Constantino, Mike

From: anne.murphy@hklaw.com
Sent: Tuesday, April 19, 2011 5:16 PM
To: Constantino, Mike
Cc: Avery, Courtney
Subject: FW: Response to Request for Additional Information (Project 10-078)
Attachments: Exhibit_B_1_Apr_19_2011_11_29_03_718.pdf; Exhibit_A_1_Apr_19_2011_11_27_25_967.pdf; constantino__Apr_19_2011_18_07_06_310.pdf; Exhibit_C_1_Apr_19_2011_18_05_53_60.pdf; Exhibit_C_cont_1_Apr_19_2011_18_04_43_809.pdf; Exhibits_D_through_G_1_Apr_19_2011_17_51_22_298.pdf; Exhibits_H_and_I_1_Apr_19_2011_17_08_18_515.pdf

Mike,

As you requested, I attach a letter and various Exhibits, in response to your April 8 letter to me requesting additional information in connection with Project 10-078 (Proposed Discontinuation of Oak Forest Hospital).

Please let me know if you have any additional requests for information.

Thanks.

--Anne

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April 19, 2011

Via Email and Overnight Mail

Mr. Michael Constantino
Project Reviewer
Illinois Health Facilities and Services Review Board
525 West Jefferson Street
Springfield, Illinois 62761

Re: ***Request for Additional Information***
Discontinuation of Oak Forest Hospital (Project # 10-078)

Dear Mr. Constantino:

This letter, and its various attachments, responds to your April 8 letter to me in which you seek certain additional information on behalf of the Illinois Health Facilities and Services Review Board ("IHFSRB"), in connection with the captioned Certificate of Need Permit Application ("CON Application").

As you know, this CON Application received an Intent to Deny from the IHFSRB at its March 21 meeting. The CON Application is tentatively scheduled to be reheard at the May 10 IHFSRB meeting. Pursuant to IHFSRB Rule 1130.670, the IHFSRB may request additional information from an applicant that will assist it in consideration of a CON Application after an Intent to Deny has been issued.

On behalf of the applicant Cook County Health and Hospitals System ("System"), thank you for requesting additional information to assist the IHFSRB in its continued consideration of the CON Application to discontinue Oak Forest Hospital. We will address below each of your three requests. In formulating this response, I have relied upon information provided by System representatives, several of whom are copied on this letter.

I. Additional Detail Regarding The System's Strategic Plan, Including Additional Information Regarding: (A) How The Proposed Action At Oak Forest Hospital Fits Into That Plan; And (B) How The Strategic Plan Aligns With Enhanced Access And Public Policy.

Formation of the System in 2008. After repeated calls by many civic and health care leaders to reform oversight of Cook County's health services delivery system, the System was established by Cook County in 2008 through an Ordinance. A copy of this Ordinance is attached as Exhibit A. The System is an agency of, and is funded by, Cook County. Through this Ordinance, however, the System is to be governed by a newly-constituted governing board ("System Board").

The Ordinance clearly delineates the mission of the System. Prominently featured in this mission is the continued provision of integrated health services with dignity and respect, regardless of a person's ability to pay; and continued access to quality primary, preventive, acute and chronic health care for Cook County residents.

The System Board is comprised of 11 Directors, pursuant to the Ordinance. Ten of these Directors are independent appointed Directors, who are not Cook County employees and receive no compensation for service. These ten appointed Directors must include persons with expertise in areas pertinent to the governance and operation of a large and complex health care system. The one remaining Director serves ex officio with vote, in his or her capacity as the Chair of the Health and Hospitals Committee of the Cook County Board. A listing of the System Board of Directors is attached as Exhibit B.

The Ordinance confers broad management, strategic and financial responsibility and authority upon the System Board. These powers include, without limitation, appointment of a CEO, determining the scope and distribution of clinical services (provided that closure of an entire hospital requires the County Board's approval), developing the organization and management of the System, entering into contracts, expending funds, and carrying out a wide range of other duties.

In May 2009, the System Board appointed William T. Foley as the System CEO. Mr. Foley has extensive hospital and health system executive experience. Although Mr. Foley recently announced his impending departure from the System, he was very actively involved in the Strategic Plan development described below. Dr. Terry Mason, M.D., who is currently the System Chief Medical Officer and who will be the Interim System CEO as of May 6, also was very actively involved in Strategic Plan development and is fully committed to its implementation.

Strategic Plan Development by the System. Section 38-92 of the Ordinance mandates that the System Board develop Strategic and Financial Plans for the System. Almost immediately after the System Board was seated, it began an extensive strategic and financial planning process for the System known as "Vision 2015". This process used a nationally recognized consulting firm for data collection and analysis, took countless hours of System Board and staff time, and incorporated extensive input from interviews and meetings with over 500 stakeholders. Indeed, as part of this process, 14 town hall meetings were held throughout the County to solicit community input into the strategic planning process.

The System Board determined that the strategic planning process needed to have four key elements: (1) assessment of the current state of the Cook County health system and the current health care needs of Cook County residents; (2) an overall strategic direction, including a vision and core goals; (3) specific action priorities based on the assessment and overall strategic direction; and (4) a five-year financial plan. It is important to emphasize that the Strategic Plan does not seek to reduce operating funds or levels of financial investment in the System.

In June 2010, after about a year and one-half of effort, the System Board finalized and unanimously approved the "Vision 2015" Strategic and Financial Plan for the System. This Strategic Plan was included in the CON Application. Note that the Strategic Plan—including the proposed discontinuation of the Oak Forest Hospital in order to transform the Oak Forest campus into a Regional Outpatient Center—has been approved by the Cook County Board of Commissioners.

Key Elements of the System Strategic Plan. As indicated above, the Strategic Plan starts with a detailed assessment of the current state of the Cook County Health System, along with an assessment of the unmet health care needs of uninsured and Medicaid beneficiaries in Cook County. Among these findings:

- The System's health delivery access points are not aligned with the geographic needs of residents. This gap in access is particularly problematic in the South/Southwest portions of Cook County. (See pp. 62, 66 of the Strategic Plan).

- The System's resources are disproportionately centered around hospital care, especially when compared with other large national public health systems (see pp. 67-68 of the Strategic Plan).

- The System is not deploying providers and facilities as effectively as it could, which results in substantial wait times for patients seeking outpatient care in the System (see pp.67, 69 of the Strategic Plan).

- Redirection of care to outpatient modalities would increase the overall volume of health care services to Cook County residents, and would improve timeliness and geographic convenience in service delivery (see p. 27 of the Strategic Plan). In fact, reallocation of funds currently spent on inefficient hospital operations to primary and outpatient care is projected to result in an increase in System primary care and specialty outpatient care by about 50% from 2009 to 2015, from about 600,000 to 900,000 visits per year.

The Strategic Plan then takes these findings, and applies certain guiding principles to them for future development of the System (see pp.21-22 of the Strategic Plan). These guiding principles include:

- The System should deliver the best possible care for the vulnerable population of Cook County within the dollar resources available.
- System care should be population-centered rather than hospital-centered.
- The System must provide services that are accessible.
- The System should focus on the services needed by vulnerable populations, with an emphasis on specialty care and extension of primary care.

Based on these key findings and the guiding principles, the System Board identified five core strategic goals, each to be achieved through specific strategic initiatives:

1. **Access to Healthcare Services**
   - Eliminate access barriers at all sites.
   - Strengthen the primary care network, through increased staffing and enhanced partnerships with FQHCs.
   - Comprehensive Regional Outpatient Centers at strategically-located sites, including Oak Forest Hospital. [NOTE: This specific strategic initiative, which is designed to achieve the core strategic goal of enhanced access, is one basis for the proposed transformation of the Oak Forest campus from an underutilized hospital to a Regional Outpatient Center.]
2. **Quality, Service Excellence and Cultural Competence**
   - Have an integrated, System-wide approach and infrastructure for patient care coordination.
   - Implement Continuous Quality Improvement.
   - Comprehensive program to instill cultural competency.
   - Develop an Electronic Medical Records infrastructure for the System.
3. **Service Line Strength**
   - Develop and strengthen service lines based on vulnerable patient population needs. [NOTE: As detailed in Section II of this letter, the proposed Regional Outpatient

Center at the Oak Forest campus would focus on these primarily chronic conditions. In Phase 1, new service lines would be established for pain management, urology and infectious disease; outpatient volume in clinical specialties such as cardiology, psychiatry, orthopedics and rehab medicine would increase dramatically.]

- Partner with community providers.
- Assure provision of the Ten Essentials of Public Health.

4. **Staff Development**

- Implement initiatives to improve caregiver and employee satisfaction.
- Focus on effective recruiting and retention processes.
- Develop robust in-service education and professional skill-building.

5. **Leadership and Stewardship**

- Hold System Board and management accountable for agreed-upon performance targets.
- Foster leadership development and succession planning.
- Develop long-term financial plans and sustaining funding.

Role of the Oak Forest Campus Transformation in Implementing the System Strategic Plan. As indicated above, the Strategic Plan has concluded that: (1) the current System is overly-dependent on inpatient hospital care; (2) residents of Southern Cook County need better geographic access to System-sponsored health care; and (3) vulnerable Cook County residents would have dramatically improved access to health care through the transition of underutilized hospital services in favor of much-needed outpatient specialty care and primary care.

In this context, the proposal to discontinue inpatient hospital operations at Oak Forest Hospital, in order to develop a comprehensive Regional Outpatient Center on the Oak Forest campus, is obviously an important means of achieving core goals of the Strategic Plan.

Oak Forest Hospital is a grossly underutilized and inefficient hospital. It currently runs an average daily census of about 40+ patients in 213 authorized beds. The physical plant is comprised of multiple buildings totaling about 1.2 million square feet of facility space originally constructed to house up to 1100 long-term care patients.

Until 2002, the hospital was licensed as a Chronic Disease Hospital with a census of primarily long-term care patients. Since 2002, the hospital's census has been declining. In 2007, the hospital significantly reduced its long-term care service capabilities, and in that process discharged about 20

long-term custodial inpatients into long-term care facilities. No new long-term care patients have been admitted to the hospital since that time. The System continues to pay for the care provided to those discharged residents, and monitors the quality of this care on an ongoing basis.

Oak Forest Hospital has a stand-by emergency department that cannot and does not accept ambulance runs. In addition, multiple clinicians can attest to the fact that its ICU beds historically have not been utilized by what most would think of as patients requiring comprehensive intensive care services.

Despite a low volume of service demand and profound historical and current limitations on the scope of services provided, Oak Forest Hospital is one of the most expensive hospitals in the State to operate on a per-patient basis (see p. 73 of the Strategic Plan). On an annualized basis, hospital operations total about $91 million per year in expenditures.

According to the State Agency Report, Oak Forest Hospital's planning area has an excess of 503 med/surg/pediatric beds, an excess of 77 rehabilitation beds, and an excess of 36 obstetrics beds. The System has documented that several area hospitals, including Ingalls Memorial Hospital, Jackson Park Hospital, and South Shore Hospital, each are willing and able to absorb all or most of the Oak Forest Hospital patient load on an ongoing basis. Two additional area hospitals, Holy Cross Hospital and MetroSouth Medical Center, have just submitted letters in support of the project. In the case of MetroSouth, the hospital indicates that it is available as a facility to treat current Oak Forest Hospital patients.

Of course, the John H. Stroger, Jr. Hospital of Cook County also will be available to any uninsured and Medicaid inpatients from the Southland who need its services. In the event patients needing inpatient care present at the Immediate Care Center, they would be transported to Stroger Hospital under the System's ambulance contract. This ambulance transport would not be charged to patients who lack health insurance covering transport.

The remaining 5 long-term care patients at the hospital will be transferred to long-term care facilities or other suitable homes, with their input and with support from System social workers. If no other funding source becomes available, the System intends to fund care for these residents indefinitely into the future, and will monitor the quality of that care. Similar contracts will be entered into to provide acute ventilator and rehabilitation care for unfunded area residents; the hospital currently has 2 unfunded ventilator patients.

Area hospitals have indicated a willingness and ability to absorb the hospital's remaining patient volume now and into the future. Approximately 85-90 percent of current ED visits could be seen either at the campus Immediate Care Center, or at one of the specialty clinics to be operated on the Oak Forest campus. Transition from reliance on a stand-by ED to patient-centered outpatient service sites will both improve care and reduce unnecessary expense.

While the State Agency Report shows a need for 21 ICU beds in the Planning Area, the elimination of the 8 limited-use ICU beds at Oak Forest Hospital will not have a meaningful adverse impact on access to ICU services in the area. And finally, the 5 remaining long-term care patients and 2

ventilator-dependent patients at the facility will be cared for through the transition plan described above.

As for employees, all of the approximately 115 registered nurses at the hospital who are members of a collective bargaining unit have been offered nursing positions in the System, some of which will be at the Regional Outpatient Center. Most of these registered nurses have chosen to accept those offers. It is currently expected that all these nurses will have transitioned into these new positions by May 20.

Of the physicians currently on staff at the hospital, all ED physicians will immediately transition into servicing the Immediate Care Center on the Oak Forest campus. Similarly, the majority of the specialist physicians at the hospital will immediately transition into full-time outpatient specialty care. Eight hospital-based physicians, two of whom are part-time employees and all of whom are members of a collective bargaining unit have received or will receive displacement notices. These physicians are primarily hospitalists and rehabilitation physicians. The System is actively working, on a voluntary basis, to facilitate the possible placement of these physicians into System vacancies. In addition, approximately 12 physicians who are not members of the collective bargaining unit have received or will receive notice that their positions are being eliminated. The majority of these physicians are consulting physicians who work less than forty hours per pay period.

Once the hospital is discontinued, the Regional Outpatient Center will be able to begin immediately its Phase 1 operations. Physicians who currently spend much of their time attending to hospital services will be freed up to provide expanded outpatient and immediate care, resulting in a projected immediate increase of 2525 outpatient primary care and specialty care visits per month on the Oak Forest campus.

As described in Section II of this correspondence, the System projects delivering 125,000 annual outpatient visits on the Oak Forest campus by 2015. The site will include an immediate care center, specialty outpatient clinics, increased primary care, and diagnostic testing facilities. The System will give serious consideration to partnerships with one or more FQHCs to enhance primary care services on-site. An ASTC also might be developed on campus, which of course would be submitted to the IHFSRB CON for review.

Please refer to Section II for a detailed description of the Regional Outpatient Center plan.

Public Policy Basis for the Strategic Plan. On behalf of the IHFSRB, you have also requested an explanation as to how the Strategic Plan, and the proposed action at Oak Forest Hospital, aligns with good public policy and enhanced access.

As indicated above, the System Board, through its strategic planning process, has identified critical gaps in access for Medicaid and uninsured individuals in Cook County. Chief among them is the current System's disproportionate reliance on inpatient care rather than primary and outpatient care, when compared with other large national public health systems. The current System concentrates its existing outpatient specialty care at the John H. Stroger, Jr. Hospital campus, which causes Southland residents in need of these safety net services to endure long waits and excessive travel

times. The net result is a lack of adequate access to primary and outpatient specialty care for Southland residents, many of whom have chronic medical conditions.

We are grateful to have received letters of support for our project from numerous public policy leaders at the national, regional and local levels. Without exception, these supporters note the strong public policy reasons for our proposed transformation of the Oak Forest campus in order to increase access to health care services for the medically vulnerable residents of Cook County. These letters of support have been submitted, for example, by the National Association of Public Hospitals and Health Systems, the Illinois Primary Health Care Association, Access to Care, the South Side Healthcare Collaborative, Sinai Health System, Rush University Medical Center, Holy Cross Hospital, and at least eight Federally Qualified Health Centers. Because these letters have been submitted to the IHFSRB, I am not enclosing additional copies here.

We also thought it appropriate to document that it is widely-recognized among public policy researchers and experts that there is a critical gap among safety net health care systems nationally in access to specialty outpatient care and diagnostic testing for Medicaid and uninsured patients. Accordingly, we enclose as Exhibit C several articles and publications, from independent authors and sources, that detail this pervasive lack of specialty care access for medically underserved communities. Two of these articles discuss a 2007 Commonwealth Fund study showing that Community Health Center patients nationally have difficulty accessing specialty services, including referrals to Medical specialists and diagnostic testing.

A November 2010 article underscores that in an era of health reform, safety net health care delivery systems will need to transform quickly into patient-centered care models that coordinate care, rather than continue to provide fragmented episodic care through Emergency Departments and otherwise. Like the other articles we have provided, this reform article notes that it is urgently important for safety net health systems to improve access to outpatient specialty care for Medicaid and uninsured patients. Because the Medicaid and uninsured patient populations are generally sicker, and have more chronic medical conditions than other patient populations, access to coordinated care that includes specialists and diagnostic testing is critically important.

We have provided a 2009 study that documents the need for improved outpatient specialty care access for California's medically underserved populations. Finally, we have included a 2002 NEJM article that details the positive connection between ambulatory care access to cardiologists (as opposed to non-specialist physicians) and improved health outcomes for post-Myocardial Infarction patients. Coordinated access to specialist care improves health outcomes, especially for those with chronic disease.

Independent sources have long recognized that the gap in access to outpatient specialty care is a significant problem for Medicaid and uninsured patients in Cook County. Aside from the letters of support and articles referenced above, we also enclose as Exhibit D an except from a 2008 report, entitled "The Chicago Health Care Access Puzzle: Fitting the Pieces Together", which details this specialty care access problem in Chicago, along with a 2005 Chicago Tribune article highlighting this problem. We enclose as Exhibit E a listing of the more than 70 FQHCs and other safety net clinics serving Cook County that currently rely on the System for access to outpatient specialty care

through the "IRIS Partners" program. The demand for outpatient specialty care from these clinic partners has increased by well over 80 percent since 2007, and these referred patients currently experience significant treatment delays because the System does not currently have the outpatient capacity to handle all the referrals.

II. Additional Detail Regarding the Scope of Services, Staffing and Implementation Timetable for the Regional Outpatient Center the System Intends to Establish on the Oak Forest Hospital Campus.

The CCHHS implementation plan for the Regional Outpatient Center (ROC) on the Oak Forest campus provides for the expansion of primary and specialty care services on that campus in order to provide greater access to this critically needed care for patients in the Southland.

There are currently 16 specialty physicians from Oak Forest Hospital providing outpatient services on a part-time basis for the patients seen in clinics of the Ambulatory and Community Health Network (ACHN) located in the E Building on the Oak Forest campus. There are also seven (7) specialty physicians from the John H. Stroger, Jr. Hospital of Cook County providing limited specialty care sessions in the ACHN clinics located on that campus.

The ROC implementation plan provides for the expansion of these existing specialty services, including the addition of three (3) new specialty services, namely, Pain Management, Infectious Disease, and Urology, and the supplementation of the existing ACHN primary care physician staff of four (4) with three (3) additional primary care physicians for a total of seven (7) primary care physicians.

In addition, the ROC will include a new Immediate Care Center with health care providers on site from 7 a.m. to 11 p.m., Monday through Friday, and 7 a.m. to 7 p.m. on weekends and holidays, to provide stabilizing care for patients presenting to the Center.

Vision 2015 will transform the Oak Forest Hospital campus from a small, narrowly focused inpatient facility to be a robust, regional outpatient facility for our Southland community. The planned transition at Oak Forest will occur in three distinct phases.

Phase 1 begins in June, 2011 and continues throughout FY2011. As the number of patients being treated in the primary care practice begins to increase, it is anticipated that the number of specialty consults will also increase. The implementation plan addresses this through the expansion of these specialty services.

Under the implementation plan, as of June 1, 2011, inpatient services on the campus will discontinue, allowing for a resource shift enabling the growth of existing outpatient services as well as the addition of new outpatient services on the Oak Forest campus. Moreover, many of the caregivers currently staffing the inpatient units will transition to staffing the ROC. Arrangements already have been made for interim management of the ROC commencing June 1, using current hospital employees pending hiring of permanent management into newly created positions.

The following existing services will be significantly expanded on June 1st, adding the following numbers of additional half day sessions and patient visits. The expansion of existing services is projected to provide an additional 875 hours of clinical time per month resulting in an additional 2525 visits per month.

Current Specialty Expansions (ramp up beginning June 1st)	Additional ½ Day Sessions (per month)	Additional Visits (per month)
Cardiology	40	340
Endocrinology	15	110
Gastroenterology - Visits	4	30
Gastroenterology - Procedures	8	80
General Surgery	4	120
Nephrology	0	20
Neurology	16	160
Optometry	2	75
Orthopedics	12	100
Podiatry	8	70
Psychiatry	18	70
Rehab Medicine	16	150
Primary Care	105	1200
TOTAL	248	2525

Additionally, as stated above, three new specialty services will be added, namely, Infectious Disease, Pain Management, and Urology. The Pain management and Infectious Disease specialty services will begin in June, 2011 and Urology services will be added later in FY2011 after a new physician provider is recruited. The table below projects capacity of the number of new sessions and visits for these new specialties.

New Specialty Additions (ramp up beginning June 1st)	Additional ½ Day Sessions (per month)	Additional Visits (per month)
Pain Management	8	35
Infectious Disease	8	70
Urology	8	70
Total	24	175

In summary, including both specialty expansions and new specialty additions, the Oak Forest campus will be adding a total of 959 clinical hours per month and adding availability for an additional 2700 visits per month, greatly expanding capacity and access to these much needed specialty services for patients in the Southland.

In addition, under the implementation plan, as of June 1, 2011, the current standby emergency department at Oak Forest Hospital will transition to an Immediate Care Center with hours from 7 a.m. to 11 p.m., Monday through Friday, and 7 a.m. until 7 p.m. on weekends and holidays. We

have attached the Scope of Services for our Immediate Care Center set to open June 1, 2011 (Exhibit F - Attachment No. 1), as well as the Immediate Care Staffing plan for FY2011 (Exhibit G - Attachment No. 2).

Phase 2 of the Oak Forest transition runs throughout FY2012 and involves significant facility expansion centering on the complete renovation of the New "E" building on the Oak Forest Campus. The expansion involves a complete conversion of the current imaging system to a state-of-the-art digital facility assuring that Oak Forest patients receive the very best care. Additional clinic space, outpatient surgery space and a new immediate care center will be added during the second phase with a relocation of most major services to the newly renovated building. If an ASTC is proposed, the System will, of course, seek IHFSRB review and approval. Additional specialty care will be added as determined by the needs of the community.

Phase 3 of the Oak Forest transition plan will occur during FY2013 through FY2015 and will involve continued expansion and significant growth in terms of service additions and patient visits. During Phase 3 of the plan, the Health System will add a women's health center to the Oak Forest campus. Additional healthcare providers will be added to support these efforts. By way of comparison, in FY2010, the Oak Forest campus delivered 35,000 primary care and specialty care visits in the outpatient setting. By 2015, the Health System's goal is to provide 125,000 visits in the outpatient setting on the Oak Forest Campus.

III. Documentation Regarding System Budget, and Funds Availability, for Implementation of the Proposed Regional Outpatient Center.

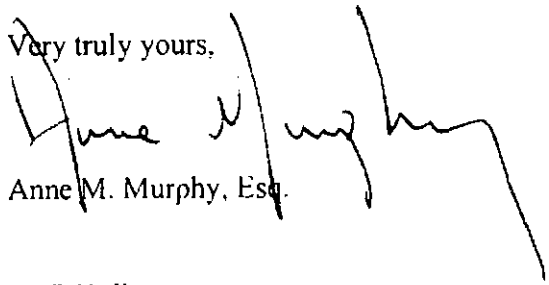
I have enclosed as Exhibit H the proposed Oak Forest ROC FY 2011 Budget. This Budget would be effective June 1, 2011.

With the exception of the proposed capital improvements, all other aspects of the Budget have been approved by the Cook County Board of Commissioners. This approved Budget includes funding for 296 staff positions. It also includes over $19 million in other operating expenses.

The proposed $3 million in capital improvements, and the proposed $2.2 million in equipment expenditures, have been included in President Preckwinkle's proposed 2011 capital improvement program budget for Cook County. This capital improvement budget likely will be finalized in May 2011. Please also refer to President Preckwinkle's April 12 letter attached as Exhibit I, in which she expresses strong support for the System's Strategic Plan and commits to funding the FY 2011 proposed budget for Oak Forest.

Once again, thank you for the opportunity to provide additional information on this project. Please do not hesitate to let me know if the IHFSRB seeks any further information to assist in review of Project 10-078.

Very truly yours,



Anne M. Murphy, Esq.

AMM/cdj
cc: Elizabeth Reidy, Esq.
Terry E. Mason, M.D.
Randall L. Mark
Tony Tedeschi, M.D.

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ARTICLE V. - COOK COUNTY HEALTH AND HOSPITALS SYSTEM [9]

Sec. 38-70. - Short title.

This Ordinance shall be known and may be cited as the "Ordinance Establishing the Cook County Health and Hospitals System."

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-71. - Declaration.

(a) The County Board hereby establishes the Cook County Health and Hospitals System ("CCHHS or System") which shall be an agency of and funded by Cook County. All personnel, facilities, equipment and supplies within the formerly constituted Cook County Bureau of Health Services are now established within the CCHHS. Pursuant to the provisions contained herein, the CCHHS and all personnel, facilities, equipment and supplies within the CCHHS shall be governed by a Board of Directors ("System Board") as provided herein. The System Board shall be accountable to and shall be funded by the County Board and shall obtain County Board approval as required herein. The County Board hereby finds and declares that the CCHHS shall:

(1) Provide integrated health services with dignity and respect, regardless of a patient's ability to pay;

(2) Provide access to quality preventive, acute, and chronic health care for all the People of Cook County, Illinois (the "County");

(3) Provide quality emergency medical services to all the People of the County;

(4) Provide health education for patients, and participate in the education of future generations of health care professionals;

(5)

Engage in research which enhances its ability to meet the healthcare needs of the People of the County; and,

(6) Perform, through the Cook County Department of Public Health, essential services of a local public health authority as provided in the Cook County Board of Health Ordinance, Sections 38-26 through 38-40 of the Cook County Code, other Cook County Ordinances imposing duties upon the Cook County Department of Public Health, and the regulations of the Cook County Department of Public Health promulgated thereunder; the Department of Public Health Act, 20 ILCS 2305/1 et seq.; the Civil Administrative Code of Illinois, 20 ILCS 2310/2310-1 et seq.; and as further detailed in regulations promulgated by the Illinois Department of Public Health under the Certified Local Health Department Code, 77 Ill. Adm. Code 600.110 et seq.; provided, however, that the County Board shall continue to serve as the Board of Health of Cook County.

(b) This article recognizes the essential nature of the Mission of the CCHHS as set forth in Section 38-74, and the need for sufficient and sustainable public funding of the CCHHS in order to fulfill its mission of universal access to quality health care.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-72. - Definitions.

For purposes of this article, the following words or terms shall have the meaning or construction ascribed to them in this section:

Chairperson means the chairperson of the System Board.

Cook County Code means the Code of Ordinances of Cook County, Illinois.

Cook County Health and Hospitals System also referred to as "CCHHS", means the public health system comprised of the facilities at, and the services provided by or through, the Ambulatory and Community Health Network, Cermak Health Services of Cook County, Cook County Department of Public Health, Oak Forest Hospital of Cook County, Provident Hospital of Cook County, Ruth M. Rothstein CORE Center, and John H. Stroger, Jr. Hospital of Cook County, (collectively, the "CCHHS Facilities").

County means the County of Cook, a body politic and corporate of Illinois.

County Board means the Board of Commissioners of Cook County, Illinois.

Director means a member of the System Board.

Fiscal Year means the fiscal year of the County.

Ordinance means the Ordinance Establishing the Cook County Health and Hospitals System, as amended.

President means the President of the Cook County Board of Commissioners.

System Board means the 11-member board of directors charged with governing the CCHHS.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-73. - Establishment of the Cook County Health and Hospitals System Board of Directors ("System Board").

(a) The System Board is hereby created and established. The System Board shall consist of 11 members called Directors. The County Board delegates governance of the CCHHS to the System Board. The System Board shall, upon the appointment of its Directors as provided herein, assume responsibility for the governance of the CCHHS.

(b) Notwithstanding any provision of this article, the Cook County Board of Health Ordinance, Sections 38-26 through 38-40 of the Cook County Code of Ordinances, and other provisions of the Cook County Code of Ordinances conferring authority and imposing duties and responsibilities upon the Board of Health and the Cook County Department of Public Health, shall remain in full force and effect.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-74. - Mission of the CCHHS.

(a) The System Board shall have the responsibility to carry out and fulfill the mission of the CCHHS by:

(1) Continuing to provide integrated health services with dignity and respect, regardless of a patient's ability to pay;

(2) Continuing to provide access to quality primary, preventive, acute, and chronic health care for all the People of the County;

(3) Continuing to provide high quality emergency medical services to all the People of the County;

(4) Continuing to provide health education for patients, and continuing to participate in the education of future generations of health care professionals;

(5) Continuing to engage in research which enhances the CCHHS' ability to meet the healthcare needs of the People of the County;

(6) Ensuring efficiency in service delivery and sound fiscal management of all aspects of the CCHHS, including the collection of all revenues from governmental and private third-party payers and other sources;

(7) Ensuring that all operations of the CCHHS, especially contractual and personnel matters, are conducted free from any political interference and in accordance with the provisions of the Supplemental Relief Order and Consent Decree established in the federal civil litigation filed in the Northern District of Illinois under Case No. 69 C 2145 and titled Shakman, et al. v. Democratic Organization, et al. and all applicable laws; and,

(8) Perform, through the Cook County Department of Public Health, essential services of a local public health authority as provided in the Cook County Board of Health Ordinance, Sections 38-26 through 38-40 of the Cook County Code, other Cook County Ordinances imposing duties upon the Cook County Department of Public Health, and the regulations of the Cook County Department of Public Health promulgated thereunder; the Department of Public Health Act, 20 ILCS 2305/1 et seq.; the Civil Administrative Code of Illinois, 20 ILCS 2310/2310-1 et seq.; and as further detailed in regulations promulgated by the Illinois Department of Public Health under the Certified Local Health Department Code, 77 Ill. Adm. Code 600.110 et seq.; provided, however, that the County Board shall continue to serve as the Board of Health of Cook County.

(b) The System Board shall be responsible to the People of the County for the proper use of all funds appropriated to the CCHHS by the County Board.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-75. - Nominating committee.

