

## AGENDA

Date: June 15, 2011

Time: 8:00 a.m. to 11:00 a.m.

Place: Human Services Office

555 South 10<sup>th</sup> Street, Suite 107, Conference Room

**The purpose of this County Task Force is: “to provide the Lancaster County Board of Commissioners with an effective, sustainable long term plan regarding how CMHC services are provided.”**

1. Approval of Minutes for June 2, 2011
2. Overview of CMHC
  - A. History
  - B. Clientele
  - C. Programs, Collaborations, Partnerships
  - D. Staffing
  - E. Budget
3. Meeting with Pat Terrell, Health Management Association (June 16, 2011, 2pm, at Health Department)
4. Proposed tour, Meeting with Management Committee
5. General Assistance Office – Gary Chalupa
6. Future Meetings
  - A. Other Service Models
  - B. Consultant
  - C. Other
7. Committee Timeline

**MINUTES**  
**COMMUNITY MENTAL HEALTH CENTER (CMHC) PLANNING COMMITTEE**  
**WEDNESDAY, JUNE 15, 2011**  
**COUNTY-CITY BUILDING, 555 SOUTH 10<sup>TH</sup> STREET**  
**HUMAN SERVICES CONFERENCE ROOM**  
**8:00 A.M.**

Present: Dean Settle, Community Mental Health Center (CMHC) Director; Travis Parker, CMHC Deputy Director; Pat Talbott, Mental Health Association (MHA); C. J. Johnson, Administrator, Region V Systems; Joan Anderson, Executive Director, Lancaster County Medical Society (LCMS); Deb Shoemaker, Executive Director, People's Health Center (PHC); Lori Seibel, President/Chief Executive Officer (CEO), Community Health Endowment (CHE); Kerry Eagan, County Chief Administrative Officer (ex-officio); and Kit Boesch, Human Services Administrator (ex-officio).

Also Present: Jane Raybould, County Commissioner; Gary Chalupa, Veterans Service Officer/General Assistance Director; and Ann Taylor, County Clerk's Office.

**NOTE:** Prior to this meeting Committee members of the Task Force were provided information related to Emergency Protective Custody (EPC) previously requested by Shoemaker (Exhibit A).

Eagan called the meeting to order at 8:07 a.m.

**AGENDA ITEM**

**1 APPROVAL OF MINUTES OF THE JUNE 2, 2011 MEETING**

Settle said the first bullet point in the minutes should read as follows:

- *This year CMHC is admitting approximately 100 clients per month, an increase of 30-40 from the year before. Approximately 30 clients are discharged each month.*

Settle said CMHC serves approximately 5,000 clients.

**MOTION:** Shoemaker moved and Parker seconded approval of the minutes with the noted correction. Settle, Parker, Talbott, Johnson, Anderson, Shoemaker, and Seibel voted aye. Motion carried 7-0.

## **2 OVERVIEW OF THE COMMUNITY MENTAL HEALTH CENTER (CMHC)**

### **A. History**

Dean Settle, Community Mental Health Center (CMHC) Director, presented background information and a history of the CMHC (Exhibit B). He said CMHC was established in 1976 (80% of the funding was through a federal grant and 20% was a local match that diminished over an eight-year period). Settle said the following components were mandated: In-Patient Services; Out-Patient Services; Medical Services/Administration; Day Treatment/Partial; Consultation and Education; Children's Services; and Program Evaluation. The Crisis Center was opened in 1988 to serve all of Region V. He noted the following programs have been added through the years: Midtown Center (rehabilitation program); The Heather (community transition program); S.T.O.P. (Sexual Trauma/Offense Prevention) Program (facilitates, monitors and manages risk of individuals who are reintegrated into the community following incarceration); The Outsider Art Program (provides an outlet for artists living with substance use or mental health problems); Harvest Program (a program designed specifically to work with individuals who are over the age of 55 and suffer the combined effects of advanced age, impaired health, mental illness and/or substance abuse); Mental Health Jail Diversion Program (diverts persons with a serious mental illness or co-occurring substance use disorder who are in the Lancaster County Jail for nonviolent crimes); and the ACT (Assertive Community Treatment) Team (a collaboration with CenterPointe, Inc., and Lutheran Family Services).

### **B. Clientele**

Anderson questioned the number of participants in the S.T.O.P. program. Settle said they currently serve around 40. He said the referrals come from the Lincoln Regional Center (LRC) because all discharges are made to Lancaster County. Seibel asked how the program is funded. Settle said CMHC has a sliding fee scale and can bill Region V if they also have an Axis 1 diagnosis (major or serious mental illness). Parker said CMHC was able to secure a contract with the State that will take effect July 1<sup>st</sup> to provide treatment for sex offenders who are discharging from either LRC or Corrections. CMHC will receive up to \$700 per month for their care, i.e. case management, medications and therapy. Seibel asked whether the funds have to go to a community mental health center or could follow the program. Settle said CMHC is the only community management program for sex offenders in Nebraska. Seibel asked whether the funding would follow the program should the system of providing the services change. Settle said no, the grant came to CMHC because of its history and experience with this population. Parker felt the State would only contract with an agency, not a private practitioner. Seibel suggested data showing the disproportionate nature of what was happening should be made part of the Committee's report. Johnson felt any challenge of out-of-county discharges and allocation of funding should be done from a regional standpoint. Eagan suggested that further discussion of this issue be scheduled on the next agenda.

Johnson noted the ACT Team works with high utilizers of services to try to minimize those costs. Eagan said that data is also relevant for the Committee's report, i.e. if you cut back on community mental health services on the front-end, what is the cost on the back-end?

### **C. Programs, Collaborations & Partnerships**

The following information was disseminated (Exhibits C-F):

- Other Information Regarding CMHC
- CMHC Contracts and Vendors
- CMHC Collaborations
- In-kind Services from Lancaster County

Settle noted plans for the Harvest Project to partner with the Seniors Foundation and St. Elizabeth Regional Medical Center on a Affordable Care Act grant to analyze why elderly patients with depression are being readmitted so frequently at St. Elizabeth's. He said St. Elizabeth's exceeds the norm for hospitals in Nebraska. Seibel said this group should keep in mind that there was an indication that funds from the County's sale of Lancaster Manor (nursing home facility) could be designated to help care for the elderly. Eagan said that decision has not been made, although there has been strong advocacy to do so.

Boesch noted the Joint Budget Committee (JBC) has ceased to fund other agencies' crisis lines because it was felt only one was needed in the community (CMHC's Crisis Hot Line). Settle said the Crisis Hot Line's usage is trending downward even though it has absorbed other hot lines. He said most of calls are generational (over 35 years of age) and said he believes younger individuals are utilizing a different support system, such as social networks.

Anderson asked whether there are other community mental health centers still in existence. Settle said the majority are now in the not-for-profit sector. Lancaster and Douglas County's facilities are the only ones remaining in Nebraska.

Seibel noted the Mental Health Association (MHA) is doing more programming and asked whether that is in response to County budget cuts. Settle said they are consumer-driven programs. Seibel said she is trying to understand how MHA fits with the transition. Johnson said MHA is a network provider but their focus is on recovery, from a consumer perspective. Talbott said it is consumer choice/consumer empowerment.

Boesch ask how much is money is in the CMHC Foundation. Settle estimated a balance of \$200,000. Shoemaker asked its purpose. Settle said it has two purposes: 1) Support CMHC and its mission; and 2) Education and stigma reduction. He said their funding assistance is minimal.

Eagan asked Settle whether he has calculated indirect costs. Settle said the amount was estimated several years ago to be \$350,000 a year. He said that is a huge cost for another entity to absorb if merged with CMHC.

#### **D. Staffing**

Seibel asked how Blue Valley Behavioral Health (a private non-profit organization that provides outpatient behavioral health services in 15 counties in Southeast Nebraska) differs from CMHC in terms of salaries and benefits. Parker said Blue Valley's staff are paid less and receive fewer benefits. Settle said they also have a much higher turnover rate. He said CMHC is the largest employer of mental health professionals in Region V and has the lowest staff turnover rate. Seibel asked whether Blue Valley can participate in fund-raising. Settle said it can, adding Blue Valley also has a foundation.

#### **E. Budget**

Parker presented a summary analysis of the budget (Exhibit G). Seibel asked the cost per patient at the Crisis Center. Settle estimated it at \$400 per day and compared that to \$600 per day at LRC and \$1,000 a day at Bryan/LGH (hospital). Parker said part of the rate is based on capacity (the Crisis Center can serve a maximum of 15 patients). Johnson estimated that 10% of individuals admitted to the Crisis Center need additional acute care afterwards and the remainder stabilize within 72 hours. He said only 20% of those individuals need additional services which can usually be handled on an out-patient basis.

Settle said CMHC's administration costs are high because they do not receive reimbursement for nurses. Anderson suggested use of nurse practitioners, which are reimbursable. Johnson said the primary issue is how Medicaid defines medication management.

Shoemaker noted CMHC serves 5,000 individuals each year and asked what types of services they typically require. Settle said medication management, community support and the Crisis Center are the three services most utilized.

Shoemaker then inquired about lab work. Settle said they utilize Quest for the Crisis Center and the People's Health Center (PHC) for other lab work. He said the company that provides Clozaril (a psychotropic that is used to treat severe schizophrenia symptoms in people who have not responded to other medications) to CMHC for one of its specialized clinics also provides a phlebotomist because it is imperative that those individuals be carefully monitored. Shoemaker said the individuals coming to PHC are seeking a discounted rate. She said their visits qualify for the federal qualified (FQ) rate, if they are on Medicaid, but not the lab work.

Information regarding the amount of county property tax dollars going to individual services and an article from the Mental Health Weekly Newsletter titled *"What Will Become of the Mental Health Safety Net?"* were also disseminated (Exhibits H & I).

**3 MEETING WITH PATRICIA TERRELL, MANAGING PRINCIPAL, HEALTH MANAGEMENT ASSOCIATION (HMA) OF CHICAGO, ILLINOIS (2:00 P.M. ON JUNE 16, 2011 AT THE LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT, 3140 "N" STREET)**

Seibel invited members of the Committee to attend the meeting. She also provided them with information on Terrell's background and two reports that HMA completed that relate to safety net issues (Exhibits J-L).

**4 PROPOSED TOUR OF THE COMMUNITY MENTAL HEALTH CENTER (CMHC) AND MEETING WITH MANAGEMENT COMMITTEE**

A tour of the facility and a meeting with the Management Committee were tentatively scheduled for Monday, July 11th and Wednesday, July 13<sup>th</sup>, respectively.

**5 GENERAL ASSISTANCE - GARY CHALUPA, GENERAL ASSISTANCE (GA) DIRECTOR**

Gary Chalupa, Veterans Service Officer/General Assistance (GA) Director, presented a three-month "snapshot" of active GA clients that received services at the CMHC and a calculation of costs using the current Medicaid rate (Exhibit M). Services include nursing, psychiatry, clinician, Partial Hospitalization Program (PHP)/groups and community support. In response to a question from Seibel, Chalupa said everyone who is on GA qualifies for primary health care at the Lincoln-Lancaster County Health Department (LLCHD). Boesch suggested that church volunteers may be able to assist clients with compliance issues. It was noted that the Health HUB advocates also provide assistance. **NOTE:** The Health Hub is a program offered through the Center for People in Need.

**6 FUTURE MEETINGS**

- A. Other Service Models**
- B. Consultant**
- C. Other**

Further discussion of the following was suggested: 1) Cost of providing services to discharges from LRC or Corrections; 2) Indirect costs; 3) People's Health Center (PHC); 4) Funding sources; and 5) Other service models.

**7 COMMITTEE TIMELINE**

Item was held.

**8 ADJOURNMENT**

There being no other business, the meeting was adjourned a 11:01 a.m.

Submitted by Ann Taylor, County Clerk's Office.

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**71-919. Mentally ill and dangerous person; dangerous sex offender; emergency protective custody; evaluation by mental health professional.**

(1) A law enforcement officer who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender and that the harm described in section 71-908 or subdivision (1) of section 83-174.01 is likely to occur before mental health board proceedings under the Nebraska Mental Health Commitment Act or the Sex Offender Commitment Act may be initiated to obtain custody of the person may take such person into emergency protective custody, cause him or her to be taken into emergency protective custody, or continue his or her custody if he or she is already in custody. Such person shall be admitted to an appropriate and available medical facility, jail, or Department of Correctional Services facility as provided in subsection (2) of this section. Each county shall make arrangements with appropriate facilities inside or outside the county for such purpose and shall pay the cost of the emergency protective custody of persons from such county in such facilities. A mental health professional who has probable cause to believe that a person is mentally ill and dangerous or a dangerous sex offender may cause such person to be taken into custody and shall have a limited privilege to hold such person until a law enforcement officer or other authorized person arrives to take custody of such person.

**CMHC BACKGROUND AND HISTORY  
FOR PLANNING AND TRANSITION COMMITTEE  
JUNE 15, 2011**

- 1963 Federal Community Mental Health Centers enabling legislation signed into law by Pres. Kennedy

In the early 1960's The Nebraska Department of Public Institutions reported the following data regarding the three state institutions serving persons with mental illness: Lincoln Regional Center could serve up to 5,000 persons - Norfolk Regional Center could also serve up to 5,000 and Hastings served as many as 10,000 individuals. Counties in this era were billed per bed day for each County resident residing in the institutions. Deinstitutionalization was driven in part by the County's desire to save money. The other driver was advancements made in psychotropic medications.

- 1968 Congress passed the Comprehensive Community Mental Health Centers Act which provided states and communities an 80% federal funding incentive to initiate community based services. The funding was set to reduce the federal share over 8 years. The plan was that state and county funding would supplant the diminishing federal portion.

In the early 1970's Comprehensive Health Planning was accomplished in five planning areas of the state. That plan called for eight mental health centers in Nebraska. Scottsbluff was already open and was the first community mental health center in the state. Grants were submitted for the other seven CMHCs, they were Lancaster, N. Platte, Blue Valley, North East, Pioneers and two in the Omaha area. All were funded except the second one in Omaha. Key leaders were Department of Institutions staff members: Dr. Osborne, Dr. Anderson, and Dr. Smith and Dr. Gary Lorenzen (now chair of the Lincoln/Lancaster Mental Health Foundation)

- 1972 The Lincoln Regional Center piloted community based programs in Lincoln, at Tabitha Southeast Nebraska Psychiatric Clinic, at 13<sup>th</sup> and South Street in small white house on the south west corner a Therapeutic Day Program and downtown on S. 13<sup>th</sup> in The Lincoln Benefit Life Building, Out Patient and Medical Services on the 9<sup>th</sup> and 11<sup>th</sup> floors.

- 1971-74 The six Nebraska Behavioral Health Regions were established.

- 1975 Lancaster County wrote and received a CMHC grant, key people were Dr. Henry Smith of NE DPI, Judge Grant, and two County Commissioners Jan Gauger and Joe Edwards.

1976 The Community Mental Health Center of Lancaster County was opened, and it had to include all of the required federal initiatives: **In Patient** (contracts were made with both Lincoln Regional Center and Lincoln General Hospital. Note: (Lincoln General Hospital was the first community hospital in the nation to provide acute psychiatric services - 1938, key Dr. Stien).

**Out Patient** key person Dr. Carlton Paine, **Medical Services/ Administration**, Dr. Richardson, **Day Treatment/Partial**, Mik Verhar, **Consultation and Education**, Larry Frohm, **Children's Services**, Dr. Howard Halpren of Child Guidance, **Program Evaluation**, Dr. Gary Lorenzen.

1978 Two programs were added Case Management, key person Wendy Andorf and Aging Services, key person Gail Lockard, which was later defunded due to County budget cuts.

1986 Adams Street Center property was purchased and a Fountain House Clubhouse model program developed, to day the program has evolved into a Rehabilitation Center at Midtown Center which was purchased by The County Board in 2003. The Adams Street property was sold.

1988 The Crisis Center was opened to serve all of Region V, first 10 beds at LRC then 12 beds and now 15 individuals can be accomodated.

1998 The Heather was established, a step down program from LRC providing Psychiatric Rehabilitation, 15 beds. We lease apartments from OUR Homes.

1999 Two programs initiated, STOP, community sex offender management and The outsider arts program.

2000 Harvest Program collaboration services to addicted mentally ill elderly, CenterPointe, and Aging Partners work with CMHC

2003 Midtown Center opens and the SAMHSA funded MH Jail Diversion is funded

2004 Nebraska enacts Behavioral Health Reform

2005 ACT Team collaboration opens, CenterPointe and Lutheran Family Services work with CMHC,, offices leased from OUR Homes

**OTHER INFORMATION REGARDING CMHC****JUNE 15, 2011**

30,000 Out Patient Case Records and 16,000 Crisis Center Case Records

33 vehicles as of July 1, 2011 as 3 will be transferred with Jail Diversion to Community Corrections

CMHC is accredited by CARF; we have always received the highest award – three years

\$3 million in sample medication given to CMHC this fiscal year, 2010 – 2011

Several specialized clinics are offered through CMHC, Clozaril (85), Smoking Cessation, Diabetes

Sole provider for GA mental health services, 65 – 75 per month

Lowest staff turnover of all Region V Providers

Largest Community Support Program in Nebraska, over 900 served last fiscal year

Largest staff compliment of BH professionals in Region V, most experienced, as well

Only community based management program for sex offenders in the state

18 integrated apartments in the Near South Neighborhood - ILP

Two imbedded case managers in OUR Homes – TLF

Free Family Support Group offered each Wednesday evening since 1974

Largest Provider Contract in Region V

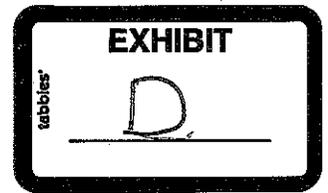
30 year old Crisis Hot Line have absorbed several others in last decade

Nebraska's oldest Homeless Outreach Program

Lincoln's largest student intern/extern program (40 to 50 per year) all disciplines

Nations largest Outsider Arts Program for BH

A ten year old peer and WRAP training effort



**CMHC CONTRACTS AND VENDORS**

**JUNE, 15 2011**

Physicians, including coverage for the Crisis Center

Psychologists

APRNs

Substance Abuse Evaluations

RN Agencies

Food Service

Laundry

Pharmacy

Snow Removal

Custom Software support

Phlebotomist/Lab

Dr. Mary Paine's Group (Sex Offender Management)

UNL Graduate Student Interns

Dr. Will Spaulding (Heather)

Mary Sullivan (RAISE)

Open Door Initiative

LMHPs for supervised hours

eBHIN

Medical Society

OUR Homes Apartments, third shift coverage at The Heather

Aging Partners

Region V



**CMHC COLLABORATIONS**

**JUNE 15, 2011**

CenterPointe

Lutheran Family Services

Aging Partners

Lincoln Parks and Recreation

Cornhusker Place

Peoples Health Center

Mental Health Association

Counseling Associates of Nebraska

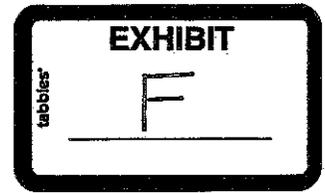
ByranLGH West

Lancaster County Medical Society

OUR Homes

Union College, UNL, UNO, Doane College, SCC, BEACON, UNMC

And others



**INKIND SERVICES RECEIVED BY CMHC FROM LANCASTER COUNTY**

**JUNE 15, 2011**

County Attorney

Purchasing

Personnel

Risk Management

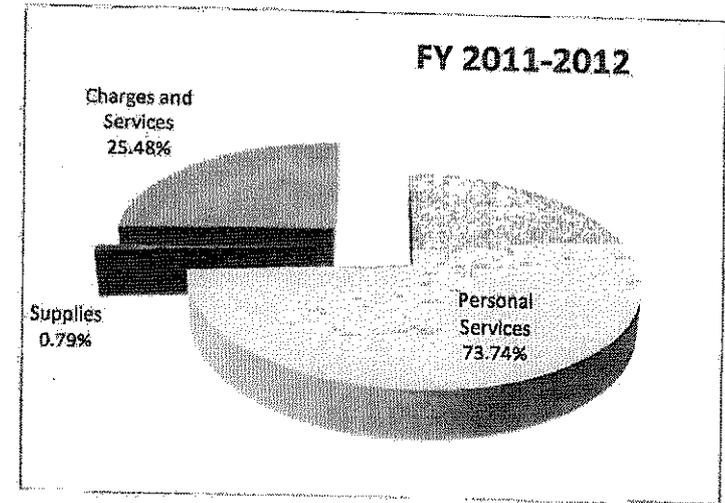
Fiscal, payables, receivables audits

Also assistance from the County Motor Pool/Shop

Assistance from The Public Building Commission

Lancaster County  
Summary Analysis of Requested Budget  
Community Mental Health Center

|                       | FY11<br><u>Adopted</u> | FY12<br><u>Requested</u> | Change<br><u>Amount</u> | <u>Percent</u> |
|-----------------------|------------------------|--------------------------|-------------------------|----------------|
| FTE's                 | 117.00                 | 105.05                   | (11.95)                 | -10.21%        |
| Personal Services     | 7,734,152              | 7,351,273                | (382,879)               | -4.95%         |
| Supplies              | 91,026                 | 76,655                   | (12,370)                | -13.59%        |
| Charges and Services  | 2,271,878              | 2,539,863                | 267,985                 | 11.80%         |
| Capital Outlay        | 30,000                 | -                        | (30,000)                | -100.00%       |
| Total Expenditures    | 10,127,055             | 9,969,791                | (157,264)               | -1.55%         |
| Revenue Estimate:     | 9,014,497              | 7,252,466                | (2,662,031)             | -26.85%        |
| Taxes                 | <u>(2,801,408)</u>     |                          |                         |                |
|                       | 7,113,089              | 7,252,466                | 139,377                 | 1.96%          |
| Same Tax as last year |                        | (2,801,408)              |                         |                |
| Net Amount            | 212,558                | (84,083)                 | (296,641)               | -10.59%        |



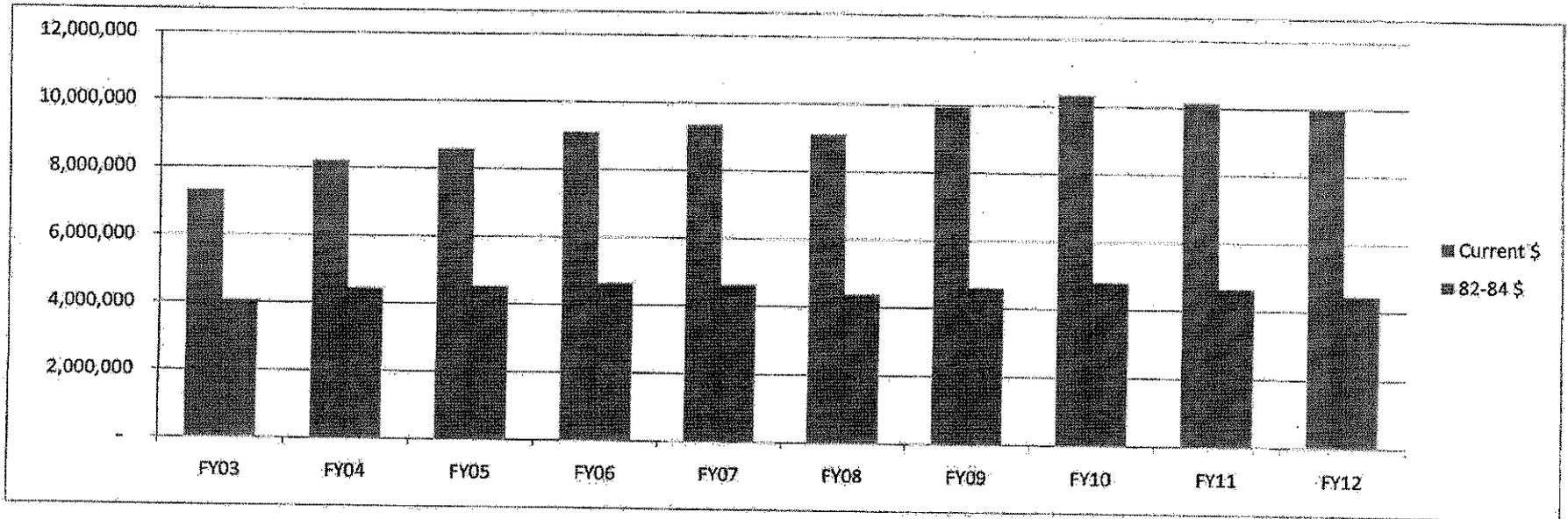
| Year             | FTE's  | Amount     | Change    | Percent |
|------------------|--------|------------|-----------|---------|
| FY03             | 94.32  | 7,316,846  | 434,509   | 6.31%   |
| FY04             | 98.26  | 8,197,223  | 880,378   | 12.03%  |
| FY05             | 101.56 | 8,568,026  | 360,803   | 4.40%   |
| FY06             | 106.55 | 9,088,369  | 530,343   | 6.20%   |
| FY07             | 114.80 | 9,333,912  | 245,543   | 2.70%   |
| FY08             | 115.55 | 9,094,486  | (239,426) | -2.57%  |
| FY09             | 117.25 | 9,953,157  | 858,671   | 9.44%   |
| FY10             | 117.25 | 10,335,214 | 382,057   | 3.84%   |
| FY11             | 117.00 | 10,127,055 | (208,159) | -2.01%  |
| FY12             | 105.05 | 9,969,791  | (157,264) | -1.55%  |
| Average Increase |        |            | 308,746   | 3.88%   |

113

1-CA  
1:20 - Sheriff  
1:50 - Human Services  
2:10 - G.A.  
2:30 - Comm. Corrections  
2:50 - Break  
3:00 - Supv. Conf  
3:20 - Court  
3:50 - Juvenile Services

Lancaster County  
 Current \$ Budget Compared to Constant \$ Budget  
 Community Mental Health Center

|      | Current \$<br>Budget | CPI - U<br>1982-84= 100 | Budget in<br>82-84 \$ |
|------|----------------------|-------------------------|-----------------------|
| FY03 | 7,316,845            | 179.9                   | 4,067,173             |
| FY04 | 8,197,223            | 184.0                   | 4,455,013             |
| FY05 | 8,558,026            | 188.9                   | 4,530,453             |
| FY06 | 9,088,389            | 195.3                   | 4,653,543             |
| FY07 | 9,333,912            | 201.6                   | 4,629,917             |
| FY08 | 9,094,486            | 207.342                 | 4,386,225             |
| FY09 | 9,953,157            | 215.303                 | 4,622,860             |
| FY10 | 10,335,214           | 214.537                 | 4,817,451             |
| FY11 | 10,127,055           | 218.056                 | 4,644,245             |
| FY12 | 9,969,791            | 223.41                  | 4,462,554             |



EXPENSE BUDGET COMPARISON  
MENTAL HEALTH

FUND 00063

REPORT AS OF 5/10/2011

| OBJECT ACCOUNT | DESCRIPTION                | CURRENT YEAR<br>FY10-11<br>EXPENSES | CURRENT YEAR<br>FY10-11<br>ENCUMBRANCES | CURRENT YEAR<br>FY10-11<br>APPROVED<br>BUDGET | FY11-12<br>BUDGET<br>REQUEST | CHANGE FROM CURRENT<br>BUDGET TO FY11-12<br>BUDGET REQUEST |          |
|----------------|----------------------------|-------------------------------------|---|---|------------------------------|--|----------|
|                |                            |                                     |   |   |                              | AMOUNT   | %        |
| 61110          | Official's Salary          | \$84,679                            | \$0                                     | \$105,244                                     | \$104,840                    | -\$404   | -0.38%   |
| 61150          | Deputy's Salary            | \$68,316                            | \$0                                     | \$84,906                                      | \$84,581                     | -\$325   | -0.38%   |
| 61210          | Regular Salary             | \$4,347,772                         | \$0                                     | \$5,656,241                                   | \$5,246,372                  | -\$409,869   | -7.25%   |
| 61250          | Temporary Salary           | \$77,830                            | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 61310          | Overtime                   | \$48,428                            | \$0                                     | \$58,700                                      | \$63,500                     | \$4,800  | 8.18%    |
| 61510          | FICA Contributions         | \$331,857                           | \$0                                     | \$434,889                                     | \$409,450                    | -\$25,439  | -5.85%   |
| 61520          | Retirement Contributions   | \$320,634                           | \$0                                     | \$404,653                                     | \$401,556                    | -\$3,097   | -0.77%   |
| 61530          | Group Health Insurance     | \$715,579                           | \$0                                     | \$828,637                                     | \$873,340                    | \$44,703   | 5.39%    |
| 61540          | Group Dental Insurance     | \$37,030                            | \$0                                     | \$40,291                                      | \$44,960                     | \$4,669  | 11.59%   |
| 61650          | Long-Term Disability       | \$16,366                            | \$0                                     | \$20,948                                      | \$20,075                     | -\$873   | -4.17%   |
| 61660          | Post-Employment Health Pr  | \$68,582                            | \$0                                     | \$61,326                                      | \$59,280                     | -\$2,046   | -3.34%   |
| 61710          | Unemployment Compensation  | \$6,288                             | \$0                                     | \$0   | \$5,000                      | \$5,000  | N/A      |
| 61750          | Workers' Comp Insurance    | \$38,316                            | \$0                                     | \$38,317                                      | \$38,319                     | \$2  | 0.01%    |
| 63110          | Office Supplies            | \$4,947                             | \$0                                     | \$6,285                                       | \$6,400                      | \$115  | 1.83%    |
| 63120          | Duplicating Supplies       | \$3,898                             | \$0                                     | \$6,400                                       | \$5,150                      | -\$1,250   | -19.53%  |
| 63225          | Janitorial Supplies        | \$1,524                             | \$0                                     | \$2,000                                       | \$1,200                      | -\$800   | -40.00%  |
| 63250          | Laundry Supplies           | \$283                               | \$0                                     | \$240   | \$400                        | \$160  | 66.67%   |
| 63255          | Craft Supplies             | \$0                                 | \$0                                     | \$500   | \$300                        | -\$200   | -40.00%  |
| 63260          | Household Supplies         | \$480                               | \$0                                     | \$900   | \$2,300                      | \$1,400  | 155.56%  |
| 63285          | Linen & Bedding Supplies   | \$839                               | \$0                                     | \$3,500                                       | \$3,500                      | \$0  | 0.00%    |
| 63345          | Other Operating Supplies   | \$14,150                            | \$0                                     | \$25,250                                      | \$15,450                     | -\$9,800   | -38.81%  |
| 63410          | Medical Supplies           | \$4,491                             | \$0                                     | \$6,350                                       | \$6,200                      | -\$150   | -2.36%   |
| 63415          | Non-Prescription Meds      | \$3,828                             | \$0                                     | \$3,300                                       | \$5,850                      | \$2,550  | 77.27%   |
| 63420          | Prescription Meds          | \$2,776                             | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 63470          | Employee Immunizations     | \$132                               | \$0                                     | \$2,000                                       | \$1,000                      | -\$1,000   | -50.00%  |
| 63510          | Motor Fuels                | \$25,099                            | \$0                                     | \$34,300                                      | \$30,905                     | -\$3,395   | -9.90%   |
| 64140          | Accounting & Auditing Svs  | \$4,950                             | \$0                                     | \$6,000                                       | \$5,500                      | -\$500   | -8.33%   |
| 64150          | Consulting Services        | \$445                               | \$0                                     | \$2,000                                       | \$0                          | -\$2,000   | -100.00% |
| 64155          | Snow Removal/Grounds Ma    | \$1,039                             | \$0                                     | \$5,000                                       | \$3,000                      | -\$2,000   | -40.00%  |
| 64165          | Building Maintenance Serv  | \$950                               | \$0                                     | \$10,500                                      | \$0                          | -\$10,500  | -100.00% |
| 64175          | Comput Softwr Maint/Licens | \$1,144                             | \$0                                     | \$5,000                                       | \$3,000                      | -\$2,000   | -40.00%  |
| 64195          | Janitorial Services        | \$45,387                            | \$0                                     | \$64,000                                      | \$58,800                     | -\$5,200   | -8.13%   |
| 64215          | Cable TV Service           | \$8,060                             | \$0                                     | \$8,470                                       | \$8,645                      | \$175  | 2.07%    |
| 64220          | Laundry & Dry Cleaning     | \$6,652                             | \$0                                     | \$8,150                                       | \$8,100                      | -\$50  | -0.61%   |
| 64230          | Pest Control Services      | \$635                               | \$0                                     | \$800   | \$780                        | -\$20  | -2.50%   |
| 64285          | Information Services       | \$39,903                            | \$0                                     | \$51,336                                      | \$51,285                     | -\$51  | -0.10%   |
| 64295          | Other Misc Contracted Svs  | \$651,984                           | \$0                                     | \$646,310                                     | \$769,570                    | \$223,260  | 40.87%   |
| 64565          | Mental Health Region V     | \$292,022                           | \$0                                     | \$585,730                                     | \$579,823                    | -\$5,907   | -1.01%   |
| 64585          | Region V                   | \$191,651                           | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 64710          | Meals                      | \$150                               | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |

|                       |                            |                    |            |                     |                    |                   |               |
|-----------------------|----------------------------|--------------------|------------|---------------------|--------------------|-------------------|---------------|
| 64715                 | Lodging                    | \$704              | \$0        | \$0                 | \$0                | \$0               | 0.00%         |
| 64720                 | Fares                      | \$45               | \$0        | \$0                 | \$0                | \$0               | 0.00%         |
| 64725                 | Mileage                    | \$11,311           | \$0        | \$15,700            | \$14,650           | -\$1,050          | -6.69%        |
| 64730                 | Parking & Tolls            | \$78               | \$0        | \$85                | \$90               | \$5               | 5.88%         |
| 64810                 | Telephone - Local          | \$32,870           | \$0        | \$46,675            | \$37,350           | -\$9,325          | -19.98%       |
| 64815                 | Telephone - Long Distance  | \$2,574            | \$0        | \$4,170             | \$2,858            | -\$1,312          | -31.46%       |
| 64825                 | Cellular Phone Service     | \$18,822           | \$0        | \$23,843            | \$21,440           | -\$2,203          | -9.32%        |
| 64830                 | Paging Service             | \$4,729            | \$0        | \$5,000             | \$6,100            | \$1,100           | 22.00%        |
| 64855                 | Postage                    | \$8,332            | \$0        | \$11,550            | \$9,050            | -\$2,500          | -21.65%       |
| 64910                 | Printing                   | \$5,101            | \$0        | \$7,775             | \$4,800            | -\$3,175          | -40.84%       |
| 64915                 | Photocopying               | \$9,810            | \$0        | \$15,120            | \$12,710           | -\$2,410          | -15.94%       |
| 64925                 | Advertising                | \$1,167            | \$0        | \$0                 | \$0                | \$0               | 0.00%         |
| 65145                 | Hospitalization            | \$56,712           | \$0        | \$60,000            | \$75,000           | \$15,000          | 25.00%        |
| 65155                 | Laboratory                 | \$4,878            | \$0        | \$10,000            | \$8,000            | -\$2,000          | -20.00%       |
| 65160                 | Pharmacy                   | \$72,928           | \$0        | \$52,000            | \$95,000           | \$43,000          | 82.69%        |
| 65185                 | Nursing Services           | \$53,026           | \$0        | \$60,000            | \$60,000           | \$0               | 0.00%         |
| 65195                 | EPC Housing                | \$10,789           | \$0        | \$9,000             | \$13,000           | \$4,000           | 44.44%        |
| 65210                 | Client Heat                | \$2,409            | \$0        | \$3,000             | \$3,000            | \$0               | 0.00%         |
| 65215                 | Client Food                | \$64,506           | \$0        | \$79,090            | \$75,100           | -\$3,990          | -5.04%        |
| 65225                 | Client Electricity         | \$3,624            | \$0        | \$3,900             | \$4,200            | \$300             | 7.69%         |
| 65230                 | Client Rent                | \$30,700           | \$0        | \$37,200            | \$37,200           | \$0               | 0.00%         |
| 65245                 | Client Production Pay      | \$22,488           | \$0        | \$35,000            | \$30,000           | -\$5,000          | -14.29%       |
| 65250                 | Client Sundries            | \$63,178           | \$0        | \$36,500            | \$63,500           | \$27,000          | 73.97%        |
| 65660                 | Memberships & Dues         | \$4,375            | \$0        | \$3,725             | \$4,475            | \$750             | 20.13%        |
| 65665                 | Books & Subscriptions      | \$2,585            | \$0        | \$3,310             | \$2,460            | -\$850            | -25.68%       |
| 65670                 | Enrollment Fees & Tuition  | \$320              | \$0        | \$10,000            | \$10,000           | \$0               | 0.00%         |
| 65675                 | Licensing                  | \$250              | \$0        | \$550               | \$550              | \$0               | 0.00%         |
| 65685                 | Refunds & Repayments       | \$1,373            | \$0        | \$0                 | \$0                | \$0               | 0.00%         |
| 65740                 | Interpreter                | \$12,563           | \$0        | \$13,600            | \$13,100           | -\$500            | -3.68%        |
| 65845                 | Other Misc Fees & Services | \$5,297            | \$0        | \$7,360             | \$4,875            | -\$2,485          | -33.76%       |
| 65910                 | Property Insurance         | \$1,409            | \$0        | \$1,500             | \$0                | -\$1,500          | -100.00%      |
| 65915                 | Liability Insurance        | \$43,640           | \$0        | \$11,585            | \$39,733           | \$28,148          | 242.97%       |
| 65920                 | Vehicle Insurance          | \$9,360            | \$0        | \$9,500             | \$9,400            | -\$100            | -1.05%        |
| 65935                 | Other Insurance            | \$0                | \$0        | \$100               | \$100              | \$0               | 0.00%         |
| 66110                 | Electricity                | \$8,410            | \$0        | \$9,000             | \$9,000            | \$0               | 0.00%         |
| 66115                 | Natural Gas                | \$2,353            | \$0        | \$4,000             | \$3,000            | -\$1,000          | -25.00%       |
| 66120                 | Water & Sewer              | \$838              | \$0        | \$1,200             | \$1,000            | -\$200            | -16.67%       |
| 66145                 | Other Utilities            | \$490              | \$0        | \$600               | \$600              | \$0               | 0.00%         |
| 66210                 | Motor Vehicle R&M          | \$11,632           | \$0        | \$14,500            | \$13,850           | -\$650            | -4.48%        |
| 66220                 | Office Equipment R&M       | \$728              | \$0        | \$0                 | \$500              | \$500             | N/A           |
| 66225                 | Building R&M               | \$1,916            | \$0        | \$2,000             | \$3,000            | \$1,000           | 50.00%        |
| 66230                 | Grounds Equipment R&M      | \$0                | \$0        | \$950               | \$0                | -\$950            | -100.00%      |
| 66280                 | Security Equipment R&M     | \$677              | \$0        | \$700               | \$700              | \$0               | 0.00%         |
| 66410                 | Other Equipment R&M        | \$3,602            | \$0        | \$2,200             | \$2,200            | \$0               | 0.00%         |
| 66520                 | Building Rent              | \$333,227          | \$0        | \$366,794           | \$356,869          | -\$9,925          | -2.71%        |
| 67475                 | Computer Equipment         | \$0                | \$0        | \$30,000            | \$0                | -\$30,000         | -100.00%      |
| 69150                 | Transfer to State of NE    | \$187              | \$0        | \$0                 | \$0                | \$0               | 0.00%         |
| <b>TOTAL EXPENSES</b> |                            | <b>\$8,401,314</b> | <b>\$0</b> | <b>\$10,127,055</b> | <b>\$9,969,791</b> | <b>-\$157,264</b> | <b>-1.55%</b> |

