WASHTENAW HEALTH INITIATIVE

Safety Net Team Final Report

January 2014

The Charge

The Washtenaw Health Initiative-Safety Net Coordination Team was formed in early 2013. The teams' first meeting was held in January 2013 and subsequent meetings were held on the first and third Tuesdays of the month for all of 2013. The charge of the team was as follows:
Develop a plan for the distribution and structure of safety net providers in Washtenaw County.

1. Define the current state of the safety net in the county
    a. Descriptive information for current safety net clinics including: patient populations, services offered, physical infrastructure and key processes
    b. Descriptive information of other safety net capacity in the community including: private practice physicians, hospitals and any other identified safety net providers.
    c. Gaps/weaknesses in the safety net
2. Articulate a vision for the ideal safety net system in the county.
    a. What clinics and other providers would be involved?
    b. What would the coordination/governance system look like?
    c. How would resources be distributed?
    d. How would patients access the system?
    e. How would patients move through the system?
    f. What financing structures should be considered (i.e. is there a role for FQHCs)?
3. Develop a strategic plan to improve the safety net in the county and move toward the ideal system articulated above.
    a. Consider areas such as:
        i. Opportunities to rationalize care capacity between clinics
            1. Exam room capacity
            2. Provider capacity
        ii. Leveraging existing purchasing power for goods and services
            1. Medical Supplies
            2. Electronic equipment/computers
            3. Equipment maintenance/servicing
        iii. Strengthening referral networks
        iv. Improving care coordination
        v. Identifying opportunities to improve financing

The Team

The Safety Net Coordination group consists of the following members:

- Chairperson- Tom Biggs
- Corner Health Clinic- Ellen Clement and Lisa Lewis
- Hope Clinic- Cathy Robinson, Jean Cederna and Greta Buck
- Regional Alliance for Healthy Schools (RAHS)- Angie Spence, Lydia McBurrows and Lauren Renalli
- SJMHS-Neighborhood Family Health Canter- Amy Murphy and Deb Young
- Grace Clinic- Sarah Shugart
- IHA- Bill Feleti and Sarah Bradley
- Packard Health- Ray Rion, MD. and John Martin
- UMHS- Brent Williams, MD.
- The Shelter Association (Delonis Shelter Clinic)- Ellen Schulmeister
- Community Support and Treatment Services (CSTS)- Brandie Hagaman

The Findings

Phase 1: Define the current state of the safety net in the county

a. Descriptive information for current safety net clinics including: patient populations, services offered, physical infrastructure and key processes
b. Descriptive information of other safety net capacity in the community including: private practice physicians, hospitals and any other identified safety net providers.
c. Gaps/weaknesses in the safety net

The safety net clinics are primarily located in the southeastern portion of Washtenaw County.

- Ypsilanti: Hope Clinic, SJMHS Neighborhood Family Health Center, SJMHS Academic Internal Medicine (AIM) Clinic, The Corner Clinic, RAHS (Ypsilanti Community Middle and High School), and UMHS Ypsilanti Family Practice.
- Lincoln: RAHS (Lincoln Middle and High School)
- Ann Arbor: Packard Health (main and west locations), Taubman General Medicine Clinic, RAHS (Mitchell Elementary, Scarlett Middle and Ann Arbor Technological High School), The Delonis Shelter Clinic.

The Grace Clinic in Chelsea is the only safety net clinic located in western Washtenaw County.

With the exception of Hope Clinic, Grace Clinic and the Delonis Shelter Clinic, Medicaid and the Washtenaw Health Plan are the primary payers for patients at the safety net clinics. See Appendix A for a breakout the payer mix of each clinic and Appendix B for the percentage each safety net clinic represents of the total WHP patients in the county. Hope Clinic and Grace Clinic are 100% free clinics that only accept patients who have no coverage for health care. The Delonis Shelter Clinic accepts patients with health coverage but is not billing at this time.

In addition to third party payers, the community based safety net providers are dependent upon other forms of funding to cover their expenses. This includes gift giving, WHP safety net grants, general grants, community funding and Coordinated Funding grants. This supplemental funding is critical to the long term success of the safety net clinics as third party payments usually only cover 60-80% of the overall funding needs of the clinics.