(a) The Nominating Committee shall elect its chair from among its members and all decisions shall be by majority vote of the membership. The Nominating Committee shall include one representative from each of the following organizations:

(1) Civic Federation of Chicago;

(2) Civic Committee of the Commercial Club of Chicago;

(3) Chicago Urban League;

(4) Healthcare Financial Management Association;

(5) Suburban Primary Healthcare Council;

(6) Illinois Public Health Association;

(7) Metropolitan Chicago Healthcare Council;

(8) Health and Medicine Policy Research Group;

(9) Chicago Department of Public Health;

(10) Cook County Physicians Association;

(11) Chicago Federation of Labor;

(12) Chicago Medical Society;

(13) Association of Community Safety Net Hospitals; and

(14) Midwest Latino Health Research Center.

(b) Pursuant to Ordinance 08-O-22, "Ordinance Concerning The Bureau of Health Services Notwithstanding Any Provision in Existing Ordinances," which ordinance is amended by this Ordinance, the Nominating Committee convened, selected the names of 20 individuals and transmitted these names to the President for nomination to the System Board. Pursuant to Ordinance 08-O-22, "Ordinance Concerning The Bureau of Health Services Notwithstanding Any Provision in Existing Ordinances," which ordinance is amended by this Ordinance, the President then selected nine names from among the names submitted by the Nominating Committee for the office of Director, and forwarded the list of nine names to the County Board for its approval.

(c) Pursuant to this Amendatory Ordinance, the number of Directors on the System Board shall increase from nine to 11, one of whom shall be the Chairperson of the County Board's Health and Hospitals Committee, serving ex officio. Accordingly, the President shall now select one additionel name from among the names initially submitted to the President by the Nominating Committee for nomination to

the System Board, and shall transmit that name to the County Board for its approval, pursuant to Subsection 38-76(b)(1) of this article.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-76. - Members of the System Board.

(a) One of the 11 Directors shall be the Chairperson of the Health and Hospitals Committee of the County Board and shall serve as an ex officio member with voting rights. This Director shall serve as a liaison between the County Board and the System Board.

(b) The remaining ten Directors of the System Board shall be appointed and removed as follows:

(1) For the initial Directors, the County Board shall approve or reject each of the names submitted by the President within 14 days from the date the President submitted the names, or at the next regular meeting of the County Board held subsequent to the 14-day period. Where the County Board rejects the President's selection of any name for the office of Director, the President shall within seven days select a replacement name from the remaining names on the initial list of 20 names. There is no limit on the number of names the County Board may reject. The County Board shall exercise good faith in approving the initial Directors as soon as reasonably practicable. In the event the 20 names initially submitted to the President by the Nominating Committee are exhausted before the County Board approves ten names, the President shall direct the Nominating Committee to reconvene and to select and submit an additional three names for each Director still to be appointed.

a. Each appointed Director, whether initial or subsequent, shall hold office until a successor is appointed. Any appointed Director shall be eligible for reappointment, but no appointed Director shall be eligible to serve more than two consecutive five-year terms.

b. Upon the expiration of an appointed Director's term, the successor Director shall be appointed in the same manner as the process set forth above for the nomination, selection and appointment of initial Directors; provided, however, that the Nominating Committee shall recommend three names for each Director position to be filled at that time.

c. Any appointed Director may be removed for incompetence, malfeasance, willful or negligent failure to perform assigned duties, culpable inefficiency in performing assigned duties, or any cause which renders the Director unfit for the position. The President or one-third (of the members of the County Board shall provide written notice to that Director of the proposed removal of that Director from office; which notice shall state the specific grounds which constitute cause for removal. The Director in receipt of such notice may request to appear before the County Board and present reasons in support of his or her retention. Thereafter, the County Board shall vote upon whether there are sufficient grounds to remove that Director from office. The President shall notify the subject Director of the final action of the County Board.

(2) In the event of a vacancy in an appointed Director position on the System Board, the President may recommend a replacement name to the County Board for its approval from the remaining names on the most recent list of names recommended by the Nominating Committee. In the alternative, the President may direct that the Nominating Committee reconvene to prepare a new list of three names for the vacancy within 30 days of the President's request. The successor Director shall then be appointed in the same manner set forth above for the selection and appointment of initial Directors.

a. A vacancy shall occur upon the:

1. Resignation,

2. Death,

3. Conviction of a felony, or

4. Removal from the office of an appointed Director as set forth in paragraph (b)(1)(c) of this section.

b. Any appointed Director who is appointed to fill a vacancy shall serve until the expiration of his predecessor's term.

(c) The appointed Directors are not employees of the County and shall receive no compensation for their service but may be reimbursed for actual and necessary expenses incurred as a result of performance of their duties as set forth in Section 38-80 of this Article.

(d) Directors shall have a fiduciary duty to the CCHHS and the County.

(Ord. No. 08-O-35, 5-20-2008; Ord. No. 08-O-37, 6-3-2008.)

Sec. 38-77. - Qualifications of appointed directors.

The appointed Directors shall include persons with the requisite expertise and experience in areas pertinent to the governance and operation of a large and complex healthcare system. Such areas shall include, but not be limited to, finance, legal and regulatory affairs, healthcare management, employee relations, public administration, and clinical medicine. The Nominating Committee, the President and the County Board shall take this section into account in undertaking their respective responsibilities in the recommendation, selection and appointment of Directors.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-78. - Chairperson/officers of the System Board.

(a) The Directors shall select the initial Chairperson of the System Board from among the initial Directors. The Chairperson shall serve a one-year term and, thereafter, the System Board shall annually elect a chairperson from among the Directors.

(1) The Chairperson shall preside at meetings of the System Board, and is entitled to vote on all matters before the System Board.

(2) A Director may be elected to serve successive terms as Chairperson.

(b) The Directors may establish such additional offices and appoint such additional officers for the System Board as they may deem appropriate.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-79. - Meetings of the System Board.

(a) The President shall call the first meeting of the System Board. Thereafter, the Directors shall prescribe the times and places for their meetings and the manner in which regular and special meetings may be called.

(b) Meetings shall be held at the call of the Chairperson, however, no less than 12 meetings shall be held annually.

(c) A majority of the voting Directors shall constitute a quorum. Actions of the System Board shall require the affirmative vote of a majority of the voting members of the System Board present and voting at the meeting at which the action is taken.

(d) To the extent feasible, the System Board shall provide for and encourage participation by the public in the development and review of financial and health care policy. The System Board may hold public hearings as it deems appropriate to the performance of any of its responsibilities.

(e) The System Board shall comply in all respects with "An Act in relation to meetings," as now or hereafter amended, and found at 5 ILCS 120/1, et seq.

(f) The System Board shall be an Agency to which the Local Records Act, as now or hereafter amended, and found at 50 ILCS 205/1, et seq. applies.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-80. - General powers of the System Board.

Subject to the Mission of the CCHHS and consistent with this article, the System Board shall have the following powers and responsibilities:

(a) To appoint the Chief Executive Officer of the CCHHS ("CEO") or interim CEO, if necessary, as set forth in Section 38-81 hereinafter, to hire such employees and to contract with such agents, and professional and business advisers as may from time to time be necessary in the System Board's judgment to accomplish the CCHHS' Mission and the purpose and intent of this article; to fix the compensation of such CEO, employees, agents, and advisers; and, to establish the powers and duties of all such agents, employees, and other persons contracting with the System Board;

(b) To exercise oversight of the CEO;

(c) To develop measures to evaluate the CEO's performance and to report to the President and the County Board at six-month intervals regarding the CEO's performance;

(d) To authorize the CEO to enter into contracts, execute all instruments, and do all things necessary or convenient in the exercise of the System Board's powers and responsibilities;

(e) To determine the scope and distribution of clinical services; provided, however, if the System Board determines that it is in the best interest of the CCHHS to close entirely one of the three CCHHS hospitals, such closure will require County Board approval;

(f) To provide for the organization and management of the CCHHS, including, but not limited to, the System Board's rights and powers to approve all personnel policies, consistent with existing state laws, collective bargaining agreements, and court orders;

(g)

To submit budgets for the CCHHS operations and capital planning and development, which promote sound financial management and assure the continued operation of the CCHHS, subject to approval by the County Board;

(h) To accept any gifts, grants, property, or any other aid in any form from the federal government, the state, any state agency, or any other source, or any combination thereof, and to comply with the terms and conditions thereof;

(i) To purchase, lease, trade, exchange, or otherwise acquire, maintain, hold, improve, repair, sell, and dispose of personal property, whether tangible or intangible, and any interest therein;

(j) In the name of the County, to purchase, lease, trade, exchange, or otherwise acquire, real property or any interest therein, and to maintain, hold, improve, repair, mortgage, lease, and otherwise transfer such real property, so long as such transactions do not interfere with the Mission of the CCHHS; provided, however, that transactions involving real property valued at $100,000.00 or greater shall require express approval from the County Board;

(k) To acquire space, equipment, supplies, and services, including, but not limited to, services of consultants for rendering professional and technical assistance and advice on matters within the System Board's powers;

(l) To make rules and regulations governing the use of property and facilities within the CCHHS, subject to agreements with or for the benefit of holders of the County Board's obligations;

(m) To adopt, and from time to time amend or repeal bylaws and rules and regulations consistent with the provisions of this article;

(n) To encourage the formation of a not-for-profit corporation to raise funds to assist in carrying out the Mission of the CCHHS;

(o) To engage in joint ventures, or to participate in alliances, purchasing consortia, or other cooperative arrangements, with any public or private entity, consistent with state law;

(p) To have and exercise all rights and powers necessary, convenient, incidental to, or implied from the specific powers granted in this article, which specific powers shall not be considered as a limitation upon any power necessary or appropriate to carry out the CCHHS' Mission and the purposes and intent of this article;

(q) To perform, through the Cook County Department of Public Health, essential services of a local public health authority as provided in the Cook County Board of Health Ordinance, Sections 38-26 through 38-40 of the Cook County Code, other Cook County Ordinances imposing duties upon the Cook County Department of Public Health, and the regulations of the Cook County Department of Public Health promulgated thereunder; the Department of Public Health Act, 20 ILCS 2305/1 et seq.; the Civil Administrative Code of Illinois, 20 ILCS 2310/2310-1 et seq.; and as further detailed in regulations promulgated by the Illinois Department of Public Health under the Certified Local Health Department Code, 77 Ill. Adm. Code 600.110 et seq.; provided, however, that the County Board shall continue to serve as the Board of Health of Cook County; and

(r) To be the governing body of the licensed hospitals or other licensed entities within the CCHHS.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-81. - Chief executive officer.

(a) The System Board shall appoint a Chief Executive Officer of the CCHHS ("CEO") or an interim CEO as necessary.

(b) The System Board shall conduct a nationwide search for a CEO which shall be concluded no later than 180 days from the date of the County Board's approval of the appointment of the initial System Board.

(c) The CEO shall have the responsibility for:

(1) Full operational and managerial authority of the CCHHS, consistent with existing federal and state laws, court orders and the provisions of this article;

(2) Preparing and submitting to the System Board the Budgets and Strategic and Financial Plans required by this article;

(3) Operating and managing the CCHHS consistent with the Budgets and Financial Plans approved by the County Board;

(4) Overseeing expenditures of the CCHHS;

(5) Subject to Subsection 38-74(a)(7) of this article, hiring and discipline of personnel in conformity with the provisions of this article, all state laws, court orders, and collective bargaining agreements;

(6) Negotiating collective bargaining agreements as set forth in Section 38-84(c); and

(7) Carrying out any responsibility which the System Board may delegate; however, said delegation shall not relieve the System Board of its responsibilities as set forth in this article.

(d) The CEO shall report to the System Board.

(e) The CEO shall provide, through the System Board, quarterly reports to the County Board concerning the status of operations and finances of the CCHHS.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-82. - Strategic and financial plans.

(a) As soon as practicable following the establishment of the System Board, the President shall provide to the System Board copies of the audited financial statements and of the books and records of account of the Bureau of Health Services for the preceding five Fiscal Years of the County.

(b) The System Board shall recommend and submit to the President and the County Board Strategic and Financial Plans as required by this section.

(c) Each Strategic and Financial Plan for each Fiscal Year, or part thereof to which it relates, shall contain:

(1) A description of revenues and expenditures, provision for debt service, cash resources and uses, and capital improvements, each in such manner and detail as the County's Budget Director shall prescribe;

(2) A description of the strategy by which the anticipated revenues and expenses for the Fiscal Years covered by the Strategic and Financial Plan will be brought into balance;

(3) Such other matters that the County Board, in its discretion, requires; provided, however, that the System Board shall be provided with a description of such matters in sufficient time for incorporation into the Strategic and Financial Plan.

(d) Strategic and Financial Plans shall not have force or effect without the approval of the County Board and shall be recommended, approved and monitored in accordance with the following:

(1) The System Board shall recommend and submit to the President and the County Board, on or before 180 days subsequent to the date of the appointment of the initial Directors or as soon as practicable thereafter, an initial Strategic and Financial Plan with respect to the remaining portion of the Fiscal Year ending in 2008 and for Fiscal Years 2009 and 2010. The Board shall approve, reject or amend this initial Strategic and Financial Plan within 45 days of its receipt from the System Board.

(2) The System Board shall develop a Strategic and Financial Plan covering a period of three Fiscal Years.

(3) The System Board shall include in each Strategic and Financial Plan estimates of revenues during the period for which the Strategic and Financial Plan applies. In the event the System Board fails, for any reason, to include estimates of revenues as required, the County Board may prepare such estimates. In such event, the Strategic and Financial Plan submitted by the System Board shall be based upon the revenue estimates prepared by the County Board.

(4) The County Board shall approve each Strategic and Financial Plan if, in its judgment, the Strategic and Financial Plan is complete, is reasonably capable of being achieved, and meets the requirements set forth in this section. After the System Board submits a Strategic and Financial Plan to the President and the County Board, the County Board shall approve or reject such Strategic and Financial Plan within 45 days or such Strategic and Financial Plan is deemed approved.

(5) The System Board shall report to the President and the County Board, at such times and in such manner as the County Board may direct, concerning the System Board's compliance with the Strategic and Financial Plan. The President and the County Board may review the System Board's operations, obtain budgetary data and financial statements, require the System Board to produce reports, and have access to any other information in the possession of the System Board that the President and the County Board deem relevant. The County Board may issue recommendations or directives within its powers to the System Board to assure compliance with the Strategic and Financial Plan. The System Board shall produce such budgetary data, financial statements, reports and other information and comply with such directives.

(6) For each Strategic and Financial Plan applicable to a Fiscal Year subsequent to the current Fiscal Year, the System Board shall regularly reexamine the revenue and expenditure estimates on which it was based and revise them as necessary. The System Board shall promptly notify the President and the County Board of any material change in the revenue or expenditure estimates in that Strategic and Financial Plan. The System Board may submit to the President and the County Board, or the County Board may require the System Board to submit, modified Strategic and Financial Plans based upon revised revenue or expenditure estimates or for any other good reason. The County Board shall approve or reject each modified Strategic and Financial Plan pursuant to paragraph (d)(4) of this section.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-83. - Preliminary CCHHS budget and annual appropriation ordinance.

(a) The System Board shall not make expenditures unless such expenditures are consistent with the County's Annual Appropriation Bill ("Annual Appropriation Ordinance") as provided in 55 ILCS 5/6-24001 et seq.

(b) The System Board may, if necessary, recommend and submit to the President and the County Board, for approval by the County Board, a request for intra-fund transfers within the Public Health Fund to accommodate any proposed revisions by the System Board to the line items set forth for the Bureau of Health Services in the existing Fiscal Year 2008 Annual Appropriation Ordinance.

(c) For Fiscal Year 2009 and each Fiscal Year thereafter, the System Board shall recommend and submit a Preliminary Budget for the CCHHS to the President and the County Board, for approval by the County Board, not later than 45 days prior to the first date for submission of budget requests set by the County's Budget Director.

(d) Each Preliminary Budget shall be recommended and submitted in accordance with the following procedures:

(1) Each Preliminary Budget submitted by the System Board shall be based upon revenue estimates contained in the approved Strategic and Financial Plan applicable to that budget year.

(2) Each Preliminary Budget shall contain such information and detail as may be prescribed by the County's Budget Director. Any applicable fund deficit for the Fiscal Year ending in 2008 and for any Fiscal Year thereafter shall be included as an expense item in the succeeding Fiscal Year's Budget.

(e) The County Board shall approve each Preliminary Budget if, in its judgment, the Budget is complete, is reasonably capable of being achieved, and will be consistent with the Strategic and Financial Plan in effect for that Fiscal Year. The Board shall approve or reject each Preliminary Budget within 45 days of submission to the County Board or such Preliminary Budget is deemed approved. Such Preliminary Budget shall be included in the President's Executive Budget Recommendation.

(f) The CCHHS's Annual Appropriation shall be monitored as follows:

(1) The County Board may establish and enforce such monitoring and control measures as the County Board deems necessary to assure that the revenues, commitments, obligations, expenditures, and cash disbursements of the System Board continue to conform on an ongoing basis with the Annual Appropriation Ordinance. If, in the discretion of the County Board, and notwithstanding the approved Annual Appropriation Ordinance, the County Board imposes an expenditure limitation on the System Board, the System Board shall not have the authority, directly or by delegation, to enter into any commitment, contract, or other obligation that would result in the expenditure limitation being exceeded. Any such commitment, contract or other obligation entered into by the System Board in derogation of this section shall be voidable by the County Board. An expenditure limitation established by the County Board shall remain in effect for that Fiscal Year or unless revoked earlier by the County Board.

(2) The System Board shall report to the President and the County Board at such times and in such manner as the County Board may direct, concerning the System Board's compliance with each Annual Appropriation Ordinance. The President and the County Board may review the System Board's operations, obtain budgetary data and financial statements, require the System Board to produce reports, and have access to any other information in the possession of the System Board which the President and the County Board deem relevant. The County Board may issue recommendations or directives within its powers to the System Board to assure compliance with the Annual Appropriation Ordinance. The System Board shall produce such financial data, financial statements, reports and other information and comply with such directives.

(3) After approval of each Annual Appropriation Ordinance, the System Board shall promptly notify the President and the County Board of any material change in the revenues or expenditures set forth in the Annual Appropriation Ordinance. In Fiscal Year 2009 and thereafter, the System Board has the authority to make intra-fund transfers within the Public Health Fund, if necessary, to accommodate any proposed revisions by the System Board to the line items set forth in the Annual Appropriation Ordinance. Such transfers shall be reported by the CEO in the quarterly reports required in Subsection 38-81(e) of this article.

(4) The County Comptroller is hereby authorized to process invoices and make payments against line items set forth in the Annual Appropriation Ordinance at the direction of the System Board or, if authorized by the System Board, at the direction of the CEO. The System Board shall provide the Comptroller with all documentation necessary for the Comptroller to perform this accounts payable function and to perform the budget control function. The Comptroller shall also issue payroll checks for employees within the CCHHS.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-84. - Human resources.

(a) Notwithstanding the provisions of the Cook County Code, including, but not limited to, provisions pertaining to Personnel Policies, the System Board shall have authority over all human resource functions currently performed by the Cook County Bureau of Human Resources with regard to all employees, including physicians and dentists, within the CCHHS, including, but not limited to, position classification, compensation, recruitment, selection, hiring, discipline, termination, grievance, affirmative action, performance management, probationary periods, training, promotion and maintenance of records. The System Board shall adopt written rules, regulations and procedures with regard to these functions. Until such time as the System Board adopts its own rules, regulations or procedures with regard to these functions, the existing Personnel Rules, regulations and procedures of the County shall apply. The System Board may exercise the authority granted in this section, in whole or in part, pursuant to its discretion and consistent with existing collective bargaining agreements and obligations.

(b) Employees within the CCHHS are employees of the County, and as such, shall be free from any political interference in accordance with the Supplemental Relief Order and Consent Decree established in the federal civil litigation filed in the Northern District of Illinois under Case No. 69 C 2145 and titled "Shakman, et al. v. Democratic Organization, et al."

(c) The CEO shall participate with the County in negotiating collective bargaining agreements covering CCHHS employees. All such collective bargaining agreements must be approved by the System Board and the County Board.

(d) The System Board or the CEO shall not hire or appoint any person in any position in the CCHHS unless it is consistent with the Annual Appropriation Ordinance in effect at the time of hire or appointment.

(e) Nothing herein shall diminish the rights of Cook County employees who are covered by a collective bargaining agreement and who, pursuant to this article, are placed under the jurisdiction of the System Board, nor diminish the historical representation rights of said employees' exclusive bargaining representatives, nor shall anything herein change the designation of "Employer" pursuant to the Illinois Public Labor Relations Act. The System Board shall honor all existing collective bargaining agreements, between Cook County and exclusive bargaining representatives, which cover employees under the jurisdiction of the System Board.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-85. - Procurement and contracts.

(a) The System Board shall have authority over all procurement and contracts for the CCHHS. The System Board shall adopt written rules, regulations and procedures with regard to these functions, which must be consistent with the provisions set forth in the Cook County Code on Procurement and Contracts; provided, however, that approval of the County Board or County Purchasing Agent required under the Cook County Code on Procurement and Contracts is not required for procurement and contracts within the CCHHS. The System Board shall act in place of the County Board in any contract, bylaws or agreement with the County which requires the approval or other action of the County Board unless expressly prohibited otherwise in this article or unless the contract expressly provides that the System Board shall not have such authority. Until such time as the System Board adopts its own rules, regulations or procedures with regard to Procurement and Contracts, the existing provisions of the Cook County Code pertaining to Procurement and Contracts shall apply. The System Board may exercise the authority granted in this section, in whole or in part, pursuant to its discretion.

(b) No contract or other obligation shall be entered into by the System Board unless it is consistent with the Annual Appropriation Ordinance in effect.

(c) Any multiyear contracts entered into by the System Board must contain e provision stating that the contract is subject to County Board approval of appropriations for the purpose of the subject contract; and that in the event funds are not appropriated by the County Board, the contract shall be cancelled without penalty to, or further payment being required by, the System Boerd or the County. The System Board shall give the vendor notice of failure of funding as soon as practicable after the System Board becomes aware of the failure of funding. Multiyear contracts shall also contain provisions that the System Board's or County's obligation to perform shall cease immediately upon receipt of notice to the vendor of lack of appropriated funds; and that the System Board's or County's obligation under the contract shall also be subject to immediate termination or cancellation at any time when there are not sufficient authorized funds lawfully available to the System Board to meet such obligation.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-86. - Disclosure of interests required.

(a) Any Director, officer, agent, or professional or business adviser of the System Board, or the CEO who has direct or indirect interest in any contract or transaction with the CCHHS, shall disclose this

interest in writing to the System Board which shall, in turn, notify the President and the County Board of such interest.

(b) This interest shall be set forth in the minutes of the System Board and the Director, agent, or professional or business advisor or CEO having such interest shall not participate on behalf of the CCHHS in any way with regard to such contract or transaction unless the System Board or County Board waives the conflict.

(c) The Cook County Board of Ethics shall have jurisdiction over the investigation and enforcement of this section and over the sanctions for violations as set forth in Sections 2-601 and 2-602 of the Cook County Code of Ethical Conduct.

(d) Employees of CCHHS shall be bound by the Cook County Code of Ethical Conduct set forth in the Cook County Code, Article VII, Ethics.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-87. - Annual report of the System Board.

(a) The System Board shall submit to the President and the County Board, within six months after the end of each Fiscal Year, a report which shall set forth a complete and detailed operating and financial statement of the CCHHS during such Fiscal Year.

(b) Included in the report shall be any recommendations for additional legislation or other action which may be necessary to carry out the mission, purpose and intent of the System Board.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-88. - Managerial and financial oversight.

(a) The County Board may conduct financial and managerial audits of the System Board and the CCHHS.

(1) The County Board may examine the business records and audit the accounts of the System Board or CCHHS or require that the System Board examine such business records and audit such accounts at such time and in such manner as the County Board may prescribe. The System Board shall appoint a certified public accountant annually, approved by the County Board, to audit the CCHHS' financial statements.

(2) The County Board may initiate and direct financial and managerial assessments and similar analyses of the operations of the System Board and CCHHS, as may be necessary in the judgment of the County Board, to assure sound and efficient financial management of the System Board and the CCHHS.

(3) The County Board shall initiate and direct a management audit of the CCHHS at least once every year. The audit shall review the personnel, organization, contracts, leases, and physical properties of the CCHHS to determine whether the System Board is managing and utilizing its resources in an economical and efficient manner. The audit shall determine the causes of any inefficiencies or uneconomical practices, including inadequacies in internal and administrative procedures, organizational structure, uses of resources, utilization of real property, allocation of personnel, purchasing policies and equipment.

(4) The County Board may direct the System Board to reorganize the financial accounts and management and budgetary systems of the System Board or CCHHS in a manner that the County Board deems appropriate to achieve greater financial responsibility and to reduce financial inefficiency.

(b) The System Board and the CCHHS shall be subject to audit in the manner now or hereafter provided by statute or ordinance for the audit of County funds and accounts. A copy of the audit report shall be submitted to the President, the Chairperson of the Finance Committee of the County Board, the Chairperson of the Health and Hospitals Committee, and the Director of the County Office of the Auditor.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-89. - Indemnification.

(a) The County shall defend and indemnify patient care personnel and public health practitioners, including, but not limited to, physicians, dentists, podiatrists, fellows, residents, medical students, nurses, certified nurse assistants, nurses' aides, physicians' assistants, therapists and technicians (collectively "practitioners") acting pursuant to employment, volunteer activity or contract, if provided for therein, with the County with respect to all negligence or malpractice actions, claims or judgments arising out of patient care or public health activities performed on behalf of the CCHHS. The County shall also defend and indemnify the members of the Nominating Committee and the System Board with respect to all claims or judgments arising out of their activities as members thereof which

defense and indemnification shall be subject to the same provisions which apply to the defense and indemnification of practitioners as set forth below.

(b) The County shall not be obligated to indemnify a practitioner for:

(1) Punitive damages or liability arising out of conduct which is not connected with the rendering of professional services or is based on the practitioner's willful or wanton conduct.

(2) Professional conduct for which a license is required but the practitioner does not hold a license.

(3) Conduct which is outside of the scope of the practitioner's professional duties.

(4) Conduct for which the practitioner does not have clinical privileges, unless rendering emergency care while acting on behalf of the CCHHS.

(5) Any settlement or judgment in which the County did not participate.

(6) The defense of any criminal or disciplinary proceeding.

(c) To be eligible for defense and indemnification, the practitioner shall be obligated to:

(1) Notify, within five days of receipt, the Cook County Department of Risk Management and the Civil Actions Bureau of the Cook County State's Attorney's Office of any malpractice claim made against the practitioner and deliver all written demands, complaints and other legal papers, received by the practitioner with respect to such claim to the Department of Risk Management.

(2) Cooperate with the State's Attorney's Office in the investigation and defense of any claim against the County or any practitioner, including, but not limited to, preparing for and attending depositions, hearings and trials and otherwise assisting in securing and giving evidence.

(3) Promptly notify the Cook County Department of Risk Management and the Civil Actions Bureau of the Cook County State's Attorney's Office of any change in the practitioner's address or telephone number.

(d) All actions shall be defended [by] the Cook County State's Attorney. Decisions to settle indemnified claims shall be made by the County or the State's Attorney's Office, as delegated by the County, and shall not require the consent of the indemnified practitioner. If a practitioner declines representation by the State's Attorney's Office, the County shall have no obligation to defend or indemnify the practitioner.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-90. - Applicability of the Cook County Code.

Except as otherwise provided herein, provisions of the Cook County Code shall apply to the System Board and the CCHHS and their Directors, officers, employees and agents. To the extent there is a conflict between the provisions of this article and any other provision in the Cook County Code, the provisions in this article shall control.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-91. - Transition.

(a) The County Board recognizes that there will be a necessary transition period between the adoption of this article and the point at which the System Board is capable of assuming all of its powers and responsibilities as set forth in this article. The Office of the President shall cooperate with the System Board during this transition to enable the System Board to assume fully its authority and responsibilities in as timely a manner as practicable. Such cooperation shall include accommodating requests from the System Board to provide adequate staffing at the CCHHS through the transfer or reassignment of personnel to the CCHHS, including, but not limited to, personnel to perform human resource and procurement/contracting functions.

(b) In order to avoid unnecessary duplication of services, the System Board, on behalf of the CCHHS, may, at its discretion, continue to utilize various ancillary services provided through the Office of the President, including, but not limited to, those services provided by the Office of Capital Planning and Policy, the Bureau of Information Technology, the Department of Risk Management, the Department of Facilities Management, the Department of Real Estate Management, the Office of the Comptroller, and the Office of the County Auditor.

(c) Any contracts entered into by the County on behalf of the Bureau of Health prior to the adoption of this article shall remain in effect; provided, however, that the System Board shall act in place of the County Board in any contract, bylaws or agreement with the County which requires the approval or other action of the County Board unless expressly prohibited otherwise in this article.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-92. - Severability.

Any provision of this article declared to be unconstitutional or otherwise invalid shall not impair the remaining provisions of this article.

(Ord. No. 08-O-35, 5-20-2008.)

Sec. 38-93. - Making CCHHS permanent.

The Cook County Health and Hospitals System and this article shall continue, unless the Cook County Board of Commissioners acts to revoke its powers and responsibilities.

(Ord. No. 08-O-35, 5-20-2008; Ord. No. 10-O-30, 6-1-2010.)

FOOTNOTE(S):

[8] ***Editor's note***— *Ord. No. 08-O-35, adopted May 20, 2008, set out provisions intended for use as Art. IV. §§ 38-70—38-93. Inasmuch as this article so numbered already exists, to avoid duplication and at the editor's discretion, these provisions have been included as Art. V. §§ 38-70—38-93.* *(Back)*

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Exhibit B

Special Article

SPECIALTY OF AMBULATORY CARE PHYSICIANS AND MORTALITY AMONG ELDERLY PATIENTS AFTER MYOCARDIAL INFARCTION

JOHN Z. AYANIAN, M.D., M.P.P., MARY BETH LANDRUM, PH.D., EDWARD GUADAGNOLI, PH.D., AND PETER GACCIONE, M.A.

ABSTRACT

Background The outcome after myocardial infarction may be influenced by the type of physician providing ambulatory care.

Methods We studied 35,520 patients 65 years of age or older who were hospitalized for myocardial infarction in seven states during 1994 and 1995 and who survived for at least three months after discharge. From Medicare claims, we identified ambulatory visits to cardiologists, internists, and family practitioners. Using propensity scores to adjust for demographic, clinical, and hospital characteristics, we analyzed treatment and mortality at two years among patients matched according to their estimated propensity to receive care from a cardiologist within three months after discharge.

