIUS HOSPITAL
11. SAINT LOUIS UNIVERSITY HOSPITAL

FREESTANDING
12. ST. ANTHONY'S MEDICAL CENTER
13. ST. JOHN'S MEDICAL CENTER
14. SAINT LOUIS CONNECTCARE
15. ST. LUKE'S MEDICAL CENTER

APPENDIX 2: ST. LOUIS REGIONAL HEALTH COMMISSION WORKPLAN*Revised June 19, 2002**Approved by Commission on June 19, 2002***TABLE OF CONTENTS**

I. BACKGROUND & HISTORY	PAGE 244
II. MISSION/ ROLE	PAGE 245
III. PROPOSED STRUCTURE	PAGE 249
IV. PROPOSED APPROACH	PAGE 254
V. POTENTIAL ACTIVITIES OF WORKGROUPS	PAGE 254
VI. KEY SUCCESS FACTORS	PAGE 260

I. Background and History

A task force was convened by Civic Progress in April 2000 to address an immediate crisis related to funding for St. Louis ConnectCare. The Indigent Health Task Force was chaired by James Buford and William Danforth, M.D. and was successful in securing funding to avert the immediate crisis. The task force also recognized that the issue was much broader than the immediate funding shortfall of ConnectCare and elected to continue meeting to address the issue.

As part of this process, the Lewin Group was engaged to provide an in-depth analysis on the provision of indigent health care in St. Louis City and St. Louis County. The Lewin Group presented its findings in November 2000 and recommended the formation of a body to collect and analyze data, coordinate efforts, and provide leadership toward indigent health care needs.

Based on the findings and recommendations of the Lewin Group, the Indigent Health Task Force formed a subcommittee to begin to develop the framework of a Regional Health Commission. This framework was presented as part of their recommendations to the entire task force in February 2001, and was approved unanimously.

In May 2001, the Board of Directors of Access to Health Partnership (AHP) unanimously voted to transfer AHP's corporate identity and assets to help form the St. Louis Regional Health Commission. AHP was established as a tax-exempt non-profit corporation in March 2000 by St. Louis 2004's Access to Health Executive Committee. AHP was a collaborative effort by the region's health care leaders and the community to address health access issues in the St. Louis area.

In June 2001, the co-chairs of the Indigent Health Task Force, in coordination with leaders of the AHP initiative, met with representatives from the Governor's Office, St. Louis Mayor's Office, and St. Louis County Executive's Office and secured enthusiastic governmental support for the creation of the RHC. The formation of the RHC was announced publicly in late July 2001 at a press conference held by Governor Holden, Mayor Slay, and a representative of County Executive Westfall.

The first organizational meeting of the St. Louis Regional Health Commission was held on September 13, 2001. Subsequently, by-laws for the Commission were developed, and a twenty-five (25) member Community Advisory Board and twenty-five (25) member Provider Services Advisory Board were established. A search for a permanent Chief Executive Officer began in February 2002, and a new CEO was hired beginning May 1, 2002.

II. Mission/Role

The mission/role of the St. Louis Regional Health Commission (RHC), as discussed and confirmed in a June 12th, 2002 Special Session of the Commission, is as follows:

Strategic Planning

- Design a financially sustainable system for the delivery of public health and health services to the medically indigent population in St. Louis City and Saint Louis County
- Utilize an "intensive and inclusive" approach that seeks the active participation all segments of the community in its planning efforts

Communication/Reporting

- Advance the tracking of specific metrics documenting progress toward better health care outcomes in St. Louis
- Seek to become the authoritative source of information for dealing with the problem of the delivery of services to the medically-indigent population in St. Louis City and County
- Create various communication vehicles and venues to keep the public informed of the Regional Health Commission's activities

Education

- Actively educate the public and various constituencies about the needs of the uninsured in the community, the state, and, when appropriate, nationally

Funding Guidance

- Work to attract additional funds to support the delivery of care to the medically underserved, and, to the extent possible, distribute, or at least assure, those funds support the strategic plan
- Make recommendations to the Regional DSH Funding Authority (RDFA) concerning the disbursement of the DSH funds available to the RDFA

Community Health Improvement

- Create, support, and help implement community health initiatives that will increase access to care, reduce health disparities, and improve health outcomes in St. Louis City and County

Other documentation of the Mission/Role of the RHC can be found in:

(I) The Corporate Purpose, as filed with the State of Missouri; (II) The Missouri Medicaid 1115 Waiver, submitted by the State of Missouri in August 2001 to the Centers of Medicare and Medicaid Services (CMS); and (III) a May 15 2002 Resolution of the RHC in response to recommendations from the “Call to Action” Steering Committee, as follows:

A. Corporate Purpose

The Corporate Purpose for the St. Louis Regional Health Commission, filed with the State of Missouri, states that the Commission will:

1. “Seek the active participation and support of a wide range of agencies and organizations in the metropolitan area in its planning and program efforts;
2. Design and undertake an intensive and inclusive planning process involving all segments of the community, and prepare a strategic plan for delivery of public health and health services to the medically indigent in St. Louis City and County;
3. Develop and carry out activities which promote the strategic plan and which promote patient-centered continuity of care involving a variety of community agencies and organizations that provide public health and/or health care services to medically underserved people;
4. Develop and maintain both structural and operational linkages to units of local government and to the state government;
5. Seek to become the authoritative source of information and program suggestions for dealing with the problem of uninsurance and delivery of services to the medically-indigent population on a region-wide basis, including needed data acquisition, analysis and dissemination;

6. Undertake to attract additional funds from current sources as well as developing new sources of support for delivery of care to the medically underserved, and, to the extent possible, distribute, or at least assure, those funds support the strategic plan;
7. Develop a regional plan designed to continuously improve the collective health status of the St. Louis community by promoting 100 percent Access to health services and Zero Disparities in health status amongst different types of groups of people. Provide leadership for securing sufficient resources for the implementation of such a plan;
8. Actively advocate for the needs of the uninsured in the community, the state, and, when appropriate, nationally in order to provide a voice for this largely “voiceless” population at risk; and
9. Periodically assess the effectiveness of activities either coordinated or funded in meeting the community needs identified in the planning process and report to the community concerning such assessment.”

B. Missouri Medicaid 1115 Waiver

In addition, the following description of the mission and role of the St. Louis Regional Health Commission was submitted to the Centers for Medicare and Medicaid Services as part of the Missouri Department of Social Services (DSS) Missouri Medicaid 1115 Waiver, August 21, 2001:

“A new Regional Health Commission (RHC) will be established as the foundation of the 1115 Demonstration to bring together the various participants in the region’s fragmented safety net for uninsured and medically underserved residents. The RHC will submit to the director of DSS and the RDFA [the St. Louis Regional DSH Funding Authority] a long-range, community based plan designed to continuously improve the collective health status of the St. Louis community by promoting 100% access to health services and improved quality of care for the indigent by:

- Assessing current indigent care service delivery patterns
- Identifying areas of need, gaps in the system
- Supporting and encouraging the RDFA’s efforts to engage the area provider systems in developing an area-wide indigent care management system. This system would be a collaborative effort by the health provider community working throughout St. Louis City and County.
- Facilitating an on-going public dialog about the health care needs of the area
- Making recommendations to the RDFA and area health care providers on current and future delivery system needs and improvements.
- Providing assessment and input on the importance of developing a 24-hour urgent care center in north St. Louis City and identifying service needs a center would need to address.

- Advising the St. Louis City, County, Missouri state, and federal governments on health care issues and needs important to their citizenry and suggesting ways to support improvements.
- Assessing the problem of uninsured and indigent care and recommending ways to develop global access to a functioning health care system.

Annually, the Commission shall make a recommendation to the RDFA concerning the disbursement of the DSH funds available to the RDFA for that year.

The St. Louis City/County RHC will be chartered to seek the active participation and support of a wide range of agencies and organizations in the metropolitan area in its planning and program efforts; design and undertake an intensive and inclusive planning process involving all segments of the community and prepare a strategic plan for delivery of public health and health services to the medically-indigent in St. Louis City and Saint Louis County; and actively advocate for the needs of the uninsured in the community, the state, and when appropriate, nationally in order to provide a voice for this largely “voiceless” population at risk.”

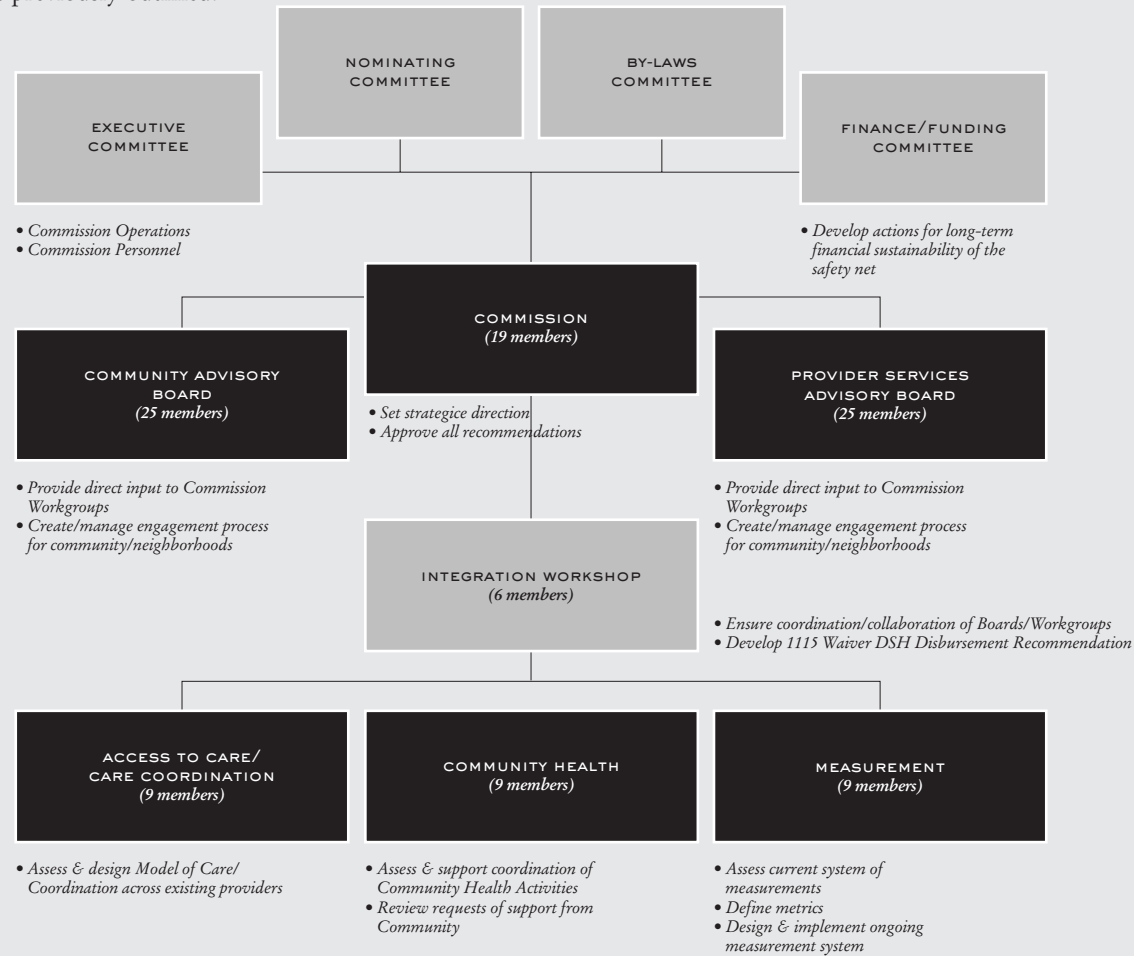
C. Resolution of St. Louis Regional Health Commission - May 15, 2002

Additionally, on May 15, 2002, the Regional Health Commission unanimously passed a resolution in response to a report from a “Call to Action” summit of over 350 St. Louis community leaders concerning access to health and health care issues. In the resolution, the RHC committed to the community that they would:

- “Support the linking of currently available community resources and enhance coordination of effort across key components of our local health care safety net;
- Develop a coordinated business plan for moving toward 100% Access and Zero Health Disparities in our community;
- Advance the tracking and regularly reporting to the public of specific metrics documenting progress toward better health care outcomes in St. Louis; and
- 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 report summarizing the RHC’s progress, and iii) position the broad community for future pace setting events at periodic intervals.”

III. Proposed Structure

The following organizational structure has been designed to meet the mission and objectives of the Commission, as previously outlined:



Description of Proposed Roles

Regional Health Commission

A major task of the RHC is to (1) create a business plan for the provision of health care to the indigent in the St. Louis region, based upon rigorous analysis and collaboration, and then (2) coordinate the implementation of the plan once developed. In order to achieve this task, the RHC will assume various key “roles” throughout the life cycle of the process, including being:

- The body that initiates dialogue, seeks input, and engages the community on the issues of the health care safety net in our community;
- The body that filters and analyzes data, facts, and various points-of-view;
- The body that proposes and recommends changes to the current system, and develops priorities and coordinates areas of focus for action;
- The body that builds support for the changes through communication, education, and organizational support and commitment;
- The body that mobilizes and coordinates resources for achieving the plan, once developed;
- The body that develops vehicles for measurement and communication of success on a long-term basis.

Specifically, and in relation to the other Advisory Boards and workgroups of the RHC, the 19-member Commission will:

- Serve as the chartering authority for Advisory Boards and workgroups
- Serve as the final approval body for all decisions/recommendations from the Commission
- Establish direction and priorities of the Commission
- Approve all work plans/budgets
- Hire and supervise Commission staff
- Approve RHC policies/procedures
- Submit strategic business plan to DSS and RDFA
- Finalize and approve public communication vehicles (i.e. periodic reports, plans, press releases)
- Make annual recommendations to the RDFA concerning the disbursement of the DSH funds available to the RDFA.

Regional Health Commission Executive Committee

The Executive Committee of the Regional Health Commission shall:

- Serve as the liaison with Chief Executive Officer to provide guidance on day-to-day operational issues of Commission, as necessary
- Serve as Personnel Committee to provide recommendations to the Commission regarding staffing, hiring practices, performance management structures, compensation decisions, and discipline matters regarding Commission staff
- Execute its duties as described in Article VIII, Section 1 of the Bylaws of the Commission

Nominating Committee

The Nominating Committee of the Regional Health Commission shall:

- Nominate Directors and officers for election by the Board of Directors in accordance with the provisions of the Bylaws, Article VIII, Section 2
- Nominate members of Advisory Boards, Workgroups, and Committees, for the approval of the Commission, in accordance with the provisions of the Bylaws

Bylaws Committee

The Bylaws Committee of the Regional Health Commission shall:

- Assess and recommend to the Commission any changes to the Bylaws of the Commission

Finance/Funding Committee

The Finance/Funding Committee of the Regional Health Commission shall:

- Provide recommendations as to specific actions to support the long-term financial sustainability of the “safety-net” system, as designed in the coordinated business plan for indigent care to be completed by the Commission

Advisory Boards

The Advisory Boards shall support the work of the Commission in three critical ways: (1) to provide direct input to the Commission and the Commission’s Workgroups concerning the work being completed; (2) to create and manage the engagement of the broader community into the planning process of the Commission; and (3) to serve as a primary conduit of information from the Commission out to the broader community.

Community Advisory Board

The Community Advisory Board will:

- Provide constructive input and feedback to the Commission regarding Commission activities;
- Act as a “sounding board” for initial ideas and draft plans of the Workgroups of the Commission;
- Create and manage the process for seeking the active participation and support of a wide range of agencies and organizations in the metropolitan area in the Commission’s planning and program efforts;
- Design and implement a process to involve all segments of the community and neighborhoods in the planning process of the Commission;
- Serve as a primary vehicle for dissemination of information from the Commission to the community/neighborhoods in the St. Louis region;
- Have a voice and vote on the Commission decisions through its Chairperson.

Provider Services Advisory Board

The Provider Services Advisory Board will:

- Provide constructive input and feedback to the Commission regarding Commission activities;
- Act as a “sounding board” for initial ideas and draft plans of the Workgroups of the Commission;
- Create and manage the process for seeking the active participation and support of a wide range of provider services agencies and organizations in the metropolitan area in the Commission’s planning and program efforts;
- Design and implement a process to involve all segments of the provider services community in the planning process of the Commission;
- Serve as a primary vehicle for dissemination of information from the Commission to the broader provider services community in the St. Louis region;
- Have a voice and vote on the Commission decisions through its Chairperson.

