

Abstract

The applicant community for the *HealthLink* Miami Valley project is Montgomery County, Ohio, in Southwestern Ohio with a population of 580,000. Dayton is the urban center of the County, the fourth largest city in the state, and home to 184,000 County residents. Twenty-one percent of Dayton households have an annual income of less than \$20,000 while 15% of County households fall into this income category. Similarly, over ten percent of eligible workers in Dayton are unemployed in contrast to less than five percent of eligible workers in the county. Recent census data demonstrate the continuing loss of residents from the urban core. In the city 40% of residents are African American and 60% are Caucasians of Appalachian heritage. At the County level, the racial breakdown is 80/20 white to black. About half of County residents are aged 18-44, and approximately 25% are 17 years of age and under.

This project targets the 84,000 Montgomery County residents who do not have access to commercial health care insurance. These people represent 15% of the population, an increase from 11% in 1996. Of those residents who are uninsured by commercial carriers, close to 50,000 are enrolled in Medicaid. We estimate an additional 15,000 residents are eligible for Medicaid but not enrolled, and the remainder, uninsured and not qualified for Medicaid, fall into the category of working poor.

Public health services are available through a patchwork of services. There are seven hospitals, five of which support clinics that provide primary care and some specialty, dental, mental health, and social services for the uninsured. There are also five urgent care facilities, available to Medicaid patients and several free clinics. Five pediatric/youth clinics are provided through the Combined Health District, Montgomery County, and in partnership with local hospitals, four neighborhood health centers are supported providing over 36,000 patient visits annually. Two of these facilities offer dental services and mental health and social services are available at seven of the facilities. Montgomery County has an established Medicaid HMO which enrolls approximately 12,000 community residents, or 38% of those receiving Healthy Start/Healthy Family Medicaid services in the County. An additional 21,000 residents access Medicaid on a fee-for-service basis directly through providers. Close to 15,000 residents access Medicaid through the Aged, Blind and Disabled program. There is an active Health Ministries Association as well as many faith-based initiatives that offer health education services. The Dayton Public Schools provides over 87,000 clinic visits to children through school-based and mobile units.

Services for mental health and substance abuse are coordinated through the Alcohol Drug Addiction and Mental Health Services (ADAMHS) Board for Montgomery County, which supports over 30 provider agencies, including: three community mental health centers; mental health services at health and human services sites; substance abuse treatment centers, and drop-in centers and in-patient psychiatric and drug treatment services. The ADAMHS Board also operates CrisisCare, a central intake and referral process available 24 hours a day, 365 days a year, and serves over 15,000 community residents each year.

There are multiple resources available for health care services in Dayton, even for the economically disadvantaged. However many people remain without care. Although Montgomery County has developed several community wide programs these have not strongly challenged the traditional “silo” mentality of multiple strong but relatively independent institutions. *HealthLink* will do so through a highly integrated system of care. The overall goal of the *HealthLink* initiative is to strengthen our community-wide safety net by developing an integrated system of care. This will be accomplished by enhancing electronic management information systems and a coordinated system of person-to-person outreach services. GDAHIN and AgencyLink are electronic patient data management systems. GDAHIN tracks information through hospitals and primary care providers and AgencyLink tracks information through human services providers. By integrating these systems we can provide a County-wide patient registry system with which we will coordinate outreach services to insure that all residents have health care.

During the planning grant year, we will; 1) put into place protocols and procedures to integrate the two databases systems, expand health and human services provider participation in the integrated system, and pilot the integrated system with respect to routine report generation and ongoing maintenance; 2) develop protocols and procedures to provide outreach services to each of the three groups of residents described above, and pilot the program; and 3) complete an implementation plan for the continued integration of health care services for all County residents. Solid foundations much of this work are already in place in Montgomery County.

The project will be managed through the *HealthLink* Network with representatives from the Miami Valley Health Improvement Council, the Combined Health District Montgomery County, the Montgomery County Department of Job and Family Services, the Greater Dayton Area Hospital Association, the Dayton Public Schools, CareSource (a Medicaid managed care organization), the Dayton Area Chamber of Commerce, the Gem City Medical, Dental and Pharmaceutical Association, the Health Ministries Association, the Alcohol, Drug Addiction and Mental Health Services Board, the Dayton Foundation, Sinclair Community College and Wright State University.

We anticipate with these additional tools in place, we will facilitate better use of existing resources, assisting those without health insurance to find care, and increasing use of services for those who have access to care. Additionally, we will have better capacity to respond to gaps in services and plan for future needs to insure zero disparities and one hundred per cent access for all community residents.

Narrative

Section 1: Community Needs Assessment

Description of current delivery system

The service area of the project is Montgomery County, Ohio. Geographically located in Southwestern Ohio the County covers approximately 462 square miles, with a population of 580,000. Dayton is the urban center of the County, the fourth largest city in the state, and home to 184,000 County residents. As is often true of mid-sized mid-western cities, urban residents on average tend to be less economically advantaged than their suburban or rural counterparts. Twenty-one percent of Dayton households have an annual income of less than \$20,000 while 15% of County households fall into this income category. Similarly, over ten percent of eligible workers in Dayton are unemployed in contrast to less than five percent of eligible workers in the county. Recent census data demonstrate the continuing loss of residents from the urban core. In the city 40% of residents are African American and 60% are Caucasians of Appalachian heritage. At the County level, the racial breakdown is 80/20 white to black. About half of County residents are aged 18-44, and approximately 25% are 17 years of age and under.

A regional Community Health Survey based on the Behavioral Risk Factor Surveillance System indicates that 85% of County residents report having a usual source of health care, and close to 87% rated their health as good or very good. Cardiovascular illnesses are significant health problems for the community; 21% of County residents report high blood pressure, 17% report high cholesterol and 60% report a sedentary lifestyle. When compared to comparable counties, Montgomery has higher incidences of breast, colon and lung cancer. Only 55% of women report ever having had a mammogram. Most County residents get health insurance through their employers, and there is an extensive safety net of medical and social services for the uninsured.

Commercial health care services are provided through three main and several secondary managed care organizations available to County residents primarily through employers. There are seven community hospitals including Children's Medical Center and Miami Valley Hospital which houses the region's only level one trauma center and Careflight, a helicopter emergency transportation service. With a regional capacity of 3,106 beds, 91,581 in-patient hospitalizations were provided in 1999 with an average length of stay of 4.9 days. The area also supports a Veteran's Administration Hospital and a hospital at Wright Patterson Air Force Base.

Public health services are available through a patchwork of services provided by federal, state, county, and hospital organizations. Free clinics are coordinated through hospital facilities. Five pediatric/youth clinics are provided through the Combined Health District, Montgomery County. In partnership with local hospitals, the Combined Health District supports four neighborhood health centers. Two of these facilities offer dental services and mental health and social services are available at seven of the facilities. Each year over 36,000 patient visits are provided through these facilities. Funding for Combined Health District services is provided from the following sources: 19% federal,

17% state, 18% fees and 45% local human services levy (see Chart #1 below, Montgomery County Human Services Programs Overview). Five hospital-based clinics provide public health services. Primary care and some specialty, dental, mental health, and social services are available through these facilities. There are also ten urgent care facilities, five of which are available to Medicaid patients.

Close to 50,000 Montgomery County residents receive health care through Medicaid. Montgomery County has an established Medicaid HMO which enrolls approximately 12,000 community residents, or 38% of those receiving Healthy Start/Healthy Family Medicaid services in the County. An additional 21,000 residents access Medicaid on a fee-for-service basis directly through providers. Close to 15,000 residents access Medicaid through the Aged, Blind and Disabled program. There is an active Health Ministries Association as well as many faith-based initiatives that offer health education services. The Dayton Public School system provides a wide array of primary care services to children in the community through school-based and mobile units. Such clinic visits total over 87,000 annually.