Results As compared with patients who saw only an internist or a family practitioner in the three months after discharge, patients who saw a cardiologist were younger, were more likely to be white, were more likely to be male, had fewer coexisting conditions, and were more likely to have undergone invasive cardiac procedures while hospitalized ($P<0.01$ for all comparisons). Patients who saw a cardiologist were more likely to undergo cardiac procedures and rehabilitation after discharge. Patients who saw a cardiologist had a lower two-year mortality rate than matched patients who saw only an internist or a family practitioner (14.6 percent vs. 18.3 percent, $P<0.001$). Patients who saw both a cardiologist and an internist or a family practitioner had a lower mortality rate than matched patients who saw only a cardiologist (11.1 percent vs. 12.1 percent, $P=0.02$).

Conclusions Ambulatory visits to cardiologists were associated with greater use of cardiac procedures and decreased mortality after myocardial infarction. Concurrent care by an internist or a family practitioner was associated with a further reduction in mortality. (N Engl J Med 2002;347:1678-86.)

EFFECTIVE ambulatory care after acute myocardial infarction can identify related complications, such as chest pain or depression, and promote appropriate therapies for the prevention of recurrent myocardial infarction.[1] High-quality ambulatory care can also reduce or prevent complications of coexisting illnesses, such as diabetes mellitus.

Previous studies have assessed patients' treatment and mortality after myocardial infarction according to the specialties of the physicians who provided hospital care.[2-4] In some studies, patients of cardiologists had lower adjusted mortality than patients of internists or family practitioners,[5-8] but in other studies, differences in mortality were smaller in magnitude and were largely explained by the characteristics of the patients and the hospitals.[9-12] The use of cardiac drugs that are effective in reducing the risk of cardiovascular events may increase when both cardiologists and generalist physicians participate in the care of patients with myocardial infarction.[9,13] Building on these hospital-based studies of physicians' specialties and outcomes, we evaluated the relation between ambulatory care and mortality among elderly patients after myocardial infarction.

METHODS

Study Population

Patients were identified from the Cooperative Cardiovascular Project, a federal evaluation of approximately 225,000 elderly Medicare beneficiaries who were hospitalized in the United States with a principal diagnosis of acute myocardial infarction during 1994 and 1995.[14,15] We studied patients in seven states (California, Florida, Massachusetts, New York, Ohio, Pennsylvania, and Texas). The study was approved by the Committee on Human Studies of Harvard Medical School.

We identified 52,064 patients 65 to 84 years of age with fee-for-service Medicare coverage who were discharged alive after a clinically confirmed myocardial infarction.[14] We excluded 4146 patients who died within three months after discharge, 3115 who had metastatic cancer or a do-not-resuscitate order, 411 who were enrolled in

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a health maintenance organization within three months after discharge, 773 who resided in nursing homes, and 648 who lacked Medicare Part B coverage for physicians' care. Of the remaining 42,971 patients, we excluded 7341 without at least one claim for an ambulatory visit to a cardiologist, family practitioner, or internist within three months after discharge and 110 for whom clinical data were incomplete, yielding a study cohort of 35,520 patients.

Sources of Data

Trained abstracters reviewed hospital records using a standardized instrument with excellent reliability to ascertain patients' demographic characteristics, coexisting illnesses, cardiac complications, test results, cardiovascular medications, and treatment involving coronary angiography, angioplasty, and bypass surgery.[14] The use of these coronary procedures within three months after discharge was determined from Medicare Part A and hospital outpatient claims. Hospitals' teaching status, ownership, and location and the availability of coronary angiography and revascularization procedures were determined from Medicare and American Hospital Association data. Patients' vital status during the two years after discharge was determined from Medicare enrollment files.

The use of cardiovascular medications was assessed approximately 18 months after discharge by a telephone survey of 3271 patients (with a response rate of 78 percent), as previously described.[15] Patients also reported whether they underwent cardiac rehabilitation or exercise testing or received advice on diet or exercise from the physicians who provided ambulatory care.

Ambulatory visits to physicians were determined from Medicare Part B and hospital outpatient claims available for 18 months after discharge. For each patient, we identified all paid claims with Current Procedural Terminology (CPT-4) codes for office-based evaluation and management services (codes 99201 through 99215 and 99241 through 99245).[17] The physician's specialty was listed on the Part B claims. We determined a physician's specialty for hospital outpatient claims by linking with the Medicare physicians' registry. To determine whether a patient had received care from a cardiologist while hospitalized, we analyzed Part B claims for attending or consultative services (codes 99217 through 99239 and 99251 through 99275).

Statistical Analysis

Our primary analysis was a comparison between patients who had at least one office visit with a cardiologist during the three months after discharge (with or without a visit to an internist or a family practitioner) and those who had at least one visit with an internist or a family practitioner but no visit with a cardiologist. Because of marked differences in observed characteristics between patients in these two groups, we analyzed patients closely matched for the likelihood that they would receive ambulatory cardiology care.[18,19] As demonstrated in other observational studies of health outcomes,[20-23] propensity-score methods are a powerful tool for comparing groups that are similar in observed characteristics without specifying the relation between confounders and outcomes, as is required by more traditional multivariate-regression approaches.[24]

We fitted a logistic-regression model that predicted whether a patient would visit a cardiologist within three months after discharge as a function of 36 variables, including the patient's demographic and clinical characteristics, care provided in the hospital, medications at discharge, and hospital characteristics (Table 1).[25] Each patient who did not see a cardiologist was matched with a patient who did see a cardiologist with the closest estimated propensity on the logit scale within a specified range (≤0.6 of the pooled standard deviation of estimated logits) to reduce differences between treatment groups by at least 90 percent.[26] Using identical methods among patients with at least one cardiology visit, we matched patients who did not see an internist or a family practitioner with patients who did. Among survey respondents, we also matched patients according to physician's specialty in a similar manner.

In descriptive analyses of unmatched and matched cohorts, we compared patients' characteristics according to the specialty of the physicians who provided ambulatory care. In the unmatched cohort, we analyzed the numbers of visits (median and interquartile range) according to physician's specialty within 3 months after discharge and during the subsequent 15 months. In the matched cohort, we assessed the use of coronary angiography, angioplasty, and bypass surgery within three months after discharge. Among matched survey respondents, we analyzed the rates of receipt of aspirin, beta-blockers, angiotensin-converting–enzyme inhibitors, cholesterol-lowering drugs, cardiac rehabilitation, exercise testing, and dietary or exercise counseling.

We analyzed the unadjusted mortality rates at two years after discharge according to physician's specialty in the unmatched cohort using Pearson's chi-square test. We used McNemar's test for paired data to compare two-year mortality among all matched patients and according to quintiles of propensity to visit a cardiologist, and we compared risk ratios across quintiles with the Mantel–Haenszel test. We assessed Kaplan–Meier survival curves with log-rank tests in the matched samples. We also performed a sensitivity analysis to evaluate whether unmeasured characteristics of patients might explain differences in mortality associated with the physician's specialty.[27] We report two-tailed tests of significance for all analyses using SAS statistical software.

RESULTS

Characteristics of the Patients

Table 1 shows the characteristics of the initial study cohort of 35,520 patients before and after they were matched according to their propensity to visit a cardiologist within three months after discharge. In the sample of unmatched patients, 24,656 patients (69.4 percent) had at least one visit with a cardiologist. The likelihood of visiting a cardiologist was significantly greater for younger, male, and white patients than for older, female, and black patients and for patients in California, Florida, or Texas than for those in New York, Ohio, or Pennsylvania.

In comparison with those who saw only a generalist physician, patients who had ambulatory visits with cardiologists were less likely to have had major coexisting conditions or impaired mobility before admission to the hospital for myocardial infarction. These patients were also more likely to have been admitted to nonrural hospitals or major teaching hospitals that offered invasive coronary procedures. While hospitalized, they were less likely to have had congestive heart failure or renal insufficiency but were more likely to have had recurrent chest pain, cardiac arrest, or cardiogenic shock. These patients were much more likely to have been treated by a cardiologist while hospitalized and to have received thrombolytic therapy, coronary angiography, angioplasty, or bypass surgery. They were also more likely to have been discharged taking aspirin, beta-blockers, or cholesterol-lowering drugs but were less likely to have been discharged taking angiotensin-converting–enzyme inhibitors or to have been transferred to a skilled-nursing facility after discharge.

Of the 10,864 patients who visited an internist or a family practitioner but not a cardiologist within

TABLE 1. CHARACTERISTICS OF PATIENTS WHO RECEIVED AMBULATORY CARDIOLOGY CARE WITHIN THREE MONTHS AFTER MYOCARDIAL INFARCTION AND PATIENTS WHO DID NOT.*

CHARACTERISTIC	UNMATCHED PATIENTS			MATCHED PATIENTS†		
	CARDIOLOGIST (N=24,656)	GENERALIST ONLY (N=10,864)	P VALUE	CARDIOLOGIST (N=10,199)	GENERALIST ONLY (N=10,199)	P VALUE
Mean age (yr)	73.2	74.4	<0.001	74.1	74.2	0.24
Male sex (%)	59.6	50.9	<0.001	51.9	52.0	0.87
Race or ethnic group (%)			<0.001			0.77
White	92.1	89.8		90.1	90.2	
Black	3.3	5.5		5.3	5.1	
Hispanic	3.6	3.8		3.6	3.7	
Other	1.0	0.9		1.0	1.0	
State (%)			<0.001			0.96
California	15.0	8.3		8.8	8.8	
Florida	19.1	17.7		18.2	18.1	
Massachusetts	7.3	7.4		7.5	7.6	
New York	14.2	16.8		17.2	16.8	
Ohio	12.7	15.2		14.7	14.9	
Pennsylvania	17.4	23.0		22.3	22.1	
Texas	14.3	11.6		11.3	11.7	
Conditions before admission (%)						
Myocardial infarction	29.2	29.2	0.99	29.8	29.1	0.30
Angina	55.4	51.8	<0.001	53.1	52.7	0.49
Congestive heart failure	13.3	18.5	<0.001	17.4	17.7	0.56
Stroke	9.2	12.9	<0.001	12.1	12.1	0.98
Peripheral vascular disease	10.3	11.3	0.005	11.0	11.1	0.95
Hypertension	62.2	64.8	<0.001	65.8	64.6	0.15
Diabetes mellitus	28.7	34.2	<0.001	33.7	33.5	0.74
Chronic obstructive pulmonary disease	17.9	22.8	<0.001	21.6	21.7	0.76
Impaired mobility	19.1	24.6	<0.001	23.6	23.4	0.69
Dementia	1.3	2.9	<0.001	2.2	2.3	0.48
Rural hospital (%)	6.0	11.7	<0.001	9.4	10.0	0.12
Hospital teaching status (%)			<0.001			0.19
Major teaching	14.5	12.3		13.3	12.9	
Other teaching	30.8	32.0		33.3	32.4	
Nonteaching	54.7	55.7		53.4	54.7	
Hospital ownership (%)			<0.001			0.91
Not-for-profit	78.6	80.5		80.5	80.4	
For-profit	12.7	10.7		10.6	10.9	
Public	8.7	8.8		8.8	8.7	
Coronary procedures available on site (%)			<0.001			0.08
Coronary angiography and bypass surgery	57.6	46.9		50.0	48.7	
Coronary angiography only	21.9	22.1		22.5	22.5	
None	20.5	30.9		27.5	28.9	
Clinical complications in hospital (%)						
Cardiac arrest	6.6	4.9	<0.001	5.1	5.0	0.77
Cardiogenic shock	3.4	2.6	<0.001	2.7	2.7	0.80
Congestive heart failure	35.9	40.5	<0.001	40.4	39.6	0.22
Recurrent chest pain	32.1	28.6	<0.001	29.9	29.2	0.28
Serum creatinine ≥2.0 mg/dl (≥176.8 μmol/liter)	8.6	11.4	<0.001	10.9	10.8	0.84
Serum albumin <3.0 g/dl	3.1	3.9	<0.001	3.7	3.8	0.85
Care provided in hospital (%)						
Attending or consultant cardiologist	77.5	56.9	<0.001	60.6	60.3	0.66
Thrombolytic therapy	23.2	16.3	<0.001	17.5	17.2	0.63
Echocardiography	62.0	63.3	0.02	63.8	63.6	0.80
Stress test	17.2	17.4	0.70	17.7	17.8	0.87
Coronary angiography	48.7	33.6	<0.001	36.7	35.6	0.10
Coronary angioplasty	17.8	10.7	<0.001	11.9	11.3	0.20
Coronary bypass surgery	10.0	6.5	<0.001	7.2	6.9	0.30
Care at discharge from hospital (%)						
Aspirin	66.5	64.6	<0.001	64.9	64.9	0.93
Beta-blockers	43.3	41.0	<0.001	41.8	41.7	0.78
Angiotensin-converting–enzyme inhibitors	28.6	32.9	<0.001	32.5	32.1	0.63
Cholesterol-lowering drugs	8.8	7.2	<0.001	7.5	7.4	0.91
Transfer to skilled-nursing facility	1.7	3.9	<0.001	3.0	3.1	0.84

*A generalist physician was defined as an internist or a family practitioner. All P values are based on the Pearson chi-square test, except for that for age, which is based on Student's t-test. Because of rounding, percentages may not total 100.

†Patients were matched according to their estimated propensity to visit a cardiologist within three months after discharge.

90 days after discharge, 10,199 (93.9 percent) were matched with a similar patient who visited a cardiologist. After matching, no statistically significant differences were noted between the characteristics of patients who visited a cardiologist and those who did not (Table 1). Unlike the substantial differences between unmatched patients in these two groups, the differences in the unmatched analysis between the 10,871 patients (44.1 percent) who visited only a cardiologist and the 13,785 patients (55.9 percent) who also visited an internist or a family practitioner were much smaller and often nonsignificant (Table 2). Among patients who visited only a cardiologist, 10,415 (95.8 percent) were matched with a similar patient who also visited an internist or a family practitioner; no significant differences were noted between matched patients in these two groups.

Office Visits

The initial patterns of ambulatory care were largely maintained over time. In the unmatched cohort, most patients who saw only a cardiologist during the 3 months after discharge (median, two visits; interquartile range, one to three) continued to see a cardiologist in the subsequent 15 months (median, three visits; interquartile range, two to six); 42 percent saw an internist or a family practitioner in this later period, but only 22 percent had three or more visits. Most patients who saw only an internist or a family practitioner in the first 3 months after discharge (median, three visits; interquartile range, two to four) continued to do so in the subsequent 15 months (median, five visits; interquartile range, three to nine); 22 percent saw a cardiologist in the later period, but only 8 percent had three or more cardiology visits. Most patients who initially saw both an internist or a family practitioner (median, two visits; interquartile range, one to three) and a cardiologist (median, two visits; interquartile range, one to two) continued to see both types of physician, although they had more subsequent visits with internists or family practitioners (median, five visits; interquartile range, two to eight) than with

TABLE 2. SELECTED CHARACTERISTICS OF PATIENTS WHO RECEIVED AMBULATORY CARDIOLOGY CARE WITH OR WITHOUT CARE FROM A GENERALIST PHYSICIAN WITHIN THREE MONTHS AFTER MYOCARDIAL INFARCTION.*

CHARACTERISTIC	UNMATCHED PATIENTS			MATCHED PATIENTS†		
	CARDIOLOGIST AND GENERALIST (N=13,785)	CARDIOLOGIST ONLY (N=10,871)	P VALUE	CARDIOLOGIST AND GENERALIST (N=10,415)	CARDIOLOGIST ONLY (N=10,415)	P VALUE
Mean age (yr)	73.2	73.2	0.23	73.2	73.2	0.69
Male sex (%)	57.2	62.6	<0.001	61.4	61.6	0.78
White race (%)	92.8	91.3	<0.001	91.8	91.9	0.88
Conditions before admission (%)						
Myocardial infarction	27.5	31.4	<0.001	30.0	30.3	0.60
Congestive heart failure	13.3	13.2	0.70	13.2	13.1	0.97
Hypertension	64.2	59.6	<0.001	60.9	60.6	0.58
Diabetes mellitus	31.9	24.5	<0.001	25.9	25.4	0.44
Chronic obstructive pulmonary disease	18.8	16.9	<0.001	17.2	17.3	0.90
Hospital characteristics (%)						
Major teaching hospital	13.9	15.3	0.003	15.0	15.1	0.82
Coronary angioplasty and bypass surgery available on site	57.5	57.6	0.92	57.8	57.8	0.99
Clinical complications in hospital (%)						
Congestive heart failure	36.0	35.6	0.50	35.4	35.7	0.65
Recurrent chest pain	32.9	31.1	<0.001	31.3	31.5	0.82
Serum creatinine ≥2.0 mg/dl (≥176.8 μmol/liter)	8.3	9.0	0.04	8.6	8.8	0.86
Care provided in hospital (%)						
Attending or consultant cardiologist	77.3	77.8	0.38	77.8	77.6	0.80
Thrombolytic therapy	23.0	23.6	0.27	23.7	23.7	0.99
Coronary angiography	48.3	49.2	0.14	49.3	49.1	0.80
Care at discharge from hospital (%)						
Aspirin	66.6	66.5	0.95	66.7	66.7	0.96
Beta-blockers	43.8	42.8	0.11	43.3	43.2	0.83
Cholesterol-lowering drugs	9.0	8.5	0.15	8.5	8.5	0.96

*A generalist physician was defined as an internist or a family practitioner. All P values are based on the Pearson chi-square test, except for that for age, which is based on Student's t-test.

†Patients were matched according to their estimated propensity to visit both a cardiologist and a generalist physician within three months after discharge.

cardiologists (median, two visits; interquartile range, one to four).

Cardiac Care

In the full matched cohort, the use of coronary angiography, angioplasty, and bypass graft surgery within three months after discharge was significantly more frequent among patients who visited a cardiologist than among those who did not visit a cardiologist (Table 3). In contrast, among those who saw a cardiologist, those who also saw a generalist were significantly more likely to undergo coronary angiography, but there was no difference in the likelihood of undergoing angioplasty or bypass surgery between those who did and those who did not see a generalist. Among matched survey respondents, patients who saw a cardiologist were more likely than those who did not to report having received cardiac rehabilitation or undergone exercise testing after discharge. The use of cardiovascular drugs and reports of receiving dietary or exercise advice 18 months after discharge did not differ according to the physician's specialty.

Mortality

The two-year mortality rate in the unmatched cohort was 11.8 percent for those who saw a cardiologist in the first three months after discharge and 19.1 percent for those who saw only an internist or a family practitioner ($P<0.001$). This absolute difference in mortality of 7.3 percent was reduced by half, to 3.7 percent (14.6 percent vs. 18.3 percent), after matching but remained statistically significant ($P<0.001$). The Kaplan–Meier survival curves for this matched cohort are depicted in Figure 1A. When the matched cohort was divided into quintiles according to the propensity to visit a cardiologist, the absolute reduction in mortality associated with cardiology care was greatest among patients with the least propensity to visit a cardiologist (Fig. 2). The relative reduction in mortality did not differ significantly among quintiles, with values of 0.76, 0.79, 0.86, 0.85, and 0.80 for the relative risk of death in quintiles one (lowest propensity) to five (highest propensity), respectively, as compared with patients who did not visit a cardiologist ($P=0.66$).

In a sensitivity analysis, we estimated the effect of controlling for an unmeasured factor, such as a high-school degree, that could have been present in two thirds of the cohort, could have increased the likelihood of visiting a cardiologist by 10 percent, and could have been associated with a 40 percent reduction in mortality.[38] Adjusting for such a factor would reduce the absolute difference in mortality between patients who did and who did not visit a cardiologist from 3.7 percent to 2.8 percent, but this difference would remain significant. For this difference to become nonsignificant, an unobserved variable would have to be associated with a 40 percent relative in-

TABLE 3. CARE RECEIVED AFTER MYOCARDIAL INFARCTION AMONG MATCHED PATIENTS ACCORDING TO TYPE OF PHYSICIAN PROVIDING AMBULATORY CARE WITHIN THREE MONTHS AFTER DISCHARGE.*

TYPE OF CARE	CARDIOLOGIST	GENERALIST ONLY	P VALUE	CARDIOLOGIST AND GENERALIST	CARDIOLOGIST ONLY	P VALUE
Coronary procedures within 3 mo (%)†						
Angiography	26.8	16.7	<0.001	25.9	24.0	0.002
Angioplasty	11.8	6.9	<0.001	12.7	12.1	0.17
Bypass graft surgery	11.9	7.0	<0.001	11.7	11.4	0.53
Ambulatory care reported at 18 mo (%)‡						
Cardiac rehabilitation	36.4	29.0	0.03	39.8	33.8	0.06
Exercise-tolerance testing	61.4	52.8	0.003	64.0	64.4	0.88
Dietary counseling	57.4	58.8	0.65	61.4	60.0	0.62
Exercise counseling	63.1	60.8	0.45	65.9	64.7	0.65
Cardiovascular drugs reported at 18 mo (%)‡						
Aspirin	72.1	72.1	1.00	76.8	74.3	0.30
Beta-blockers	40.8	40.0	0.77	39.7	38.8	0.73
Angiotensin-converting–enzyme inhibitors	31.6	31.3	0.85	28.6	30.8	0.39
Cholesterol-lowering drugs	23.2	20.8	0.33	28.4	27.3	0.66

*All P values are based on the chi-square test.

†Data are from Medicare Part A and hospital outpatient claims for matched cohorts, as described in the Methods section. The numbers of subjects were 10,199, 10,199, 10,415, and 10,415, respectively, for the cardiologist, generalist-only, cardiologist-and-generalist, and cardiologist-only groups.

‡Data are from matched cohorts of survey respondents, as described in the Methods section. The numbers of respondents were 595, 595, 642, and 642, respectively, for the cardiologist, generalist-only, cardiologist-and-generalist, and cardiologist-only groups.

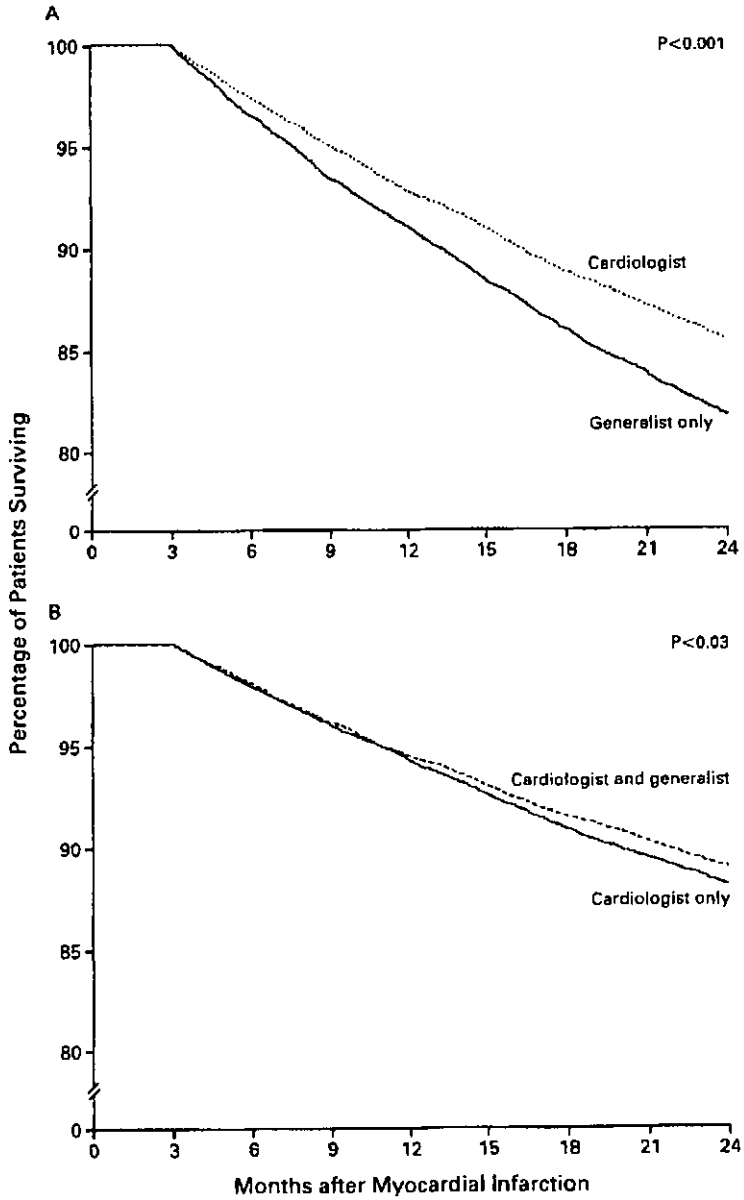

Figure 1. Kaplan–Meier Survival Curves for Two Years after Myocardial Infarction, According to the Types of Physicians Providing Ambulatory Care during the Initial Three Months.

Panel A shows a matched cohort of 10,199 patients who saw a cardiologist and 10,199 patients who saw an internist or a family practitioner, but not a cardiologist. Panel B shows a matched cohort of 10,415 patients who saw both a cardiologist and an internist or a family practitioner and 10,415 patients who saw only a cardiologist. P values are derived from log-rank tests. Note expanded scale on the ordinates in both panels.

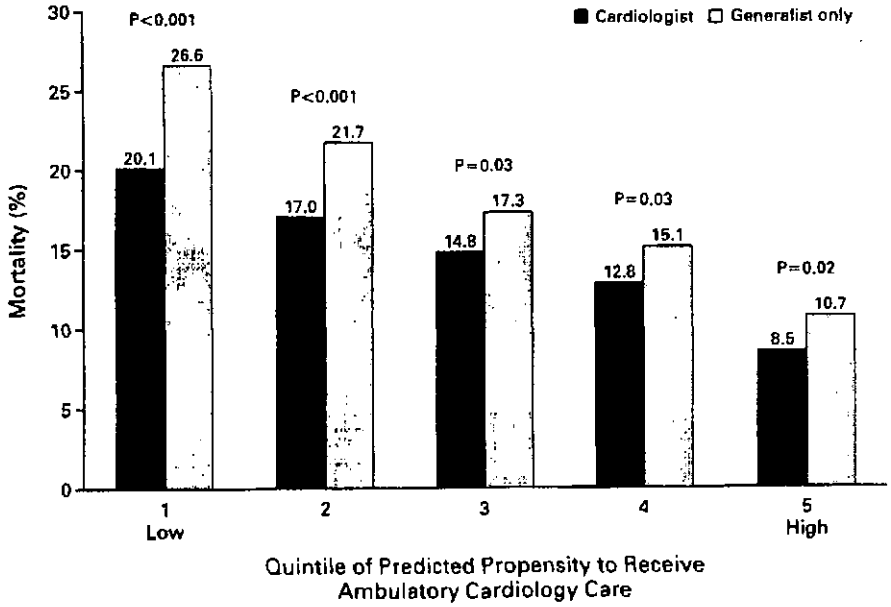

Figure 2. Mortality within Two Years after Myocardial Infarction in a Matched Cohort of 10,199 Patients Who Saw a Cardiologist and 10,199 Patients Who Saw Only an Internist or a Family Practitioner during the Initial Three Months, Stratified According to Quintile of Estimated Propensity to See a Cardiologist.

All P values are based on McNemar's test.

crease in the likelihood of visiting a cardiologist and a 60 percent relative reduction in the two-year mortality rate.

Among patients in the unmatched cohort who visited a cardiologist in the first three months after discharge, the two-year mortality rate was slightly, but not significantly, lower for those who also visited an internist or a family practitioner than for those who did not (11.5 percent vs. 12.2 percent, P=0.12). After these two groups of patients were matched according to their propensity to visit an internist or a family practitioner, the difference in the mortality rate was statistically significant (11.1 percent vs. 12.1 percent, P=0.02) and was initially apparent about one year after discharge (Fig. 1B). This 1.0 percent absolute difference would be reduced to 0.8 percent and would become nonsignificant if an unobserved variable were associated with a 10 percent relative increase in the rate of concurrent care by cardiologists and generalist physicians and a 25 percent relative reduction in two-year mortality.

DISCUSSION

Among Medicare beneficiaries who were hospitalized in seven states for acute myocardial infarction during 1994 and 1995, the likelihood of visiting a cardiologist within three months after discharge varied markedly according to characteristics of the patient and the hospital. Older patients, women, black patients, patients with major coexisting illnesses, and those admitted to hospitals that did not offer invasive coronary procedures were less likely to visit a cardiologist for subsequent ambulatory care. These results extend those of previous studies that have demonstrated similar differences in patients' access to cardiologists while hospitalized for acute myocardial infarction.[5,9,11,29] Patients who saw both a cardiologist and an internist or a family practitioner had somewhat higher rates of coexisting illness than those who saw only a cardiologist; these two groups of patients were fairly similar in terms of other characteristics.

When propensity-score methods were used to account for differences in observed characteristics of patients, visits to a cardiologist during the initial three months after discharge were associated with a significant reduction in two-year mortality. The absolute differences in mortality were greatest among patients least likely to visit a cardiologist, a result suggesting that the marginal benefit of improving access to cardiologists could be greatest for these patients. Among patients who saw a cardiologist, two-year mortality was lower for those who also saw an internist or a family practitioner, indicating that concurrent — and, ideally, collaborative — ambulatory care by generalists and

specialists may provide the best prospect for improving outcomes after myocardial infarction.

Two main factors could explain the differences in mortality associated with the specialty of the physician providing ambulatory care after myocardial infarction. First, unobserved variations in patients' severity of illness, socioeconomic status, extent of social support, or adherence to therapy may persist, even after patients are matched closely with regard to numerous observed characteristics. Controlling for an unobserved variable, such as the patient's level of education, in a sensitivity analysis reduced, but did not eliminate, the statistically significant difference in mortality associated with care by a cardiologist. The reduction in mortality associated with concurrent care by both a cardiologist and an internist or a family practitioner was more sensitive to mild residual confounding.

A second possible explanation is that the quality of care after myocardial infarction may be enhanced when cardiologists provide ambulatory care or collaborate with internists or family practitioners.[30] Patients who saw a cardiologist were more likely than patients who saw only an internist or a family practitioner to undergo invasive coronary procedures, exercise testing, and cardiac rehabilitation after discharge, which may have contributed to differences in mortality over the ensuing two years. Similarly, mortality may have been further reduced among patients who saw both a cardiologist and an internist or a family practitioner if they received better care for common coexisting conditions, such as diabetes mellitus.