REVENUE BUDGET COMPARISON  
MENTAL HEALTH

FUND 00063

REPORT AS OF 5/10/2011

| OBJECT<br>ACCOUNT | DESCRIPTION               | CURRENT YEAR<br>FY10-11<br>RECEIPTS | CURRENT YEAR<br>FY10-11<br>ENCUMBRANCES | CURRENT YEAR<br>FY10-11<br>APPROVED<br>BUDGET | FY11-12<br>BUDGET<br>REQUEST | CHANGE FROM CURRENT<br>BUDGET TO FY11-12<br>BUDGET REQUEST |          |
|-------------------|---------------------------|-------------------------------------|---|---|------------------------------|--|----------|
|                   |                           |                                     |   |   |                              | AMOUNT   | %        |
| 51105             | Real Estate Taxes 2005    | \$51                                | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51106             | Real Estate Taxes 2006    | \$137                               | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51107             | Real Estate Taxes 2007    | \$193                               | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51108             | Real Estate Taxes 2008    | \$737                               | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51109             | Real Estate Taxes 2009    | \$1,143,395                         | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51110             | Real Estate Taxes 2010    | \$1,309,613                         | \$0                                     | \$2,720,108                                   | \$0                          | -\$2,720,108   | -100.00% |
| 51207             | Pers Property Taxes 2007  | \$18                                | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51208             | Pers Property Taxes 2008  | \$103                               | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51209             | Pers Property Taxes 2009  | \$56,841                            | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51210             | Pers Property Taxes 2010  | \$79,957                            | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51305             | Int-Real Estate Tax 2005  | \$30                                | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51306             | Int-Real Estate Tax 2006  | \$69                                | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51307             | Int-Real Estate Tax 2007  | \$65                                | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51308             | Int-Real Estate Tax 2008  | \$136                               | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51309             | Int-Real Estate Tax 2009  | \$6,187                             | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51310             | Int-Real Estate Tax 2010  | \$126                               | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51407             | Int-Pers Prop Tax 2007    | \$3                                 | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51408             | Int-Pers Prop Tax 2008    | \$13                                | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51409             | Int-Pers Prop Tax 2009    | \$162                               | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 51410             | Int-Pers Prop Tax 2010    | \$20                                | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 54125             | Health                    | \$18,019                            | \$0                                     | \$20,000                                      | \$20,000                     | \$0  | 0.00%    |
| 54180             | Homeless                  | \$24,376                            | \$0                                     | \$32,500                                      | \$32,500                     | \$0  | 0.00%    |
| 54185             | Alcohol Evaluations       | \$106,143                           | \$0                                     | \$140,711                                     | \$141,415                    | \$704  | 0.50%    |
| 54265             | Medicaid                  | \$312,008                           | \$0                                     | \$329,400                                     | \$373,755                    | \$44,355   | 13.47%   |
| 54270             | Medicare A                | \$62,689                            | \$0                                     | \$89,100                                      | \$87,600                     | -\$1,500   | -1.68%   |
| 54275             | Medicare B                | \$144,523                           | \$0                                     | \$193,600                                     | \$177,680                    | -\$15,920  | -8.22%   |
| 54285             | HHS MRO Funds             | \$1,621,337                         | \$0                                     | \$2,192,410                                   | \$2,073,463                  | -\$118,947   | -5.43%   |
| 54404             | 2010 Property Tax Credit  | \$108,257                           | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 54435             | Homestead 2009            | \$44                                | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 54436             | Homestead 2010            | \$35,093                            | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 54460             | Carline Tax               | \$2,058                             | \$0                                     | \$0   | \$0                          | \$0  | 0.00%    |
| 54470             | MV Prorate Tax Allocation | \$5,794                             | \$0                                     | \$7,000                                       | \$0                          | -\$7,000   | -100.00% |

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|                       |                              |                    |            |                    |                    |                     |                |
|-----------------------|------------------------------|--------------------|------------|--------------------|--------------------|---------------------|----------------|
| 54490                 | Flexible Funding             | \$49,907           | \$0        | \$30,000           | \$55,000           | \$25,000            | 83.33%         |
| 54520                 | State 302 Funds Region V     | \$2,860,398        | \$0        | \$3,207,016        | \$3,040,150        | -\$166,866          | -5.20%         |
| 54525                 | Region V Post Commitment     | \$8,265            | \$0        | \$0                | \$297,540          | \$297,540           | N/A            |
| 54580                 | Assertive Community Treatm   | \$157,728          | \$0        | \$214,725          | \$216,005          | \$1,280             | 0.60%          |
| 54799                 | Miscellaneous State Receipt  | \$0                | \$0        | \$0                | \$235,000          | \$235,000           | N/A            |
| 54810                 | Inlieu of Taxes 1957 & Prior | \$40               | \$0        | \$0                | \$0                | \$0                 | 0.00%          |
| 54820                 | Inlieu of Taxes 5% Gross Re  | \$89,476           | \$0        | \$74,300           | \$0                | -\$74,300           | -100.00%       |
| 54840                 | Joint Budget City of Lincoln | \$43,177           | \$0        | \$43,177           | \$43,719           | \$542               | 1.26%          |
| 54850                 | Inlieu Northern Ponca        | \$26               | \$0        | \$0                | \$0                | \$0                 | 0.00%          |
| 55610                 | Client Private Pay           | \$61,486           | \$0        | \$179,500          | \$71,183           | -\$108,317          | -60.34%        |
| 55630                 | Client Insurance             | \$92,425           | \$0        | \$155,200          | \$101,400          | -\$53,800           | -34.66%        |
| 55810                 | Contract Revenue/Reimburs    | \$26,920           | \$0        | \$35,000           | \$30,000           | -\$5,000            | -14.29%        |
| 55830                 | County Contract Revenue      | \$87,514           | \$0        | \$93,000           | \$95,000           | \$2,000             | 2.15%          |
| 55870                 | Meal Reimbursements          | \$25,396           | \$0        | \$30,000           | \$30,000           | \$0                 | 0.00%          |
| 58130                 | Client Rent                  | \$36,647           | \$0        | \$56,000           | \$54,500           | -\$1,500            | -2.68%         |
| 58535                 | Retirement Forfeitures       | \$19,618           | \$0        | \$0                | \$0                | \$0                 | 0.00%          |
| 58565                 | Community Health Endowme     | \$18,750           | \$0        | \$18,750           | \$0                | -\$18,750           | -100.00%       |
| 58568                 | Non-Governmental Grant       | \$38,998           | \$0        | \$0                | \$0                | \$0                 | 0.00%          |
| 58595                 | Other Miscellaneous Revent   | \$39,671           | \$0        | \$53,000           | \$76,556           | \$23,556            | 44.45%         |
| <b>TOTAL REVENUES</b> |                              | <b>\$8,742,143</b> | <b>\$0</b> | <b>\$9,914,497</b> | <b>\$7,252,466</b> | <b>-\$2,662,031</b> | <b>-26.85%</b> |

Community Mental Health Center

| <u>Business Unit</u> | <u>Program</u>                                | 2011-12             | 2010-11              | <u>Change</u>       | <u>% Change</u> |
|----------------------|---|---------------------|----------------------|---------------------|-----------------|
|                      |   | <u>Budget</u>       | <u>Budget</u>        |                     |                 |
| 7830                 | Region V                                      | 579,823.00          | 585,730.00           | (5,907.00)          | -1.01%          |
| 7840                 | Administrative Services                       | 352,987.00          | 351,284.00           | 1,703.00            | 0.48%           |
| 7841                 | Support Services                              | 590,014.00          | 581,689.00           | 8,325.00            | 1.43%           |
| 7843                 | Medical Services                              | 797,395.00          | 849,838.00           | (52,443.00)         | -6.17%          |
| 7844                 | Outpatient - Acute                            | 274,809.00          | 385,915.00           | (111,106.00)        | -28.79%         |
| 7845                 | Harvest Project                               | 213,184.00          | 218,349.00           | (5,165.00)          | -2.37%          |
| 7846                 | Client Assistance                             | 55,000.00           | 30,000.00            | 25,000.00           | 83.33%          |
| 7847                 | Outpatient - Chronic - <i>CLS</i>             | 1,855,460.00        | 1,760,289.00         | 95,171.00           | 5.41%           |
| 7848                 | Partial Hospital                              | 535,435.00          | 511,141.00           | 24,294.00           | 4.75%           |
| 7849                 | Art Studio                                    | 2,439.00            | 2,332.00             | 107.00              | 4.59%           |
| 7850                 | Homeless Grant                                | 86,840.00           | 86,417.00            | 423.00              | 0.49%           |
| 7851                 | Crisis Center                                 | 2,340,502.00        | 2,432,499.00         | (91,997.00)         | -3.78%          |
| 7852                 | Residential Treatment                         | 836,741.00          | 787,240.00           | 49,501.00           | 6.29%           |
| 7853                 | Daywatch - <i>Med <del>Fr</del> Transport</i> | -                   | 24,571.00            | (24,571.00)         | -100.00%        |
| 7855                 | Match - Prevoc Aware                          | 114,248.00          | 139,600.00           | (25,352.00)         | -18.16%         |
| 7857                 | Clubhouse                                     | 463,339.00          | 504,550.00           | (41,211.00)         | -8.17%          |
| 7858                 | Emergency Services                            | 185,994.00          | 322,023.00           | (136,029.00)        | -42.24%         |
| 7859                 | Case Management - Special Needs               | 86,807.00           | 86,354.00            | 453.00              | 0.52%           |
| 7861                 | Independent Living                            | 54,500.00           | 53,840.00            | 660.00              | 1.23%           |
| 7863                 | Outpatient Therapy - <i>STOP</i>              | 139,000.00          | -                    | 139,000.00          |                 |
| 7864                 | Substance Abuse - <i>Jail Diversion</i>       | 209,512.00          | 218,500.00           | (8,988.00)          | -4.11%          |
| 7866                 | ACT Program                                   | 195,762.00          | 194,894.00           | 868.00              | 0.45%           |
|                      | <b>TOTALS</b>                                 | <b>9,969,791.00</b> | <b>10,127,055.00</b> | <b>(157,264.00)</b> | <b>-1.55%</b>   |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011 - 12 BUDGET**

**BUS UNIT**

All

**AGENCY: Community Mental Health Center**

| CLASS CODE | CLASS TITLE                  | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS   |                  |
|------------|------------------------------|---------------------|--------------------|-----------|------------------|------------------|
|            |                              | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET  | FY 11-12 REQUEST |
| 7841       | Support                      | 8.00                | 8.50               |           | 285,130          | 304,928          |
| 7840       | Administration               | 3.00                | 3.00               |           | 249,898          | 249,525          |
| 7843       | Medical Services             | 5.38                | 3.81               |           | 503,291          | 298,502          |
| 7844       | Outpatient                   | 3.00                | 3.00               |           | 186,321          | 183,211          |
| 7845       | Harvest Project              | 1.00                | 1.00               |           | 41,475           | 43,396           |
| 7847       | Community Support            | 23.62               | 23.65              |           | 1,175,461        | 1,237,264        |
| 7848       | Partial Hospitalization      | 6.38                | 6.40               |           | 345,468          | 362,601          |
| 7849       | Open Studio/Wordshop         | 0.08                | 0.05               |           | 2,166            | 1,471            |
| 7850       | Homeless Project             | 1.00                | 1.00               |           | 51,897           | 52,206           |
| 7851       | Emergency Protective Custody | 30.75               | 28.34              |           | 1,564,897        | 1,410,660        |
| 7852       | Residential Rehab            | 10.50               | 10.50              |           | 485,321          | 504,217          |
| 7853       | CHE Medical Transportation   | 0.76                |                    |           | 20,577           |                  |
| 7855       | A W A R E                    | 1.20                | 1.00               |           | 67,247           | 52,306           |
| 7857       | Day Rehab                    | 6.08                | 5.30               |           | 300,697          | 272,055          |
| 7858       | 24 Hour Emergency            | 4.25                | 2.50               |           | 226,668          | 125,972          |
| 7859       | Special Needs                | 1.00                | 1.00               |           | 51,997           | 52,306           |
| 7864       | Jail Diversion               | 3.00                | 3.00               |           | 150,118          | 150,920          |
| 7866       | ACT - Pier                   | 3.00                | 3.00               |           | 137,762          | 134,253          |
| BA1        | <b>TOTALS</b>                | <b>112.00</b>       | <b>105.05</b>      |           | <b>5,846,391</b> | <b>5,435,793</b> |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

**BUS UNIT** 7840

*Administration*

**AGENCY: Community Mental Health Center**

| CLASS CODE | CLASS TITLE                    | NUMBER OF POSITIONS |                   | PAY RANGE | SALARY AMOUNTS |                 |
|------------|--------------------------------|---------------------|-------------------|-----------|----------------|-----------------|
|            |                                | FY10-11 BUDGETED    | FY11-12 REQUESTED |           | FY10-11 BUDGET | FY11-12 REQUEST |
| 7280       | Administrator                  | 1.00                | 1.00              | MSS       | 105,244        | 104,840         |
| 7151       | Administrative Service Officer | 1.00                | 1.00              | C15       | 59,748         | 60,104          |
| 7198       | Deputy Administrator           | 1.00                | 1.00              | MSS       | 84,906         | 84,581          |
| <b>BA1</b> | <b>TOTALS</b>                  | <b>3.00</b>         | <b>3.00</b>       |           | <b>249,898</b> | <b>249,525</b>  |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Support Staff*

BUS UNIT: 7841

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE                | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|----------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                            | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 2431       | Clerk I                    |                     | 0.50               | A10       |                 | 12,164           |
| 2712       | Clerk Typist II            | 2.00                | 2.00               | A14       | 68,719          | 68,070           |
| 2432       | Clerk II                   | 2.00                | 2.00               | A13       | 62,116          | 65,108           |
| 2444       | Medical Records Technician | 1.00                | 1.00               | A17       | 37,733          | 40,235           |
| 2831       | Account Clerk II           | 2.00                | 2.00               | A17       | 72,831          | 75,361           |
| 2833       | Account Clerk III          | 1.00                | 1.00               | C06       | 43,731          | 43,990           |
| BA1        | <b>TOTALS</b>              | 8.00                | 8.50               |           | 285,130         | 304,928          |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Medical Services*

BUS UNIT 7843

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE       | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|-------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                   | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 7728       | Psychiatrist      | 2.00                | 0.66               | MSS       | 343,078         | 138,516          |
| 2713       | VanDriver         | 0.38                | 0.15               | A14       | 10,287          | 7,356            |
| 2712       | Clerk Typist II   | 1.00                | 1.00               | A14       | 32,172          | 34,153           |
| 7706       | Register Nurse II | 2.00                | 2.00               | C15       | 117,754         | 118,477          |
| BA1        | <b>TOTALS</b>     | 5.38                | 3.81               |           | 503,291         | 298,502          |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-2012 BUDGET**

*Outpatient*

BUS UNIT 7844

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE                   | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|-------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                               | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9746       | Mental Health Clinician II    | 1.00                | 3.00               | C17       | 63,951          | 183,211          |
| 9760       | Mental Health Program Manager | 1.00                |                    | C22       | 76,250          |                  |
| 9745       | Mental Health Clinician I     | 1.00                |                    | C13       | 46,120          |                  |
| BA1        | <b>TOTALS</b>                 | 3.00                | 3.00               |           | 186,321         | 183,211          |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

AGENCY: 7845

*Harvest Project*

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE              | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|--------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                          | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9738       | Mental Health Specialist | 1.00                | 1.00               | C08       | 41,475          | 43,396           |
| <b>BA1</b> | <b>TOTALS</b>            | 1.00                | 1.00               |           | 41,475          | 43,396           |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Community Support*

**BUS UNIT**                      7847

**AGENCY: Community Mental Health Center**

| CLASS CODE | CLASS TITLE                       | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|-----------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                                   | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9760       | Mental Health Program Manager     | 0.50                | 0.50               | C22       | 38,125          | 38,353           |
| 9746       | Mental Health Clinician II        | 2.00                | 2.00               | C17       | 125,428         | 128,368          |
| 9738       | Mental Health Specialist          | 15.00               | 16.00              | C08       | 658,085         | 762,714          |
| 9742       | Mental Health Program Coordinator | 5.00                | 4.00               | C11       | 259,790         | 209,124          |
| 7723       | Psychologist                      | 1.00                | 1.00               | C27       | 90,784          | 91,349           |
| 4503       | Van Driver                        | 0.12                | 0.15               | A14       | 3,249           | 7,356            |
| BA1        | <b>TOTALS</b>                     | 23.62               | 23.65              |           | 1,175,461       | 1,237,264        |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Partial Hospitalization*  
AGENCY: 7848

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE                   | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|-------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                               | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9760       | Mental Health Program Manager | 1.00                | 1.00               | C22       | 76,250          | 76,706           |
| 9738       | Mental Health Specialist      | 1.00                | 1.00               | C08       | 46,249          | 46,530           |
| 6746       | Mental Health Clinician II    | 3.00                | 3.00               | C17       | 183,293         | 192,329          |
| 2712       | Clerk Typist II               | 1.00                | 1.00               | A14       | 29,387          | 35,757           |
| 4503       | Van Driver                    | 0.38                | 0.40               | A14       | 10,289          | 11,279           |
| BA1        | <b>TOTALS</b>                 | 6.38                | 6.40               |           | 345,468         | 362,601          |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Open Studio /  
Workshop*

**BUS UNIT** 7849

**AGENCY: Community Mental Health Center**

| CLASS CODE | CLASS TITLE   | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|---------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |               | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 4503       | Van Driver    | 0.08                | 0.05               | A14       | 2,166           | 1,471            |
| BA1        | <b>TOTALS</b> | 0.08                | 0.05               |           | 2,166           | 1,471            |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Homeless Project*

BUS UNIT 7850

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE                       | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|-----------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                                   | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9742       | Mental Health Program Coordinator | 1.00                | 1.00               | C11       | 51,897          | 52,206           |
| BA1        | <b>TOTALS</b>                     | 1.00                | 1.00               |           | 51,897          | 52,206           |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Crisis Center*

BUS UNIT 7851

**AGENCY: Community Mental Health Center**

| CLASS CODE | CLASS TITLE                    | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|--------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                                | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 7752       | Mental Health Program Manager  | 1.00                | 1.00               | C22       | 80,474          | 76,606           |
| 7728       | Psychiatrist                   | 0.75                | 0.34               | MSS       | 176,800         | 71,356           |
| 9745       | Mental Health Clinician I      | 1.00                |                    | C13       | 54,979          |                  |
| 9738       | Mental Health Care Coordinator | 1.00                | 1.00               | C11       | 49,609          | 52,767           |
| 9740       | Crisis Center Team Supervisor  | 3.00                | 3.00               | C10       | 146,810         | 157,769          |
| 9732       | Mental Health Technician       | 15.00               | 15.00              | A19       | 598,238         | 604,572          |
| 2444       | Medical Records Technician     | 1.00                | 1.00               | A17       | 37,733          | 40,235           |
| 7781       | Nursing Supervisor             | 1.00                | 1.00               | C18       | 65,346          | 65,718           |
| 7706       | Registered Nurse II            | 6.00                | 5.00               | C15       | 265,110         | 251,288          |
| 7723       | Psychologist                   | 1.00                | 1.00               | C27       | 89,798          | 90,349           |
| BA1        | <b>TOTALS</b>                  | 30.75               | 28.34              |           | 1,564,897       | 1,410,660        |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*CTP @ The Heater*

BUS UNIT 7852

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE                   | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|-------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                               | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9760       | Mental Health Program Manager | 0.50                | 0.50               | C22       | 38,125          | 38,353           |
| 9731       | Mental Health Technician      | 9.00                | 9.00               | A19       | 387,809         | 406,120          |
| 7706       | Registered Nurse II           | 1.00                | 1.00               | C15       | 59,387          | 59,744           |
| <b>BA1</b> | <b>TOTALS</b>                 | <b>10.50</b>        | <b>10.50</b>       |           | <b>485,321</b>  | <b>504,217</b>   |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Medical Transportation*

AGENCY: 7853

AGENCY: Community Mental Health Center

| CLASS CODE    | CLASS TITLE | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|---------------|-------------|---------------------|--------------------|-----------|-----------------|------------------|
|               |             | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 4503          | Van Driver  | 0.76                |                    | A14       | 20,577          |                  |
| <b>TOTALS</b> |             | 0.76                | 0.00               |           | 20,577          | 0                |

BA1

20

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*AWARE*

AGENCY: 7855

AGENCY: Community Mental Health Center

| CLASS CODE    | CLASS TITLE                   | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|---------------|-------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|               |                               | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9760          | Mental Health Program Manager | 0.20                |                    | C22       | 15,250          |                  |
| 9742          | Mental Health Coordinator     | 1.00                | 1.00               | C11       | 51,997          | 52,306           |
| <b>TOTALS</b> |                               | 1.20                | 1.00               |           | 67,247          | 52,306           |

BA1

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-2012 BUDGET**

*Midtown Center*

BUS UNIT 7857

**AGENCY: Community Mental Health Center**

| CLASS CODE | CLASS TITLE                   | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|-------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                               | FY 10-12 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9760       | Mental Health Program Manager | 0.80                | 1.00               | C22       | 61,000          | 76,706           |
| 9738       | Mental Health Specialist      | 5.00                | 4.00               | C08       | 232,116         | 187,012          |
| 4503       | Van Driver                    | 0.28                | 0.30               | A14       | 7,581           | 8,337            |
| <b>BA1</b> | <b>TOTALS</b>                 | <b>6.08</b>         | <b>5.30</b>        |           | <b>300,697</b>  | <b>272,055</b>   |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*24 Hour Emergency Services*

AGENCY: 7858

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE                     | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|---------------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                                 | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9733       | Mental Health Emergency Service | 1.25                | 1.50               | C13       | 53,440          | 64,732           |
| 9746       | Mental Health Clinician II      | 3.00                | 1.00               | C17       | 173,228         | 61,240           |
| BA1        | <b>TOTALS</b>                   | 4.25                | 2.50               |           | 226,668         | 125,972          |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Special Needs*

AGENCY: 7859

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE   | NUMBER OF POSITIONS |                                   | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|---------------|---------------------|-----------------------------------|-----------|-----------------|------------------|
|            |               | FY 10-11 BUDGETED   | FY 11-12 REQUESTED                |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
|            |               | 9742                | Mental Health Program Coordinator |           | 1.00            | 1.00             |
| BA1        | <b>TOTALS</b> | 1.00                | 1.00                              |           | 51,997          | 52,306           |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*Sail Division*

BUS UNIT 7864

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE                | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                 |
|------------|----------------------------|---------------------|--------------------|-----------|-----------------|-----------------|
|            |                            | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY11-12 REQUEST |
| 9746       | Mental Health Clinician II | 1.00                | 1.00               | C17       | 57,267          | 59,684          |
| 9738       | Mental Health Specialist   | 2.00                | 2.00               | C08       | 92,851          | 91,236          |
| BA1        | <b>TOTALS</b>              | 3.00                | 3.00               |           | 150,118         | 150,920         |

**LANCASTER COUNTY  
PERSONNEL SUMMARY FORM  
2011-12 BUDGET**

*ACT Team/PIER*

BUS UNIT 7866

AGENCY: Community Mental Health Center

| CLASS CODE | CLASS TITLE              | NUMBER OF POSITIONS |                    | PAY RANGE | SALARY AMOUNTS  |                  |
|------------|--------------------------|---------------------|--------------------|-----------|-----------------|------------------|
|            |                          | FY 10-11 BUDGETED   | FY 11-12 REQUESTED |           | FY 10-11 BUDGET | FY 11-12 REQUEST |
| 9738       | Mental Health Specialist | 3.00                | 3.00               | C08       | 137,762         | 134,253          |
| BA1        | <b>TOTALS</b>            | 3.00                | 3.00               |           | 137,762         | 134,253          |

**LANCASTER COUNTY**  
**REQUEST FOR CONTRACTUAL SERVICES & LEASES**  
**2011 - 12 BUDGET**

BUS UNIT ALL

AGENCY: Community Mental Health Center

| DESCRIPTION                          | FUTURE IMPACT                                      | BUDGET AMOUNT           |       |         |
|--------------------------------------|--|-------------------------|-------|---------|
|                                      |  | OBJECT CODE DESCRIPTION | #     | AMOUNT  |
| Lancaster County Property Management | 2201 South 17th Street                             | Rent                    | 66520 | 320,869 |
| OUR Homes                            | 2423 R Street #6 TLF office space                  | Rent                    | 66520 | 12,000  |
| OUR Homes                            | 2039 Q Street #202 Heather office space            | Rent                    | 66520 | 24,000  |
|                                      |  |                         |       | 356,869 |
| Tri Win Properties<br>Century Realty | Six ILP client apartments                          | Rent                    | 65230 | 37,200  |
| Mary Paine                           | Counseling Affillates of NE - Sex Offender & CC    | Contract Service        | 64295 | 133,000 |
| Lisa Young & Cynthia Petersen        | Nurse Practitioner - Outpatient Clinic & Jail Div. | Contract Service        | 64295 | 160,160 |
| Patricia Bohart MD                   | Psychiatrist                                       | Contract Service        | 64295 | 156,000 |
| Lancaster Medical Society            | Free Med Program                                   | Contract Service        | 64295 | 13,800  |
| WAR JAR                              | Alcohol Counselor                                  | Contract Service        | 64295 | 10,000  |
| OUR Homes                            | Night staff at Heather - OUR Homes                 | Contract Service        | 64295 | 43,800  |
| eBHIN                                | Electronic Medical Records                         |                         | 64295 | 25,000  |
| Lincoln Area Agency on Aging         | Harvest Project                                    | Contract Service        | 64295 | 132,050 |
| University of Nebraska               | Externs  | Contract Service        | 64295 | 80,510  |
| Turner & Associates                  | Computer Programming                               | Contract Service        | 64295 | 7,000   |
| University of Nebraska               | Heather  | Contract Service        | 64295 | 8,250   |
|                                      |  |                         |       | 769,570 |

BA3

**LANCASTER COUNTY**  
**REQUEST FOR MEMBERSHIPS, SUBSCRIPTIONS, SCHOOLS, CONFERENCES**  
**TRAVEL AND SUBSISTENCE**  
**2011-12 BUDGET**

BUS UNIT ALL

**AGENCY: Community Mental Health Center**

| NAME AND POSITION | EXPLANATION AND JUSTIFICATION  | BUDGET AMOUNT      |               |        |
|-------------------|--|--------------------|---------------|--------|
|                   |  | DESCRIPTION        | OBJECT CODE # | AMOUNT |
| All Programs      | Human Service Federation<br>Linc/Lanc County Homeless Coalition<br>NE Association of Behavioral Health Organization<br>NACBHDD | Membership         | 65660         | 600    |
|                   |  |                    |               | 100    |
|                   |  |                    |               | 3,025  |
|                   |  |                    |               | 750    |
| Center Staff      | Use of Staff Vehicles for Center Business  | Mileage<br>Parking | 64725         | 14,650 |
|                   |  |                    | 64730         | 90     |
| Center Staff      | Workshop & Classes   | Enroll & Tuition   | 65670         | 10,000 |
| All Programs      | Lincoln Journal<br>Physician Desk Reference<br>DSM-IV-TR<br>Other  | Subscriptions      | 65665         | 2,460  |
|                   |  |                    |               |        |
|                   |  |                    |               |        |
|                   |  |                    |               |        |

BA5

**LANCASTER COUNTY**  
*List of Cuts to come in at 97% of FY2011 Budget*  
**FISCAL YEAR 2011-12**

**AGENCY: Community Mental Health Center**

| OBJECT CODE  | OBJECT DESCRIPTION | AMOUNT         | ADDITIONAL INFORMATION                        |
|--------------|--------------------|----------------|---|
| 61210        | Regular Salary     | 76,708         | Program Manager - Outpatient                  |
| 61510        | FICA               | 5,868          |   |
| 61520        | Pension            | 5,983          |   |
| 61530        | Health             | 11,022         |   |
| 61540        | Dental             | 585            |   |
| 61650        | Disability         | 299            |   |
| 61660        | PEHP               | 650            |   |
| 61210        | Regular Salary     | 46,120         | Mental Health Clinician - Outpatient          |
| 61510        | FICA               | 3,528          |   |
| 61520        | Pension            | 3,597          |   |
| 61530        | Health             | 14,676         |   |
| 61540        | Dental             | 912            |   |
| 61650        | Disability         | 180            |   |
| 61660        | PEHP               | 650            |   |
| 61210        | Regular Salary     | 54,979         | Mental Health Clinician - Crisis Center (EPC) |
| 61510        | FICA               | 4,278          |   |
| 61520        | Pension            | 3,409          |   |
| 61530        | Health             | 5,790          |   |
| 61540        | Dental             | 259            |   |
| 61650        | Disability         | 214            |   |
| 61660        | PEHP               | 650            |   |
| 61210        | Regular Salary     | 145,080        | Psychiatrist - Crisis Center                  |
| 61510        | FICA               | 8,725          |   |
| <b>TOTAL</b> |                    | <b>394,160</b> |   |

These four personnel reductions made March 1, 2011 take into account the County's 97% budget request, as well as cuts to other CMHC-LC funding sources which have already been communicated to us.



**Travis W. Parker**

**From:** Judi Tannahill  
**Sent:** Tuesday, June 14, 2011 5:39 PM  
**To:** Travis W. Parker  
**Subject:** RE: County Dollars

Travis

These numbers are approximate because taking Jail diversion out of our Budget changes everything and I didn't have time to adjust for that.

County Dollar per Program

|                        |         |
|------------------------|---------|
| Med Services           | 412,344 |
| Outpatient             | 106,463 |
| Com Sup (include Harv) | 238,620 |
| Day Treatment          | 262,227 |
| Path-Homeless          | 54,340  |
| Crisis Center          | 221,414 |
| Day Rehab (incl AWARE) | 78,481  |
| Special Needs          | 43,088  |
| Admin Support          | 798,056 |

Judith

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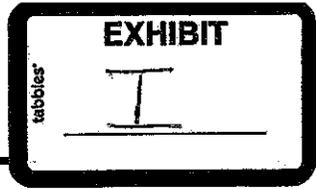
**From:** Travis W. Parker  
**Sent:** Monday, June 13, 2011 6:15 PM  
**To:** Judi Tannahill; Dennis M. Meyer  
**Subject:** County Dollars

Judi/Dennis,

Would one of you be able to send me a document demonstrating the most recent numbers regarding county property tax dollars going specifically to each of our individual services? Thanks.

Travis

Travis Parker, M.S., L.I.M.H.P., C.P.C.  
Deputy Director  
Community Mental Health Center of Lancaster County  
2201 S. 17th Street  
Lincoln, NE 68502  
(402) 441-6610 business  
(402) 441-8625 fax  
[tparker@lanaster.ne.gov](mailto:tparker@lanaster.ne.gov)



**Travis W. Parker**

**From:** J. Rock Johnson [jrock10@sprynet.com]  
**Sent:** Thursday, June 02, 2011 10:31 AM  
**To:** Travis W. Parker  
**Subject:** FW: [NYAPRS Enews] Freeman: What Will Become Of The Mental Health Safety Net?

Fyi and  
FQHC mergers with CMHC

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**From:** [nyaprs-bounces@kilakwa.net](mailto:nyaprs-bounces@kilakwa.net) [mailto:[nyaprs-bounces@kilakwa.net](mailto:nyaprs-bounces@kilakwa.net)] **On Behalf Of** Harvey Rosenthal  
**Sent:** Tuesday, May 31, 2011 7:40 AM  
**To:** [nyaprs@kilakwa.net](mailto:nyaprs@kilakwa.net)  
**Subject:** [NYAPRS Enews] Freeman: What Will Become Of The Mental Health Safety Net?

*NYAPRS Note: A thoughtful and timely piece on the integrative path mental health services are on to ensure their value and survival.*

**What Will Become Of The Mental Health Safety Net?**

by Dennis Freeman, Ph.D. From the Field Mental Health Weekly May 31, 2011

A primary challenge in community mental health is to find the means to serve those who have no means. It has always been that way for those who hold the mission dear. Over the years it has become increasingly more difficult to meet the challenge.

It has become nearly impossible for Community Mental Health Centers (CMHCs) to serve the community at large. Funding sources tie reimbursement to those who meet stringent eligibility criteria such as severity of condition, diagnosis or income level. Many in need fall through the cracks of our eligibility-based system of community mental health care. Eligibility-based care is a poor fit for a safety net mission.

The current economic climate is further impacting access. Most states are struggling to make ends meet. Mental health budgets are on the chopping block in many states. There may be some, but I don't know of a state that is increasing funding for mental health or substance abuse services. We celebrate if we survive the state budget cycle without significant cuts despite the fact that all our costs continue to increase. At best, we are losing ground due to inflation.

Some await health care reform and payment reform and project these forces will reverse the trends and elevate the relevance of mental health services within the health care constellation. Some expect expanded coverage of those currently without health insurance will bring many more, and a wider variety of paying customers to their doors. If the Affordable Care Act (ACA) dodges the intentions of many elected officials and remains in place, these changes are slated to begin in earnest in 2014. Three years is a long time to wait for an uncertain future.

**Working In Partnership With PC**

Throughout the country many community-based mental health organizations are finding that it is possible to reach new populations by working in

partnership with primary care colleagues who are committed to serving the underserved. Many of these primary care providers work in Federally Qualified Health Centers (FQHCs). Ironically, in many states it seems easier to carry out the community mental health mission from the FQHC platform than from the confines of a community mental health center. Of course, many FQHCs are also building mental health service capacity on their own because they recognize the behavioral health needs of their patient population are currently unmet.