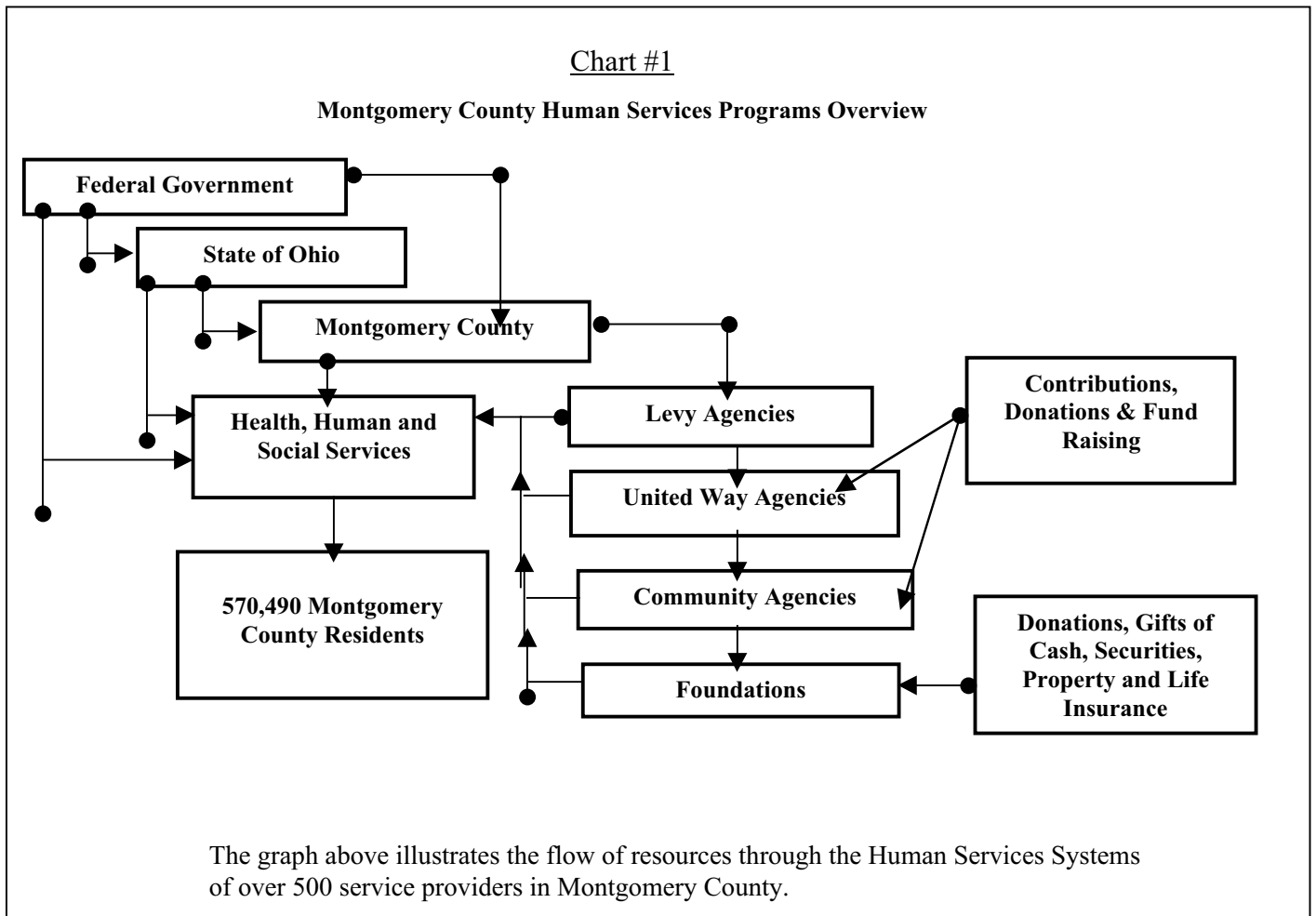


Chart 1 Continued

Over **90** revenue sources fund human services, including:

- funding from federal departments including Medicaid and Medicare;
- funding from state agencies, some of which are matched with federal funds, e.g. Children's Trust Fund;
- funding from local levies (real estate taxes) are allocated to the major levy funded agencies (The Alcohol Drug Abuse and Mental Health Services (ADAMHS) Board, Combined Health District, Mentally Retarded/Developmentally Disabled (MR/DD) and Montgomery County Children Services (MCCS); other levy programs include: Indigent Ill Hospital Programs; the Juvenile Court; City of Oakwood; Children with Medical Handicaps; and the Stillwater Center. Also, from the Levy Supported Services Fund, the Contingency Fund, and the Agency and Community Projects (ACP) Fund;
- funding from local revenue sources include: Regional Transit Authority (RTA) fares, sales taxes, city income taxes;
- funding from other major revenue sources include: contributions and/or donations by citizens and businesses to the United Way of Dayton and to the Dayton Foundation; and,
- funding for other Montgomery County health, human and social service agencies include: matching federal and state funds; fees for services, insurance, private for profit organizations, donations, and fundraising activities, e.g. Montgomery County Community Action Agency (MCCAA).

Services for mental health and substance abuse are coordinated through the Alcohol Drug Addiction and Mental Health Services (ADAMHS) Board for Montgomery County. The ADAMHS Board supports over 30 provider agencies, including: three community mental health centers; mental health services at health and human services sites; substance abuse treatment centers, and drop-in centers. The ADAMHS Board also operates CrisisCare, a central intake and referral process available 24 hours a day, 365 days a year, and provides in-patient psychiatric services through local hospitals which support over 200 in-patient psychiatric beds and 150 alcohol and other drug residential treatment beds in the area. The ADAMHS Board, provides services to over 15,000 community residents each year with funds totaling over 40 million dollars from the following sources: 30% federal, 32% state and 37% local human services levy campaign.

Target population

This project targets the 84,000 Montgomery County residents who do not have access to commercial health care insurance. These people represent 15% of the population, an increase from 11% in 1996. Of those residents who are uninsured by commercial carriers, close to 50,000 are enrolled in Medicaid. Twenty percent of this number are African American, 78% are Caucasians of Appalachian heritage, and the rest are Asian, Hispanic or from the Middle-East. We estimate an additional 15,000 residents are eligible for Medicaid but not enrolled, and the remainder, uninsured and not qualified for Medicaid, fall into the category of working poor. A recent study conducted locally by Wright State University reported that working poor were 27% less likely to qualify for health insurance than were non-working poor.

Community needs assessments and focus groups rated “health care for all” as the number one priority for the community, and identified the top two barriers to self-sufficiency and sustainable employment as mental health and substance abuse problems. Focus groups and needs assessments with county residents have identified barriers to accessing health care services. These include: lack of knowledge of services; lack of trust in institutions providing services; fear of stigma attached with accessing services; lack of money; lack of transportation; lack of child care. Many community residents still confuse Medicaid and Temporary Aid to Needy Families (TANF), and choose not to enroll in Medicaid because they are fearful of exhausting their cap on TANF. Community residents access health care only when in need of help for acute care problems, and need to be educated about the importance of preventive and chronic care. Finally, many community residents who may be enrolled in Medicaid have never been to see a provider for reasons ranging from not being able to take off work to the lack of knowledge about or trust in health care providers. The Community Health Survey of residents in Montgomery County found that 13% of all respondents reported that their health status was poor.

Projection of potential changes in insurance coverage

In July 2000, the eligibility requirement for Medicaid increased to 200% of the federal poverty level for children under the age of 19 and to 150% above poverty for adults. *HealthLink* Miami Valley will begin by insuring that all people eligible for Medicaid are enrolled in care, and work to find health care for the working poor. This will affect approximately thirty thousand people, 15,000 who are eligible for Medicaid and not enrolled and another 15,000 who are not in the system at all. The *HealthLink* Miami Valley project has the long term goal of providing health care services to all Montgomery County residents

Assessment of most urgent needs

Multiple needs assessments conducted through consumer focus groups, community meetings, health status analysis, state and federal assessments and provider surveys indicate two ways to identify most urgent needs: first by population group, and second by disease state. Although across the state Ohio was successful in enrolling children in CHIP, in the urban areas we still lag far behind our goals. Close to 40% of the children in the city of Dayton live below poverty. One of our first priorities is children, and insuring that all children in the County have health care. Additionally, Dayton has a large elderly population with multiple health concerns, and often no primary care provider. A second top priority for our community is the elderly. In terms of disease conditions, cardiovascular disease and cancer remain our top two concerns.

Information provided in the above section can be verified through the following sources:

- *A Report on Community Focus Groups*, Montgomery County Department of Community and Economic Development, October, 1999
- *A Report of the Montgomery County Community Meeting*, Supporting Council of Preventive Effort, October, 1999
- *CitiPlan Dayton: the 2020 Vision*, City of Dayton Department of Planning, December, 1996

- *Community Health Status Report: Data Sources, Definitions and Notes*, Montgomery County, Health Resources and Services Administration, July, 2000
- *Community Regional Health Assessment*, Greater Dayton Area Hospital Association, 1996
- *Dayton's Neighborhood Profiles*, City of Dayton Department of Planning, 1999
- *Healthy People, 2004*, Combined Health Department Montgomery County, April, 1999
- *Playbook to the Future: Community Based Health Resources Plan, 1996-2000*, Miami Valley Health Improvement Council, 1996
- *Report to the Community on Outcomes and Indicators*, Montgomery County Family and Children First Council, 2000
- *The Health of Montgomery County 1985-1997*, Combined Health District Montgomery County, 1998.
- *The Montgomery County Plan*, Montgomery County Board of Commissioners, 1999
- *The Poor of Montgomery County: An Assessment of Work Status, Health Insurance and Health Care Barriers*, Center for Urban and Public Affairs and Reach Out Montgomery County, 1996

Section 2: Evidence of Progress Towards Developing Integrated System of Care

History and progress of collaboration

There is a long history of City and County initiatives working toward integrated systems in the Dayton community. A former Model Cities Community, Dayton city government is organized by Priority Board districts and supported by neighborhood associations and block groups. These citizen-led groups regularly coordinate community health assessments, determine use of funds for services, and identify unmet needs for services and resources. The County administrative office of the human services levy, Family and Children First Council, further focused coordination efforts through the Community Outcomes and Indicators Initiative. This community-wide strategic planning effort focused on establishing standards for integrated services in six general areas: healthy people, young people succeeding, stable families, positive living for special populations, safe and supportive neighborhoods and economic self-sufficiency. Two years ago baseline data were identified in all areas and the community began measuring outcomes. For example, in the healthy people arena, the focus is on low birth weight, air quality and years of potential life lost. Funding resources are tied to the development of integrated services and success in meeting goals for improvement on these measures.