In this study, however, we did not find significantly higher rates of use of effective cardiovascular drugs among patients of cardiologists surveyed in 1996 and 1997. Many patients, regardless of their physician's specialty, were not receiving effective drugs or relevant counseling, suggesting that substantial opportunities exist for both cardiologists and generalist physicians to improve their care. In a subsequent survey conducted during 1999 and 2000, elderly patients who were cared for by a cardiologist were more likely to be taking cholesterol-lowering drugs after myocardial infarction than those treated by an internist or a family practitioner (67 percent vs. 58 percent),[31] a result consistent with previous research indicating that specialists adopt new cardiovascular drugs more rapidly than generalist physicians.[32,33]

The strengths of our study include the large and representative cohort, detailed data from hospital records, longitudinal assessment of Medicare claims for ambulatory care, and the use of rigorous propensity-score methods to minimize selection bias in the analysis. Our study also had several limitations. We relied on specialty designations obtained from Medicare data, as has been done in previous studies of myocardial infarction.[5,10-12,29] These designations may differ somewhat from other sources of specialty information, such as the American Medical Association Physician Masterfile.[34] Data on the use of cardiovascular drugs were available for only a sample of patients who completed a telephone survey, and we did not have data on coronary procedures performed more than three months after discharge. We excluded patients enrolled in health maintenance organizations, in which the effects of primary and specialty care may differ from the effects we observed with fee-for-service care. Assessments of office records, which we did not review, would provide additional insights into the quality of ambulatory care after myocardial infarction.

In conclusion, access to cardiologists for ambulatory care after hospitalization for myocardial infarction varied substantially according to characteristics of the patient and the hospital. Ambulatory care by cardiologists was associated with lower mortality among elderly patients, and a further reduction in mortality was noted among patients treated by both cardiologists and internists or family practitioners. Involvement of cardiologists in ambulatory care after myocardial infarction and effective collaboration between cardiologists and generalist physicians have the potential to improve long-term outcomes after myocardial infarction, particularly for patients who are least likely to receive care from cardiologists.

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CALIFORNIA HEALTHCARE FOUNDATION

Specialty Care in the Safety Net: Efforts to Expand Timely Access

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Specialty Care in the Safety Net: Efforts to Expand Timely Access

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by

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Contents

I. Introduction

The work focused on three areas: the demographics of specialty care for California's underserved; the size and scope of access problems; and the cultivation of innovative strategies to improve access and manage demand.

TIMELY ACCESS TO SPECIALTY CARE IS A SIGNIFICANT AND growing challenge for low-income Californians who depend on safety-net institutions—public hospitals and community clinics and health centers—for their health care.

To better understand the size and causes of the problem, as well as to encourage effective solutions, Kaiser Permanente Northern and Southern California Regions' Community Benefit Programs partnered with the California Association of Public Hospitals (CAPH) and the California Primary Care Association (CPCA) in 2006 to examine specialty care access for uninsured and Medi-Cal populations. Project activities included a statewide survey of safety-net providers, discussion papers, roundtable forums, and technical assistance teleconferences. Then, in 2007 Kaiser Permanente Community Benefit and the California HealthCare Foundation (CHCF) came together to fund 28 planning grants and 23 implementation grants to regional provider coalitions across California to identify local barriers to care and develop strategies to improve access. Implementation projects began in early 2009.

The work has focused on three areas: the demographics of specialty care for California's underserved; the size and scope of access problems; and the cultivation of innovative strategies to improve access and manage demand.[1] The purpose of this report is to share findings from these activities with a broad audience.

Major Activities and Sources of Data

This report highlights findings from a series of activities that address specialty care access and the promotion of integrated community care in the safety net. The Specialty Care Access Initiative (SCAI) was established in 2006 by Kaiser Permanente Community Benefit in partnership with the California Association of Public Hospitals and Health Systems/California Health Care Safety Net Institute (CAPH/SNI), and the California Primary Care Association (CPCA). Kaiser

1. The work focused on internal medicine sub-specialty services to adults and did not include mental health or dental care.

Permanente Community Benefit brought CAPH and CPCA together as partners to examine the problem of specialty care access and explore promising approaches to improving access. Building a strong collaborative alliance between these institutions was an important component of the overall project.

To provide benchmark information, the Pacific Health Consulting Group conducted a specialty care survey of the state's community clinics and health centers (CCHCs) and public hospital systems in 2007. Fifty-eight percent of California's clinic corporations responded to the survey, as did 80 percent of the state's public hospital systems.

At the end of 2007, Kaiser Permanente Community Benefit (throughout its Northern and Southern California regions) and CHCF (for rural communities not covered by Kaiser facilities) offered local safety-net coalitions the opportunity to develop community plans to improve specialty care access. In most cases, coalitions were county-based, comprised of community health centers, public hospital systems, and other partners such as county health departments, private providers, and medical societies. In other areas, such as Los Angeles, coalitions were based on specific geographic planning areas within the county. In some rural areas regional coalition members partnered across county lines. Coalitions received planning grants and the opportunity to apply for multi-year implementation grants in 2008. A total of 28 coalitions completed planning grants and 23 coalitions received implementation grants, representing a four-year commitment of more than $20 million by the funders. A complete list of grants is included in Appendix A.

The funders developed, and will continue to provide, training and technical assistance resources for learning about promising practices across California's safety-net organizations. Included are reports, discussion papers, roundtable forums, and technical assistance teleconferences. These activities are detailed in Appendix B.

II. California's Safety Net for Specialty Care

Public hospitals are the largest provider of specialty care in California's safety net.

WHILE THE SAFETY NET FOR PRIMARY CARE IS CLEARLY defined, the safety net for specialty care is not well understood. Safety-net primary care providers throughout California rely on three principle sources for specialty care: public hospital systems, community clinics and health centers (CCHCs), and private specialists.

Public hospital systems. These are the largest provider of specialty care for the safety net in California, offering a wide range of onsite services for their own primary care patients and those in the community. The vast majority of public hospital patients' specialty care needs are met in-house. Where there are no public hospital systems, patients receive specialty care from an array of sources, including private providers, CCHCs, out-of-area specialty centers, and private hospitals. Further findings:

- Most referrals to public hospitals for specialty care come from providers within the public hospital systems: In-house primary care providers account for 52 percent of the total referrals, and in-house specialists provide another 12 percent. One-fifth of the referrals come from CCHCs, and 11 percent from private providers.
- Public hospital systems are the largest referral destination for outside specialty care for CCHCs, receiving 39 percent of their total outside referrals.
- All of the public hospital systems refer at least some patients to sources outside of their systems for specialty care.

Community clinics and health centers. Though the level of specialty care provided by CCHCs is often limited, 61 percent of CCHCs indicated that their organizations provide at least one specialty service onsite, and more than a third offer three or more different specialties. Despite the generally limited role that CCHCs play in providing specialty care services, a few serve as major safety-net specialty care providers in their communities; this is particularly true in rural Northern California.

Specialty care services offered by CCHCs tend to be targeted to their own primary care patients. Of the specialty care referrals that CCHCs receive, 82 percent come from in-house primary care providers. Ten percent come from primary care providers at other CCHCs, and 4 percent come from private providers. Only 16 percent of the CCHCs that provide onsite specialty care do so with special funding. Almost half of those with special funding for specialty care are located in the Los Angeles area; this indicates that most CCHCs absorbed these services into their annual operating budget.

Private providers. These deliver a significant amount of specialty services for safety-net patients. Survey respondents reported that 33 percent of all CCHC referrals for outside specialty care were made to private providers. The lowest percentage of referrals from CCHCs to private providers was reported in communities with public hospital systems, such as Los Angeles County (16 percent); the highest percentage was in rural Northern California (61 percent) and other communities without access to public or University of California hospital systems.

Areas of Highest Need

The 2007 survey findings reaffirm a 2004 Mathematica survey commissioned by CHCF that found significant barriers to timely access for specialty care by Medi-Cal and uninsured patients. In the 2004 study, 85 percent of clinic medical directors in California's federally funded health clinics said their patients "often" or "almost always" had trouble accessing specialty care. Half of the surveyed medical directors described the situation as having worsened over the prior two years.

One-third of safety-net primary care providers "frequently" limit referrals to high-need specialty services because of perceived lack of access.

As reflected in both the 2007 statewide survey and the regional coalition needs assessments, orthopedics, gastroenterology, neurology, and dermatology were perceived as the services most difficult for safety-net patients to access. These specialty areas were also among the top ten most needed services identified in the 2004 Mathematica study. Not surprisingly, the 2007 survey showed that the longest mean wait time for CCHC patients referred out were ones identified by survey respondents as being among the most needed and most difficult to access: neurology, orthopedic surgery, and dermatology. For two-thirds of the types of specialty services referred out, CCHC patients typically waited between one and three months to see specialists. Public hospital patient referrals to neurology care outside of the public hospital system also had long waits (three to six months). The longest wait time of all was for dermatology services referred out of public hospital systems for patients with complex needs; the typical wait was more than six months.

The survey inquired about the extent to which primary care providers limit patient referrals due to anticipated access difficulties. Respondents estimated that approximately one-third of their primary care providers "frequently" limit referrals to high-need specialty services because of perceived access difficulties. This type of referral suppression was more pronounced among CCHC providers than those in public hospital systems, possibly because these hospitals provide a range of specialty services in-house.

Furthermore, primary care providers in CCHCs had difficulty accessing consultation with specialists when they needed it. The clinics reported that their primary care providers were able to consult with a specialist less than half of the time that consultation was needed. Some regional differences were notable, with primary care providers in Los Angeles County reporting particularly high levels of difficulty obtaining consultation. Primary care providers in the public hospital systems were somewhat less impacted; survey respondents reported that these providers were able to access consultation 50 percent to 75 percent of the time.

Efforts to Expand Access

Prior to new funding there were already efforts underway to increase access to specialty care, according to survey respondents. These strategies included providing onsite specialty care, expanding the scope of practice for primary care providers, building a specialty referral network, and acquiring the capacity to get access via telemedicine.

- Onsite specialty care, provided to some degree by 61 percent of responding CCHCs and all the public hospital systems, reduced patient wait time, improved primary care providers' ability to expedite service delivery, and enhanced the frequency and ease with which primary providers could access consultation. For example, while the typical wait time for a majority of outside referrals was between three and six months, CCHC patients typically waited less than four weeks for onsite care. In addition, primary care providers were much more likely to receive consultation reports back from onsite specialists.
- Only 14 percent of CCHC respondents indicated that some of their primary care providers incorporated specialty dermatology, infectious disease (including HIV/AIDS), or orthopedic care into their scope of practice. There was little evidence of expanded scope activities in other specialties.
- Personal relationships were critically important in engaging specialists and obtaining care for patients and consultations with providers. Safety-net institutions overwhelmingly depended on providers' personal relationships to recruit specialists. Concern was expressed about the risk of overburdening a limited number of specialists personally known to safety-net providers.
- Although nearly one-third of the responding CCHCs had telemedicine equipment available, it was not widely used to expand access to specialist providers in the safety net, except in isolated rural areas.

Challenges in Referral and Communication Processes

Referral processes generally were not standardized and did not incorporate referral guidelines and treatment protocols. The resulting inefficiencies were particularly problematic in an environment of limited resources. They included:

- Inappropriate or ambiguous referrals (those without sufficient information);
- Incomplete or insufficient work-ups better addressed with more complete primary care attention, resources, or training to manage routine specialty needs in-house;
- Difficulty allocating specialty appointments rationally for the sickest or most complex patients; and
- Over-reliance on one-to-one personal relationships and informal processes that are

inefficient and do not build a reliable and sustainable institutionalized network of specialty providers.

Few CCHCs and public hospital systems had or used written guidelines for referring patients for outside specialty care. Most of the public hospital systems had written referral guidelines for at least some onsite specialty areas.

Furthermore, strategies for improving coordination of specialty care referrals had not been widely adopted in safety-net practice. These strategies include technology enhancements, such as tracking, electronic health records (EHRs), email, and Web-based referral, as well as offering patient support to insure that appointments are kept and that records are in order and present at appointments. A significant survey finding was that 68 percent of the CCHCs and 53 percent of public hospitals used a manual log to track referrals, and 30 percent of safety-net institutions did not track specialty referrals in any formal way. Only 4 percent of the CCHCs and 20 percent of the public hospitals reported using electronic medical records, and less than 15 percent of all respondents used email to communicate with specialists.

Most safety-net primary care providers used manual logs to track specialty referrals; 30 percent did not track referrals at all.

Challenges in Data Collection

In order to establish a baseline understanding of specialty care access, the authors used the survey and the needs assessment component of the implementation planning grants to assess the access problems in a range of ways. For example, the survey included queries regarding numbers of patients seen, specialty visits provided, and number of patients referred.

There were significant difficulties in capturing consistent, reliable, and valid information about the level of care provided by CCHCs and public hospital systems and the amount of care needed by their patients. Often, the data were incomplete, inaccurate, or missing. Only a minority of the organizations consistently tracked referrals in searchable and quantifiable ways. The safety-net organizations had very different processes for tracking referrals and accessing data about them. Some only kept information in patient charts or handwritten logs; some that had computer systems did not use them; and others used computer referrals, but with systems that were not searchable. Even clinics that maintained computerized referrals often captured information that was inconsistent across standard fields. This meant that observations regarding need were likely to reflect qualitative impressions.

The lack of a common understanding of metrics created other problems. For example, "wait time" for specialty care could be defined as beginning when a provider identifies the need for specialty care, or when a referral clerk records and enters the need.

Another measurement challenge was the difficulty of accounting for demand *suppression*—which occurs when providers do not refer patients to specialty care because they have not been successful in accessing it in the past. A related problem was measuring the impact of referral lists being closed because they were too long or full to accept referrals.

III. Findings and Future Directions

Three broad approaches emerged: Reduce the demand for specialty care; expand the supply of available services; and strengthen the coordination of care.

In late 2008, Kaiser Permanente Community Benefit and CHCF Specialty Care Initiative grantee coalitions submitted implementation proposals describing local strategies to improve access to specialty services. Twenty-three coalitions received funding to implement the strategies. Three broad approaches emerged: Reduce the demand for specialty care; expand the supply of available services; and strengthen the coordination of care. The plans reflected the unique needs and capabilities of individual coalitions, as well as knowledge and opportunities that emerged through the statewide survey, discussion papers, technical briefs, roundtable forums, and regional planning processes. The goal of coalition activities is to enable systemwide change and advance the larger goal of integrated community care in the safety net. It is anticipated that future work will extend far beyond the life of the grants.

More than half of the regional coalitions plan to implement one or more of five types of improvement activities, including:

- Development and implementation of referral and/or clinical care guidelines;
- Training for primary care providers, including fuller scope to incorporate specialty care activities;
- Expanded specialist networks;
- Web-based referral or consult systems; and
- Referral coordination improvements.

In addition, a wide range of other approaches are being planned or expanded by the coalitions, including:

- Shared specialist or hub models to expand specialist networks;
- Use of mid-level providers;
- Internal specialty clinic redesign;
- Chronic disease registries;

- Clinical care screening programs;
- Community collaborations and regional partnerships;
- Public health campaigns; and
- Transportation services to specialty care appointments.

The planned improvement activities tend to be multi-dimensional. Adoption of one approach typically involves a range of inter-connected activities. For instance:

- Primary care provider training to incorporate some degree of specialty care or diagnostic activity into the primary care setting is almost always planned alongside clinical guideline adoption;
- Expanded specialty care networks designed to encourage broader participation by private specialists are generally accompanied by complementary strategies to simplify the referral process, ensure appropriate referrals, and improve provider communication (i.e., referral coordinators, Web-based referral systems, referral guidelines);
- Web-based referral projects are frequently implemented with the use of referral guidelines; and
- Telemedicine, Web-based consulting technologies, shared specialists, and circuit riders are all strategies that require recruitment of specialists or expansion of specialist networks; some of the plans articulate recruitment strategies.

The specialty areas most frequently focused on in implementation plans include:

- Orthopedics (addressed in 50 percent of the coalition plans)
- Gastroenterology (38 percent)
- Neurology (31 percent)
- Dermatology (23 percent)
- Cardiology (19 percent)
- Endocrinology (19 percent)
- Ophthalmology (15 percent)
- Rheumatology (15 percent)

The implementation plans are not necessarily directed toward highest-need specialties. In a number of situations, coalitions selected specialties perceived as having the greatest opportunity for success. For example, while cardiology and ophthalmology were identified by CCHC survey respondents as two of the easiest specialty services for their patients to access, they are included as focus areas in a number of the coalition plans. Feasibility and ease of implementation, regardless of relative assessment of need, was a significant factor for some coalitions. In fact, one plan characterized a component of their activities as a "low-hanging fruit" approach, in which it was determined that a large impact on access and quality could be realized with minimal added cost.

Referral and Clinical Care Guidelines

Safety-net providers see guidelines as a way to standardize and streamline specialty referral, improve provider relations, and triage specialty resources by preserving them for higher-need cases. Rather than designing guidelines from scratch, a number of coalitions and safety-net providers intend to use guidelines that have already been implemented in other settings. Significant concern was expressed about the extent to which guidelines incur additional diagnostic services and care management resources for which there is generally no compensation. In addition, internal resources need to be allocated for provider education and training to use guidelines effectively. The coalitions that plan to develop guidelines through specialist/primary care collaborative processes, sometimes referred to as "consensus guidelines," see this as an opportunity to create the trust needed to build future clinical collaboration—including patient co-management, consultation, and mentoring.

Safety-net providers see guidelines as a way to standardize and streamline specialty referral, improve provider relations, and triage specialty resources by preserving them for higher-need cases.

Provider Training and Expanded Scope of Practice

Training for primary care providers, included in 61 percent of the coalition plans, focused on general specialty training and skill development in specific diagnostic and treatment procedures. A range of purposes were given, including:

- Increasing comfort and familiarity in expanded clinical areas in order to implement care guidelines effectively in specialty areas and pre-referral work-ups;
- Enabling primary care providers to expand their scope of practice in order to directly provide specialty care and diagnostics;
- Allowing primary care providers to adopt the role of specialist champion at their sites, providing internal training for and consultation with other primary care providers; and
- Enhancing the possibilities for co-management between specialists and primary care providers for patients with complex specialty care needs.

The plans identified a range of delivery approaches to expanded training, including:

- Mini-fellowships, in which specialists provide intensive clinical training opportunities (often alongside themselves) as well as mentoring, patient co-management, and access to future consultation;
- Monthly or quarterly CME workshops, typically onsite in the primary care provider environment, focused on effective triage and delivery of specialty care;
- Access to Webinar classes or telemedicine consults for training purposes; and

- Procedure-intensive training opportunities, including short courses and focused procedural mini-fellowships.

These approaches often focus on the most common procedures and conditions with high unmet need, such as flexible sigmoidoscopy, colposcopy, breast cyst aspirations, facial lesions, cryotherapy, splinting, casting, joint injections, diabetic foot care, nail/callous removal, stress testing, and office ultrasound.

Because the scope of practice for primary care providers has narrowed over the past decades, there is vigorous debate within national family and internal medicine societies regarding the need to train and certify primary care providers in a fuller range of procedural and diagnostic skills. The potential benefits include better access for patients, greater continuity of care, and professional growth and competence-building opportunities for providers. A discussion paper about an expanded scope of primary care practice described eight examples in safety-net institutions throughout California. Major discussion points included the following:

- Activities most frequently identified as appropriate for primary care provider fuller scope include: colonoscopy, esophagogastroduodenoscopy, diagnostic ob/gyn ultrasound, colposcopy, outpatient radiography, office orthopedics (including joint exams, injections, simple castings, and fracture care), fine-needle aspiration, skin cancer screening and biopsy, EKG interpretation, diabetes care, and infectious disease management.
- Expanded scope activities that specialists do not want to do tend to happen naturally and with relatively little "turf" conflict. The same is true for locations, settings, and populations (e.g., rural areas and safety-net patients) that specialists are less interested in. Geography plays an important role.
- Providing primary care providers with training in procedures is resource intensive in terms of time, cost, and personnel. A growing number of fellowships as well as successful commercial ventures offer hands-on CME specialty procedures training for primary care providers. In making decisions, safety-net providers must weigh need, capacity, and access to cost-effective training.
- Consideration must be given to managing time and resource demands as well as financial disincentives such as reimbursement obstacles and productivity pay arrangements. One viewpoint is that primary care providers can most easily train to provide procedures and diagnostics that are more objectively assessed and amenable to practice guidelines (e.g., ENT, diabetes, fractures, and sigmoidoscopies). Further, it is argued by some experts that the more "cognitively complex" and time-consuming areas (e.g., neurology, psychiatry, and pain) pose too great a potential drain on basic primary care to recommend as a strategy.

Ongoing consulting relationships with specialists are an important support for expanded scope of practice. Collaborative training experiences, including mini-fellowships and formal and informal mentoring relationships, all provide opportunities for the growth of consultative relationships and patient co-management.

The benefits of an expanded scope of practice must be balanced against potential negative impacts on primary care time and overburdening primary care providers. Concerns include increased marginal

costs (diagnostics, medications, and provider time dedicated to specialty care), the need for expanded liability coverage, and increased demand for specialty services. In addition, fear was expressed about increased demands of more complex, medically difficult patients.

Strategies for retention of primary care providers included opportunities for professional growth such as teaching, leadership, clinical care, and procedural training activities. However, it was noted that such experiences make primary care providers more eligible for recruitment to specialty practices. Additionally, the role and training of mid-level clinicians such as nurse practitioners and physician assistants was discussed as a strategy to further reduce the burden on primary care physicians.

Expanding Specialist Networks

About one-third of coalitions proposed developing "specialist networks" that formally engage a larger network of volunteer and paid specialists to serve safety-net patients. This differs markedly from the historically informal personal relationships that characterize specialty care in many safety-net settings. In order to make participation more attractive to specialists and efficient for safety-net primary care providers, coalition strategies typically include system improvements such as strengthened utilization tracking, clear contractual agreements, Web-based referral systems, and implementation of consensus care guidelines. Benefits of developing more formalized referral processes include simplifying participation for specialty providers, ensuring that there are clear terms of participation for them, and reducing the burden on primary care providers caused by having to manage multiple individual relationships. Some providers plan to use physician champions or specialty care coordinators for their recruitment efforts to develop and publicize system improvements.

Expanded efforts are expected to help support professional norms and expectations regarding participation in safety-net care, which, in turn, helps create sufficient "critical mass." When more specialists are engaged to help, those who do can be assured that the burden will be spread so they are not overwhelmed with unmet need.

Not all of the plans intend to use newly recruited specialists in the same way. Some are committed to having decentralized onsite services, although only four programs plan to recruit for the purpose of scheduling specialists onsite. To attain malpractice coverage and enhanced Medi-Cal reimbursement, some plans are moving toward shared specialist care through a specialty care "hub" at sites with federally qualified health center (FQHC) approval.

A discussion paper and technical brief commissioned for this project address some of the financial, legal, and regulatory challenges safety-net institutions face as they offer more specialty care within primary care settings. Providing onsite care requires considerable administrative time and attention to manage. Safety-net providers must attend to a complex set of federal and state policies and regulations that govern accepted scope of practice and licensing. Additionally, there are financial implications of onsite care, including:

- Risk of increased levels of uncompensated care;
- Increased auxiliary staffing and other resources, including space, equipment, pharmaceutical and diagnostic needs; and
- Need to provide malpractice "gap" coverage for specialists who otherwise would not be covered (e.g., retired specialists).

A January 2009 Policy Information Notice (PIN) regarding "Specialty Services and Health Centers' Scope of Project" describes the criteria federal agencies will use to evaluate requests from health centers seeking to add specialty services. Important implications for staffing arrangements, malpractice coverage, data requirements, and compliance reporting are outlined in these new criteria.

Web-Based Referrals

Over 60 percent of the coalitions plan improvements to their referral and consulting systems. Some encompass full integration with EHRs and interoperability with other systems management tools, while others focus on specific specialty areas or on standardizing email protocols. A range of goals were identified for these initiatives, including:

- Automation of appointment reminders;
- Integration of guidelines;
- Convenient review and triage of requests;
- Increase in legibility and completeness of referral and scheduling;
- Ability to expedite urgent referrals;
- Ability to track referral progress;
- Capacity to store and forward diagnostic information and images; and
- Standardization and improvement of consultation reports back.

Even implementation plans that lack guideline and decision-support or provider communication mechanisms can enable the tracking of access and utilization data (e.g., referral or consult request and utilization by specialty, reason for referral, provider, specialist, time from initiation to appointment, number of patients referred, seen, closed, remaining open, and directly booked).

There are financial implications of referral technologies and Web-based programs. Advantages range from improved allocation of scarce resources, reduced waste and inefficiency, improved communication between primary care providers and specialists, and enhanced capacity to track and report on referral metrics. The costs are also significant: intensive commitment of staff resources; hardware; software licensing, subscription, and maintenance; implementation support; training; and maintenance. An additional obstacle is that some private specialist offices may be unequipped to handle referrals or connect electronically to the referral system.

Some implementation plans proposed new or modified staff roles to help oversee improved specialty referral and case management. These varied by institution with respect to terminology and functions of personnel. Specific activities described for these staff roles include:

- Recruiting and maintaining relationships with specialty providers;
- Overseeing care coordination and planning (work-ups, patient education, tertiary care, follow-up);
- Referral coordinating and tracking;
- Standardizing, streamlining, and coordinating communication between specialists and primary care providers and between patients and providers;
- Developing and/or implementing referral guidelines and treatment protocols;
- Managing chronic disease registry activities;
- Internal quality improvement and referral review;

- Patient navigation and advocacy;
- Matching patient requests with volunteer specialists;
- Staff training;
- Appointment reminders and scheduling; and
- IT support and review of alternative vendors for new systems acquisition.

Telemedicine

Telemedicine is gaining attention as a way to address the gap in specialty care access for both urban and rural patients. In the statewide survey, nearly one-third of the CCHCs indicated they had some availability of onsite telemedicine equipment; however, only rural sites reported using telemedicine with any frequency. Half of the coalition implementation plans included some telemedicine-related activity, often targeting ophthalmology (for retinal screenings) and dermatology. Other plans included provider continuing education and consultation for specialty care.

Primary care sites have significant difficulty finding specialists who are equipped and willing to see their patients via telemedicine, particularly if patients are uninsured or on Medi-Cal.

California has been a pioneer in telemedicine policy, enacting one of the first state telemedicine laws in 1996 and expanding it in 2005. Nevertheless, reimbursement policies lag behind current practice. Though a "site fee" designed to cover the costs of telecommunication, setup, and administration of the program for some referring provider sites is provided by some payers, there is still significant confusion among providers about whether and how to bill for telemedicine consultations. In addition, primary care sites have significant difficulty finding specialists who are equipped and willing to see their patients via telemedicine, particularly if patients are uninsured or on Medi-Cal. To date, most telemedicine providers have had difficulty developing a viable business model, and safety-net providers have relied heavily on grant funding to support telemedicine activities.

Infrastructure and broadband connectivity have also been barriers to more widespread use of telemedicine. The California Telehealth Network, established in 2008 under a federal grant from the FCC, will provide access to subsidized, high-speed broadband for hundreds of safety-net providers throughout the state. This will allow them to connect to one another more easily and with the security and service-level guarantees necessary for telemedicine. Funds available through the American Recovery and Reinvestment Act (ARRA) will also offer funding opportunities for the advancement of broadband and telehealth programs.

IV. Conclusions

These findings and the integrated project activities engaged safety-net participants across the state in learning from one another and developing a common understanding of the challenges they face.

THE PROJECT SURVEY ESTABLISHED A FOUNDATION FOR conversations about specialty care access for California's underserved. These findings and the integrated project activities engaged safety-net participants across the state in learning from one another and developing a common understanding of the challenges they face. A number of overarching themes emerged from this multi-phase project:

- While initiatives are locally designed and implemented, they share common goals and strategies across the state in their efforts to impact the demand for care, the supply of providers, and coordination of patient care;
- To the extent possible, the one-on-one relationships need to be transformed into institutional relationships, so they can be sustained over time and are not solely dependent on specific individuals and situations;
- The ability to capture accurate information about the status of specialty care and of the need for specialty care in the safety net are critical to progress;
- Improvement activities and systemwide changes aimed at providing more integrated and comprehensive care require multi-dimensional approaches;
- Planning and implementing improvement activities are resource-intensive in terms of time, funding, and individual and organizational motivation;
- Relationships, effective communication, and recognition of individual and partner contributions build the trust and create the foundation upon which collaborations depend; and
- Coalition-building—among regional safety-net partners and between professional institutions like CAPH and CPCA—is necessary for systemwide change as well as for implementation of specific strategies.

The funding for planning and implementation projects enabled most of the coalitions to move forward with a variety of projects. The participants offered general guidelines for others pursuing similar goals:

- Carefully craft the early steps, with strong vision, leadership, and achievable goals;
- Begin with smaller projects or pilots to build competence and confidence;
- Establish adequate time for planning that includes detailed business and feasibility assessments and addresses strategies for sustainability;
- Recruit internal champions and identify, support, and develop capable and visionary leaders;
- Attain "buy-in" from impacted staff—from administrators to line staff; and
- Be committed to adaptation and change, which are not universally embraced within systems.

Both the statewide survey and the planning grant needs assessments revealed the need to establish standardized and reliable methods for specialty care related data collection—a challenge common among safety-net institutions in many areas of patient care. Systemwide use of some common metrics and comparable data fields to capture and report on a range of variables is critical to creating an accurate clinic, regional, and statewide picture of access to care. Without valid and reliable data, it is not possible to capture and report on the status of safety-net care, establish benchmarks, assess progress, and demonstrate return-on-investment.

Numbers will not, on their own, tell the whole story. As one participant stated: "High care utilization rates do not necessarily imply waste; low utilization rates do not necessarily imply prudence." To give the data meaning, it is important to set benchmarks for judging progress, whether it be Medi-Cal or other cost savings, reduced wait times, increased patient and staff satisfaction, or improved performance standards.

The findings from this project so far provide a snapshot in time, but the implementation of local access strategies will continue to reflect a dynamic process and changing environmental conditions. In addition, the experiences of participating coalitions will further highlight statewide policy opportunities to address systemic barriers to specialty care access.

Future publications will address new lessons that emerge as local specialty care access strategies are implemented and evaluated. The stage is now set for supported implementation of projects around the state that are designed to reduce obstacles and to increase access to specialty care for California's safety-net patients.