It is unclear where these collaborations between safety net organizations will lead. A few CMHCs and FQHCs have merged and others are discussing a merger. A few CMHCs have become, or seek to become FQHCs. Other safety net organizations are broadening their service array unilaterally. Many FQHCs are evolving integrated service models and blending behaviorists into patient-centered medical homes. Time will reveal the viability of CMHCs who are attempting to import primary care.

Delivery systems and safety net organizations will likely be reconfigured over the next few years. The evolution that is occurring across the safety net is encouraging. At the core of these initiatives is the commitment of dedicated clinicians and administrators to reach the underserved with a care model that is a better match for the complex needs these individuals often present. That resolve will assure the preservation of a mental health safety net. It just may not look like it did in the past. Where there's a will, there's a way.

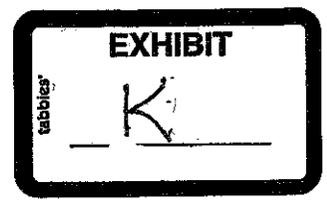
*Dennis Freeman, Ph.D., is CEO of Cherokee Health Systems, a non-profit corporation. The Federally Qualified Health Center and Community Mental Health Center has 42 clinical sites in 12 Tennessee counties.*



**Patricia Terrell** has more than twenty-five years of nationally recognized expertise in health and hospital system development. She has also worked extensively in the areas of policy formation, particularly related to health coverage for the uninsured, and strategic planning focused on the creation of effective and efficient health care delivery systems, with a specific focus on providers serving medically needy populations and communities. Ms. Terrell assists clients with formulating and executing strategies to address internal structural, clinical and operational issues related to the successful delivery of care. She also works with hospitals and health networks to develop relationships with other institutions to bring about mutually beneficial alliances. She has, for Health Management Associates (HMA), led large multi-disciplinary teams that:

- restructured public health and hospital systems in Memphis, Dallas, Phoenix, Austin, San Mateo and San Francisco;
- developed a model delivery system for post-Katrina health care delivery involving public and private providers in the four-parish region surrounding New Orleans;
- facilitated training for new public hospital CEOs for the National Association of Public Health and Hospital Systems;
- established operational partnerships between public and private providers to meet the needs of underserved populations for hospitals of a large west coast Catholic system and their public sector counterparts in Los Angeles and San Francisco and for all providers in San Mateo County, California;
- assessed and recommended specific operational changes for County-run correctional health services in Dallas and Los Angeles;
- developed and assisted in the implementation of the transformation of a public hospital into a multi-specialty ambulatory facility in Los Angeles;
- identified a series of options integrating the large public hospital system in Miami with the area's Federally Qualified Health Centers;
- renegotiated affiliation agreements between public hospital systems and their medical school/medical staffs in Dallas and Phoenix;
- evaluated and recommended operational changes for the public hospital systems in Dallas (emergency department, primary care, inpatient acute), Los Angeles (length of acute inpatient stay), San Mateo (specialty outpatient care) and San Francisco (long term care-acute care connections);
- identified, through a report supported by a local foundation, strategic priorities for the Cook County Bureau of Health Services; and
- developed a plan for a large foundation that would create a network of providers to meet the full scope of health care needs for vulnerable populations on the south side of Chicago.

Prior to joining HMA, Ms. Terrell served as the Deputy Chief of the Cook County Bureau of Health Services in Chicago, one of the largest public health and hospital systems in the nation, and was the President of a health policy consulting group concentrating primarily on the reconfiguration of public and private safety net institutions, including hospitals, community health centers and public health services. Ms. Terrell was the first Executive Director of the Chicago-based Health and Medicine Policy Research Group and managing editor of its national journal.



HEALTH MANAGEMENT ASSOCIATES

*An Analysis of Health Services for the  
Uninsured and Underinsured in the  
River Region of Alabama*

AUTAUGA, ELMORE, LOWNDES, MACON, AND MONTGOMERY COUNTIES

PREPARED FOR  
ENVISION2020, MONTGOMERY, ALABAMA

MARCH 21, 2008

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics  
and Finance. Program Evaluation, Data Analysis, and Health System Restructuring*

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## **Table of Contents**

|  |    |
|--|----|
| Introduction .....   | 1  |
| Executive Summary .....  | 2  |
| Section 1: Health Services for the Uninsured and Underinsured in the River Region .....  | 4  |
| <i>Vulnerable Populations</i> .....  | 4  |
| <i>What is the Magnitude of the Indigent and Underinsured Population in the River Region Counties?</i> .....                                 | 5  |
| <i>What are the Sources of Care for the Indigent and Underinsured Population in the River Region Counties?</i> .....                         | 6  |
| <i>Barriers to Care</i> .....  | 20 |
| <i>Other Critical Issues Facing the River Region</i> .....   | 25 |
| <i>A Community Perspective</i> .....   | 26 |
| <i>Section One Recommendations</i> .....   | 30 |
| Section 2: Physical and Functional Assessment of the Federally Qualified Health Centers (FQHCs) in the River Region of Central Alabama ..... | 42 |
| <i>Assessment</i> .....  | 42 |
| <i>Section Two Recommendations</i> .....   | 51 |
| Section 3: Financial Analysis .....  | 53 |
| Appendices .....   | 61 |
| <i>Appendix A: Top 22 Service Sites by ER Visits/Zip Codes, 2006</i> .....   | 62 |
| <i>Appendix B: Replacement Family Healthcare Center</i> .....  | 63 |
| <i>Appendix C: Interview List</i> .....  | 71 |
| <i>Appendix D: Documents Reviewed</i> .....  | 75 |

## **Introduction**

Envision 2020 contracted with Health Management Associates (HMA) in October 2007 to provide an in-depth analysis of how the indigent and uninsured population in the River Region access care and how that care is financed. The analysis also includes barriers to access, an assessment of the current supply of primary care physicians and specialty physicians, and a review of current clinic facilities to determine the scope of services available in the River Region. This study was funded by the City of Montgomery, the Montgomery County Commission, Jackson Hospital, The Health Care Authority for Baptist Health, the Joint Public Charity Hospital Board, the City of Prattville, the Autauga County Commission, the Elmore County Commission, and the Montgomery Area Chamber of Commerce. In order to accomplish this analysis, HMA assembled a team of senior staff representing a variety of disciplines, including health care finance, health systems operations and management, clinical care, health care architecture, and public and community health. This team worked closely with the staff of Envision 2020 to determine the issues facing the River Region. More than 100 people were interviewed including physicians, other providers, health care administrators, health center leaders, city and county officials, politicians, academic leaders, ministers, foundation leaders, and other prominent members of the community. All of those interviewed were asked to give their perspective on the issues we were told existed at the beginning of the project: unreimbursed health care for the indigent, inability to recruit professionals, lack of comprehensive approach to care delivery, lack of transportation for rural and poor, burdens on business to provide health care coverage, and the lack of coverage for adults aged 19 – 64. Hospital Financial Statements, Cost Reports, FQHC Financial Reports, Revenues by Payer Mix, and other data documents were carefully assessed. Health Centers and clinics in each of the River Region Counties (excluding Macon County) were toured and clinical operations were observed. Officials from Macon County were interviewed in Montgomery.

This process allowed HMA to view how health care is provided to the uninsured and the underinsured population in the River Region and to now provide our findings and recommendations for review by the many stakeholders committed to finding solutions to the problems facing a vulnerable population. As HMA noted on our first trip to Alabama to meet with the Health Care Task Force and Envision 2020: “You will find that the effort to find long term solutions takes sustained energy and almost always requires more than originally thought. But the solutions exist. The critical factor is the ‘want to.’” We believe this report will provide a basis for health care leaders and others in the River Region who “want to” to begin to develop a plan to transform how care is provided to the uninsured and insured in their communities.

While many people and organizations in the River Region contributed to this report, HMA would like to thank Dr. Donald Bogie and Envision 2020, especially Lynn Beshear and her staff, for assisting in numerous ways throughout the entire project.

## **Executive Summary**

As in much of America, there is a health care crisis in Alabama's River Region. With a population of nearly 400,000 residents, the River Region is marked by high rates of poverty and limited access to medical care. Approximately 17.8 percent of area residents live below the federal poverty level, while 21.5 percent of the population between the ages of 18 and 64 is uninsured. The Kaiser Commission on Medicaid and the Uninsured estimates that 100,000 people in the region are medically indigent or underinsured. Those who do have coverage through Medicare or Medicaid often have difficulty accessing physicians, and others depend on local fire departments or ambulance services, either for transportation to routine medical care or for the care itself. River Region residents most in need of immediate care, and trauma care in particular, frequently travel more than two hours to Birmingham, regardless of their insurance coverage status. For the uninsured, dental care and mental health services are even more difficult to access than physical health services. The local physician community is aging, with an average age in the mid-fifties (and higher for certain specialties) and recruitment of younger physicians is lagging, as it is in many parts of the country.

Although the health care system in the River Region faces a host of challenges, there are positive aspects within the delivery system as well. There are a number of clinics dedicated to caring for the most vulnerable, some of which are staffed by volunteers and others which have relatively steady sources of operating funds. Organizations that were created in times of crisis to preserve critical services like obstetrical care and the Gift of Life Foundation have maintained their services, while others are working to develop better models of care, such as the Wellness Coalition's medical home. Other organizations, including strong churches, have stepped in to fill critical needs and help individuals navigate a complex system. Despite all these efforts, however, considerable work remains to be done.

Currently, the level of indigent care at the region's hospitals and major clinic system is above what would be expected in similar facilities nationally. While these providers are in no immediate financial danger, they have not been able to reinvest in their facilities or in needed services such as trauma care. The two Montgomery health systems have average age of plants above the desired norm, with one system above 12 years. The major site for the key Federally Qualified Health Center is in need of replacement. Trauma services in the region will require additional resources to reach optimal levels and to meet the state's goal of establishing a statewide trauma system. Additional resources will also be necessary over the long term if any significant effort to recruit new physicians is undertaken. (The investment in physician recruitment will pay dividends, however, as new physicians serve as major economic development engines in themselves. Each physician represents potentially a \$1 million dollar enterprise.)

The following report makes a number of recommendations for increasing access to health care in the River Region, including extending hours, adding new sites for existing providers, improving recruitment of health professionals, and better coordination of

services for those in need. **However, without an influx of financial resources, coordination of efforts and the avoidance of unnecessary duplication, it is unlikely that any of these steps will be enough to preserve and enhance the delivery system in the River Region.**

Any new financial resources brought to bear on this issue should be leveraged through Medicaid whenever possible, since the federal government reimburses the state roughly 70 cents for every dollar spent in Medicaid. While Medicaid budget constraints and constitutional limitations of taxes and their use make it unlikely that any new funding will come from state general funds, options to provide match funds and increase coverage in the River Region still exist. Development of new funding approaches will not be easy and will require assistance and sponsorship from Alabama Medicaid, providers and local governments, but it can be done. Given the federal return on the state's investment, an increase in state matching funds of slightly more than \$12 million would produce a \$40 million program. If \$30 million could be raised, nearly \$100 million could be made available for programs to cover more than 25,000 people. Even if the amount is only \$3 million, it would generate \$10 million in new revenue to help address the issue. It is likely that this funding will need to be raised from several sources. Some of these funds could be used to create school-based health centers to benefit children, their parents, and teachers, while additional funds can be leveraged through an existing program of enhanced physician rates to make caring for Medicaid patients more viable for providers.

Specifically, we recommend that you work with Medicaid to expand coverage to parents up to 100 percent of the federal poverty level, and higher as more match becomes available. For childless adults, we propose a locally funded program with proceeds from a Medicaid supplementary payment program to private hospitals serving as the backbone of funding. Finally, we recommend increased physician rates from Medicaid for physicians providing the greatest access to these patients and expressing a willingness to be part of the trauma program. We believe these financial resources will make it possible to expand service hours and sites for existing providers, fund plant expenditures, trauma services, and additional physician recruitment. To ensure that local resources are found and to help coordinate future investments, we recommend the establishment of a coordinating council that recognizes through its membership that health care is a jointly held responsibility between providers, business, government, and the community at large.

A strong investment in the health care system is good economic development. There will always be individuals without coverage, but reducing that number makes it possible to provide care for them within a sustainable system. Seldom can an investment by the local community have such a high guaranteed return.

## **Section 1: Health Services for the Uninsured and Underinsured in the River Region**

Envision 2020 contracted with Health Management Associates (HMA) in October 2007 to provide an in-depth analysis of how the indigent and uninsured population in the River Region access care and how that care is financed for this population. The analysis also points out barriers to access, an assessment of the current status and supply of primary care physicians and specialty physicians, and a review of current clinic facilities to determine the scope of services available in the River Region.

### **Vulnerable Populations**

By a wide variety of measures – including rural composition and poverty – the River Region stands apart in terms of being home to some of the state’s most vulnerable populations. This Region is defined as the five counties – Autauga, Elmore, Lowndes, Macon, and Montgomery – in central Alabama that are located around the tributaries and watershed of the Alabama River. The city of Montgomery is at the center of the River Region.

According to the Office of Primary Care and Rural Health, 55 of Alabama’s 67 counties are considered rural, and 44% of the State’s population lives in rural areas. Access to health care poses a challenge in rural Alabama. In the 2007 National KIDS COUNT Data Book, Alabama was ranked 48<sup>th</sup> (down from 43<sup>rd</sup>) in the nation on measures of child well-being. The percentage of children living in poverty in Alabama increased from 21% in 2000 to 25% in 2005 – a 19% increase in five years. The national percentage also increased over the same period from 17 % to 19%. Table 1 below summarizes some important demographics for the counties in the River Region.

**Table 1**

| County                               | Ranking in Child Well-being (67 counties) | Total County Population | County Child Population | Median Household Income | All Persons Living Below Poverty Level | Children in Extreme Poverty (see * below) |
|--------------------------------------|---|-------------------------|-------------------------|-------------------------|--|---|
| Elmore                               | 15  | 73,937                  | 19,553                  | \$43,645                | 12.5%                                  | 6.2%                                      |
| Autauga                              | 33  | 48,612                  | 13,801                  | \$45,379                | 11.6%                                  | 6.6%                                      |
| Montgomery                           | 54  | 221,619                 | 63,887                  | \$35,680                | 19.4%                                  | 12.9%                                     |
| Macon                                | 60  | 22,810                  | 6,670                   | \$23,378                | 28.3%                                  | 21.4%                                     |
| Lowndes                              | 61  | 13,076                  | 4,022                   | \$24,967                | 25.5%                                  | 27.1%                                     |
| <b>River Region Total population</b> |   | <b>380,054</b>          | <b>107,933</b>          |                         |  |   |

\* Number of children under 18 living in a household where the household income is less than 50% of the poverty threshold expressed as a percentage of all children under 18.  
Source: VOICES for Alabama’s Children, *Alabama KIDS COUNT 2007 Data Book*

This HMA report focuses not only on children, but also their families and all vulnerable populations in the five county region; however, the data provided in the Alabama KIDS

COUNT Data Book is significant and needs to be kept at the forefront as we address the issues and problems facing the River Region related to access to quality health care. This is because a key way to improve the underlying socioeconomic structure of the state is to improve the education system. In turn, one of the pre-conditions for improving the educational system is to improve the health status of the students. If students are not well-fed and do not receive adequate health care, they will not be able to succeed in school or succeed later in life.

Teenage pregnancy is a significant concern and one important area where education makes a difference is in teen pregnancy. One of the highest correlations with teenage pregnancy is educational status. The less education an individual has, the higher the likelihood of teen pregnancy. Individuals who drop out of school as teens are much more likely to get pregnant. Individuals in this situation are also ill-prepared to take care of a child. According to the Alabama Campaign to Prevent Teen Pregnancy Fact Sheet, Social and Public Cost of Teen Childbearing, January 14, 2008, the pregnancy rate in Montgomery County in 2006 was 47.6 per 1,000 girls (ages 10 – 19). There were 507 births in 2006 in Montgomery County. Alabama has one of the highest teen pregnancy rates in the United States.

**Resource: Alabama Campaign to Prevent Teen Pregnancy. [www.acptp.org](http://www.acptp.org)**

There is also a high correlation between graduation from high school and future risk of incarceration. A high school graduate is four times less likely to ever be arrested, detained, and incarcerated than an individual who did not complete high school.

Because of the work of many statewide advocacy groups such as VOICES for Alabama's Children and Alabama Campaign to Prevent Teen Pregnancy, HMA found there is a relatively high degree of awareness and consensus about the need to expand access for quality health coverage for children. Nonetheless, the most frequent and the most expensive needs for additional coverage are for adults of all ages including even the Medicare population and the Veteran's population who supposedly have access to a system for their health care needs. Inadequate access to affordable, preventive care, prescription drugs, and appropriate care management systems encourage inappropriate use of ERs and scarce specialty care, thereby depleting both financial and human resources for health care coverage.

While there are currently many services provided to this population, there is a critical lack of coordination of the services and communication among service providers in the five counties. Existing services are disjointed and not well publicized. There is certainly willingness among some providers to collaborate and establish partnerships; however, the consistent leadership that would be needed is lacking. Some key questions:

### **What is the magnitude of the Indigent and Underinsured Population in the River Region Counties?**

Although it is difficult to estimate with pinpoint accuracy the number of people in the River Region who are indigent and uninsured, according to HMA's best estimates there is a disproportionately high number. Medically indigent or uninsured are generally defined

as individuals and families without health insurance or health care coverage who cannot afford to pay for their health care. Underinsured are patients/families with limited health care coverage. They either can't afford the co-pay, their type of coverage is not accepted by a significant number of the health providers in their communities, or the benefit limits are inadequate for key services.

HMA attempted to quantify the number of indigent and underinsured individuals in the River Region Counties. As Table 2 indicates, it is conservatively estimated that there are 400,000 people living in these five counties. Based on data in the 2007 Kaiser Commission report, over 63,000 individuals in the River Region are medically indigent. However, this number does not reflect the true volume of individuals who have difficulty accessing health care because their coverage is inadequate or because their coverage is not readily accepted. A number of private primary and specialty care practices in the River Region either limit or restrict the availability of appointments to adults with Medicaid. Unlike most states and many other regions in Alabama, children with Medicaid and even adults with Medicare may also have limited choices of physicians who will accept these types of coverage.

| <b>TABLE 2</b>                   |                          |                          |                 |                  |                   |              |
|----------------------------------|--------------------------|--------------------------|-----------------|------------------|-------------------|--------------|
| <b>River Region Payor Status</b> |                          |                          |                 |                  |                   |              |
| <b>Age Cohort</b>                | <b>Private Insurance</b> | <b>All Kids Medicaid</b> | <b>Medicare</b> | <b>Uninsured</b> | <b>Other Govt</b> | <b>Total</b> |
| Age 0-18                         | 63,360                   | 35,640                   | n/a             | 9,000            | n/a               | 108,000      |
| Age 18-64                        | 162,260                  | 20,984                   | n/a             | 52,460           | 8,296             | 244,000      |
| Age > 65                         | 7,000                    | n/a                      | 38,000          | 2,000            | 1,000             | 48,000       |
| Total Population 2006 #s         | 232,620                  | 56,624                   | 38,000          | 63,460           | 9,296             | 400,000      |

Source: The Kaiser Commission on Medicaid and the Uninsured, October, 2007.

Conservatively, we estimate that over 25% (over 100,000) of persons living in the five counties in the River Region areas are medically indigent or underinsured.

**What are the Sources of Care for the Indigent and Underinsured Population in the River Region Counties?**

An important part of the HMA study was to develop a description of the variety of sources of care used by the target population. A cornerstone of health care is primary care. It is recommended that all individuals in all age groups have an identifiable source of primary care. There are data that indicate that patients with a medical home have better outcomes and improved quality of life.

The American Academy of Pediatrics has defined a medical home as: *Primary care that is accessible, continuous, comprehensive, coordinated, whole-person centered, compassionate and culturally effective.* “The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.”

**Reference:** <http://www.NCQA.org>

The Medical Home system of care is a concept that has been described as a model of health care delivery centered on the needs of the patient and family, and is guided by a personal primary care provider who partners with the patient to coordinate and facilitate care in order to help him or her navigate the complexities of the health care system. The medical home is not a “gatekeeper (who) restricts patient access to services,” but rather facilitates and coordinates care. The Medical Home system of care provides an organized continuum of care that delivers accessible, evidence-based care extending from first contact primary care through referral to specialty consultation, inpatient admission when necessary, and follow-up care in a connected and coordinated manner.

**Reference:** Rosenbaum S., Shin P., Whittington R. *Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative, 2006.*

The River Region has a limited number of clinical settings where the medically indigent and underinsured can opt to receive primary and specialty care services. Unfortunately, most of their options do not fully, or perhaps even marginally, qualify as “medical homes,” even though many providers wish they could refer these patients to a true medical home.

## **Primary Care**

### **Health Services, Incorporated (HSI)**

One of the larger clinic providers is HSI. Incorporated in April 1968 as a non-profit organization with a mission to provide primary health care services primarily for underserved populations including the medically indigent, HSI is accredited by the Joint Commission and provides comprehensive primary health care and preventive services through nine (9) health centers serving six contiguous counties in south central Alabama. Four of the HSI health centers are located in Montgomery County, one in Elmore County, two in Lowndes County, one in Autauga County, and one in Chilton County. The FQHC designation is given to health centers that meet federal requirements including at least one site being physically located in a Medically Underserved Area (MUA) or serving a Medically Underserved Population (MUP), the latter a designation provided by the federal government at the request of a governor. The centers must provide comprehensive primary care and preventive services with established linkages to hospitals for inpatient care and processes to refer patients to specialty services. HSI provides on-site prenatal, gynecological, pediatric, dental, psychiatric, pharmacy, podiatry, and social services.

HSI receives an annual Section 330 grant from the federal government and receives Medicaid reimbursement at a higher rate than non-FQHC providers. HSI receives

approximately \$875,000 from the city to operate the Montgomery Primary Health Center on Mobile Highway. They receive no other financial support from the city or the county. United Way provides HSI with a \$25,000 annual grant to help coordinate and pay for specialty referrals. These contributions assist HSI in providing services to its impoverished patient population as documented in the table below.

**Table 3**

**Federal Poverty Level (FPL) of HSI patients**

| Patient Profile    | 2006 | 2007 |
|--------------------|------|------|
| 100% and below FPL | 87%  | 83%  |
| 101-150            | 8%   | 7%   |
| 151-200            | 1%   | 2%   |
| Over 200%          | 4%   | 8%   |

Source: UDS 2006 and 2007

In 2007, seventy six percent (76%) of HSI’s patient population was African-American. Over 50% of HSI’s medical and dental encounters in 2007 were to patients that lacked any form of health insurance. Patients without coverage are charged a sliding scale fee for clinical visits and laboratory services. The minimum fee is \$20/visit. HSI is open Monday through Friday with one evening (Tuesday) session at the Lister Hill Health Center site. HSI medical and pediatric providers are available “on call” during the off hours.

HSI’s patient population declined in 2007 after several clinical and dental staff created vacancies and the staff were not immediately replaced. In response, the Board of Directors authorized a reduction in expenses of \$630,000.

**Table 4**

**HSI Patients and Clinical Encounters**

| Year | Unduplicated Users | Medical/Dental Encounters |
|------|--------------------|---------------------------|
| 2005 | 30,633             | 94,679                    |
| 2006 | 30,187             | 93,783                    |
| 2007 | 28,833             | 88,869                    |

Source: UDS 2007, 2006, 2005

In 2007, HSI provided prenatal care for 388 patients at the Montgomery Primary Care Center. Mothers are referred to Jackson Hospital for delivery. Inpatient care for adults and children is primarily provided at Baptist South. An HSI pediatrician makes rounds on HSI children at all three hospitals in the Montgomery area. The HSI health centers do not have an established computer linkage with the hospitals in the River Region area.

In September of 2006, HSI was one of four FQHCs in the nation funded as part of a federal demonstration project (Sickle Cell Disease Treatment Demonstration Program) to develop a collaborative approach to address the unique needs of persons suffering with sickle cell disease. HSI’s collaborative partners include the Department of Pediatric Hematology/Oncology School of Medicine, University of AL at Birmingham; two other FQHCs; and three local sickle cell organizations.

HSI refers almost all uninsured specialty care to private practitioners with whom it has developed relationships. Case managers have been able to negotiate deep discounts with these providers and some providers take patients for free. HSI's leadership believes the current referral system works well and that the supply of specialists is adequate, but they also say that significantly more dollars are needed to pay for uninsured specialty care. As noted above, specialty referrals are financed through a \$25,000 grant from the United Way.

HSI's dental operations primarily serve adults, though they would like to implement a consultant recommendation to provide more pediatric dental services. The ability to attract and retain medical providers willing to see the pediatric population has been a major obstacle. When compared to other FQHCs in Alabama and nationally, HSI's productivity exceeds or is comparable to other health centers.

**Table 5**

| <b>Productivity</b>                   | <b>HSI<br/>(2007)</b> | <b>State of AL<br/>(2005)</b> | <b>National (2005)</b> |
|---------------------------------------|-----------------------|-------------------------------|------------------------|
| Physician productivity                | 3,989                 | 4,522                         | 3,944                  |
| Mid-level productivity                | 3,568                 | 3,017                         | 2,903                  |
| Medical Team productivity             | 4,790                 | 4,791                         | 4,338                  |
| Dentist productivity                  | 2,115                 | 2,941                         | 2,727                  |
| Medical patients per medical provider | 1,211                 | 1,443                         | 1,126                  |
| Dental patients per dental provider   | 897                   | 1,121                         | 986                    |

Source: UDS 2007 (AL and national 2006 & 2007 comparables not available)  
Numbers represent visits (patients) per provider (or team) per year

During 2007, 35% of HSI's charges were to Medicaid, 8% to Medicare, 6% to private insurance and 51% were self-pay charges. This compares to the FQHC national average payer distribution of 45% Medicaid, 9% Medicare, 12% private insurance and 31% uninsured. Clearly, HSI faces a challenge in expanding services to more medically indigent patients with this payer mix profile.

When compared to the Alabama and national cost averages, HSI's cost structure is comparable. (Note: State of AL and national comparisons unavailable for 2006 and 2007.)

**Table 6**

| <b>Costs per Patient</b>              | <b>HSI<br/>(2007)</b> | <b>State of AL<br/>(2005)</b> | <b>National<br/>(2005)</b> |
|---------------------------------------|-----------------------|-------------------------------|----------------------------|
| Medical cost per medical patient      | \$341                 | \$295                         | \$380                      |
| Medical cost per dental patient       | \$252                 | \$199                         | \$318                      |
| Total cost per total patient          | \$496                 | \$351                         | \$514                      |
| Medical cost per medical encounter    | \$108                 | \$94                          | \$110                      |
| Dental cost per dental encounter      | \$132                 | \$96                          | \$134                      |
| Lab/ X-ray cost per medical encounter | \$20                  | \$11                          | \$9                        |
| Pharmacy cost per medical encounter   | \$14                  | \$9                           | \$13                       |

The HSI centers have a total of 70 exam rooms, which gives them sufficient space to accommodate more visits. However, the organization faces several significant obstacles to expanding services. Due to budget constraints and the recent loss of several providers, HSI currently does not have the staff to expand. While they have been successful at recruiting and retaining providers, they have yet to fully recover from the loss of providers last year and acknowledge that their salaries are not as competitive as they need to be.

Perhaps the most serious issue facing HSI is its payer mix. As noted above, more than 50 percent of HSI's charges were to self-pay patients, compared to approximately 31 percent nationally. Over the long term, this payer mix is unlikely to be sustainable, and HSI will need to attract more patients with a payer source, especially children and pregnant women covered by Medicaid. While HSI's leadership acknowledges its payer mix problem, they describe a very competitive market for pediatric and especially OB patients, who are currently triaged via the Gift of Life Foundation and have access to approximately 90 private physicians. They also believe that their Montgomery Primary Health Center site, which is located in a public health facility and serves as the only site providing OB care within HSI's network, carries with it a "public health department stigma" that keeps expectant mothers away. Safety is also a concern, especially at the Lister Hill site.

HSI's leadership believes that, in order to attract more pediatric and OB patients, a new safer site is needed. As a result, the organization has made replacement of the current Lister Hill site its highest priority. HSI's leadership believes the ideal location, for both safety and proximity reasons, is a plot of land adjacent to Jackson Hospital. They also cite a recent study showing that a large number of visits to the Jackson Hospital ER were for primary care and note that this location would position them to provide much-needed after hours care to help alleviate pressure on the ER.

Although HSI is the largest provider of primary care for the medically indigent population in the River Region, there are several others. These are described below.

#### **Medical Outreach Ministries (MOM)**

MOM is located on South Boulevard and provides primary care for people aged 18 – 64 who have no health insurance or whose income is less than 200% of the federal poverty level. They serve approximately 900 unique individual patients per year with over 5,200 annual visits. They give out \$80,000 to \$100,000 worth of free prescriptions per month. They are currently funded by grants and donations from area churches, local charitable and business organizations, Community Development Block Grant (CDBG) funds from the Department of Housing and Urban Development (HUD), and the Montgomery County Health Department. MOM has an agreement to admit its patients to the Baptist Health Family Medicine Clinic and its patients receive discounted rates for clinical services provided at Baptist South. MOM has a cadre of 10 volunteer physicians who augment its full time providers and has established relationships with over 50 specialists who will accept limited numbers of medically indigent referrals. MOM does not have a computer linkage with the hospitals in the River Region area.

### **Community Care Network (CCN)**

The CCN provides monthly services with a Mobile Medical Clinic at four sites (two are in rural areas) each month. They see both insured and uninsured patients. Funding is a major problem. Most of CCN's funding comes from grants that require a re-application every year. CCN has a CDBG block grant and receives some financial support from churches, hospitals, and physicians. CCN sees a limited number of patients and has a low volume of patient visits.

### **Internal Medicine and Family Medicine Residency Training Programs at Baptist South**

These training programs operate outpatient primary care clinics adjacent to each other in an ambulatory care center on Narrow Lane Road. The UAB Internal Medicine Resident Clinic sees 3,000 unduplicated patients per year and provides 12,000 annual visits. Approximately 15% (1,800) of the visits are patients who are uninsured and approximately 20% (2,400) have Medicaid. The medically indigent are generally seen for one post-hospitalization visit and then referred to an HSI health center. The Baptist Health Family Medicine Clinic also sees approximately 3,000 unduplicated patients per year with 12,000 annual visits. 5% (600 visits) of the patient visits are medically indigent. The Family Medicine inpatient service treats 100% of the admissions from the MOM clinic; 90% of these patients are uninsured. Upon discharge most patients are referred back to MOM.

### **Private Practices and Groups**

Private practices in the River Region have very few, if any, medically indigent patients on their patient panels. Most private providers and groups who accept Medicaid actively limit the number and may have a strict quota on the percentage of Medicaid patients who can be given appointments. However, there is at least one private practice in Montgomery that provides primary care to a large pediatric and adolescent population with a significant portion of Medicaid coverage. This practice appears to be the exception in the Montgomery and River Region Counties.

### **Montgomery VA Health Care System**

The Veterans Administration runs a single primary care center in the River Region that provides medical, mental health, dental care, and pharmacy services to veterans in the Montgomery area. This center serves approximately 6,000 of the 30,000 veterans in the Montgomery catchment area. This center sees its role as primarily serving veterans who are uninsured or underinsured. It has the capacity to see more patients and is accepting new patients. It currently has no ongoing relationship with the HSI primary care network, MOM, or the hospital emergency rooms.

### **Montgomery County Jail**

Health care services at the Montgomery County Jail are contracted to a private correctional health care firm. The Jail has approximately 720 beds with an additional 700 currently under construction and has 10,000-12,000 new admissions annually, all of whom are given an intake screening assessment. The Jail offers daily primary health care services provided by its nursing staff and a physician on-site two days per week. Of all detainees, 85-90% are uninsured. An estimated 10-15% of the Jail's detainee population has a significant mental illness. The Jail has on-site dental and psychiatry clinics. The vast majority of the men and women admitted are discharged back to their home communities. Through its

mental illness and substance abuse court, the Montgomery Courts and the Jail have a facilitated referral process to send mentally ill patients to the mental health center in Montgomery upon release. Prescriptions for a two-week “bridge” supply of psychotropic medications written by the Jail provider can be filled without charge to the patient at a pharmacy in downtown Montgomery near the Jail. Medically ill detainees being discharged are advised to seek care at the HSI health centers. The Jail does not have a discharge coordinator to arrange follow-up medical care in the community. The Montgomery County Jail has no established relationship with the HSI health centers or with the MOM clinic, nor does it have computer linkage with the HSI health centers, MOM, the mental health center, or the hospitals in the River Region Counties.

### **Emergency Rooms**

It is not by accident that the ERs are included in the section about primary care access for the medically underserved. The data in Appendix A indicates that a large number of medically indigent and Medicaid patients are using the ER, often for primary and non-urgent care. The ERs may in fact be their only source of primary care. Many of the uninsured patients go to the ER because they do not have access to a primary care provider or to obtain medication refills. Very often the ER will not ask patients to pay a fee prior to being seen. They also use the ER as a night and weekend clinic. Although primary preventive care should not be provided in the ER, hospitals are legally obligated to triage, assess, and treat everyone who comes through their doors.

As noted in the section on Emergency Room services below, an estimated 40-50% of the over 76,000 ER visits in 2007 by uninsured and underinsured patients could have been managed in a primary care or a walk-in center. This is a very costly and inappropriate way to deliver non-emergent care. This data reinforces the recommendations of all providers and health leaders interviewed in the River Region that primary care needs to be expanded in the same communities that generate high numbers of ER visits. There is also the need to create walk-in, non-urgent care capacity in the evening and weekend hours in the same communities where primary care is needed. It is important to note that a number of leading zip codes of patients receiving primary care in HSI centers matches directly with the zip codes of self-pay and Medicaid patients using ERs in high numbers. HSI centers appear to be situated in the right locations, but lack the capacity to entirely meet the non-emergent needs of its patients and/or are not open during hours that could better meet these needs.

Emergency Rooms in the River Region have become an integral component of the “safety net” for the uninsured. Using ERs in this manner as part of the safety net does not create a network of care; rather, it simply means the ERs serve as places to receive episodic care at a very high cost with very little follow-up and no continuity. ERs may be part of the safety net, but they will not replace the need for a “medical home.”

### **Urgent and After-Hours Care**

One reason individuals may seek non-emergency care in the ER is lack of availability of services during night and weekend hours, so this is an important part of the study. HMA included questions about after-hours care in its interviews of providers.

HSI's **Lister Hill Health Center** is open on Tuesday evening. Walk-in patients with or without insurance as well as patients with appointments are accepted at this session. There is a sliding scale fee with the lowest payment being \$20 for the visit. Smaller co-pays are charged to patients with Medicaid and Medicare. The HSI system has one adult and one pediatric care provider on-call after-hours. The pediatric on-call provider is especially busy on the weekends and holidays.

**American Family Care** provides urgent care and primary care at two walk-in clinics in Montgomery County located on Marti Lane and Vaughn Road. The hours of operation are 8:00 am – 6:00 pm Monday to Friday. Medicaid and Medicare are accepted, but medically indigent patients are referred to the HSI health centers or other providers that accept indigent care patients. They only accept uninsured patients if they have the ability to pay. Only about 5% of their patients are on Medicaid.

Private physicians own and operate five urgent care centers (**PriMed**) in the River Region: three in Montgomery, one in Prattville and one in Wetumpka. All types of insurance are accepted, but the medically indigent must pay upfront. The hours of operation are 7:00 am – 9:00 pm Monday – Friday; 9:00 am – 6:00 pm Saturday and Sunday; Vaughn Road location 7:00 am – 9:00 pm Saturday and Sunday.

The **Emergency Rooms** at the Baptist Hospitals, Jackson Hospital, Elmore Community Hospital, and Tallassee Community Hospital are virtually the only after-hours care centers in the River Region where the medically indigent and underinsured can be seen and treated by paying at the point of service. Whether the visit is urgent or not, hospital ERs are mandated to screen and triage all patients irrespective of their ability to pay.

None of the hospitals maintain a non-emergency room after-hours care center for patients who are judged not to require the intensive services of an Emergency Room.

### **Emergency Room Services**

The Emergency Rooms at Jackson, Baptist South, Baptist East, Baptist Prattville, Tallassee and Elmore Community Hospitals provide over 170,000 emergency room visits per year. (Data from Elmore Community Hospital was not available at the time this report was written.) Cumulatively, self-pay patients accounted for 23.9% of the ER visits to Jackson, Baptist, and Tallassee Hospitals, although the percent varied from hospital to hospital.