Workgroups

Given the complex analysis and planning necessary to achieve its mission, the Commission has chartered three (3) “Workgroups” to be responsible for the execution of day-to-day project tasks. They will be responsible for conducting the primary analyses and creating the set of recommendations for the “community-wide business plan for health care services for the uninsured and underinsured” in the St. Louis City and County region, pending Commission approval. The members of the workgroups will coordinate and manage these necessary work steps with Commission staff/consultants, as directed by the Commission. As with the Advisory Boards, the Nominating Committee of the Commission will recommend the members of the workgroups to the Commission for their approval.

The Workgroups initially chartered include:

Access to Care/Care Coordination

- Will focus on the model of care and care coordination of primary and specialist services in the St. Louis City and County to enhance access to care, reduce duplication, encourage coordination among existing providers, and reduce health disparities across the region.

Community Health

- Will focus on supporting and strengthening collaborative community health efforts in the St. Louis City and County region.
- Will also define process for handling requests of support to the Commission by community/provider groups, and make recommendations to the Commission regarding such requests.
- Will determine specific elements of “Call to Action” recommendations, and other reports as appropriate, to begin immediate implementation.

Measurement

- Will focus on advancing the tracking and regularly reporting to the public of specific metrics documenting progress toward: status of access to care, advancements in coordination of care and efficient allocation of resources; progress toward better health care outcomes in St. Louis

Integration Committee

Due to the potential for overlaps and gaps in the work of Workgroups, the Chairs of each Committee, plus the Chairs of the Community and Provider Services Advisory Boards and the Chair of the Commission will serve as an Integration Committee. This body will resolve issues such as questions of scope, potential conflicting designs, and gaps in the Workgroup’s recommendations. They will also work together to synthesize the recommendations for the 1115 DSH Waiver Disbursements, for final approval by the Commission.

IV. Proposed Approach

Potential Activities of Workgroups

WORKGROUP	INITIATE	DEVELOP SITUATIONAL ANALYSIS	CONCEPTUAL PLAN/Framework	IMPLEMENTATION
ACCESS TO CARE/ CARE COORDINATION	(2-3 MONTHS)	(4-6 MONTHS)	(6-8 MONTHS)	(ON-GOING 3-5 YEARS)
COMMUNITY HEALTH	(2-3 MONTHS)	(4-6 MONTHS) (2-3 MONTHS) DEVELOP PROCESS FOR COMMUNITY INITIATIVES	(6-8 MONTHS) INITIATE AND SUPPORT COMMUNITY HEALTH INITIATIVES	(ON-GOING 3-5 YEARS)
MEASUREMENT	(2-3 MONTHS)	(4-6 MONTHS)	(6-8 MONTHS)	(ON-GOING 3-5 YEARS)
	INITIATE	DEVELOP ENGAGEMENT PLAN	IMPLEMENT ENGAGEMENT PLAN	
COMMUNITY ADVISORY BOARD	(2-MONTHS)	(2 MONTHS)	(ON-GOING 3-5 YEARS)	
PROVIDER	(2 MONTHS)	(2 MONTHS)	(ON-GOING 3-5 YEARS)	

REGIONAL HEALTH COMMISSION WORKPLAN SCHEDULE

RHC ACTIVITIES	JULY 02	AUG 02	SEPT 02	OCT 02	NOV 02	DEC 02	JAN 03	FEB 03	MAR 03	APR 03	MAY 03	JUNE 03	JULY 03	AUG 03	SEPT 03	OCT 03	NOV 03	DEC 03	JAN 04
WORKGROUPS	INITIATE (2-3 MONTHS)			DEVELOP SITUATIONAL ANALYSIS (4-6 MONTH)						ACTION PLAN/Framework (6-8 MONTHS)					IMPLEMENTATION (ONGOING)				
ACCESS TO CARE/ CARE COORDINATION	<ul style="list-style-type: none"> Nomination of members (July 02) Review of existing reports (Aug 02 - Sept 02) 			<ul style="list-style-type: none"> Collection missing data and hire consultants, as needed Confirm number of uninsured Collect models from other communities Examine issues such as <ul style="list-style-type: none"> Current capacity vs. need/demand Current referral patterns Funds flow analysis 						<ul style="list-style-type: none"> Create detailed recommendations on future state delivery system Examples may include actions to strengthen/streamline <ul style="list-style-type: none"> Points of access Care coordination mechanisms Payment mechanisms Provider networks Future referral patterns Recommendations for DSH fund disbursements 					<ul style="list-style-type: none"> Create detailed transition plans, where necessary Begin implementation, where appropriate, with state/local/community organizations 				
COMMUNITY HEALTH	<ul style="list-style-type: none"> Nomination of members (July) Review of existing reports (Aug - Sept) 			<ul style="list-style-type: none"> Examine what is working well in St. Louis community public health arena Assess key areas for potential collaboration Collect models from other communities Develop and implement a process for how to handle requests from community for RHC support Begin to initiate and support community health initiatives 						<ul style="list-style-type: none"> Develop recommendations for enhancing community collaboration and strengthening non-traditional health infrastructure Continue to manage process for handling requests from community Continue to initiate and support community health initiatives 					<ul style="list-style-type: none"> Develop detailed transition plans for recommendations where appropriate Basic implementation, where appropriate, with state/local/community organizations Continue managing requests from community 				
MEASUREMENT	<ul style="list-style-type: none"> Nomination of members (July 02) 			<ul style="list-style-type: none"> Examine examples/models of measurement in St. Louis Assess gaps/overlaps in current system Research models in other communities 						<ul style="list-style-type: none"> Create recommendations on how to strengthen/streamline current system of measuring and reporting Develop and validate metrics to be used for measurement Develop structure/process for return on investment reporting Begin populating baselines 					<ul style="list-style-type: none"> Begin implementation for long-term measurement/reporting of progress 				
INTEGRATION	<ul style="list-style-type: none"> Nomination of members (July 02) 			<ul style="list-style-type: none"> Begin to ensure coordination of efforts between groups 						<ul style="list-style-type: none"> Continue to ensure coordination on efforts between groups 					<ul style="list-style-type: none"> Continue to ensure coordination of efforts between groups 				
							<div style="border: 1px dashed black; padding: 2px; display: inline-block;">Publish first report (Situational Analysis and Accomplishments to Date)</div>								<div style="border: 1px dashed black; padding: 2px; display: inline-block;">Publish second report (Detailed Recommendation Accomplishments to Date)</div>				

REGIONAL HEALTH COMMISSION WORKPLAN SCHEDULE *(continued)*

RHC ACTIVITIES	JULY 02	AUG 02	SEPT 02	OCT 02	NOV 02	DEC 02	JAN 03	FEB 03	MAR 03	APR 03	MAY 03	JUNE 03	JULY 03	AUG 03	SEPT 03	OCT 03	NOV 03	DEC 03	JAN 04		
WORKGROUPS	INITIATE (2-3 MONTHS)			DEVELOP SITUATIONAL ANALYSIS (4-6 MONTH)				ACTION PLAN/Framework (6-8 MONTHS)				IMPLEMENTATION (ONGOING)									
ADVISORY BOARDS	<ul style="list-style-type: none"> Develop "Engagement Plan" for obtaining input into planning process 			<ul style="list-style-type: none"> Review and comment on workgroup report drafts Begin process for obtaining community input Feedback to commission input 				<ul style="list-style-type: none"> Continue to review and comment upon workgroup report drafts Aggressively implement community engagement process 				<ul style="list-style-type: none"> On-going review/input/feedback through implementation 									
COMMISSION	<ul style="list-style-type: none"> Oversight Approve recommendations Set strategic direction Funding 																				
FUNDING	<ul style="list-style-type: none"> \$ 250,000 AHP – carry (July 02) \$ 100,000 City – receive (July 02) \$ 100,000 County – receive (July 02) \$ 200,000 Pending CMS/DSH waiver approved (July 02) 			<ul style="list-style-type: none"> \$100,000 – From other sources (Oct 02) Seek foundation support for consultants as needed (Aug-Oct 02) 				<ul style="list-style-type: none"> \$100,000 City (Jan 03) \$100,000 County (Jan 03) 				<ul style="list-style-type: none"> \$200,000 DSH/State (July 03) 					<ul style="list-style-type: none"> \$ 100,000 From other sources (Oct 03) 				
STAFFING	<ul style="list-style-type: none"> Interview for 3 professionals, (July 02) Hire staff (Aug 02) 																				

Access to Care/ Care Coordination — Potential Activities

<p>INITIATE 2-3 months</p>	<p><i>Key Activities</i></p> <ul style="list-style-type: none"> • Form Committee • Define scope/work plans • Review reports/data • Assess need for additional data 	<p><i>Key Outputs</i></p> <ul style="list-style-type: none"> • Work Program • Agreement on viability of existing data • List of information/data still needed
<p>SITUATIONAL ANALYSIS 4-6 months</p>	<p><i>Key Activities</i></p> <ul style="list-style-type: none"> • Examine primary/specialist capacity • Review demand/use rate projections • Confirm/Detail Community Needs Assessment • Confirm number of uninsured • Research models of care from other communities • Develop a rationale for change • Examine projected funding needs and current funding sources 	<p><i>Key Outputs</i></p> <ul style="list-style-type: none"> • Capacity/demand analysis with analysis of mismatches • Referral flow analysis • Community needs assessment documentation • Report from other communities • Rationale for change • Funds flow analysis
<p>DEVELOP CONCEPTUAL PLAN 6-8 months</p>	<p><i>Key Activities</i></p> <ul style="list-style-type: none"> • Agree to, and validate, key elements of coordinated care system 	<p><i>Key Outputs</i></p> <p>Examples of concepts may include:</p> <ul style="list-style-type: none"> • Strategic actions to strengthen/streamline: <ul style="list-style-type: none"> – Points of access – Provider networks <ul style="list-style-type: none"> • Primary networks • Specialists • Facility capacity – Care coordination mechanisms <ul style="list-style-type: none"> • Care management (intra-organizational) • Clinical information sharing – Future referral patterns – Payment mechanisms • Recommendations for DSH fund disbursements
<p>IMPLEMENTATION On-going (Pending Conceptual Plan)</p>	<p><i>Key Activities/Outputs</i></p> <ul style="list-style-type: none"> • Develop transitional plans for items such as: <ul style="list-style-type: none"> – Facilities – Information systems – Staffing – Physician recruitment – Patient flow – Funding streams/mechanisms – Legislative actions – Legal frameworks • Begin coordination implementation of new model of care 	

Community Health — Proposed Activities

INITIATE
2-3 months

Key Activities

- Form Committee
- Define scope/work plans
- Review reports/data
- Assess need for additional data

Key Outputs

- Work Program
- Agreement on viability of existing data
- List of information/data still needed

SITUATIONAL ANALYSIS
4-6 months

Key Activities

- Investigate what is working well in St. Louis
- Research examples from other communities
- Assess areas of potential community collaboration efforts

Key Outputs

- Community asset list with areas of potential collaboration highlighted
- Report on models from other communities
- Community support process/procedures

DEVELOP CONCEPTUAL PLAN
6-8 months

Key Activities/Outputs

- Develop/encourage vehicles for community collaboration
- Recommend ways to strengthen current community/public health system
- Review requests for support/recommend Commission action where appropriate
- Continue to initiate and support community health initiatives, as appropriate

IMPLEMENTATION
On-going

Key Activities/Outputs

- Continue to review requests for support from community
- Implement collaborative designs, as appropriate

Note: Within 2-3 months of Initiation, it is expected that the Community Health Workgroup will develop and begin to implement processes for (1) reviewing requests for support from community and (2) initiating and supporting community health initiatives.

Measurement — Proposed Activities

INITIATE
2-3 months

Key Activities

- Form Committee
- Define scope/work plans

Key Outputs

- Work Program

SITUATIONAL ANALYSIS
4-6 months

Key Activities

- Research examples/models of measurement in other communities
- Determine current systems for health measurement used in St. Louis community
- Assess gaps/overlaps in current systems, as appropriate

Key Outputs

- Report on models of measurement in other communities
- Needs analysis of reporting/measurement in St. Louis community
- Inputs into rationale for change document

DEVELOP CONCEPTUAL PLAN
6-8 months

Key Activities/Outputs

- Develop and validate metrics
- Develop structure/process for baseline development
- Develop structure/process for ROI reporting
- Develop design for on-going support of measurement activities
- Begin populating baselines, as appropriate

IMPLEMENTATION
On-going

Key Activities/Outputs

- Finalize population of baselines
- Implement system for long-term measurement/reporting of progress

VI. Key Success Factors

Throughout the planning process, the members of the Commission, Advisory Boards, Workgroups, and Staff will continuously need to manage the following key success factors:

- Maintaining *sponsorship* of the process through frequent communication with governmental, community, and health care leaders, whose support will be critical to long-term success;
- Championing a *fact-based, data-driven approach* that engenders trust in the process and seeks to maximize benefit for those that utilize the health care safety net in our community;
- Passionately and systematically *communicating* with the groups of people (i.e. providers, community and faith-based groups, schools, advocacy groups, legislators and governmental bodies) whose support and mobilization will be essential to achieving the plan;
- Creating and maintaining a *disciplined approach* to getting the vast amount of work accomplished in such a short period of time;
- Facilitating *integration and collaboration* between the Commission and its Work Groups and Advisory Boards, and among each other;
- Communicating the *sense of purpose and urgency* needed to capitalize on the narrow window of opportunity the St. Louis community now has to truly make progress in stabilizing the health care safety net.

APPENDIX 3: ST. LOUIS REGIONAL HEALTH COMMISSION ROSTERS AS OF APRIL 2003

COMMISSION ROSTER

<p>Peter Sortino (Chair) <i>President</i> St. Louis 2004</p>	<p>Betty Jean Kerr <i>Chief Executive Officer</i> People's Health Centers</p>	<p>Melba R. Moore, MS (Secretary) <i>Commissioner of Health</i> City of St. Louis Department of Health</p>
<p>E. Andrew Balas, MD, PhD <i>Dean</i> School of Public Health Saint Louis University</p>	<p>Scott Lakin <i>Director</i> Missouri Department of Insurance</p>	<p>Reverend B.T. Rice <i>Pastor</i> New Horizon Seven Day Christian Church</p>
<p>Sister Betty Brucker, FSM (Chair, Community Advisory Board) <i>Executive Director</i> Catholic Community Services/ Archbishop's Commission on Community Health</p>	<p>Ron Levy <i>President & Chief Executive Officer</i> SSM Health Care St. Louis</p>	<p>Beverly Roche <i>Finance Director</i> City of Jennings</p>
<p>James Buford <i>President & Chief Executive Officer</i> Urban League of Metropolitan St. Louis</p>	<p>Steven Lipstein (Treasurer) <i>President & Chief Executive Officer</i> BJC HealthCare</p>	<p>Will Ross, MD <i>Associate Dean & Director</i> <i>of the Office of Diversity Programs</i> Washington University School of Medicine</p>
<p>Deborah Cooper <i>Chief Program Officer</i> Missouri Foundation for Health</p>	<p>Ancelmo Lopes <i>President & Chief Executive Officer</i> Saint Louis ConnectCare</p>	<p>Corinne A. Walentik, MD, MPH (Chair, Provider Services Advisory Board) <i>Professor of Pediatrics, Division</i> <i>of Neonatal-Perinatal Medicine</i> Saint Louis University and SSM Cardinal Glennon Children's Hospital</p>
<p>James P. Crane, MD (Chair, Access To Care Workgroup) <i>Associate Vice Chancellor</i> <i>for Clinical Affairs</i> Washington University School of Medicine</p>	<p>Robert Massie, DDS <i>Chief Executive Officer</i> Family Care Health Center</p>	<p>Robert Freund, Jr. (Ex Officio) <i>Chief Executive Officer</i> Regional Health Commission</p>
	<p>Jacquelynn A. Meeks, DrPH (Vice Chair) <i>Director</i> Saint Louis County Department of Health</p>	

COMMUNITY ADVISORY BOARD ROSTER

Sister Betty Brucker, FSM (Chair)

Catholic Community Services/
Archbishop's Commission
on Community Health

Jean Abbott, LCSW

Provident Counseling

Nancy J. Buechler

Older Women's League

Donald Bradley

Shalom Community
Christian Church

Patrick Caccione

Advocacy Strategies

Christine A. Chadwick

FOCUS St. Louis

Wilma E. Clopton, PhD

The Clopton Group, Inc.