Appendix A: Specialty Care Coalitions and Grants

COALITION	LEAD AGENCY	PLANNING GRANT	IMPLEMENTATION GRANT
California HealthCare Foundation			
ACCEL Specialty Access Project	El Dorado County Department of Public Health	✔	✔
Gold Country Access to Care Coalition	Northern Sierra Rural Health Network	✔	
Improving Appropriate Access to Specialty Care in Rural California	Del Norte Clinics, Inc.	✔	
Improving Specialty Care Access on the North Coast	Humboldt Del Norte IPA / North Coast Clinics Network	✔	✔
Lassen Modoc Shasta Siskiyou Coalition	Shasta Consortium of Community Health Centers	✔	✔
MCHCC Specialty Care Planning Project	Merced County Health Care Consortium	✔	
Mendocino County Specialty Care Access Project	Alliance for Rural Community Health	✔	
Kaiser Permanente Community Benefit Programs			
NORTHERN CALIFORNIA REGION			
Ad-hoc Specialty Care Access Committee	Santa Clara Community Health Partnership	✔	✔
Alameda County Access to Care Collaborative	Alameda County Medical Center	✔	✔
Community Clinic Consortium	Community Clinic Consortium of Contra Costa	✔	✔
Fresno Healthy Communities Access Partners	Fresno Healthy Communities Access Partners	✔	✔
Marin Specialty Access Coalition	Marin County HHS	✔	✔
San Francisco Safety-Net Coalition	San Francisco General Hospital/UCSF	✔	✔
San Joaquin County Specialty Access Coalition	Health Plan of San Joaquin	✔	✔
San Mateo County SCAI	San Mateo Medical Center	✔	✔
Solano Coalition for Better Health	Solano Coalition for Better Health	✔	✔
Yolo County Future of the Safety Net	Communicare Health Centers	✔	✔

COALITION	LEAD AGENCY	PLANNING GRANT	IMPLEMENTATION GRANT
Kaiser Permanente Community Benefit Programs, *continued*			
SOUTHERN CALIFORNIA REGION			
Access OC Specialty Care Work Group	Access OC (Orange County)	✔	
Coalition of Safety-Net Access Providers	Valley Care Community Consortium (Los Angeles)	✔	✔
Kern Medical Center Specialty Care Coalition	Kern Medical Center	✔	✔
LAC+USC Camino de Salud Network Specialty Care Access Project	LAC+USC Healthcare Network	✔	✔
Long Beach Community Increased Access Specialty Care Coalition	The Children's Clinic	✔	✔
San Bernardino Specialty Care Coalition	Latino Health Collaborative	✔	✔
San Diego Specialty Care Access Initiative	Council of Community Clinic Health Care Network	✔	✔
Service Planning Area (SPA) 3 Specialty Care Planning Coalition	East Valley Community Health Centers (Los Angeles)	✔	✔
South Los Angeles Collaborative for Specialty Care Access	Southside Coalition of Community Health Centers	✔	✔
Ventura County Safety-Net Specialty Care Access Coalition	Ventura County Medical Center Health Care Agency	✔	✔
Westside Specialty Care Access Project	Venice Family Clinic (Los Angeles)	✔	✔

Appendix B: Resources to Support Specialty Care Access

	DATE/ LOCATION	FUNDER/ ORGANIZER
California HealthCare Foundation Publications		
Examining Access to Specialty Care for California's Uninsured www.chcf.org/specialtycare or www.chcf.org/topics/healthinsurance/index.cfm?itemID=102587	May 2004	CHCF
Transforming the Specialty Referral Process www.chcf.org/specialtycare or www.chcf.org/topics/view.cfm?itemID=133607	March 2008	CHCF
Bridging the Care Gap: Using Technology for Patient Referrals www.chcf.org/specialtycare or www.chcf.org/topics/view.cfm?itemID=133761	September 2008	CHCF
Understanding Common Reasons for Patient Referrals in Difficult-to-Access Specialties www.chcf.org/specialtycare	May 2009	CHCF
Telehealth Reports and Initiatives (multiple reports) www.chcf.org/telehealth	Ongoing	CHCF
Pending specialty reports on these topics will become available in June 2009: • Nurse practitioner and physician assistant specialty practice models • Federally qualified health centers as specialty care providers—business planning tool • Regulatory issues related to federally qualified health centers as specialty care providers • Improving specialty access through enhanced primary care scope—mini-fellowship models www.chcf.org/specialtycare	June 2009	CHCF
Discussion Papers		
Fuller Scope of Practice for Primary Care Providers: A Strategy to Improve Access to Specialty Care in the Safety Net by Pacific Health Consulting Group 208.176.52.104/content/Upload/AssetMgmt/Site/programs/specialtycarematerials/roundtable3/ScopeofPracticeDiscussionPaper.pdf	February 2008	KPSC CB
Weaving Webs in the Safety Net: Public Hospital Systems and Community Health Centers Collaborating to Improve Specialty Care by Pacific Health Consulting Group 208.176.52.104/content/Upload/AssetMgmt/Site/programs/specialtycarematerials/SCAIDiscPaper2Collaboration.pdf	July 2008	KPSC CB
A Slippery Slope: Financing Specialty Services in California's Safety Net by Pacific Health Consulting Group www.safetynetinstitute.org/content/upload/AssetMgmt/Site/DiscussionPap3SpecialtyCareFinancing.pdf	January 2009	KPSC CB

	DATE/ LOCATION	FUNDER/ ORGANIZER
Roundtable Forums www.safetynetinstitute.org/content/SpecialtyCareResources.htm		
Developing and Managing Effective Referral Systems (65 attendees)	July 30, 2007 Oakland	KPSC CB
E-Health (70 attendees)	November 5, 2007 Burbank	KPSC CB
Scope of Practice (70 attendees)	March 6, 2008 Burlingame	KPSC CB
Protocols and Guidelines (90 attendees)	June 17, 2008 Sacramento	KPSC CB
Workforce Strategies (45 attendees)	September 22, 2008 San Diego	KPSC CB
Financing (60 attendees)	November 3, 2008 Burbank	KPSC CB
Technical Assistance Teleconference Calls www.communityclinicvoice.org/webx/.eeaef98 (register to enter)		
Needs Assessment (participant numbers unavailable)	March 8, 2008	KPCB
Coalition Building (28 participants/17 coalitions)	April 4, 2008	KPCB
Building a Case for Sustainable Strategies (35 participants/24 coalitions)	May 21, 2008	KPCB
Business Case Statements (7 participants/6 coalitions)	June 25, 2008	KPCB
Promising Practices: Telemedicine (20 participants/14 coalitions)	July 15, 2008	KPCB
Promising Practices: Volunteer Model (21 participants/14 coalitions)	July 22, 2008	KPCB
Promising Practices: Hub Model (21 participants/14 coalitions)	July 22, 2008	KPCB
E-Referral Approaches (38 participants/20 coalitions)	October 8, 2008	KPCB

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SPECIAL REPORT

Monitoring Local Safety-Net Providers: Do They Have Adequate Capacity?

In five diverse cities, safety-net capacity was strained for specialty and pharmaceutical services.

by Suzanne Felt-Lisk, Megan McHugh, and Embry Howell

ABSTRACT: The safety-net providers that serve the nation's thirty-nine million uninsured residents are vulnerable organizations even in good economic times, yet efforts to monitor their capacity have been limited at best. This study of the safety-net in five cities found that capacity was strained for specialty services and that access to pharmaceuticals was difficult, while primary care capacity was more often adequate to serve those who presented themselves for care. Also, free clinics grew during the 1990s, while many other safety-net providers focused on improving their efficiency and collecting more fees from patients.

THE SAFETY-NET PROVIDERS that serve the nation's thirty-nine million uninsured residents are fragile organizations, as documented in the Institute of Medicine's 1999 report, *America's Health Care Safety Net: Intact but Endangered*.[1] Yet policymakers concerned about potential breakdowns in the health care safety net are hampered by a lack of key data on both the well-being of safety-net providers and their capacity to meet community needs. In the absence of such data, the information gathered for this study provides a current picture of safety-net providers' capacity to provide care to uninsured, low-income patients in five cities: Columbus, Detroit, Kansas City (MO), Oklahoma City, and San Antonio.

Study Methods

Using a case-study methodology, we selected five medium-size cities, all with mandatory Medicaid managed care experience and varied types of safety nets (for example, at least one with and one without a public hospital).[2] We found that the cities differed on characteristics such as degree of local support for the safety net, generosity of Medicaid benefits and eligibility, and economic environment (Exhibit 1).

The consistency of our substantive findings across all five of these relatively diverse cities was striking for our findings on the strains in specialty care access, the difficult access to pharmaceuticals, and the growth in free clinics. Although they are not nationally representative, we believe that our findings are notable both because of this consistency and because various recent studies of other communities and safety-net providers also report similar findings (cited throughout). Our information about the increased focus on business aspects of health care is consistent across the cities where the topic was discussed.[3]

For each city, we collected information

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EXHIBIT 1
Profile Of Safety-Net Study Cities

City	Population, 2000	Percent white	Percent African American	Percent Hispanic[a]	Index of Medicaid eligibility generosity[b]	Percent of Medicaid enrollees in HMOs, 1999	Percent below poverty[c]	Medicaid spending per enrollee, 1998
Columbus	711,470	69.8%	26.0%	2.5%	8	27.9%	11.1%	$4,330
Detroit	951,270	13.8	82.8	5.0	2	61.5	18.0	3,944
Kansas City[d]	441,545	62.5	32.3	6.9	7	39.9	12.2	3,436
Oklahoma City	506,132	71.7	16.4	10.1	6	10.4	15.8	2,864
San Antonio	1,144,646	70.8	7.4	58.7	7	4.3	18.5	3,101

SOURCES: Population and population characteristics are from D.A. Gaquin and K.A. DeBrandt, eds., *County and City Extra, Special Decennial Census Edition* (Lanham, Md.: Berman Press, 2002). Percent of enrollees in health maintenance organizations (HMOs) was developed through Mathematica Policy Research analysis of InterStudy data. Medicaid spending per enrollee is from the Kaiser Family Foundation State Health Facts, www.statehealthfacts.kff.org (21 May 2002).

[a] Hispanic persons may be of any race.

[b] This measure was developed by the Urban Institute to assess the generosity of states' Medicaid eligibility rules. Among other factors, the scale accounts for state eligibility expansions beyond mandatory populations, the percentage of the population below 200 percent of poverty eligible for Medicaid, Temporary Aid for Needy Families (TANF) income limits, and the existence and size of general-assistance medical care and/or other state-subsidized health insurance programs. States with the most generous Medicaid eligibility rules are in Category 1; those with the most restrictive are in Category 8.

[c] Percentage of persons below poverty is based on county data from quickfacts.census.gov/qfd/index.html (21 May 2002).

[d] Population data are from 1998; population characteristics are from 1990.

from secondary data sources, telephone interviews, and site visits. This UpDate is based primarily on the telephone interviews and site-visits. The site visits involved interviews with hospitals, community health centers, health departments, other safety-net organizations, and one or two nonprovider informants in each city. More than 100 people were interviewed from more than sixty-five organizations during May 2000 through January 2001. Site-visit interview guides were tailored to each type of respondent; topics included the provider's role in the safety net, their current capacity, and recent and planned changes in capacity.[4]

Study Findings

We used the information we collected from interviews and secondary data sources to assess the capacity of the safety net in the five cities and to describe how capacity was changing. We found that safety-net capacity was strained for specialty services (five cities), pharmaceutical services (five cities), dental care (three cities), and behavioral health care (three cities). With small-scale exeptions, primary care capacity was generally adequate to serve those who sought care.[5] The study findings are presented in full in the study report.[6] Here, we highlight several issues that may be of particular interest to policymakers.

■ **Specialty services.** Capacity was strained for many specialties in each city, according to our respondents.[7] In all five cities waiting times for nonurgent appointments for specialty care were reported to be much longer than for primary care and were often expressed in months.

In four cities we heard that uninsured patients in need of specialty care were consistently referred to local hospitals. The exception was in Columbus, where providers referred patients to a free clinic that was open one night per week. This free clinic, although not able to fully meet the demand for specialty care, was well known throughout the community as a dignified place for uninsured patients to receive specialty care services.

In the other four cities one or two local hospitals tended to provide the outpatient specialty care (offering a sliding fee scale), while the rest refused uninsured patients unless they paid in full prior to treatment. Even in hospitals that offered a sliding fee scale, access to

specialty care tended to be difficult. For example, in Oklahoma City and Detroit the major hospital providers for specialty care required patients to pay some (even half) of the specialty procedure up front.[8] In San Antonio and Kansas City hospital respondents noted a staffing shortage of specialty care physicians, resulting in long waiting times for certain specialties (in some cases six to twelve months).[9] In Kansas City the major safety-net hospital had difficulty recruiting specialists because the hospital was unable to compete with the prevailing wages offered by other local hospitals. In one San Antonio hospital, specialists were refusing to provide service on an on-call basis to emergency room patients because of the large number of uninsured patients.

However, the availability of specialists was better for children than for adults in Kansas City, Columbus, and San Antonio. Each of these cities had a children's hospital that assumed responsibility for uninsured children needing specialty care.

Despite capacity strains for specialty services, we did not identify any planned increases in capacity for serving the uninsured who need specialty care. This is probably because many of the hospitals we visited that provided these services were under financial strain.

Still, some providers had taken steps to lessen the barriers. In one city the federally qualified health center (FQHC) and free-clinic providers began quarterly meetings with hospital administrators after a patient with esophageal cancer reported a nine-month wait for consultation with a gastrointestinal specialist. As a result of the meetings, FQHC physicians can make appointments for patients at the major safety-net hospital, and transmission of patient records was eased. In Detroit one of the FQHCs developed a special arrangement with a local hospital that agreed to accept all FQHC patients for specialty care on a sliding fee scale.

Business aspects of health care. *Collection procedures.* Traditionally, safety-net providers have focused on service delivery far more than the "business" of health care. However, this balance is shifting as safety-net providers look for ways to maintain their financial stability and increase their capacity in an ever-changing and always challenging financial environment. For example, over the past few years, especially in the past year or two, many safety-net providers have begun insisting that their patients pay their fees. In two cities all of the community health centers (CHCs) had taken specific steps to improve collections. In one city both CHCs hired an accounting staff person, who is responsible for helping to improve collection from patients. In both cases, the CHCs report improvement (one increased its collections by $1,000 per day). Also, the safety-net hospital in this city now uses a collection agency for delinquent accounts. CHCs in the second city reported less effectiveness from their efforts; the CHC that now sends more than 3,000 statements per month, and uses a collection agency after three or four statements have been ignored, reports that little is collected as a result.

"Most of the safety-net providers who had stepped up collections said that they had not denied services to those who failed to comply with payment rules."

In a third city the major safety-net hospital entered into a long-term joint operating agreement with a for-profit firm. Although overall service to the uninsured has remained level, patient bills, often totaling large sums because of the costly nature of hospital care, are now sent to uninsured patients. A local CHC explained that the large number of undocumented Hispanic residents it serves are fearful of receiving bills. The CHC itself had a history of not billing but has recently become more aggressive and now asks for proof of income to qualify for sliding-scale charges, expects payment, and bills patients when necessary. Most of the safety-net providers who had stepped up collections said that they had not to date

denied services to those who failed to comply with payment rules, or that such cases were extremely rare.

Improving efficiency. The safety-net providers also focused on other business-related concerns, especially improving patient flow, and in several cases were using new information systems to improve their financial management.[10] In Columbus in 1997, largely as a result of the upcoming implementation of mandatory Medicaid managed care, seven small public health clinics that provided primary care to the uninsured consolidated to become a single CHC. In so doing they improved their combined revenue and the consistency of service, and they made other changes to increase their combined efficiency.

In Kansas City three of the four major safety-net providers were focusing on efficiency as a means to relieve financial problems that had threatened their survival. One clinic had affiliated with a local nonprofit hospital and in the process had to give up its FQHC designation. Despite a substantial budget reduction, the clinic was able to add a pediatrician because of the new affiliation and is seeing more patients than before by operating more efficiently. Another changed its management team. The new management cut the number of staff about 25 percent without reducing service. At the same time, the public hospital was testing a redesign of its outpatient clinic operations intended to reduce appointment waiting times and per patient costs. The new design called for training staff in customer service practices, testing a new registration and billing system, and adding a social worker and clerical staff.

In Oklahoma City and San Antonio safety-net hospitals had set up fast-track clinics adjacent to their emergency rooms so that ER patients without urgent conditions (those most often uninsured) could be shifted to outpatient clinics for rapid treatment. In the Oklahoma City hospital the shift to a fast-track clinic reportedly reduced waiting times by 66 percent.

Both CHCs in San Antonio had expanded or were expanding the number of examination rooms per physician. The centers believed that the change in space configuration would allow the same number of physicians to see more patients.

Finally, new information systems in CHCs in Columbus and Kansas City were reported to be key to improving financial management. For example, one CHC reported that its collections had improved 25–30 percent with the new system.

■ **Access to pharmaceuticals.** Safety-net providers in all five cities assisted their uninsured patients in obtaining necessary pharmaceuticals, but the process was cumbersome and could have resulted in suboptimal treatment for many patients.[11] Safety-net providers with full pharmacies or dispensaries were able to obtain medications using primarily three methods. First, almost all reported relying heavily on charity programs from pharmaceutical companies, but, consistent with past research, providers complained about administrative difficulties associated with the programs and limits on the supply (one to three months) of the medication.[12] Second, safety-net providers took advantage of sample medications provided by pharmaceutical companies. One provider noted that his son in private practice sends all samples he receives to a CHC in Kansas City. Finally, several relied on grants from foundations and government assistance, from either city/county and state grants or the federal 403B and AIDS Drug Assistance programs to purchase pharmaceuticals for their patients.[13] For example, pharmacies at the CHCs in Columbus, Detroit, and Kansas City are largely funded by state or local grants. The state provides some funding for pharmacy to the CHCs in Oklahoma City, although one reported having to turn pharmacy patients away by the fifteenth of every month because of lack of funding.

Duplication of physician visits. The lack of pharmacy programs available to all uninsured patients in the community sometimes created unnecessary duplication of physician visits. Two different hospital providers, one in Columbus and one in San Antonio, reported advising patients in need of assistance obtaining

medications to schedule appointments for the same condition at a provider with the pharmacy program, to be able to obtain the necessary prescription. The referring physicians viewed the situation as not ideal but necessary.

Keeping costs down. To keep costs down, many safety-net providers explained that they prescribed older drugs and generics, used samples provided by drug companies, and in one case partnered with a local grocery/pharmacy chain to reduce costs. Despite these efforts, some respondents raised concerns about whether their patients were able to obtain what they needed. Some reported that their patients go without medication or use their medications sparingly so they will last. Others reported that although their patients never go without the medicine they need, many have to take suboptimal drugs because of cost.

"Free clinics provide a comfortable environment for undocumented residents since they are not asked for their addresses."

Shortage of pharmacists. Complicating the access issues further, several safety-net organizations reported facing difficulty recruiting pharmacists. In Detroit, where there is great competition for pharmacists, a CHC and a hospital were both having trouble recruiting. Under an arrangement with the city, the health department hires and supervises pharmacists at the CHC, and the local pharmacists' salaries were too high for the health department's civil service guidelines. As a result, the CHC had temporarily closed its pharmacy until the position could be filled. A San Antonio CHC also was having trouble finding a pharmacist. A CHC in Oklahoma City was planning to open an in-house pharmacy at the time of our visit. Initially it tried to obtain a pharmacist from a pharmacy management organization, but since the CHC could not guarantee a certain number of prescriptions per day, efforts were unsuccessful.

Columbus was the only community where access to pharmaceuticals may be improving. There, a local foundation had undertaken a major initiative to support development of a more rational system for providing pharmaceuticals to the uninsured.

■ **Growth of free clinics.** All of the studied cities have one or more free clinics that play a role in the safety net, and nearly all of these were established in the past decade.[14] In Columbus, Detroit, and Oklahoma City the free clinics are small. They are open during limited hours (typically only a few evenings per month); are staffed by volunteer nurses, doctors, or medical residents; and typically provide service to 30–200 patients per month. The clinics are funded by churches, hospitals, or private donations (or some combination) and are often located in makeshift facilities in schools or churches. They primarily provide adult primary care (one also provided specialty care), and most acted as dispensaries, providing patients with free pharmaceuticals. In Columbus most of the church-based clinics had been established with ongoing technical assistance from a hospital program that aimed to ensure that the nurse-staffed clinics linked their patients to other health care services. In the same community a free clinic for specialty care had been established by the local medical society and operated from a school. In Detroit the clinics were also church-based but were not part of an organized program supported by a hospital partner.

In Kansas City and San Antonio the free clinics are larger and operate in a roughly similar manner as other safety-net health centers, except that they are free. One began as a clinic focused on care for people with HIV/AIDS and then expanded to provide general primary care. It operates with grant funding and volunteer physician and nurse staffing. The two clinics in San Antonio were established by a hospital conversion foundation and thus enjoy a predictable budget from the foundation and employ their staff. Two of these three larger clinics were constantly operating at maximum capacity, according to respondents, which suggests that there is a real need for such entities.

The free clinics offer an alternative for patients who are unsuccessful or simply not comfortable seeking care from other providers, including other safety-net providers.[15] We asked why someone would be more comfortable at a free clinic than at another safety-net provider. One respondent explained that the large size and busy feel of the major safety-net hospital that provides much of the care in that city can be intimidating for some residents. Also, although other safety-net clinics do not turn people away, people know that they will be asked questions about their income, and if they owe money to the clinic for past care, they will be asked to pay. This does not occur in free clinics. Finally, we heard that at least in some cases, free clinics provide a comfortable environment for undocumented residents since they are not asked for their addresses.

The new presence and growth of free clinics in the 1990s raises several issues. The limited and sporadic hours of the smallest free clinics make them unreliable places for patients to receive continuous care. Also, the heavy dependence on donations and volunteers makes the very existence of small clinics tenuous. Since we found differences across cities in the structure and operation of the clinics, further research could identify the best free-clinic models. Such models could encourage physician volunteerism. We heard that many private physicians preferred to volunteer at free clinics instead of seeing uninsured patients in their offices. Finally, while the appeal of care that is completely free is hardly a mystery, the growth of free clinics in a particular community could also indicate that traditional providers such as hospitals and CHCs cannot handle the volume of uninsured patients, are not conveniently located, or do not provide a comfortable environment for all patients.

Conclusions

Lacking data to assess the need for services by the uninsured, we were nevertheless successful in learning qualitatively about the extent to which safety-net providers are meeting the expressed demand for care by the uninsured in five cities. Here we identify several follow-up issues of likely interest to policymakers.

First, follow-up research could determine whether the health care system's capacity for providing specialty services to the uninsured is as strained nationwide as it is in the five cities we studied; if it is, policymakers at all levels of government should pursue timely solutions.

Second, while the new focus on the business aspects of health care is allowing some safety-net providers to increase their capacity for serving the uninsured while maintaining their financial stability, we are concerned that it might also have the unintended effect of discouraging some people from seeking care.

Third, we are concerned that heavy reliance on pharmaceutical companies' voluntary programs may not be a viable long-term strategy. Also, some respondents suggested that patients are not complying strictly with their treatment protocols or are receiving suboptimal medications because of cost issues.

Finally, issues for follow-up include the extent to which small free clinics link people to other providers rather than serving as their sole source of primary care, and whether they may be a positive force to encourage physician volunteerism. We also need a better understanding of these clinics' contribution to the community's safety net as a whole.

In spite of these concerns, it is reassuring that at least in the five cities we studied, with certain small-scale exceptions, the safety net for primary care is generally adequate to meet the needs of those who present themselves for care. This does not mean that the primary care safety-net is secure for the future, however, nor does it help the many uninsured persons who do not seek primary care. Also, safety-net providers' increased focus on efficiency holds promise for continued ability to expand service without increasing cost.

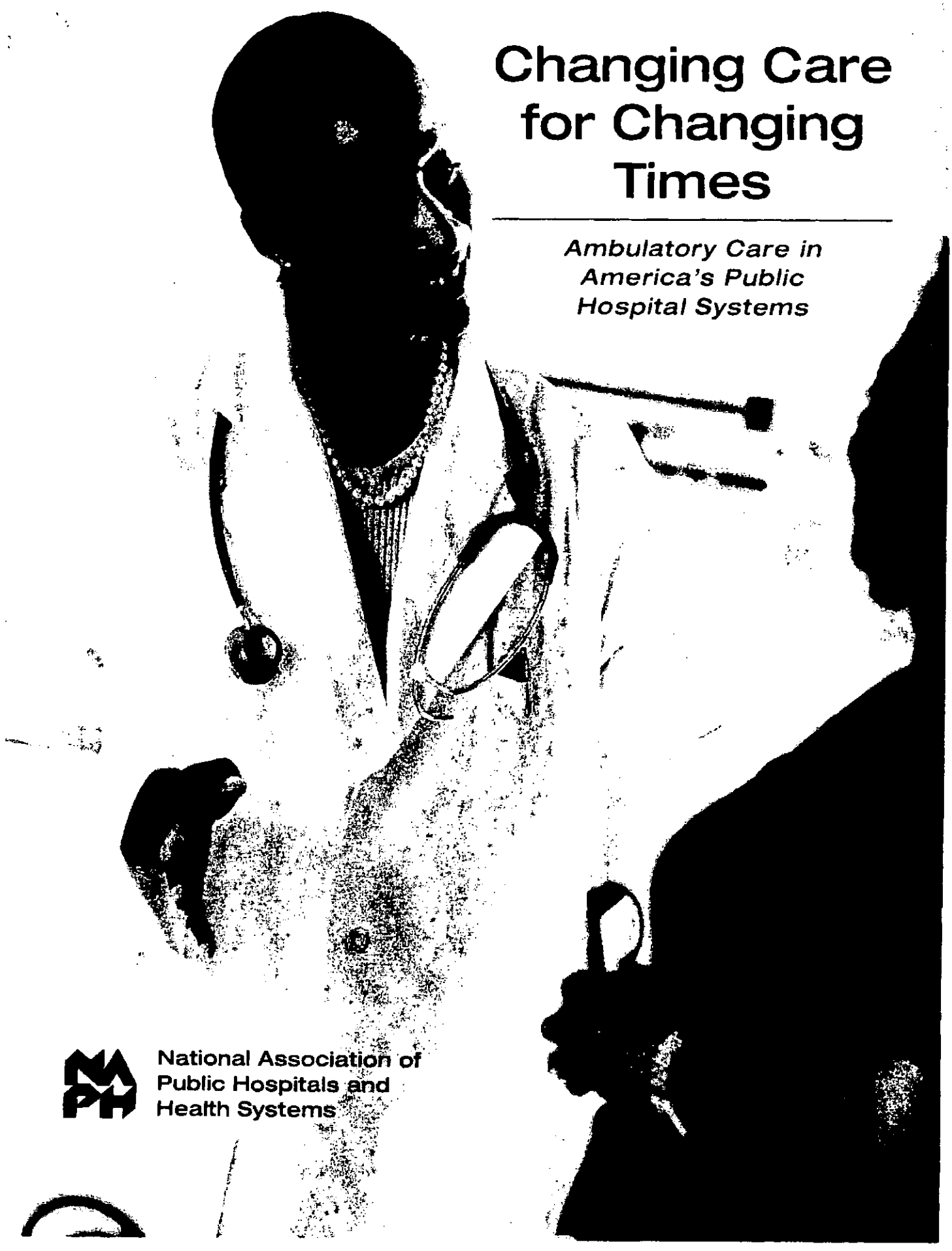
The research presented in this paper was funded by the Health Resources and Services Administration (HRSA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services [Grant no. 282-98-0021 (09)]. The authors gratefully acknowledge the many individuals in Columbus, Detroit, Kansas City, Oklahoma City, and San Antonio who contributed their time, granted interviews, and furnished data. Rhoda Abrams, Michael Millman, Alexander Ross, and Jessica Townsend of HRSA and Caroline Taplin of ASPE participated with the research team on the site visits and provided valuable input throughout the project as well as helpful comments on an earlier draft of this paper.

NOTES

1. U.S. Census Bureau, "Health Insurance Coverage: 2000," www.census.gov/hhes/hlthin00/dtable1.html (21 May 2002); and M.E. Lewin and S. Altman, eds., *America's Health Care Safety Net* (Washington: National Academy Press, 2000).
2. However, all selected cities had to have a federally funded community health center (CHC), since the CHCs' roles in local safety nets was an issue of interest to the project's sponsor, the Health Resources and Services Administration (HRSA).
3. This issue emerged rather than being a central focus for our study design, and we therefore do not have complete information for Detroit, in particular.
4. Our assessment of the adequacy of primary and specialty care in each city relative to the expressed demand for services by the uninsured population was based on our review of typical waiting times for appointments reported by interviewees, whether various services or clinics were open versus closed or sometimes closed to new uninsured patients, and the interviewees' characterization of the experiences of their patients in seeking services. Interviews with emergency department directors about use of the emergency department for nonurgent care also contributed to our assessment.
5. Primary care capacity for women's and children's services was more consistently adequate than was primary care capacity for adult medicine. For example, waiting times for an appointment were generally short. Also, in most cities there were one or more small sites that were operating at maximum capacity for primary care.
6. S. Felt-Lisk, M. McHugh, and E. Howell, *Study of Safety Net Provider Capacity to Care for Low-Income Uninsured Patients* (Washington: Mathematica Policy Research, September 2001).
7. This is consistent with findings from the Center for Studying Health System Change's Community Tracking Study, which has examined the safety net longitudinally across a diverse group of communities from 1996 to 2001. Barbara Ormond and Amy Westpfahl Lutzky also mention difficulties in specialty care referral in Los Angeles county, one of three safety-net systems they recently studied. B.J. Ormond and C.W. Lutzky, "Ambulatory Care for the Urban Poor: Structure, Financing, and System Stability," Occasional Paper no. 49 (Washington: Urban Institute, June 2001).
8. The Oklahoma City and Detroit hospitals were for-profit and private nonprofit hospitals, respectively.
9. These hospitals were the two government-run hospitals in the study.
10. Laurie Felland and colleagues similarly report that safety-net providers are focusing on efficiency, instituting fees for the uninsured, and, in some cases, beginning to enforce and collect payments from the uninsured on sliding fee schedules. L. Felland et al., "The Resilience of the Health Care Safety Net, 1996–2001" (Washington: Center for Studying Health System Change, under review).
11. Felland and colleagues similarly report difficult access to pharmaceuticals. Ibid.
12. This finding is consistent with research on a sample of California safety-net providers. K. Raube and T. Douglas, *Managing Pharmaceutical Costs among California Safety Net Providers* (Final Report to the California Program on Access to Care, University of California, Berkeley, Hass School of Business, January 2001).
13. The 403(b) drug pricing program allows FQHCs, disproportionate-share hospitals, and certain other safety-net providers to receive the same discounted drug pricing and rebates that the Medicaid program receives.
14. "Free clinics" are defined as clinics that never bill third-party payers and that are not operated by the local health department or other government entity.
15. Free-clinic patients may also find the location of the free clinics more convenient than the location of other safety-net providers, although we did not specifically hear this reason from respondents.