**Table 7**

| <b>Hospital</b>    | <b>ER Visits</b> | <b>Self-Pay<br/>(overall 23.9% of<br/>ER visits)</b> | <b>Medicaid<br/>(overall 22.5% of<br/>ER visits)</b> |
|--------------------|------------------|--|--|
| Baptist South      | 50,633           | 13,102<br>(26%)                                      | 14,369<br>(28%)                                      |
| Jackson            | 41,297           | 12,175<br>(30.5%)                                    | 7,559<br>(18%)                                       |
| Baptist East       | 33,678           | 5,434<br>(16%)                                       | 6,294<br>(19%)                                       |
| Baptist Prattville | 26,770           | 5,524<br>(21%)                                       | 6,061<br>(23%)                                       |
| Tallassee          | 12,603           | 3,261<br>(25.8%)                                     | 2,903<br>(23%)                                       |
| Totals             | 164,981          | 39,496<br>(23.9%)                                    | 37,186<br>(22.5%)                                    |

Emergency Room specialists in the Montgomery area estimate that a minimum of 40-50% of all their ER visits could have been treated in a primary care setting.

Providers interviewed complained that the waiting rooms in the Jackson and Baptist South Emergency Rooms were crowded, undersized, and inappropriately mixed sick and healthy adults and children. It was repeatedly commented that children needed to have their own waiting and triage areas and that a walk-in center needed to be identified where triaged non-urgent patients could be sent, decongesting the ERs and providing a more suitable level of care at a lower cost. The ERs give uninsured and underinsured patients being discharged an informational sheet with the phone number of centers where follow-up care could be arranged. The ERs do not have a formal referral process for sending patients to HSI health centers or MOM. The ERs do not send any detailed medical information with patients being discharged to care in the community. The ERs do not have a computer linkage with the HSI or MOM community health centers.

### **Hospital Inpatient Services**

There are seven hospitals in the River Region. Four are in Montgomery County (Jackson, Baptist South, Baptist East, and the Veterans Administration), two are in Elmore County (Elmore Community and Tallassee Community), and one is in Autauga County (Baptist Prattville). The seven hospitals have 1,206 beds. There are 301.5 beds for every 100,000 residents in the River Region. The USA average is 270-280 beds per 100,000 residents. With the Region's current population of approximately 400,000, especially with the accessibility of the UAB super-tertiary medical center, the Region has an adequate number of hospital beds. Medically indigent and underinsured patients are admitted to these hospitals or transferred to a higher level of care if their condition so warrants. Elmore Community Hospital transfers patients to Baptist South or Jackson. All the hospitals send

patients to the University of Alabama – Birmingham (UAB) Medical Center for super-tertiary care.

The Veterans Administration Health Care System runs a 30-bed acute care hospital with a 24 hour per day, 7 day per week Emergency Room in Montgomery County that only serves veterans. The ER does not accept ambulances. It is classified as a “rural hospital.” All complicated cases are either transferred to the VA in Birmingham or to contracted partners at Jackson and Baptist South hospitals. The University of Alabama at Birmingham Medical Center serves as an invaluable safety net inpatient tertiary and super-tertiary hospital for the under and uninsured not only for the River Region but also for a large portion of the State of Alabama. However, UAB Medical Center is nearly 120 miles away for patients living in the more distant section of the River Region. From 2005 through 2007, 332 indigent or true self-pay patients from the River Region Counties were hospitalized at UAB Medical Center.

### **Specialty Care Consultation**

Even in instances where primary care is available, the next challenge is ensuring that specialty care, when needed, is readily available. The River Region has specialists in 36 different specialties and sub-specialties. The vast majority of the specialists are concentrated in the Montgomery area with very limited access to specialty care in the remainder of the River Region Counties. Even in Montgomery, it is difficult for the uninsured and underinsured to obtain specialty consultation. A number of specialists in the River Region refuse to accept Medicaid (primarily for adults) and some even reject Medicare patients. It was repeatedly heard during physician interviews that specialists in Montgomery see patients “out of their good will”.

This impeded access to specialty care is compounded by the increasing age of the specialists. The average age of specialists in the River Region area is now in the mid-fifties and is even higher in select specialties. Older specialists tend to work fewer hours per week and are more reluctant to provide off-hours, on-call care for patients who are not in their established practices. This is the situation at Montgomery area hospitals and practices. **The extremely limited access to specialty care, especially for the uninsured and underinsured, has reached a crisis state in the River Region Counties.**

Specialists who do take hospital call will examine and treat the uninsured even though they receive no reimbursement. It is their perception that the uninsured patient population generates the majority of the after-hours inpatient and emergency room calls for specialty consultation. Specialists spoke of being exhausted post-call and that after being on-call they lack the energy that they had when they were younger physicians. Specialists stated that they will only see post-hospital medically indigent patients one time in their offices; thereafter, patients are advised to seek care in one of the HSI health centers. Specialists commented that it would minimize the growing unwillingness of specialists to provide inpatient care to the medically indigent if they could have a tax write-off or even limited reimbursement for their services.

Providers in the HSI community health centers repeatedly indicated it was relatively easy to obtain specialty consultations in 1-2 weeks for patients with private insurance or

Medicare, but difficult to find specialists who will accept Medicaid. If a specialist does accept Medicaid or in some cases Medicare, there is generally a much longer wait for the appointment (2-6 months). It is almost impossible to get a specialty consultation for medically indigent patients; however, according to HSI leadership, this is a function of a lack of resources to pay for specialty care rather than a shortage of specialists. In some circumstances, United Way will subsidize a visit to a specialist after the patient has been interviewed and approved by United Way's social workers. Most medically indigent patients are referred to UAB's Kirklin Outpatient Clinic with variable waiting times from weeks to months for the first appointment. Uninsured and underinsured are readily accepted at the Kirklin Clinic, but the travel to Birmingham creates a barrier to compliance for a number of referrals.

The Medical Outreach Ministries (MOM) has arrangements with 50 or more specialists in the Montgomery area who will accept carefully selected and limited numbers of referrals. The specialists generally provide these consultations to MOM patients without charge.

It was reported that Montgomery County has the highest incidence of HIV in Alabama. Providers interviewed stated that care was readily available, even for the uninsured, at the Montgomery AIDS Outreach Clinic in Montgomery. This organization has done a lot of work recently to stabilize their financial position. If they had an additional \$250,000 in one time unrestricted grant monies, they could bring a like amount of additional federal funding to the community to pay for services for this population. In addition, women and children with HIV infection are treated in the grant-supported UAB Montgomery Family Clinic housed in the UAB Health Center Montgomery.

Cancer care for the uninsured and underinsured appears to be reasonably accessible either through referral to an oncologist at UAB or in Montgomery with the support of local agencies such as the Montgomery Cancer Wellness Foundation. The Foundation has a \$500,000 budget and reports to have received nearly \$250,000 of in-kind services from providers, the Montgomery Cancer Center, and other clinical entities. It was stated in interviews that "No patient with cancer is turned away." The Foundation's social worker and patient advocate try to match patients with needed services to help the patient maintain a standard of living, including assistance with transportation and drugs if so needed. The Foundation's number one issue is the variable flow of the grant and charitable support that it receives. Predictable sustained funding would significantly facilitate the ongoing care of uninsured cancer patients.

The UAB specialty care clinics at the Kirklin Clinic in Birmingham truly serve as a safety net of specialty consultation and care for the uninsured and underinsured in the River Region Counties. Although there are moderately long waits for the first appointment to some of the specialty clinics, the appointments to Kirklin are felt to be readily available. The distance and travel time to Kirklin makes it difficult for some patients to keep these valuable specialty appointments.

### **Dental Care**

Access to dental care for the uninsured and Medicaid population is also a serious issue for the River Region. Alabama has 30% fewer dentists statewide than the United States

average. Alabama ranks the fourth lowest in the country for dental care spending. An estimated 40% of Alabama children have untreated dental decay. In addition, 35 – 40% of Alabama adults have unmet dental care needs. Last year 70% of Alabama children did not visit a dentist. There are a total of 159 dentists in River Region Counties, with 124 of them located in Montgomery. There are no dentists in Lowndes County. Of the dentists practicing in the River Region, 31% see Medicaid patients and 61% see ALL Kids patients.

Dental services for the medically indigent are provided at two HSI health centers in the Montgomery area: Lister Hill and the Montgomery Primary Health Center. The Lister Hill dental clinic is currently not fully staffed due to the resignation of a dental provider. Dental clinical services were discontinued at HSI health centers in Ramer and Hayneville.

The privately owned Small Smiles and Tooth Zone dental centers readily accept Medicaid patients.

### **Mental Health Care**

While access to primary and specialty care is a challenge in the River Region, the situation with respect to mental health care is even more serious. Montgomery, Lowndes, Autauga, and Elmore Counties are designated as Mental Health Shortage Areas. These four counties are also designated as low income Mental Health Catchment Areas. There is only one Community Mental Health Center, the Montgomery Area Mental Health Authority, to serve the medically indigent and underinsured mentally ill patients in this four county region. The Montgomery Area Mental Health Authority has satellite offices in Prattville and Wetumpka.

The Montgomery Area Mental Health Authority (MAMHA) serves over 5,000 adults and 1,000 children and adolescents. It was reported that there are long waits to obtain an appointment. A significant number of MAMHA appointments are used to treat court ordered referrals and discharges from the State mental hospitals. MAMHA also accepts referrals from the Montgomery Jail, especially patients who are being adjudicated by the Mentally Ill and Substance Abuse Court. The Montgomery Area Mental Health Authority is staffed by psychiatrists, a physician assistant, a nurse practitioner and a number of social workers and mental health clinicians. The psychiatric staffing amounts to 3.7 FTEs (fulltime equivalents).

Inpatient mental health services are provided at the State Hospital (Greil) through court order and physician referral. Baptist South has a 37 bed mental health unit. Jackson Hospital has an 8 bed crisis unit that may be closed in the next 6 months. There is a geriatric mental health center in Tallassee and a unit is being planned in Prattville that will serve 19 geriatric patients (age 55+) and 29 adolescent patients (age 12-18). A private 60 bed mental health inpatient facility is under construction in Montgomery on Narrow Lane Road. With the exception of the State Hospital, all of these inpatient mental health units accept only insured patients.

The HSI health center at Montgomery Primary Care Center has a 0.11 FTE psychiatrist. This is the only psychiatric physician in the HSI network that accepts referrals from the

other 7 HSI community health centers. In 2007, the psychiatrist provided services to 335 patients.

The Montgomery County Jail has an on-site psychiatric clinic. It is estimated that 15% of the 720 (soon to be 1,420) men and women housed at the Jail on any given day have a serious mental illness. The Jail admits over 10,000 new admissions annually. Montgomery has an active Mentally Ill and Substance Abuse Court that deflects a number of mentally ill offenders into community based care at the Montgomery Area Mental Health Authority in lieu of incarceration. Upon discharge from the Jail, detainees who require mental follow-up have appointments arranged at MAMHA and a two-week "bridge" supply of psychotropic medications is provided at no charge to the patient at a nearby private pharmacy.

It was the opinion of providers interviewed that there is a terrible shortage of mental health services and professionals for both adults and children in the River Region Counties. This lack of access to psychiatrists and psychologists in the River Region is especially exaggerated for medically indigent patients of all ages.

### **Pharmaceutical Services**

HSI has licensed pharmacies in its Lister Hill and Montgomery Primary Health Centers where prescriptions are filled on the same day for patients receiving care in these centers. The FQHC designation of its centers allows HSI access to 340B pricing for medications. Prescriptions are faxed from all the outlying HSI health centers and the medications are delivered to the originating clinic for pick-up by the patient in 1 to 3 days. All of the HSI centers maintain a limited supply of stock medications to cover patients who need their medication immediately. On an annual basis, through the Pharmacy Assistance Program, Pfizer donates approximately \$1,500,000 of pharmaceuticals for HSI's uninsured patients.

Wal-Mart's provision of a variety of medications at the cost of \$4 per prescription assists many patients in the River Region comply with the prescriptions ordered by their providers.

Catholic Charities, through its Direct Aid program, assists the uninsured and patients who cannot afford co-pays to help purchase prescribed medications. They have an agreement with a private pharmacy where prescriptions can be purchased with a 20% discount. This program assists approximately 30 patients per month to acquire 3-4 prescriptions per person.

Some of the churches in Montgomery have social support service programs that assist in the purchase of limited amounts of prescription medications. One church spends \$1,500 per month assisting patients with pharmaceutical costs.

Medicare Part D was repeatedly criticized by health care providers and administrators. Elderly patients have found the program to be extremely complicated and difficult to understand and navigate. Cancer providers complained that Part D has been "awful for cancer patients."

It was somewhat surprising to HMA that there weren't more complaints about the ability of patients to acquire prescription medications. With the number of people living in poverty, clearly there are patients who can't afford to purchase medications. It is possible that the \$4 prescriptions at a large national retail store has minimized the impact of pharmaceutical costs to the medically indigent and underinsured in the River Region Counties.

### **Other Social Service Agencies**

There are a number of other social service agencies and foundations, other than those noted above, that provide services to the uninsured. Each one talked about the great need but the limited resources. None of them can meet the demand alone. But with more funding each of them could provide services to more people. Table 8 lists some (not all) of the agencies/foundations that HMA spoke to and the services they provide.

**Table 8**

| <b>Provider</b>                                | <b>Service</b>  |
|--|---|
| Montgomery Cancer Wellness Foundation          | Social work, counseling, diet/nutrition, patient advocacy. Assists patients undergoing chemotherapy and/or radiation who have no access to drugs and transportation. Primarily serves the elderly on Medicare who have fallen into the Part D gap. "No patient is turned away."   |
| The Joint Public Charity Public Hospital Board | Funds for specialty care.   |
| AL Child Caring Foundation                     | Outpatient coverage; set up by BC/BS.   |
| Catholic Social Services                       | <i>Direct Aid Program</i> provides medications, money for utilities, food, clothing, and dental care to all ages. Serves approximately 1,000 people at any one time. Provides bus tickets to Lister Hill Health Center. Has a large food pantry, and thrift store. Provides psychological and financial counseling. They are limited by lack of financial resources. <i>Frail Elderly Care</i> for clients age 60 and > who need help to stay independent with dignity and who need transportation. Services are provided through St. Margaret's Foundation. Other funding sources as well. |
| Churches                                       | Support services for referrals and medications.   |
| Gift of Life Foundation                        | Supports a network of OB physicians and pays for Maternity Care including delivery for women in the River Region through a global fee.  |
| Montgomery AIDs Outreach                       | Provides a full service medical clinic. Montgomery Co. has the highest rate of HIV in the state.  |
| Volunteer and Information Center (VIC)         | Connects area residents to community service organizations. Dial 2-1-1 free for information on available community resources.   |

**Note: The Community Resources Guide is an excellent resource for review of other service providers available in the region.**

## **Barriers to Care**

There is a semblance of a structure already in place in the River Region Counties, but there really is not an integrated network of care. As noted previously, there are health centers and clinics that are free, sliding scale, and walk-in. There is the ER. There appear to be multiple options for the vulnerable populations. However, due to various barriers these options are not always viable as a way to access care. Some of these barriers are:

- The indigent may not be able to provide the documents that would qualify them for free care.
- They may not be able to pay even a small fee based on a sliding scale.
- There are not enough primary care providers in their county.
- The clinics in their area do not have full time providers.
- They have trouble getting specialty care.
- They don't feel they are treated fairly.
- There is not a provider that speaks their language.
- They are not aware of their options.
- The hours are not convenient because they work during clinic hours.
- They do not have transportation.
- They go to the already over-crowded Emergency Room where they know they will not be turned away.

## **Access to Care**

Medicaid for adults is not readily accepted by a number of providers in the River Region Counties. In fact, some providers do not accept Medicaid at all. Surprisingly, Medicare is also not being accepted by some physicians in these five counties. Pediatric Medicaid reimburses providers at a higher rate than adult Medicaid, but the majority of pediatric practices either do not accept Medicaid or have limited the number of patients with Medicaid and ALL Kids in their practices. Also, most of the services provided for this vulnerable population in the River Region are available Monday through Friday during the day. Due to lack of transportation and/or job responsibilities, many are not able to access care during these hours so they go to the ER for care, especially with their children. A number of the providers talked about having evening hours one day per week and a half day on Saturday, but in some cases these hours were discontinued due to the low number of patients who were utilizing them.

HSI, Inc. provided services to 18,327 adults in 2007 and Medicaid was the major payer. The payer status of the adults was 61% uninsured, 14% Medicare, and 13% Medicaid. While HSI has the physical space capacity to provide additional services, the financial reality is that existing resources are insufficient to support expansion given this payer mix. The table below illustrates this point. HSI must attract more patients with a payer source, or secure additional resources to support the expansion of services.

**Table 9**

|   |                        |
|---|------------------------|
| <b>Uninsured – Direct Costs and Grant Revenue</b> |                        |
| Medical Cost Per Medical Encounter                | \$108                  |
| Lab & X-Ray Cost Per Medical Patient              | \$20                   |
| Pharmacy Cost Per Medical Encounter               | \$14                   |
| <b>Total Direct Cost Per Medical Encounter</b>    | <b>\$142</b>           |
| <b>Total Direct Cost Per Dental Encounter</b>     | <b>\$132</b>           |
| Medical Encounters                                | 79,297                 |
| Dental Encounters                                 | 9,237                  |
| Estimated Uninsured Medical Encounters            | 40,441                 |
| Estimated Uninsured Dental Encounters             | 4,711                  |
| <b>Total Direct Cost – Uninsured</b>              | <b>\$6.3 million</b>   |
| <b>330 Grant</b>                                  | <b>\$3.9 million</b>   |
| <b>Montgomery County Subsidy</b>                  | <b>\$0.9 million</b>   |
| <b>Difference (Cost vs Grant + Subsidy)</b>       | <b>(\$1.5 million)</b> |

Source: 2007 UDS

## **Provider Workforce in the River Region Counties**

### **Insufficient Number of Providers to Serve the Medically Indigent**

There are an insufficient number of primary care providers in the River Region who are willing to accept uninsured or underinsured (and in some cases Medicaid) patients. Access to specialty care is also limited. Specialists will manage uninsured and underinsured in the hospital, but will provide only one post-hospitalization visit in the community. Some specialists also refuse to take call, so there is limited specialty coverage for the ERs unless they are willing to pay for call time. They are also less willing to take care of the uninsured. The average age of physicians in the five county region is in the mid to high 50s. Recruitment of providers to the River Region Counties is a major concern.

Physicians, nurse practitioners, physician assistants, and administrators in the health care delivery systems in the River Region Counties were interviewed about the recruitment and retention of health care providers. All stated that there is a belief that physicians, both primary care and specialists, are difficult to recruit to the five counties in the River Region area. It was of interest that one nurse practitioner, who is on the local mid-level provider association, felt that nurse practitioners could be identified and hired in, at least, the Montgomery area. All expressed concern that the physician population is aging and that younger providers are not readily joining practices in the River Region area. Providers noted that as difficult as it was to find providers to work in Montgomery County, it was even more complex to convince physician and mid-level providers to practice in the more distant, rural areas of the River Region Counties.

### **Difficulty Recruiting**

Reasons stated as barriers to recruitment include perceived and real isolation in rural areas, need for improvement in the public school system that results in providers having to pay for the cost of private grammar school and high school education, increasing work load when taking hospital call, increasing numbers of complex, uninsured patients with whom

the provider has not had a previous relationship when on-call, and a lingering negative perception about race relations in central Alabama. It was voiced by a number of the physicians interviewed that some providers over-emphasize to potential recruits their concerns about the public school system, never commenting on the recent development of magnet public high schools. We were also informed that some specialists are less than enthusiastic about young physicians in their specialty coming to Montgomery and potentially attracting patients away from their established practices.

The increasing average age of physicians is not unique to Alabama; rather, this is a nationwide phenomenon. According to data from the American Medical Association (AMA), the number of physicians in the US has nearly tripled in the 45-54, 55-64, and 65 and older age groups in the last 25 years. By contrast, the number of physicians aged 35-44 has not even doubled, and the number of physicians 35 years old and younger has only increased by 10%. Younger physicians are willing and able to work more hours. By age 55, the average US physician has decreased his/her work hours by 25%. The River Region Counties physician ages reflect those of physicians throughout the USA. It was estimated by a number of physicians that the average age of providers in the 5 county area is approximately 55 years. In certain specialties and sub-specialty groups in the Montgomery area, the majority of physicians are near or over 55 years of age. This is serious concern for the River Region area. It is also an opportunity to recruit providers who will realize that their services will be needed.

**Table 10**

**Physician Age Distribution**

| Age   | USA | River Region |
|-------|-----|--------------|
| <35   | 16% | 8%           |
| 35-44 | 24% | 24%          |
| 45-54 | 25% | 35%          |
| 55-65 | 17% | 27%          |
| >65   | 19% | 6%           |

This increasing age of the USA physician workforce is compounded by the fact that medical school enrollments have not proportionately grown with the increase in the USA population. This is in no small part due to decreased federal payments and subsidies and policies that have limited the ability of medical schools to increase in number and enrollment size even though there continues to be a qualified pool of medical school applicants who are rejected annually. It has resulted in 20-30% of all residency positions in US hospitals being filled by International Medical School graduates.

**Reference: Helwick, Catherine. Shrinking Workforce: No Quick Fix. Internal Medicine World Report. Vol 22, No. 12. December, 2007, p. 1 & 6.**

The River Region Counties are not unlike other cities and communities in Alabama and in other states. Many communities are having difficulty in recruiting primary care and specialty physicians.

Alabama has two medical schools, University of Alabama Birmingham (UAB) and University of South Alabama. UAB has three campuses – Birmingham, Huntsville, and Tuscaloosa. South Alabama’s campus is in Mobile. Approximately 10-35% of students in Health Management Associates

Alabama medical schools are from out-of-state. We were advised that Alabama is now exporting physicians to other states. The number of Alabama medical students in out-of-state medical schools was not available.

The State of Alabama has initiated some programs that are attempting to attract physicians to practice in both rural and micro-urban areas. The Rural Medical Scholars Program operated out of Tuscaloosa since 1996 identifies and recruits high school and college students from rural areas who have an interest in attending medical school. The students must be committed to returning to their rural communities to practice. Once accepted in medical school, the students do a pre-medical school year being trained and mentored in community rural health and rural sociology. Each class continues to meet and train on a regular basis throughout medical school. There are now 37 students from this program in medical school and 14 in the Family Practice residency in Tuscaloosa. There are currently 30 students in the recruitment phase and 3 medical students from the River Region Counties. Montgomery County is for the most part considered an urban area and does not qualify for this program. It costs an average of \$30,000 per student per year for the 5 year program.

Federal Graduate Medical Education funding helps to finance the Family Medicine and Internal Medicine Residency training programs at Baptist South. One or the other, or both of these training programs, generate additional support from a variety of sources including Baptist South, the County of Montgomery, inpatient and outpatient billing, and others. These residency training programs recruit young physicians-in-training to Montgomery and the River Region Counties. A number of the graduates of these residency programs are subsequently recruited to practice in the River Region area. More than 30% of the graduates remain in the Montgomery area and 40-50% remain in Alabama. It is unknown whether some of the graduates who enter sub-specialty fellowship programs will be more willing to return to Montgomery in the future to set up their practices.

The nine Health Services, Inc. (HSI) Federally Qualified Health Centers have been designated as Health Manpower Shortage Sites (HMSA) serving underserved patient populations. This designation enables these community health centers to be eligible to recruit recent graduates of residency training programs who had received National Health Service Corps (NHSC) scholarships during medical school. Physicians without NHSC obligations who select to practice in the HSI centers can also apply for "loan repayment" stipends for payment of private loans that were used to finance medical school training. International graduates who desire to stay in the USA can also obtain J-1 work visas if they are selected to practice for 2-3 years in Health Manpower Shortage Centers such as HSI. Qualification as NHSC scholarship repayment and loan repayment sites are tremendously effective recruitment tools. Upon completion of their scholarship and loan repayment obligations, there is great opportunity to recruit these providers to remain in the River Region area. However, this past year HSI had difficulty replacing several physicians who left.

Alabama has also developed an Osteopathic Medicine –Alabama Consortium that is recruiting Alabama pre-medical students to apply for four or five out-of-state Osteopathic Schools with the expectation that these students will return to Alabama to complete their

residencies, hopefully in primary care programs. This is a new program and time will tell whether the students return to Alabama.

A 2006 Survey of Medical Students by Merritt, Hawkins & Associates revealed that residents primarily learned about practice opportunities from 1) the internet and 2) personal networking with additional significant input from physician recruiters and their residency programs. The majority start investigating practice opportunities one year or greater before completion of their residency programs. Other than quality of care considerations, their top four considerations in descending order were 1) geographic location/life style, 2) good financial package, 3) adequate call/coverage, and 4) loan forgiveness. Few recent graduates show interest in practicing solo. Over 70% expressed an interest in practicing in communities with populations between 50,000 and 500,000. Less than 1% voiced any interest in working in a community of less than 25,000. Availability of free time was a significant factor for 63% in selecting a practice. Merritt, Hawkins & Associates stated that residents select their initial practice based on “pre-determined geographic locations, usually close to where they trained, where they grew up, or where their spouse grew up.”

**Reference: Merritt, Hawkins & Associates. 2006 Survey of Final Year Medical Residents.**

#### **Transportation to Health Services for the Medically Indigent**

Transportation, especially in the rural counties, appears to be a problem for many but not all of the indigent population. The transportation system in the city of Montgomery does not always provide access to the areas of the city where services are provided to this population. HMA heard many different opinions from service providers regarding transportation.

- “Transportation is not as big a problem as others may think. .... It is important to make appointment times convenient for the patient, so as to coincide with rides the patient may have from friends or family for other errands, such as trips to Wal-Mart.”
- “In Montgomery the public transit is OK, but in other areas of the River Region it is a problem.”
- “Transportation is a big issue as is the issue of medications, which are very expensive.”
- “Autauga Rural Transport provides transportation, including wheelchair transport Monday through Friday from 8-5, through the use of 7 or 8 mini-buses.”
- “Transportation is not that big a problem but access to primary care appointments is a big problem.”
- “Many patients miss appointments because they don’t have cash to pay neighbors or relatives to drive them.”
- There are some assisted government –funded transportation options for special populations but these vans do not coordinate their times and routes. Collaboration between these special transportation services would maximize the number of patients served.

Even though conflicting opinions were voiced, HMA agrees there are huge problems with transportation and any proposed solution will have to identify the means to change the service or change the geographic distribution of the system.

## **Other Critical Issues Facing the River Region**

### **Public Education**

When talking with physicians and other business executives, it was clear to them that the lack of quality public education in Montgomery County was one of the main reasons it was difficult to recruit younger physicians and other health care professionals to the Montgomery region. While there are excellent private schools in the area, they are apparently expensive, costing as much as \$10,000 per year per student. This needs to be addressed when thinking about recruitment issues for professionals in the River Region.

### **Medical Information Sharing**

The HSI health centers have installed terminals in virtually all of their exam rooms and clinical support areas. The HSI health centers use a shared electronic scheduling system linked by servers housed on the second floor of the Lister Hill Health Center. Their two pharmacies are automated, but the prescriptions are hand-written and there is not access to patients' medication profiles in the clinics. The results of the laboratory tests performed by the HSI laboratories are not available electronically. HSI has not yet implemented an electronic medical record and has not created access to online medical references.

Medical information generated in the River Region clinics and hospitals is not electronically shared with other clinics and hospitals. Clinical data is only provided through the paper-driven "release of information" processes. Community health centers did note that hospital discharge summaries are reasonably easily obtained from their own physicians who are assigned to inpatient rounds. Clinical data from the hospital emergency rooms is difficult to retrieve. The Jail is not linked to the information systems of any of the private or public health systems in the River Region.

A cursory review of the zip codes of patient visits to the hospital ERs and the HSI centers revealed that patients who frequent HSI health centers originate from the same zip codes that generate large volumes of ER visits in the River Region. It is logical to project that visits to the MOM, the Montgomery AIDS Outreach Clinic, the Montgomery Area Mental Health Authority, the Montgomery Cancer Center, and other centers that treat the medically indigent and underinsured, and admissions to the Montgomery County Jail will undoubtedly have overlapping communities of origin with patients who are users of the hospital inpatient services and ERs and HSI health centers. There is a staggering amount of wasted clinical resources that are being duplicated when patients move back and forth between these various health settings.

Integrating the health information systems of the various hospitals and clinical services that provide care to the medically indigent and underinsured in the River Region Counties would have an immediate and ongoing positive impact on the continuity and quality of care throughout the River Region community. Having patients' laboratory and diagnostic tests and pharmacy profiles readily available at all points of care throughout the five counties would be a model for the USA. The avoidance of the duplication of testing

would result in significant savings for all entities involved in providing health care services to patients in the River Region.

The Montgomery Area Community Wellness Coalition has identified the development of region-wide health information sharing as one of its top priorities. A large amount of work has gone into planning such a system, but certain obstacles still need to be overcome prior to implementation. Shared River Region-wide health information that is accessible and still protects confidentiality is a goal that is attainable.

### **A Community Perspective**

The Montgomery Area Community Wellness Coalition, as noted on their website, is a community-managed, non-profit organization of health and human service providers who share information and coordinate resources to increase quality, efficiency and effectiveness of services within the River Region. The coalition is comprised of members representing the hospitals in the River Region, the Joint Public Charity Hospital Board, Community Care Network, Medical Outreach Ministries, Montgomery AIDs Outreach, The Alabama Department of Public Health Area 8, Health Services, Inc, Mid-AL Homeless Coalition (in a collaborative partnership with the Volunteer and Information Center), the Family Guidance Center, and Montgomery Area Mental Health. Their mission is “To conduct and support activities and services that improve health and wellness through coordination and information-sharing; health promotion and disease prevention; and by providing wellness case management services that help individuals and families at risk of or having diabetes, obesity or asthma to make healthy lifestyle changes, and/or to find and use health services and community resources.” As noted on the Wellness Coalition’s website, the purpose of the Wellness Coalition is threefold: 1) Identify and quantify the needs of the medically uninsured and underinsured population in the Montgomery, Alabama area; 2) Strengthen the health services infrastructure by coordinating the efforts of various agencies providing services to this medically uninsured and underinsured population; and 3) Increase access to appropriate resources for improving health and wellness.

**Reference:** <http://www.healthystepsalabama.com/>

At a meeting of the Goals Committee of The Wellness Coalition in early November the members shared the goals they are currently focusing on. These include:

- Every person to have a medical home - Their community wellness advocates are focusing on helping patients find medical homes and coordinating appointments and also addressing avoidable ER visits. They are not able to track the impact of the advocates on decreasing ER visits as they have no way of tracking. It is currently a manual system.
- Funding the Montgomery Area Information Network (MAIN) - Finding funding for information technology (IT) will enable them to integrate patient information into a shared database. This would not only help to avoid duplication of services, but would provide the data needed to track important indicators of well-being in the uninsured population.
- Life style education - The Coalition is also working on lifestyle education with a special emphasis on the poor. This has apparently not been a priority for the city or county governments in the past.

- Transportation - Transportation has been mentioned a number of times as a barrier to receiving health care. The coalition believes this is more of a critical problem in the rural areas.
- Affordable medications - While many of the social service agencies and the clinics provide medications, many are only able to provide one month or “first doses” based on their limited supply and/or lack of resources. Wal-Mart offers \$4 prescriptions and Publix offers specified antibiotics from a list for free with a physician’s prescription. Obtaining medications and refills is a challenge for the uninsured.
- Funding for Specialty Care - Specialty care seems to be provided at the “good will” of the specialists. There may still be high out of pocket costs for the patient. Access to specialty care for the poor is “hit or miss”.

## **River Region Stakeholders**

The stakeholders in the River Region vary significantly on the perception of the status of the health system as it impacts the community, economic vitality of the region and, in particular, vulnerable populations. A number of initiatives have the attention of the stakeholders, but there is still a serious disconnect in the perceptions of community leaders.

### **Government**

There is interest at all levels of government in the health care issues of the River Region. However, there is not consensus on the level of the problem, the need for intervention, or even whether there is a problem. Montgomery City and County officials have been asked to fund the replacement of one of the primary FQHC sites in the community as well as to dedicate more money to indigent care at the hospitals. Based on our discussions, we believe there is openness to attempting to help, but also a need to have the problem clearly laid out and the financial needs verified. This comes at a time when tax increases are not any more popular in the River Region than they are nationally.

Other government leaders in surrounding counties are also engaged. In Autauga County, there is a close relationship between the Baptist Prattville hospital and local leaders. At the city level they have also taken control of their own employee health costs in innovative ways gaining control of the previously spiraling increases by involving employees and stressing education and prevention. They feel they need an expanded hospital presence. The local providers don’t necessarily disagree, but cite the payer mix as an issue that makes achieving the community’s goals without aid from some source difficult to achieve.

In Elmore County, there are two small hospitals. These are Tallassee Community Hospital, a not-for-profit, and Elmore Community Hospital, a for-profit. County officials in Elmore know their hospitals are providing significant charity care, but believe they are managing and even improving.

In Macon County there appear to be sharp differences between the Mayor’s call for a new hospital and the Health Authority Board which has built a modern clinic facility that stands empty as they pay the debt on the facility. It is questionable how a hospital will fare

if the community cannot support a clinic. It is important to note that Macon once had a hospital, but that too closed.

Finally, when we reviewed self-reported amounts budgeted by individual counties, the amounts were extraordinarily low. Montgomery County budgeted \$107,955 and an additional \$85,000 for the Joint Public Charity Hospital Board, Elmore County \$1,000, Macon County \$18,000 and \$25,000 for the Health Authority. We do realize that other amounts go to mental health, public health, and support services for low income individuals, as well as indirectly help to fund Medicaid, but this overall level of support appears low compared to urban areas in Alabama, particularly Birmingham.

In terms of state officials, they are struggling with potential significant shortfalls in not just Medicaid funding, but in all general fund expenditures. The State of Alabama has had creative leadership in Medicaid and they have historically done a very good job of operating their program with a very tight state budget and only small growth in available funds. However, they may now be running out of ways to stretch their limited dollars and face challenges as do all states based on proposed new federal rules. Medicaid leadership remains very open to new ideas to help the River Region and other parts of the state. Legislatively, there is a feeling among some key leadership that until local government is willing to invest more money they are not inclined to help with state funds. They believe the need exists, but wonder if the community is prepared to step up. By contrast, a number of local officials believe they are already contributing in significant ways.

#### **Chamber of Commerce**

In many communities the involvement of the Chamber of Commerce in identifying health care for vulnerable populations as an issue and supporting solutions is critical to success. This is true in Dallas County, Texas and looks to have that potential in Kansas City. In Montgomery, health care does not seem to be on the Chamber's radar as a critical issue. They have mobilized in past years to assist in getting their Medicare payment level, which remains among the lowest in the country, increased. And they have expressed interest in assisting when asked to help recruit physicians for the Region. However, they were not sure they would get a huge response from CEOs if they held a meeting on the subject. Anecdotally they indicated many people in leadership receive their health care in Birmingham, not locally, due to a perception of quality differences.

#### **Ministerial Alliance**

This group seemed most involved in the current problems of getting health care for low income people in their community and most willing to unite to find solutions. At least three of the churches offer assistance in finding health care and making appointments as well as obtaining pharmaceuticals. But information on how the system works was not universal even among this group.

#### **Department of Public Health**

There is a serious effort to create a trauma system in the State of Alabama and the River Region is seen as one of the most problematic areas of the state in which to accomplish that effort. This is consistent with other issues identified as challenges in the River Region in terms of physician services and recruitment. The River Region has a high uninsured rate and level of poverty and the new businesses that have been attracted to the state have had

less impact on these issues than expected. The Department of Public Health was extremely knowledgeable about the issues and is willing to help if there is a role for them.

**Providers**

There is significant strain between providers. The change in “ER of the day” practices seems to be a lightning rod in terms of disagreements amongst providers, but the issues appear to be deeper. Clearly, providers agree on the need for relief from the costs of indigent care; however, they disagree on many other key issues. The difficulty in recruiting primary care physicians was alternatively described as a large issue, or not an issue at all, depending upon who was speaking. The problems with trauma care and the long-term impact on referrals of all kinds was also approached very differently. Another area of disagreement was whether increasing reimbursement for current patients or expanding coverage was more critical.

## **Section One Recommendations**

The recommendations that follow focus on expanding access to care by improving coordination and reducing duplication of services; expanding hours of services, especially during the critical evening hours; adding additional access points in communities of highest need; and improving recruitment of health professionals. It is extremely important to note, however, that these efforts are unlikely to be successful or sustainable in the absence of additional financial resources. In Section 3 below, HMA makes several specific recommendations to bring additional resources into the community, including targeted Medicaid coverage expansions and local coverage for the uninsured. These access recommendations must be viewed in the context of a concerted effort to bring substantial additional resources into the River Region.