Debra Cochran

Office of Congressman Akin

Mary Ann Cook

JVC Radiology and Medical
Analysis, L.L.C.

Rita Denise Heard Days

Mid-County Partners for Progress

Reverend Douglas Parham

St. Louis African American
Clergy Coalition

Kathy Gardner

United Way of
Greater St. Louis

Orvin T. Kimbrough

Faith Beyond Walls

Susan Lauritsen

Lauritsen & Associates

Suzanne LeLaurin, LCSW

International Institute St. Louis

Roxanna Parker

Witness Project

Reverend Jerry W. Paul

Deaconess Foundation

James C. Stutz

Catholic Charities of St. Louis

Rabbi Susan Talve

Central Reform Congregation

Chuck Tyler

Adams Park Community Center

Sidney Watson

School of Law,
Saint Louis University

Pamela Willingham

Patient Advocate

Robert Freund, Jr. (Ex Officio)

Chief Executive Officer
Regional Health Commission

PROVIDER SERVICES ADVISORY BOARD ROSTER

RHC STAFF

Corinne A. Walentik, MD, MPH

(Chair)
Saint Louis University
and SSM Cardinal Glennon
Children's Hospital

Erol Amon, MD, JD

School of Medicine,
Saint Louis University

Judy A. Bentley, RNC, MA

Community Health-In-Partnership
Services (CHIPS)

Ross C. Brownson, PhD

School of Public Health,
Saint Louis University

Johnetta M. Craig, MD, MBA

Family Care Health Center

Ronnie Drake, DDS

Private Practice

Bradley Freeman, MD

School of Medicine, Washington
University

Lisa M. Heisserer, LCSW

Unity Health Hospice

Mildred Jamison

Faith Village

Katherine Jahnige

Siteman Cancer Center

Andrea Johnson

Saint Louis County
Department of Health

Nita Fowler Johnson, DDS

John C. Murphy Family
Health Center

Rosetta Keeton

Saint Louis ConnectCare

Deborah W. Kiel, MSN, RN, CS

University of Missouri - St. Louis

Jerry Linder

Community Care Plus

Mark B. Mengel, MD, MPH

School of Medicine,
Saint Louis University

**Amanda Luckett Murphy, BsNr,
PhD**

Hopewell Center

Mike Meyer

SLUCare University Medical
Group, Saint Louis University

Mary Patton RPh

St. Louis College of Pharmacy

Katie Plax, MD

St. Louis Children's Hospital

Carolyn J. Pryor-Luster, MD

Serenity Women's Healthcare, Inc.

Sharon Rohrbach, RN

Nurses for Newborns

Michael Spezia, DO

Private Practice

Denise R. Thurmond, MSW,

LCSW, DCSW

Private Practice

James M. Whittico, MD

Mound City Medical Center

Robert Freund, Jr. (Ex Officio)

Chief Executive Officer
Regional Health Commission

Robert Freund, Jr. (Ex Officio)

Chief Executive Officer

Brooke Hatton

Director of Strategic Planning

Edward L. Bryant

*Director of Communications /
Community Engagement*

APPENDIX 4: CALL TO ACTION UPDATE: THE ST. LOUIS REGIONAL HEALTH COMMISSION RESPONSE TO COMMUNITY RECOMMENDATIONS

In February 2002, over 350 individuals in the St. Louis community participated in a “Call to Action” Initiative to develop recommendations for improving access to health care and reducing health disparities in St. Louis City and County.^{A4.1} The Call to Action participants developed 13 recommendations for the RHC. These recommendations and the RHC response to date are listed in the table below.

<i>Recommendation for the RHC</i>	<i>RHC Response</i>
<p>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.</p>	<p>The RHC Access to Care Workgroup and the Community Health Workgroup are in the process of developing a plan for linking community resources and enhancing coordination across the local health care safety net. Recommendations for primary and specialty care will be released in late 2003. Recommendations for prevention and education will be released in 2004.</p>
<p>2. Develop a coordinated business plan for achieving 100% Access and Zero Health Disparities in our community. This plan should have:</p> <ul style="list-style-type: none"> • Measurable goals and objectives. • A demonstrable return on investment (ROI). 	<p>The Commission and three RHC Workgroups are collecting and analyzing data on:</p> <ul style="list-style-type: none"> • Community priorities. • Supply and demand. • Access to care. • Disparities. • Funds flow. <p>The RHC will release a coordinated business plan in late 2003.</p>

<i>Recommendation for the RHC (continued)</i>	<i>RHC Response (continued)</i>
<p>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.</p>	<p>The RHC worked with the health departments to report zip-code specific metrics for over 60 indicators in this report and the accompanying data book. In addition, the RHC Measurement Workgroup is assessing the current system of metrics and developing recommendations for documenting progress toward better health outcomes. The RHC will release the recommendations in 4th quarter 2003.</p>
<p>4. Create appropriate communication vehicles and venues to:</p> <ul style="list-style-type: none"> • Keep the public informed of the Regional Health Commission's activities. • Complement these communication efforts by issuing an annual written report summarizing the RHC's progress. • Position the broad community for future pacesetting events at periodic intervals. 	<p>The RHC communications and community engagement process is underway:</p> <ul style="list-style-type: none"> • The RHC hired a Director of Communications/Community Engagement • The RHC Advisory Boards are charged with engaging the community in the RHC planning process • The RHC has met with over 100 community/neighborhood groups and health associations and advocacy groups • The RHC produces a monthly newsletter and appears in local media (print and broadcast) • The RHC is planning a series of Town Hall meetings for the months of April, May and June

RECOMMENDATIONS FOR IMMEDIATE TACTICAL ACTION BY THE RHC

<i>Recommendation for the RHC</i>	<i>RHC Response</i>
5. 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.	Presumptive Eligibility for Children passed the Missouri State Legislature in 2002.
6. 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.	The RHC adopted a Resolution to Recommend the Protection of State Funds to Missouri Medicaid Program at it February 19, 2003 meeting. The RHC Community Advisory Board and the Provider Services Advisory Board adopted the resolution in a joint session on March 10, 2003.
7. 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.	The RHC endorsed Proposition A, the “Tobacco Tax,” at its September 19, 2002 meeting. The RHC Provider Services Advisory Board endorsed the Proposition at its October 1, 2002 meeting. The RHC Community Advisory Board endorsed the Proposition at its October 14, 2002 meeting.

<i>Recommendation for the RHC (continued)</i>	<i>RHC Response (continued)</i>
<p>8. Recognize Saint Louis ConnectCare and the 4 Federally Qualified Community Health Centers (FQHCs) for reaching a new cooperative agreement, encourage additional efforts to enhance communication and care coordination between ConnectCare and the FQHCs, and ask for periodic progress reports on specific milestones resulting from this new collaborative</p>	<p>The Access to Care/Care Coordination Workgroup is developing a plan for enhancing communication and care coordination among health care safety net providers, and creating a process for documenting progress on specific milestones. The CEOs of ConnectCare and the Federally Qualified Community Health Centers (FQHCs), as members of the RHC, are continuing to work together to improve access and reduce disparities in the region.</p>
<p>9. 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.</p>	<p>63106 is one of the initial zip code areas to which the RHC gives priority in responding to requests from the community. Also, the RHC Community Health Workgroup has directed RHC staff to coordinate with the “Friends of 106 Campaign” to determine how the organizations can work together long-term.</p>

RECOMMENDATIONS FOR THE RHC TO CONSIDER AS PART OF ITS STRATEGIC PLANNING PROCESS

<i>Recommendation for the RHC</i>	<i>RHC Response</i>
<p>10. Promote the St. Louis Lead Prevention Coalition to other health care safety net stakeholders as a model for success.</p>	<p>Lead poisoning is one of 9 diseases/conditions to which the RHC gives priority in responding to requests from the community. The RHC has endorsed the efforts of the St. Louis Lead Prevention Coalition, offered to provide assistance in building community partnerships between the Coalition and other groups, and will utilize the information included in the Coalition’s research.</p>
<p>11. Actively encourage area health care providers to:</p> <ul style="list-style-type: none"> • Offer and provide language assistance at no cost to patients with limited English proficiency. • Develop collaborative health care and wellness programs with ethnic communities. 	<p>The RHC Access to Care/Care Coordination Workgroup gathered data on barriers to care for new Americans, including issues surrounding the availability of language assistance and cultural services. This information is reported in Section V and the Cultural and Linguistic Barriers for New Americans Appendix of this report (Appendix 10). The RHC has included this issue in its strategic planning process will release recommendations in late 2003.</p>

<i>Recommendation for the RHC (continued)</i>	<i>RHC Response (continued)</i>
<p>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.</p>	<p>The RHC Access to Care/Care Coordination Workgroup collaborated with the St. Louis College of Pharmacy to gather data from the City and County pharmacy community. The findings are included in Section IV of this report. The RHC has included this issue in its strategic planning process will release recommendations in late 2003.</p>
<p>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.</p>	<p>Lack of dental care is one of 9 diseases/conditions to which the RHC gives priority in responding to requests from the community. In addition, the RHC Provider Services Advisory Board includes two members from the dental community. The RHC surveyed dental safety net providers and included this information in Section IV. of this report. The RHC has included this issue in its strategic planning process will release recommendations in late 2003.</p>

APPENDIX 5: SAFETY NET AFTER-HOURS RESOURCES

The following chart lists the hours of operation of the 33 primary care safety net institutions in St. Louis City and Saint Louis County as of January 2003. Shaded boxes indicate evening hours.

ORGANIZATION	HEALTH CENTER NAME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
SAINT LOUIS CONNECTCARE	DELMAR	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	CLOSED	CLOSED
SAINT LOUIS CONNECTCARE	FLORENCE HILL CENTER - RIVERVIEW	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	CLOSED	CLOSED
SAINT LOUIS CONNECTCARE	HOMER G. PHILLIPS HEALTH CENTER	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	CLOSED	CLOSED
SAINT LOUIS CONNECTCARE	MAX C. STARKLOFF HEALTH CENTER	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	CLOSED	CLOSED
SAINT LOUIS CONNECTCARE	LILLIAN E. COURTNEY	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	CLOSED	CLOSED
SAINT LOUIS COUNTY HEALTH CENTERS	NORTH CENTRAL COMMUNITY HEALTH CENTER (PINE LAWN)	8:30-5	8:30-5	8:30-6	8:30-6	8:30-5	CLOSED	CLOSED
SAINT LOUIS COUNTY HEALTH CENTERS	JOHN C. MURPHY	8:30-5	9:30-6	8:30-5	8:30-5	8:30-5	CLOSED	CLOSED
SAINT LOUIS COUNTY HEALTH CENTERS	SOUTH COUNTY	8:30-5	8:30-5	9:30-6	8:30-5	8:30-5	CLOSED	CLOSED
PEOPLES HEALTH CENTERS	DELMAR	8:30-5:30	8:30-8:30	8:30-5:30	8:30-8:30	8:30-5:30	CLOSED	CLOSED
PEOPLES HEALTH CENTERS	FLORISSANT	8:30-5:30	8:30-5:30	11:30-8:30	8:30-5:30	8:30-5:30	CLOSED	CLOSED
PEOPLES HEALTH CENTERS	MAPLEWOOD	8:30-5:30	11:30-8:30	8:30-5:30	8:30-5:30	8:30-5:30	CLOSED	CLOSED
FAMILY CARE HEALTH CENTER	CARONDOLET	8-5	8-8	8-5	8-8	8-5	12-2	CLOSED
FAMILY CARE HEALTH CENTERS	FOREST PARK SOUTHEAST	8-5	8-7	8-5	8-5	8-5	10-2	CLOSED
MYRTLE DAVIS COMPREHENSIVE	COMBINED LOCATIONS	9-5:30	9-8:30	9-8:30	9-5:30	9-5:30	CLOSED	CLOSED
GRACE HILL HEALTH CENTERS	HADLEY	10-6:30	9-5:30	10:30-7	9-5:30	9-5:30	CLOSED	CLOSED
GRACE HILL HEALTH CENTERS	SOULARD HEALTH CENTER	9-5:30	10-6:30	10:30-7	9-5:30	9-5:30	9:00-1	CLOSED
GRACE HILL HEALTH CENTERS	GRACE HILL SOUTH	9-5:30	10-6:30	10:30-7	9-5:30	9-5:30	9-5:30	CLOSED
GRACE HILL HEALTH CENTERS	ST. PATRICK HEALTH SERVICES	8-4:30	CLOSED	8:00 - 12	8:00 - 12	8:00 - 12	CLOSED	CLOSED
GRACE HILL HEALTH CENTERS	ST. STEPHENS HEALTH SERVICES	9:30-5:30	9:30-5:30	9:30-5:30	9:30-5:30	CLOSED	CLOSED	CLOSED
GRACE HILL HEALTH CENTERS	WATERTOWER	10-6:30	9-5:30	10:30-7	9-5:30	9-5:30	CLOSED	CLOSED
GRACE HILL HEALTH CENTERS	MOBILE SERVICES "SEVENTH SITE"	8-5	8-5	8-5	8-5	8-5	CLOSED	CLOSED
HEALTH CARE FOR KIDS	LINDELL AVE	9-9	9-9	9-9	9-9	9-9	12-6	12-6
ACCION SOCIAL COMUNITARIA LA CLINICA HEALTH CENTER	LA CLINICA	9-5	10-JAN	10-JAN	10-JAN	9-5	CLOSED	CLOSED

ORGANIZATION	HEALTH CENTER NAME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
CHIPS	2431 N. GRAND	9:00-5:00	9:00-5:00	9:00-7:00	9:00-5:00	9:00-5:00	9-12 (EVERY 3RD SATURDAY)	CLOSED
BARNES JEWISH HOSPITAL	BJH MEDICINE CLINIC	8:00-5:00	8:00-5:00	8:00-5:00	8:00-5:00	8:00-5:00	CLOSED	CLOSED
BARNES JEWISH HOSPITAL	WOMEN'S WELLNESS CENTER (OB-GYN CLINIC)	8:30-5	8:30-5	8:30-5	8:30-5	8:30-4:30	CLOSED	CLOSED
TENET FOREST PARK HOSPITAL	AMBULATORY CARE CENTER (INTERNAL MEDICINE)	1:00-5	1:00-5	1:00-5	1:00-5	1:00-5	1-SEP	CLOSED
TENET FOREST PARK HOSPITAL	WOMEN'S HEALTH CENTER	8:00-4	8:00-4	8:00-4	8:00-4	8:00-4:00	CLOSED	CLOSED
TENET FOREST PARK HOSPITAL	FAMILY MEDICINE OF ST. LOUIS	8:30-4:30	8:30-4:30	8:30-4:30	8:30-4:30	8:30-4:30	12-SEP	CLOSED
ST. JOHN'S MERCY MEDICAL CENTER	MERCY NEIGHBORHOOD HEALTH CENTER (SOUTH CITY)	7:30-4	9:30-4	CLOSED	7:30-4	7:30-4	CLOSED	CLOSED
ST. JOHN'S MERCY MEDICAL CENTER	JOHN F. KENNEDY CLINIC (ST. JOHN'S CAMPUS)	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	CLOSED	CLOSED
ST. JOHN'S MERCY MEDICAL CENTER	MEACHAM PARK CLINIC	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	CLOSED	CLOSED
DEPAUL HEALTH CENTER	ADULT CLINIC	8-4	8-4	8-4	8-4	8-4	CLOSED	CLOSED
DEPAUL HEALTH CENTER	OB CLINIC	8-12	8-12	8-12	8-12	8-12	CLOSED	CLOSED
ST. MARY'S HOSPITAL	CLAYTON	CLOSED	1:00-4:00	1:00-4:00	1:00-4:00	CLOSED	CLOSED	CLOSED
ST. LUKE'S HOSPITAL	PEDIATRIC CENTER	8-4:30	8-4:30	8-4:30	8-4:30	8-4:30	CLOSED	CLOSED



EVENING OR WEEKEND HOURS

APPENDIX 6: RESOLUTION TO RECOMMEND THE PROTECTION OF STATE FUNDS TO MISSOURI MEDICAID PROGRAM

WHEREAS, St. Louis Regional Health Commission (hereafter referred to as “the Commission”) was established in the Fall of 2001 to bring together the leaders of the health care safety net in St. Louis City and Saint Louis County; and

WHEREAS in its corporate mission the Commission has determined to “actively advocate for the needs of the uninsured in the community, the state, and, when appropriate, nationally in order to provide a voice for this largely “voiceless” population at risk”; and

WHEREAS, the Commission recognizes there is a need to at least maintain the level of services currently available in the community for the medically underserved as improvements are made to the safety net system; and

WHEREAS, in 2002 the State of Missouri reduced health care services to those most in need in our community, including:

- Reduced Medicaid eligibility benefits for poor adults from 100% of the poverty level to 77% of the federal poverty level, cutting health care service effective June 30, 2002 to 24,987 individuals. (17,051 had benefits restored for up to one year under a court injunction.)
- Altered the Medicaid Spend-Down structure to require individuals to pay more out of pocket costs to access health care.
- Eliminated dental care for adult Medicaid recipients affecting over 350,000 people. (Service restored due to court injunction.)
- Eliminated optical services (eyeglasses) for adult Medicaid recipients with limited exceptions, affecting over 350,00 people. (Court action pending.)
- Reduced by \$1.9 million the Department of Mental Health budget for children’s services to children with severe emotional disturbances.
- Reduced Women’s health services for poor women who have just given birth from two years of follow-up treatment to one year, impacting 4,810 individuals.
- Eliminated Medicaid coverage for non-custodial parents and Parent’s Fair Share participants, affecting 1,617 individuals.
- Reduced Temporary Assistance to Needy Families (TANF) funding by \$5 million.
- Limited extended transitional Medicaid for low-income working parents from two years to one year, and required that to be eligible the family’s income must remain under the federal poverty level, affecting 1,125 individuals beginning June 30, 2002.