Changing Care for Changing Times

Ambulatory Care in America's Public Hospital Systems



National Association of Public Hospitals and Health Systems

Changing care for changing times

Just a few short years ago, a cancer patient in need of chemotherapy would have required hospitalization for treatment. Today, thanks to tremendous advances in modern medicine, patients routinely receive a host of health care services – including chemotherapy and other life-saving treatments – in the ambulatory care setting. The development of sophisticated new medical devices, pharmaceutical innovations, and creative models of patient care have all contributed to this important shift in the way people receive care.

Also known as outpatient care (because the patient does not need to be admitted to the hospital as an inpatient), ambulatory care services are typically provided through daytime visits to a doctor's office or health clinic. Both major and minor health concerns are now commonly addressed in the outpatient setting. From high-tech diagnostic and surgical procedures like magnetic resonance imaging and laparoscopy, to high-touch basics like well-baby check-ups and physical exams, outpatient care affords patients a more convenient and cost-effective approach to staying well.

Over the last two decades, the use of ambulatory care services has sharply increased. Along with the rest of the health care industry, the members of the National Association of Public Hospitals and Health Systems (NAPH) have adapted to keep pace with this growing trend, experiencing unprecedented growth in the amount of ambulatory care they deliver.

Because public hospitals and health systems comprise the heart of America's health care safety net, most people are familiar with the trademark services they provide on the inpatient side: life-saving tertiary services such as trauma and burn care; resident training programs that prepare the next generation of doctors; health care services for low-income and uninsured populations. However, few people have a solid understanding of the important role public hospitals and health systems play by providing more than 28 million outpatient visits each year through their extensive ambulatory care networks.

A full spectrum of care

Access to quality health care is an essential ingredient to maintaining good health, and public hospitals and health systems have hit on a sure-fire recipe for wellness: offer patients a comprehensive range of ambulatory care services designed to keep them healthy, functioning and out of the hospital.

Routine care benefits both patient and provider by effectively addressing conditions before they become more dangerous, difficult or costly to treat. A diabetic patient diagnosed early is more likely to be able to control his symptoms through a regimen of proper diet and exercise. A simple well-baby exam might identify a respiratory problem that can be easily treated with proper medication and prevent more serious health problems from developing later. Help for a patient who wants to quit smoking can greatly enhance her quality of life – and avoid triggering a multitude of tobacco-related health problems down the road.

About half of all visits to NAPH outpatient facilities are for prevention-oriented primary care services intended to identify and address health problems early, such as annual physical check ups, Pap smears, vision tests, mammograms and screenings for hypertension or cholesterol.

The other half of outpatient visits involves more specialized services, such as dialysis, physical rehabilitation, ambulatory surgery, treatment for substance and alcohol abuse, or care by medical specialists such as cardiologists and neurologists. In many communities, NAPH members provide access to these crucial specialty services for the poor and uninsured which would otherwise be unavailable.

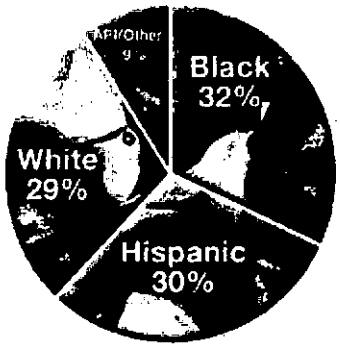
In this way, public health system patients can enjoy all the benefits of a full spectrum of health services in the convenience and ease of the ambulatory care setting.

Services Provided

- Ambulatory Surgery
- Asthma Care
- Cardiology
- Chemotherapy
- Child Care during Appointments
- Dental Care
- Diabetes Care
- Diagnostic Lab Services
- Diagnostic X-Ray Procedures
- Dialysis
- Extended Hours
- Financial Eligibility Workers
- HIV / AIDS Care
- Housing Counseling
- Mental Health Treatment
- Physical Rehabilitation
- Prenatal Care
- Substance Abuse Treatment
- Transportation Assistance to/from Appointments
- Urgent Care
- Women's Health

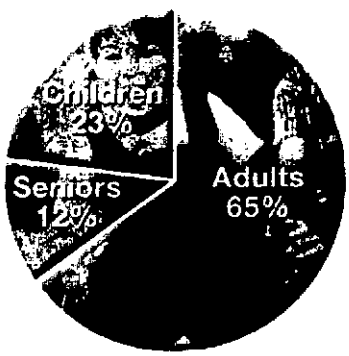
Something for everyone

Distribution by Race



Distribution by Gender

Distribution by Age



Public hospitals and health systems provide ambulatory care to a diverse cross-section of Americans. The patient mix of NAPH members as a group is distributed in near-equal thirds among African Americans (32%), Hispanics (30%) and Caucasians (29%), with Asian Americans, Pacific Islanders and other groups comprising about 9 percent.

While these statistics illustrate the overall national picture, it is important to note that in many regions of the country, public health systems serve communities that are home to unique populations, such as Somalian immigrants in Minnesota or Bosnian refugees in Iowa.

In addition to racial and ethnic distinctions, public hospitals and health systems cut across gender and generational lines. Women account for almost two-thirds of patients, and seniors account for one in every eight. Children make up about one-quarter of all ambulatory care visits provided by public hospitals and health systems.

Recognizing that a one-size-fits-all approach to patient care doesn't always work, public hospitals and health systems create ambulatory care programs specially tailored to meet the unique health care needs of these different groups. To address the needs of a culturally and linguistically diverse patient population, NAPH members foster a multilingual staff environment, provide face-to-face medical interpretation services and translate into multiple languages everything from patient education materials to facility signs.

Many public health systems have established special outpatient clinics to meet the distinctive needs of patients at various stages of life, such as school-based clinics for kids, OB clinics for pregnant women and geriatric clinics for seniors.
In short, when it comes to ambulatory care, public hospitals and health systems have something for everyone.

Here, there, and everywhere

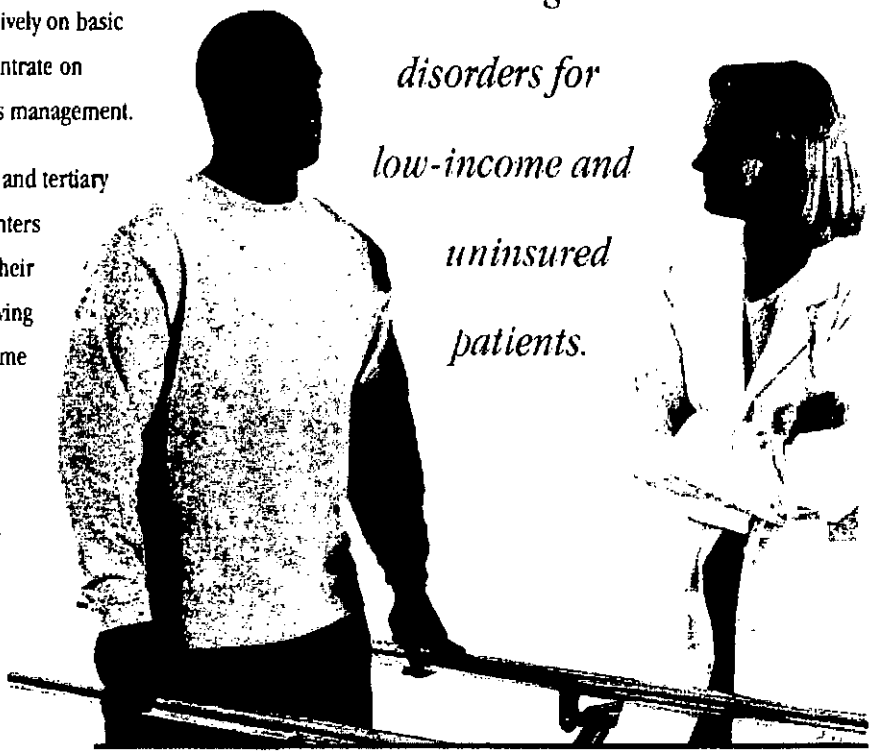
Although many of the better-known safety net providers are located in some of the country's largest urban centers (Los Angeles, New York City, Atlanta, Denver), many public health systems operate in smaller communities like Monroe, Louisiana or Colton, California. To make it as easy as possible for patients to gain access to health services regardless of where they live, ambulatory care services are provided through a wide variety of means.

Approximately two-thirds of all ambulatory care visits to NAPH members take place at hospital outpatient departments, and about one-third occurs at off-site locations, such as freestanding neighborhood clinics, primary and secondary schools, housing developments, homeless shelters and mobile vans.

In 2000, more than 10 million visits occurred at 668 community-based care sites affiliated with NAPH members. About two-thirds of these sites offer a combination of primary and specialty services; the rest focus exclusively on basic primary care or provide tailor-made clinics that concentrate on particular health concerns, such as asthma or diabetes management.

NAPH members are an important source of secondary and tertiary care for patients initially seen by community health centers or other federally funded health care delivery sites in their area. Over 80 percent of NAPH members report receiving such referrals from other community providers. At a time when federally funded clinics are reporting increasing difficulty finding providers who will accept specialty care referrals for their patients, NAPH members fill an important role in ensuring high quality comprehensive care for all.

Public hospitals are usually the only source of specialty treatment for such serious illnesses as cancer, heart disease, and neurological disorders for low-income and uninsured patients.



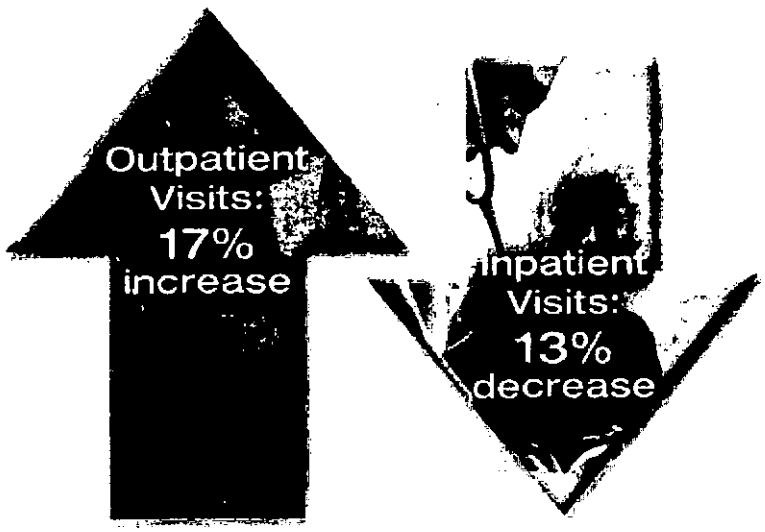
28 Million and counting

Given all the efforts to enhance access to ambulatory care, it should come as no surprise that the popularity of outpatient services at NAPH members has steadily increased. Over the past several years, demand for outpatient services has rapidly outpaced that for inpatient services in the nation's public hospitals and health systems.

Between 1993 and 1999, the number of outpatient visits to NAPH members increased 17 percent, while inpatient visits decreased 13 percent. On average, NAPH member hospitals also provide almost double the volume of outpatient services of other acute care hospitals in their markets, suggesting that safety net providers place a singularly high importance on prevention-focused ambulatory care.

As a group, NAPH hospitals provided more than 28 million ambulatory visits in the year 2000. This clearly illustrates that public health systems are major providers of outpatient care to America's communities. It also suggests that the remarkable growth of ambulatory care services in recent years is a sign of things to come.

Outpatient Visits vs. Inpatient Visits, 1993 - 1999



A matter of trust

A strong, trusting relationship between a patient and his or her provider is one of the most important factors in ensuring good health. That's why public hospitals and health systems give high priority to making sure that the patients in their ambulatory care systems are given a primary care provider – a doctor, nurse practitioner or physician assistant – who is their main connection to the health care system. In fact, two out of every three patients who regularly visit public hospital ambulatory care sites have a designated primary care provider.

Ambulatory care fosters strong patient–provider relationships.

As the name implies, primary care providers manage the primary care needs of patients; but they also oversee the management and treatment of patients' chronic conditions, coordinating referrals to specialized services when necessary. Simply put, the role of the primary care provider is to get to know a patient's medical history, look after his or her health care needs and provide patients with a reliable "medical home."

Outpatients at public health systems can rest easy knowing they have a trusted provider they can turn to in times of need.

A helping hand

Ambulatory care is more than medical care. It's about the realities of life.

Many people are reluctant or unable to seek health care simply because of the realities of life. A single mother may not schedule a medical appointment if there's no place to leave her preschooler. A low-income elderly man without a car doesn't know how he will get to his medical appointment across town. A young TB patient is unable to follow a medication regimen because he has no regular place to live. But these realities should not stand in the way of needed medical care.

Public hospitals and health systems are uniquely practiced in helping patients overcome these barriers by offering an array of supportive services that put medical services within the reach of patients. Public hospitals provide such supportive services as:

- Help in filling out paperwork
- Childcare during a parent's medical appointment
- Extended evening or weekend hours
- Housing counseling
- Transportation vouchers

A way to pay

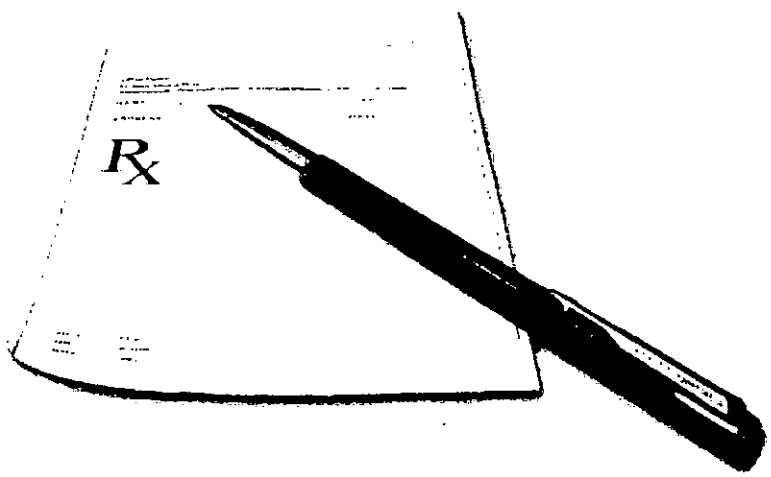
For obvious reasons, financial worries are frequently the main reason why some patients delay seeking needed health care services. An uninsured worker, for example, may put off going to the doctor for a persistent health problem out of fear that she won't be able to pay her medical bills.

Because the vast majority of patients who use the services of public hospitals and health systems are low-income, NAPH members work closely with outpatients to seek ways to identify sources of coverage and payment for uninsured individuals. Almost 90 percent of NAPH members have some type of on-site eligibility worker to help patients determine whether they are eligible for Medicaid or other sources of funding.

From the uninsured child with asthma, to the elderly patient whose Medicare doesn't cover drugs, the public hospital outpatient pharmacy is often the only option for free or reduced cost pharmaceuticals. Such pharmacies dispense large volumes of outpatient drugs in spite of their rising costs.

Without these supportive services, patients may be more likely to delay seeking care until their health conditions become serious. Such delays can needlessly jeopardize a patient's health and create circumstances that require higher levels of care and higher costs.

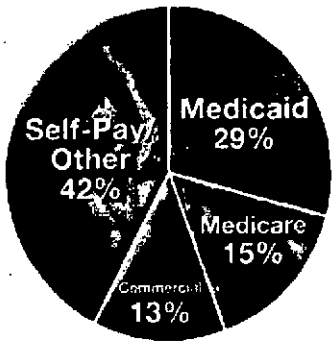
Public hospital pharmacies continue to provide free prescription drugs to outpatients, despite the rising cost of medications.



An under-funded investment in our future

Ensuring the availability of comprehensive, easy-to-access, culturally appropriate health care services for all Americans is not only good for the health of our families and our communities – it's also good public policy. The investment of public dollars to support cost-effective, prevention-oriented outpatient care, for example, can help reduce the much greater expenses associated with emergency room visits or hospital admissions for healthcare needs that can be met in less costly ways.

Ambulatory Care Visits by Payer Source



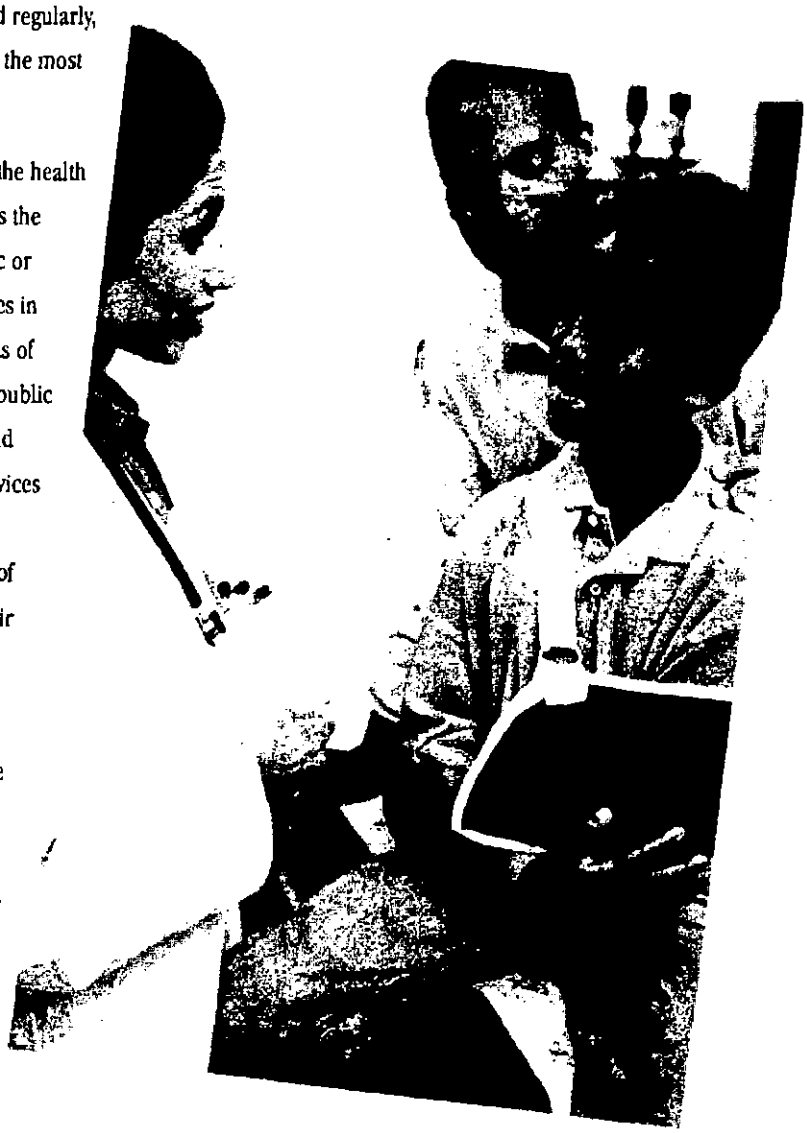
Unfortunately, the value of ambulatory care services at public health systems is not always recognized, nor is it adequately funded. Most of the patients who receive ambulatory care services through public hospitals and health systems are low-income or uninsured. Indeed, more than 40 percent of ambulatory care patients at public health systems do not have any health coverage at all (known as "self pay" patients). These patients usually can afford to pay only a fraction – if any – of the costs associated with their care.

Medicaid – the state-federal health insurance program for low-income populations – covers three in ten ambulatory patients at NAPH members. But Medicaid reimbursement rates do not sufficiently cover the costs of care, leaving providers and individuals to bear more of the expense. At the same time, funding from Medicare and commercial insurers, which covers 28 percent of ambulatory patients, is not able to make up for these shortfalls. In the end, this chronic under-funding steadily erodes the financial stability of public hospitals and health systems, compromising their ability to meet the health care needs of the communities they serve.

Always room for improvement

Over the past several years, NAPH members have made great strides in building patient-friendly ambulatory care systems designed to enhance the health and well being of the individuals and families they serve. As a result, they know first-hand that ensuring easy access to a full scope of outpatient services encourages patients to seek care early and regularly, assuring that emerging health needs can be met in the most appropriate and cost-effective manner possible.

But they also know that when it comes to meeting the health care needs of a community, the only thing that stays the same is change. Even relatively subtle demographic or socioeconomic shifts can lead to significant changes in the health status of a community. Because the needs of patients and communities are constantly evolving, public health systems continually seek ways to evaluate and improve the care they provide, developing new services and adapting old ones as necessary. In this way, NAPH members aim to further strengthen the role of ambulatory care and raise the level of health in their communities.



Still, with nearly one out of two outpatient visits provided to uninsured patients, NAPH members are finding it increasingly difficult to serve the growing needs of their communities. Given the importance of these services, it is imperative that the search for solutions to this challenging dilemma becomes a public policy priority.

NAPH Members

Alameda County Medical Center (Oakland, CA)

Arrowhead Regional Medical Center (Colton, CA)

Boston Medical Center (Boston, MA)

Broadlawns Medical Center (Des Moines, IA)

Cambridge Health Alliance (Cambridge, MA)

Central Georgia Health System Inc. (Macon, GA)

Community Health Network of San Francisco (San Francisco, CA)
- Laguna Honda Hospital & Rehabilitation Center (San Francisco, CA)
- San Francisco General Hospital (San Francisco, CA)

Community Medical Centers (Fresno, CA)

Contra Costa Regional Medical Center (Martinez, CA)

Cook County Bureau of Health Services (Chicago, IL)
- Cook County Hospital (Chicago, IL)
- Oak Forest Hospital (Oak Forest, IL)
- Provident Hospital of Cook County (Chicago, IL)

Cooper Green Hospital (Birmingham, AL)

Denver Health (Denver, CO)

Erlanger Medical Center (Chattanooga, TN)

Governor Juan F. Luis Hospital and Medical Center (St. Croix, VI)

Grady Health System (Atlanta, GA)

Halifax Community Health Systems (Daytona Beach, FL)

Harborview Medical Center (Seattle, WA)

Harris County Hospital District (Houston, TX)
- Ben Taub General Hospital (Houston, TX)
- Lyndon B. Johnson Hospital (Houston, TX)

Hawaii Health Systems Corporation (Honolulu, HI)
- Hale Ho'ola Kamaku Hospital (Honokaa, HI)
- Hilo Medical Center (Hilo, HI)
- Ka'u Hospital (Pahala, HI)
- Kauai Veterans Memorial Hospital (Waimea, HI)
- Kohala Hospital (Kapaau, HI)
- Kona Hospital (Kealakekua, HI)
- Kula Hospital (Kula, HI)
- Lana'i Community Hospital (Lanai City, HI)
- Leahi Hospital (Honolulu, HI)
- Maui Memorial Hospital (Wailuku, HI)
- Samuel Mahelona Memorial Hospital (Kapaa, HI)

The Health and Hospital Corporation of Marion County (Indianapolis, IN)

Hennepin County Medical Center (Minneapolis, MN)

Hurley Medical Center (Flint, MI)

Jackson Memorial Hospital (Miami, FL)

JPS Health Network (Fort Worth, TX)

Kern Medical Center (Bakersfield, CA)

Los Angeles County Department of Health Services (Los Angeles, CA)
- Harbor/UCLA Medical Center (Torrance, CA)
- High Desert Hospital (Lancaster, CA)
- Martin Luther King/Drew Medical Center (Los Angeles, CA)
- LAC+USC Medical Center (Los Angeles, CA)
- Olive View-UCLA Medical Center (Sylmar, CA)
- Rancho Los Amigos National Rehabilitation Center (Downey, CA)

LSU Health Sciences Center Health Care Services Department (Baton Rouge, LA)
- E.A. Conway Medical Center (Monroe, LA)
- Earl K. Long Medical Center (Baton Rouge, LA)
- Huey P. Long Medical Center (Pineville, LA)
- Lallie Kemp Regional Medical Center (Independence, LA)
- Leonard J. Chabert Medical Center (Houma, LA)
- Medical Center of Louisiana at New Orleans (New Orleans, LA)
- University Medical Center (Lafayette, LA)
- Washington-St. Tammany Regional Medical Center (Bogalusa, LA)
- Dr. Walter O. Moss Regional Medical Center (Lake Charles, LA)

Maricopa Integrated Health System (Phoenix, AZ)

Memorial Healthcare System (Hollywood, FL)
- Joe DiMaggio Children's Hospital at Memorial (Hollywood, FL)
- Memorial Hospital Pembroke (Pembroke Pines, FL)
- Memorial Hospital West (Pembroke Pines, FL)
- Memorial Regional Hospital (Hollywood, FL)

Metropolitan Nashville General Hospital (Nashville, TN)

The MetroHealth System (Cleveland, OH)

Mississippi Public Hospital Coalition (Gulfport, MS)
- Singing River Hospital (Pascagoula, MS)
- Southwest Mississippi Regional Medical Center (McComb, MS)
- Memorial Hospital at Gulfport (Gulfport, MS)
- Field Memorial Community Hospital (Centerville, MS)

Nassau University Medical Center (East Meadow, NY)

Natividad Medical Center (Salinas, CA)

New York City Health and Hospitals Corporation (New York, NY)
- Bellevue Hospital Center (New York, NY)
- Coler-Goldwater Memorial Hospital (Roosevelt Island, NY)
- Coney Island Hospital (Brooklyn, NY)
- Elmhurst Hospital Center (Elmhurst, NY)
- Gouverneur Nursing and Diagnostic & Treatment Center (New York, NY)
- Harlem Hospital Center (New York, NY)
- Jacobi Medical Center (Bronx, NY)
- Kings County Hospital (Brooklyn, NY)
- Lincoln Medical and Mental Health Center (Bronx, NY)
- Metropolitan Hospital Center (New York, NY)
- North Central Bronx Hospital (Bronx, NY)
- Queens Hospital Center (Jamaica, NY)
- Sea View Hospital Rehabilitation Center & Home (Staten Island, NY)
- Woodhull Medical and Mental Health Center (Brooklyn, NY)

North Broward Hospital District (Fort Lauderdale, FL)
- Broward General Medical Center (Fort Lauderdale, FL)
- Coral Springs Medical Center (Coral Springs, FL)
- Imperial Point Medical Center (Imperial Point, FL)
- North Broward Medical Center (Pompano Beach, FL)

The Ohio State University Hospital (Columbus, OH)

Parkland Health & Hospital System (Dallas, TX)

Regional Medical Center at Memphis (Memphis, TN)

Riverside County Regional Medical Center (Riverside, CA)

San Joaquin General Hospital (Stockton, CA)

San Mateo County General Hospital (San Mateo, CA)

Santa Clara Valley Health & Hospital System (San Jose, CA)

Thomason General Hospital (El Paso, TX)

Truman Medical Centers (Kansas City, MO)
- TMC Hospital Hill (Kansas City, MO)
- TMC Lakewood (Kansas City, MO)
- TMC Behavioral Health (Kansas City, MO)

UMDNJ-University Hospital (Newark, NJ)

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Abstract

Accountable Care has emerged as a critical delivery system redesign companion to expanded coverage within federal health reform. Accountable Care calls for providers to organize to provide a full continuum of care to patients and populations, to commit to improving quality while controlling cost, and to be rewarded as they succeed. However, the principles of Accountable Care are based upon demonstrations and lessons learned primarily in Medicare populations served by highly organized and integrated health systems. The Safety Net differs in the patient populations it serves, the structures and relationships between its providers, and its funding, which is mainly concentrated in Medicaid and local government reimbursement. Thus, the federal emphasis on the development of Accountable Care will need to be tailored differently for the Safety Net. Further, California's Safety Net will face the challenges of building collaborative delivery models earlier than the rest of the nation as the renewal of the State's 1115 Medicaid Waiver is implemented during the next year. These State and national moves toward integrated care offer both opportunity and challenge to the Safety Net and progress toward Accountable Care will be made only after embarking on an honest and thorough examination of necessary changes in relationships and organization, delivery system design, infrastructure, and revenue distribution. Taking leadership now to create Accountable Care is a strategy that is most likely to secure the ongoing existence of Safety Net providers, assure access for the patients they have historically served, and improve the health status of their communities. It is also a strategy that is likely to gain the support of the federal government as new models are sought to efficiently and effectively deliver care for a population that will soon represent the single largest publically-funded health coverage program.

Introduction

In the post-health reform flurry of speculation and amidst the scramble to prepare for 2014, the Accountable Care Organization (ACO)—which is the focus of the newly created Innovation Center within the Center for Medicaid and Medicare Services (CMS)—is emerging as a centerpiece of federal strategy to implement vast coverage expansions while also assuring and promoting quality of care, improving the health status of defined populations and, at the same time, not bankrupting future generations. It appears that CMS is seriously and quickly moving to assist in the establishment of these new delivery systems.

Further, the focus on integrated health care delivery is being echoed in the renewal of the California Medicaid Waiver,[1] which will precede national reform in its implementation. Both major Waiver

components—expansion of the "Coverage Initiative" for the uninsured and the transition of Seniors and Persons with Disabilities (SPDs) from fee-for-service into managed care—will require a new integrated delivery approach that is reflective of the basic tenets of an ACO model. The Waiver offers a further incentive to California providers that rely on Medicaid reimbursement to start moving toward new accountable care models that will ultimately be required under federal reform.

Why should the Safety Net focus on the development of integrated delivery systems, including ACOs? The ACO concept is still indistinct. Past CMS demonstrations have involved large physician groups with predominantly Medicare and commercially insured patients—not the primary populations served by the Safety Net. The vision of shared responsibility required by an ACO is complicated within the Safety Net which includes entities as disparate as public health and hospital systems, Federally Qualified Health Centers (FQHCs), private community hospitals and physician groups. State Medicaid agencies will need to be involved in ACOs focused on the Safety Net and they are now inundated with budget deficits and faced with staff furloughs. It may seem more prudent, and certainly easier, to wait and see how things fall out as health reform moves toward implementation.

However, there is a compelling case to be made that the Safety Net should not only participate in the development of ACOs and other integrated delivery system models, they should lead. Among the reasons to proceed aggressively now are the following:

- **CMS needs models for ACOs that target the populations cared for by the Safety Net.** Patients covered by Medicaid and the uninsured will be a significant focus for health reform expansion in 2014. Safety Net systems have the opportunity to help shape the evolving concept of ACOs for these groups. Safety Net systems can build collaborations with little active competition from others concentrating on ACOs predominately serving Medicare and commercial patients.

- **The Safety Net would benefit from the support that will be offered by CMS to prepare for the massive change that this transformation will require.** An ACO governance model will need to be built that takes into account the various accountabilities of County systems, FQHCs and private hospitals and physicians. An ACO finance strategy will need to be conceived that transforms the current complexity of Intergovernmental Transfer agreements (IGTs), Disproportionate Share Hospital (DSH) payments and FQHC PPS reimbursement into a "bundled" revenue stream that encourages efficiencies and best practices. Clinical silos will need to be replaced with integrated approaches and shared agreement on approaches to care delivery. This transformation will require an infusion of financial, regulatory, legal and technical assistance.