The Miami Valley Health Improvement Council, Inc., which serves Ohio Health Service Area II, developed the Community Based Health Resources Plan 1996-2000. The plan was developed to support efforts to:

- promote a healthful environment;
- review proposed changes to the area's health care system;
- promote and maximize unnecessary duplication of services and technology;
- promote a reduction in deficiencies and inefficiencies within the health system; and
- promote identified areas of improvement in cost, accessibility, and quality of health care services.

Building on this plan the Combined Health District, Montgomery County established Healthy People 2004, a community-wide program that focuses on health promotion, health protection, and preventive services. Healthy People 2004 in Montgomery County identifies forty-seven objectives in seven health priority areas: healthy behaviors, violence prevention, environmental health, maternal and infant health, chronic disease, sexually transmitted diseases and immunizations. These local objectives were based on the national Healthy People 2000 and 2010 standards. Health services were then coordinated for each priority area through a number of specific initiatives including the Immunization Coalition, the Violence Prevention Partnership, the AIDS/HIV Education Collaborative, the Cardiovascular Risk Reduction Program and the Child Death Registry. The Department of Job and Family Services coordinated a parallel and highly integrated effort at the County level. Three years ago, a one-stop multi-service facility, the Job Center, opened in Montgomery County to provide support to county residents in the areas of job training and employment opportunities, health and human services, and utilities and housing services. The Job Center also houses and coordinates the Combined Health District, Office of Medicaid Services, ADAMHS Board services, and numerous health and human services programs. The Job Center is part of a larger economic development initiative dedicated to reforming the welfare system, de-fragmenting the community's major employment and training resources and improving the coordination of the existing social services system. AgencyLink, an electronic management information system that connects client records across numerous health and human services agencies is being piloted with services housed at the Job Center.

Formal arrangements established in the community

Three years ago when the Robert Wood Johnson Foundation launched the Communities in Charge initiative, members of the *HealthLink* Miami Valley Network (*HealthLink*) first came together to plan an integrated system of health care services for Montgomery County residents. Since beginning this work, the team has encountered a number of significant impediments to achieving this goal. These have included the closing of a major hospital, the loss of several Medicaid HMOs and the effects of the Balanced Budget Act of 1997 on local in-patient and community-based services. However, even in the face of these formidable problems, *HealthLink* has been meeting on a monthly basis for the past fourteen months and has accomplished a number of important tasks that move us closer to achieving an integrated system of care. The tasks accomplished have included: (1) identifying and involving appropriate organizations for inclusion; (2) laying the foundation for the integration of two electronic management information systems; and (3) conceptualizing strategies to reach all uninsured members of the community.

HealthLink represents all major hospitals, commercial and public health insurers, county and city government, health and human services organizations, faith based communities, the business sector, the philanthropic community, the public schools, higher education institutions, and physician professional associations in the community. Member organizations and their *HealthLink* Miami Valley participating member are as follows.:

- Rudy Arnold, MD is the Executive Director of the Miami Valley Health Improvement Council. The Miami Valley Health Improvement Council has been

serving the Dayton community since 1964 to plan for meeting the current and future health care needs of the residents of Ohio Health Service Area II, to identify resources essential to meet defined needs and to promote appropriate use of resources.

- Bill Bines, Health Commissioner, Combined Health District Montgomery County. Governed through the Board of Health, the Combined Health District provides services to community residents through its Divisions of Community Health, Environmental Health, Personal Health and Special Services. Additionally, the Combined Health District tracks disease trends and maintains vital statistics for the city-county combined region.
- Danna Graves, Executive Director of the Montgomery County Department of Job and Family Services. The mission of the Montgomery County Department of Job and Family Services is to provide county residents with financial, medical, and other supportive needs while providing opportunities to reduce dependency and strengthen the quality of life, and enable participants in public assistance programs to attain and sustain economic independence.
- Joe Krella, President and CEO of the Greater Dayton Area Hospital Association. The Greater Dayton Area Hospital Association is a service organization representing 17 hospitals and health systems in the greater Dayton area working with its members to improve the delivery of health care services in this region.
- Kathryn McCombs is the Director of the Office of Health Services for the Dayton Public Schools. The Dayton Public Schools serves over 30,000 children, and through the Office of Health Services, manages a mobile health unit, twenty school based clinics, preventive, screening, and primary care services for students and employees.
- Pam Morris, President and CEO of CareSource. CareSource was established in 1989, and is now the largest Medicaid HMO in Ohio exclusively serving low income, high-risk and medically underserved populations.
- Phil Parker is the President and CEO of the Dayton Area Chamber of Commerce. The Dayton Area Chamber of Commerce represents over 3600 businesses in the Dayton community.
- Alonzo Patterson, MD, is the President of the Gem City Medical, Dental and Pharmaceutical Association. The Gem City Medical, Dental and Pharmaceutical Association has been serving the community for over fifty years to address the professional and sociopolitical needs of minority providers and the populations they serve.
- Diane Pettis represents the Health Ministries Association of Southwest Ohio. The Health Ministries Association is a support network for people of faith who promote whole person health through places of worship and in the communities they serve.
- Sinclair Community College
Kate Cauley, PHD, Director of the Center for Healthy Communities, represents Sinclair Community College Division of Allied Health Technologies. Sinclair Community College, recognized as a Vanguard Institution by the National Association of Community Colleges has been serving the Dayton community for over 100 years. The Division of Allied Health Technologies supports fourteen allied health degree programs and the Division of Community Health Advocacy of the Center for Healthy Communities.

- Joe Szoke, is the Executive Director, and Bob Mullins, the Director of Public Affairs of the Alcohol Drug Addiction and Mental Health Services Board. The Alcohol Drug Addiction and Mental Health Services Board is the primary mental health and substance abuse services provider for the region, operating a single point of entry referral service and multiple in-patient and out-patient programs for Montgomery County residents.
- Judy Thompson is the Executive Vice President of the Dayton Foundation. The Dayton Foundation, a \$250 million dollar community foundation, operates under the mission: To promote and help facilitate the development of community philanthropy and to provide leadership in helping to meet changing needs in Dayton, Montgomery County and the Greater Miami Valley.
- Wright State University, School of Medicine is a community-based medical school with an emphasis on primary care. Each year over 60% of graduates pursue further training in family, internal and pediatric medicine. Wright State University School of Medicine was the 1997 recipient of the American Association of Medical Colleges Community Service Award. Wright State University is represented as follows:
 - Syed Ahmed, MD, MPH, is Associate Professor in the Department of Family Medicine, and the Director of Reach Out Montgomery County, and the Alliance for Research in Community Health. Reach Out Montgomery County operates free clinics in the evenings at community health centers providing primary health care to the uninsured in the community using volunteer providers. The Alliance for Research in Community Health develops community responsive health services research to improve health care services for the underserved in the community;
 - Kate Cauley, PHD, is Associate Professor in the Department of Community Health and the School of Professional Psychology, and the Director of the Center for Healthy Communities, a community-academic partnership dedicated to improving the health of the community and health professions education programs;
 - Don Jentleson, PHD, is an Associate Professor in the Department of Community Health;
 - Richard Schuster, MD, is an Associate Professor in the Departments of Community Health and Internal Medicine and the Director of the Division of Health Systems Management in the Department of Community Health. The Division of Health Systems Management operates under the mission: To promote the development of management, health economics, leadership, and population based skills for physicians, hospitals, health systems and other health care providers to facilitate dialogue in health care public policy;
 - Arthur Pickoff, MD, is Professor and Chair of the Department of Pediatric Medicine, Jack Pascoe, MD, is a Professor with the Department of Pediatric Medicine, and Alonzo Patterson, MD, is an Assistant Professor with the Department of Pediatric Medicine and Assistant Dean of Student Affairs for the School of Medicine.

(Please see Appendix 2 for a full listing of the current *HealthLink* Network and memoranda of agreement).

Over the past fourteen months each *HealthLink* participant has contributed, on average, a half day a week to plan integrated services, solidify the work to date, and prepare this proposal to support the further development and actualization of integrated services for our community.