### **Access to Health Care**

- **Expand Hours of Service at Community Health Centers that Accept the Medically Underserved**

There is no question that there is a palpable deficiency of evening and weekend hours where the uninsured and underinsured can receive primary care and low level urgent care. If in an after-hours clinic, sessions are simply shifted sessions from daytime to evening without adding additional numbers of sessions, there may be little notable gain to the primary care capacity for uninsured and underinsured patients. It is possible that there will be a somewhat different patient population that uses the evening clinic sessions (i.e. younger, working poor).

Lister Hill Health Center is the only HSI health center with evening hours and only on Tuesday evenings. The Lister Hill zip code, 36104, had 5,028 ER visits from Medicaid (2,599) and uninsured (2,429) patients in 2007. With the proposed Medicaid expansions, it might be financially feasible for Lister Hill to expand into evening and weekend hours with a particular focus on providing non-urgent walk-in services. None of the HSI community health centers have weekend or holiday hours. Likewise, the Montgomery Primary Health Center is located in the zip code (36108) that generated the most Medicaid and self pay ER visits in 2007. These are two of the three health centers where it would be logical to expand the availability of health care services. The third is Chisholm Health Center that is predominantly a nurse practitioner pediatric center; Chisholm zip code (36110) generates the 3<sup>rd</sup> highest number of "self-pay" and Medicaid visits in the River Region (4,924). It would serve little to simply shift daytime clinic hours to evening hours in these three HSI health centers. There is no guarantee that more patients will be treated; maybe a small undetermined number of ER visits might be deflected to these evening sessions. HSI has limited capability to expand without additional staffing. These HSI health centers are struggling to fiscally survive, making it unlikely that they could actually add additional hours of service by expanding their hours to evenings and weekends unless additional funding is made through either the recommended Medicaid expansion and/or the federal government, local government, grants, or charitable organizations that underwrite care for the uninsured.

- **Expansion of Dental Services**

Dental care for the underserved is considered to be the greatest unmet health care need in the USA. Given that the highest concentration of underserved live in the Montgomery area, it is important that the Lister Hill and the Montgomery Primary Health dental services, the only dental providers that serve the medically indigent, operate at full capacity. The dentist vacancy at Lister Hill needs to be expeditiously filled. The dental appointments at these two centers must be maximally booked. If staffing allows, evening and weekend hours need to be opened. The HSI health centers at Hayneville and Ramer have fully equipped dental suites that are currently unused due to budgetary limitations. With additional funding the three dental suites at Hayneville and the single suite at Ramer could be providing an additional 10,000 dental visits per year. It would cost approximately \$500,000 per year to staff and supply these fully equipped 4 dental suites on a full time basis. Although the projected cost per visit of \$132 would be a very affordable to the community given the huge amount of lost work time due to dental pain, it would be currently more cost effective to fund transportation from Lowndes and southern Montgomery County to the dental services at Lister Hill and Montgomery Primary Health Center than to hire the dental staff required to operate these two unused dental facilities. HSI needs to determine the payer mix they would need to have to make this service financially viable and set up appointment criteria to achieve it. For example, some clinics prioritize children and pregnant women. These are crucial populations to be served and also tend to have more funded patients. As money becomes available along with a plan for adult emergencies, dental care should be considered for covered services in the plan.

There exists a wonderful opportunity for the Dental Society(s) in the River Region Counties to establish a volunteer dentist, dental hygienist, and dental assistant program that could allow the expansion of dental hours at Lister Hill and Montgomery Primary Health Centers and even open a number of dental sessions at Hayneville and Ramer Health Centers. If a moderate number of the >150 dentists in the River Region volunteered 1 four-hour session per quarter, there would a dramatic increase in the availability of primary dental care for the medically indigent and underinsured.

- **Refer Uninsured Veterans to the Veterans Administration Outpatient Health Center**

The Veterans Administration has the capacity to treat and provide care to more outpatients at its Montgomery ambulatory care center. A system to identify veterans without adequate medical coverage in River Region hospitals and ERs, the MOM clinic, the HSI health centers, the UAB Internal Medicine Resident Clinic, the Baptist Health Family Medicine Clinic, the Montgomery County Jail, and the Montgomery Area Mental Health Authority (and others) must be instituted. Medically indigent veterans should be referred to the Veterans Outpatient Clinic for follow-up care. This could free up a number of appointments for uninsured and underinsured non-veterans in the already busy ambulatory health centers that provide care to the medically indigent. A meeting between the Montgomery Veterans Administration health care leadership and the medical leadership of HSI, MOM, the hospital ERs, et al to arrange a process that coordinates this process

needs to be arranged. The cost of implementing a medically indigent veteran's referral process in the River Region is negligible.

- **Establish Medical Home System**

Strong support should be given to the Wellness Coalition as they continue efforts to meet their goal: "Every person to have a medical home." The foundation of the Medical Home System of Care is the primary care provider who partners with the patient to coordinate and facilitate care. The medical home networks would be made up of an integrated system of primary care services (including behavioral health services), specialty care groups, and hospital providers. Although anchored by a primary care provider, it will be important to view the entire network as the medical home to assure the greatest potential for coordinated management of care and services delivered.

- **Build New HSI Facility**

The Lister Hill Health Center is housed in an aging structure whose maintenance will continue to consume already limited resources. The layout of the physical plant limits the ability of the Center to create an optimally efficient flow of patient services and interferes with the clinic's productivity. A new expanded Lister Hill that is located in a similar community, preferably the same or adjacent zip code, where there exists a patient population that is uninsured or underinsured and who currently utilize the expensive local ERs for services, could be provided in a primary care setting. It must be remembered that for an FQHC to survive it must attract significant numbers of patients who have medical coverage, especially Medicaid. While we understand that there is currently a request to directly fund a replacement facility (located near Jackson Hospital), we would recommend a new facility in or near Lister Hill's current location based on the zip code analysis. While this site may not necessarily attract the traditional Medicaid population, at least a modest increase in insured patients may result if several Medicaid expansions recommended in Section 3: Financing are implemented. HMA also believes this effort is worthy of community funding, either directly by foundations and/or governmental entities and/or bank financing and bridge financing to be arranged or guaranteed by local governments. However, any funding should be related directly to patient volume and/or expanded hours.

- **Construct Additional Comprehensive Primary Care Site(s) in Montgomery**

The construction of additional health centers in or near zip codes that currently generate a large number of underinsured visits to the Montgomery area hospitals would definitely increase access to primary care for a number of uninsured patients. The largest number of underinsured patient visits to the three major hospitals live in zip codes 36108, 36116, 36110, 36104, 36105, 36107, and 36109.

| Zip code | Jackson  |          | Baptist South |          | Baptist Prattville |          | Baptist East |          | Totals   |          |
|----------|----------|----------|---------------|----------|--------------------|----------|--------------|----------|----------|----------|
|          | Medicaid | Self-pay | Medicaid      | Self-pay | Medicaid           | Self-pay | Medicaid     | Self-pay | Medicaid | Self-pay |
| 36108    | 1362     | 1991     | 2,900         | 2,422    | 162                | 171      | 572          | 327      | 4996     | 4911     |
| 36116    | 584      | 1015     | 3,178         | 2,911    | 22                 | 39       | 867          | 728      | 4651     | 4693     |
| 36110    | 950      | 1205     | 754           | 531      | 69                 | 81       | 840          | 494      | 2613     | 2311     |
| 36104    | 1326     | 1491     | 1,034         | 780      | 21                 | 29       | 218          | 129      | 2599     | 2429     |
| 36105    | 607      | 863      | 2,014         | 1,641    | 16                 | 27       | 187          | 169      | 2824     | 2700     |
| 36107    | 596      | 1102     | 338           | 413      | 22                 | 30       | 310          | 311      | 1266     | 1856     |
| 36109    | 312      | 659      | 233           | 291      | 12                 | 36       | 444          | 467      | 1001     | 1453     |
| Subtotal | 5737     | 7224     | 10,451        | 8,989    | 324                | 413      | 3,438        | 2,625    | 19950    | 20353    |

HSI currently has clinics in zip codes 36108, 36104, and 36110 (Chisholm site - mostly children). MOM's existing site is in zip code 36104. We are aware of the pending proposals to construct new facilities. HSI has a proposal to replace their Lister Hill site with a new facility near Jackson Hospital that would operate a comprehensive health center with an after-hours, non-urgent care alternative to the ER. MOM has a pending proposal to locate a facility in zip code 36116, one of the zip codes listed above that generated 4,693 uninsured visits to the ER last year. HMA believes that new facilities will need to be constructed to meet the primary care needs of the underserved populations in Montgomery and surrounding counties. This report provides the data to allow the community to make its own best decision on where additional and/or replacement facilities should be located.

- **Expand the Medical Outreach Ministries (MOM) Health Center at its Current Site**

The MOM serves only adult patients without medical coverage. This is the patient population for whom it is most difficult to identify a consistent source of health care. These patients commonly do not have a medical home. The current MOM space limits the clinic's ability to expand services. As noted above, the location of the MOM existing site is a zip code in need of more primary care. With a physical expansion of the current space, MOM could provide services to more uninsured adults.

- **Increase the Number of Uninsured and Medicaid Patients on the Panels of the Residents at the Family Medicine and Internal Medicine Ambulatory Health Clinic**

Both the Baptist Health Family Medicine Clinic and the UAB Internal Medicine Resident Clinic accept uninsured and Medicaid patients; however, due to the fiscal pressure of the programs, the numbers of patients in these categories are quite limited. Traditionally throughout the USA, resident outpatient clinics serve a high percentage of medically indigent patients. This is especially true in urban public hospital programs but is also the case in private and not-for-profit hospital programs. For these programs to expand the coverage of the uninsured and underinsured, they must be provided with a reliable funding source that will

support this needed service. It would be worthwhile to explore the feasibility of bringing these programs under the existing FQHC as a strategy to increase Medicaid revenues. However, there are federal requirements that must be considered as well as federal approval. It may also be worthwhile to see if there is any room for Medicaid to make IME payments to the hospital for indirect education costs with a portion to be directed here.

- **Implement School-Based Clinics**

School-based health centers help to support treatment for relatively inexpensive services that treat children with acute and chronic illnesses. Most school-based clinics are staffed by a mid-level provider, nurses, and a clerk. They predominantly do school physicals, vaccinations, some acute care (minor injuries, viral syndromes, asthma care), and family planning education and interventions. They are most valuable in schools with a large number of children from low income families. School-based health centers have been shown to be instrumental in minimizing absenteeism for self-limited diseases. Because school-based clinics do not offer after-hours consultation or summer session services, they do not qualify as true medical homes for children; however, in partnership with an FQHC or similar partner, they have the potential to fill service gaps not only for children but for their parents as well.

- **Fund a Discharge Planner at Montgomery County Jail to Coordinate Follow-up Primary Care Appointments for Men and Women Being Released to the Community**

The rates of acute and chronic medical and surgical illnesses in men and women detained in county jails are much higher than in similarly aged populations in the community. Coordinating needed medical care in the community for detainees being discharged from the Montgomery County Jail is part of any comprehensive safety network health care system. Sustained funding for a discharge medical care coordinator is needed.

- **Improve Access for the Medically Underserved to Specialty Services**

With the exception of inpatient specialty consultation or an hour trip to Birmingham, the uninsured in the River Region have extremely limited access to specialty consultation and even patients with Medicaid and Medicare have diminished access to timely specialty appointments. Currently, funding from the Joint Public Charity Hospital Board, the United Way, and the “good will” of select specialists allow for some access to specialty consultation in the River Region counties. Ideally, increased federal, state, and local governmental funding for specialty care would allow for expanded or even partial financing of specialty care for the medically indigent. The potential for “write-offs” for medically indigent care is unlikely but is worth investigating.

- **Secure Grant Funding for AIDs and HIV Specialty Services**

An additional \$250,000 in one time unrestricted grant monies for the Montgomery AIDS Outreach Clinic in Montgomery would allow them to bring a like amount of additional federal funding to the community to pay for services for this population.

- **Expand Community-Based Outpatient Mental Health Services**  
Access to mental health services for the medically underserved in the River Region is extremely limited. The Montgomery Area Mental Health Authority, the Montgomery County Jail, the Veteran's Administration, and the Montgomery Primary Health Center provide mental health services to the medically underserved but the need far exceeds the capacity of these centers. This is a major public health deficiency that requires governmental attention and funding.

In order to increase access to outpatient mental health care, there needs to be an expansion of numbers of all categories of mental health providers serving both adults and children in the River Region Counties. Additional psychiatrists, case managers, and direct care mental health workers are needed.

- **Improve Systemic Coordination of All Agencies Serving Mentally Ill Children**  
In order to effectively address the mental health needs of children, there needs to be systemic coordination by all agencies providing physical and mental health care to children. Given the limited resources, any duplication of services is wasteful and costly. All agencies must be electronically linked so that key information can be shared and readily available to maximize the delivery of care to this vulnerable population. This coordination is needed at the local, region, and state levels. Collaborating agencies should include the Department of Human Resources (DHR), Education, Public Health, Department of Youth Services, the Juvenile Judicial System, and private and public mental health centers and providers.
- **Increase Supported Housing and Community Beds for Mentally Ill Adults**  
Although there are inpatient beds being constructed to serve patients with adequate coverage, there exists a shortage of beds and supportive permanent and transitional housing for the medically indigent and underinsured. This results in the constant recycling of mentally ill adults through ERs, acute inpatient units, and Detention facilities. Until adequate access and fully staffed outpatient mental health services are available, protective and supportive housing and inpatient beds will be needed in the River Region Counties.
- **Support the Recommendations of the Region III Mental Health Taskforce**  
The State Department of Mental Health and Mental Retardation Region III Taskforce is in the final stages of formatting its recommendations concerning the mental health needs in the River Region. Their recommendations should be used to prioritize efforts to improve the access of the mentally ill to services in the River Region. *(HMA did not meet with the Taskforce but received a copy of the Taskforces' potential recommendations.)*

## **Emergency Room Services**

- **Open Non-Urgent Care Opportunities on Campus at Baptist South and Jackson Hospitals**

The Emergency Rooms at both Jackson Hospital and Baptist South are extremely busy. Both ERs serve a large number of patients who are “self-pay” or have Medicaid coverage. ER specialists stated that more than 40% of the ER visits are for conditions that could have been managed in a less intensive clinical setting. It is in the best interest that the hospitals develop and fund on-campus or near-campus urgent care capabilities. For example, Jackson may be able to fund an Urgent Care physician in its primary clinic setting. Baptist South could place an Urgent Care physician at one of its residency sites to deflect non-emergent patients from the ER. This, combined with the recommendations above on Access will help alleviate the issue of ER overcrowding. In addition, ERs should establish protocols to ensure that patients who present and/or are treated in the ER are referred back to a primary care setting to establish a regular medical home for these patients.

- **Create Separate Emergency Room Waiting Areas for Adults and Children at both Baptist South and Jackson Hospitals**

Multiple providers strongly voiced their dissatisfaction with the physical environment in the ER waiting rooms at Baptist South and Jackson Hospital. The mixing of pediatric and adult patients in very congested waiting and treatment areas was unacceptable, not only to these providers, but also to many of their patients. There was discussion about the need to create different triage and treatment areas for children and adults in these Emergency Rooms.

## **Recruitment and Retention**

- **Establish an Ongoing Health Professional Recruitment Taskforce for the River Region**

The River Region should establish an ongoing Health Professional Recruitment Taskforce. The Taskforce will implement and track progress on the recommendations noted in this section and work closely with all the local hospitals. The Taskforce should have representation of business, government, education, medical professional education, health professional societies including medical, dental, mental health, nursing, mid-level societies, local hospitals, HSI, and other community leadership groups. Interactions with the state and federal governmental entities will require the active involvement of the Montgomery Area Chamber of Commerce and local elected officials.

- **Emphasize Positives of the River Region Counties as a Practice Choice**

Beautiful topography

Bountiful outdoor recreation opportunities

The presence of the State Capitol creates a stable economic practice environment

Even rural practices are within 30-45 minute drive of Montgomery

2 hours from Gulf of Mexico

Variety of education choices  
Proximity to Birmingham/Atlanta  
Expanding cultural, recreational, culinary opportunities  
Increasing community development

- **Involve Entire Community in Recruitment Process**  
The business, church, political, educational, and community leaders must participate in the recruitment of health care professionals to the River Region Counties. Hospital, group practices, and health systems must remember that they are “not just recruiting a doctor but an entire family”. The Montgomery Area Chamber of Commerce, which fully understands that each physician is a million dollar business, should be fully engaged in this process and has indicated a willingness to do so if asked.
- **Continue to Expose and Encourage Young Students in the River Region to Select Careers in Health Care**  
Health professionals should regularly lecture about their careers and the health career opportunities in grammar schools, high schools, and local colleges. One of the leading reasons that medical providers and other health professionals choose a practice site is the proximity to their parents and siblings. The leaders in the River Region Counties must continually encourage and support high school, college, and health professional school students who are most likely to return to the River Region area. The River Region’s Health Profession Societies must be actively involved in the coordination and ongoing implementation of this recommendation.
- **The River Region Should Provide Scholarships/Financial Assistance to Medical and Dental Students and Advanced Practice Providers (Nurse Practitioners and Physician Assistants) Students From These Five Counties**  
Even students from the River Region who are enrolled in out-of-state health profession schools should be eligible for these scholarships. Students with these scholarships will be obligated to return to the River Region for a defined number of years. Although the yearly cost per professional scholarship can exceed \$30,000, it will be cost effective in the long run for the health care system in the five-county region. The Chamber of Commerce and the business community should take the lead in identifying funds for the establishment of this scholarship program.
- **Track Medical, Dental, Nursing, Health Professional Students from Alabama**  
The River Region should work with the State of Alabama to maintain a list of the students with an Alabama, and especially a River Region County, home address who are enrolled in medical, dental, nursing, and health professional schools. These students should receive ongoing communication advising them of opportunities and advantages of eventually working in central Alabama.
- **Alabama Medical, Dental, and Other Health Professional Schools Should Give Preferential Admission to Qualified In-State Students**  
This may already be happening, but qualified River Region students must be equitably represented in the enrollment classes of all the professional schools in the State of Alabama.

- **Alabama Medical, Dental, Nursing, and Allied Health Professional Schools Must be Encouraged and Pressured to Instill Medical, Dental, Advanced Practice, Nursing, Ancillary Health Students with an Accountability to Their Home Communities and Foster Linkages with Existing Health Care Providers and Hospitals in Medical Students' Home Communities**

The State of Alabama academic health training schools have a primary obligation to strive to recruit students who represent all the communities of Alabama and to have elements of their training programs that continually expose students to the value and importance of serving their home communities.

- **Continue to Support Residency Training Programs in the River Region Area and Expand the Opportunity for Residents in Primary Care and Specialty Residencies to do Rotations in the Montgomery and River Region Practices/Hospitals**

Physicians very commonly decide to stay in the community or hospital system where they did some or all of their residency training. Young physicians find it very attractive and less anxiety provoking if they join practices near their training programs. It is not uncommon for them to have had interactions with the area's providers and therefore to be somewhat "known quantities" to some of the physicians in the community. Residents with families may have already bonded and developed roots in the community.

- **The River Region Leadership Needs to Implement a Long Term Plan, Vision, and Commitment to the Recruitment of Health Professionals to the Five County Area**

This will demand patience and persistence. Contact may begin with high school or college students, continuing through medical school and then 3+ years of residency. Although results may begin to be seen in 2-4 years, the lag time may be as long as 8-10 years before there would be a steady stream of physicians, dentists, and nurses back into the River Region.

- **Advocate the State and Federal Level for an Increase in the Availability of National Health Service Corps (NHSC) Scholarships and Loan Repayment Options**

Federal scholarships during medical and dental school commit medical students to serving in underserved communities and centers for a number of years after the completion of residency training. Loan repayment programs can be obtained by physicians with outstanding private loans that financed their graduate education, if they commit to working for a specified duration of time in health manpower shortage communities and centers. These scholarships are invaluable in recruiting young physicians into needy communities. Some of these providers will stay after their obligation to the government is fulfilled.

- **Advocate at the State and Federal Levels for Medical School Expansion**

The entire country is competing for a limited number of physicians. The medical schools are not expanding at the rate the US population is growing. A large number of qualified medical school applicants are turned away each year because

there are not enough available openings. Yet each year US hospitals have to recruit internationally to fill 20-30% of their residency positions. This issue needs to be immediately addressed at the national level. The River Region's elected officials and the business and medical leadership must be directly engaged in this recommendation that will have long range impact on the availability of health care services in the River Region.

## **Transportation**

- **Communication Regarding Existing Services**

During our discussions with state, regional and local transportation leaders, it was clear that there are services currently available that not everyone understands are there or how to access them. It also appeared that there is additional federal funding available for some communities to add services. While there is work going on in the community to better understand the options, this information needs to be communicated to the wider community. Churches, United Way, provider groups, and others need to fully understand the current realities and possibilities. Any forum on health care should have a transportation component. The leadership people in this area appear very knowledgeable and willing to help.

- **Improved Coordination of Services**

Many states have gone to a network management system or "brokerage" concept for Medicaid transportation. This could be expanded to all populations in the River Region, assuming a funding source can be found for indigent care transportation. This "broker" would be responsible to assure the underserved, "hard to reach" geographical areas had adequate options for transportation to medical appointments. The network manager would establish a call center to manage the efficient operation of the type of transportation needed and to make sure it was timely. The broker would be responsible for the quality of service provided through a network of commercial, not-for-profit, and volunteer resources. It could also work cooperatively with Medicaid to compare transportation claims to medical claims to not only identify fraud, but also guarantee program integrity.

The state pilot program in Lee and Russell Counties should also be monitored for potential implementation in the River Region. This program breaks down the funding silos that have limited certain transportation based on population group or service creating inefficient use of scarce resources.

## **IT Infrastructure**

- **Implement an Information System to Effectively Share Clinical Information Between the Providers of Care to the Medically Indigent**

Integrating the health information systems of the various hospitals and clinical services that provide care to the medically indigent and underinsured in the River Region Counties would have an immediate and ongoing positive impact on the

continuity and quality of care throughout the River Region community. There would be significant cost savings. If the existing systems cannot be readily integrated, then placing a computer terminal or linkage in each clinical setting where care is frequently provided to the medically indigent should be done. Clinical sites that should be priorities for the sharing of medical information include the hospital Emergency Rooms, the HSI health centers, MOM, Montgomery AIDS Outreach, the Montgomery Area Mental Health Authority, the Montgomery County Jail, and other private and public clinical settings where the uninsured and underinsured receive care. Medicaid currently has a number of initiatives in this area. To the extent it involves patients who receive Medicaid funding, one of these initiatives may help or a new initiative could receive some federal reimbursement if coordinated through Medicaid.

- **Support Wellness Coalition Efforts**  
The Coalition has a goal to identify funding for information technology (IT) that will enable them to integrate patient information into a shared database. This would not only help to avoid duplication of services but would provide the data needed to track important indicators of well-being in the uninsured population. This is a superb project that needs to be aggressively encouraged and supported.

## **Community Wellness and Health**

- **Teach, Facilitate, Encourage, Enable, and Legislate Healthy Lifestyles**  
There is universal agreement that teaching, facilitating, encouraging, and enabling healthy lifestyles is the most cost effective and logical approach to improving the health of all individuals and communities. Healthy children are better positioned to succeed in school and are more likely to become healthy adults. Healthy adults are more productive members of the workforce and consume fewer health care resources. It is the obligation of levels of society, business, and government to insure that all communities have accessible and safe parks, walking paths, bike paths, community centers and recreation centers. All individuals of all ages must be consistently provided with information about healthy diets and promote healthy foods. Schools are important settings to provide health education and serve only healthy lunches and snacks. Health is the responsibility of everyone in every community.
- **Support Community Efforts to Establish Youth Fitness Centers in the River Region**  
Children who complete programs that encourage fitness and healthy lifestyles will not only be better prepared to maintain a healthy lifestyle, but may also be an effective conduit for bringing healthy education and healthy habits back into their families. The YMCA is implementing one example of such an effort. They are establishing Youth Fitness Centers at nine YMCA's in Montgomery and Elmore Counties. After-school programs of eight weeks duration will be given to groups of 8-12 primary school children. The program will include exercise training and

exercise habit development, use of exercise equipment, utilization of interactive exercise video games, provision of nutritional snacks, and health food education.

## **Section 3: Financial Analysis**

### **Medicaid**

To understand the financing of health care for low income individuals, it is important to understand a little about Alabama Medicaid, the state and federal partnership that funds health care for low-income populations.

In 2006, the most recent year for which data is available, total state and federal Medicaid spending in Alabama was nearly \$3.9 billion. Of this amount, approximately \$2.1 billion was spent on acute care services, while \$1.3 billion was spent on long term care services. An additional \$416 million in disproportionate share hospital (DSH) payments were also made. With a federal matching rate of 69.51 percent in 2006, the state share of overall Medicaid spending was roughly \$1.2 billion.

The state's share of Medicaid spending is funded through two primary sources: general fund appropriations and "other state funds". General fund appropriations represent only 32 percent of the state share, with the remainder composed of public hospital transfers (36 percent), departmental receipts and intergovernmental transfers (17 percent), other sources, such as drug rebates and the Medicaid Trust Fund (11 percent) and the Alabama Health Care Trust Fund (4 percent). The Medicaid Trust Fund is supported by funds appropriated to the Medicaid Agency from any source which has not been expended or encumbered at the end of any fiscal year, while the Alabama Health Care Trust Fund is supported by a tax levied on all providers of pharmaceutical services and nursing home care.

Because a relatively small percentage of Alabama's Medicaid program is financed through general fund appropriations, the state's use of "other state funds" has come under considerable federal scrutiny. In particular, the state's aggressive use of the DSH program, intergovernmental transfers (IGTs) and provider taxes to finance the bulk of the state match for Medicaid has been subject to a number of reviews by federal oversight agencies. Reports issued in 2004 and 2005 by the Department of Health and Human Services Inspector General's office called into question the state's compliance with federal DSH and upper payment limit rules and recommended that the state return more than \$73 million in overpayments to Alabama health care providers. The primary objection raised by the federal government was the lack of transparency in the state's distribution of DSH funds and Upper Payment Limit (UPL) payments. Under the state's current payment structure, DSH funds are folded into the capitation rates paid to the state's eight prepaid health plans (PHPs). This structure enables the PHPs to distribute DSH payments as they choose and without regard to federal rules.

While the state has historically disagreed with the federal government's assessment, the state has agreed to eliminate the PHP hospital reimbursement program and replace it with a new hospital payment system. At the outset of the planning for this new system in January 2008, the state has announced its intention to implement a system that will be "budget neutral" for the hospital program.

In addition, the state has undertaken a number of redesign initiatives, ranging from pharmaceuticals to IT infrastructure. The state has been and continues to be a creative and resourceful organization. Our discussions with them indicated they were willing to listen to new ideas and implement them if practical and within federal constraints.

### **State Budget and Constitutional Issues**

No discussion of public financing of health care in Alabama would be complete without a discussion of the constitutional impediments to developing a new health care financing strategy.

Unlike the United States Constitution, which delegates taxing authority to Congress, the Alabama Constitution contains hundreds of tax provisions that limit the type and level of taxes that can be imposed. Among other provisions, the Constitution caps the state's income tax rate, mandates certain deductions, delineates the process for assessing the value of property and strictly limits property tax rates. Neither the state legislature nor local governing bodies have taxing authority, leaving many changes in the tax system subject to a constitutional amendment passed by voter referendum. As a result, Alabama's constitution has more amendments than any other state constitution.

Expenditures of tax revenues are similarly restricted, as the state earmarks more of its revenue through constitutional or statutory provisions than any other state. With nearly 90 percent of state revenues earmarked, flexibility to reallocate tax revenue to meet changing financial needs is severely restricted. Constitutional impediments to taxing and spending have limited the state's ability to respond to the needs of its people, particularly those related to health care. While this has been a longstanding problem in the state, it is likely to be felt more acutely as the state begins to examine options for replacing its current hospital payment system. The share of state general funds allocated for Medicaid is already low in comparison with other states and the potential loss of DSH and UPL payments supported by "other state funds" could have a devastating effect on the Medicaid program.

### **Hospitals**

The financial health of a community's hospitals is often seen as a barometer for the soundness of the health care system at large, and in some cases, is a predictor for issues that will arise in the future. Therefore, any financial analysis related to health care in a particular region must include the area's hospitals. An analysis of issues affecting hospital finances reveals some issues that will bear watching; however, it does not appear necessary to push the "panic button" at this time. This does not mean there are not issues, nor does it mean that there are not steps that should be taken to shore up the financial situation of the hospitals. It may be the case, however, that there are other issues extrinsic to the hospitals themselves that have a greater impact on the indigent and uninsured populations of the area.

Since the Baptist hospital system and the Jackson hospital system are the two major hospital providers in the River Region, the bulk of this discussion focuses on these two players. In addition to representatives from Baptist and Jackson, HMA met with

executives from both Hospitals in Elmore County and conducted a desk review of documentation from these hospitals. Representatives of Community Hospital in Tallassee indicated a desire to improve that hospital's financial situation. Specifically, while they expressed concern over their ability to maintain their capital assets, carry indigent patient loads, and recruit physicians, our review indicates that they appear stable at this point. Both hospitals in Elmore County, as well as the Baptist Prattville facility, are affected by the decisions made by providers based in Montgomery in the area of trauma care, primary care competition and specialty physician services. These will be discussed later in this section.

### **Baptist Hospital System**

Baptist recently became part of a Health Authority under the University of Alabama-Birmingham (UAB). In addition to creating changes in leadership and governance, this new arrangement bestows some financial advantages on the hospital. The Baptist system history is not recounted here; however, it is important to note that the system expanded during a period when market prices for hospitals were at a premium, and there was a later retrenchment when the market was down. The net result is that the system has an unusually high debt load for an organization with its asset profile. At the same time, Baptist has significant cash and investment balances – that are well above similarly situated providers. While the cash on hand gives the system a cushion in the short run, the debt load will continue to be a long-term challenge. The net result is that the trend in payer mix and the age of the physical plant, while important to all providers, is especially important to Baptist. In addition it will be critical to maintain volume to keep the capital cost component from increasing.

While patient volumes in the facilities have been consistent and growing, the average age of plant is 12.2 years which is much higher than desired. Payer mix has also weakened. While the proportion of self-pay patients has climbed at all facilities over the past three years, it is of particular concern at South and Prattville, where it has reached 11% and 12% respectively. While these would be exceptionally positive numbers at a public hospital receiving tax support, they are more than double what is expected at a private hospital. This issue is compounded by the fact that Medicare rates in this metropolitan statistical area (MSA) are lower than most of the rest of the country. It should also be noted that South and East have Medicaid utilization rates of 16% and 14%, respectively. The private insurance numbers for Baptist in 2007 ranged from a low of 35% at South to a high of 49% at East. The dominant commercial carrier is Blue Cross, which represents about 75% of the commercial business at these hospitals. This extraordinary leverage position most likely leads to less cost shifting opportunity than in most markets. An added challenge is the need for the State to restructure some critical programs, particularly inpatient and supplemental payments including disproportionate share hospital payments.

In spite of the challenges cited above, Baptist has been able to maintain good financial performance. Prattville's margin was only in the 2.5% range in 2007. While this performance is good, it may not be strong enough to justify building a new hospital. Baptist East has performed most strongly, with a margin of almost 11% in 2007. While this margin is budgeted to decrease in 2008 to around 8%, it is still a very strong

performance. Baptist South lost money from operations in 2007 for the first time in the last three years. While the Hospital is budgeting an improvement in 2008, it still projects a loss from operations. The facility's non-operating earnings, including investments, more than made up for the loss. While the operating income has been eroding, the non-operating income has kept their total net income above 10% for the last two years. It is important to note that the 2008 budget projects this margin to drop to just over 6% in 2008.

The Baptist system is critical to the stability of the health care system in the River Region. Based on the financial information we have reviewed, it appears to be a stable system in no immediate jeopardy, however, there are long term issues related to a continued decline in payer mix, the plant age, and debt structure. These factors make it more difficult for the system to move quickly to invest in services needed by the community, particularly trauma, without some relief in the future.

### **Jackson Hospital**

Jackson Hospital has experienced improved financial results over the last three years despite a growth in self-pay patients as a percentage of total volume. The hospital's operating margin has only been around 2%, but the total margin has climbed above 3.5% for the year that ended in February 2007. Uncompensated care, including bad debts has grown from 6.7% in 2006 to 7.8% in 2007, with all the growth attributed to charity care. It is important to note that, through the first 6 months of the 2008 fiscal year, uncompensated care returned to a level more consistent with prior periods despite a growth in self pay revenue. Still, the level of uncompensated care is above national averages for private hospitals. Both Medicare and Medicaid revenues have been relatively stable, although Medicare revenues have shifted somewhat to HMOs. Consistent with the Baptist experience, however, Blue Cross is the dominant commercial payor, accounting for 75% of the hospital's commercial insurance (including HMOs) volume. This level of dominance limits the hospital's ability to cost shift to assist in caring for patients funded through governmental sources or without coverage. Jackson's cash balances, while not as strong as Baptist's, are consistent with a healthy hospital, even after coping with a transition to a new IT system. Volumes continue to improve, although the average age of the plant remains a concern. While lower than Baptist, at 9.3 years, it remains higher than the ideal average age.

On balance, Jackson Hospital has seen its financial situation improve over the last few years. While the high self pay volume is less than ideal and has contributed to a less than optimal margin, Jackson's financial viability may be somewhat at risk. Further, its average age of plant exceeds the desired level. However, with strong days, cash on hand and improving margins, it appears stable. This can all change when Medicaid makes its required changes in response to federal rules, as Medicaid accounts for nearly 10% of the volume at Jackson.

### **Other Regional Hospitals**

Decisions made in Montgomery, along with the status of Baptist and other hospitals, have significant impact on all patients in the region. The lack of a strong trauma service in Montgomery has created problems for the surrounding hospitals' emergency departments

and for their overall ability to provide care. HMA heard anecdotal accounts of individual cases that were held up in emergency rooms in smaller communities because no hospital in Montgomery hospital would accept the patient, creating situations in which the physicians were kept from being available to other patients. Smaller community Emergency Rooms are increasingly busy due to population changes and changes in practice patterns of primary care doctors. More and more emergency patients are being transferred to Birmingham or even out of state, and this trend is seen in elective care as well. If this trend continues, it will become even more difficult to maintain specialty services in Montgomery at the current levels.

### **Specialist Community**

The stronger the specialist community is in Montgomery, the more likely some specialty services can be provided in more rural settings leading to increased vitality for providers and a steady referral base for Montgomery. It is important to coordinate and not duplicate services, since in areas where resources are always going to be thin, any duplication is problematic. This can be especially true in primary care, where the need for resources closer to the patients will always exceed the ability to pay for them. Past practices such as locating competing practices in close proximity to each other in very small communities are unacceptable, and should be avoided through improved communication and planning.

### **Section Three Recommendations**

As stated above, issues identified in other sections of the report may have a more immediate impact on the ability of the uninsured and underinsured residents of the River Region to access care. Chief among these are workforce issues, including the increasing average age of primary care providers and specialists. Clearly, these issues are intertwined with the financial health of hospitals and the system at large. Sections 1 and 2 include specific recommendations relating to these issues. If some or all of these recommendations can be implemented, then the strain on hospitals that is created by over-utilization of the ER can be reduced. Without some attention to increasing the amount of sustainable financing for the system at large, however, the efficacy of the strategies identified elsewhere will be limited.

The goal of these strategies is to protect and sustain the region's financial resources in the long term, thus allowing the flexibility to more aggressively recruit health care professionals to the community and provide needed expensive services like trauma.

### **Creation of a Health Authority**

The first issue to be explored is one that has already been utilized in the case of Baptist: converting to a Health Authority. The immediate benefits of this approach are an exemption from sales tax and a likely exemption from antitrust regulations in working with other providers in the region. A Health Authority also carries with it a potential to increase some reimbursements. There are two types of Health Authorities: one organized under a city or county, which appoints the majority of the Board, and another organized under one of the Universities, which would appoint the majority of the Board.

While the sales tax savings alone is significant, there are other advantages to converting to a health authority as well. Private hospitals that can coordinate with public hospitals for the provision of care create both positive reimbursement potential and flexibility in meeting the needs of the community. Potential barriers to pursuing a health authority strategy are presented by Jackson Hospital, which is clearly not interested in ceding control to a Health Authority Board and new federal rules regarding reimbursement to public entities, which need to be taken into consideration.