NOW, THEREFORE, BE IT RESOLVED that the St. Louis Regional Health Commission recommends that the State of Missouri:

- Assure that all income eligible children obtain and retain Medicaid/MC+ health insurance.
 - Maintain current eligibility levels for Medicaid/MC+
 - Assure full access to federally mandated EPSDT services
 - Provide funding to allow youth (18 to 21 years old) moving out of foster care to continue Medicaid/MC+ coverage
- Protect funding for Medicaid/MC+ reimbursements to pediatric dental, mental health and pediatric providers at a level sufficient to ensure health professionals' participation in the program.
- Restore the eligibility of low-income families for Medicaid to 100% of the federal poverty level.
- Expand eligibility for low-income elderly and disabled adults to 100% of the federal poverty level pursuant to state law.
- Avoid instituting Medicaid co-payments or other cost-sharing measures on Medicaid recipients.
- Continuing Medicaid co-payments and deductibles for low-income Medicare/Medicaid dual eligible individuals.

Adopted by a vote by:
St. Louis Regional Health Commission
February 19, 2003

Peter Sortino, Chairman
Jacquelynn Meeks, Dr.PH, Vice Chair
Steven Lipstein, Treasurer
Melba Moore, MS, Secretary
E. Andrew Balas, M.D., Ph.D.
Sister Betty Brucker, FSM
James Buford
Deborah Cooper
James P. Crane, M.D.
Betty Jean Kerr
Scott Lakin
Ron Levy
Ancelmo Lopes
Robert Massie, D.D.S.
Reverend B.T. Rice
Beverly Roche
Will Ross, M.D.
Corinne Walentik, M.D.

APPENDIX 7: 330 LEGISLATION

As described by the law firm of Feldesman, Tucker, Leifer, Fidell, & Bank LLP, the benefits of 330 Legislation include:

1. Access to Federal grants, i.e. expansion grants, to support the cost of otherwise uncompensated comprehensive primary and preventative health care and “enabling services” delivered to uninsured and underinsured populations.
2. Access to Federal grants to support the costs of planning and developing a network or plan for the provision of health services which may include the provision of services on a prepaid basis or through another managed care arrangement.
3. Access to grant support and loan guarantees for capital improvements.
4. Access to reimbursement under the Prospective Payment System (PPS) or other state-approved alternative payment methodology (which is predicated on a cost-based reimbursement methodology) for Medicaid services and cost-based reimbursement for services provided under Medicare.
5. Access to Federal loan guarantees of the principal and interest on loans made by non-Federal lenders for the costs of developing and operating managed care networks or plans which are majority owned and/or controlled by Section 330-supported health centers.
6. Access to Federal Tort Claims Act (FTCA) coverage (in lieu of purchasing malpractice insurance) for the Section 330-supported health center and its health care professionals.
7. Access to favorable drug pricing under Section 340B of the PHS Act, which allows FQHCs to purchase covered outpatient prescription pharmaceuticals for health center patients at substantially discounted prices for distribution either directly by a health center pharmacy or through contract with a retail pharmacy.
8. Absent an alternative approved by Centers for Medicare and Medicaid Services (CMS), right to have State Medicaid agencies outstation Medicaid eligibility workers on FQHC site.
9. Reimbursement by Medicare for “first dollar” of services rendered to Medicare beneficiaries, i.e., deductible is waived.
10. Safe harbor under the Federal anti-kickback statute for waiver of co-payments to the extent a patient is below 200% of Federal income poverty guidelines and therefore entitled to a discount based on the health center’s application of its schedule of discounts.
11. Access to providers through the National Health Service Corps if the health center’s service area is designated a Health Professional Shortage Area.
12. Access to the Federal Vaccine for Children Program, which distributes to FQHCs vaccinations at no charge for either the vaccine or its delivery to the FQHC to be provided by the FQHC to uninsured children.

APPENDIX B: METHODOLOGIES USED TO ESTIMATE SOURCES AND USES OF FUNDS FOR PRIMARY AND SPECIALTY CARE — ST. LOUIS CITY AND COUNTY

As noted earlier in this report, the health care safety net in St. Louis City and County is a complex system. Unlike some major metropolitan areas, St. Louis does not have a single coordinating, monitoring, or financing body for its health care safety net. Each entity within the safety net has access to different funding streams to finance care for the uninsured and underinsured, depending on its structure and relationships with Federal and local governmental bodies. This fragmentation has historically made accounting for the dollars spent in health care safety net impossible to assess and report to citizens in the region.

The Financing analysis is intended to provide estimates of the financial resources available to support outpatient primary and specialty care to safety net patients in St. Louis City and County. This includes physician services, outpatient pharmacy, outpatient diagnostic testing, transportation, social services and other wrap-around services.

Much of the data used in this analysis has been voluntarily self-reported. Where possible, public documents such as IRS 990 forms and financial statements have been examined for purposes of verification.

Categorization and allocation methods may vary from provider to provider. Also, in most instances, existing accounting methods do not clearly identify uninsured patients or their cost of care, and payments received by providers are seldom explicitly earmarked as paying for the care of uninsured. Therefore, many of the methodologies employed in this analysis only provide “high-level” estimates of the need for care, the sources of funds to pay for this care, and the uses of funds.

Also, various entities that fund safety net care do not explicitly track if money is spent for safety net care, or if it is specially utilized to support primary and specialty care operations.

The RHC is not attesting to the complete accuracy of all of the data in this report due to the margin for error in data sources and estimating methodology. However, the extensive effort to validate the data has significantly minimized potential inaccuracies. Data inaccuracies that may remain for individual entities, we believe, would have minimal impact on average values and would have no impact on the overall conclusions made in this report.

In this Appendix, each significant estimate of the RHC is listed, with a description of the methodology used to obtain this estimate, as follows:

Estimate of Need

Calculation

NUMBER OF SAFETY NET POPULATION
 X
 AVERAGE ANNUAL COST OF PROVIDING PRIMARY
 AND SPECIALTY CARE TO ONE PATIENT

Sources

- The Number of Safety Net Population = 307,000 individuals

Derived by adding the number of individuals in the Missouri Medicaid program, per Missouri Department of Social Services, Division of Medical Services, as of September 2002, to the estimated number of uninsured in the region (see Appendix 9 for description of estimating the number of uninsured). As noted in Section IV, the number of individuals dually eligible for Medicare and Medicaid was not included in this total.

164,000	INDIVIDUALS COVERED BY MANAGED MEDICAID (MC+)
14,000	INDIVIDUALS COVERED BY TRADITIONAL MEDICAID, EXCLUDING "DUAL ELIGIBLES"
31,000	INDIVIDUALS COVERED BY BOTH MEDICARE AND MEDICAID (GENERALLY OVER AGE 65)
209,000	TOTAL INDIVIDUALS COVERED BY MISSOURI MEDICAID
178,000	INDIVIDUALS COVERED BY MEDICAID, EXCLUDING "DUAL ELIGIBLES"
129,000	ESTIMATED NUMBER OF UNINSURED IN ST. LOUIS CITY AND COUNTY (SEE SECTION V FOR DETAIL)
307,000	TOTAL ESTIMATED SAFETY NET POPULATION

- Average annual cost of Providing Primary /Specialty Care to One Person under the age of 65 = \$1,498 per person

This benchmark for average annual cost of medical care was derived by triangulating estimates from three (3) sources: a research study on "How Much Medical Care Do the Uninsured Use, And Who Pays For It"; ^{A8.1} data from the US Census Bureau Statistical Abstract of the United States, 2001; ^{A8.2} and a benchmark from data provided by a private insurer concerning its Missouri population. ^{A8.3} This total was then multiplied by 58.5%, which according to data from the Missouri Division of Medical Services was the percentage of the total medical costs spent for physician care, outpatient pharmacy and outpatient hospital and ancillary services in FY01. ^{A8.4}

Hadley & Holohan

The total cost of providing medical care to privately insured persons under age 65 averaged \$2,233 per person per year, according to the report written by Hadley & Holohan, based upon data from 1996-1998 Medical Expenditure Panel Survey. ^{A8.1} This amount was inflated by the medical CPI for 1998-2001 (approximately 13%, per U.S. Department of Labor, Bureau of Labor Statistics) to arrive at a benchmark of \$2,516.

US Census Bureau, Statistical Abstract

The total cost of providing hospital care, physician and clinical services, and prescription drugs per consumer unit was obtained from the US Census Bureau, Statistical Abstract, 2001 ^{A8.2}, Table No 122. ^{A8.5} The reported amount of \$2,735 per person. This figure was adjusted to exclude costs associated with the over 65 population yielding an annual per capita benchmark of \$2,606 for individuals under age 65.

Private Insurer

Data from a large private HMO insurer was obtained for a Missouri-based population. The total cost of providing hospital care, physician care, prescription drugs and other clinical services averaged \$2,573 per consumer unit for this population in FY01.

These three numbers were averaged to arrive at a final benchmark figure of \$2,565 utilized in this report. This average per capita benchmark excludes costs for behavioral health and dental care services as well as the cost of support services such as transportation and interpretative services which are critical to safety net populations. ^{A8.3}

Sources of Revenue

Calculation

Sum of all identified sources of safety net care.

The sources of revenue were identified by a focus group of Chief Financial Officers from safety net providers in the St. Louis area and State of Missouri held October 29, 2002. Three types of sources of funds to safety net providers were excluded from this analysis by definition: Medicare payments, payments made by patients themselves (self-pay), and payments to safety net providers from Commercial Insurers. Medicare and Commercial Insurance payors represented approximately 13% of the total number of visits to safety net providers in 2001, per the RHC Institutional Provider Primary Care survey, 2002. ^{A8.6}

Source identified and quantified for this analysis included:

MEDICAID TRADITIONAL & MEDICAID MANAGED CARE PAYMENTS	\$205,000,000
DISPROPORTIONATE SHARE HOSPITAL (DSH) FUNDING THROUGH A SPECIAL FEDERAL	\$20,000,000
SECTION 1115 WAIVER (X%) GRANTS FROM THE STATE OF MISSOURI	\$4,000,000
FEDERAL SUPPORT UNDER SECTION 330	\$13,000,000
LEGISLATION (TO FEDERALLY QUALIFIED CENTERS) FOUNDATION SUPPORT	\$5,000,000
ST. LOUIS CITY TAX SUPPORT	\$5,000,000
SAINT LOUIS COUNTY TAX SUPPORT	\$15,000,000
UNCOMPENSATED CARE PROVIDED BY MEDICAL SCHOOLS	\$16,000,000
UNCOMPENSATED CARE PROVIDED BY HOSPITAL-BASED CLINICS	\$11,000,000

Medicaid traditional & Medicaid managed care payments (\$205 million)

The total paid claims for the Missouri Medicaid Program were obtained from the Missouri Department of Social Services Report, FY2001, pages 61 and 62.^{A8.7} The Total Paid Claims line items for St. Louis City and Saint Louis County were added together. This report delineated the total paid claims into the following categories, with associated amounts for St. Louis City and Saint Louis County:

CATEGORY	TOTAL PAID CLAIMS, FY2001	PERCENT OF TOTAL
NURSING FACILITIES	\$ 158,703,279	18.9%
HOSPITALS	\$ 144,665,440	17.2%
DENTAL SERVICES	\$ 1,642,688	0.2%
PHARMACY	\$ 113,802,147	13.5%
PHYSICIAN RELATED	\$ 42,283,028	5.0%
IN-HOME SERVICES	\$ 65,916,096	7.8%
MENTAL HEALTH	\$ 59,075,014	7.0%
STATE INSTITUTIONS	\$ 52,083,032	6.2%
REHAB & SPECIALTY SERVICES	\$ 13,001,023	1.5%
MANAGED CARE	\$ 189,323,820	22.5%
TOTAL	\$840,495,567	100%

To compare to the Estimate of Need benchmark utilized in this analysis, it was determined in conversations with staff from the Division of Medical Services (DMS) that the following categories should be excluded from this analysis:

- Nursing Facilities
- Dental Services
- In-Home Services
- Mental Health
- State Institutions
- Rehab & Specialty Services

It was also determined that the following line items had a portion of the total supporting outpatient primary and specialty care:

- Hospitals
- Managed Care
- Physician Related

It was determined that the following line items fully supported outpatient primary and specialty care:

- Pharmacy

It was also determined that the cost for individuals dually eligible for Medicare and Medicaid should not be included in this analysis, as the volume counts provided by most safety net providers did not include the over 65 population in the volume counts for Medicaid. An ad hoc report was created by DMS that quantified the number and cost for dual eligible individuals by category. This amount was then subtracted from the total amount of each category.^{A8.8}

To estimate the total amount of outpatient primary and specialty care hospital claims included in the total \$144,65,440 payments to hospitals in FY01, a rate of outpatient to total claims was derived from data provided by DMS, calculated at 38.12%, and then the amount was adjusting for the portion of these costs attributable to dual eligibles, per DMS data.

RATE OF OUTPATIENT HOSPITAL TO TOTAL HOSPITAL PER DMS DATA:	38.12%
TOTAL CLAIMS PAID TO HOSPITALS IN HOSPITAL LINE ITEM FROM DSS REPORT:	\$144,665,440
TOTAL CLAIMS PAID IN HOSPITALS LINE ITEM – OUTPATIENT ONLY (\$144,665,440 X 38.12%)	\$55,146,466
COSTS ASSOCIATED WITH DUAL ELIGIBLES	(\$10,678,876)
HOSPITAL LINE ITEM NET DUAL ELIGIBLES	\$44,467,589

To estimate the total amount of outpatient primary and specialty care pharmacy claims included in the total \$113,802,147 payments in pharmacy in FY01, a rate of outpatient to total claims was derived from data provided by DMS, calculated at 100%, and then the amount was adjusted for the costs of dual eligibles, per DMS data.

TOTAL CLAIMS PAID PHARMACY LINE ITEM PER DMS DATA (100% OUTPATIENT)	\$113,802,147
COSTS ASSOCIATED WITH DUAL ELIGIBLES	(\$75,543,234)
PHARMACY LINE ITEM NET DUAL ELIGIBLES	\$38,258,913

To estimate the total amount of outpatient primary and specialty care physician claims included in the total payments to physicians in FY01, a rate of outpatient payments to physicians as a percent of the total claims was derived from data provided by DMS, calculated at 33.45%, and then the amount was adjusted for the costs of dual eligibles, per DMS data.