A major accomplishment has been laying the foundation to integrate two critical electronic management information systems, the Greater Dayton Area Health Information Network (GDAHIN), and AgencyLink. *HealthLink* has also been in extensive dialogue with Dayton residents. Presentations about *HealthLink* have been made at multiple community meetings, and articles about the initiative have been disseminated through health and human services organization newsletters. A number of educational materials have been developed and several community-wide coordinating efforts in specific areas of health care such as Medicaid Enrollment, Kinship Care Services, and Lead Hazard Reduction have begun.

HealthLink members represent additional collaborative efforts which have been underway for many years. Examples include: the Center for Healthy Communities, Reach Out Montgomery County, and the Dayton Area Graduate Medical Education Consortium. For ten years the Center for Healthy Communities (Center) has been working to improve health care services for the underserved of the Dayton community and to improve health professions education. The Center is a community-academic partnership that brings together residents of Dayton, health and human services providers and health professions programs at Wright State University and Sinclair Community College. The Center has facilitated coordination of several community-wide efforts to integrate services, including the Montgomery County Medicaid Outreach Consortium, the Kinship Care Services Network, and the Lead Hazard Reduction Task Force.

Reach Out Montgomery County was established through Robert Wood Johnson funding five years ago to coordinate volunteer providers and students in the health professions to provide free health care clinics to the uninsured population. Reach Out is a partnership that brings together local hospitals, the Montgomery County Medical Association, and Wright State University School of Medicine in order to supplement existing community resources for the working poor.

Other existing resources relevant to our initiative include programs through the Miami Valley Health Improvement Council and the Greater Dayton Area Hospital Association. Through the Miami Valley Health Improvement Council there are community wide tobacco and diabetes prevention education programs supported with tobacco settlement money. A regional teen tobacco survey was administered and, based on the results, educational programs have been developed for area youth. All regional hospitals support the Greater Dayton Area Health Information Network which links patient records across institutions.

Capacity to assume grant

The applicant for this proposal is the Center for Healthy Communities, (Center), established in 1991 and jointly supported by Wright State University and Sinclair

Community College. The Center is a community-academic partnership dedicated to enhancing the delivery of health care services and to improving the education of health professionals. The Center provides health and health education services to over 30,000 community members each year and works closely with public education, health, and housing organizations, city, county and state government, local hospitals, churches, businesses, Medicaid and commercial insurance companies, and health and human service organizations.

The Center is fiscally managed in the School of Medicine at Wright State University and has administrative offices at a Wright State building in downtown Dayton, at Sinclair Community College, and at two community health centers. The Center manages one million dollars in federal, state and local grants and contracts annually, convenes coalitions, provides health education and health care services, conducts state-wide program evaluations, and regional faculty training and development programs. Some examples of current programs include: 1) the Center administers a regional consortium which involves sixteen additional institutions and provides faculty training, community based clinical training for students and makes small grants available to institutions in six states; 2) the Center also administers a statewide program to improve access to health care, housing and education through public policy and outreach worker intervention for grandparents who have responsibility for raising their grandchildren; 3) the Center designed and administered a statewide survey of behavioral health organizations assessing core competencies and developing a curriculum for the workforce; and 4) the Center administers the Montgomery County Medicaid Outreach program increasing the number of CHIP enrollees in the community.

The Center is supported by the Office of Research and Sponsored Projects of Wright State University, and is governed through a Community Advisory Board with representatives from both community and academic constituencies. The Center has received national recognition as a model program by the Health Resources Services Administration, and was instrumental in securing the Association of American Medical Colleges Community Service Award for Wright State University School of Medicine. Additionally, the Center's Division of Community Health Advocacy was recognized by Seedco as one of fifteen model programs nationally in the area of community health workers.

Section 3: Statement of Project and Budget

Statement of project

As has been described, there are multiple resources available for health care services in Dayton, even for the economically disadvantaged. There are seven community hospitals, each with outpatient clinics and/or community health centers that collectively support over 450 medical residency positions. The combined city/county public health department operates nine community health centers and there are free clinics for homeless, working poor and migrant workers. The Alcohol Drug Abuse and Mental Health Board supports services through thirty different provider organizations. Never-

the-less, even with these resources there are many people who never visit a primary care provider, and many people who continue to rely on hospital emergency rooms for primary health care, often in conjunction with crisis care for acute illness or injury. And, there is a growing number of working poor in the Dayton community for whom access to health care is fleeting and sporadic.

For most of these people, the problem is not lack of services for health care. Rather, problems are under-utilization and inappropriate utilization of existing resources and systemic disincentives to make significant changes in the status quo. Although Montgomery County has developed several community wide programs to address specific health care concerns, these have not strongly challenged the traditional “silo” mentality of multiple strong but relatively independent institutions. *HealthLink* will do so through a highly integrated system of care, recognizing that the uninsured person in the emergency room today is tomorrow’s managed care patient. Following the success of several community wide assessments and cross services initiatives for welfare reform and social services administration, a focus on integrating health care is the next logical step for the region.

Montgomery County is rich with community resources to *potentially* deliver health care to the uninsured population. However, these resources are not now centralized, coordinated or supported by an integrated, structured, community-supported process for delivering health care to the targeted population. The overall goal of the *HealthLink* Miami Valley initiative is to strengthen our community-wide safety net by developing an integrated system of care. This will be accomplished by enhancing electronic management information systems and person-to-person outreach services.

We conceptualize the work in terms of assisting three different groups of community residents within our target population. First there are people who have accessed health and/or human services but do not have a regular primary care provider. These are people who may have been to a hospital emergency room or who may have received assistance from a human services organization, and whose names would appear in the client records of either the GDAHIN or AgencyLink data bases, but are not enrolled in any basic health care services. Second, there are people who have accessed health and human services organizations who would not appear in the GDAHIN or AgencyLink databases because the organization they accessed is not currently registered with either database. The third group of County residents are people who have not accessed health and human services for several years, people who stay out of the “system” until they require external intervention. They are not be in either of the databases because the last time they accessed the system was before the databases were established.

Our goal over time would be to reduce membership in each of these groups. During the planning grant year, we will; 1) put into place protocols and procedures to integrate the two databases systems, expand health and human services provider participation in the integrated system, and pilot the integrated system with respect to routine report generation and ongoing maintenance; 2) develop protocols and procedures to provide outreach services to each of the three groups of residents described above, and pilot the

program; and 3) complete an implementation plan for the continued integration of health care services for all County residents. Solid foundations much of this work are already in place as is demonstrated below.

Objectives and Activities

HealthLink Miami Valley has adopted the following mission statement:

HealthLink Miami Valley will promote universal access and care coordination to the uninsured population of the Dayton Metropolitan Area. It will do so through value driven health care services, an enhancement of a community-wide electronic management information system, and expanded education and outreach. Universal access will be accomplished as a self-sustaining process through local collaborations.

Objective #1: Develop an integrated electronic management information system with the capacity to identify community members without appropriate health care, monitor and analyze use of health care services among the targeted population

Progress to Date:

The Greater Dayton Area Hospital Association has developed the Greater Dayton Area Health Information Network (GDAHIN), to facilitate the sharing of clinical, financial and demographic information about patients in order to improve quality of care and reduce health care costs. GDAHIN provides an intranet application available to the seven hospitals in the area, commercial insurers, Medicaid and managed care companies, and 1000 local physicians in over 250 practices. Over the past five years, 15 million dollars have been invested to provide the region with this resource.

Montgomery County Job and Family Services, in partnership with twenty-five health and human services agencies has developed the AgencyLink Network, a metropolitan area network that connects social services, law enforcement, and the courts in order to facilitate communication, collaboration and data collection among agencies. Over two million dollars have been invested to establish the infrastructure and pilot test this network

Both GDAHIN and AgencyLink use a web based application. This means that any provider organization that is registered with either GDAHIN or AgencyLink maintains its own client/patient database as usual, and when a request for information is made by a registered user about a particular person, the GDAHIN or AgencyLink system searches through all registered organization databases to gather basic demographic information and all contacts with previous providers. Both systems use Nokia IP650 firewalls and VPN concentrators to ensure necessary confidentiality and HIPPA compliance, and both use a system for creating programming language, XML, which provides the capacity for expansivity as the systems are integrated.

Proposed Next Steps:

1a. Integrate and expand the GDAHIN and AgencyLink Networks and develop protocols for classification and analysis of data obtained

- Identify community members without health care and
- Categorize those without health care into priority groups beginning with children and pregnant women, followed by the elderly followed by other adults, in order to
- Produce reports from which outreach efforts can be coordinated.
- 1b. Monitor health care services use in the targeted population
 - Determine when inappropriate use is occurring, i.e., a person eligible for public health insurance is not enrolled, and/or a person with health care insurance is using a hospital emergency department or a free clinic for primary care, and
 - Produce reports from which to coordinate outreach efforts for more treatment and cost effective utilization.
- 1c. Analyze health care system use in the targeted population to determine underused services and actual gaps in service availability.

Objective #2: Develop the infrastructure for and pilot a coordinated outreach and follow-up system to be used in concert with the integrated electronic management information system.