- **Local community and government support of health care in California is currently an advantage but may change under health reform and new delivery systems will need to be developed that assure access and maximize efficient use of resources.** In California, counties have long been mandated to address the care of the medically indigent and, while this charge has materialized in different forms, the building blocks are there to begin to construct a new model. Further, as health reform moves toward implementation, the role of local government as

both a payor and provider of health care services will, more and more, come into question. This next period of time, with potential for both State and federal support, provides a window of opportunity for the local Safety Net to define and shape its role in the future.

- **The core principles inherent in ACOs offer a strategy to the Safety Net to improve health outcomes and reduce costs.** The care provided in the Safety Net should be more coordinated, produce better outcomes, result in greater patient satisfaction and cost less. This is an opportunity for providers to be supported to do what they know should be done anyway.

This paper offers a broad analysis of the elements of ACOs and their likely role in the future, the particular challenges faced by the Safety Net in moving toward this new model and basic steps that Safety Net providers need to take to achieve a population-focused, collaborative approach to delivering health care services. While the focus of this paper is on the ACO (because of the emerging federal opportunities), the principles that make up these models are applicable to many different approaches to integrated care delivery that would be of significant benefit to the Safety Net. It is the premise of the authors that the Safety Net must be preserved—not because "it is too big to fail" but because it is likely to continue to be needed[2] and has a *responsibility* to survive. The lessons of the past have confirmed that "coverage" does not equal "access." There will always be those that have no other place to go for care and there will always be those that rely on the services that only Safety Net providers have the experience and expertise to provide. The potential failure of Safety Net providers would have a more profound impact than the failure of other providers for whole communities and for their most vulnerable residents.

It will be important, though, not to be like the generals who repeatedly plan to "win the last war;" preparation must be for the emerging challenges ahead. The transition period between the way that care is delivered and funded today to the model for the future will be the most critical time for the Safety Net. Lack of capital and infrastructure, difficult and cumbersome bureaucracies and governing organizations, financial arrangements that reward processes and expenditures rather than quality and outcomes—all of these issues are very real in the Safety Net and will take leadership, collaboration and intensive effort to address. It must be done, however, and it must start now.

It will be important (for the Safety Net) not to be like the generals who repeatedly plan to "win the last war;" preparation must be for the emerging challenges ahead.

What is "Accountable Care"?

"Accountable care" is a mechanism that the federal government hopes will address what is widely acknowledged to be poor value for the money spent in the U.S. health system, which is more expensive and inflationary while, at the same time, failing to achieve even comparable health status of other countries.[3] Further, within the borders of the United States, there is wide variability of health care costs and no seeming relation between the cost of care and the outcomes achieved.[4] Health care in this country can be dazzling and dramatic but fails to broadly provide even half of the services

recommended to achieve and maintain good health, resulting in life spans, infant mortality rates, potential years of life lost, and health-related quality of life that are clearly subpar. In addition, the population is generally dissatisfied with their care and certain populations have shamefully and disproportionately poor health outcomes.

If health care value were improved, it would mean the population would receive more value for what they pay. This could happen if health care quality and outcomes improved while cost remained the same or if costs decreased while quality remained constant. Of course, improving quality and decreasing cost would enhance value the most. Expanding health insurance coverage for the population is necessary but not sufficient to improve value. Coverage might improve outcomes for those who previously had no access to medical care but would also add new cost and would not end the current inflationary spiral. Further, increased coverage might not completely address access problems as providers shift their focus to take advantage of the most profitable "lines of business," while avoiding "losing services," leaving already underserved communities with high risk populations served unequally. This complex intersection of cost, quality and health status is the paradigm that ACOs are meant to address.

While the definition of ACOs is still being fully refined and may, in fact, take multiple forms, several elements must be in place. Care must be provided to a distinct population, large enough to be able to show a clear impact of organized care delivery but not too large that such an impact would be impossible to accomplish. The ACO should eventually care for patients covered by all types of payers, public and private. The ACO must be driven by providers, with decisions made that reflect the elements of practice that can deliver higher quality care at lower cost. Among current providers, there are likely to be winners and losers in a successful ACO. Based on previous federal ACO demonstration experience, it is clear that, to achieve its objectives, a new practice model must be adopted that is heavily focused on primary care medical homes, care management and connective health information technology.[5] Progress in meeting cost, quality and improved health status goals must be able to be measured. A new financial model must be established that aligns provider incentives to meet cost, quality and health status improvement objectives rather than basing payment on service volume. Finally, ACO governance must rely on integrated clinical leadership, organized in a way to constantly evaluate medical evidence and health outcomes and, as necessary, alter resources and practice to meet the needs of the population.

What are Challenges for Safety Net Participation in Accountable Care?

The Safety Net has been determined to be "those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients.[6]"These providers typically include public health care systems, FQHCs, community hospitals that serve vulnerable populations (because of either mission or geography), and private practitioners located in underserved areas. Health care delivered by the Safety Net is financed predominantly by Medicaid, local government funds, out-of-pocket payments by patients, Medicare, and a small percentage of commercial health insurance.[7] A significant, but undetermined amount of care is completely uncompensated. Patients served by the Safety Net have generally lower health status than that of the broader population in their communities, whether measured by health outcomes or self-reported, and

tend to have a higher prevalence of chronic illness, suffer from a higher incidence of catastrophic occurrences, and have a higher prevalence of serious and persistent mental illness, substance abuse, and co-morbid chronic conditions.[8] Safety Net patients are expensive.

The Safety Net is not currently, in most communities, a *system of care*. It is, rather, a fragmented and unsystematic collection of hospitals and doctors and clinics that deliver care to complex patients in a way that can be episodic and reactive, though often heroic. As the name implies, the Safety Net has focused much of its energy and resources on catching those who already are "falling" due to lack of prevention or complications of uncontrolled illness. Safety Net institutions are generally characterized by poor data generation with resulting scanty information on cost of care or health outcome measurements. Particularly for public Safety Net providers (local government-operated hospitals and health systems), the main business strategy has historically focused on increasing revenues, not controlling costs. One of the unique features of many Safety Net institutions is that they are reimbursed by Medicaid based on the costs they generate.[9] These institutions may be adept at calculating the total overall costs used for reimbursement, but have a poor sense of the specific distribution and reasons for cost that might be helpful to generate cost-reducing interventions.

> The Safety net....deliver(s) care to complex patients in a way that can be episodic and reactive, though often heroic....(Safety Net providers) developed originally as services of "last resort" without incentives or direction to become "patient-centered."

While Safety Net providers often have unique and distinctive expertise in caring for complex patients, they have limited tradition of collaboration or formal partnering with each other. There is often no history of prospective joint planning to improve the health of the population, to secure revenue, or to share in savings. Even within public health systems, primary care and behavioral health services are often disconnected from emergent and inpatient care. These institutions have usually developed their information systems separately and communicate inadequately to improve patient care or to fill gaps and eliminate costly duplications in service delivery. Complex and difficult patients are often sent without adequate coordination of care to other providers within the Safety Net, causing them to fall through the "cracks" in the system, suffer adverse health consequences, and ultimately incur higher health care costs.

Central to the ACO model (and all effectively managed integrated delivery systems) is a Patient Centered Medical Home (PCMH) for each patient.[10] The PCMH is the starting point for all health care coordination and offers prevention, management of chronic illness, and access for acute problems. The PCMH initiates and coordinates referrals for subspecialty consultation and diagnostics and receives recommendations, shares in the development of the patient's care plan and is the point in the health system that brings together all the patients health needs and treatments. The PCMH, however, is not simply a conventional primary care practice. It is expected to supply team-based care where staff roles are optimized and defined to meet the needs of patients in a planned, rather than a reactive, manner. It manages transitions between levels of care as, for example, in post-hospital discharge back to primary

care. While many Safety Net providers are attempting to move toward the PCMH model, it is not yet widely implemented. The Safety Net is characterized by lack of reserves to meet the financial challenges that even well-funded systems met during the transition to PCMH.[11] Safety Net providers are less likely to have invested in the information technology that is necessary to support the implementation of the PCMH.[12] "Patient-Centeredness" is a fundamental attribute of the PCMH but Safety Net providers developed originally as services of "last resort" without incentives or direction to become "patient-centered." The participation of FQHCs, many of which have greater experience in Medical Home conversions than other providers serving similar populations, could be an asset in the development of ACOs in the Safety Net. Further, some of the California Counties that have participated in the State's "Coverage Initiative" over the past several years have experimented with converting old forms of episodic care delivery to Medical Home models and could serve as the basis for building integrated delivery systems.

The Safety Net shares in the national crisis of an inadequate supply of primary care practitioners, as fewer and fewer medical students enter primary care careers.[13] However, unlike the commercially-insured health care system which has an overabundance of specialists, the Safety Net strains to provide minimum access to specialists and diagnostics for its patients[14] and the lack of access to these services may contribute to the less than optimal health outcomes of its patients.[15] Further, poor communication between providers of specialty care and primary care in the Safety Net often squanders scarce resources by causing a repetition of treatment and testing or "churning" of patients in specialty settings who could have been returned to primary care. Lack of common information systems between specialty and primary care practitioners, the insular culture of training clinics at public academic medical centers, and little financial incentive to communicate with primary care all conspire to decrease the effectiveness of specialty care when it can be obtained. The role of both public hospital systems and private doctors in the development of specialty care panels tied to the ACO (and the assurance of their connection to primary care) will be a critical feature in an effective integrated ACO model, as will exploring the potential expansion of specialty care in innovative collaborations between specialists and FQHCs. The involvement in Medicaid managed care plans (in particular, California's Local Initiatives and County Organized Health Systems, plans with a mandate to preserve the Safety Net) can provide assistance in identifying those specialty providers who have traditionally served Safety Net populations, often in isolation from each other.

Information technology (IT) is an essential tool for care coordination and disease management; it improves quality and may help to control costs. Safety Net investment in IT, however, has lagged behind the broader health care community.[16] The establishment of an Electronic Health Record (EHR) is the focus for integrated delivery systems and the inclusion of a chronic disease registry is a necessity in effective disease management. Further, EHRs need to be connected to all providers that make up the ACO as efficient care in one sector (primary care, for example) is limited if it is not connected to other parts of the continuum of care, such as hospitals and outpatient specialty consultation. All levels of care in an ACO need to share a common patient care plan, be able to refer and gain advice from specialists, access diagnostics easily and appropriately, and manage the transition of patients between institutions and toward lower levels of care. Information systems that do exist within Safety Net institutions are

rarely connected or consistent with each other and their potential to support an ACO is limited by their isolation. Solutions such as Health Information Exchanges are needed and have been developed in Safety Nets,[17] as have other creative approaches that have emanated from the Safety Net and are available, less expensive and readily implementable that can: provide registry functions short of a complete EHR (*i2i* disease registries initiated in the Bay Area); assure accessible but efficient links between primary care and specialists for referral and communication (the *IRIS* clinical rules-based specialty referral system conceived in the Cook County system in Chicago); and connect hospitals and EDs to Medical Homes in near real time (*Safety Net Connect* that links all of the hospitals in the community with physician practices and clinics caring for the uninsured supported by Orange County).

Beyond the need for using information technology to manage and coordinate the care for individual patients, the ACO must be accountable for cost and quality and must be able to measure both in a reasonable time. Ultimately, revenue will depend upon these factors and the successful ACO must know the status of quality and cost of care of its population[18]. Safety Net systems are weak in this regard as data often cannot be generated in real time and its accuracy may be suspect because, historically, Safety Net systems have not needed to closely tie expenditures to utilization. The change in orientation of the Safety Net to generate and use valid and timely utilization, cost and quality data is critical. Further, ACOs may ultimately be held responsible to demonstrate improvement in the health status outcomes of the whole geography its serves, not simply those enrolled in the ACO itself. In that case, the Safety Net ACO must be connected to data that currently resides in the public health realm. In some local communities within the United States, these linkages already exist.[19]

ACOs must be formed by provider collaborations of practitioners and institutions willing to be held responsible for the quality and cost of patient care and health outcomes. They also must agree to be reimbursed in new ways. The ACO will be a new organization with a legal structure that must accommodate an abundance of complicated existing regulations and laws (and politics). The agreements that establish and organize the Safety Net ACO are likely to be even more complex than those that will be utilized in the private health care system, as most will include local government health systems and FQHCs and private hospitals--all with their own governance structures. The participation of a public system in an ACO will involve internal policies, such as human resource rules, that extend beyond the health care sector. The high percentage of unionization of public systems (compounded further by civil service) may heighten resistance to change. On the other hand, organized labor may serve as an agent that helps this restructuring proceed if brought to the table early in the process. In Santa Clara County, for example, Local 521 of the Service Employees International Union (SEIU) was instrumental in both developing a broad analysis of the challenges facing the County in light of the California Waiver renewal and national health reform and in providing the catalyst to bring together all components of the local Safety Net—public and private—to begin to discuss the potential for forming an ACO focused on the meeting the health care needs of the most vulnerable residents of the County.

Payment in the ACO will be different than conventional medical revenue generation, particularly for the public sector but also for private Safety Net provider participants. Revenue will not be based on volume of service delivered but rather on the number of persons served by the ACO and meeting benchmarks for the quality of their care and its cost. Reimbursement will include sharing of savings through a system

of incentives that emphasize the most effective and lowest cost care. This is in direct opposition to the current focus of investment in and reimbursement of care within the United States where the highest cost, highest utilizing areas of the country often demonstrate worse health outcomes than areas of lower cost and utilization[20]. A single ACO financial model does not exist and will have to be tested and refined based on the principles of cost and quality tied to reimbursement. A starting point might be chosen from the experience of the CMS Physician Group Practice (PGP) Demonstrations[21 22] or evaluations of practice incentives such as the Pay for Performance (P4P) initiatives.[23] The PGP experience is helpful but was focused entirely on Medicare populations and tested in settings of established and successful, highly structured physician group practices that most resembled integrated delivery systems. Even with guidance from evaluations of P4P initiatives, unique models will have to be fashioned for a Safety Net ACO, since many of the evaluations of models existing today are from the commercial insurance market. When P4P in the Safety Net has been examined, concerns about comparability have arisen due to differences in the patient population, data sources, and the type and employment status of physicians who practice in the Safety Net.[24 25] But new Safety Net financing models are starting to emerge. In Chicago, for example, a group of FQHCs, private hospitals and the Cook County Health and Hospital System, spurred by foundation support, have come together to develop an integrated delivery model, first targeting Medicaid patients, and are working with the State of Illinois to test a new "gain-share" payment methodology that would allow cost-savings to be returned to the new entity to improve quality and access. Lessons learned from efforts like these will be important in making the transition from current Safety Net payment mechanisms that incentivize cost and volume.

The makeup, coverage and nature of the patient population cared for by the Safety Net will require additional consideration in an ACO, which assumes not only patient cooperation but increased patient-centeredness and empowerment. The Safety Net's patients are, by definition, poor and have had little political, individual or market force strength. Health services available to them have been episodic and reactive so it is not surprising that their health-seeking behavior reflects this pattern. The patient population within the Safety Net is not only socially complex and disadvantaged; they are sicker. Health disparities are a recognized fact in the United States[26] and an ACO within the Safety Net must be prepared to address these disparities. The population suffers and dies mainly from poorly-controlled chronic illness and experiences a higher level of serious and persistent mental illness and substance abuse.[27] Services available to these persons may be inadequate but do exist within the current Safety Net, although they are often organized separately from the rest of the health care delivery system. Integration of medical, mental health and behavioral health will have to be a priority but the mere availability of these services can be a tremendous advantage to effective care for a Safety Net ACO. These models are also starting to be explored in places like Los Angeles, where an integration is being implemented between FQHCs, the County's medical system and its mental health services, all focused on the highest utilizing and most complex patients in the skid row area of the city.

> The Safety Net may be unique in its inclusion of the uninsured....This is another reason to ...influence the process as (they) offer a unique laboratory for building effective approaches to these populations.

The Safety Net may be unique in its attention to the uninsured, including persons who are not legal residents or otherwise are not likely to be covered under health reform. Formation of ACOs will not change this commitment but practitioners and institutions within the Safety Net are concerned that the uninsured are not discussed in proposed models or evaluations of past initiatives and worry that they may be overlooked or crowded-out by ACO planning. This is another reason to step up and influence the process now as Safety Net ACOs offer a unique laboratory for building effective approaches to these populations. In Orange County, for example, the leaders of all of the private hospitals have begun to collaborate with the Orange County Health Care Agency and CalOptima (the County Organized Health System Medicaid managed care plan) to help expand the County's current approach to meeting the needs of the nearly half million uninsured by finding new ways to expand the pool of dollars available and to develop a more coordinated delivery system that includes the hospitals, clinics and private physicians. By starting with those patients with few options, a better system can be developed to meet the needs of those who have coverage.

What Steps Must the Safety Net Take to Participate in or Direct the Development of Approaches to Accountable Care?

As Safety Net leaders move their own institutions toward more integrated approaches to care delivery, they will first need to accept the inevitability of the change that health reform presents and reach the conclusion that there won't be a "magic bullet" reprieve for the Safety Net, as there has been in the past. When the management of Safety Net institutions is so often dominated by moving from one crisis to the next, it is difficult to focus—and be supported in that focus—on planning for the future. As the country approaches 2014—and as California approaches the implementation of its Medicaid Waiver next year—there will need to be a resolve on the part of the leadership of Safety Net institutions (as well as their governing boards) that they are going to help to shape the transformation in how health care is delivered, not to wait for change to be imposed upon them. It is critical to move before policies are set in stone. There is enough fluidity now—and apparent openness to trying new things—that the Safety Net can be in the forefront of developing models that make sense for its providers and, even more important, its patients and communities.

It is important to understand that there is still a great deal of ambiguity about the specifics of ACO development and implementation. This uncertainty is likely to cause ambivalence, a lack of urgency and even hostility to change within the Safety Net. However, the massive expansion of coverage will clearly require new models to both assure access and contain costs. The focus on the core principles of ACOs (management of a population, direction by a coordinated set of providers, financial incentives aligned with clinical goals, containment of cost, enhancement of quality and the patient experience, improvement of overall health status) will benefit the Safety Net institutions and all of its patient populations, whether ultimately covered by health reform or not, or whether the adoption of these principles results in the formation of an ACO or not.

The steps that the Safety Net should take to prepare for the likely movement into integrated systems of care through ACOs are detailed below.

1. **Someone has to step up and lead.** The key to forming an approach to accountable care is to find a leader or leaders who can look beyond the self interest of any one provider. In Chicago, that leader was a foundation that committed both start-up and long term support to the effort that is resulting in an integrated system of care for Medicaid patients on the south side of the city. In North Carolina, private physicians directed the development of integrated networks that eventually formed the basis for service delivery for Medicaid patients throughout the state. In South Los Angeles, a private hospital system served as the convener of a group that now includes FQHCs, the public health and hospital system, other private hospitals and the Local Initiative Medicaid managed care plan to take on the development of an integrated approach to the care of vulnerable populations in that community. In San Mateo, the County government initiated a process that has resulted in collaboration between the public health system, private hospitals, large physician groups and FQHCs in the care of traditional Safety Net populations. FQHCs, public hospitals, local business groups concerned about access for their employees, unions, foundations, private hospitals—the impetus for change, and the tenacity and skill to keep all of the players at the table, can come from many quarters.

2. **Determine the geographic area to be covered by a Safety Net ACO.** The area should be large enough to demonstrate the impact of the ACO on cost, quality and health status but not too large to be impossible to manage effectively. For example, some California counties would likely represent a plausible target area while others would need to be divided into rational sub-divisions. Within the geographic target area, while understanding that all populations would ultimately be included, a plan for an incremental approach to population inclusion will need to be developed, likely starting with Safety Net populations (i.e., Medi-Cal, uninsured, dually Medicare and Medicaid eligible).

3. **Thoroughly understand the target populations and communities.** A Safety Net ACO will need to identify vulnerable populations, their current utilization patterns (ED use, connection to primary care, hospital readmission rates), and their health problems. This analysis will then need to be compared with what care *should be* provided and what health status goals *should be* achieved. It is not enough to identify, for example, how many outpatient specialty visits were generated by a given population; it must be compared to objective criteria for what should be occurring in a managed approach for a comparable group of patients. Other information to be identified should include: gaps in care (i.e., too few specialty visits compared to what is indicated for the care of certain chronic illnesses), duplication of services (i.e., diagnostics at multiple institutions) and inappropriate use of certain levels of care (i.e., excessive Emergency Department visits for ambulatory sensitive conditions). This process of assessing the population is a critical step in allocating resources and setting goals in an integrated delivery system that will effectively care for the population. All available data should be thoroughly examined: County health utilization, FQHC federal reports, state Medicaid data. Medicaid managed care plans, particularly those that have a commitment to preserve the Safety Net, can be invaluable partners in assessing current utilization patterns and identifying trends, gaps and duplications.

4. **Begin to build a framework for how different providers could fit into an integrated delivery system.** It is important to identify the providers to whom target populations have traditionally gone for their care. These clinicians and institutions (public and private) should form the first critical mass of those who will come together to begin to plan for this new and integrated approach to care delivery through an ACO. Developing an ACO made up of providers with little history of collaboration and joint planning for a population is a delicate endeavor. Conversations must start between individual leaders to build relationships, to demonstrate a clear willingness to "put everything on the table" and to build on the assets of individual providers, sharing what one does best and giving up other services when there are better options. In some areas it may become clear, for example, that certain providers are better suited to become the primary care Medical Homes for some patients, while another provider may develop "Enhanced Medical Homes" for those patients that require greater access to specialty, behavioral health and diagnostic support. One hospital provider may be seen as the primary resource for cancer care for the ACO and another may develop cardiac services. Still another provider participant may have the most effective model for care management that can be disseminated throughout the ACO. FQHCs will need to coordinate with each other and with the large number—in many communities—of private physicians who are caring for Safety Net populations, building on each other's strengths in the development of Medical Homes and specialty panels. These preliminary discussions are vital to assembling this inventory and engaging in creative thinking among provider participants.

The focus on the core principles of ACOs (management of a population, direction by a coordinated set of providers, financial incentives aligned with clinical goals, containment of cost, enhancement of quality and the patient experience, improvement of overall health status) will benefit the Safety Net institutions and all of its patient populations, whether ultimately covered by health reform or not.

5. **Bring a critical mass of providers into discussions about an ACO.** Once it is clear that there is the potential for an integrated approach to the delivery of care to a defined population, those providers should be convened and start meeting together to plan for the development of an ACO. It will be important that the CEOs and other senior administrators—including clinical leaders—of these provider organizations compose the planning group so that commitments can be made for the individual institutions. Eventually, this body will need to further expand to include other key stakeholders (schools, mental/behavioral health, business, etc.). Local Initiatives and County Organized Health Systems can provide expertise in both identifying key private physician groups that have traditionally been major providers for Safety Net populations and offer resources in the development and implementation of infrastructure in managing the integrated delivery system.

6. **Agree to move together in phases but with a clear timeline.** The issues that will require scrutiny and decision once there is a determination of the target area and the initial component of providers will be daunting. These issues must be developed in a "forced march" of timelines and clear deliverables. Each area will appear overwhelming and must be pushed through, often with incremental solutions.

   The list includes, but is certainly not limited to:

   - setting priorities and a schedule for *patient inclusion* (who will be cared for when will impact the scope of the provider network, the financial strategies, the infrastructure and the shape of the organization):
   - establishing a model or models for an *organizational structure for the ACO* which will likely include public health and hospital systems, FQHCs, private hospitals and even private practitioners—all with their own constraints and all required to be represented;
   - determining an approach to *integrated clinical leadership and goal setting* that will assure provider inclusion in the operation of the ACO;
   - setting a plan for *patient management infrostructure*, including connective information technology, targeted care management, utilization review; and
   - establishing *financial strategies* that incent best practices, fill gaps in the continuum of care, minimize duplication or inappropriate use of resources, identify the potential use of shared savings.

7. **Involve the major payers of the Safety Net, including State and local governments that reimburse for the care of the Medicaid population and the uninsured.** It is important that these entities are included and, perhaps through CMS, supported to partner with Safety Net ACOs as they attempt to build integrated delivery systems to provide higher quality, better coordinated and more cost-efficient care for vulnerable populations.

8. **Start by starting: begin to act as a "virtual ACO" as the real one is being developed.** Even before the final structures are in place, the provider participants in the ACO should start to find ways to operationally and clinically collaborate or expand coordinated activities already in place. Further, health care institutions (whether they are large academic medical centers or community-based FQHCs or faith-based community hospitals or two-physician private practice offices) all have employees and systems and cultures. They may have limited experience with working collaboratively with other providers. The understanding of new ways of operating, of working and openly communicating with partners, is a new lesson to be learned and is counter-intuitive on many levels. The ability to make this concept real will be contingent on developing and doing real work together.

9. **Get help to build the infrastructure that will make the ACO a reality.** The transition period will be a very difficult one. It is projected that there will be support available from the Center for

Innovation in CMS and that Safety Net ACOs will be viewed as attractive partners as the federal government moves to cover tens of millions of patients who have traditionally relied on Safety Net providers for their care. Other sources of support should be mined, however. Foundations could play an important role in seeding real and ultimately sustainable infrastructure elements (IT, legal assistance as governance is being developed, medical home readiness training, etc.) and sponsoring formal interactions between Safety Net ACO efforts to share best practices as learning from each other will likely be more helpful than drawing lessons from traditional ACO models.

What is the Conclusion about Accountable Care and the Safety Net?

The Safety Net, like the rest of the country, is about to experience the greatest change in health care delivery in several generations. As its patients move from uninsurance to coverage, as payment mechanisms transition from subsidizing providers who care for underserved populations to incentivizing quality and cost-controls and as new clinical models emerge that demand integration and best practice, the Safety Net must be prepared. These institutions are critical resources in their communities and waiting for changes to be imposed without influencing how they impact the Safety Net, and those patients who have traditionally relied upon it, is a bankrupt strategy. There is a window of opportunity to lead and the Safety Net has an obligation to be in the forefront of change, not resistant or ambivalent to it. Across the country, small groups of hospitals, FQHCs, physician groups, and public health systems are beginning to talk about the populations that they all serve and how to serve them more effectively and efficiently. These efforts should be incubated and brought to fruition. The entire US health system will be better for it.

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Chicago Tribune
May 15, 2005 Sunday
Chicago Final Edition

SECTION: NEWS ; ZONE C; Pg. 1
LENGTH: 2091 words

HEADLINE: Needy patients find door shut when searching for specialist

BYLINE: By Judith Graham, Tribune staff reporter.

BODY:

Sandra Herron's health was taking a sharp turn for the worse. It was becoming hard to breathe. Lesions were sprouting around her nose. She was tired all the time.

Herron worried it was a serious flare-up of the chronic inflammatory disease she has had for 24 years--a clear signal she needed help from a doctor who specialized in her illness, sarcoidosis.

But Herron, 51, a part-time psychology instructor, didn't have health insurance and couldn't afford to pay a specialist's fees. Not sick enough to go to an emergency room, too distressed to ignore her symptoms, and without a regular doctor to ask for advice, she was at a loss for where to turn.

Millions of uninsured Americans face a similar challenge. Although basic medical services for the needy are available at community clinics across the country, specialty care is scarce for people without health insurance.

"It's the biggest hole in the safety net," said Patricia Terrell, the former deputy chief of Cook County's Bureau of Health Services.

Several factors are fueling a growing sense of crisis surrounding specialty care for the uninsured. The number of people without medical coverage, now estimated at 45 million, is rising steadily, and experts project the trend will continue.

As a group, the uninsured tend to have more chronic illnesses than the population at large. Medical complications requiring specialists' attention also are more common because these patients often forgo routine medical care.

At the same time, public hospitals, which provide the bulk of care to the uninsured, are under intense financial pressure as governments cut back support. Though physicians and private hospitals offer some free or discounted services, they are not sufficient to meet demand.

The result is that uninsured patients with conditions ranging from diabetes to arthritis to Parkinson's disease don't get regular consultations with the doctors who know best how to treat their conditions.

The health consequences are dire: "People get sicker, they die earlier, or they end up with disabling conditions that can create problems throughout the remainder of their lives," said Diane Rowland, executive director of the Kaiser Commission on Medicaid and the Uninsured.

Cancer is an example. Every year, 200,000 uninsured cancer patients spend more than twice as much out of pocket on medical services even though they see doctors far less often than patients with insurance, according to research by experts at Emory University's school of public health.

People with insurance also get sophisticated medical tests such as MRI scans, high-tech services such as heart bypass operations, and preventive screenings such as colonoscopies at much higher rates than those without.

"It's time to examine the current state of specialty care for the uninsured in our communities and talk seriously about what health-care systems across thc area can and should be doing," said Donna Thompson, chief executive of Access Community Health Network, which runs 44 clinics for the medically underserved.

New research confirms the scope of the problem. Marsha Regenstein, professor of health policy at George Washington University, recently completed a survey of public hospital systems in 10 cities, including Boston and Detroit. In every case, access to specialty services was limited, poorly coordinated with primary care or extremely confusing to patients.

"This is a crisis of national proportions," Regenstein said.

Payment upfront--in cash

American medicine is flush with specialists, experts who know particular body systems or diseases inside-out and stay on top of the most advanced treatments. For someone with insurance, access to these physicians is usually as easy as calling for an appointment.

But if a patient without insurance contacts a private doctor's office, he will typically be asked for payment upfront--in cash. If he doesn't have the money, he often is politely asked to seek care elsewhere.

"There are very few physicians in private practice who make themselves available to the uninsured," said Alan Channing, chief executive officer of Sinai Health System in Chicago, where one out of every five patients has no medical coverage.

If a patient tries a community clinic for the medically needy, and a doctor there finds a problem that needs a more expert examination--let's say, a suspicious mass in the abdomen--the options are limited.

Often, "the doctor will pick up the phone and call a specialist he knows, asking for a favor: Please, can you see this patient; she really needs attention," said Bruce Johnson, executive director of the Illinois Primary Health Care Association. Specialists will frequently agree to help a colleague.

If that doesn't work, patients often seek specialty care at hospital emergency rooms. But that isn't a good solution for the 1.8 million Illinoisans without medical coverage.

Though hospitals are required to treat patients in medical crises, there's no such requirement for non-emergency or follow-up care--the kind of specialty services that are most needed and hardest to get.

Most community hospitals supply only limited amounts of charity care, and then mostly for patients with acute conditions. As a rule, their specialists are in private practice and don't take many patients without insurance.

There are exceptions: Some private institutions, such as Mt. Sinai Hospital and St. Anthony's Hospital in Chicago, among others, open their doors to large numbers of indigent patients.