TOTAL CLAIMS PAID PHYSICIAN-RELATED PER DMS DATA:	\$42,283,028
COSTS ASSOCIATED WITH DUAL ELIGIBLES	(\$7,751,224)
PHYSICIAN-RELATED LINE ITEM NET DUAL ELIGIBLES	\$34,531,804
TOTAL CLAIMS PAID TO OUTPATIENT PHYSICIAN SERVICES PER DMS DATA (\$34,531,224 X 33.45%)	\$11,550,888

To estimate the total amount of outpatient primary and specialty care claims paid within the total Managed Care line item, the Division of Medical Services of the State of Missouri provided an estimated breakdown of the Managed Care Capitation rates, by percentage by major category, for the Eastern Region for the Contract Period 2003.

This data indicated that Total Outpatient Amount in the Managed Care Line Item was 58.36% for the three outpatient categories: O/P Hospital – Physical Health, Physician Services, & Pharmacy. These categories were selected to match the benchmark utilized to calculate the Estimate of Need. Inpatient categories, Behavioral Health, Dental, and Transportation percentages were excluded for this purpose.

Applying this percentage to the \$189,323,820 Managed Care line item produces an estimated total of \$110,489,381 paid claims to support outpatient primary and specialty care services, as defined above.

The total Missouri Medicaid estimate for outpatient primary and specialty care services was then calculated as \$204,766.772, as follows:

CATEGORY	TOTAL PAID CLAIMS, FY2001
HOSPITALS LINE-ITEM (OUTPATIENT ONLY)	\$44,467,589
PHARMACY	\$38,258,913
PHYSICIAN RELATED	\$11,550,888
MANAGED CARE (OUTPATIENT ONLY)	\$110,489,381
TOTAL	\$204,766,772

Disproportionate Share Hospital (DSH) Funding through a special Federal Section 1115 Waiver (\$20 Million)

Per the Section 1115 Waiver Addendum documentation submitted by the State of Missouri to the Centers for Medicare and Medicaid in August, 2001, the total capped amount of the DSH payments to the St. Louis community to support outpatient care will be 9.89% of the statewide DSH cash distributions, excluding DSH distributions to state mental hospitals. This percentage was equivalent to the share of DSH payments made in state fiscal year 2001 to ConnectCare.

This amount is subject to annual fluctuation, depending on the amount of total statewide DSH cash distributions each year. However, in FY2001 and FY2002, these payments approximated \$20 Million, according to data provided by the State of Missouri and Saint Louis ConnectCare.^{AS.9}

Grants from the State of Missouri (\$4 Million)

The Missouri Department of Health and Senior Services provided a listing of all existing contracts in place with St. Louis City and County entities. The end dates of these contracts were selected to be those after 6/30/02, which is the beginning of the state fiscal year. In cases where there had been contract amendments, the Current Amount total was utilized rather than the Original Amount total.

The total grant amounts provided to safety net providers, as listed in Appendix 1, were then segregated and totaled to arrive at a total of approximately \$4 Million.

Federal support under Section 330 Legislation (to Federally Qualified Centers) (\$13 Million)

Through the Missouri Bureau of Primary Care, each Federally Qualified Health Center in St. Louis City and Saint Louis County was asked to provide budget data concerning revenue sources and the total amount of Federal grants received in their most recent Fiscal Year. Each center responded, and the total amount from each center was added together to produce the \$13 Million estimate.

The total estimate provided was then correlated to each entity's most recent Return of Organization Exempt from Income Tax Form 990 to verify for reasonableness.

Foundation support (\$5 Million)

The total estimate of \$10-\$15 Million in annual giving for the Missouri Foundation for Health was provided by Foundation staff. Estimates of \$2-\$3 Million in average disbursements for other Health Funders was derived from interviews with selected Foundation staff and Board members, and a review of annual reports for those Foundations that made such reports available. The estimate of the total to support safety net care was derived from these interviews, as well as a review of Return of Organization Exempt from Income Tax Form 990 of Community Health Centers.

St. Louis City Tax Support (\$5 Million)

Amount reported by City Health Department personnel.

Saint Louis County Tax Support (\$15 Million)

Per analysis completed by the Financial Department of the Saint Louis County Department of Health and provided to the Saint Louis Regional Health Commission.

A portion of the funds raised through the Saint Louis County Property Tax is spent on providing direct care to the uninsured and underinsured. The total budgeted costs for the Saint Louis County Health Department for providing primary and specialty care to the residents of Saint Louis County in 2003 is approximately \$22.5 million. This amount includes the operations of 3 primary care clinics, pharmacy and dental services, and the cost of specialty care services provided through Saint Louis ConnectCare.

The total budgeted revenue for these services are approximately \$7.5 million from Medicare, Medicaid, self-pay patients, and other sources. The total tax amount that is allocated to indigent care costs by Saint Louis County is approximately \$15 million for 2003, the difference between the total budgeted costs and the revenue that these services generate. ^{A8.10}

This amount excludes an additional \$6 Million dollars of net tax revenue spent on family mental health, health services to individuals in correctional facilities, and home health/homemaker chore services.

Uncompensated care provided by medical schools (\$16 Million)

Amounts provided directly by Washington University School of Medicine and St. Louis University School of Medicine. Methodology utilized to calculate this amount was cost, not charge, basis.

Uncompensated care provided by hospital-based clinics (\$11 Million)

The RHC asked the hospital systems in St. Louis City and Saint Louis County to estimate their cost for uncompensated primary and specialty care. Two hospital systems responded to this request. These two systems accounted for approximately 70% of the total primary care visits to hospital-based systems. A cost per visit for these two systems was then calculated, and applied to the total number of visits seen by all hospitals in the area.

Uses of Funds

Calculation

Sum of all identified uses of funds for safety net care.

The identified uses were segregated into two categories:

- Community Health Centers
- Other recipients of Medicaid Payments

Community Health Centers

Data was collected from financial information provided directly by the Community Health Centers, and/or information from the Return of Organization Exempt from Income Tax Form 990 of each institution for the most recently available 12 month period. The entities for which data was collected included:

Primary Care Clinic Sites (n=23 sites + 1 “mobile” site)

- Saint Louis County (3 sites)
- Community-Health-In-Partnership (CHIPS) (1site)
- ConnectCare (5 sites + Specialty care + Urgent Care)
- Family Care Centers (2 sites)
- Grace Hill (6 sites + 1 “mobile” site)
- HC for Kids (1 site)
- Myrtle Davis Comprehensive Care (2 sites)
- People’s Health Centers (3 sites)

Data concerning pharmacy, dental, specialty care, dialysis, urgent care, and lab/radiology line items were provided directly by the Community Health Centers.

The full cost of operating the community health safety net sites (direct care costs plus administrative overhead and support services such as transportation, social workers, and interpreters) was included in this analysis.

Medicaid Payment Allocations

The Division of Medical Services of the State of Missouri provided an estimated breakdown of the Managed Care Capitation rates, by percentage by major category, for the Eastern Region for the Contract Period 2003. From this data, estimates were derived for major Medicaid primary/speciality care expenditures (net expenses for dual eligibles), as follows:

MEDICAID PAYMENTS TO OUTPATIENT (O/P) HOSPITAL	\$72,621,755
MEDICAID PAYMENTS TO OUTPATIENT (O/P) PHARMACY	\$73,188,769
MEDICAID MANAGED CARE PLANS ADMIN	\$13,092,992
MEDICAID PAYMENTS TO PHYSICIANS	\$45,863,256
TOTAL	\$204,766,772

In order to derive these totals, the amounts supporting each category that are imbedded in the Managed Care line item of \$189,323,820 had to be allocated to each category, and added to the amounts as indicated in the other respective line items as reported by the Department of Social Services (DSS).

As noted earlier, the Division of Medical Services of the State of Missouri provided an estimated breakdown of the Managed Care Capitation rates, by percentage by major category, for the Eastern Region for the Contract Period 2003. This data indicated that Total Outpatient Amount in the Managed Care Line Item was 58.36% for the three outpatient categories: O/P Hospital - Physical Health, Physician Services, & Pharmacy. These categories were selected to match the benchmark utilized to calculate the Estimate of Need. Inpatient categories, Behavioral Health, Dental, and Transportation percentages were excluded for this purpose.

Prior to allocating the \$189,323,820 Managed Care line item to the categories, the estimated amount of administration costs for managed care plans of 11.85% (from data from the Missouri Division of Medical Services) was subtracted from the remaining total, for a total allocated amount of \$166,888,947.

Utilizing this total figure of \$166,888,947 and the estimated percentages by category from the Managed Care Capitation rates, the amounts in each Managed Care line item were estimated, as follows:

MEDICAID PAYMENTS TO OUTPATIENT (O/P) HOSPITAL	
RATE OF OUTPATIENT HOSPITAL TO TOTAL HOSPITAL PER DMS DATA:	38.12%
<hr/>	
TOTAL CLAIMS PAID TO HOSPITALS IN HOSPITAL LINE ITEM FROM DSS REPORT:	\$144,665,440
<hr/>	
TOTAL CLAIMS PAID IN HOSPITALS LINE ITEM – OUTPATIENT ONLY (\$144,665,440 X 38.12%)	\$55,146,466
<hr/>	
COSTS ASSOCIATED WITH DUAL ELIGIBLES	(\$10,678,876)
<hr/>	
HOSPITAL LINE ITEM NET DUAL ELIGIBLES	\$44,467,589

AMOUNT O/P HOSPITAL IMBEDDED IN MANAGED CARE LINE ITEM REPORTED BY DSS:	
MEDICAID PAYMENTS TO OUTPATIENT (O/P) HOSPITAL (O/P HOSPITAL - PHYSICAL HEALTH PERCENTAGE FROM DMS APPLIED TO TOTAL MANAGED CARE MEDICAID AMOUNT: (\$166,888,947 X 16.87%))	\$28,154,165
<hr/>	
TOTAL MEDICAID PAYMENTS TO O/P HOSPITAL (\$44,467,589 + \$28,154,165)	\$72,621,755

MEDICAID PAYMENTS TO OUTPATIENT PHARMACY	
AMOUNT FROM PHARMACY LINE ITEM REPORTED BY DSS: (ALL OUTPATIENT CLAIMS PAID, PER DMS) NET DUAL ELIGIBLES	\$38,258,913

AMOUNT O/P PHARMACY IMBEDDED IN MANAGED CARE LINE ITEM REPORTED BY DSS:	
MEDICAID PAYMENTS TO O/P PHARMACY (O/P PHARMACY PERCENTAGE FROM DMS APPLIED TO TOTAL MANAGED CARE MEDICAID AMOUNT: (\$166,888,947 X 20.93%))	\$34,929,857
<hr/>	
TOTAL MEDICAID PAYMENTS TO PHARMACY (\$38,258,913 + \$34,929,857)	\$73,188,769

MEDICAID MANAGED CARE PLAN ADMINISTRATION

AMOUNT OF OUTPATIENT MEDICAID PAYMENTS:	\$110,489,381
ESTIMATED ADMINISTRATION PERCENTAGE:	11.85%
TOTAL MEDICAID MANAGED CARE PLANS ADMINISTRATION COSTS	\$13,092,992

MEDICAID PAYMENTS TO PHYSICIAN SERVICES

TOTAL CLAIMS PAID PHYSICIAN-RELATED LINE ITEM FROM DSS REPORT, NET DUAL ELIGIBLES	\$34,531,804
RATE OF PAYMENTS TO PHYSICIANS IN PHYSICIAN-RELATED SERVICES LINE ITEM PER DMS DATA	33.45%
TOTAL CLAIMS PAID TO PHYSICIANS IN PHYSICIAN-RELATED LINE ITEM (\$34,531,804 X 33.45%)	\$11,550,888

AMOUNT PAYMENTS TO PHYSICIANS IMBEDDED IN MANAGED CARE LINE**ITEM REPORTED BY DSS:**

MEDICAID PAYMENTS TO O/P PHYSICIAN (O/P PHYSICIAN PERCENTAGE FROM DMS APPLIED TO TOTAL MANAGED CARE MEDICAID AMOUNT: (\$166,888,947 X 20.56%)	\$34,312,368
TOTAL MEDICAID PAYMENTS TO PHYSICIANS (\$11,550,888 + 34,312,368)	\$45,863,256

APPENDIX 9: ESTIMATE OF NUMBER OF NON-ELDERLY, UNINSURED PERSONS IN ST. LOUIS CITY AND COUNTY

Overview

There are several sources of information about the number of uninsured in the United States. Two widely used are the Behavioral Risk Factor Surveillance System (BRFSS) and the Current Population Survey (CPS). Both of these surveys are done by, or under the auspices of, federal governmental agencies. Each of these surveys has its own advantages and disadvantages, which are discussed further below.

To estimate the number of uninsured persons in St. Louis City and County, state-wide rates of uninsured for the non-elderly population by federal poverty level from the CPS A9.1 for Missouri were applied to the numbers of non-elderly persons in St. Louis City and County by federal poverty level. Table 1 shows the details of this calculation which results in an estimate of approximately 129,000 persons in the area without insurance at the time of the most recent CPS survey (March, 2002). The table, below, shows the results of this calculation by St. Louis City and County separately and combined.

	BELOW POVERTY	ABOVE POVERTY	TOTAL
A. POPULATION AGED 0 TO 65 IN IN STL CITY (US 2000 CENSUS)	77,476	224,171	301,647
B. RATES OF UNINSURED FOR MO (US CENSUS, MARCH 2002 CPS)	25%	9%	-
C. NUMBER UNINSURED IN STL CITY (COLUMNS A X C)	19,369	20,175	39,544 (13.1%)
D. POPULATION AGED 0 TO 65 IN STL COUNTY (US 2000 CENSUS)	62,463	815,496	877,958
E. RATES OF UNINSURED FOR MO (US CENSUS, MARCH 2002 CPS)	25%	9%	-
F. NUMBER UNINSURED IN STL COUNTY (COLUMNS D X E)	15,616	73,395	89,011 (10.1%)
G. NUMBER OF UNINSURED IN STL CITY & COUNTY (COLUMNS D + G)	34,985	93,570	128,555 (10.9%)

The previous estimate is what is called a “point-in-time” estimate. That is, it represents the number of individual’s who did or did not have health insurance at the time of either the CPS or BRFSS surveys. There are significant numbers of persons, however, who may have been uninsured for only a portion of a year. To determine the number of these individuals researchers often use a “period-of-time” approach to size the population of uninsured persons in an area. A period-of-time estimate determines the number of individuals who did not have health insurance at any time over a set time period. Most often this time period is 12 months.

A period-of-time estimate of uninsured persons in St. Louis City and County was made through a complex modeling process based on several assumptions. This model produced an estimate of approximately *151,000 persons* in the area who were without insurance for some amount of time during a 12-month period. This number is approximately *22,000 more persons* than the point-in-time estimate of uninsured persons (129,000 persons without insurance). The remainder of this narrative describes the modeling process used to develop this period-of-time estimate.

Discussion of Estimate of Uninsured Persons

Estimating the number of uninsured in a small geography can be problematic. This is because many people’s health insurance status changes in relationship to their employment status, since the majority of persons under age-65 get health insurance through an employer. This fact is reflected in the large variances often seen in estimates of uninsured persons from different sources. Some estimates are based on a “point-in-time” (e.g., uninsured at the time of a survey) while others are based on a “period-of-time” (e.g., uninsured at any time during a specific period to the survey); the range in estimates of uninsured made using different time frames can be significant. For example, the US Census Bureau’s estimate of uninsured persons in the United States, based on the CPS, is approximately *41 million persons*. In a recent study titled, “Going Without Health Insurance: Nearly One in Three Non-Elderly Americans”, which was done by the Lewin Group and Families USA for the Robert Wood Johnson (RWJ) Foundation, the authors estimate the number of uninsured to be *72 million persons*.^{A9.2} The difference between the two estimates, over *30 million persons*, is due to the different time frames used by the Census Bureau and RWJ studies, which is discussed in more detail below.

As noted earlier the Current Population Survey (CPS) is one of two sources for state-wide rates of uninsured. The other source is the Behavioral Risk Factor Surveillance System (BRFSS).