Progress to Date:

With support from the Ohio and Montgomery County Departments of Job and Family Services the Montgomery County Medicaid Outreach Consortium has been meeting monthly for the past three years. Administered through the Center for Healthy Communities, this Consortium includes over forty health and human services organizations. It provides a centralized clearinghouse for people who are potentially eligible for Medicaid and who are identified through the county hotline, at point-of-service sites such as hospitals and community health clinics, through direct referrals from health and human services organizations, or through outreach efforts in schools and neighborhoods. It takes an average of four contacts by an outreach worker to complete an application for the Children’s Health Insurance Program. About 55 percent of completed applications result in enrollment. The Center for Healthy Communities maintains a client database of all residents potentially eligible for Medicaid and follows up with denied CHIP applications to determine reasons for denial and explore other potential sources of care.

Through the Center for Healthy Communities, the Outreach Workers Consortium has provided continuing education services to outreach workers in Montgomery County for the past five years. Consortium meetings are scheduled quarterly and provide outreach workers with an opportunity to network and receive up-to-date information on changes in Medicaid eligibility, managed care plans and community resources.

Proposed Next Steps:

- 2a. Develop protocols for routine outreach worker follow-up with all community residents who are entered into GDAHIN/AgencyLink system and who are identified as not having health care
 - Review current intake questions for participating organizations and revise as needed to respond to expanded use of integrated electronic management information system

- Develop a system for appropriate referrals to outreach workers determining if community member already has a case manager/outreach worker, or if a *HealthLink* outreach worker is needed to secure regular health care
- Pilot outreach efforts and monitor success
- 2b. Develop protocols for routine outreach worker follow-up with all community residents who are not entered into the GDAHIN/AgencyLink, i.e., clients of as yet non-participating organizations
 - Pilot outreach efforts and monitor success
- 2c. Develop protocols for rotating responsibilities of health and human services organizations with outreach workers to canvas neighborhoods in order to identify community members not identified through the safety net who may not have health care.
 - Pilot outreach efforts and monitor success

Objective #3: Develop a detailed plan for further community-wide integration of health care services which uses, expands and maintains the integrated electronic management information system and the coordinated outreach and follow-up system, and begins to address community-wide disease management/clinical practice indicators, the potential for re-allocation of resources, and the potential need for additional services to insure ongoing access to health care for all Montgomery County residents.

Progress to Date:

Multiple consortia, collaborations, and associations of organizations through which providers and health and human services agencies serve community residents exist in the Dayton area, many of whom are already participants in the *HealthLink* Miami Valley Network, which was originally convened in 1998 and has been meeting regularly for the past fourteen months. The *HealthLink* Network serves as a meeting ground for providers, improving communication between services, and facilitating better collaboration and referral across services.

The Ohio Department of Job and Family Services maintains a database of Medicaid eligibles in Montgomery County which can serve as both the baseline and monitoring source for determining underutilization of existing services and needs for additional services.

The Montgomery County Family and Children First Council (FCFC) developed a community-wide set of standards for improvements across six sectors in Montgomery County. As the FCFC is the fiscal authority for the distribution of County Human Services Levy funds, the plan enjoys a broad-based constituency, and has established baseline data and clear benchmarks for measuring success. Similarly, the United Way of the Greater Dayton Area has adopted funding protocols which identify specific standards for non-duplication of services, cross agency coordination/collaboration and outcome specific evaluation requirements. These kinds of community wide efforts have established common awareness of community needs and are increasingly successful in reducing redundancy among health and human services programs while at the same time increasing cross services collaboration, and better integration of services. These efforts

support community wide integrated systems of care to insure access to health care services for all Montgomery County residents.

Proposed Next Steps:

- 3a. Expand the *HealthLink* Miami Valley Network
 - Increase each of the *HealthLink* Task Forces by at least five members representing health and human services providers not yet participants of *HealthLink*
 - Increase the number of health and human services providers connected electronically through the GDAHIN/AgencyLink network
- 3b. Explore current distribution of resources to determine areas for needed redistribution and/or added resources to meet health care needs of the community
 - Develop procedures to determine actual capacity for health care service delivery, full capacity and requirements to expand capacity incrementally and to respond to specific gaps in services
- 3c. Identify components of a more detailed community wide plan such as community-wide disease management/clinical practice indicators
- 3d. Investigate potential innovative health care financing structures which may be applicable to Montgomery County

Objective #4: Develop a structure and process of communication among health and human service provider agencies in Montgomery County that will increase providers' knowledge of services, improve collaboration/coordination, and increase cross referrals between agencies.

Progress to Date

Members of the *HealthLink* Network have been meeting for over three years, and intensively for the past fourteen months. During this time organizational representatives have reached a common understanding about the nature of the difficulty in Dayton with respect to providing health care for all residents. Additionally, enough familiarity with the GDAHIN and AgencyLink MIS systems has been developed to facilitate the creation of a plan to integrate the systems.

Proposed Next Steps:

- 4a. Initiate regular, frequent Task Force meetings and periodic meetings of all members of the *HealthLink* Network.
- 4b. Prepare and circulate monthly *HealthLink* Miami Valley Network updates to all Montgomery County health and human services providers.

Short Term Outcomes:

- Improved communication and information exchange between health and human services organizations
- Increased collaboration/coordination across providers
- Decreased duplication of services
- Increased referrals to appropriate services for better care
- Successful creation of an integrated, centralized and comprehensive electronic information system characterizing the demographics, health care utilization

patterns and social services needs of the uninsured residents of Montgomery County

- Capacity to monitor utilization of public health and safety net services through integrated electronic management information system
- Capacity to project future health care needs in the community
- Completed plan for community-wide integrated system of care for all Montgomery County residents

Long Term Outcomes

- Increased enrollment of uninsured and marginally insured in existing services
- Decreased emergency department visits
- 100% access/0% disparities
- Higher quality and more cost effective care for County residents

Project management matrix

Objective 1: Develop an integrated electronic management information system (EMIS) with the capacity to identify community members without appropriate health care, monitor and analyze use of health care services among the targeted population.

Action step	Timetable	Responsible Organization/Person	Anticipated Results	How measured
1. Integrate networks and develop protocols for classification and analysis of data obtained	Sept. 1, 2001 – Feb 28, 2002	MIS Task Force MIS Technical Advisor	Electronic management information systems integrated Classification and analysis protocols developed Community members without health care categorized into priority groups	Functional system in place Written protocols Report: # of children/pregnant women; # of elderly adults; # of other adults who are not receiving appropriate care
2. Monitor health care services use in the target population	Sept 1, 2001- Feb. 28, 2002 (pre-integration) March 1, 2002 – August 31, 2002 (post-integration)	Outreach Task Force MIS Task Force	Inappropriate uses of health care services identified	Report: # of incidents of inappropriate health care utilization
3. Analyze health care system use in the targeted population to determine underused services and gaps in service availability	April 1, 2002 – Sept. 1, 2001.	MIS Task Force Strategic and Long Range Planning Task Force	Underused services and gaps in service availability identified	Report: list of underused services; analysis of gaps in service

Objective 2: Develop the infrastructure for and pilot a coordinated outreach and follow-up system to be used in concert with the integrated electronic management information system.

Action step	Timetable	Responsible Organization/Person	Anticipated Results	How measured
1. Develop protocols for routine outreach worker follow-up with all community residents who are entered into GDAHIN/ AgencyLink system and who are identified as having no health care	Sept. 1, 2001- Jan. 31, 2002 Feb. 1, 2002- Aug. 31, 2002	Outreach Task Force MIS Task Force	Outreach function is linked to electronic management information system data Current intake questions for participating organizations revised to respond to expanded use of EMIS Outreach efforts piloted	Written protocols and flow charts Examples of revisions of questions and intake procedures Report: # and type of contacts of outreach workers with clients
2. Develop protocols for routine outreach worker follow-up with all community residents who are not entered into GDAHIN/ AgencyLink System (i.e., clients of as yet non-participating agencies)	Sept. 1, 2001- Jan. 31, 2002 Feb. 1, 2002- Aug. 31, 2002	Outreach Task Force Public Relations and Education Task Force	Procedure established to link community residents who need health care to outreach function Outreach efforts piloted	Written protocols and flow charts Report: # and type of contacts of outreach workers with clients
3. Develop systems for appropriate referrals to outreach workers, determining if community member already has a case manager/outreach worker, or if a HealthLink outreach worker is needed to help secure regular health care.	Sept. 1, 2001- Jan. 31, 2002 Feb. 1, 2002- Aug. 31, 2002	Outreach Task Force Public Relations and Education Task Force	Procedure established to link community residents who need health care to their existing case manager/ outreach worker for follow-up if they have one; referral to HealthLink outreach worker if not Outreach efforts piloted	Written protocols and flow charts Report: # of referrals to existing case managers/ outreach workers; # residents referred to HealthLink outreach worker

4. Develop protocols for rotating responsibilities of organizations with outreach workers to canvas neighborhoods to identify community members outside of the safety net who need health care	Sept 1, 2001- Oct. 15, 2001	Outreach Task Force HealthLink Network	Canvassing schedule established Neighborhood canvassing by outreach workers is piloted	Schedule of times and neighborhoods for canvassing Report: Dates of canvassing; # of workers involved; # of contacts made
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Objective 3: Develop a detailed plan for further community-wide integration of health care services which uses, expands, and maintains the integrated electronic management information system and the coordinated outreach and follow-up system and begins to address community wide disease management/clinical practice indicators, the potential for reallocation of resources, and the potential need for additional services.