Academic medical centers once offered a fairly substantial amount of care. But now, under financial pressure, specialists at these institutions are treating more people with private insurance and fewer of the uninsured.

A 2003 study by researchers at Boston's Massachusetts General Hospital documents the trend: Of 2,000 physicians surveyed across the country, one in four said they had problems admitting uninsured patients to teaching hospitals or were forced to limit those patients' care

Public institutions like Stroger Hospital are the largest providers of specialized medical services to the uninsured. Patients who get basic medical care from these hospitals' clinics also are eligible for more advanced care.

But getting an appointment can take months. And patients who try to see a specialist without a referral from an affiliated doctor won't get to see one.

"At most public hospitals, the attitude has been, `We'll do a great job for you as long as you can get in the door.' But good luck getting in," said Dr. Terry Conway, an internist who splits his time between Cook County's sprawling health-care system and a consulting practice.

`I get so worried'

On a recent rainy morning, Sandra Herron was wondering how she was going to do it all--get expensive tests, arrange for specialty care, pay for needed medicines--as she sat in the crowded waiting room of an Access Community Health clinic in Chicago Heights.

A part-time social worker and psychology instructor at South Suburban College, Herron has known for 24 years that she has sarcoidosis, an inflammatory disease that can cause lumps to form in the lungs and other organs.

Most of the time, her symptoms were manageable, and she thought she could get by without medical checkups or insurance, which she dropped about five years ago because of the expense.

That changed in January after she started waking up gasping for air in the middle of the night and her son took her to the emergency room at South Suburban Hospital in Hazel Crest.

Three months and several doctor visits later--but still without a specialist managing her condition--she was having trouble breathing on a regular basis, nasty-looking bumps were popping up around her nostrils, and she was scared.

"I get so worried that I don't know what's going on with my body, and that I'm getting worse," Herron said.

On this dismal spring day, she decided to go to a federally funded health clinic for the medically needy in search of help, and it was Dr. Kevin Gordon's turn to take a look at her.

"This is really not something I know much about," he said after an examination. Gordon, a family physician, proposed referring her to a pulmonologist at Mt. Sinai Hospital.

"That's an hour from where I live: I want something closer to home in case I have another attack," Herron responded.

Doctor and patient agreed her best strategy was to go to Oak Forest Hospital, part of Cook County's sprawling health system, and try to get a referral from an emergency room physician to a pulmonologist.

It would be a long wait, but it was also her best bet, Gordon told Herron, who later acknowledged she was nervous about what lay ahead.

What would the hospital bill her for the services? How could she pay for further treatments with other unpaid medical bills sitting at home? And what if something were to happen to her before she saw a specialist and she again suffered that devastating feeling of not getting enough air into her lungs?

"If only clinics like these had it so those who cannot afford much could still go to a specialist around where they live, it wouldn't be nearly so scary," Herron sighed.

If Herron's medical concerns had been the kind general doctors see every day--say, an infection--she wouldn't have had to worry so much.

Over the last decade, the federal government has poured significant amounts of money into expanding neighborhood health clinics for the needy, increasing the capacity to deliver basic care. Boosting the number of such centers is a significant priority for the Bush administration.

In Illinois, 43 federally qualified health centers now offer services at 250 sites across the state to 850,000 patients--including 325,000 without insurance--every year, according to the Illinois Primary Health Care Association.

Yet the federal government hasn't devoted funding to expanding specialty care; neither have most local and state governments.

Without a reliable funding stream, "these [specialty] services just aren't readily available," said Conway, who consults widely with public hospital systems across the country.

Specialists in short supply

Aggravating the situation is a nationwide shortage of certain specialists--for instance, orthopedists and radiologists.

Few choose to practice in disadvantaged locations, with demand for their services high, and with much more money to be made in the suburbs.

"Even if we had lots and lots of extra money, we still couldn't totally staff our clinics," said Dr. Daniel Winship, chief of Cook County's Bureau of Health Services, which runs three hospitals and 28 clinics across the city and suburbs.

Oak Forest Hospital, for example, lost its sole gastroenterologist--a doctor that handles diseases of the digestive system--last year and has not yet been able to replace him. As a result, patients from the south suburbs have to find their way to Stroger Hospital, where waits in the gastroenterology clinic now extend about 12 months, Winship said.

The chaos surrounding specialty care plays out every day in Chicago Heights at Access Family Health Society, the center run by Access Community Health, the nation's largest chain of federally funded clinics for the needy.

On a recent morning, Gordon paused between exams to describe the difficulties he routinely faces when a sick patient walks in the door.

"If the person doesn't have insurance, I can't order up MRI or CT scans even if I think they're necessary," he said. "The best I can do, usually, is to send them over to the Oak Forest Hospital emergency room and hope they can get it done over there."

Once a patient goes off to the hospital, however, "I don't have much control over what happens," Gordon said. "Often, you lose them and just hope everything turned out all right."

"Sometimes I'm on the phone for hours at a time, trying to make things work," chimed in Dr. Cynthia Thomas, the clinic's medical director.

Although the Chicago Heights clinic has a referral relationship with specialists at Mt. Sinai Hospital, many south suburban patients don't have a way to get to the West Side hospital. Others can't afford even the scaled-back fees that Sinai physicians charge patients without insurance.

Thomas remembered a patient the week before with kidney stones who needed to see a urologist and get two important diagnostic tests. After negotiating reduced rates at Mt. Sinai through a financial counselor, Thomas told the woman what she'd pay: at least $50 for the urologist, $70 for the ultrasound, $100 for the CT scan.

It was a fraction of the true cost, but it was too much.

"She just started crying," Thomas said.

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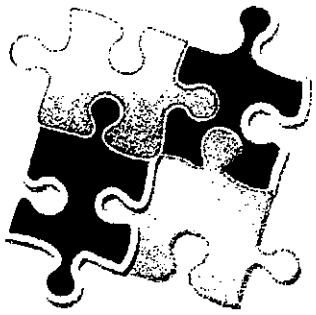
LOAD-DATE: May 15, 2005

The Chicago Health Care Access Puzzle



Fitting the Pieces Together

November 2008

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Mayor

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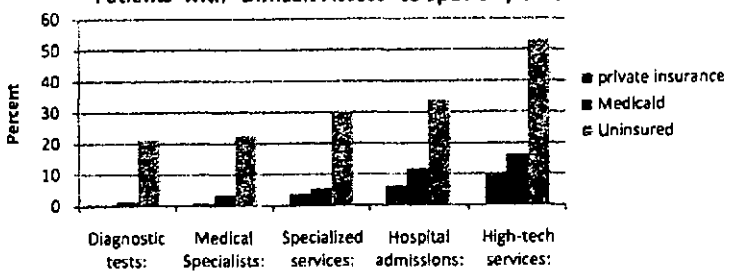
It is increasingly difficult for the uninsured and Medicaid population to access specialty care.

The difficulty in accessing specialty care was a major issue identified at each meeting. Patients who are uninsured or who receive Medicaid benefits are reportedly having a more difficult time receiving needed specialty care. There also seems to be a maldistribution of services geographically, which corresponds to the socioeconomic conditions found within certain communities.

A recent study documented the problems experienced by CHC patients. While CHCs provide comprehensive primary and preventive care to uninsured and patients covered by Medicaid, they do not have the expertise or equipment to provide much of the needed diagnostic or specialty care. Obtaining referrals for these off-site services, however, can be difficult, especially for patients who are uninsured or covered by Medicaid.[21] (Figure 6)

Patients covered by private insurance or Medicare were better able to access these services. In contrast, patients that had Medicaid or were uninsured had difficulties obtaining the same types of services. One promising finding, however, was that CHCs affiliated with medical schools or hospitals reported better access for the uninsured and patients covered by Medicaid.

Figure 6: CHC Directors Report Uninsured and Medicaid Patients with "Difficult Access" to Specialty Care*



**"Difficult access" defined as patients that were "never" or "rarely" able to access services

Nonetheless, it is locally acknowledged that many Chicagoans, especially those uninsured, are experiencing difficulty in accessing specialty care. Locally, providers reported that despite new community health center collaboratives and collaborative relationships between some community health centers and hospitals, securing timely subspecialty care for patients remains difficult. Access problems also exist for diagnostic testing, including cardiovascular disease, colonoscopy, and other cancer screening. Even with expansion of the Illinois Breast and Cervical Cancer Program, which has greatly expanded eligibility for state-funded cervical and breast cancer screening and treatment, the community lacks access to mammograms and radiology services.

As would be expected, given the concentration of academic medical centers in Cook County and the typical concentration of specialists in metropolitan areas, Cook County overall is not a shortage area for specialty care. Lack of access is likely an artifact of medical, social, and economic conditions. Large numbers of uninsured Chicagoans; lack of primary care and medical homes even among the insured; the

[21] Nakela L. Cook, LeRoi S. Hicks, A. James O'Malley, Thomas Keegan, Edward Guadagnoli and Bruce E. Landon. "Access To Specialty Care And Medical Services In Community Health Centers." Health Affairs. 26, no. 5 (2007): 1459-1468.

prevalence of chronic diseases and high incidence in minority populations; low Medicaid reimbursement rates; long wait times at County facilities; clustering of specialty care providers in specific practices and institutions; and few collaborative arrangements among institutions all contribute to the difficulty of access to specialty care in the safety net.

While clearly these and many other issues help determine the availability of specialty care services for patients, especially those who are uninsured or are covered by Medicaid, it is useful to look at local access issues in a broader context.

Nationally. The adequacy of the present and future supply of physicians is continually being debated in the literature.

There is a consensus in the literature that the overall physician supply will slowly increase over the next fifteen years. Yet the supply of specialty physicians in clinical care is projected to grow at a slower rate, 10%, than that of primary care physicians, 18%, between 2005 and 2020. The total U. S. population is projected to grow 14% between 2005 and 2020. This is approximately the same anticipated growth rate as that of the combined primary and specialty FTE physician supply resulting in an expected and unvarying physician to patient ratio of 259 nationally.

Physician supply projections (Figure 7) from the Health Resources and Services Administration (HRSA) assume that current patterns of new graduates, specialty choice, and practice behavior continue.[22]

[22] "Physician Supply and Demand: Projections to 2020." October 2006. USDHHS, HRSA, Bureau of Health Professions.

Figure 7: FTE Supply of Physicians in Clinical Practice*: 2000, Projected to 2020

Specialty	Base Year	Projected				Percent Change from 2005- 2020
	2000	2005	2010	2015	2020	
Total	597,430	635,780	669,010	699,450	719,940	13%
Primary Care	214,810	228,660	244,370	259,910	271,440	19%
Gen. & Family Practice	89,710	94,380	99,850	105,460	109,980	17%
General Internal Med.	82,250	88,620	95,410	102,230	106,910	21%
General Pediatrics	42,850	45,670	49,110	52,230	54,560	19%
Other Med. Specialties	84,460	90,130	93,040	96,370	98,540	9%
Allergy	3,320	3,140	2,970	2,860	2,730	-13%
Cardiovascular Disease	18,690	19450	19,940	20,370	20,420	5%
Dermatology	8,630	9,420	9,880	10,310	10,680	13%
Gastroenterology	9,660	10,220	10,430	10,630	10,650	4%
Internal Med Sub Spec	27,450	29,350	30,240	31,620	32,650	11%
Pediatric Cardiology	1,210	1,410	1,530,	1,650	1,750	24%
Pediatrics Sub Spec	8,060	9,360	10,440	11,490	12,390	32%
Pulmonary Diseases	7,460	7,690	7,610	7,450	7,270	-5%
Surgical Specialties	134,470	138,990	141,750	143,140	143,090	3%
General Surg Sub Spec	5,780	6,410	6,900	7,180	7,310	14%
General Surgery	23,610	22,570	21,970	21,510	21,040	-7%
Neurological Surgery	4,220	4,380	4,490	4,520	4,490	3%
Obstetrics & Gynecology	35,990	38,790	41,280	43,240	44,630	15%
Ophthalmology	16.820	17,440	17,560	17,550	17,350	-1%
Orthopedic Surgery	20,170	21,210	21,740	21,870	21,710	2%
Otorhinolaryngology	8,440	8,820	8,980	9,050	9,030	2%
Plastic Surgery	5,760	5,890	5.820	5,690	5,510	-6%
Thoracic Surgery	4,480	4,270	4,070	3,850	3,620	-15%
Urology	9,200	9,200	8,950	8,680	8,400	-9%
Other Specialties	163,690	178,010	189,860	200,020	206,860	16%
Anesthesiology	33,560	37,680	41,080	43,690	45,250	20%
Child Psychiatry	5,550	6.440	7,240	8,070	8,800	37%
Diagnostic Radiology	18,130	20,570	22,100	23,120	23,640	15%
Emergency Medicine	21,890	25,450	28,490	30,770	32,490	28%
Gen. Prevent Medicine	2,160	1,850	1,680	1,620	1,560	-16%
Neurology	10,810	12,040	12,870	13,660	14,160	18%
Nuclear Medicine	1,230	1,280	1,300	1,320	1,330	4%
Occupational Medicine	2,320	2,520	2,690	2,880	3,020	20%
Other Specialties	3,280	3,200	3,290	3,400	3,450	8%
Pathology	14,240	14,730	14,880	14,970	14,940	1%
Physical Med. & Rehab	5,790	6,830	7,770	8,610	9,250	35%
Psychiatry	33,120	33,630	34,410	35,510	36,230	8%
Radiation Oncology	3,560	4,100	4,500	4,810	5,020	23%
Radiology	8,090	7,690	7,560	7,600	7,730	0%

**Includes MD and DO office-based and hospital staff physicians. Excludes residents, and those in non-patient care. Physicians age 75 and older are excluded.*

Note: Totals might not equal sum of subtotals due to rounding.

Estimated need for clinical care specialists nationally in 2000 was 33 for medical specialties, 55 for surgery, and 70 for other specialty care per 100,000. Between 2005 and 2020, the population under 65 is expected to grow by 9%. The population 65 and older is projected to grow by 50%. Although they vary by specialty type, these data reflect the impact of changing demographics on requirements and demonstrate that the aging population will contribute to foster growth for specialty services relative to the demand for primary care. According to HR5A, the projections likely overestimate projected shortages and surpluses in individual specialties because it is easier to adjust nationally to inadequacies in specialties than to inadequacies in overall physician supply. The length of time invested in training, eight to 15 years depending on specialty, guides educational policies that control admissions. At the conclusion of the training period, market forces affect individual choices by newly practicing physicians.

Projections by medical specialty are difficult to predict. While the number of medical school graduates is expected to increase over the next 20 years, while it has been stable over the past two decades, the specialties chosen will reflect the dynamics of market and other forces.

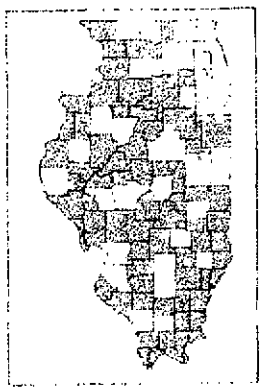
Career and lifestyle issues influence the selection of residency programs by new graduates. Future employment opportunities and reimbursement patterns for specialty care are particularly important. Knowing what specialties or subspecialties are being recruited by physician groups or healthcare providers will significantly influence the choices made by those entering residency programs.

Financial pressures, including the cost of malpractice coverage, rates of reimbursement, and loan repayment options, affect choices. One increasingly important factor is that the number of older Americans will increase dramatically by 2020 as will the need for geriatricians and other specialists that predominantly serve that population.

Locally. There is growing concern at the local level about whether the supply of physicians in Illinois, including specialists, will keep pace with anticipated future need. According to the Governor's Office, the number of potential physicians and other caregivers is projected to decrease 4.2% between 2000 and 2020[23]. At the same time, the number of Illinoisans needing care is projected to increase by 31% during that period.

In 2007, 59% of the 41,826 physicians in Illinois were specialists resulting in a ratio of 50 per 100,000.[24] There is an uneven distribution of specialists throughout the state with all or most of 70 counties designated as federal underserved areas for specialty care (Figure 8).[25]

Figure 8: Specialty Care Physician Scarcity



Shaded areas represent zip codes that have been designated as specialty care physician scarcity areas by the U. S. Department of Health and Human Services Centers for Medicare and Medicaid Services.

[23] Press Release: "Gov. Blagojevich introduces plan to address nursing shortage, ensure adequate level of frontline healthcare providers as baby-boomers age." February 7, 2006. Office of Governor Rod R. Blagojevich.
[24] Kaiser State Health Facts. www.statehealthfacts.org. Retrieved August 25, 2008.
[25] "Specialty Care Shortage Areas in Illinois." Shortage Designations, Illinois Department of Public Health Center for Rural Health. http://icahn.org/scarcityareas/SpecialtyCare/default.asp. Accessed September 11, 2008.

In a dynamic health care environment, market forces that drive individual and institutional choice exacerbate specialty care shortages in the safety net. The Centers for Disease Control and Prevention (CDC) has documented how emergency department diversions reduce patient access to timely care. CDC estimates that the aging population will increase the demand for specialist care in emergency departments.

A recent article, for example, documented the absence of surgical subspecialty emergency care in community hospitals as a growing public health concern in Cook County. Fully 66% of neurosurgical transfers to academic medical facilities originated at hospitals without full-time neurosurgery coverage. The mean transfer time was five hours ten minutes. Delays led to deterioration in patient condition with 29 patients showing a decline in Glasgow Coma Scale score. A shortage of neurosurgical intensive care unit beds occurred on 55% of the days in the study. The authors believe that coordinated efforts among local governments, medical centers, and emergency medical services to efficiently coordinate subspecialty services will be necessary to manage this problem.[26]

Research on the relationship of provider type to health outcomes, measured by traditional population based disease related mortality rates and life expectancy, is beginning to show distinct patterns. States with more primary care physicians per capita have better health outcomes than states with fewer primary care physicians. Among the benefits of primary care medicine for patients is greater likelihood of receiving preventive care, better management of chronic diseases, and higher satisfaction with the care they receive.

Areas with more specialists or higher specialist to population ratios, by contrast, appear to have no advantages in meeting population health needs. A recent article in the New England Journal of Medicine,[27] for example, was critical of the growing emphasis on specialty care. The article asserts that areas with more specialist-oriented patterns are associated with higher spending but are not related to improved access to care, higher quality, better outcomes, or greater patient satisfaction.

Possible Solutions

One possible local solution discussed was a system for specialty referrals similar to the Robert Wood Johnson medical school initiative, which places academic center-based specialists in community hospitals at no expense to the community hospitals.

Hospital provider staff as a resource for community-based specialty care remains an underutilized strategy; training programs should be encouraged to continually move more of their training opportunities into the community.

FQHC-hospital relationships should be fully utilized, as research has shown, in addition to other benefits, that patients of FQHCs with strong hospital affiliations have an easier time accessing specialty care; this finding was borne out anecdotally among meeting participants as well.

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[26] Byrne, Richard W. MD; Bagan, Bradley T. MD; Slavin, Konstantin V. MD; Curry, Daniel, MD; Kostl, Tyler R. MD. "Neurosurgical Emergency Transfers to Academic Centers in Cook County: A Prospective Multicenter Study." Neurosurgery. 62(3):709-716, March 2008.

[27] Iglehart, John K, "Medicare, Graduate Medical Education, and New Policy Directions." New England Journal of Medicine, Volume 359:643-650, August 7, 2008.

Another strategy to be explored is expanding the use of physician assistants (PAs), advance practice nurses, and other mid-level practitioners in specialty care practices. PAs, in particular, have been used to great success in several specialty areas, with the results being high quality and efficient care that permits the physician to see a greater number of patients.

Public policy, rather than market forces, must guide a national solution to specialist shortages. Reform in the current Graduate Medical Education (GME) system, incentives tied to safety net practice, increases in Medicaid reimbursement for specialty care, and other financial inducements require political will and the support of policymakers.

Cook County Health & Hospitals System IRIS Partners

Name of Facility:	Refers for ADULT Specialty:	Refers for PEDS Specialty:
* Access - Auburn Gresham		Yes
* Access - Booker		Yes
* Access - Brandon		Yes
* Access - Grand Blvd.		Yes
* Access - Jackson Park		Yes
* Access - South State		Yes
* Access Illinois Eye Institute		Yes
Access to Care	Yes	
** Aliaga Health Center		Yes
Alivio - 21st Street	Yes	
Alivio - Cicero	Yes	
Alivio - Little Village High School	Yes	Yes
Alivio - Orozco	Yes	
Alivio - Spry Elementary School	Yes	Yes
Alivio - Western	Yes	
American Indian Health Center	Yes	
* Beloved Community Health		Yes
*** Cavero Medical Group		Yes
CDPH Englewood Health Center	Yes	
CDPH Lawndale Mental Health Center	Yes	
CDPH Lower Westside Neighborhood Clinic	Yes	
CDPH Near North Mental Health Center	Yes	
CDPH North West Mental Health Center	Yes	
CDPH Roseland City	Yes	
CDPH South Chicago City	Yes	
CDPH South Lawndale Clinic	Yes	
CDPH Uptown City	Yes	Yes
CDPH West Town Neighborhood Clinic	Yes	
Chicago Family - Roseland	Yes	
* Chicago Family South Chicago		Yes
* Christian Community - Calumet City		Yes
* Christian Community - Halsted		Yes
* Christian Community - South Holland		Yes
Community Health Center	Yes	
*** Dr. Kowalski's Office		Yes
Erie Family Health	Yes	
Erie Family Health Humboldt Park	Yes	
Erie Family Health, West Town	Yes	
Erie Family Health, Westside	Yes	
Erie FHC Erie Teen Health Center	Yes	
Erie Helping Hands Clinic	Yes	
Esperanza Health Center	Yes	Yes
* Friend Family Health - East		Yes
*** Harvey DeBofsky, M.D., Ltd		Yes
Heartland Health Center	Yes	
Infant Welfare Health Center	Yes	Yes
* Komed Near North Health Center		Yes
*** Kunhunni Vellody, M.D.		Yes
La Rabida		Yes
Lawndale Christian Health Center	Yes	
*** MD Pediatric Center - Omar Sawlani, M.D.		Yes
*** Mercy Medical on Pulaski		Yes
* Mile Square - BOTY		Yes
* Mile Square - Main		Yes
Mile Square Better Care for Youth Health	Yes	Yes

Mile Square Center @ Suder Elementary	Yes	Yes
Mile Square Health Center	Yes	
Mile Square Health Center @ James	Yes	
Mile Square Jordan Boys and Girls Club	Yes	
Mile Square Near West Family Center	Yes	
*** Nazin Khatib, M.D.		Yes
* Near North - Komed Health Center	Yes	Yes
Near North HSC: Louise Landau Clinic	Yes	
Near North HSC; Winfield Moody Clinic	Yes	
** PCC Lake Street Family Health (Oak Park)		Yes
** PCC South		Yes
*** Pilsen Community Pediatrics - Cermak		Yes
*** Pilsen Community Pediatrics - Pilsen		Yes
*** Practice Administrative Services		Yes
*** Practice Administrative Services - Berwyn		Yes
*** South Suburban Pediatrics		Yes
St. Anthony Centro Medico @ Cicero	Yes	
*** St. Anthony Health Affiliates Brighton Park		Yes
St. Anthony Hospital	Yes	
St. Anthony Hospital Physicians Center	Yes	
*** St. Jude Medical Practice		Yes
* TCA - Health		Yes
* U of C Emergency		Yes
* U of C Pediatric Outpatient		Yes
*** Vandna A. Shah, M.D., S.C.		Yes
** Young Family Health Associates		Yes
*** UCMC Southside Collaborative Members**		
**** Illinois Health Connect Partners**		
***** Medical Home Network Partners**		

CCHHS Response No. 2

Attachment No. 1

REGIONAL HEALTH CENTER

IMMEDIATE CARE CENTER

SCOPE OF SERVICES

2011

I. SCOPE OF SERVICES

A. Department Structure & Key Functions

The Department of Emergency Services oversees the plan for the Immediate Care Scope of Services based on the community needs and internal capabilities. Incoming patients are examined by a physician and the examination/findings documented. Appropriate referrals for follow-up are documented. Patient/family is educated to referrals, prescribed medications and the presenting medical condition. Specialty consultation is available by transfer to a designated hospital to provide definitive care. If necessary, patients are transferred to other higher level facility.

The Department provides:

- Daily supervision and coordination of department operations
- Personnel functions (job description, recruitment, hiring, orientation and ongoing training of staff, supervision of staff, timekeeping/attendance monitoring, performance evaluations, disciplinary actions, handling of grievances, etc.)
- Coordinate patient care and administrative services with other departments and agencies
- Participation in committees and task forces
- Budget preparation and ongoing departmental financial management
- Collection of data: performance, analysis and preparation of reports

Hours of operation

The Regional Outpatient Center (ROC) is classified as an Immediate Care Center offering selective care from 8 to 15 hours a day 7 days per week with at least one physician and RN available during business hours. The hours of operation may change depending on staffing. No patient is registered after 8 pm unless approved by the physician on duty.

Staff Qualifications

The physician must hold a valid license in the State of Illinois, be Board Certified/eligible in Emergency Medicine, Internal Medicine or Family Practice and ACLS and PALS certified. The Physician Assistant/Nurse Practitioner must hold a valid license in the State of Illinois, be certified and ACLS and PALS certified The registered nurse must be licensed in the State of Illinois, ACLS and PALS certified, and experienced in emergency nursing care.

B. REPORTING RELATIONSHIPS

1. Chairperson, Emergency Department
2. Director, Immediate Care Center
3. Nurse Manager

C. CHARACTERISTICS OF POPULATION BEING SERVED

Patients Served:

All age groups

Scope and Complexity

The ROC Immediate Care Center provides stabilizing emergency care for all patients. On the patient's arrival, triage is completed and ESI category assigned. Patients are stabilized and managed in the immediate care until the transporting team arrives. If the patient is ESI category 1, then 911 (Oak Forest Fire Department) is called to transfer the patient to the nearest ED. For ESI category 2, patients are transferred to another facility using ATI. Lower risk asymptomatic patients are treated in the Immediate Care facility as ESI categories 3, 4 and 5.

If at any time the patient's condition worsens, then appropriate transfer is arranged by the treating physician. It is the treating physician's decision to manage the patient in immediate care or transfer to another facility. Any patient requiring either emergency observation or inpatient admission is transferred to either Stroger hospital or any other accepting facility via EMS. See examples below:

ESI 1	**ESI 2**	**ESI 3**
1. Call 911 (OF Fire Department) **2. Stabilize the patient**	**1. Arrange ATI transfer** **2. Stabilize the patient**	**Treat in Immediate Care**
STEMI	High risk active chest pain	Chest pain asymptomatic
Active labor	Pregnant abdominal; pain/distress	Pregnant abdominal pain, asymptomatic
Acute CVA	Altered mental status, new onset	Hyperglycemia - asymptomatic
Cardio/respiratory arrest	Trouble breathing, moderate to severe	Trouble breathing, mild
Unresponsive	Unstable vital signs	
Airway compromise	Unstable vaginal bleeding	Stable vaginal bleeding
Shock	Moderate to Severe abdominal pain, unstable vitals	Abdominal pain - mild
Severe trauma	Uncontrollable bleeding	Open fracture
	Active GI bleed	
	Severe headache, sudden onset	
	Severe DKA	Stable DKA
	Acute alcohol intoxication	
	Active seizure	Seizure, not active
	Tachyarrhythmia, unstable	Testicular pain
	Hypertensive emergencies Urgencies - distress	Hypertension urgencies, asymptomatic
	Suicidal/homicidal/psychotic	

D. Methods used to assess and meet the needs or services of patients

1. Review of the Immediate Care Center's documentation for timeliness of service, accuracy of documentation, appropriateness of medical evaluation and treatment.
2. Regular Departmental Meeting, discussion of observed problems, solutions and case review.

E. Departmental Performance Improvement Plan

1. Performance Improvement

The purpose of the Department of Emergency Services Quality Improvement Program is to assure the quality and appropriateness of all services rendered to patients and employees.

2. **PERFORMANCE ASSESSMENT**

Substantial compliance is maintained with all applicable Joint Commission and Professional Standards.

3. **APPROPRIATENESS, EFFICACY (CLINICAL NECESSITY), & REQUIRED TIMELINESS OF SERVICES PROVIDED**

The following Center Indicators are continuously monitored:

(a) Time intervals from entry, triage, registration, examination, discharge
(b) Volume based on ESI score
(c) Patient/Family educated about use of medication and discharge instructions.
(d) Pain reassessed

4. **ANNUAL REVIEW**

The Immediate Care Center's Organization Performance Improvement is assessed and measured annually for its effectiveness and consistency within the improving organization performance framework.

5. **PROFESSIONAL GUIDELINES OR PROTOCOLS USED**

Substantial compliance is maintained with all applicable Joint Commission and Professional Standards.

6. **LIST REGULATORY AGENCIES/ASSOCIATIONS/LICENSURES APPLICABLE TO THE EMERGENCY SERVICES DEPARTMENT**

- Joint Commission Standards
- ACEP/ACOEP Professional Standards
- ENA Professional Standards

Approvals:

A. Hussain, DO, FAAEM
Director
Emergency Department

Pierre Wakim, DO, FACEP
Chairman
Emergency Department

Review/Revisions: 6/3/03
3/8/04
4/26/04
10/04
8/3/05
8/10/06
1/18/2011

MONTHLY ROC PROJECTED SESSIONS/VISITS
SPECIALTY AND PRIMARY CARE

SPECIALTY	# OF SESSIONS	# OF VISITS	PROJECTED # SESSIONS	PROJECTED # VISITS	
Cardiology	8	80	48	420	EKG; ECHO readings
Endocrinology	1	29	16	140	
Gastroenterology	8	77	12	105	Endoscopy Procedures
General Surgey	12	55	16	140	Some minor procedures
Nephrology	8	47	8	70	
Neurology	8	47	24	210	EEG readings
Oncology			8	70	
Opthalmology	24	222	24	210	Some minor procedures
Optometry	34	231	36	315	
Orthopedics	3	56	16	140	
Podiatry	51	604	60	525	Some minor procedures
Psychiatry	18	118	36	190	
Pulmonary	4	35	4	35	
Rehab Medicine	7	22	24	210	
Sleep Clinic	5	58	5	58	
Anticoagulation	11	104	12	105	
Infectious Disease*	0	0	8	70	
Pain Management*	0	0	8	35	Some minor procedures
Urology*	0	0	8	70	
TOTAL	202	1785	373	3118	

* New Service

PRIMARY CARE				
4 Providers	105	794		
7 Providers			210	2205

Exhibit G