The BRFSS is conducted by states as a telephone survey. The survey process is coordinated nationally by the Centers for Disease Control of the Department of Health and Human Services. The CPS is a monthly survey conducted by The U.S. Census Bureau. The primary intent of the CPS is to provide government statistics on labor force participation. However, each year, in March, a supplement to the core CPS survey includes questions concerning respondents' health insurance coverage.

It is important to note that for purposes of estimating the number of uninsured in St. Louis City and County that the rates of uninsured reported from the CPS were treated as “point-in-time” estimates. The US Census Bureau, itself, reports the rates of uninsured from the CPS as “period-of-time” estimates. Many researchers, however, feel that the CPS results are actually a point-in-time estimate because individuals interviewed seem to be reporting their current health insurance status rather than their coverage over the past year. In the RWJ study, referenced above, the authors compared the CPS to another survey which gives both period in time and point in time estimates of uninsured persons. Using data from the Survey of Income and Program Participation (SIPP) the RWJ researchers found that the CPS “period” rate was closer to the SIPP “point” estimate of the rate uninsured. (The SIPP, also conducted by the U.S. Census Bureau, collects information about labor force behavior, income, and participation in public programs, to measure the effectiveness of various federal programs. The structure of the survey does not allow for state-level estimates to be made from SIPP data. *However, at the national level, SIPP is felt by many experts to be the best data set for analyzing the dynamics of the uninsured over long time periods.*)^{A9.3}

Assuming the CPS provides point-in-time estimates of uninsured allows comparison of the CPS rates to the BRFSS rates. The BRFSS does not report uninsured rates for persons under 18. However, comparison of the rates for persons 18 to 64 years of age can be made between the BRFSS and the CPS for Missouri.

The uninsured rates for this age group in Missouri are 12.9% and 13.0% for the BRFSS^{A9.4} and CPS^{A9.1} respectively. The fact that two surveys, done by separate organizations, determine approximately the same rate of uninsured should give a degree of confidence in the validity of this approach.

Admittedly, it would be wrong to infer that this estimate of uninsured persons in St. Louis City and County has the same degree of confidence as the state-level estimates from either the BRFSS or CPS. However, without data from a specific survey for St. Louis City and County, it is reliable enough for the purposes of this report.

Period-of-Time Estimate of Uninsured Persons in St. Louis City and County

The determination of 129,000 uninsured persons in St. Louis City and County is a “point-in-time” estimate based on the CPS survey. That is, it is the number of persons without health insurance at the time of the CPS survey. Included in this number are both persons who may have been without health insurance for only a short time (e.g., 3 to 5 months or less) and those whose uninsured status is a long-term situation (e.g. more than 1-year). For purposes of planning an appropriate “safety net” of services it is helpful to have some idea of the length of time, or duration, uninsured persons are likely to be uninsured. It is also useful to have an idea of the number of persons who become uninsured over a “period-of-time” as opposed to just the number who are uninsured at a point-in-time. Estimates of both these variables can be derived from the point-in-time estimate of 129,000 uninsured persons in St. Louis City and County.

To develop these estimates it is necessary to use data from both the BRFSS and the RWJ study cited earlier. The BRFSS survey asks persons how long they have been without health insurance at the time of the survey. Based on recent BRFSS results it is likely that approximately 70% of the 129,000 uninsured, approximately 89,000 persons, have been without insurance for more than 1 year. Of the remaining 40,000 persons, approximately 23,000 are likely to have been without insurance for less than 6 months and 17,000 are likely to have been without insurance for more than 5 months, but less than 1 year. How much longer the individuals in this cohort of 40,000 persons will go without insurance can be estimated. Data from the RWJ A9.2 study, shown in Table 2 below, give a base for estimating the total length of time these individuals will be without insurance.

DURATION WITHOUT HEALTH INSURANCE FOR UNINSURED PEOPLE UNDER AGE 65, 2001-2002

MONTHS INSURED	NUMBER INSURED	AS PERCENT OF ALL INSURED
1 TO 2 MONTHS	7,502,000	10.0%
3 TO 5 MONTHS	18,634,000	24.9%
6 TO 8 MONTHS	9,374,000	12.5%
9 TO 12 MONTHS	7,314,000	9.8%
13 TO 23 MONTHS	13,959,000	18.7%
24 MONTHS	17,924,000	24.0%
TOTAL	74,706,000	100.0%

Incorporating the percentages from Table 2 in a matrix model (shown on the next page) it is estimated that the approximately 40,000 persons in St. Louis City and County without insurance for less than 1- year will go without insurance for the following total time periods;

TIME WITHOUT INSURANCE	# OF PERSONS
1 TO 2 MONTHS	922 PERSONS
3 TO 5 MONTHS	6,109 PERSONS
6 TO 8 MONTHS	4,441 PERSONS
9 TO 12 MONTHS	5,227 PERSONS
1-YR AND LONGER	22,786 PERSONS.

It should be noted that the data regarding the duration without health insurance are based on the period 2001–2002. Given that many persons get their health insurance from an employer any change in the labor market due to the economy since that time period could change the length of time persons go without health insurance.

It can be assumed that in a declining economy, such as exists at the time of this report’s publication, the numbers of persons losing their health insurance because of a job loss are increasing. It can also be assumed as jobs become more difficult to obtain, again because of the declining economy, the length of time persons go without health insurance is probably increasing as well. Therefore, because of the current poor economy relative to the period 2001–2002 it is likely that these estimates are conservative, that is, they are likely to understate both the number of uninsured persons in St. Louis City and County and the length of time that they are likely to go without insurance.

The matrix in Table 3, below, shows the likelihood, or probability, of the total length of time a person will be without health insurance based on the period of time that they have already been uninsured. For example, a person who just recently became uninsured (e.g. 1 month already uninsured) has a 10% probability of being uninsured a total of 1 to 2 months and a 25% probability of being uninsured 3 to 5 months. A person entering their 12 month without insurance has a 36% probability of being uninsured another 13 to 23 months.

TABLE 3. LIKELIHOOD OF TOTAL LENGTH OF TIME UNINSURED

TOTAL LENGTH OF TIME UNINSURED	NUMBER OF MONTHS ALREADY UNINSURED AT TIME OF SURVEY					
	1 MO	2 MO	3 MO	4 MO	5 MO	6 MO
1-2 MO	10.0%	10.0%	0.0%	0.0%	0.0%	0.0%
3-5 MO	24.9%	24.9%	27.7%	27.7%	27.7%	0.0%
6-8 MO	12.5%	12.5%	13.9%	13.9%	13.9%	19.3%
9-12 MO	9.8%	9.8%	10.9%	10.9%	10.9%	15.1%
13-23 MO	18.7%	18.7%	20.8%	20.8%	20.8%	28.7%
24+ MO	24.0%	24.0%	26.7%	26.7%	26.7%	36.9%

TOTAL LENGTH OF TIME UNINSURED	NUMBER OF MONTHS ALREADY UNINSURED AT TIME OF SURVEY					
	7 MO	8 MO	9 MO	10 MO	11 MO	12 MO
1-2 MO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3-5 MO	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
6-8 MO	19.3%	19.3%	0.0%	0.0%	0.0%	0.0%
9-12 MO	15.1%	15.1%	18.7%	18.7%	18.7%	18.7%
13-23 MO	28.7%	28.7%	35.6%	35.6%	35.6%	35.6%
24+ MO	36.9%	36.9%	45.7%	45.7%	45.7%	45.7%

Table 4, on the following page, applies the percentages from Table 3 to the estimate of uninsured persons in St. Louis City and County. The total estimate of approximately 129,000 uninsured persons in St. Louis City and County likely includes 89,000 persons who have been without health insurance for 1-year or longer and 40,000 persons who likely have been without health insurance for less than 1-year. Of the persons without insurance for less than 1-year approximately 23,000 are likely to have been without insurance for less than 6 months and 17,000 are likely to have been without insurance for more than 5 months, but less than 1-year. These estimates are based on data from the BRFSS.^{A9.4} Unfortunately, the BRFSS does not give more detailed breakdowns of time without insurance (for example, the number uninsured for one month, two months, three months and so on). In the Table 4, below, absent specific month to month estimates, the number of persons without health insurance for less than 6 months (22,956 persons) was divided by 5 and the result allocated to each of the first five months (4,591 per month). The number of persons without health insurance for 6 to 12 months (16,529 persons) was similarly distributed across the remaining 7 individual months by dividing the total by 7 and then allocating the result (2,361 per month) to each month.

TABLE 4.

TOTAL LENGTH OF TIME UNINSURED	NUMBER OF UNINSURED IN ST. LOUIS CITY & COUNTY BY NUMBER OF MONTHS ALREADY UNINSURED AT TIME OF SURVEY					
	1 MO ⁽¹⁾	2 MO ⁽¹⁾	3 MO ⁽¹⁾	4 MO ⁽¹⁾	5 MO ⁽¹⁾	6 MO ⁽²⁾
	4,591	4,591	4,591	4,591	4,591	2,361

NUMBER OF UNINSURED BY TOTAL LENGTH OF TIME UNINSURED							
1-2 MO	461	461	0	0	0	0	
3-5 MO	1,145	1,145	1,273	1,273	1,273	0	
6-8 MO	576	576	640	640	640	456	
9-12 MO	449	449	500	500	500	356	
13-23 MO	858	858	954	954	954	679	
24+ MO	1,102	1,102	1,225	1,225	1,225	871	

	7 MO ⁽²⁾	8 MO ⁽²⁾	9 MO ⁽²⁾	10 MO ⁽²⁾	11 MO ⁽²⁾	12 MO ⁽²⁾	TOTAL
	2,361	2,361	2,361	2,361	2,361	2,361	39,485
1-2 MO	0	0	0	0	0	0	922
3-5 MO	0	0	0	0	0	0	6,109
6-8 MO	456	456	0	0	0	0	4,441
9-12 MO	356	356	441	441	441	441	5,227
13-23 MO	679	679	841	841	841	841	9,976
24+ MO	871	871	1,080	1,080	1,080	1,080	12,810

⁽¹⁾ Monthly number is one-fifth of total number of uninsured persons without insurance for 5 months or less, or 22,956/5.

⁽²⁾ Monthly number is one-seventh of total number of uninsured persons without insurance for 6 to 12 months, or 16,529/7.

For example, in the matrix delineated in Table 4, of the total persons in St. Louis City and County estimated to have been uninsured for less than 6 months (23,000 persons) one-fifth, or approximately 4,600 persons, are assumed to have been without insurance for only 1 month. Of these, given the probabilities associated for the duration without health insurance from Table 3, it is estimated that 10%, or approximately 460 persons, will likely go without insurance for only 1 to 2 months. An additional 24.9%, or 1,145 persons, will likely go without insurance for 3 to 5 months.

Table 4 shows that given the probabilities of the total length of time without insurance (from Table 3), one could expect the following results for uninsured persons in St. Louis City and County;

- 922 of the approximately 40,000 persons uninsured-for-less-than-a-full-year will be uninsured for a total of 1 to 2 months,
- 6,109 of the 40,000 will be uninsured for a total of 3 to 5 months,
- 4,441 of the 40,000 will be uninsured for a total of 6 to 8 months,
- 5,227 of the 40,000 will be uninsured for a total of 9 to 12 months, and,
- 22,786 of the 40,000 will go on to be uninsured for more than one year.

The above information is useful for planning an appropriate “safety net” of services because it gives an idea of the length of time, or duration, uninsured persons are likely to be uninsured. That is, the health care needs of individuals only uninsured 1 to 2 months are likely to be different than the needs of those who have been uninsured for longer periods. Also for purposes of planning an appropriate safety net of services it is useful to have an idea of the number of persons who become uninsured over a “period-of-time” as opposed to just the number who are uninsured at a point-in-time.

For example, during a year's time the number of persons uninsured for 1 to 2 months will "turn-over" approximately 8 times (12 months divided by 1.5—the midpoint of the 1 to 2 month range). The number of persons uninsured 3 to 5 months will turn-over approximately 3 times (12 months divided by 4—the midpoint of the 3 to 5 month range). The number of persons uninsured 6 to 8 months will turn-over approximately 1.7 times (12 months divided by 7). The number of persons uninsured 9 to 12 months will turn-over approximately 1.1 times.

Based on these turn-over rates, a year-long, period-of-time estimate of uninsured persons can be made for St. Louis City and County. This estimate is shown in Table 5. During a year, the population of persons who are likely to be without insurance for a short period of time, 1 to 2 months, turns over 8 times. Therefore the total number of persons in St. Louis City and County who are without health insurance for a period of 1 to 2 months during a 12-month period is approximately 7,400. The number of persons without insurance for 3 to 5 months during a year's time is approximately 18,000.

TABLE 5. PERIOD-OF-TIME ESTIMATE OF UNINSURED PERSONS IN ST. LOUIS CITY AND COUNTY

NUMBER OF TOTAL MONTHS WITHOUT INSURANCE	NUMBER OF UNINSURED PERSONS (POINT-OF-TIME ESTIMATE)	TURN-OVER RATES RATES PER YEAR	NUMBER OF UNINSURED PERSONS (PERIOD-OF-TIME ESTIMATE)
1-2 MOS	922	8.0	7,377
3-5 MOS	6,109	3.0	18,328
6-8 MOS	4,441	1.7	7,612
9-12 MOS	5,227	1.1	5,974
13+ MOS	111,856	-	111,856
TOTAL	128,555	-	151,147

Summary

The population of uninsured persons in St. Louis City and County is estimated, as of March, 2002 to be approximately 129,000 persons. This is a point-in-time estimate of the number without insurance as of that date. An estimate of the number of persons without insurance at anytime during a 12-month period-of-time in St. Louis City and County is approximately 151,000 persons. Both of these numbers are estimates based on multiple assumptions.

The two primary assumptions underlying these estimates are;

1. the rate at which people lose their insurance, and,
2. the duration they are likely to be without insurance.

The assumptions used in this analysis are based on data gathered from 2001 to 2002. Since health insurance in this country is frequently linked to employment it is likely that swings in the economy impacting employment rates are also very likely to impact factors related to health insurance coverage. In fact recent economic data shows that the St. Louis area has 10,000 fewer persons employed in January, 2003 ^{A9.5} compared to the same time last year.

It can be assumed that in a declining economy, such as exists at the time of this report's publication, the numbers of persons losing their health insurance because of a job loss are increasing. It can also be assumed as jobs become more difficult to obtain, again because of the declining economy, the length of time persons go without health insurance is probably increasing as well. Therefore, because of the current poor economy relative to the period 2001–2002 it is likely that these estimates are *conservative*, that is, they are likely to understate both the number of uninsured persons in St. Louis City and County and the length of time that they are likely to go without insurance.

APPENDIX IO: CULTURAL AND LINGUISTIC BARRIERS FOR NEW AMERICANS

Key Findings:

1. *The immigrant and refugee population in St. Louis City and Saint Louis County has grown rapidly over the past two decades.*
2. *There are a number of physical diseases and conditions that particularly impact new Americans, including dental problems, nutritional deficiencies, untreated and undertreated chronic conditions and diseases, disfigurement from trauma and war violence, and others.*
3. *There are aspects of the safety net health care system that are working well for new Americans, including:*
 - *Newly arrived refugees receive effective support in finding out how to access the health care safety net upon arrival and for future needs.*
 - *Though improvements can be made, resources are becoming more available for non-English speaking citizens at safety net providers.*
 - *Some safety net providers are doing a better job at coordinating health care resources across entities for the new American population.*
4. *However, refugees and immigrants encounter unique barriers to accessing the health care system, including:*
 - *Language barriers.*
 - *Obtaining information on where to go for care and how the American health care system works.*
 - *Fear of deportation or detainment, even for those who are legally in the country, especially given the amount of information asked for by health care providers.*
5. *New Americans are disproportionately affected by mental health issues, often due to trauma associated with war or violence in their home countries or difficulty in adjusting to a new language and culture. Some specific mental health issues include:*
 - *Cultural barriers.*
 - *Fear and lack of understanding of “modern” medicine and westernized medicine providers.*
 - *Post Traumatic Stress Disorder (PTSD) and other consequences of oppression and trauma experienced by refugees*
 - *Depression*
 - *Anxiety*
 - *Difficulty adjusting to new culture*
 - *Grief*
6. *There are barriers limiting new Americans’ ability to access mental health services, including a lack of providers and difficulty in providing counseling and therapy using interpreter services. Also, there is a lack of standardized trauma and torture assessment performed by providers.*

New Americans¹ often encounter difficulties in accessing the system or understanding health care providers due to differences in language and culture. These barriers are becoming increasingly acute in the region as the immigrant and refugee population in St. Louis City and Saint Louis County has grown rapidly over the past two decades.