Action step	Timetable	Responsible Organization/Person	Anticipated Results	How measured
1. Expand HealthLink Miami Valley network by increasing both HealthLink Task Force Membership and number of health and human services providers connected electronically through the EMIS	Sept. 1, 2001 – Aug. 31, 2002	Task Force Coordinators Public Relations and Education Task Force	30 additional organizations are part of HealthLink network 20 additional providers are electronically connected through GDAHIN/Agency Link network	# additional task force members and their organizations # providers connected to network
2. Explore current distribution of resources	Sept. 1, 2001 – Feb. 28, 2002	Strategic and Long Range Planning Task Force	Procedures to determine actual capacity, full capacity, and expansion requirements for health care service delivery developed	Report: Actual capacity for health care service delivery in Montgomery County; draft of requirements to expand capacity and respond to specific gaps in service
3. Identify components of a more detailed community wide plan, such as community-wide disease management/clinical practice indicators	Jan. 1, 2002- July 31, 2002	Strategic and Long Range Planning Task Force Outcomes and Evaluation Task Force	Draft of implementation plan for integrated community-wide plan	

4. Investigate potential innovative health care financing structures which may be applicable to Montgomery County	Jan. 1, 2002 – July 31, 2002	Strategic and Long Range Planning Task Force Outcomes and Evaluation Task Force	Innovative health care financing structures identified and feasibility assessment performed	Report: Description of financing structures and feasibility for application to Montgomery County.
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Objective 4: Develop a structure and process of communication among health and human service provider agencies in Montgomery County that will increase providers' knowledge of services, improve collaboration/ coordination, and increase cross-referrals between agencies.

Action step	Timetable	Responsible Organization/Person	Anticipated Results	How measured
1. Initiate regular, frequent Task Force Meetings and periodic meetings of all members of HealthLink network	Sept. 1, 2001 – August 31, 2001	Task Force Coordinators Chair/co-chair, Project Management Team	Exchange of information increased and facilitated Working relationships between all health and human service safety net providers in Montgomery County will be established and improved	Review of Task Force and HealthLink meeting minutes HealthLink Miami Valley Network member satisfaction with processes and collaboration
2. Prepare and circulate monthly HealthLink Miami Valley Network updates to all Montgomery County health and human service providers	October 1, 2001 – Aug. 31, 2002	Program Assistant	All providers in Montgomery County will be kept abreast of progress in integrated plan development	Copies of monthly updates, # of recipients

Management information systems

(Please see Appendix 3 for a detailed description of the current MIS systems and proposed integration.)

Organizational structure and accountability

Fiscal administration of the *HealthLink* Miami Valley initiative is housed in Wright State University School of Medicine which provides personnel, payroll, legal, accounting, and facilities services. Programmatic functions of the initiative will be coordinated through the Project Management Team, with oversight authority from the expanded *HealthLink*

Miami Valley Network. Day to day monitoring of project activities will be the responsibility of the Center for Healthy Communities.

The Project Management Team will include:

Co-Chairs, Kate Cauley and Rudy Arnold

MIS Coordinators, Joe Krella and Danetta Graves

Public Relations and Education Coordinators, Bill Bines and Diane Pettis

Outreach Coordinators, Kathryn McCombs and Art Pickoff

Outcomes and Evaluations Coordinators, Richard Schuster, Carla Clasen, and Jack Pascoe

Strategic and Long Range Planning Coordinators, Pam Morris and Syed Ahmed.

The Project Management Team will be supported by a Program Assistant, an MIS Technical Advisor, a Site Development Coordinator, an Outreach Worker Supervisor, and six Outreach Workers.

Co-Chairs of the Management Team will take responsibility for overseeing all aspects of the project, providing a liaison with the funder, coordinating and monitoring the work of all project task forces, and drafting the plan for the ongoing work of maintaining a community wide integrated system of care for all residents of Montgomery County. The Program Assistant will coordinate and staff all meetings, assist in the evaluation and development of the overall plan and serve as liaison between and among all project constituents.

The MIS Task Force will be responsible for recruiting additional Task Force members, facilitating regular Task Force meetings, expanding the existing MIS systems, integrating the existing MIS systems, establishing a database of uninsured county residents, maintaining the database, and developing necessary protocols and procedures for routine input and retrieval of data by health and human services providers. The MIS Technical Advisor will support the integration process and development of required protocols.

The Public Relations and Education Task Force will be responsible for recruiting additional Task Force members, facilitating regular Task Force meetings, developing and implementing a public education campaign about the new community-wide integrated system of care being developed through the *HealthLink* initiative, developing articles for local organization newsletters, coordinating press conferences, planning a community wide continuing education conference for health and human services providers, and holding four town hall style meetings for county residents to insure continued feedback from consumers.

The Outreach Task Force will be responsible for recruiting additional Task Force members, facilitating regular Task Force meetings, developing and implementing procedures for enrolling health and human services providers not currently included in GDAHIN or AgencyLink electronic management information systems to participate in the integrated system, developing and implementing the procedures for insuring that all intake encounters with clients at multiple sites routinely include information required for the integrated database, and coordinating the efforts of the Site Development

Coordinator, Outreach Workers, and the Outreach Workers Supervisor. This will include directing and monitoring uninsured residents to appropriate health care services.

The Outcomes and Evaluation Task Force will be responsible for recruiting additional Task Force members, facilitating regular Task Force meetings, defining the baseline/starting point for project objectives and outcomes, monitoring progress toward meeting project objectives, reporting on outcomes, and facilitating the project evaluation plan.

The Strategic and Long Term Planning Task Force will be responsible for recruiting additional Task Force members, facilitating regular Task Force meetings, serving as liaison between the *HealthLink* initiative in Dayton and the Community Access initiatives in the Midwest region including projects in Cincinnati, Ohio and Lexington, Kentucky, conducting a capacity analysis of health care services in Montgomery County, exploring best practices for potential reallocation of existing resources and/or expansion of services, and completion of the *HealthLink* implementation plan.

(Please see Appendix 4 for resumes of key personnel.)

Budget

Personnel

Principal Investigator/Project Manager/Chair Project Management Team	\$41,317
Co-Principal Investigator/Co-Chair Project Management Team	\$7,500
Program Assistant	\$34,358
MIS Task Force Coordinators (2)	\$21,875
MIS Technical Advisor	\$62,500
PR/ED Task Force Coordinators (2)	\$17,500
Outreach Task Force Coordinators (2)	\$27,365
Site Development Coordinator	\$17,179
Outreach Worker Supervisor	\$13,155
Outreach Workers (6)	\$145,666
Outcomes/Evaluation Task Force Coordinators (2)	\$40,294
Strategic Planning Task Force Coordinators (2)	\$34,249
Personnel Subtotal	\$463,002

Non-Personnel

MIS systems integration/development	\$250,000
Travel	\$5,000
Materials and Supplies	\$3,000
Educational Materials	\$3,000
Meetings Supplies	\$2,000
Copying, Printing	\$4,000
Postage	\$1,500
Non-Personnel Subtotal	\$268,500
Direct Cost Total	\$714,505
Indirect Costs at federally negotiated rate of 28%	\$204,823
Project Total	\$936,335

Grant funds will be fiscally managed through Wright State University and all non-university personnel *HealthLink* Miami Valley Network partners will be sub-contracted to the University. None of the funds requested for this project will be used to supplant other funding that is currently supporting services to the target population. The *HealthLink* Miami Valley Network has been able to accomplish a great deal during the past fourteen months. At this point, we are ready to move into the initial phases of implementation and more advanced stages of planning to provide a community-wide integrated system of health care for all Montgomery County residents. In order to establish the electronic capacity for an ongoing management information and monitoring system, to develop community-wide protocols for outreach, and to develop the detailed plan to move forward, we are requesting funds for this critical planning year. During this planning year we will be able to dedicate necessary personnel resources to move to the next step for our community.

Section 4: Scope and Quality of Services

Collaboration among a range of providers in the community

The *HealthLink* Miami Valley Network is best described as a metaphor of an ever expanding living organism which grows in concentric circles until health and human services providers and all formal and informal structures in the community are around the virtual table of community members working together to establish a fully integrated system of care. Currently twenty-one individuals representing seventeen different health and human services organizations which in turn serve the entire Dayton community are represented on the Network. Included are hospitals, primary care providers, professional associations, health professions training institutions, the public health department, public schools, health and human services organizations, mental health and substance abuse treatment and prevention providers, managed care organizations, the faith community, the job and family services department the area health planning agency, the business community and the philanthropic community. In the first year, over thirty additional health and human services safety net providers will join the *HealthLink* Network through their work on the Task Forces, and will regularly be providing input about the evolving plan.