#### **Expansion of Medicaid Eligibility**

Another strategy with significant potential to increase funding to the entire system is to expand Medicaid eligibility. Under federal law, Medicaid eligibility can be conferred to groups of individuals considered "categorical," i.e., children, parents, pregnant women, and the aged, blind and disabled. Non-pregnant, non-disabled adults without dependent children cannot be made eligible for Medicaid without a waiver of federal Medicaid rules.

In light of the discussions above regarding the constitutional financing structure and the current status of the Medicaid budget, HMA understands that there is no appropriation of general fund monies available to pay for an expansion. The potential tripling of available resources resulting from a Medicaid expansion must be strongly considered, particularly since there are a variety of ways of creating the state share of payments. Currently, many county tax revenues are utilized to generate match. While the local tax situation does not make it reasonable to expect new taxes to be raised for this purpose, as funds become available at the county level (primarily through expiring debt payments), Montgomery County should consider redirecting this money to a local Medicaid expansion. HMA's discussions with representatives of the State Medicaid agency indicate they would be willing to consider this approach, and we believe that other communities would choose to participate as well, creating a statewide network. In the meantime, the match for an expansion should be sought by re-examining all funding streams for matchability and considering a regional hospital tax to pay for coverage.

It is also important to understand that Medicaid expansions bring the added benefit for hospitals of potentially increasing their Medicare reimbursement. This occurs because the Medicare program pays an additional amount for the care of Medicare recipients to hospitals with higher Medicaid utilization. If the goal is to spread Medicaid patients to all providers willing to care for them, then a regional tax will make the most sense. If this is not possible due to constitutional constraints or other hospital tax issues, another option would be to involve the state to assume a portion of the costs of educating health care professionals at state supported schools. In either case, a certain amount of state match can be generated. Using rough calculations, if the State could generate \$12 million in match, it would create \$40 million to cover approximately 10,000 people. As explained above, this approach works for categorically covered individuals. Another way to finance the expansion would be to limit the network for this new group of eligibles to Health Authority hospitals and clinics. This would require a waiver to limit choice, but could be replicated across Alabama. Health Authority providers could certify the match for this population and be paid about 70% of their cost for serving this expansion population.

Childless adults would still not be covered under these plans. It is not practical to seek a federal waiver to cover these populations due to the impact on the entire provider community in Alabama, as funding for this program would require coordination between the hospitals. If the Health Authority would fund the state share of a Medicaid supplementary payment which would be limited to the state upper payment limit for private hospitals, additional funds would flow to Jackson Hospital. If Jackson were willing to fund a program for indigent health care purchased from a third party, it would be possible to create an insurance-like program for childless adults. The funding here will not be able to meet all the need, but by covering some patients an opportunity is created for HSI and others to direct the limited resources available to the remaining indigent.

These programs would not only benefit the Hospitals, but would also move many HSI and UAB Residency patients from indigent care to Medicaid. They would also create a payment source for specialists, although, many specialists would still be reluctant to care for these patients at the reimbursements available. At the same time an enhancement to physician rates could also be created. Euphemistically called the physician UPL program, many states provide higher rates for those who treat larger than average Medicaid populations. This approach has been primarily utilized for Faculty practice plans, but it could be adapted here as required, possibly for specialists willing to take trauma call or more than a specified number of Medicaid referrals. Our understanding from another consultant active in Alabama is that Alabama has a program, but it has not been available in the River Region because of a lack of a host partner.

#### **Coordination of Action**

If the community is going to make the health care system for all residents of the River Region a priority, then some method for monitoring progress and assuring the system works must be implemented. Avoiding duplication of effort and unnecessary and unproductive meetings is critical to continued buy-in by stakeholders. We recommend taking advantage of existing resources wherever possible. The leadership group must have broad representation, but be small enough to get things done. It must also have the ability to develop influence or actual authority over resources, and balance provider needs, community needs, and the requirements of government. We would suggest the following structure:

#### **Coordinating Council**

Representatives from:

- 1) Montgomery County Commission
- 2) Montgomery Mayor's office
- 3) Rotating member from one of surrounding counties governments
- 4) A primary care physician
- 5) Two specialists, one hospital based and one other
- 6) HSI
- 7) Ministerial group
- 8) Montgomery Area Chamber of Commerce
- 9) Rotating member from Gift of Life/MOM/etc
- 10) Montgomery hospitals' CEOs

- 11) Rotating member from Elmore County hospitals' CEOs
- 12) River Region United Way
- 13) Envision 2020
- 14) State Public Health Department

This group should be chaired by a non-provider as recognition that this is a community issue and not solely a health care system issue. The *chairperson* should be a strong leader who is respected by the community and has recent experience in both business and government.

**Committees** will be key to move the agenda forward. HMA's recommendations for the committee responsibilities appear below. In cases where HMA has a recommendation regarding who should chair the committee, this is included in the recommendation.

**Research and Education** should be chaired by Envision 2020. ARISE may be the organization to be hired to do particular pieces of the research. This committee should be charged with public awareness campaigns as well as reporting on progress of health status.

**Transportation** should be a committee until a broker type arrangement could be created.

**Finance** committee should be created to follow up on expansion and physician UPL programs. It should also be their responsibility to work with Medicaid and local players to assure the match mechanism works and provides sufficient match.

**School-Based Health** should be chaired by a representative from the Public School District and should include both Hospitals and HSI. (Note: there are a number of funding sources available through Medicaid and others and we would be willing to give them people they can talk with.)

**Physician Recruitment** coordinating group should not interfere with individual efforts to recruit physicians, but should help coordinate efforts to organize the efforts of the community. These would include the business community, churches, social organizations and schools.

These committees would need to meet at least monthly to start, with most of the work conducted outside the meetings. Once operational, these committees would either disappear or reduce to quarterly meetings.

The childless adult medical program will require a small infrastructure of its own. Ideally, someone like Blue Cross/Blue Shield of Alabama would donate or at least significantly discount the enrollment and third party administrator functions. If not them, potentially UAB or the Public Health Department might have these resources within their system. While the results of this activity should be reported to the larger group, this work is not for committees.

## **Appendices**

Appendix A: Top 22 Service Sites by ER Visits/Zip Codes, 2007

Top 22 Service Sites by ER Visits/Zipcodes 2007

| Zip code        | Jackson  |          | Baptist South |          | Baptist Prattville |          | Baptist East |          | Totals   |          | HSI unique Patients by Zip |
|-----------------|----------|----------|---------------|----------|--------------------|----------|--------------|----------|----------|----------|----------------------------|
|                 | Medicaid | Self-pay | Medicaid      | Self-pay | Medicaid           | Self-pay | Medicaid     | Self-pay | Medicaid | Self-pay |                            |
| 36108           | 1362     | 1991     | 2900          | 2422     | 162                | 171      | 572          | 327      | 4996     | 4911     | 4978                       |
| 36116           | 584      | 1015     | 3178          | 2911     | 22                 | 39       | 867          | 728      | 4651     | 4693     | 3646                       |
| 36110           | 950      | 1205     | 754           | 531      | 69                 | 81       | 840          | 494      | 2613     | 2311     | 2857                       |
| 36104           | 1326     | 1491     | 1034          | 780      | 21                 | 29       | 218          | 129      | 2599     | 2429     | 2477                       |
| 36105           | 607      | 863      | 2014          | 1641     | 16                 | 27       | 187          | 169      | 2824     | 2700     | 2336                       |
| 36040           | 125      | 143      | 369           | 302      | 3                  | 3        | 80           | 29       | 577      | 477      | 1423                       |
| 36107           | 596      | 1102     | 338           | 413      | 22                 | 30       | 310          | 311      | 1266     | 1856     | 1370                       |
| 36117           | 190      | 452      | 320           | 350      | 6                  | 35       | 944          | 884      | 1460     | 1721     | 1146                       |
| 36067           | 137      | 232      | 238           | 201      | 2637               | 2171     | 109          | 102      | 3121     | 2706     | 1037                       |
| 36111           | 141      | 303      | 725           | 706      | 11                 | 10       | 155          | 99       | 1032     | 1118     | 846                        |
| 36109           | 312      | 659      | 233           | 291      | 12                 | 36       | 444          | 467      | 1001     | 1453     | 782                        |
| 36092           | 109      | 209      | 147           | 139      | 168                | 164      | 174          | 175      | 598      | 687      | 701                        |
| 36106           | 247      | 526      | 229           | 242      | 12                 | 8        | 137          | 121      | 625      | 897      | 512                        |
| 36054           | 61       | 127      | 118           | 117      | 852                | 687      | 76           | 69       | 1107     | 1000     | 422                        |
| 36069           | 19       | 26       | 114           | 87       | 1                  | 1        | 38           | 24       | 172      | 138      | 418                        |
| 35045           | 1        | 5        | 7             | 9        | 25                 | 65       | 1            | 3        | 34       | 82       | 378                        |
| 36043           | 64       | 106      | 165           | 147      | 16                 | 11       | 41           | 33       | 286      | 297      |                            |
| 36785           | 16       | 21       | 44            | 30       |                    |          | 7            | 6        | 67       | 57       |                            |
| 36752           | 32       | 26       | 64            | 50       | 11                 | 10       | 20           | 15       | 127      | 101      |                            |
| 36078           | 31       | 53       | 42            | 28       | 4                  | 2        | 64           | 66       | 141      | 149      | 283                        |
| 36024           | 7        | 22       | 25            | 30       | 8                  | 9        | 33           | 15       | 73       | 76       | 263                        |
| 36003           | 0        | 0        | 20            | 16       | 224                | 148      | 1            | 6        | 245      | 170      | 262                        |
| Subtotal        | 6917     | 10577    | 13078         | 11443    | 4302               | 3737     | 5318         | 4272     | 29615    | 30029    |                            |
| Total ER Visits | 7559     | 12175    | 14369         | 13102    | 6061               | 5524     | 6294         | 5434     |          |          |                            |

## Appendix C: Interview List

| Title         | First       | Last        | Business Title  | Organization                                       |
|---------------|-------------|-------------|---|--|
| Ms.           | Robin       | Barca       | Chief Operations Officer  | Baptist Health                                     |
| Mr.           | Stan        | Barnard     | Clinical Director   | Montgomery Area Mental Health Authority            |
| Dr.           | Harry (Mac) | Barnes      | Executive Director  | Montgomery Cancer Center                           |
| Dr.           | Steve       | Barrington  |   | Orthopedics  |
| Dr.           | Johnny      | Bates       | Inmate Physician  | Montgomery County and Autauga County Jails         |
| Ms.           | Tracey      | Bates       | RN  | Montgomery County Jail                             |
| Ms.           | Carolyn     | Bern        | Outreach Coordinator, Office of Primary Care & Rural Health     | AL. Dept. of Public Health                         |
| Ms.           | Lynn        | Beshear     | Executive Director  | Envision 2020                                      |
| Dr.           | Robert      | Beshear     | Pediatrician  | Children's Hospital of AL                          |
|               |             |             | Co-Founder  | Gift of Life Foundation                            |
| Dr.           | Cynthia     | Bisbee, PhD | Acting Executive Director                                       | Montgomery Area Community Wellness Coalition       |
| Ms.           | Rosemary    | Blackmon    | Chief Operations Officer  | Alabama Hospital Association                       |
| The Honorable | Bobby       | Bright      | Mayor   | City of Montgomery                                 |
| Rev.          | Paul        | Britner     | Minister  | Unitarian Universalist Fellowship                  |
| Ms.           | Carol       | Brown       | Partner (lobbyist)  | Southern Strategy Group of Alabama                 |
| Mr.           | Jim         | Brown       | Sr. Vice-President of Customer Relations & Information Services | Blue Cross Blue Shield of Alabama                  |
| Ms.           | Susan       | Bruchis     | Director  | Montgomery Cancer Wellness Foundation              |
| The Rev.Dr.   | Lawson      | Bryan       | Senior Minister   | First United Methodist Church                      |
| Ms.           | Anna        | Buckalew    | Senior Vice-President   | Montgomery Area Chamber of Commerce                |
| Ms.           | Mindy       | Burdick     | Administrator   | Baptist Health East                                |
| Councillor    | David       | Burkette    |   | Montgomery City Council                            |
| Ms.           | Carol       | Butler      | Executive Director  | Central Alabama Community Foundation               |
| The Honorable | Jim         | Byard       | Mayor   | City of Prattville                                 |
| Mr.           | Billy       | Canary      | CEO   | Business Council of Alabama                        |
| Mr.           | Jim         | Carnes      | Publications Director   | Alabama ARISE & Arise Citizens' Policy Project     |
| Mr.           | Doug        | Carter      | Chief Financial Officer   | Baptist Health                                     |
| Mr.           | Barry       | Cavan       | Director  | Catholic Social Services                           |
| Ms.           | Susan P.    | Chambers    | Assoc. Commissioner for Mental Illness                          | AL Dept. of Mental Health and Mental Retardation   |
| Mr.           | Jeff        | Clark       |   | Catholic Social Services                           |
| Ms.           | Pat         | Clay        | Chair   | Macon County Healthcare Authority                  |
| Ms.           | Irene       | Collins     | Commissioner  | Alabama Department of Senior Services              |
| Mr.           | Charlie     | Colvin      | Executive Director  | River Region United Way                            |
| Ms.           | Portis      | Cunningham  | Social Worker   | First United Methodist Church                      |
| Dr.           | Leon        | Davis       | Founder & Director  | Community Care Network                             |
| Commissioner  | Elton       | Dean        | Vice-Chair  | Montgomery County Commission                       |
| Ms.           | Tracy       | Delaney     | Consultant  | South Central Alabama Regional Planning Commission |
| Rev.          | Susan       | Diamond     | Minister  | First Christian Church                             |
| Mr.           | John        | Dilworth    | Superintendent  | Montgomery Public Schools                          |
| Senator       | Larry       | Dixon       | Executive Director  | Alabama Board of Medical Examiners                 |
| Dr.           | Jayson      | Dorey       | Radiology; President  | Medical Society of Montgomery County               |
| Mr.           | Jeff        | Downes      | Assistant to the Mayor  | City of Montgomery                                 |
| Dr.           | Olan        | Evans       |   | Otolaryngology                                     |
| Mr.           | Gordon      | Faulk       | CEO   | Elmore County Community Hospital                   |

|               |           |                 |   |  |
|---------------|-----------|-----------------|---|--|
| Mr.           | Joe       | Faulk           | Chair                                       | Elmore County Commission                             |
| Mr.           | Lloyd     | Faulkner        | Finance Director                            | City of Montgomery                                   |
| Ms.           | Jane      | Ferguson        | Social Worker                               | First Baptist Church                                 |
| Ms.           | Mary      | Finch           |   | AL. Primary Health Care Association                  |
| Mr.           | Kimble    | Forister        | State Coordinator                           | Alabama ARISE  |
| Mr.           | Doug      | Freeman         | Civil Law Clerk                             | Office of Judge Tracey McCooley                      |
| Mr.           | Dell      | Gamble          | Director of Operations                      | Care Ambulance Service                               |
| Mr.           | Thomas    | Gilliland       | Incoming Chair                              | Montgomery Cancer Wellness Foundation                |
| The Honorable | Jo        | Glenn           | Mayor                                       | City of Wetumpka                                     |
| Mr.           | Steve     | Golson          | Finance Director                            | Autauga County Commission                            |
| Ms.           | Bianca    | Granger         | Clinical Operations Director                | Health Services Inc.                                 |
| Mr.           | Joe       | Greene          | VP of Military & Government Affairs         | Montgomery Area Chamber of Commerce                  |
| Mr.           | Ken       | Groves          | Director                                    | City of Montgomery Planning & Development Department |
| Ms.           | Patsy     | Guy             | VP of Member & Investor Relations           | Montgomery Area Chamber of Commerce                  |
| Dr.           | Ellis     | Hall            | Board of Directors                          | Macon County Healthcare Authority                    |
| Ms.           | Sallie    | Hand            | Asst. Treasurer/ Administrator              | Autauga County Commission                            |
| Dr.           | David     | Harwood         |   | Psychiatry   |
| Ms.           | Dawn      | Hathcock        | VP of Convention & Visitor Bureau           | Montgomery Area Chamber of Commerce                  |
| Mr.           | Don       | Henderson       | President & CEO                             | Jackson Hospital & Clinic, Inc.                      |
| Ms.           | Ginger    | Henry           | Administrator                               | Baptist Health Prattville                            |
| Ms.           | Carol     | Hermann-Steckel | Commissioner                                | Alabama Medicaid Agency                              |
| Dr.           | David     | Herrick         |   | Anesthesiology & Pain Management                     |
| Ms.           | Carol     | Herron          |   | Catholic Social Services                             |
| Rev.          | John      | Hillary         | Minister                                    | Love & Peace Baptist Church                          |
| Dr.           | Albert Z. | Holloway        | Chair                                       | Joint Public Charity Hospital Board                  |
|               |           |                 | President                                   | AL Chapter of American Academy of Pediatrics         |
| Mr.           | Mike      | Horsley         | CEO   | Alabama Hospital Association                         |
| Mr.           | John      | Houston         | Commissioner                                | AL Dept. of Mental Health & Mental Retardation       |
| Mr.           | Tyson     | Howard          | Executive Director                          | South Central Alabama Development Commission         |
| Mr.           | J. Kent   | Hunt            | Assoc Commissioner for Substance Abuse      | AL Dept. of Mental Health and Mental Retardation     |
| Mr.           | David     | Ingram          | Area Manager                                | Care Ambulance Service                               |
| Commissioner  | Reed      | Ingram          |   | Montgomery County Commission                         |
| Councillor    | Charles   | Jinright        | President                                   | Montgomery City Council                              |
| Ms.           | Martha    | Jinright        | Executive Director & Program Director       | Gift of Life Foundation                              |
| Commissioner  | Carl      | Johnson         |   | Autauga County Commission                            |
| Ms.           | Heather   | Johnson         | Clinical Quality Management                 | Tallasse Community Hospital                          |
|               |           |                 | Board Member                                | Montgomery Area Community Wellness Coalition         |
| Dr.           | Henry     | Johnson         |   | OB/GYN   |
| Rep.          | Ronald    | Johnson         | Vice Chair                                  | House Committee on Health                            |
| Mr.           | Douglas   | Jones           | VP of Small & Minority Business Development | Montgomery Area Chamber of Commerce                  |
| Ms.           | Vicky     | Jones           | Vice-President                              | Jackson Hospital & Clinic, Inc.                      |
|               |           |                 | Board Member                                | Montgomery Area Community Wellness Coalition         |
| Mr.           | Mike      | Jordan          | Associate Executive Director                | Alabama Nursing Home Association                     |
| Mr.           | Ben       | Kelley          | Vice-President                              | Baptist Health                                       |

|               |           |             |  |   |
|---------------|-----------|-------------|--|---|
|               |           |             | Executive Director                     | Baptist Health Care Foundation                                  |
|               |           |             | Board Chair                            | Montgomery Area Community Wellness Coalition                    |
| Rev.          | Charlie   | Kendall     | Minister, Community Ministries         | Frazer Memorial United Methodist Church                         |
| Dr.           | Thomas G. | Kincer      | Program Director                       | Family Medicine Residency Program                               |
| Rep.          | John      | Knight      | Chair                                  | AL House Committee on Government Appropriations                 |
| Mr.           | Cary      | Kuhlmann    | Executive Director                     | Medical Association of the State of Alabama (MASA)              |
| Mr.           | Chuck     | Lail        | Director                               | Office of Primary Care & Rural Health                           |
| Rep.          | Richard   | Laird       | Member                                 | AL House Committee on Health                                    |
| Councillor    | Tracy     | Larkin      |  | Montgomery City Council   |
| Dr.           | Stuart    | Lockwood    | State Dental Director                  | AL Department of Public Health                                  |
| Dr.           | Rick      | Love        |  | Otolaryngology  |
| Dr.           | Wick      | Many        | Program Director                       | UAB Health Center Montgomery Internal Medical Residency Program |
| Mr.           | Bernell   | Mapp        | CEO                                    | Health Services Inc.  |
| Ms.           | Amanda    | Martin      | Director, Health Professional Shortage | AL Dept. of Public Health                                       |
| Mr.           | Gordon    | Martin      | Immediate Past Chair                   | Montgomery Area Chamber of Commerce                             |
| Mr.           | James     | Martin      | Administrator                          | Montgomery County Health Department                             |
|               |           |             | Board Member                           | Montgomery Area Community Wellness Coalition                    |
| Mr.           | Maurice   | Mayes       | Clinic Director                        | American Family Care Bellwood                                   |
| Judge         | Tracey    | McCooey     | Circuit Judge                          | 15th Judicial Circuit   |
| Mr.           | Bob       | McGaughey   | President, CEO                         | Montgomery YMCA   |
| Mr.           | Chris     | McInnish    | Deputy Commissioner                    | AL Dept. of Children's Affairs                                  |
| Dr.           | Julian    | McIntyre    | Chief Medical Officer                  | Health Services Inc.  |
| Ms.           | Margaret  | McKenzie    | Policy Analyst                         | Advisor to Gov. Riley on Health & Human Services                |
| Dr.           | Wayne     | McMahan     | Executive Director                     | Alabama Dental Association                                      |
| Ms.           | Tina      | McManama    | VP of Marketing & Communications       | Montgomery Area Chamber of Commerce                             |
| Ms.           | Jeanette  | Medders     | County Administrator                   | Elmore County   |
| Mr.           | Kelvin    | Miller      | General Manager                        | Montgomery Area Transit Authority                               |
| Rep.          | Michael   | Millican    | Chair                                  | AL House Committee on Health                                    |
| Mr.           | Donnie    | Mims        | County Administrator                   | Montgomery County Commission                                    |
| Dr.           | David     | Montiel     |  | Radiology   |
| Dr.           | John      | Moorehouse  | President                              | Alabama Emergency Room Services                                 |
| Mr.           | Rod       | Morgan      | Finance Director                       | City of Prattville  |
| Mr.           | Mike      | Murphree    | Executive Director                     | Montgomery AIDS Outreach  |
| Dr.           | Steven    | O'Mara      | Medical Director                       | Jackson Hospital ER Department                                  |
| Dr.           | Kevin     | Pace        |  | Anesthesia  |
| Ms.           | Lynne     | Parker      | Administrator                          | Baptist Health South  |
| The Honorable | Bobby     | Payne       | Mayor                                  | City of Tallassee   |
| Dr.           | Dennis    | Pearman     | Medical Director                       | Medical Outreach Ministries                                     |
| Mr.           | Mark      | Platt       | Chief Operations Officer               | Baptist Health  |
| Ms.           | Karina    | Polen-Davis | Executive Director                     | Community Care Network  |
|               |           |             | Goals Committee Member                 | Montgomery Area Community Wellness Coalition                    |
| Commissioner  | Dimitri   | Polizos     |  | Montgomery County Commission                                    |
| Ms.           | Camilla   | Prince      | Executive Director                     | The Volunteer & Information Center                              |
| Dr.           | Walter    | Pugh        | Volunteer Director                     | Medical Outreach Ministries (MOM)                               |
| Dr.           | Robert    | Ratliff     | Interim Medical Director               | VA Health Care System   |

|              |          |            |                         |  |
|--------------|----------|------------|-------------------------|--|
| Ms.          | Jennie   | Rhinehart  | CEO                     | Tallasse Community Hospital                                |
| Dr.          | Kanini   | Rodney     | Chief Medical Officer   | Community Care Network                                     |
| Ms.          | Sharon   | Roten      | Clinic Director         | Medical Outreach Ministries (MOM)                          |
| Dr.          | Patrick  | Ryan       |                         | Neurosurgery   |
| Mr.          | Lee      | Sanders    | Coordinator             | United We Ride, AL Dept of Senior Services                 |
| Ms.          | Pat      | Schloeder  | Nurse Manager           | Montgomery County Health Department                        |
| Mr.          | Ed       | Scholl     | Chief Financial Officer | Jackson Hospital & Clinic, Inc.                            |
| Councillor   | Charles  | Smith      |                         | Montgomery City Council                                    |
| Mr.          | Robert   | Smith      | Transportation Planner  | City of Montgomery - Department of Planning & Development  |
| Dr.          | Wil      | Smith      |                         | Orthopedics  |
| Rabbi        | Elliot   | Stevens    | Rabbi                   | Temple Beth Or   |
| Mr.          | Allen    | Stewart    | Director                | Greil Memorial Psychiatric Hospital                        |
| Mr.          | Henry    | Stough     | Executive Director      | Mid-Alabama Coalition for the Homeless                     |
|              |          |            | Board Member            | Montgomery Area Community Wellness Coalition               |
| Commissioner | Todd     | Strange    | Chair                   | Montgomery County Commission                               |
| Dr.          | Gerald   | Sweeney    | ER Director             | Elmore Community Hospital                                  |
| Dr.          | Stewart  | Tankersley |                         | Family Practice  |
| Mr.          | Jim      | Taylor     |                         | Care Ambulance Service                                     |
| Dr.          | David    | Thrasher   |                         | Pulmonologist  |
| Mr.          | Bill     | Tucker     | Director                | Central Alabama Regional Planning & Development Commission |
| Ms.          | Ruby     | Turner     |                         | Freewill Baptist Church                                    |
| Mr.          | Russ     | Tyner      | President & CEO         | Baptist Health   |
| Ms.          | Julia    | Ventress   | System Vice-President   | Baptist Health   |
| Ms.          | Michelle | Waren      | Communications Director | Alabama Dental Association                                 |
| Ms.          | Mary     | Weidler    |                         | Joint Public Charity Hospital Board                        |
|              |          |            | Board Member            | Montgomery Area Community Wellness Coalition               |
| Mr.          | George   | Waldrop    | Chief Financial Officer | Health Services Inc.                                       |
| Lt.          | Michael  | Whaley     |                         | Prattville Fire Department (Ambulance Service)             |
| Dr.          | John     | Wheat      | Director                | Univ. of AL College of Community & Rural Medicine          |
| Dr.          | Walter   | White      | Executive Director      | Family Guidance Center                                     |
| Dr.          | Donald   | Williamson | State Health Officer    | Alabama Department of Public Health                        |
| Mr.          | Tommy    | Wright     | Executive Director      | Montgomery Area Mental Health Authority                    |
|              |          |            |                         |  |

## Appendix D: Documents Reviewed

1. Experimental Small Area Health Insurance Estimates by County; *US Census Bureau Health Insurance Coverage Status by Age for Counties and States: 2000 Census Bureau Website*
2. Aged-2005 Enrollment, Reimbursement, Per Capita Cost (Monthly) and 2005 Demographic factors for Hospital and Supplementary Medical Insurance by State and County of Residence, Persons Aged 65 and Older
3. Age by Ratio of Income in 1999 to Poverty Level [144]; *US Census Bureau 2000 Census for Population and Housing, Summary File 4, Table PCT144, Census Bureau Website* (8 charts detailed by race)
4. Estimated Population by Age and Race, 2006; *US Census Bureau, County Population by Age, Sex, Race, and Hispanic Origin: April 1, 2000 through July 1, 2006, Census Bureau Website*
5. The Status of Primary Healthcare in Macon County; *The Alabama Medical Consortium*
6. The Status of Primary Healthcare in Lowndes County; *The Alabama Medical Consortium*
7. Selected health status indicators, Central Alabama action commission; *The Office of Primary Care and Rural Health, Alabama Department of Public Health and The Alabama Rural Health Association*
8. Indicators of Health Status in Alabama, Health Diseases Mortality; *The Office of Primary Care and Rural Health, Alabama Department of Public Health and The Alabama Rural Health Association*
9. Selected Health Status Indicators, County Specific Data; *The Office of Primary Care and Rural Health, Alabama Department of Public Health and The Alabama Rural Health Association*
10. Physicians' Alabama Opportunity Fair; *Informative Pamphlet*
11. A Snapshot of the Alabama Office of Primary Care Rural Health; *Alabama Department of Public Health, Office of Primary Care and Rural Health*
12. Community Health Centers, Meeting America's Most Pressing Health Needs; *National association of Community Health Centers*
13. Physician Interview Form; *Alabama Department of Public Health, Office of Primary Care and Rural Health*

14. Alabama Mental Health Catchment Area, November 2007
15. 2004-2005 Community Resources Directory for Autauga, Elmore, Lowndes, and Montgomery Counties; *The Volunteer & Information Center, Inc.*
16. Community Counts Report; *PARCA*
17. Alabama Dental Statistics Fiscal years: 1998-2007
18. Comparison of Physicians in Practice as of 2006
19. Prisons Becoming Mental Health Centers, Officials Say; *Montgomery Advertiser, Dec 21, 2007*
20. Funding for Mental Health Lacking; *Montgomery Advertiser, Nov 16, 2007*
21. Understanding the Shortage of Psychiatrists in Alabama; *Richard E. Powers MD, April 2, 5 2007*
22. Defining the Mental Health Manpower Crisis in Alabama; *Power point Presentation*
23. Baptist Health Workload Statistics
24. Baptist Health Payor Mix
25. Consolidated Statements of Net Assets June 30, 2007 and 2006; *The Health Care Authority for Baptist Health, An Affiliate of UAB Health Systems*
26. Baptist Medical Center East Hospital and Hospital Health Care Complex Cost Report, Certification and Settlement Summary
27. Prattville Baptist Hospital and Hospital Health Care Complex Cost Report, Certification and Settlement Summary
28. Baptist Medical Center East Hospital and Hospital Health Care Complex Cost Report, Certification and Settlement Summary
29. Baptist Medical Center South Settlement Summary
30. Jackson Hospital ER Visits by Financial Class and Zipcode. 10/1/06 - 9/30/07
31. *The Kaiser Commission on Medicaid and the Uninsured.* October, 2007
32. *2006 Survey of Final Year Medical Residents.* Merritt, Hawkes & Associates

33. Helwick, Catherine. Shrinking Workforce: No Quick Fix. *Internal Medicine World Report*. Vol.22, no.12. December, 2007. p.1 & 6



HEALTH MANAGEMENT ASSOCIATES

*A Plan for the Equitable, Organized and  
Integrated Delivery of Health Care Services for  
Underserved Residents of Orange County*

JANUARY 2010

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics  
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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*Table of Contents*

Introduction..... 3

Findings/Conclusions..... 5

Principles..... 9

Model ..... 10

Recommendations..... 13

    Formalizing the Network..... 13

    Target Population ..... 15

    Delivery System Restructuring ..... 16

        Primary Care ..... 16

        Specialty Outpatient Care ..... 17

        Emergency/Urgent Care Services ..... 18

        Inpatient Care ..... 19

    Managing the Population..... 20

    Financing the Network ..... 21

Work Plan: Next Steps..... 26

Appendices..... 33

    Appendix A: Individual Interviews..... 34

    Appendix B: Specialty Care Provision in FQHCs ..... 36

    Appendix C: Behavioral Health IGT Citation ..... 38

    Appendix D: Maximizing Enrollment into Coverage Programs ..... 40

## *Introduction*

The most clinically-effective and cost-efficient approach to assure medically vulnerable populations and communities access to health care services is the topic of the hour in both Washington, DC and in Sacramento. While the details of what will become the final plan are still unclear, there are provisions in both the national reform proposals and in California's proposed Medi-Cal 1115 waiver that will, in all likelihood, be adopted and will significantly change both the funding and organization of health care delivery in communities across the State and country. The plan detailed in this report was initiated by providers and agencies that are determined to internally impact that re-organization of care delivery before change is imposed externally; to start now to prepare for a more rational, equitable and sustainable delivery system for the underserved in a way that makes the most sense for Orange County.

This document is meant to be a work plan. While it does describe what exists now, its primary focus is what could be in the relatively near future. It has been developed through a process that identifies and builds upon the extensive innovation already undertaken by individual providers and agencies, attempting to broaden the scope of existing efforts and consolidating parallel initiatives. It does not suggest changes that are dramatically outside of the political and cultural realities of the community or try to revise the institutional missions and areas of expertise of participants in this effort but, instead, builds within that framework while still challenging all of the participants in this effort to move beyond the current approaches. It draws from experiences and lessons in other communities and seeks to adapt them to the unique nature of Orange County, when applicable. It builds on the anticipated health care needs of the underserved population, not simply upon the goals of providers who deliver care. Finally, it is developed within the context of and consistent with the key tenets of both state and federal health care reform most likely to shape the health care industry over the coming years.

Described within this plan are recommendations calling for both immediate action and further exploration and debate. Moving beyond discussion to implementation will take a directed and coordinated effort with clear short- and long-term goals defined and with specific roles for all participants identified. Most of all, it will require leadership, tenacity and unified focus. There are some individual recommendations that may not be acceptable for all and there may be some institutions that contribute more than others to get this enormous effort underway. These issues are not as important as a firm understanding of and agreement by all participants on the following concepts:

- What is being attempted through this effort is extremely difficult and counter-intuitive to the way in which most health care providers have always related to each other. It calls upon individual providers and government agencies to act as "good citizens" and to agree to participate in building something that, while initial sacrifice may be required, will ultimately result in a change that will benefit all of those that participate. This process requires a commitment to continue to remain at the table, even when there is disagreement.

- What is being proposed is nothing less than a transformation of the current approach to caring for the most vulnerable members of our community. Delivery system capacity and infrastructure will need to be invested in up-front to minimize the current reliance on emergency departments and waiting until illness requires hospital admission. Highly complex patients will need to be sought out, not avoided, as this strategy will ultimately result in a more effective—and less costly—delivery of health care services. As a community, the currently segmented and siloed approach to delivery of care to different populations will need to be challenged and collaborative and integrated efforts that maximize all of the resources available will need to be insisted upon.
- Finally, the participants in this effort will not wait until change is imposed be as a result of a State waiver or a new national plan but, rather, will lead the way and will be emulated by other communities.

Health Management Associates (HMA) has been honored to be a part of this critical effort in Orange County, an initiative which, if implemented, could become a national model for a collaborative, population-based, equitable, cost-effective and sustainable delivery system that assures access and improves the health status of its community.

Pat Terrell  
Terry Conway, MD  
Stan Rosenstein  
Doug Elwell  
Mitch Katz, MD

## *Findings/Conclusions*

Over the course of the past four months, HMA has: reviewed utilization, financial and demographic data and past reports; explored potential synergies with State and national reform efforts; held individual discussions with leaders in Orange County (see list in Appendix A); and facilitated several group discussions about the future of health service delivery for vulnerable populations and communities. Among the conclusions and findings that shape the recommendations detailed in this plan are the following:

- The organization of health care services in Orange County is unlike most other communities in California and is also dissimilar to other counties in the US that have as large a population of uninsured and under-insured residents. It relies almost entirely on the private sector (physicians, hospitals, clinics) for the care of the uninsured and Medi-Cal populations. Thus, as a plan is developed, providers not generally considered as part of the “safety net” will need to be addressed and involved. The continued role of private providers in both maintenance of effort and in the management of populations is critical in the development of a network for the uninsured and underserved in Orange County. This is particularly true because of the relatively small number of Federally Qualified Health Centers (FQHCs) and the lack of a public hospital and health system.
- While there are a significant number of people in Orange County without health insurance (with estimates ranging from 385,000 to over half a million), the underserved population (despite some concentrated pockets of medical need) is spread over a large geographic area. Further, data documenting emergency room and inpatient admissions do not describe the level of uninsured utilization one would expect with such a large population of people without coverage. This dispersal of the impact of the uninsured offers the opportunity to bring all providers in the community to the table in the development of a collaborative network to address a problem that is truly community-wide, not one that is only impacting a few overwhelmed institutions.
- Because there is no county public hospital system in Orange County and because the current level of FQHC capacity to provide care to for the uninsured is limited, with the two largest networks providing a significantly lower proportion of care to the uninsured than State or national averages, the delivery system that serves the indigent population currently depends heavily on community clinics and private providers, including hospital emergency departments and physicians (who provide services for cash or at no charge). Although this lack of FQHC capacity for the uninsured has not been addressed in any coordinated way, it seems to be widely acknowledged that the major FQHCs (Alta Med and UCI) are not serving the number of uninsured that FQHCs would be expected to serve in other communities.