On the whole the safety net clinics report limited provider and physical capacity. Only the Corner Clinic has excess provider capacity, and we expect that capacity to be absorbed with the full implementation of the Affordable Care Act. Any physical capacity that is available now will also likely be absorbed as coverage expands under the Affordable Care Act. The VA Hospital and clinics are an important provider of safety net services for veterans in the community; however, we do not have data on capacity within the VA system. The team was unable to make an assessment of private practice physicians and other sources of care for patients utilizing the safety net due to challenges in identifying and scheduling representatives from these clinics.

Many of the safety net providers have implemented an integrated care model similar to what is used at Packard Health, in which they provide a full array of physical health services, mental health services, social services, patient advocacy, case management and even nutrition counseling to their patients. This full array of services is necessary due to the complexity of physical, mental, and social needs many of the safety net patients face on a daily basis. CSTS is the primary provider of mental health services for patients seen at the safety nets.

The Team initiated a process in which it reviewed and discussed the major operating functions and processes that are common to each of the safety nets. After extensive discussion the team identified six major issues that are of the highest priority to the safety nets. The six issues with proposed solutions are as follows:

1. Human Resources/Staffing: All clinics have staffing needs and must deal with vacation, sick leave, retirement, and turnover related disruptions to staffing. The clinics also often serve as training grounds for early career employees who move to new employers once they gain experience.
    - Goal: (1) Develop a way to ensure an adequate pool of qualified applicants and temporarily staff. (2) Improve employee compensation to increase competitiveness and retention.
    - Proposed Solution(s): The Human Resource departments of UMHS and IHA have agreed to collaborate with and/or advise the safety nets in setting up temporary staffing pools, in sharing applicants for open positions, in partnering in pre-employment application screening, and other such functions as deemed necessary. Additionally, IHA has shared information regarding a program they currently use to manage clinical and support staff scheduling.
    - Implementation: An implementation plan must be developed in partnership with the safety nets, IHA, and UMHS.

2. Mental Health and Substance Use Disorder Care: There are limited resources for patients with mild to moderate mental health and substance use treatment needs, especially patients living outside of Washtenaw County. Currently CSTS works effectively with a number of clinics to provide care but there is concern about the sustainability of these services moving forward.
    - Goal: Develop sustainable options for long term outpatient care for substance use and mental health care.
    - Proposed Solution: The WHI Safety Net Team will work directly with the WHI Mental Health work group to discuss financing and sustainability options for mental health care in the county, especially the mild and moderates who are primarily served by the safety net clinics.

3. Patient Advocate Sustainability: Many of the clinics use patient advocates that are supported by funding streams that may not be sustainable in the future (example: Hospital Disproportionate Share payments used to fund advocated through the WHP).
    - Goal: Create a stable group of patient advocates to support safety net patients. (Patient advocated need to be able to work within the clinics due to the importance of the face to face encounter and close relationship with clinic providers).
    - Proposed Solution: Develop an advocacy platform/message to stress the importance of patient advocates to funders. Continue to monitor the status of current funding sources.

4. Revenue Cycle Management: Revenue cycle management is important for all of the clinics that bill or plan on billing in the future. Good RCM requires a level of dedicated expertise that many clinics do not currently have.
    - Goal: Identify a local resource for advice/assistance with RCM for the clinics in the county.
    - Proposed Solution: IHA and UMHS have agreed to assist the safety net clinics by providing management consultation, training on a limited basis, general assistance, and ongoing advice.
    - Implementation: The safety net team needs to develop a document outlining the services which will be available from IHA and UMHS and develop a list of

contacts that will be available to the management and revenue cycle staff at each safety net clinic.

5. Electronic Medical Record Systems: EMRs are becoming increasingly important and in some cases required for clinics. These systems are also expensive to establish and maintain placing them out of reach for many clinics working with underserved populations.
    - Goal: Ensure that clinics have the support necessary to establish and maintain an EMR.
    - Proposed Solution: Identify potential sources of grant funding and ongoing community support to establish and maintain EMR's. Corner Health had a very good experience with their EMR provider (Athena) and worked with Altarum to secure funding for the upgrades. Corner Health will develop a formal guide to assist other clinics interested in implementing/upgrading an EMR. It has also been noted that increased coordination between the safety net clinic record systems and CSTS records would improve patient care.
    - Implementation: As the individual safety nets transition to new EMR systems, they have agreed that having a single common system is beneficial to the safety nets. Where possible, they agree in principle to make this happen.