The U.S. Census Bureau reported the number of foreign-born residents in St. Louis City and Saint Louis County in 2000 as 62,244, or approximately 5% of the total population. The estimate for St. Louis City alone is 19,542, or nearly 6% of the total population. ^{A10.2}

Although more recent Census data is not available, community groups that work with new American populations believe that the number of foreign-born residents is actually greater than 62,244 due to a significant influx of immigrants and refugees since 2000. ^{A10.1}

The influx of foreign-born residents is reflected in the populations served by the safety net providers. In a survey of Institutional Safety Net Providers in the St. Louis community, 13 of the 33 sites reported that 10% or more of their clients do not have English as their primary language. Of these 13 sites, five

reported seeing over 10% Spanish-speaking residents, four reported seeing over 10% Bosnian/Serbian/Croatian residents, and one reported seeing over 10% Vietnamese residents. ^{A10.3}

It is anticipated that the number of new Americans seen by safety net providers will continue to grow as the refugee and immigrant population increases, and as foreign-born residents access the health care system in greater numbers.

In an effort to gather information on health and access issues facing new Americans, the RHC partnered with the International Institute and the City of St. Louis Mental Health Board of Trustees to hold two focus groups of community organization representatives and health care providers who serve the new American community. The first group discussed general health and access issues. The second group focused on mental health issues and access to mental health services for immigrants and refugees.

Much of the information discussed in this section was gathered through these focus groups and through the RHC survey of Institutional Safety Net Providers in the St. Louis community. ^{A10.3}

FOREIGN-BORN RESIDENTS BY ORIGIN – U.S. CENSUS BUREAU, 2000

	EUROPE	ASIA	AFRICA	NORTH & SOUTH AMERICA	TOTAL	PERCENT OF TOTAL POPULATION
ST. LOUIS CITY	8,543	6,538	1,500	2,961	19,542	5.6
SAINT LOUIS COUNTY	14,042	19,198	2,306	7,156	42,702	4.2
TOTAL	22,585	25,736	3,806	10,117	62,244	4.6

¹ The term “new Americans” generally refers to newly arrived immigrants and refugees, and also includes undocumented and migrant workers. ^{A10.1}

A. *Health Issues for New Americans*

The new American community is impacted by many of the same health problems that affect the general population. However, there are a number of diseases and conditions that are particularly problematic or that generally only exist among refugee and immigrant populations, including:

- Osteoporosis due to inadequate dietary calcium
- Severe dental problems due to lack of preventive care and lack of fluoridated water in native country
- Nutritional deficiencies due either to long-term dietary issues in the country of origin or problems arising during recent periods of civil unrest and/or war
- Goiter due to lack of iodized salt
- Gastrointestinal problems and parasites
- Untreated and undertreated chronic conditions and diseases such as heart disease and diabetes
- Smoking-related diseases
- Hypertension
- Disfigurement from trauma and war violence
- Obstetrical and gynecological problems related to female cutting (sometimes referred to as female circumcision or female genital mutilation), and problems associated with relatively high utilization of abortion as a method of birth control

- Tuberculosis, rubella, congenital rubella syndrome, and other conditions which are preventable with immunizations
- Untreated or undertreated cancer
- Specific mental health issues discussed later in this section

Many of these health issues affect both children and adults, with children's conditions possibly having complications into adulthood. Focus group members indicated that the new American community is less likely to receive treatment for health problems than the general population. In addition, refugees and immigrants are generally diagnosed later and have a higher rate of morbidity for many conditions. According to one focus group member, new Americans suffer from: ^{A10.4}

“Higher morbidity and mortality for just about everything that benefits from early detection and intervention. Higher morbidity because things are caught later and require more aggressive management...Higher mortality in that studies have shown that diagnosis is often made at later stages of diseases.”

Focus group members also noted that some new Americans come from cultures that are not aware of prevention tools to obtain and maintain good health.

B. Current System for New Americans

St. Louis City and County safety net providers have a number of processes in place to help meet the health care needs of refugees and immigrants. The responses of safety net providers to the RHC survey, while self-reported, give a picture of the services targeted to foreign-born residents that are being provided by area safety net providers.

The 33 identified primary care “safety net” sites (those seeing a large percentage of Medicaid and/or uninsured patients) were asked questions regarding services for foreign-born, non-English speaking patients.

Thirty-one of these 33 sites responded to questions regarding this topic. The self-reported responses are as follows:

Culturally Appropriate Services (n=31)

- 28 reported incorporating patient cultural health beliefs and practices.
- 23 reported staff and leadership are representative of the demographic characteristics of the service area.
- 27 reported having ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services at No Cost to the Patient (n=31)

- 28 reported having bilingual staff available.
- 30 reported contracting for on-site interpreter services.
- 21 reported having telephone interpreter services available.
- 20 reported using friends and/or family members of the patient.

In addition, 24 of the 31 respondents reported that a verbal notice of the right to receive language assistance services at no cost was provided, and most reported that their staff had attended training sessions on cultures and sensitivities hosted by either the International Institute of Metro St. Louis or by Language Access Metro Project (LAMP).

Survey responses indicate a need for improvement in several areas. For example, it is considered medically inappropriate and contrary to federal policy guidance to use friends and/or family members of the patient for language services. In addition, only seven of the 31 respondents (23%) indicated that a written notice is given to the patient informing him/her of the right to receive language assistance services at no cost. Also, only 15 of the 31 respondents (48%) reported that vital documents (e.g., consent forms, requests for records, Patient’s Bill of Rights, etc.) are available in the most frequently encountered languages, and only 14 (45%) reported that signage in the most frequently encountered languages is utilized in service areas. ^{A10.3}

Assets of the Current System

Participants from the new American focus groups indicated that, in recent years, safety net providers have made improvements in their efforts to meet the needs of refugees and immigrants. The participants also identified a number of aspects of the safety net health care system that are working well for new Americans, including: ^{A10.4}

- Newly arrived refugees receive support in accessing the safety net system
- Improved interface among some components of the safety net system
- Groups advocate for the health care needs of new Americans
- Improved data collection on new Americans

Newly Arrived Refugees Receive Support in Accessing the Safety Net System

Focus group members agreed that newly arrived refugees are often able to access and navigate the primary care safety net system with assistance from resettling organizations. System navigation and comprehension often takes a great deal of time and instruction. Resettlement caseworkers take clients to and from medical services, explain the system processes, and model behaviors to access care.

“Resettling agencies play an important role in giving information for the health care system here. Without them, they get lost...[These organizations] help link them into the system...Many people I talk to express this.” ^{A10.4}

Improved Coordination Among Some Components of the Safety Net System

New Americans are experiencing fewer difficulties in moving between different components of the safety net system. One focus group member explained: ^{A10.4}

“I see a lot more cooperation among the various hospitals and clinics.”

In particular, focus group members discussed improved interfaces between one hospital system and certain primary care sites. When a refugee or immigrant is seen at a hospital, the system for moving that patient back into the primary care system for follow-up care has improved.

“The interfaces have improved tremendously in terms of the interfaces between say [a primary care clinic and a hospital] for pregnant women, and between neighborhood health centers and [a hospital system]. The interfaces between the primary sites and the tertiary care sites where the patient’s been identified have strengthened entirely in terms of being able to track back to hand back off that sort of stuff. That seems a lot more solid than it has been in recent history. But again, that’s for an identified and engaged patient.” ^{A10.4}

In addition, there is improved coordination in providing interpreter services and translated materials for patients once they have entered the system.

Groups Advocate for the Health Care Needs of New Americans

There are a number of groups that advocate for the needs of new Americans and work to help them access health care.

“We’ve grown in advocacy a lot...There are people out in the community who care a lot about what is happening to refugees and immigrants. The [large number of groups] may tell us that they’re an indicator that our system is not working great, but they are an asset. They are a huge asset for St. Louis. All these little groups that have popped up, either social services or health services, are the way to link people into the bigger services... I don’t think we can overlook them as being a really important part of the puzzle.” ^{A10.4}

These groups have made strides in raising awareness about the needs of new Americans using the health care system. One focus group participant commented that her organization has experienced an increase in requests for language services, indicating that more providers may be referring patients to the organization.

“We have seen some increase in patients calling us for language services. This is a sign...[providers] know there is a language issue.” ^{A10.4}

Improved Data Collection on New Americans

Focus group members also indicated that the safety net providers have improved in their ability to track the number of new Americans accessing the system and the services provided to them. Better accuracy in tracking has helped raise awareness about the need for culturally and linguistically appropriate services.

“I would say the tracking has improved in terms of numbers. Even if it’s not ideal and we won’t be able to meet the CLAS guidelines, I can easily now go to an ethics committee and say we need to look at how we’re doing consent because we’ve got X number of patients for whom the western model of consent is a real [problem] and we need to look at something else. And I have enough numbers and enough data to be able to say, ‘Look, here it is.’” A10.4

C. Barriers to Accessing Health Services for New Americans

While a number of aspects of the safety net health system work well for new Americans, significant barriers still limit the ability of refugees and immigrants to access health services. Many of the barriers discussed in Section V of this report are true for new Americans. Issues such as lack of transportation, lack of insurance, and prioritization of other needs over health care all limit access for new Americans.

There are also a number of barriers that particularly impact refugees and immigrants, including:

- Language barriers, including lack of literacy in native language
- Few linkages into the health care system
- Fear of deportation or detainment for those who are undocumented or out of status
- Cultural barriers

Language Barriers

Providers have made strides in ensuring that interpreter services are available for appointments. But there are a number of areas in which interpretation and translation services could be improved.

Lack of “Gateway” Interpretation

Immigrants and refugees who speak limited English often have difficulty entering and navigating the safety net health care system. While interpreter services are generally available for appointments, interpretation often is not provided at the initial entry point into the health care system. This causes new Americans difficulties in scheduling appointments and gaining information about health services. One focus group member explained: ^{A10.4}

“Even if you have a system that has interpreters buried deep, they may not be at the reception level and the initial referral level. The gatekeeping system is nonlinguistically friendly.”

In addition, many providers do not have interpreters on staff. In cases where system gatekeepers do not know the interpreter requirements or procedures, new Americans must take on the responsibility of securing an interpreter from another organization themselves.

“Many [providers] don’t have interpreters on staff. What we see every day is a patient calling us from the reception desk saying, ‘I need an interpreter and I’m not getting one.’ Then you would get a nurse on the phone who doesn’t even know this patient has been sitting there.” ^{A10.4}

Few Rare Language Interpreters

There is a limited supply of interpreters for immigrants and refugees who speak less common languages. As one focus group member noted: ^{A10.4}

“If you speak a major language—Bosnian, Spanish, even Kurdish, you’re OK. If you speak [a lesser known language] you could be in trouble.”

Lack of Translated Communication Materials

Focus group members also noted that a number of communication materials are not translated for limited English speakers. Signage is often in English only. In addition, bills, forms, referrals, instructions on medication usage, and information about follow-up appointments are often not translated. And some refugees do not have a high level of literacy in their native language, so even translated materials using more complex language may not be useful.

Limited Linkages into the Health Care System

Focus group members noted that newly arrived refugees often receive assistance in accessing health care from resettling agencies. But other new American groups are generally not linked to resettling agencies and are less likely to receive such assistance. One focus group member noted: ^{A10.4}

“Linkages into the system for the secondary migrants [refugees who were resettled in other communities in the U.S. and then moved to St. Louis] and the immigrants are a barrier.”

Without assistance in entering the health care system, new Americans are less likely to access health services.

“I would say that there are two systems in place right now. One system is for the new [refugee] arrivals and that works pretty well. The other system is for the [refugee] non-new arrivals [and immigrants] and it’s broken.” ^{A10.4}

Fear of Deportation or Detainment

Some new Americans do not access the health care system out of a fear of deportation or detainment. This applies to those who are in the U.S. without legal status (undocumented), as well as those who are out of status (i.e., someone who has an expired visitor's visa).

“There are a lot of people who simply don't access care because of fear of deportation, or fear of imprisonment, or fear of detainment, or fear of just being booted out of the country. American-born people don't have that same fear”. ^{A10.4}

This is particularly the case for undocumented immigrants: ^{A10.4}

“Particularly for migrant or Hispanic workers, they're trying not to disclose their [undocumented] status and their perception is at they are at risk in the health care system. There is a basic fear of being found out...so they are unwilling to access parts of the system that would be available to them”.

Focus group members also noted that some legal immigrants fear that they will be deported for accessing benefits such as Medicaid, since their sponsor (usually a relative) had to assure the U.S. government that the immigrant would not access public benefits.

Cultural Barriers

Cultural differences also present barriers to accessing the health care system. These may show up in conceptual differences around such things as locus of control, concepts of self, communication styles, power distances, and levels of societal obligation. Because of these factors, immigrants and refugees do not understand or are uncomfortable with the American approach to health care.

Less Emphasis on Early Detection and Prevention

In some cultures people do not visit the doctor unless they are feeling ill. These cultures put less emphasis on early detection and prevention. As one focus group member explained: ^{A10.4}

“Some immigrants and refugees think, ‘If I am not sick why should I go to the doctor?’ If they basically are well young adults...they have absolutely no understanding or interest in getting registered in any clinic. Then they would come down with all sorts of illnesses and not get seen.”

Discomfort in Discussing Health Issues

New Americans may also be uncomfortable speaking about health issues in the frank manner that is used in western medicine. They sometimes fear that acknowledging an issue or discussing prevention may actually cause health problems. This “jinx” is much more common in other cultures than in the U.S.

“Let's not mention cancer because it might suddenly materialize...Cultural norms say that you don't talk about those bad things that could happen.” ^{A10.4}

Lack of Provider Cultural Competency

Focus group members noted that some providers are not aware of or sensitive to the culture or health issues of refugee and immigrant populations. For instance, some immigrants and refugees choose to address health issues with traditional practices. But as one focus group member commented: ^{A10.4}

“Providers may not be able to differentiate which traditional practices are harmful, harmless...or beneficial.”

As a result, providers may discourage patients from incorporating traditional practices into their health regimen.

Focus group members also agreed that providers may be able to better serve new American populations if they had a greater awareness of some of the health issues facing various refugee and immigrant groups.

“Providers don’t know the prevailing health issues of immigrant groups. We don’t know how to figure out what people need and how to ask it. Providers are also aware that new Americans sometimes distrust American providers and the system. Patients will frequently try their own remedies and only as a last resort seek medical care.”^{A10.4}

D. Mental Health Issues and Access to Services

New Americans are disproportionately affected by mental health issues, often due to trauma associated with war or violence in their home countries as well as difficulty in adjusting to a new language and culture. While immigrants and refugees are impacted by all the mental disorders and problems that affect the general population, some problems which particularly impact the new American community include:

- Post Traumatic Stress Disorder (PTSD)
- Depression
- Anxiety
- Difficulty adjusting to new culture
- Grief

There are a number of organizations in the St. Louis community specifically working to meet the mental health needs of immigrants and refugees. Several of these organizations specialize in providing services to those who have experienced war trauma and torture.

Barriers to Accessing Mental Health Services

The barriers that limit new Americans’ ability to access health services in general also affect access to mental health issues. In addition, there are barriers specific to accessing mental health services, including:

- Lack of providers knowledgeable about and skilled in providing services to war survivors.
- Difficulty in providing counseling and therapy with interpreter services.

Lack of Providers

As discussed in Section IV, there is limited availability of mental health services for the general safety net population. According to focus group members, availability of providers to serve the new American community is particularly a problem. An estimated 15,000 of the approximately 60,000 immigrants and refugees living in the city and county have experienced torture; many more have experienced varying degrees of trauma, which would suggest the need for mental health services. Yet fewer than a dozen mental health practitioners specialize in psychotherapy and counseling for such individuals.