Letters of support for this project expand the circle more broadly and include city, county and state government, additional health and human services organizations, professional associations, civic associations, ethnic heritage associations, additional health insurers and additional business representatives. Consumer advocacy groups working with a number of the *HealthLink* Network organizations have been and will continue to meet regularly, providing input into the development and implementation of project activities. There is full community support and participation in this initiative.

System coordination

As described above the project's services coordination will be through the Project Management Team. One of the primary components of the project is the development of a comprehensive patient tracking system which integrates health and human services

electronic management information systems in order to support extensive outreach and follow-up across service providers and sectors. The benefit to the community will be extensive. First, more community residents will have access to health care services. Second, for those who have access but are not using the services, the electronic management information system will facilitate identifying and supporting these community residents to use appropriate available services. Third, increased use of appropriate services for community residents will result in higher quality and more cost effective health care delivery across the region.

Clinical quality

The Outcomes and Evaluations Task Force of the *HealthLink* Miami Valley Network will be responsible for continuous monitoring of both program objectives and clinical quality, including initial assessments of program effectiveness and efficiency during the planning phases, and development of the capacity for community-wide standards of care and clinical protocols over the long term. During the first phase of the planning grant, the Task Force will perform quality assessments that will measure effectiveness in the planning process itself. Numbers and types of meetings will be tracked as well as task force membership to insure that the broad based constituency representing community agencies, health care consumers and providers of care are included in the planning process. Additionally, the effectiveness of the integrated electronic management information system to capture data for accurate identification of target families will be monitored as well the ability of the system to sort the database identifying the priority target populations as defined in the proposal for immediate case worker intervention, i.e. uninsured families with children and/or uninsured families with young pregnant women,

As protocols are developed, refinement of computer programming, data entry methods, processes or data entry sites as well as data retrieval from the information system will be accomplished in collaboration with the MIS Task Force in order to enhance the ability of the newly integrated management information system to provide *HealthLink* Miami Valley with accurate and complete information to begin the targeted efforts at securing healthcare for these uninsured, high risk families. Effectiveness of outreach efforts and the processes for establishing and maintaining initial and follow-up contact with identified families, success in enrollment for eligible families in insurance programs (such as CHIP), and success in securing primary care providers and primary care sites to provide ‘continuity of care’ to these families will be continuously evaluated.

Procedures will be developed and piloted to insure that continuous assessments are made both by evaluation of caseworker contact records and, importantly, by tracking the utilization of health care services and health care providers by these targeted families through the integrated medical information system. Thus the initial evaluation of the ‘clinical quality’ of the *HealthLink* Miami Valley program in its planning stages will largely center around the refinement of the processes that facilitate the identification of the high risk families, as defined in the proposal. Case worker intervention and tracking of utilization through the integrated information system will allow a continuous quantitative assessment of improvement in resource utilization for targeted families. In the long term, tracking of data such as utilization of primary care and safety net sites

(versus emergency department visits) for routine primary care will provide a direct and objective measure of program effectiveness and quality. Such data will be readily available from the integrated information system to be developed in this planning phase.

Toward the end of the planning grant year and ongoing, *HealthLink* will facilitate collaboration between the quality assurance and resource utilization teams of the provider organizations that are aligned with *HealthLink* Miami Valley, which includes hospitals, hospital associated clinics, emergency departments, urgent care centers, Combined Health District, local managed care organizations, free clinics, and other organizations as outlined above. Each of these organizations are self governed and many have independent, established methods for measuring clinical quality, as well as methods for quality improvement and reassessment of processes that directly relate to quality of clinical care. In partnership with these providers, *HealthLink* Miami Valley will develop the protocols to perform system wide objective assessments of both the quality and quantity of primary care services delivered to its priority target population and to compare care rendered to its population with both local and national benchmark indicators of clinical quality. Additionally, *HealthLink* will develop protocols to set into place mechanisms for assessment and continuous refinement of processes that facilitate access by its targeted families to family centered, continuity-based sites of primary care.

A key goal will be to reduce disparity (compared to community-wide indicators of quality of primary care) with respect to accessibility and quality of primary care services. Local and national benchmarks of quality will be ascertained through several methods that will include data provided by partner organizations relating to quality improvement and resource utilization, systematic chart reviews, query of local Medicaid and HMO databases and comparisons with other established local and national benchmarks.

Ultimately, the *HealthLink* Miami Valley Network would like to expand clinical quality assessment activities and processes to include focused disease management/clinical practice indicators (e.g., vaccine consumption at safety net sites, social work referrals for Medicaid at time of delivery, and use of anti-inflammatory agents in the management of asthma in childhood) and outcome assessments that will incorporate other quality tools, including patient satisfaction surveys, to provide a more global assessment of the ability of the *HealthLink* Miami Valley initiative to provide both quality comprehensive primary care and specialty care to its population.

A major goal in the later phases of the project will be the development of tools that specifically address assessment and improvement in the delivery of care and services that relate directly to the Healthy People 2010 initiative. Building on the Healthy People 2004 Plan developed by the Combined Health District, *HealthLink* will work to expand the application and continuation of the plan monitoring and tracking these important measures of a community health across provider sectors. Thus, a major goal is for partnering organizations to work collaboratively through *HealthLink* Miami Valley to share data (respecting institutional and patient confidentiality) to initiate community-wide assessments of clinical quality and population health, and to work towards refinement of processes, refinement of practice guidelines, and to conduct focused evaluations not only of specific outcome indicators and measures of quality of care but also of the overall health status of the population. These mechanisms would also permit an ongoing and

direct assessment and comparison of clinical quality of care and health status of the *HealthLink* Miami Valley target population, referenced to outcomes experienced by the community as a whole.

Cultural and linguistic competency

Though major shifts in population demographics are predicted throughout the country (with over 40% of families with school age children being of minority populations by year 2020), the general population demographics of the Miami Valley region have remained rather stable over the past several years. With the exception of the African-American community, which comprised 16.1% of the population of Montgomery County in the last Community Health Assessment of 1996, other minority groups make up less than 2% of the population. Since 1996 there have been small increases in the number of Hispanics and Asians (mainly of Vietnamese descent) within the community. Additionally there is a growing immigrant population from Middle-Eastern countries. *HealthLink* Miami Valley is committed to providing access to services that recognizes, respects and understands the beliefs, customs and values of the distinct populations. Since major demographic shifts have not occurred in our area, the majority of provider organizations, and certainly the area hospitals, have already in place identified employees and/or volunteers who are both available and skilled in interfacing with the minority cultures within the community. Efforts will continue to further implement and disseminate methods of facilitating interactions with our minority populations in a culturally sensitive manner.

Links to social services

HealthLink Miami Valley is designed to link health and human services providers in every aspect of the project as described above. In summary, first, we will integrate two electronic management information systems, one which captures patient information from hospital and primary care services provider, and a second which captures client information from human services providers. Second, we will continue to expand the *HealthLink* Network, which already includes seventeen separate health and human services providers, by at least thirty additional providers. Third, through the *HealthLink* Network and the Task Forces we will improve communications, increase interactions, and strengthen referral procedures among health and human services provider agencies. Finally, we will develop a detailed plan for implementation of an ongoing integration of health care services in the community to provide better quality and less expensive care for all residents of Montgomery County.

Section 5: Community Partnership and Sustainability

Community involvement

From the beginning the *HealthLink* initiative has enjoyed broad based community support. The *HealthLink* Network involves most of the larger safety net providers of the community and its membership is growing steadily. Many of the current *HealthLink* Network organizations have community/consumer advisor groups with whom there has

been ongoing dialogue regarding a comprehensive plan to integrate health care services. For the past year, the *HealthLink* initiative has been a regular agenda item for meetings of the Center for Healthy Communities' Community Advisory Board, CareSource's Consumer Advocacy Committee, the Combined Health District's Community Advisory Committee and the Miami Valley Health Improvement Council. Additionally, organizational and neighborhood newsletters have carried articles describing the ongoing work of the initiative and there have been several open meetings with community members to insure full involvement.

HealthLink Network members have made themselves available to make presentations and facilitate discussion at a variety of meetings including the United Way of the Greater Dayton Area's Agency Directors Meeting, the Dayton Priority Board Council Chairs meeting, and the Medicaid Outreach Consortium meeting. As more organizations are represented on the *HealthLink* Network, there will be additional opportunities to expand the level of input from an even broader constituency of the community. We consider this an ongoing interactive process.