6. Patient Transportation: While there are many transportation options to the patients, there are timing and dependability issues with the current transportation system that lead to patients missing appointments and make it more difficult to successfully manage patient's health needs.
    - Goal: Improve the transportation system for patients who need to reach appointments.
    - Proposed Solutions: The safety net team has decided to defer further work on this issue more pressing issues have been resolved. Due to the wide array of patient transportation needs the team determined that a standard solution would not be feasible at this time. Currently the safety net clinics utilize a range of available resources to attempt to address individual patient's transportation needs. This work is generally done by patient advocates and so the team views securing funding for advocates as a prerequisite to assisting patients with transportation needs.

Phase 2: Articulate a vision for the ideal safety net system in the county.

a. What clinics and other providers would be involved?
b. What would the coordination/governance system look like?
c. How would resources be distributed?
d. How would patients access the system?
e. How would patients move through the system?
f. What financing structures should be considered, i/e. is there a role for FQHCs

Since some of the safety net clinics are part of larger health systems such as UMHS and SJMHS, and some are part of religious organizations with special missions and separate boards, we decided to stay away from creating governance and operating structures for the safety net clinics. We felt that the timing is not right to take that step as the future is so unclear with the implementation of the Affordable Care Act. Furthermore, we felt that developing a single board/organization structure would be too difficult to implement at this time. Instead we agreed to focus on the operations of the safety net clinics and identify areas where we can improve patient care, increase efficiency, improve customer service, reduce cost, and enhance communication between the safety net clinics and the two major medical centers, all for the benefit of the patient.

Our focus was to identify all operating functions and to classify them it into one or more of the following categories:

- Centralized/Shared Control across safety net clinics where possible.
- Local Control at each individual safety net clinic
- Standardized across the safety net clinics

Each function we reviewed is categorized in the chart found in Appendix C.

As an example of a shared and standardized function, the safety net clinics who are not part of the health systems could agree to use the same accounting/payroll system and implement standardized accounting and payroll policies for each safety net clinic. Over time, these functions could be performed by shared staff or one clinic could provide the service for all of the clinics or they could agree to outsource the functions to a third party.

An example of a function that could remain under local control and standardized is revenue cycle registration. The function will be performed at the local level, but will have standardized procedures and processes across all of the safety net clinics.

Operating and Human Resource policies can be standardized. One policy manual can be developed and standardized for all safety net clinics.

Once the safety net clinics begin to centralize and standardized functions, the next natural step will be to look at governance and key leadership positions. However, we believe addressing the operating functions is an important first step to a longer-range solution.

Phase 3: Develop a strategic plan to improve the safety net in the county and move toward the ideal system articulated above.

a. Consider areas such as:
    i. Opportunities to rationalize care capacity between clinics
        1. Exam room capacity
        2. Provider capacity
    ii. Leveraging existing purchasing power for goods and services
        1. Medical Supplies
        2. Electronic equipment/computers
        3. Equipment maintenance/servicing
    iii. Strengthening referral networks
    iv. Improving care coordination
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The next steps in implementing the above must become an important priority of the CEOs/Executive Directors and the Board of Directors of each safety net clinic. The Boards must endorse the process and the CEOs/Executive Directors must commit to making it happen by allocating the appropriate time, energy, leadership, and resources. In addition, the community through the WHI and CHRT must agree to provide administrative support through facilitation of meetings, providing meeting space, research, and other administrative functions. Without this administrative support, the project will be domed from the start. A high level outline of the next steps is as follows:

- Commitment from the Executive Directors of the safety nets
- Commitment from the Board of Directors of the safety nets
- Commitment from the WHI/CHRT to provide administrative support
- Establish Executive Director meeting schedule(monthly at a minimum)
- Identify leadership of the Executive Directors group.
- Identify low hanging projects to implement
- Develop implementation plan for each project.
- Implement and repeat.
- Provide semi-annual reports to Board of Directors, and recommit to the process on an annual basis.