- CalOptima has traditionally relied heavily on private physicians to provide care for Medi-Cal patients and the County's MSI program also assigns many of its members to private practitioners. The willingness of private physicians to continue to deliver care to Medi-Cal patients (including those on MSI who will likely convert to Medi-Cal under health reform) may change as more residents are given the opportunity to buy health insurance through the exchanges anticipated under any new national plan and private physicians open their doors to these newly insured patients. The continued federal commitment to expansion of FQHCs over the next 2-3 years, as well as the potential inherent in new US Health Resource Service Administration guidance on specialty care provided within FQHCs, offers Orange County a unique opportunity. It would be a mistake not to take advantage of the federal commitment for expansion as well as the FQHC benefits of the discounts available through 340B drug pricing, tort coverage and a cost-based Medi-Cal rate that allows for support of increased uninsured capacity.
- While the local County tax subsidy of indigent care services is less per capita than some other California counties, it is more than others both within the State and certainly more compared with counties in states outside of California, where there is no Section 17000 requirement. In those communities around the country where local indigent health care subsidies are either holding steady or not declining significantly (very few, if any, are actually growing), the County is most often invested in operating its own hospitals and clinics and is committed to meet growing cost and demand (and preserving jobs). It is unlikely that the Orange County subsidy will increase, particularly in the current economic environment and particularly as the County is still in the process of coming out of bankruptcy. Thus, attention should be paid to maximizing the impact of that County subsidy, particularly to drawing down all potential federal match funding.
- Orange County made several notable attempts to address the deficits in the availability of health care services for uninsured that have been creative and innovative. These efforts include, but are certainly not limited to: the County's MSI program (particularly the information technology products that have been developed to connect the various providers delivering services to MSI patients); the development of community clinics, some subsidized by or connected to private hospitals; Kaiser's approach to the management of chronically ill patients; activities of the Health Funders Partnership of Orange County including the AccessOC program and its attempt to maximize private physician contribution to indigent care and the coordination of activities related to major health access and health status problems, and, of course; the creation of CalOptima, which was established by the community to assure access for Medi-Cal patients. These initiatives, each of which are valuable and should be preserved, currently operate largely in isolation from each other, not as components of one comprehensive and collaborative approach.
- Coordination of effort between the Orange County Health Care Agency (OCHCA) and CalOptima is critical to: 1) effectively use all available resources;

2) maximize federal matching opportunities, and; 3) assure a smooth transition of uninsured patients into Medi-Cal over the next several years (the extension of Medicaid coverage to all under 133% of the federal poverty level is supported by both the House and Senate reform proposals, and would move approximately 80% of the County's MSI program to Medi-Cal). Both programs independently address network development, claims processing, utilization review and care management—all functions that could be integrated. Further opportunities exist in possible collaborative approaches to behavioral health and coverage of IHHS workers. Leaders of both agencies appear to be open to such further collaboration and coordination.

- The contribution of the hospitals in Orange County—both not-for-profit and for-profit—to the care of the uninsured and Medi-Cal populations is significant and needs to be recognized and continued (and, in some systems, expanded). Several hospitals were negatively impacted when community clinics that had traditionally served as a resource for ED and inpatient discharges of “unattached” uninsured patients cut off that access and new connections for continuing care need to be forged. Other hospital systems have committed to the subsidization of community clinics and that commitment could be strengthened and developed into an integrated network. Still other hospitals have unique expertise (chronic illness care management, specialty services) that could be built upon as a collaborative delivery system is developed. The leadership role of Orange County hospitals will require proactive planning, however, not simply reaction to those who come into their EDs, and will demand that they view themselves as “citizens of the County,” a role well beyond considering only the well-being of their own individual institutions.
- The community clinics in Orange County offer access to medical homes for the uninsured; however, they currently only represent a fraction of the capacity that is needed to meet the demand of the uninsured in the County. The Coalition of Orange County Clinics provides a useful role in convening the clinics but has only a limited function in representing those networks that have the greatest potential for significantly expanding care for the uninsured (the large FQHCs) and has primarily been focused, to date, on advocacy for funding.
- Individual free-standing clinics and FQHCs are a critical resource (particularly those serving specific ethnic and special needs populations) that should be part of any delivery system focused on under-served populations. However, the hospital-subsidized clinics (CHOC's community sites, La Amistad, Camino, St. Jude, SOS) could be even more effective of as a coordinated network on which to build capacity.
- Given that there is a limited level of local tax subsidy for the uninsured, a priority for delivery system development should be the maximization of all available revenues and the assurance that no funding is left on the table unspent. There seem to be significant holes in the current approach to assuring that all of those

eligible for Medi-Cal or other coverage programs are enrolled and this failure must be aggressively addressed. In addition, there appear to be specific opportunities, particularly through cooperation between CalOptima and other public entities (i.e., the County and the University of California) to draw down additional federal dollars matching local dollars spent on indigent care. Finally, there are specific opportunities for gaining operational efficiencies by coordinating and/or consolidating administrative functions between the County and CalOptima and, even, AccessOC.

- It appears that neither business nor philanthropy play as significant a role in health care in Orange County as they do in other communities, even at the level of individual hospital support. However, the effort by the Health Funders Partnership of Orange County to consolidate and focus what is available is significant and needs to be considered as an asset in the establishment of a coordinated system of care, particularly in the building of infrastructure. Further, while there doesn't appear to be any organized interest from the business community now, the potential for the availability of an affordable "health coverage" plan for small businesses could have considerable attractiveness in the years to come.
- The various information technology initiatives underway related to the management of services for uninsured and Medi-Cal patients are both innovative and being developed in relatively isolated—even competitive--silos. Given the need to maximize all available resources and provider capacity, technologies like the MSI's *ER-connect*, *Clinic-connect* and *Community-connect* and AccessOC's *e-consult* should be consolidated as a part of this evolving delivery system and, in fact, should be assessed for further upgrading to include additional functions (assessment for eligibility into all possible coverage programs, availability of appointments in Medical Homes, etc.). Further initiatives, such as forays into telemedicine being developed at the corporate level in the St. Joseph Health System or the chronic disease registries being utilized in Kaiser have the potential for broader integration.
- The components of the Orange County Health Care Agency will be significant elements in any coordinated delivery system development. In addition to the leadership "honest broker" role that the County will need to play in moving this initiative forward, the contribution of innovations designed through its MSI program and the ongoing interaction with its behavioral health and public health activities will be vital to assure success of any restructured delivery system that is designed around the population that it is meant to serve. The County plays several critical roles: health care vendor (MSI, behavioral health) and assurer of the health of the public. It is that latter role that will need to be further developed and emphasized.
- The timing and the approach of this effort coincide well with national health care reform efforts (integrated delivery systems, Accountable Care Organizations, bundled payments, dollars for health information technology that facilitates multi-

provider networks, expansion of coverage requiring delivery systems) and efforts by the state to renew its Medicaid 1115 waiver.

## *Principles*

The plan is built upon several key principles, including:

- The delivery system network should be geographically accessible and culturally sensitive to all who need it and should be built upon a rationale that assures that care is delivered appropriately and effectively, and centered around a Medical Home for all targeted patients.
- All available resources need to be maximized (county, state, federal, philanthropic, hospital contributions) and utmost attention given to minimizing duplication of effort.
- There is not enough money in the system—even with maximizing all available dollars—to pay for a full complement of health care services for all of the uninsured immediately. Thus, the plan is built on the assumption that the delivery system will be expanded incrementally, likely focusing on 100,000 uninsured patients in the first phase, although infrastructure will need to be developed up-front and the final result will be an accessible system for all residents of Orange County.
- There will need to be objective standards established to assure equitability in the contribution of providers to this effort, with regular assessment to facilitate accountability and transparency. This contribution level will be achieved in a variety of ways (direct services, monetary support, etc.) and will be equally applied to the agreed upon standard.
- The plan must have all of the following components: identified target population; comprehensive delivery system; management infrastructure to assure patient and provider participation and compliance; financing strategies that support the delivery system, and; a formalized structure to assure accountability to all participants.
- This new delivery system should be viewed not as a transitory project but as a new way of operating as collaborators in Orange County, requiring commitment from all participants to formalize the initiative into a multi-provider network with community-wide (not institution-specific) objectives and goals.

- This effort must, whenever possible, incorporate the opportunities and directives inherent in State and national health reform efforts to assure maximum support and sustainability.

## *Model*

The recommendations and work plan that follow are specific activities that are all derived from a basic model of care that the new collaborative network will be striving for as it develops. This model for the proposed network delivery system is based upon the make-up and health status of the population of the under-served in Orange County, and the health interventions that are most likely to improve their health status and decrease overall costs. It assumes that better care, a population focus and management of those enrolled in such a comprehensive network will result in improved health at the lowest cost. It also requires and supports greater integration of its different healthcare providers.

The population to be served through this model of care can be divided into two groups in terms of health status and utilization: first, those with chronic illnesses who are likely to be repetitive users of health services, often in emergency department settings, and; second, those who are basically well and generally are lower utilizers of services but may have unrecognized health risks. The two-pronged approach recognizes that there are limited resources in the system and that focus needs to be directed to where those resources will be used most effectively. The “benefit package” for the chronically ill through the network will include a designated Patient Centered Medical Home (PCMH) for each patient as the center of the delivery system, access to a full range of diagnostics, specialty referrals, urgent care and medications. Case management is a key feature of this package. The “benefit package” for the second group of non-chronically ill will not include all the features of a full PCMH, nor medications, at least not without a more than nominal co-pay. It will include access to primary preventive measures such as immunizations, screening for infectious diseases and cancer and chronic illness as appropriate, and, perhaps, treatment of mild hypertension and intermittent asthma. Urgent care services at specific locations will also be available within this package but may include co-pays for medications or provision of certain services such as job physicals.

### The Patient Centered Medical Home

Providing a Patient Centered Medical Home has been shown to be associated with better outcomes and decreased emergency room use, hospitalization and overall costs. A primary care practice that meets the criteria of a PCMH must provide access to the patient at all times, and continuity of care with the same provider. All health problems or concerns should be brought to the PCMH first and the PCMH is expected to initiate and coordinate all referrals. The PCMH must receive results of specialty consultations, urgent care visits, emergency room visits, diagnostic tests and inpatient hospitalizations. The PCMH is usually the provider responsible for follow-up of specialty recommendations. Further, practices will be required, in time, to provide team-based care, meet standards

set by the network, participate in care management and work closely with system case management and disease management programs. Explicit quality improvement activities will be required of a PCMH.

The network may determine that some patients merit specially designated medical homes, such as those persons with special needs due to such conditions as serious mental illness, developmental disabilities, cancer, or HIV/AIDS

#### Call Center

A high quality, highly functioning after- hours nurse triage service--with documentation sent back to the PCMH--is one solution to more effectively address access and utilization issues. A Call Center may simply provide advice to patients, schedule a "next day appointment" in the patient's medical home, or refer to an Urgent Care Center or ED within the network as appropriate. The Call Center sends documentation from triage to the medical home and activates a reminder call to reinforce importance of medical home follow up.

#### Urgent Care

Urgent care is a needed service for those with chronic illness as well as persons who are otherwise well. The best place for after hours care is within the practice that cares for all of the patient's needs and much of the need can be met by assuring phone contact with the PCMH or the Call Center with follow-up during regular hours. However, health concerns may arise that must be seen directly by a health professional without delay and many of these problems do not require a full ED visit. Urgent care at designated centers should be a benefit available to all enrollees in the network. Patients should be seen at an urgent care center within 30 minutes of arrival. Staffing may be accomplished with primary care physicians, nurse practitioners or physician assistants, and with the use of telemedicine capabilities. A relationship with one or more EDs and hospitals is essential and transfer according to network protocols must be expeditious. Urgent care centers must also send information on diagnoses, results, and treatments back to the PCMH and be responsible for and have the ability to make follow-up appointments after the patient is treated.

#### Specialty Referral

Specialty consultation and management will be necessary for patients in the network and access to appropriate subspecialty appointments should be available in real time for patients with PCMHs. An electronic referral system should be used within the Network that provides for the following:

- is internet-based;
- has the ability to incorporate clinical and administrative rules that provide decision support and efficiently allow only appropriate referrals to be accepted;
- is easy to use;

- can schedule appointments once a referral has been approved;
- is able to route the consultation results back to the PCMH provider;
- provides the management tool of tracking individual referral requests; and
- reports on all aspects of specialty resource utilization (who is requesting referrals, for what, how many, where are they being referred to and whether consult results are being returned) to provide the network with important information about the effectiveness of the referral system.

Increased training for primary care practitioners may be required. Further, electronic consultation and telemedicine are appropriate alternatives for many types of consultation requests and can expand specialist resources, as well as allow co-management of a patient's condition between a specialist and primary care practitioner, decreasing follow-up appointments with a specialist.

### Care Management

The care of network patients with chronic or high resource-consuming conditions must be firmly and systematically managed. The uninsured with these conditions will otherwise consume the network's resources by utilizing the most expensive services. Care management, as conceptualized in this model, is not a stand-alone program but rather an approach that requires the participation, integration, and buy-in of all the network's health care providers. Investment in infrastructure and organization will be necessary if the network is to fully benefit from this approach. Important elements of the care management element of the model are:

- assessment of health conditions, stratified risk, and resource needs;
- development of a care plan that is accessible and used throughout the network;
- facilitation of the monitoring of utilization to assure use of needed care as well as to identify patients that are utilization outliers;
- assuring that a care team approach exists within the PCMH practice and includes care managers, pharmacists, and others;
- coordination of transition care from hospitals, EDs, and urgent care facilities back to the PCMH with care plan changes and patient self management support;
- the existence of clear, adequate and consistent communication between the PCMH, specialists, hospitals and case managers; and
- an emphasis on patient self-management that includes education, support and reminders, and goal setting.

### Information Technology

Adequate information technology support is necessary to support care management within the network. Fortunately, there are several systems in use within Orange County that can be expanded or applied in a care management program. A chronic disease registry is essential for planned care and the management of chronic conditions. It must be web-based to be accessible at multiple locations and able to receive data from other

databases. Several good registries are available commercially and Kaiser uses a registry in its disease management approach. ER-Connect allows efficient communication and transition between emergency departments and the Medical Home and could be used by hospitals at discharge of network patients.

A major focus of this model delivery system will be to continually test and refine new innovations (i.e., home monitoring) to assure that resources are always maximized and health care improves.

## *Recommendations*

The following are specific recommendations that are grouped as follows: 1) formalizing the network and governance; 2) defining the target population; 3) developing the components of a restructured delivery system; 4) approaches to manage the population; and 5) financing strategies to support the network. These recommendations will be integrated into a more specific work plan in the final section of this report.

### Formalizing the Network

In order to assure that the delivery system network developed through this effort is sustainable and not ultimately dependent upon the good will of the leaders currently around the table, it will need to be built upon sound governance and management structures and be supported by a clear financing plan. It is critical to understand that this governance will serve to coordinate and build upon what exists now, not to replicate systems and programs that have already proven to be effective. Financing is discussed in a section below. Recommendations for network governance include:

- A not-for-profit or semi-public organization (i.e., a public authority) should be established to facilitate the development and oversight of the delivery system for underserved populations in Orange County. In other communities, this oversight has been accomplished through both private organizations and governmental bodies. Whatever the organizational structure, the Board of the organization must be built on the commitment and active participation of decision-makers from the organizations making contributions to the effort, including, but not limited to, the Orange County Health Care Agency, CalOptima and hospitals. It will also be critical to have representation from the physician community, community clinics and FQHCs; with participation determined based on contribution criteria. Finally, the organization should have representation by both the patients served and the broader civic community.
- Name the new organization as soon as possible. It is important that this name reflect its role as a multi-institutional delivery system—not a project or an initiative, which implies that it is a temporary endeavor.

- The functions of the governing structure of the new body should include:
  - 1) identifying the populations and communities targeted by the network ( a fluid process as under-served populations change through both health reform and demographic shifts);
  - 2) assuring the seamless collaboration of multiple providers and monitoring the equity of contribution to the comprehensive network;
  - 3) determining gaps in the delivery system and collaborating on the building of new capacity;
  - 4) overseeing the coordination of effort between CalOptima and OCHCA (MSI, behavioral health, public health) programs related to this new delivery system;
  - 5) executing financing strategies to maximize all available resources (federal, state, philanthropic, institutional);
  - 6) organizing participating providers to serve as recruiter of new capacity into the network;
  - 7) assuring the effective management of the target patient populations;
  - 8) identifying system needs (IT, care management) and managing vendors and consultants to assure directed and coordinated efforts that function for the entire network, not in separate silos;
  - 9) setting quality benchmarks that address both effective utilization of services and, ultimately, improved individual and community-wide health status;
  - 10) seeking collaboration between the medical delivery system and other community-based programs and services (culturally-sensitive community-based organizations, transportation, housing, education, etc.) to assure a more comprehensive approach to assuring improved health;
  - 11) serving as a community-wide advocate for medically vulnerable residents;
  - 12) implementing a continuous process of monitoring, evaluation and change to assure ongoing clinical effectiveness and cost efficiency, and;
  - 13) planning for and responding to the financial and operational implications of health reform at both the federal and state levels.

- Although, in order to maintain the current momentum, consultants could be used to start the process moving, highly-skilled staff will need to be recruited by the organization's Board as soon as possible. This staff could be supplemented by those leading existing programs at OCHCA and CalOptima but will need, at least initially, to be significantly directed by an active Board and its committees (see "Work Plan" section below).
- Given the rapid health care changes being debated in Sacramento and Washington right now, this new organization should contemplate building a lobbying and public relations component that will not only stay abreast of all fast-breaking changes but will assure that the model being developed in Orange County is understood by and promoted to those who are making decisions about resource allocations.

### Target Population

Identifying the population(s) to be addressed by this effort is critical to assure the effectiveness of the network in addressing the real needs of the patients. The total number of uninsured is unclear and changeable (particularly due to the recently increased unemployment rate). Multiple tracks (focused attention on some, build capacity/network for broader group) are proposed in this plan. It is most feasible to bring populations into the network incrementally and, because of the geographic dispersal of the medically indigent throughout the County, we believe that it is preferable to target the following patient groups over the first several years of this effort:

- those with incomes under 133% of the federal poverty level who will likely move into Medi-Cal under health reform over the next several years (approximately 80% of the County's MSI program eligibility);
- the chronically ill, including those with both medical and behavioral health problems and high utilizers of services who would most benefit by significant management of their care; and
- those that are currently covered by Medi-Cal but still have difficulty accessing care and would benefit by being connected into an organized delivery system and whose inclusion could help provide support for those without any coverage.

The assumption inherent in this plan is that a target of 100,000-120,000 currently uninsured patients enrolled into this new delivery system (with some receiving more intensive services, as described in the model), is a rational goal.

## Delivery System Restructuring

In order to assure a comprehensive, geographically dispersed and high quality health care network for the medically vulnerable population for the residents of Orange County, we recommend attention to the following areas in further development of capacity for the uninsured and Medi-Cal population or the coordination of existing services:

### **Primary Care**

A major focus of this network development effort must be on the establishment of stable and expanded primary care capacity, particularly for Medical Homes for uninsured patients. Specifically, we recommend:

- Take on the issue of establishing community expectations for a proportion of uninsured patients to be cared for by FQHCs operating within Orange County, based on both State and national averages. FQHCs should be expected to provide a critical level of access for the uninsured in return for their cost-based Medicaid reimbursement, their tort coverage, access to 340B drug pricing and direct grants to support the delivery of care to those without means. In order to assist in making this transition more palatable, CalOptima should assign Medi-Cal lives to FQHCs and other community clinics based on a commitment to and demonstration of increasing capacity for the uninsured in these centers to documentable levels based on at minimum, state norms. This action will provide—particularly for FQHCs—a funding source to provide some support for expansion for uninsured patients. CalOptima is moving in this direction already but it is important to also understand that this will mean increasing the overall proportion of assignees to clinics.
- Take advantage of the federal commitment to expanding FQHC capacity to create new sites in Orange County. This focus on FQHC capacity can and likely will take several different forms and it is advisable to do a focused assessment (which can be done quickly) of which strategy or strategies will likely result in the greatest capacity expansion. All participants in this network development initiative should actively encourage current efforts to convert community clinics to FQHC status and pursue one or more of the following options to increase FQHC capacity in Orange County:
  - 1) Explore the restructuring of the UCI FQHC clinics, moving from the University management to a more community-based ownership and governance that would commit to greater capacity to care for under-served populations. The UCI Family Practice residency program could be accommodated in this restructured network and, perhaps, be seen as a focus of training FQHC physicians for the community.

- 2) Create a new FQHC, perhaps building on a restructured UCI FQHC described in #1, which would include, at minimum, the community clinics currently subsidized by St. Joseph's Health System (La Amistad, Camino, St. Jude), Hoag (SOS) and Children's Hospital of Orange County. This new FQHC would immediately have a significant Medi-Cal patient population (through the CHOC clinics) that would bring the entire FQHC network added revenue to support the full scope of adult and pediatric care. It may make sense to recruit one experienced management team to operate the new FQHC.
  - 3) Encourage another FQHC (perhaps from San Diego County with a focus on south Orange County) to take on one or more community clinics to expand capacity, an option particularly if #1 and #2 turn out not to be viable.
- In order to assure maintenance of effort from private physicians, practices should be recruited to participate in the network that currently deliver care to some significant level of CalOptima and MSI patients and that are willing to be participants in this network effort. These practices would be incentivized to serve as Medical Homes to the uninsured through new financial payments (described below). It is likely to make the most sense to first engage the major IPAs in discussion about their willingness to participate in this effort. The most likely mechanism for bringing those physicians to the table is through negotiation with and involvement of organized IPAs and CalOptima provider networks.
  - Build upon the aggressive and effective chronic care management in the Kaiser-Permanente system, perhaps by "partnering" Kaiser with the evolving new FQHC network) to utilize this expertise more broadly.
  - Create several pilot sites, pairing Orange County behavioral health staff/resources with FQHCs and community clinics that will serve as Medical Homes for identified patients with both mental health and chronic medical problems (see potential funding supplement in finance section below). This would foster better coordination between medical and behavioral health providers and would take advantage of 340 (B) discount drug pricing available through FQHCs.

### **Specialty Outpatient Care**

Access to and appropriate use of specialty care for medically indigent populations is a significant problem in Orange County, as it is across the country. To begin to rationalize the approach in Orange County, we recommend:

- Develop a network of specialty physician participants for the patients covered through this network by creating an equitable distribution and commitment from major physician groups and the current participants in CalOptima and MSI. The

UCI faculty and physicians should play a significant role in this network with clearly delineated areas of responsibility and agreement to be reimbursed at the same level as other specialty providers. The financial reimbursement rates will need to be augmented by a firm network commitment to a process that assures only those patients that truly need a specialty visit are referred and that facilitates a smooth transition back to the patient's primary care Medical Home.

- Institute *E-consult*, being developed for AccessOC, throughout the network (including CalOptima and MSI patients) to provide consultation access to primary care medical homes. Further, couple this effort with *E-referral*, being developed for the MSI program and build in "rules" to assure that the referral is appropriate, includes needed information (diagnostic test results, pharmacy, primary care notes), and that patients are returned to their Medical Homes with the advice of the specialty consultants.
- Maximize potential for specialty care provision within FQHCs, an opportunity now federally-allowed, within some limits (see Appendix B). The activity related to increasing FQHC Medical Home capacity expansion should keep in mind the potential for also increasing specialty care availability within the FQHC networks. If FQHCs are able to provide more specialty care to Medi-Cal patients and are reimbursed at FQHC rates, additional revenue could be generated to expand access for the uninsured
- Explore the use of telemedicine for some specialties.
- While it is unlikely that the specialty care needs of the uninsured will be met in any significant way through volunteer efforts, there should be a clear commitment to maintenance of current efforts like AccessOC and integration of those efforts into the network.

### **Emergency/Urgent Care Services**

In order to assure benefit to hospitals participating in the network, particularly those hospitals experiencing a disproportionately high level of emergency department (ED) use by uninsured patients, a significant commitment will need to be made by the new network to both manage patients into appropriate care settings (see section on patient management below) and to develop infrastructure to assure that redirection. A recent report compiled by OCHCA estimates that nearly half of ED visits in Orange County are for non-urgent and avoidable conditions (even more for infants and for children covered by Medi-Cal) and most often the reason given for the ED visit is the lack of access (real or perceived) to primary care services. Thus, addressing this issue is a critical component of building a new delivery system model. Specifically, we recommend:

- The network should commit to the initiation and financial support of the establishment of “urgent care centers” adjacent to high utilization hospital EDs. The centers could be collaborations with FQHCs that could receive preferential rates for both providing episodic care and, more importantly, aggressively managing patients back into their primary care Medical Homes. The establishment of these centers would be a key area for initial capital contributions from philanthropy and/or CalOptima, who would significantly benefit from redirection of patients, including its own assignees, from inappropriate ED use.
- The OCHCA’s MSI program’s *ER-connect* IT system should be further expanded to allow for easier identification of patient’s Medical Home and assistance in providing same-day appointments.
- Discussions should be initiated with the Emergency Medical System (EMS) in Orange County to determine the potential for diverting unnecessary transportation of patients to hospital EDs. In other communities, the EMS system has turned out to be an often over-looked and critical component of the safety net. Many of its “911” calls are simply seeking assistance in acquiring medical care that is not necessarily emergent. If the network could work with the EMS system, through OCHCA, to assure access to health care services—either through primary care providers or urgent care centers—there would be a significant cost-savings and greater potential for establishing a more established connection to a Medical Home for the patient.

### **Inpatient Care**

While most hospitals in Orange County experience some load of uninsured inpatient care, and some hospitals are impacted to a greater degree than others, it is not possible at this time for the costs of all services to be covered for all of the County’s uninsured through this network. Significant attention needs to be paid now to developing the outpatient capacity (particularly a primary care network) and management systems to assure that all resources are utilized most effectively. Over the next several years, it is likely that more of these patients will be covered (either through expanded Medi-Cal eligibility or through affordable plans offered by insurance exchanges) and it makes sense to spend this transition time developing a network that will provide a rational delivery system. Thus, we make the following recommendations related to inpatient care:

- Unless, by an objective measurement, a participating hospital can show significant financial distress, hospitals in Orange County should agree to forego reimbursement for uninsured patients (including those that currently qualify for MSI) for the next 2-3 years so scarce resources can be targeted to the development of primary, specialty and urgent care outpatient capacity, as well as management systems that will facilitate the most appropriate use of network services.

- The network should negotiate, devise and manage an equitable division of inpatient responsibilities, including elective and tertiary care. This network approach would take into account the geographic dispersal of patients, the expertise and investment already present in individual hospitals, the relative value of inpatient contributions being made, etc.
- Linkages should be formalized between participating hospitals and ambulatory providers (primary and specialty) to assure that inpatients are able to be effectively discharged into ongoing care, minimizing the likelihood of recurring and unnecessary ED visits.
- Hospital contributions would be monitored and applied to a calculation of their contribution to the overall network and to “community benefit.”

### Managing the Population

Population health management is the approach most likely to optimize the success of the network. The network’s potential members are all the medically indigent in Orange County. Unlike the strategy of conventional health plans and providers, the network should aggressively seek to identify and enroll the chronically ill and those with “high impact conditions” who are at risk of health declines and also high use of health resources. The network must stratify the enrolled by health status and utilize evidence-based interventions to meet the different needs, ranging from primary prevention, to monitored and supported medication management, to full care management by the primary care team, telephonic nurse and pharmacist case managers managing with standing orders and protocols, to a full court press of care management with telephonic and home support, involvement of multiple physicians at several sites.

The network will not simply await the patient to initiate needed care but will contact patients, remind them, and support them to meet their individualized plan. The Patient Centered Medical Home must remain as the center and single point of contact for most of this care but all sectors within the network must be able to communicate encounter, pharmacy and results data and share a common care plan. Attention should also be paid to reinforcing best life style and health seeking behavior. It is clear that in organizing, capitalizing and financing the Network, priority should be given to information technology, communications, care management, and self management support.

The network can build upon the resources of other providers in Orange County. CalOptima and MSI have initiated efforts in disease management and, to a lesser extent, population management. Kaiser Permanente has a robust population management system, although its closed population, employed staff and ownership of facilities may limit its

application within the network. An organized and focused approach should be initiated to facilitate the process through which these organizations may offer their experience and perhaps share resources with the network in the following areas:

- information technology, including monitoring pharmacy and managing real time utilization/inpatient census data, claims data, systems that support risk stratification, triage and medication management and those that support transition care from inpatient, ED, or Urgent Care back to the Medical Home;
- case management and care management organization, staffing, training and support;
- urgent care and convenient care standards, staffing, equipment and location;
- outpatient specialty and diagnostics referral technologies and criteria and the related management and operations of referral and reporting software, staffing and systems;
- setting and maintenance of evidence-based interventions and treatments for chronic illnesses;
- integration of different disciplines such as primary care, specialty or behavioral health;
- education and orientation programs for professionals and other staff; and
- best practices in program implementation.

### Financing the Network

Financing the evolving multi-provider network will need to optimize current resources, pairing—as much as possible—the approach to the uninsured and the Medi-Cal populations, being continually aggressive in taking advantage of new federal and state opportunities, supporting innovative integrated delivery models, coordinating institutional and philanthropic support of health care for under-served populations, and, finally, recognizing that the development of the network will be incremental and funding will need to be directed in ways that build the most rational and sustainable system possible. For example, management infrastructure to coordinate providers and assure patient compliance will be key up-front investments, as will filling current holes in the delivery system (primary care capacity, in particular). Financing will require smart people constantly assessing and re-assessing opportunities for the full network, not just individual sectors (i.e., hospitals, clinics, CalOptima). Finally, the financing strategy will have two major components: 1) how to maximize total dollars available to support the

network and the needs of the target populations and, 2) how to pay out that money to meet the goals set by the network. Specifically, our recommendations are:

- All participants should commit to an aggressive eligibility screening campaign to assure that all residents of the County—and particularly those that are chronically ill and currently using services within the system—are receiving all of the financial support to which they are entitled (see Appendix D for a more detailed discussion of this issue). Key areas for focused attention would be in the County’s behavioral health program (in which, it is estimated, only approximately 15,000 of its 42,000 patients are enrolled in Medi-Cal and 1100 in MSI) as well as in all community clinics that currently care for significant numbers of uninsured patients but which may not have the resources to pursue Medi-Cal eligibility. It is also recommended that CalOptima invest in the infrastructure—through *One-e-app*, *Auth-Med* or another product—and coordinate this effort throughout the County, as it will reap the greatest benefit in getting more people onto the Medi-Cal rolls. However, CalOptima should consult with OCHCA to be sure that its screening process also assures compatibility with current screens for eligibility into County benefit programs and full administrative match should be sought for its implementation.
  
- There are several significant opportunities available to draw down additional federal matching dollars through CalOptima in collaboration with both Orange County and the University of California-Irvine. Pursuing these opportunities represent the single most significant sources of new revenue to expand access to care for under-served populations. Specifically, attention should be paid to the following Intergovernmental Transfer Agreement (IGT) opportunities:
  - 1) Federal match of County MSI and tobacco settlement (TSR) dollars not currently matched. This initiative would require that the MSI—and, perhaps, the use of TSR money used to support primary care capacity—be funneled through CalOptima. CalOptima can then “pay out” the new dollars to Medi-Cal providers (clinics and private physicians) as “performance bonuses” in return for their also providing care to a set number of uninsured patients—thereby accomplishing the mission of the MSI program but with a near doubling of the current available dollars.
  
  - 2) An IGT for the County’s behavioral health program. California has established a vehicle that allows for a pilot program (see citation in Appendix C) to create a behavioral health IGT in two counties. Solano County is already implementing this initiative and receives much of its funding through its County Operated Health System. This allows for counties with administrative costs of less than 9% in their behavioral health programs to gain federal match of their county expenditures and move from a certified expense funded program that pays, in some cases, less than cost to an actuarial rate that would pay them at least cost plus 6% for margin. The IGT for Orange County (which appears, after initial review, to be eligible) would

run through CalOptima, which would, in turn, contract with the County—and/or others—for behavioral health services. This IGT, particularly if coupled with aggressive Medi-Cal screening of behavioral health patients, could bring significant new resources into the network and could help to fund both expansion and innovative efforts such as pilot behavioral/medical integration efforts and ED diversion management.

- 3) Federal match of UCI expenditures. There is the potential for an IGT to bring in additional federal matching dollars through collaboration between UCI and CalOptima that would allow UCI—or any providers contracting with UCI—more than cost for Medicaid services. This could create new funding to support providers within the network. In conversations with the senior financial leadership of the UC system, it was agreed that there would be University willingness to discuss this potential in a serious way.
  - 4) An IGT of some of CalOptima’s reserves. Although a match of some portion of CalOptima’s reserves would serve a one-time purpose, it could generate significant dollars that could be committed to infrastructure development or be held for transition payments over the anticipated 2-3 years before additional patients are moved into Medi-Cal under national health reform efforts. For example, acknowledging CalOptima’s need to maintain a prudent reserve, it is likely that reserve dollars could be matched to bring in new resources to be devoted to new capacity (FQHC’s urgent care centers) and paying for management infrastructure development (care management, call centers, etc.). It is estimated that up to about \$40 million could be certified for such a transfer.
- Hospitals participating in the network should agree upon an objective and accountable network contribution formula, perhaps based on gross revenues, to achieve an equitable approach to support a “pool” of funding for the network. Elements of that support could include, but not be limited to, any of the following forms:
    - 1) cash contributions;
    - 2) direct provision of services for a certain number of uninsured patients (i.e., Kaiser taking on a selected group of complex patients with chronic illnesses that would benefit from their management through their Medical Financial Assistance Program);
    - 3) agreeing to take an equitable number of uninsured patient admissions (including those previously covered by MSI) without reimbursement (currently about \$20 million annually);
    - 4) diverting some percentage of AB 1383 Hospital Fee Proposal dollars (if the plan is approved by CMS) into the network;

- 5) providing a level of diagnostic and/or procedural (i.e., “free surgery days”) support for the uninsured, organized and controlled by the network;
- 6) contributing areas of unique expertise (i.e., disease management, telemedicine) to the entire network.

The network governance would provide accountability and “credit” for community benefit for these contributions.

- It is clear that, despite aggressive attention to all of the revenue-generating activities described above, there will not now be enough money in the system to cover a comprehensive set of benefits for all of the uninsured in Orange County. It is recommended that, as described above, target populations are “taken on” incrementally, with priority given to those most likely to move onto the Medi-Cal rolls under health reform (the vast majority of the MSI patients) and those most disproportionately utilizing health care services now. It is further recommended that the network commit to a limited benefit plan which CalOptima would administer for the network. At least initially, this plan would not pay for inpatient facility or physician inpatient fees—with those costs contributed by the participating hospitals in exchange for the build-up of Medical Home and urgent care capacity and for a commitment to develop and implement a systematic approach to managing high priority uninsured patients. In similar plans in both Flint, Michigan and in San Francisco, the cost of coverage for all services except inpatient and behavioral health is remarkably similar—about \$140 per member per month. It is anticipated that, over the next several years, the benefit package will be expanded to include inpatient care. Deciding to target dollars toward the building of an effective delivery and management system now seems to be the most critical use of available dollars and it appears feasible that 100,000 patients could be initially covered under this plan.
- The network should look into the potential for uninsured residents to “buy into” this new coverage plan and to establishing sliding fee scales for patient contribution. (It should be noted that nearly \$3 million is generated annually from co-payments in the San Francisco coverage plan that covers approximately 48,000 people).
- Currently CalOptima has a 10-15% penetration in the dually eligible patient population in Orange County through their One Plus plan. This penetration currently yields a margin of \$7-8 million annually. If the community, particularly providers, worked together to increase this penetration to 50-60%, this margin could be increased to \$24-32 million. CalOptima should then be willing to reinvest part of this money into the health system for the underserved, either through direct payments or by using the money as IGTs to increase Medi-Cal capitation payments and rates to providers. Many patients with Medicaid and Medicare fear joining managed care plans, thinking that it will result in their

being restricted in their choice of providers or their access to services. The reality is, most dual eligibles would receive more services within a managed care model. In Orange County, where many private providers are caring for patients in the managed care system, hearing from their doctor that they could continue with their care and might be entitled to even more services in CalOptima's plan, would likely help convince them to join. Hospitals can help in educating their physicians about the long-term value in growing this plan in order to help subsidize care for the uninsured.

- If a partnership could be developed between the County and CalOptima, a unique opportunity exists to provide health insurance coverage to its IHHS workers who provide in-home care. As a federally claimable service that becomes part of the cost of delivering care to Medi-Cal patients, a 50% federal match could be generated to cover some of the 17,000 workers in the County, only about 2200 of who currently receive benefits through their union. As they are low-paid workers, this could further decrease the rolls of the uninsured and also maximize the opportunity to bring new dollars into the community.
- The network should aggressively pursue all federal funding available for expansion of care for the underserved through new FQHC starts and expansions. The value of incorporating the CHOC clinics into any new network—or one expanded through the UCI FQHC—is that such integration brings significant new Medi-Cal revenue to both enhance payment for specialty care and to expand access for those without payment.
- Focused attention should be paid, over the coming months, to federal dollars for model programs (Accountable Care Organizations, coordinated care networks, IT innovations) for which the network will likely be uniquely suited. In addition, as the California 1115 Waiver is up for renewal, attention should be paid to maximizing Coverage Initiative investment into Orange County, particularly as it doesn't have a public hospital system, which is the vehicle that other states use to maximize state and federal dollars. Coordinated efforts through the network should be employed to support the County in this advocacy.
- CalOptima has, in the past, sought State approval for entering into a waiver to facilitate a change in their approach to delivering long-term care services, moving away from institutionalization to building capacity in home- and community-based-care. As nursing home payments represent approximately \$300 million of the CalOptima budget, the network should work with CalOptima and the State to seek implementation of the County's inclusion in the waiver (as has been done in other California counties) and allow for more creative and cost-effective use of these funds.