“But the truth of it is we don’t have enough mental health care providers in general, and we don’t have enough that are able to provide culturally competent services. We need more providers who...develop an interest and experience in working with these populations.” ^{A10.1}

Focus group members also commented that as new populations enter the country, the region needs providers who are able to learn and adapt their practices to treat people in multiple different cultures.

“The populations change, especially with refugees. So the important thing is not just knowing a specific culture, but the willingness and openness to learn about the culture when the next population comes.” ^{A10.4}

Difficulty in Providing Counseling and Therapy with Interpreter Services

Therapy and counseling are key components of mental health treatment. Since many therapists and counselors are not fluent in the language of the mental health clients, and clients are not fluent in English, mental health interpreters become a critical part of the mental health delivery system for new Americans.

Focus group members commented that, in some cases, interpreters have not been adequately trained to provide interpreting in such situations. In therapy, the interpreter becomes a part of the therapeutic team and needs specialized training and skills for mental health settings. Less than half a dozen interpreters specialize in this. Comments from several focus group participants emphasize the need for trained interpreters. ^{A10.4}

“We need competent people who know how to interpret and who are also knowledgeable about the culture.”

“We also need people who are knowledgeable about mental health. It’s not just being fluent in two languages and being somewhat bicultural in the ability to bridge cultures. It’s also understanding mental health.”

In some cases, interpreters do not interpret all of what a client says, making it difficult to provide treatment.

“We come and see the patient. We ask a simple question, ‘How has your mood been?’ There is a 10-minute conversation between them and then the interpreter says, ‘OK.’ Ten-minute conversation and the answer is ‘OK.’” ^{A10.4}

Focus group members also noted that even in situations where interpreters have the necessary skills, the presence of an interpreter makes a client less likely to speak freely in sessions. This is especially true in smaller language groups, where the interpreter may play other roles in the ethnic community, such as community leader or case manager for resettlement.

E. Conclusion

There are aspects of the safety net health care system that are working well for new Americans. However, immigrants and refugees encounter unique linguistic and cultural barriers in accessing the safety net health care system. As the new American population continues to grow rapidly, the St. Louis community must work to correct the barriers this population encounters.

APPENDIX II: MEASUREMENT IN OTHER COMMUNITIES

The Measurement Workgroup of the St. Louis Regional Health Commission examined the methods of tracking and reporting of health status in select communities. The Workgroup researched three areas in each community: the general approach to measurement and reporting, the health status and socioeconomic indicators the communities reported to the public, and the data sources that the communities used for gathering health status information.

The communities researched include:

- Madison, Wisconsin
- Multnomah County – Portland, Oregon
- Santa Clara County – San Jose, California
- Ramsey County – St. Paul, Minnesota
- Chicago, Illinois
- Canada

MADISON, WISCONSIN	
APPROACH	<p>The Madison Department of Public Health uses five criteria to select the health indicators for its periodic community health status report:</p> <ul style="list-style-type: none"> • Data is available on a City or County-wide basis • Data can be tracked over time • Data is comparable to health data from other communities • Data is significant and will be sustained over time • Data reflects a focus area <p>Madison compares its health status to the standards or targets set by Healthy People 2010. The comparison indicates areas of favorable health status, areas that need improvement and emerging health trends to track.</p>

MADISON, WISCONSIN (<i>Continued</i>)	
HEALTH STATUS	<ul style="list-style-type: none"> • Access to Care – Insurance Status
INDICATORS	<ul style="list-style-type: none"> • Health Care Resources – Primary Care Physicians to Population Ratio; Dentists to Population Ratio • Leading Causes of Death by Age Group • Selected Preventable Causes of Death – Cancer, Coronary Heart Disease, Stroke, Lung Cancer, COPD, Breast Cancer, Diabetes, Other Injuries, Suicide, Chronic Liver Disease, Motor Vehicle Injuries, AIDS/HIV • Leading Causes of Hospitalization • Selected Chronic Diseases – Hypertension, Asthma, Diabetes • Children with Selected Chronic Disease (Asthma, Diabetes, Dental Disease) • Behavioral Risk Factors – Sedentary Lifestyle, Overweight, Smoking, Smoked while Pregnant, Chronic Drinking, Binge Drinking, Drinking and Driving, Always Use Seat Belts • Youth Behavioral Risk Factors (Vigorous Exercise, Regular Smoking, Binge Drinking, Drinking and Driving, Always Use Seat Belts) • Adult Preventive Services – Blood Pressure Screening during past 1 year • Mammograms Over 50 years during past 1 year, Medicare Flu Immunizations • Child Preventive Services (under 3 years) – Lead Screened, Immunizations

	<ul style="list-style-type: none"> • Maternal and Infant Health (by race and ethnicity) – First Trimester Prenatal Care, Low Birth Weight, Very Low Birth Weight, Infant Mortality Rate • Infectious Diseases – STDs (Gonorrhea, Chlamydia, Herpes); Gastrointestinal Illnesses (Campylobacter, Salmonella, Hepatitis A, Shigella); Tuberculosis Case Reports • Environmental Health – Air Quality, Toxic Chemicals, Water Quality, Lead Exposure
DATA SOURCES	<ul style="list-style-type: none"> • U.S. Census Bureau • U.S. Health Resources and Services Administration • Bureau of Health Information, DHFS • Bureau of Health Information - Wisconsin Behavioral Risk Factor Survey, Family Health Survey, Birth Certificates • Wisconsin Department of Health and Family Services – Office of Health Information, Bureau of Health Information, Bureau of Health Care Financing • Health Care Financing Administration • Madison Department of Public Health – National Immunization Survey • Chronic Illness Data, Madison Metropolitan School District • Dane County Youth Survey • Wisconsin Youth Risk Behavior Survey, Wisconsin Department of Public Instruction

MULTNOMAH COUNTY – PORTLAND, OREGON	
APPROACH	<p>The Health of Multnomah County 2000 report presents the County’s performance in comparison to:</p> <ul style="list-style-type: none"> • Healthy People 2010 Health Indicators • Peer counties selected by the Health Resources and Services Administration <p>Multnomah County also compares its performance to the state of Oregon and the nation.</p>
HEALTH STATUS INDICATORS	<p>Healthy People 2010 Goals</p> <ul style="list-style-type: none"> • Physical Activity – Adolescent physical activity, Adult physical activity • Overweight – Child/Adolescent Obesity; Adult Obesity • Tobacco Use – 11th grade tobacco use; Adult smoking • Substance Abuse – Adolescent alcohol use in past 30 days, Adult Binge Drinking • Responsible Sexual Behavior – Adolescent abstinence or condom use; Sexually active person condom use • Injury and Violence – Deaths due to motor vehicle crashes; homicides • Environmental Quality – Persons exposed to air that does not meet US EPA standards for ozone • Immunization – Non-institutionalized adults 65+ vaccinated annually • Access to Health Care – Persons with health insurance/specific source of ongoing care; 1st trimester prenatal care • Peer County and U.S. Comparison – Measures of Births and Deaths

	<ul style="list-style-type: none"> • Birth Measures – Low Birth Weigh; Premature Births; Teen Births; No Care in First Trimester • Infant Mortality – White, African American and total • Death Measures – Breast Cancer, Colon Cancer, Heart Disease, Homicide, Lung Cancer, Motor Vehicle Injury, Stroke, Suicide, Unintentional Injury
DATA SOURCES	<ul style="list-style-type: none"> • Oregon Youth Risk Behavior Survey • National Risk Youth Behavior Survey • Oregon Behavioral Risk Factor Surveillance System • National Behavioral Risk Factor Surveillance System • 1988-1994 Center for Disease Control and Prevention, National Center for Health Statistics, Division of Health Examination Statistics • 1998 National Household Survey on Drug Abuse • Oregon Health Division Vital Statistics • 1997 National Vital Statistics Report Vol. 27, 1999 • 1998 Oregon Population Survey • 1997 Monthly Vital Statistics Report, Vol 47 • Oregon State Department of Environmental Quality

SANTA CLARA COUNTY – SAN JOSE, CALIFORNIA	
APPROACH	<p>Santa Clara County has released periodic reports comparing its health outcomes to the goals set forth in the Healthy People 2000 Initiative.</p> <p>The 1997 Health Status Report is based, to a large degree, on data from the Santa Clara County (SCC) Behavioral Risk Factor Survey. The survey was conducted by phone in English and Spanish.</p> <p>SCC also released reports of key indicators of well-being for seniors and children, based on survey data and data maintained within the County health department.</p>

SANTA CLARA COUNTY – SAN JOSE, CALIFORNIA	
HEALTH STATUS INDICATORS	<ul style="list-style-type: none"> • Access to Care – Coverage by insurance type • Mental Health – estimated service need by race and ethnicity; usage rates • Tobacco use by race, ethnicity and gender; intent to quit; amount used; comparison of drinking practices of smokers and non-smokers; rates of COPD and lung cancer • Alcohol and drug use – binge drinking rates; chronic alcohol abuse rates; cirrhosis mortality rates; drug-related mortality • Women’s Health – utilization of cancer screening procedures – clinical breast exam and mammography; breast cancer mortality; Pap screening exam; mortality due to cervical cancer; STDs in females and among reproductive-age women; pelvic inflammatory disease • Maternal and Infant Health – infant mortality; adolescent births; conditions and outcomes in births by mother’s age and race/ethnicity; very low birth-weight babies by race and ethnicity • Heart Disease and stroke • Ambulatory Care Sensitive Conditions (ACS) • HIV and AIDS • Sexually Transmitted Disease • Tuberculosis, Immunization and Vaccine-Preventable Diseases

SANTA CLARA COUNTY – SAN JOSE, CALIFORNIA (*Continued*)

DATA SOURCES	
	• Santa Clara County Behavioral Risk Factor Survey
	• Youth Risk Behavioral Survey
	• Vital Statistics
	• Hospitalization Discharge Database
	• Census Data
	• California Department of Finance, Population Projection, 1985-1996
	• Department of Mental Health, Services Research Division
	• AIDS Registry, SCC Public Health Department
	• Confidential Morbidity Reports, Disease Control and Prevention, Public Health Department
	• HIV Medical Care Survey, Disease Control and Prevention, Public Health Department
	• Immunization Registry, Planning and Evaluation Division, Public Health Department
	• Tuberculosis Information Management System, Tuberculosis Prevention and Control, Public Health Department
	• Senior Survey, Council on Aging, Silicon Valley & Data Management and Statistics, Silicon Valley
	• California Safe Schools Assessment Data
	• California Statewide Integrated Traffic Reporting System
	• California Alcohol and Drug Data System
	• National Immunization Survey
	• Hospitalization Injury Surveillance System
	• Perinatal Substance Abuse Exposure Study – University of California, Berkeley

- | |
|---|
| <ul style="list-style-type: none"> • Santa Clara County Office of Education Vital Signs report • Santa Clara County Probation Department • Santa Clara County Social Services Agency |
|---|

RAMSEY COUNTY – ST. PAUL, MN	
APPROACH	<p>The Saint Paul – Ramsey County Department of Public Health puts out a series of fact sheets to inform citizens, health care providers and policy makers of the community’s health status. The fact sheets are based on priorities developed in the County’s Community Health Services Assessment and Plan for 2000-2003, including Health Disparities, Immunizations, and Tuberculosis.</p> <p>Ramsey County receives state funds to eliminate health disparities in the following areas: HIV/AIDS and STDs; immunizations; teen pregnancy; infant mortality; violence and unintentional injuries; diabetes; breast and cervical cancer; and cardiovascular disease</p> <p>The County reports data on those areas of health disparity from the state and Ramsey County.</p>
HEALTH STATUS	<ul style="list-style-type: none"> • HIV/AIDS and Sexually Transmitted Infections
INDICATORS	<ul style="list-style-type: none"> • Immunization Rates - % Up-to-Date at age 24 months by school district for DPT, Polio and MMR • Teen pregnancy • Infant mortality • Diabetes • Breast and cervical cancer • Cardiovascular disease

DATA SOURCES	<ul style="list-style-type: none"> • Minnesota Department of Health • Retrospective Survey – Minnesota Department of Health • St. Paul – Ramsey County Public Health • U.S. Census • Center for Health Statistics – Minnesota Department of Health • Centers for Disease Control and Prevention • American Thoracic Society
--------------	--

CHICAGO, ILLINOIS	
APPROACH	<p>Data from multiple sources are gathered and organized into five general categories to provide an overall understanding of the current health conditions in the city.</p> <ul style="list-style-type: none"> • Demographics and Socioeconomic indicators • Health status indicators • Health Perceptions and Health-Related Behaviors • Social and Environmental Factors • Health Delivery and Access to Care
HEALTH STATUS INDICATORS	<ul style="list-style-type: none"> • Mortality – Leading Causes of Death (rates of heart disease, cancer, stroke, pneumonia/ influenza, pulmonary disease, homicide, diabetes for Black, White and Hispanic); Years of Potential Life Lost • Maternal and Child Health Status – Births to Teens; Infant Mortality; Prenatal Care; Maternal Substance Abuse (smoking and other); Leading Causes of Mortality for Children • Infectious Disease Indicators – STDs (Syphilis, Gonorrhea, Chlamydia); HIV and AIDS; Tuberculosis; Coincident HIV/TB; Vaccine Preventable Diseases (Measles, Mumps, Rubella, Pertussis) • Selected Chronic Disease Indicators – Heart Disease; Cerebrovascular Disease/Stroke; Chronic Liver Disease and Cirrhosis; Diabetes • Selected Cancers – Lung Cancer; Colorectal Cancer; Breast Cancer; Cervical Cancer; Prostate Cancer

<ul style="list-style-type: none"> • Perceptions of Health • Substance Abuse – Smoking; Alcohol Use; Other Drug Use • Violence Related Behaviors – Physical Fighting; Weapon Carrying; Suicide • Exercise and Nutrition – Physical Fitness; Weight Control; Nutrition/Diet • Preventive Health Screening – Blood pressure and Cholesterol Screening; Colorectal Screening; Mammography • Sexual Activity and Related Screening – Sexual Behaviors; HIV Testing; STD Testing; Childhood Lead Poisoning; Housing Stock; Environmental Pollution; Exposure to Smoke; Neighborhood Safety and Drugs

CHICAGO, ILLINOIS (*Continued*)

DATA SOURCES The Chicago Department of Public Health (CDPH) receives reports and maintains data on a variety of health conditions for the city, vital records birth and death files, and surveillance data on several reportable diseases. These data served as the baseline of the Chicago Health Profile and were supplemented with information from several additional sources. Data sources include:

- Vital records (to determine leading causes of death and to measure maternal and child health indicators)
- Surveillance systems maintained by the City, State, or private entities (including AIDS Reporting System operated by the CDPH Epidemiology office; STD Surveillance; Tuberculosis Control; Lead Poisoning Prevention – tracked by the Systematic Tracking of Elevated Lead Levels and Remediation (STELLAR) data system; Community Health Information System (CHIS) – provides information resulting from an ongoing collaboration between the Illinois Hospital and Health Systems Association (IHHA) and the Illinois Department of Public Health)

- Metropolitan Chicago Information Center (MCIC) (Each year, MCIC conducts a large survey of the greater Chicago metropolitan area, collecting information on a broad range of policy issues, including health status and service delivery. Information is presented on the city as a whole, by race/ethnicity, and by household income.)
- Behavioral Risk Factor Surveillance System (BRFSS) (Annual CDC Survey asking adults about their health behaviors)
- Youth Risk Behavior Surveillance System (CDC survey of high school students in 17 sites around the country – including Chicago)
- Chicago Police Department Violent Crimes Dataset

CANADA	
Research on health status measurement and reporting in Canada was limited to a report of health status indicators.	
HEALTH STATUS	<ul style="list-style-type: none"> • Age – percent of population over 65
INDICATORS	<ul style="list-style-type: none"> • Poverty – percentage of population a) below federal poverty limit, b) meeting guidelines for food stamps, c) eligible for Medicaid • Violence: Per 100,000 population a) simple assaults, b) domestic violence, c) burglaries • Health care Resources: - Number of licensed MDs, dentists and RNs per 1000 population • Infectious morbidity - Enteric cases per 100,000 per children under age 6 • Cancer Morbidity – Smoking-related cancer (age-adjusted) per 100,000 population • Adverse birth outcomes – a) white and non-white infant deaths per 1000 live births, and b) white and non-white neonatal deaths per 1000 live births