Externalities that could impact safety net providers in Washtenaw County

The safety net coordination group has also identified a number of events and policy changes that could impact the safety net system in the county both positively and negatively. Potential changes include:

- The growth of ACOs in the county
- Changes/reductions in enhanced Medicaid reimbursement to the clinics
- The inclusion of co-payments in the Medicaid expansion (some clinics are anticipating a large growth in administrative work load)
- The approval of FQHC/FQHC-LA status for Packard Health

Appendix A

Payer Mix and Clinic Visits by Safety Net Clinic (2012 Data Unless Otherwise Noted)

Clinic Name	Number of Patients Served	Payer Mix		
		Public Coverage	Private Coverage	Self-Pay/Sliding Fee
Corner Clinic (2013)	5,970	68%	16%	16%
Neighborhood Family Health Center	5,000	60%	40%	-
Packard Health	19,370	63%	31%	6%
Regional Alliance for Healthy Schools (2013)	1,602	50%	25%	25% (uninsured no reimbursement)
Hope Clinic	7,319	Free Clinic (Uninsured Only)		
Grace Clinic	Unavailable	Free Clinic (Uninsured Only)		
Delonis Shelter Clinic	Unavailable	Free Clinic		

Note: For purposes of our analysis we focused on community based safety net clinics and also those safety net clinics that are located in the community and not located within a large medical complex. Thus we did not include in the above the SJMHS Academic Internal Medicine Clinic, and UMHS clinics located on the UMHS campus.

Information for Ypsilanti Family Practice was not available.

Appendix B

Washtenaw Health Plan Patients
By Safety Net Clinic

Safety Net Clinic	Plan A	Plan B	Total	% of Total
Packard Health				
Packard Road Clinic	219	124	146	17.74
Packard West Clinic		4	3	15.22
U of M Family Practice				
Ypsilanti Family Practice	324	931	125	15.22
IHA/SJMHS			5	
Neighborhood and Family Health	235	459	694	8.41
The Shelter Clinic	83	49	132	1.6
Corner Health		5	5	0.06
Total	861	1268	1549	58.25

Note: For purposes of our analysis we focused on community based safety net clinics and also those safety net clinics that are located in the community and not located within a large medical complex. Thus we did not include in the above the SJMHS Academic Internal Medicine Clinic, and UMHS clinics located on the UMHS campus.

Appendix C

Operating Functions

Washtenaw Health Initiative: Proposed Safety Net Team Long Term Coordination Plan				
Category	**Centralized**	**Local**	**Standardized**	**Comment**
Medical Staffing		yes	yes	
Clinic Administration		yes	yes	
Nurse staffing		yes	yes	
Medical Assistants		yes	yes	
Mental Health/Social		yes	yes	
Nutrition Support		yes	yes	
Care Management	yes	yes	yes	
Quality Assurance		yes	yes	
Patient Advocate		yes	yes	
Support staffing		yes	yes	
Policies		yes	yes	
Telephone/Communic			yes	
Hardware	yes		yes	Use same system as IHA
Software	yes		yes	Use same system as IHA
Management		yes	yes	Use same system as IHA
Information			yes	
Hardware	yes		yes	Use best of the existing
Software	yes		yes	Use best of the existing
Support		yes	yes	Use best of the existing
Electronic Medical			yes	N/A to UMHS/SJMHS
Software	yes		yes	Use best of the existing
Support		yes	yes	Use best of the existing
Interfaces to U of		yes	yes	
Accounting/Payroll	yes		yes	Use best of existing systems
Audit	yes		yes	One firm for all safety nets
Human Resources	yes		yes	Use best of existing systems
Patient		yes	yes	
Revenue Cycle			yes	
Policies			yes	Same across all clinics
Procedures		yes	yes	
Software	yes		yes	Use best of existing systems
Appt. Scheduling		yes	yes	
Registration		yes	yes	
Prior-Authorization	yes		yes	
Financial		yes	yes	
Call Center	yes		yes	
Patient Follow	yes	yes	yes	
Third Party Follow	yes		yes	
Fund Raising			yes	

Software	yes		yes	
Clerical/Adm.	yes		yes	
Payment	yes		yes	
Management		yes	yes	
Housekeeping		yes	yes	One contract for all
Building Maintenance		yes	yes	One contract for all
Specialty Referrals		yes	yes	
Supply Management	yes		yes	
Storage	yes		yes	One contract for all
Recycling/waste		yes	yes	One contract for all