- The Health Funders Partnership of Orange County should explore an even greater focus of its philanthropic capacity to seed this new network and assist in early implementation.

### *Work Plan: Next Steps*

It is important that there be a commitment by a critical mass of key stakeholders to move quickly toward implementation of this new approach to assuring an effective and equitable delivery system, building on the momentum generated by the planning process of the past several months. The fact that this effort falls in the midst of a national effort to dramatically change the paradigm for health care delivery, financing and organization—particularly for underserved populations—makes this imperative for quick action even more critical. The following are steps, grouped in three month intervals, to guide the development and implementation over the next year:

#### First Quarter (February-April)

The key activities for the first quarter will require heavy consultant assistance—and, perhaps, contribution of senior staff from participating agencies and providers—as the new organization is developed and staff is recruited. It is important, however, to commit to becoming a staff-run—not a consultant-run—entity as soon as it is possible to find the right staff. Also, during this initial implementation period (which will likely be a full year), the leaders of all participating entities will need to devote their own personal time and energy to lead the work in order to assure that it is moving in the direction that makes sense and is, ultimately, sustainable within the Orange County environment. Finally, while work groups and committees will need to be established, their charge should be clear and timelines should be strictly adhered to so they don't become ends in and of themselves. While it should be clearly noted that there are a significant number of individual recommendations included in this plan that could—and should-- be acted upon immediately, specific priority steps to be taken in the first quarter should include:

- 1) **Establish the new organization.** A 501(c)(3) organization should be established that will oversee and manage the development and implementation of the new collaborative delivery system. A working committee should address (and bring recommendations to all of the participating entities for approval) the following organizational issues:
  - Board membership, network name, charge/mission and structure (including standing committees);

- determination of representation of other key sectors (physicians, clinics, business/civic, patients/community);
- relationship to partners that will carry out functions of the collaborative system (CalOptima, individual providers, OCHCA);
- public relations and communication plan;
- initial start-up financing; and
- staffing and recruitment strategy.

It is recommended that this working committee include several hospital CEOs, philanthropy, the County and CalOptima. There will also need to be legal counsel provided to facilitate the organizational development—perhaps contributed by one or more of the hospital partners. The goal should be to have the new organization and Board of Directors in place by the end of the first quarter.

- 2) **Create a finance committee and set priorities for generating resources for the organization.** The financing of this effort (as described in detail in the “Recommendations” section of this plan), will fall into several categories: 1) initial support and start-up (provider contributions, philanthropy, etc.); 2) potential for accessing federal dollars tied to health reform (for FQHC expansion, model development, IT infrastructure, etc.); 3) ongoing and major sources of revenue, primarily generated by public entities through Intergovernmental Transfer Agreements; 4) maximizing all potential areas of collaboration between CalOptima and OCHCA; and 5) establishing systems that will continuously assess utilization, spending and new opportunities within the new network.

During the first quarter, a standing finance committee should be created and should consist of, at minimum: CalOptima, OCHCA, philanthropy, a for-profit hospital system CEO and a not-for-profit hospital system CEO. This committee should establish a priority agenda, with determination made by the end of the first quarter on: start-up funding, IGT targets (particularly between CalOptima and OCHCA and CalOptima and UCI), and an equitable and transparent hospital contribution formula.

- 3) **Commit to a comprehensive eligibility screening initiative to both identify people eligible for Medi-Cal and other entitlement programs as well as to identify those that would become the target of the new network.** The new organization should commit to a comprehensive process that assures that all efforts have been made to link vulnerable people to the benefits for which they may be eligible. CalOptima should take a lead in assuring that this effort is supported but must assure that OCHCA and all participating providers are active partners. The process should be implemented by the end of the first quarter. The

OCHCA enrollment operation currently utilizes more than 40 sites and these should be built upon.

4) **Initiate the establishment of a new FQHC network.** The centerpiece of the delivery system developed under this plan is the creation of a new FQHC network to significantly expand primary care capacity for the uninsured, particularly those in the target populations of the MSI-eligibles and the chronically ill. Acting quickly on the establishment of this new FQHC would also allow for maximum connection to new resources being made available through health reform efforts. The process should start immediately with an assessment of all available options for maximizing benefit and new uninsured capacity, including:

- thoroughly understanding all current federal opportunities for FQHC expansion (including meeting with the regional HRSA staff) and likely challenges that might be faced in Orange County (i.e., Medically Underserved Area status);
- exploring the potential for expanding on the current UCI FQHC network, under new governance and management, by incorporating other existing clinics (including the CHOC facilities and other clinics, particularly those that are currently hospital-subsidized);
- exploring other options if the UCI connection cannot be made, to either expand a current FQHC or to start a new one; and
- assessing all sites that would be included in the new FQHC network for compliance with clinical, financial and organizational requirements for designation.

This effort needs to be an intensive one and will require the assistance of experienced and skilled consultants working with, at minimum: UCI (if there is interest in restructuring their FQHC), CHOC, Hoag, St. Joseph Health System. There will, of course, also need to be the involvement of the participating clinic leadership and communication with CalOptima related to their willingness to guarantee some level of Medi-Cal assignees. The final recommendation related to the establishment of the new FQHC network should be presented to the newly established organizational Board by the end of the first quarter, along with a detailed plan that describes the work to be done in certification of the new FQHC network.

5) **Determine targets for the establishment of urgent care centers to assist in the diversion of patients inappropriately utilizing EDs.** There are clear hospital targets for the establishment of urgent care centers near or adjacent to EDs with high volumes of patients utilizing emergent care unnecessarily. Several “priority sites” should be determined as the first places for these models to be established

and plans developed that address: start-up financial support; potential relationships with FQHCs in the operation of the centers; financing strategies. It is recommended that the OCHCA lead this effort because of their role public health role and their experience in addressing ED utilization through the MSI program. A plan should be ready for approval for at least one center by the end of the first quarter.

- 6) **Begin intensive collaboration discussions between CalOptima and OCHCA and clearly define the roles of each in the new network.** The establishment of significant coordination between OCHCA and CalOptima is perhaps the most critical component in assuring the network's long-term effectiveness. Ongoing meetings should commence to set the agenda for: the integration of the MSI program into the network (with administration and management functions merged with CalOptima); building consolidated systems based in part upon the OCHCA's expertise in IT devoted to supporting provider networks; assuring comprehensive eligibility screening throughout the County; developing an IGT approach that will maximize federal match of County/State dollars (MSI, TSR, behavioral health, coverage of IHHS workers), and; other activities identified in this plan. As CalOptima takes on a greater responsibility for the management of patient care, OCHCA will be able to better define its role as "honest broker" for the network.

The leadership of the two organizations should commit to focused and regular meetings with key staff to establish priorities and timelines.

- 7) **Establish a set of priority areas for patient management.** In order to avoid a "standing committee" that doesn't move quickly enough to set management system priorities, it is recommended that consultants be utilized and focused on identifying specific infrastructure targets—as well as potential collaborators among the network participants—that would have the most significant impact on the management of high risk and high cost patients. This set of priorities (IT investment and coordination, care management, call center, etc.) would be delivered to the Board of the new organization by the end of the first quarter.

## Second Quarter (May-July)

During the second quarter, priority work should be to:

- 1) **Announce the new organization.** The network should be introduced in an organized and public fashion as a conscious and determined effort by community stakeholders to be "good citizens" and to create an equitable and collaborative approach to assuring an effective delivery system for all of the residents of Orange County. This communication effort should be made locally (including to individual institutional boards), with key officials in Sacramento and in Washington, DC. Special attention should be paid to the potentially unique role that the network can play in structures (Accountable Care Organizations,

Coordinated Care Networks) emanating from national health reform efforts and also to the implications of the California Medicaid 1115 waiver related to increased Coverage Initiative funding that could be applied to the network.

- 2) **Officially seat the new Board (including representation from physicians, clinics and the broader civic community) as the organizational governance.** Board leadership should be determined, working committees established and search for staff leaders (CEO, COO, CMO, CFO, CIO) should be initiated.
- 3) **Recruit key staff leaders.** The CEO should be hired before the end of the second quarter; he/she will then participate in the selection of other staff leaders and in the coordination of consultants and staff from other agencies.
- 4) **Determine the benefit package for network “enrollees.”** By the end of the second quarter, the package of services—along with any financial contributions expected from the patients- should be clearly defined. It is anticipated that there will be at least two different levels of service (with a more comprehensive set of services directed toward the more complex and costly patients).
- 5) **Formalize hospital contributions.** An equitable, transparent and documentable “contribution formula” should be determined and agreed to by all of the participating hospitals in the network (see details in the “Financial Recommendations” section). This should be accomplished by the end of the second quarter.
- 6) **Initiate one or more IGT opportunities.** The process should commence with the State for one or more of the IGT options identified as the most viable during the first quarter. This will require significant involvement by CalOptima, OCHCA and, perhaps, UCI.
- 7) **Initiate a County-wide “campaign” to enroll all eligible residents into programs to which they are entitled.** Philanthropy should assist in the publicity of this effort.
- 8) **Begin the FQHC application process for either expansion sites for an existing (but restructured) FQHC or for a new start.** This process is exhaustive and will require a staff/consultant team to both draft the application and a plan for bringing the clinics into compliance with FQHC requirements. This is likely to be a 6-month process.
- 9) **Determine a pilot site for an integrated approach to patients with both medical and behavioral health problems.** OCHCA, CalOptima and one or more clinic sites should produce a plan for an integrated practice for network patients with both medical and behavioral health problems by the end of the second quarter.

- 10) **Develop an approach to involving private practices in the network as Medical Homes.** Determining the role of private practices and the criteria for their participation should be completed by the end of the second quarter.
- 11) **Define an equitable division of specialty care resources that will be components of the network.** Commitments should be acquired by major sources of specialty care (including UCI and major IPAs) related to specific specialties, volumes, financing, referral systems, etc. by the end of the second quarter.
- 12) **Establish a mechanism to assure equity among hospitals in the provision of inpatient and diagnostic services for network patients.** As it is proposed that, for at least the first several years, funding be focused on ambulatory care capacity and infrastructure development rather than inpatient care, it is critical that a plan is in place to assure that all hospitals take their “fair share” of the load. While some may contribute because of their geography, others may take on certain specialties, while others may contribute in other ways. The inpatient rationalization component of the network plan should be developed by the end of the second quarter.
- 13) **Finalize an IT plan.** The plan should coordinate all current network support efforts (MSI, CalOptima, AccessOC) and allow for expansion to support appointment generation, disease registries, referral “rules” to better assure appropriateness, connection to enrollment eligibility efforts. The plan should also identify sources of funding (including federal dollars) and be presented to the Board by the end of the second quarter.
- 14) **Set patient management priorities.** A set of patient management priorities and resources should be finalized and presented to the Board by the end of the second quarter for a determination on next steps.

### Third Quarter (August-October)

During the third quarter, priority work should be to:

- 1) **Have all senior staff in place and establish management systems for the network.** The COO, CMO, CIO and CFO should be in place early into the third quarter. Their employment will minimize the need for consultants, requiring “outside” assistance on only targeted and specialty areas (finance, FQHC, IT, care management, etc.).
- 2) **Complete FQHC application.** The final application should be able to be completed in the third quarter, although work will need to continue on clinic compliance, board development, etc.

- 3) **Determine network for target population.** The primary, specialty and inpatient network for the target population will be determined during the third quarter, as well as the process for adding to or subtracting from that network.
- 4) **Continue development of financing strategies.** Ongoing work should continue on strategies, including those detailed in this document.
- 5) **Start behavioral health/primary care integration pilot.** This pilot site (probably at an FQHC to maximize opportunities for reimbursement, favorable 340B drug pricing, etc.) should serve as the Medical Home for a targeted number of complex network patients.
- 6) **Identify target network enrollees through comprehensive screening process.** By the end of the third quarter, the first group of targeted enrollees should be identified, most through the conversions of MSI into the network.
- 7) **Implement first urgent care center.** By the end of the third quarter, the network's first urgent care center should be established at one of the hospitals with the most significant volume of unnecessary utilization from the target population.
- 8) **Implement infrastructure priorities.** Based on the priorities determined during the planning process over the first two quarters, patient management infrastructure (call center, care management in targeted populations, IT coordination, etc.) should begin to be implemented in the third quarter.

#### Fourth Quarter (November-January)

Although the specific work of the final quarter may change and evolve, in general, priority work should be to:

- 1) **Continue to grow enrollment of target population.**
- 2) **Continue to build financing strategies.**
- 3) **Continue to refine provider network, focusing on productivity and quality.**
- 4) **Continue to build patient management infrastructure, assuring effectiveness and efficiency.**
- 5) **Set quality and utilization goals for the next year and develop a tracking and data collection system by which to monitor network impact.**
- 6) **Assess the implications of federal and state reform initiatives on the developing network.**
- 7) **Utilize the public-private nature of the network to become a positive advocate for medically under-served populations and communities.**

## *Appendices*

Appendix A: Individual Interviews

Appendix B: Specialty Care Provision in FQHCs

Appendix C: Behavioral Health IGT Citation

Appendix D: Maximizing Enrollment into Coverage Programs

## **Appendix A: Individual Interviews**

HMA conducted interviews with the following people in the course of preparing this plan:

Richard Afable, MD, MPH, President and CEO, Hoag Hospital

Barry Arbuckle, PhD, President and CEO, Memorial Care Medical Centers

Isabel Becerra, CEO, Coalition of Orange County Community Clinics

Terry Belmont, CEO, University of California-Irvine Medical Center

Michelle Blair, CEO, Orange County Medical Association

Greg Buchert, MD, COO, CalOptima

Richard Chambers, CEO, CalOptima

Joyce Cheung, Director of Care Management, Kaiser-Permanente (Orange County)

Ben Chu, MD, President, Kaiser-Permanente (Southern California Region)

Jay Cohen, MD, President and Chairman, Monarch Health Care

Kim Cripe, President and CEO, Children's Hospital of Orange County

Chris Crittenden, President, NetChemistry

Castulo de la Roche, CEO, AltaMed Health Systems

Jeffery Flocken, Regional President and CEO, Tenet Health Care

Robert Gates, Deputy Director for Medical Services, Orange County Health Care Agency

Ed Gerber, Board Chairman, Coalition of Orange County Community Clinics

John Gilwee, VP/Governmental Affairs, University of California-Irvine Medical Center

Eric Handler, MD, Public Health Officer, Orange County Health Care Agency

John Heydt, MD, President and CEO, University Physicians/Surgeons, UCI

Michael Hurwitz, MD, President, Orange County Medical Association

Ed Kacic, President, Irvine Health Foundation

Keith Matsutsuyu, Principal, NetChemistry

Julie Miller-Phipps, President and CEO, Kaiser-Permanente (Orange County)

Pam Pimental, Executive Director, MOMS

Richard Pitts, MD, Incoming President, Orange County Medical Association

Deborah Proctor, President and CEO, St. Joseph Health System

Lex Reddy, CEO, Prime Healthcare Management, Inc.

Mark Refowitz, Deputy Director-Behavioral Health, Orange County Health Care Agency

David Riley, Agency Director, Orange County Health Care Agency

Elliot Sternberg, EVP Wellness and Health Improvement, St. Joseph Health System

Paul Van Dolah, President, Van Dolah & Associates

Kenneth Westbrook, President and CEO, Integrated Healthcare Holdings, Inc.

In addition, HMA had significant interaction with and assistance from Ruth Kurisu (Health Funders Partnership of Orange County), Curt Condon (Orange County Health Care Agency) and Ilia Rolan (CalOptima).

## **Appendix B: Specialty Care Provision in FQHCs**

HRSA released its current specialty care guidance in December of 2008. The guidance is applicable FQHCs that want to add specialty services through the change of scope process (i.e., no new grant funds). Health centers that want to secure additional Section 330 funding to support the new services must apply through the competitive grant process. This guidance technically does not apply to Look Alikes, though, presumably, the Bureau would apply similar logic in considering change of scope requests for Look Alikes requesting to add specialty care.

Like most HRSA guidance, the new PIN is subject to a range of interpretations. In general, however, HRSA appears to be taking an approach that specialty care services may be included within a health center's scope as long as the health center can make a strong, data-driven case (based on the health center's current patient population and target population) that its patients have a strong need for the proposed services, and the services will support/enhance the provision of primary care within the health center.

### **Background**

Health centers are allowed to provide "additional" health services, beyond those required in statute, that are "necessary for the adequate support of the [required] primary health services" and that are "appropriate to meet the needs of the population served by the health center" (Public Health Services Act section 330(a)(1)). Federal approval is required in order to include additional services within a health center's official scope of project, thereby extending certain FQHC benefits (e.g., cost-based reimbursement) to the new service.

### **Process and Factors in Consideration**

Health centers wishing to add specialty services must file a formal change of scope request with HRSA. As part of this process, the health center must demonstrate that it is prepared to offer the service and that it has evaluated the costs, benefits and risks of adding the new service. When evaluating change of scope requests for specialty care, the Bureau will specifically look at the following factors:

1. Support for primary care. The health center must demonstrate that the new service will support, or serve as a "logical extension of," the required primary care services within the health center. For example, cardiology screenings in a health center that sees a large number of patients at risk for heart disease, would meet this standard.
2. Demonstrated need for the proposed service. The health center must demonstrate and document with data the target population's need for the proposed service. The health center must also demonstrate that it will be able to maintain its current level of primary care services for the target population.

3. Funding/financial risk. The health center must demonstrate that it can add the service without additional 330 grant support and that the addition of the new service will not jeopardize the health center's financial stability.
4. Location. The service must be provided at a current FQHC site, a new site that is being incorporated into the FQHC's scope, or at a location "where in-scope services are provided but that does not meet the definition of a service site." If the service is provided at a location that is not a service site, the health center must document how referrals will be made and how arrangements will be made for appropriate follow-up care at the health center. Regardless of the service site, services must be provided without regard to ability to pay and must be provided in a culturally and linguistically appropriate manner.
5. Other considerations. Providers must be properly licensed, pursuant to applicable state law, and must be properly credentialed and privileged to perform the activities expected of them. Health centers must also provide a clear description of the staffing arrangements that will be used to provide the new service (e.g., direct employment, contract). Certain arrangements may require a formal affiliation agreement.

As with all change of scope requests, federal tort coverage does not automatically apply to the new service. The health center must complete a separate FTCA deeming process in order to ensure coverage. Certain staffing arrangements (e.g., group contracts) may not be eligible for FTCA coverage.

## Appendix C: Behavioral Health IGT Citation

### **W&I Section 5719.5**

5719.5. (a) Notwithstanding any other provision of state law, and to the extent permitted by federal law, the State Department of Mental Health may, in consultation with the State Department of Health Services, field test major components of a capitated, integrated service system of Medi-Cal mental health managed care in not less than two, and not more than five participating counties.

(b) County participation in the field test shall be at the counties' option.

(c) Counties eligible to participate in the field test described in subdivision (a) shall include either of the following:

(1) Any county with an existing county organized health system.

(2) Any county that has been designated for the development of a new county organized health system.

(d) The State Department of Mental Health, in consultation with the State Department of Health Services, the counties selected for field testing, and groups representing mental health clients, their families and advocates, county mental health directors, and public and private mental health professionals and providers, shall develop, for the purpose of the field test, major components for an integrated, capitated service system of Medi-Cal mental health managed care, including, but not limited to, all of the following:

(1) (A) A definition of medical necessity.

(B) The preliminary definition developed pursuant to this paragraph shall be submitted to the Legislature no later than February 1, 1994.

(2) Protocols for facilitating access and coordination of mental health, physical health, educational, vocational, and other supportive services for persons receiving services through the field test.

(3) Procedures for promoting quality assurance, performance monitoring measures and outcome evaluation, including measures of client satisfaction, and procedures for addressing beneficiary grievances concerning service denials, changes, or terminations.

(e) Counties participating in the field test shall report to the State Department of Mental Health as the department deems necessary.

(f) Counties participating in the field test shall do both of the following:

(1) (A) Explore, in consultation with the State Department of Mental Health, the State Department of Health Services, and the California Mental Health Directors Association, rates for capitated, integrated Medi-Cal mental health managed care systems, using an actuarially sound rate setting methodology.

(B) These rates shall be evaluated by the State Department of Mental Health and the State Department of Health Services to determine their fiscal impact, and shall result in no increase in cost to the General Fund, compared with the cost that would occur under the existing organization of Medi-Cal funded mental health services, except for caseload growth and price increases as included in the Medi-Cal estimates prepared by the State Department of Health Services and approved by the Department of Finance. In evaluating the fiscal impact of these rates, the departments shall take into account any shift in clients

between Medi-Cal programs in which the nonfederal match is funded by state funds and those in which the match is funded by local funds.

(2) Demonstrate the appropriate fiscal relationship between county organized health systems for the federal medicaid program and integrated, capitated Medi-Cal mental health managed care programs.

## **Appendix D: Maximizing Enrollment into Coverage Programs**

### **Goal:**

Increase the proportion of eligible Orange County residents who are enrolled in Medicaid (Medi-Cal) or Healthy Families so as to decrease burden on county safety net providers and provide a revenue source for Medicaid providers.

### **Problem:**

Across the country many eligible persons are not enrolled in Medi-Cal /Healthy Families. For example, a national survey found that 35.0% of adults without private coverage eligible for Medicaid under current criteria have not enrolled.<sup>1</sup><sup>14-Davidoff '01</sup> Even if a person qualifies for Medi-Cal at the time of hospitalization, lack of Medi-Cal before hospitalization results in fewer outpatient visits and more avoidable hospitalizations.<sup>1</sup>

### **Reasons:**

Fear of application, especially among immigrants  
Language barriers  
Administrative difficulties  
Stigma attached to Medi-Cal (welfare) program  
Lack of advocacy for denied SSI applications for disabled adults.<sup>2</sup>

### **Work Plan for Increasing Medicaid Enrollment in Orange County:**

Different strategies are needed for the two distinct populations that are eligible but not enrolled in Medi-Cal /Health Families:

- Categorical eligibles: Parents with dependent children, pregnant women, children
- Adults eligible on the basis of a permanent disabling disease

#### **A. To increase enrollment for those with categorical eligibility**

- 1) Determine the cost of creating an on-line enrollment application for adults entering MSI. At least, two products should be considered. *Auth-med*, which is currently being used for MSI can be extended so it can do full on-line eligibility. Another product used in other counties for adults to screen for Medi-cal and used

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<sup>1</sup> A. Davidoff, B. Garrett, and A. Yemane, "Medicaid-eligible Adults Who Are Not Enrolled: Who Are They and Do They Get The Care They Need" New Federalism Series A, No. A-48, (Washington, Urban Institute, October 2001) [http://www.urban.org/Uploadedpdf/310378\\_anf\\_a48.pdf](http://www.urban.org/Uploadedpdf/310378_anf_a48.pdf)

<sup>2</sup> Nationally, most of the 60% of SSI applications that are denied are not appealed. However, when applications are appealed with case management and legal advocacy, 85-95% are approved. SF did a two year pilot of SSI advocacy through partnership with a community-based group<sup>2</sup>: 86% award rate with average of 12 months of retroactive benefits. Return on investment: 5 to 1 hard dollars.

in Orange County for children is *One-e-app*. For clients eligible for Medi-Cal, an application can be submitted electronically to the State from One-e-app through Cal-Win (this could also be created through One-e-app). This process markedly shortens the time to Medi-Cal thereby hastening the time during which payment is available for medical services. Having an electronic system for enrolling clients onto Medi-Cal will be even more important if Medi-Cal is expanded under federal health reform efforts. Any on-line eligibility system should include the capability of scanning documents such as birth certificates. This will enable the county to store information that will help eligibilize patients in the future for federal health insurance expansions.

The electronic eligibility system should also be used as the system of record for the MSI. This will facilitate tracking of clients, decrease duplication of care, and improve accountability. Also, by maintaining lists of patients not currently eligible for Medicaid with their documentation scanned (birth certificates, income statements) it will be easier and faster to enroll them into Medicaid or direct them to a subsidized insurance product if federal health reform efforts result in coverage expansions.

- 2) Once the costs of an electronic eligibility/system of record are understood, look for philanthropic or federal economic stimulus dollars to fund since most of the costs are one-time and ultimately having the system will improve the financial viability of the safety net. San Francisco's one-time costs for establishment of One-e-app as a uniform eligibility system and system of record was \$500,000. Given that many of the features SF uses were developed specifically for SF (e.g., Cal-Win interface, system of record), it would seem it should be less expensive now that it has already been created. There is an ongoing maintenance expense for One-e-app (in the case of San Francisco, the on-going operating cost is \$200,000 a year). However, the existing providers are likely doing eligibility now and once the system is in place there should be savings from eliminating existing efforts.
- 3) Issue an RFP for community based agencies interested in enrolling clients into Medicaid. Community application assistors have been shown to increase the number of Latino and Asian immigrants who apply for Medicaid.<sup>3</sup> This is consistent with the demographics of OC. With a web-based electronic on-line application, it can be done without expensive IT equipment for connectivity.
- 4) Consider doing a media outreach campaign to increase Medical, especially for enrolling infants.
- 5) Arrange high level meeting with OC Department of Social Services on churn rate (patients losing Medi-Cal than regaining Medi-cal due to problems during

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<sup>3</sup> Aizser A, Currie J. The impact of outreach on Medi-cal enrollment and child health: Lessons from California. California Policy Research Center, September 2002.  
[www.econ.columbia.edu/currie/Papers/The\\_Impact\\_of\\_Outreach.pdf](http://www.econ.columbia.edu/currie/Papers/The_Impact_of_Outreach.pdf)

application procedure). Other counties have been able to improve process with the result that clients do not have months when they are not on Medi-cal.

**B. To increase enrollment for adults eligible on the basis of a permanent disabling disease**

1) Estimate size of opportunity

- a) The largest group of clients eligible based on permanent disabling disease would likely be in county mental health system. Persons with diagnoses of schizophrenia, psychotic disease are very likely to be eligible. Persons with severe depression may also be eligible. Underlying substance use does not exclude them from eligibility if they have a primary medical illness. If diagnoses are not easily available, use of antipsychotic medication is a good proxy for eligibility along with recent acute hospitalization. Also, clients who are in residential placement would be eligible. However, clients who are in IMD's (institutions for mental diseases, generally defined as institutions with more than 16 beds or where more than 50% of the clients have a primary mental health disease) are not eligible to receive Medicaid or SSI payments while institutionalized.

Some proportion of the clients meeting the above criteria will already be on SSI/Medicaid. Persons who are undocumented will not be able to receive SSI/Medicaid. Based on size of the undocumented population (which may not be known), we would estimate that 70% of patients meeting the above criteria are eligible for SSI/Medicaid. The difference between the proportion already receiving it and 70% is an estimate of the opportunity for this population.

- b) Second group that would be eligible for SSI/Medicaid would be persons currently being seen through the MSI who have disabling medical illnesses. The highest percent of potential eligibles would be persons with HIV/AIDS, chronic liver disease, congestive heart failure, diabetics with blindness or amputations or severe peripheral neuropathy of severe gastroparesis.

- 2) Arrange a high level meeting with Orange County social service department. They have a lot to gain by increasing the proportion of persons who have SSI because 1) the county will receive a retroactive check repaying the county for general assistance provided to the client dating back to the date of disability; 2) the client will no longer be eligible/need county general assistance; 3) SSI checks are larger than general assistance allowing the person to have a higher standard of living (spend more within county) and require less assistance.
- 3) Create an SSI unit either within OCHCA or within the county social service department to do the preliminary outreach work with clients to help them to apply for SSI. The cost of SSI can be partially reimbursed through California Services Black Grant, a state fund that assists counties in getting individuals onto Medi-

Cal. Clients can be given a preliminary application form to be completed by their providers at the time of a visit (e.g., at the time of a visit with psychiatrist).

- 4) Issue an RFP for a provider of SSI advocacy services. The provider should have access to legal help, as well as the ability to refer patients to specialists who can complete the paperwork. The RFP can be structured either as an hourly wage, a sum for each client who receives SSI or as a percentage of what the county gains in terms of retro payments.

In gauging the financial benefits of SSI advocacy it is important to consider whether many of these patients would obtain Medi-cal without SSI advocacy under federal health reform efforts. Current bills would expand Medicaid to up to 133% or 150% of poverty without any need to demonstrate a disabling illness. The fate of these bills is likely to be known in January.

Certainly, if a Medicaid expansion passes the financial opportunity for SSI advocacy decreases, but it does not go completely away. The reason is that it may be difficult to get some of these clients to enroll in Medicaid for the same reasons that people do not enroll now in Medicaid even when they are eligible. People who either fear eligibility determinations or do not perceive benefits from enrolling do not enroll. SSI, on the other hand, has a direct financial benefit to the client—a monthly income check. This check makes it easier for clients to house themselves, eliminates the need to provide them general assistance (which will still be required with an expansion of Medicaid), and brings increased federal dollars into the county. Most importantly, the promise of a monthly check often makes it easier to motivate clients to go through the eligibility process including finding forms such as birth certificates.

Overall, it is likely that SSI advocacy will still be a financial net benefit for the county even with a federal expansion of Medicaid eligibility.

### **Tapping into VA benefits for uninsured persons in Orange County**

An under appreciated source of benefits for uninsured persons is Veteran's Administration benefits. Although there are no VA hospitals in Orange County, there appear to be three VA outpatient clinics (Santa Ana, Anaheim and Laguna Hills) that are part of the VA Long Beach network.

The challenge is to aggressively determine Veterans who are currently relying on EDs or on over-stretched community clinics and redirect them into the VA clinics, so as to build a network for persons who do not have alternatives with the available scarce resources.

There are several reasons persons do not avail themselves of VA benefits. First, there is often a misunderstanding both among veterans and service providers that only people with service related injuries are eligible for benefits. This is not true. Low income veterans are also eligible. Second, some veterans perceive the quality of services at VA facilities as low based on historic problems that the VA has had. This is no longer the

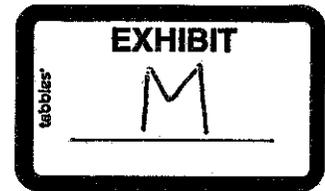
case. Third, clients who are able to obtain services at a community clinic or through a hospital ED may not perceive any benefit from going to a VA facility. However, in certain areas, especially specialty care and behavioral health services, they may be able to obtain services through the VA that are not otherwise available to them, or with a much shorter wait.

Because each VA network is paid based on the number of veterans it cares for, VA facilities are very eager to increase their enrollments. Also, VA facilities are happy to provide specialty care, prescriptions or diagnostic tests to veterans even if the veteran receives their primary care elsewhere.

Work plan for increasing the proportion of uninsured persons who seek services at the VA.

1. For MSI eligibility screen, ask enrollees whether they are veterans.
2. Meet with local VA staff to determine easiest ways for veterans to seek services.
3. Put together a glossy pamphlet, in cooperation with the local VA, on what services veterans can receive that is specific to Orange County, including phone numbers, directions to facilities.
4. Encourage veterans at entry points into the system (ED eligibility, community-clinic eligibility) to seek services at the VA.

Mitch Katz, MD



June 14, 2011  
To: Gary Chalupa  
CC.: Dean Settle, Travis Parker.  
From: Wendy Andorf

Re: General Assistance Services through CMHCLC

The following information covers a three month snapshot of active GA clients at CMHCLC. The information is broken out into categories of service and the amounts of time or units produced in each category. Costs were calculated using the current Medicaid rate for this service. As noted in the comments, there are no administrative costs factored into this data at this time.

Total GA this snapshot: **268**  
Total active at CMHCLC: **75 / 28%**  
Of those active at CMHCLC, the following services were provided in the last three months:

**Services Provided:**

|                |   |
|----------------|---|
| Nursing:       | <b>146</b> Contacts   |
| Psychiatry:    | <b>122</b> Contacts for Pharmacological Management<br><b>25</b> Contacts for Diagnostic Interview |
| Clinician:     | <b>22</b> Contacts for Pre-Treatment Assessment<br><b>48</b> Contacts for Individual Therapy      |
| PHP:           | <b>11</b> Partial Hospitalization Days  |
| Groups:        | <b>134</b> Groups   |
| Comm. Support: | <b>215</b> Hours  |

**Costs:**

|                    |                     |
|--------------------|---------------------|
| Nursing*           | <b>\$2427.00</b>    |
| Psychiatry         |                     |
| Diagnostic         | <b>\$3250.00</b>    |
| Med Mgmt           | <b>\$5140.00</b>    |
| Clinician          |                     |
| PTA                | <b>\$4070.00</b>    |
| Ind. Tx            | <b>\$4176.00</b>    |
| PHP/Groups         | <b>\$4553.00</b>    |
| Comm. Support      | <b>\$17,240.00</b>  |
| Total Quarter Cost | <b>\$ 40,853.00</b> |
| Projected Annual   | <b>\$163,424.00</b> |
| PAP contract       | <b>\$13800.00</b>   |

**Grand Total: \$177,224.00**

\*Nursing costs were calculated by figuring actual cost based on salary. Medical support services are not billable to a third party but are a necessary part of dealing with the GA population.

### **Definition of Services:**

**Nursing:** Includes medication education, injections, setting up medisets and some applications for medications (Region V).

**It is important to note that the actual use of nursing time is much larger than the above numbers indicate, however, this time is not tracked. Thus it is nearly impossible to assign a cost specific to GA clients.** The following is a listing of additional services provided by the nurses: refill requests, pharmacy calls, provision of samples, medication documentation, assistance to doctors with vitals, etc, weights, drug screens, LB95 paperwork and tracking, enter scripts in data bank, process LB95 meds, nutrition and wellness information, referrals to specialists and other providers, triage by phone, handling walk-ins, etc.

**Psychiatry:** Typically our prescriber's bill for Diagnostic Interviews and/or Pharmacological Management (we call it med management). The Diagnostic Interview is required by Medicaid at the onset of services and annually thereafter. Pharmacological Management is the ongoing services to manage and evaluate medication effectiveness.

**Clinician:** These are typically Master's Level Clinicians, although they can be PhD as well. Clinicians complete the Pretreatment Assessment (PTA) which is also required by Medicaid and Accreditation bodies prior to the onset of treatment. Clinicians also provide individual, marital, and family therapy as specified by the treatment plan.

**PHP/Groups:** CMHCLC's Partial Hospitalization Program offers full-time, part-time or outpatient level of therapeutic groups to assist in stabilizing symptoms and as an alternative to inpatient care. These groups are usually run by licensed clinicians.

**Community Support:** This is a group of supportive and rehabilitative services geared to assist mentally ill adults in developing independent community functioning. In reference to the above, the Community Support services include typical Community Support, Jail Diversion as well as the services of Homeless/Special Needs staff. Some of these services may be reimbursable through MRO funding if the individual served fits in the appropriate diagnostic category. Referral to Community Support as well as other services listed above is determined by the PTA and the treating prescriber. The importance of this service can be seen in its ability to improve consumer compliance, assist with documentation needed for Social Security Applications and providing Outreach for this often difficult to treat population.

Additional things to consider:

- These figures do not take into account any type of overhead costs.
- Nursing costs do not reflect the entirety of what they do for the GA consumer. More time would be needed to accurately price out that service.
- Clerical Support staff time for fielding phone calls, medical records, typing notes and assessments are necessary but not included in this cost estimate.
- Does not take into consideration the coordination time needed to communicate with GA, LLCHD, and Wagey Drug about ongoing consumer care.
- When looking at this data, it points to a higher acuity level with this population. **40%** of the current GA consumers have been EPC'd or in the Crisis Center at some point.
- Providers, i.e. GA, medical providers (LLCHD), psychiatric (CMHCLC), and pharmacy (Wagey) need to be able to communicate on a regular basis. There are always situations that need to be dealt with.
- **This data does not reflect the cost savings of using sample medication. It may be difficult to find a private provider able and willing to advocate for the amounts of sample medication that CMHCLC is able to provide.**
- Just a reminder that for each GA consumer receiving services at CMHCLC, a PTA and Diagnostic Interview will be mandatory. The combined Medicaid rate for these two evaluations is \$350.00. If these are not done, or not done completely, it will be impossible to recoup Medicaid costs when the client becomes eligible.
- This population has a high no show rate. Potential costs for that with an independent contractor would have to be factored in.
- Please do not underestimate the value of PHP in avoiding hospitalizations. It saves the County and GA serious dollars.