Commitment to the community and the population

As described above, there is a longstanding commitment to providing services for the uninsured of the community. In addition to being the first county in the state of Ohio to establish a Medicaid managed care organization, Dayton is the first community in the state to establish and support the multi-service, one-stop program for health and human services at the Montgomery County Job Center. The single point of entry Crisis Care program operated by the Alcohol, Drug Abuse and Mental Health Services Board is also a first in the state. There are several free clinics developed in response to the growing need for services for the working poor community members who fall between Medicaid eligibility and access to commercial insurance. All of these services were designed to support the economically disadvantaged of the community to secure health care, human services support and sustainable employment. (Please see Sections 2 and 3 above which describe the long-standing commitment to the uninsured).

Funding support and sustainability

(Please see Section 1 above for a complete description of the current sources of funding that support care for the uninsured in the community.)

The process of integrating health care and human services is an ongoing process in Montgomery County. As is true in many communities, a patchwork of public health and safety net services has developed since the late 1960's. In the last ten years, the Dayton community has begun to address the issues of fragmentation and discontinuity of care that have evolved for the economically disadvantaged in a number of creative and successful ways. *HealthLink* Miami Valley, building on the Family and Children First Council's community outcome indicators, the Combined Health District's Healthy People 2004, and the United Ways initiative to reduce duplication and encourage collaborative

across service sectors, is an intentional long term effort to identify ways to insure health care for all Montgomery County residents.

Much has already been accomplished. Multiple organizations have demonstrated a commitment to working collaboratively over the long term to meet our goals. Twenty-five human services organizations have already invested several million dollars in establishing AgencyLink. Similarly, hospitals in the area have invested over 15 million dollars in establishing GDAHIN. An one time infusion of funds to support the integration of the systems, done in concert with developing a comprehensive outreach system to follow-up with uninsured residents, and protocols for the ongoing functions of both would assist us in moving more quickly toward our goal of a fully integrated health care system available to all members of the community.

We are confident of the sustainability of our work and investment at this juncture. First, because the major costs involved in integrating the two electronic management information systems, GDAHIN and AgencyLink, is an up-front one time expense. Because the system is web-based, adding provider organizations to the system does not involve significant additional expense. We are estimating that for new provider organizations recruited to join the integrated system, the cost would be approximately \$300 to establish the connection if the organization already has necessary equipment. If equipment purchase is needed the cost per agency goes up to a little over \$3,000. Once connected however, a \$30 monthly fee is all that is required to continue to provide information to and receive information from the system.

Second, the protocols that will be developed as a part of this initial investment will be ongoing. Training for all provider organizations currently registered with either GDAHIN or AgencyLink will be part of the work of the planning year. The ongoing analysis of health care utilization available in regular reports from the integrated electronic management information system will provide data to all providers for better coordination and utilization of existing services. Routine follow-up by outreach workers to insure community members have regular health care will become a regular part of day to day business for outreach workers and case managers in provider organizations throughout the community. And third, the *HealthLink* Network has been and will continue to be committed to working together until full integration is achieved.

We will need to continue to explore if in fact our assumption is true, that are enough services available in the community when they are managed and coordinated appropriately. If through careful analysis using the newly integrated data system and follow-up protocols we discover that additional services are needed, we will need to explore resources to develop new services. This exploration will begin during the planning grant year.

Reinvestment in the community

If we are successful in integrating the electronic management information systems to facilitate redirecting those with health care to their appropriate providers, enrolling those who are eligible for Medicaid into the public health insurance program, and identifying

those who do not qualify for public health insurance in order to direct them to the free clinics and community resources available to them, we will be making significant investments in the health of the community. If we are successful in integrating the electronic management information systems to facilitate instantaneous transfer of data across service sectors and among providers we will have a significant impact on the lives of those who we serve. Let's look at some case studies.

A public school nurse has reported suspected child abuse to the Children's Services Board. A Children's Services Board caseworker is making a preliminary investigation to determine if there is a finding of fact. The caseworker makes a request of the integrated electronic management information system, and gets admission and treatment information from Children's Medical Center describing multiple hospitalizations over the past eighteen months. The caseworker also receives the name of the social worker from the hospital. The caseworker sends an e-mail to the social worker. Within hours, case records are transferred electronically from the social worker at the hospital to the case worker at Children's Services Board. A process that would normally take weeks and sometimes months of securing information from multiple providers concerning the health and well being of patients/clients is accomplished in a maximum of days, while at the same time protecting client/patient confidentiality. The Children's Services Board caseworker now has much more information to add to the data generated in careful interviews with the school nurse and the family before making a determination of how to intervene. The patient/client is better served and health and human services resources are used more efficiently.

In another example, an elderly woman arrives at a social services organization for a class in nutrition she heard about from a neighbor. While there she tells a caseworker she feels faint and needs to sit down. After a few minutes she is all right and is prepared to leave. The caseworker begins to ask her some questions, and discovers that she has been hospitalized recently "for her sugar", but she has been feeling fine. The caseworker goes into the integrated electronic management information system and discovers the woman is eligible for Medicare, but in further conversation with the woman the caseworker learns she doesn't trust doctors and only went to the hospital because her niece made her go. The caseworker then begins working with the woman, perhaps arranges for a home visit with an outreach worker, with the goal of helping the woman understand the importance of going to a doctor, and assisting her in finding a physician with whom she is comfortable.

There are many stories and many more applications of the systems we propose to put into place. These cases represent the human factor. Beyond this are as yet to be determined cost savings for the health care system as a whole, and the kinds of additional services we may be able to implement when the basic health care delivery model is cost effective, utilization appropriate and fully integrated.

Section 6: Evaluation Plan

Self evaluation plan

HealthLink Miami Valley Network's self-evaluation will be the responsibility of the Outcomes and Evaluations Task Force, with assistance from other Task Forces as appropriate. In this year of planning, we will be concerned with evaluating the process of building and strengthening the Network as well as with specific outcomes of the plan.

The three major areas of focus for the evaluation are:

- 1) Operation of the integrated electronic management information system;
- 2) Functioning of the referral and outreach component; and
- 3) Functioning of the *HealthLink* Network as a means of communication and coalition building.

Operation of the integrated electronic management information system – Initial evaluation of the of the *HealthLink* Miami Valley Network its will largely center around the refinement of the processes that facilitate the identification of high risk families. Progress in system integration and protocol development will be documented through Task Force minutes and products. The effectiveness of the integrated system in capturing data for accurate identification of target families and the ability of the system to sort the database to identify priority target populations will be measured when integration is complete by querying and reporting on: demographics (age, gender, race), medical insurance status, health and social services used. The ability of the integrated system to provide accurate and complete information for use in targeted efforts to secure healthcare for uninsured, high risk families will be assessed through a survey of *HealthLink* Network members near the end of the year.

Referral and outreach – Evaluation of the effectiveness of outreach efforts and the processes for establishing and maintaining initial and follow-up contact with identified families is a high priority. Written protocols and flow charts for initiating and continuing contact will be developed and disseminated. The number of referrals to outreach workers by Network members will be tracked with a standardized data collection form and reported monthly. Other data that will be collected from outreach worker contact records and reported monthly include the number and type (telephone, letter, face-to-face meetings) of client contacts made by outreach workers, types of information given to clients and referrals made, and number of successful enrollments in insurance programs. Utilization of health care services and providers by targeted families will be tracked through the integrated electronic information management system. Number of uninsured community members entered in the integrated system at the end of the planning year will be compared with the baseline number. The referral and outreach process will be continuously qualitatively assessed by Network members through regular meetings of the Outreach Task Force. We will assess community members' perception and satisfaction with outreach process and outcomes through a short survey at the end of the project year.

Communication and coalition building – One key goal of the *HealthLink* Miami Valley Network is to improve collaboration, coordination of services, and increase cross-referrals among health and human service provider agencies in Montgomery County. Success in reaching this goal will depend on working relations established and developed throughout the course of the project and members' sense of the effectiveness of the Network process. To evaluate this, we will survey Network members using instruments that measure constructs that have been shown to be related to organizational effectiveness and continued viability. These constructs include feelings of psychological empowerment of individual members and perceptions of positive organizational climate. An instrument designed to measure these constructs (several exist) will be found or adapted and administered to Network members six months after the start of the project. Results will be analyzed and shared with the Project Management Team so that any organizational factors which seem to be impeding the work can be addressed. At the end of the project year, the instrument will again be administered to members. Results will be compared with the initial survey to determine if we have been successful in fostering a climate of collaboration and cooperation. In addition to this structured evaluation, members' perceptions of the planning and implementation of the project will be continuously assessed through Task Force members' evaluation of Task Force meetings, an activity which will be a routine part of the agenda for all meetings.

National program evaluation

HealthLink Miami Valley Network agrees to participate in a national program evaluation. The integrated electronic management information system will provide data on insured/uninsured status with changes over time, connection of community residents with health and human service safety net providers, and health services utilization patterns. The Outcomes and Evaluation Task Force will commit to providing required interim and final program reports.

Logic matrix

The logic matrix for this project follows.