Montgomery County Healthcare Safety Net Task Force Report

June 2008

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The Montgomery County Healthcare Safety Net Task Force was appointed in September 2006 by the Montgomery County Commissioners. The Task Force was charged with recommending an innovative vision and achievable set of strategies to improve and finance the healthcare safety net for vulnerable populations in Montgomery County.

The Task Force, comprised of 19 members representing government, business, community and hospital leaders, met over the course of more than one year to assess the safety net environment and recommend possible strategies to provide and finance healthcare services for vulnerable populations. Members included hospital system leadership, safety net clinic providers, the Dean of the Wright State University Boonshoft School of Medicine, United Way, major insurance companies, and other key stakeholders.

With leadership from Mike Ervin, MD, and Kathy Hollingsworth, CEO of Innovative Interchange, the group met eight times. During these meetings, Task Force members were provided with vital information about Montgomery County, the healthcare current safety net structure and financing, and alternatives and lessons from other communities at the local, state, and national levels.

The group retained the services of The Lewin Group of Washington, D.C. to complete an environmental scan documenting the extent of uncompensated care in Montgomery County and outline key environmental factors facing the community. Key areas included demographics, county economic trends, health status, characteristics of vulnerable populations, service delivery capacity, and safety net capacity and use. The scan included an analysis of public information, emergency department utilization and inpatient statistics, and results from thirty semi-structured interviews.

The Lewin Group completed a financial analysis of the healthcare safety net in Montgomery County. The analysis outlined the landscape of the healthcare safety net, stakeholder perceptions, and the financial profile of the safety net in Montgomery County. Primary sources of funding as well as uncompensated costs are documented.

The Lewin Group findings and additional reports determined the following for 2004:

- Approximately 60,300 people or nearly 11 percent of Montgomery County residents do not have healthcare insurance. This includes about 52,400 adults and 7,900 children. These individuals along with those enrolled in Medicaid are considered the County’s vulnerable populations.

- In September 2007, 84,082 residents in Montgomery County were enrolled in Medicaid. The percentage of county residents receiving Medicaid increased from 12.2 percent in 2002 to 15.5 percent in 2007.

- Montgomery County and the surrounding region are unique as there are only four metro regions in the United States larger than Montgomery County that do not have any type of public hospital (city, county, state, or university). Premier Health Partners incurs 73.5 percent of the inpatient, outpatient and emergency department uncompensated care costs, Kettering Health Network incurs 18.3 percent, and Dayton Children’s Medical Center incurs 8.2 percent. Clinic safety net costs are similarly distributed for uncompensated care. Premier Health Partners incurs 70.2 percent, Kettering Health Network incurs 25.8 percent, and Dayton Children’s incurs 4.0 percent.

- The community faces an annual $85 million cost resulting from uncompensated care provided by Montgomery County hospitals and clinics. Premier Health Partners incurs more than 70 percent of these costs, Kettering Health Network incurs about 20 percent, and Dayton Children’s Medical Center incurs less than 10 percent.
The total shortfall for safety net hospitals in Montgomery County resulting for providing uncompensated care is more than $126 million annually.

- Montgomery County safety net hospitals report a $20 million Medicaid shortfall of reimbursement based on their costs.
- Additionally, Premier Health Partners reports a cost of almost $21 million for emergency department call payments for specialists.
- The total shortfall resulting for providing uncompensated care is more than $126 million annually. The local healthcare safety net system incurs this cost and relies on direct and indirect funding to subsidize the care to vulnerable populations. Direct funding is in the form of government reimbursement. Indirect funding occurs through cost shifting to commercial insurance, businesses, and employees through increased premiums and higher co-payments, deductibles, and premium sharing by employees.

The Task Force examined coverage and service models from other parts of the country. With local initiatives in place and many state initiatives beginning, there has been a significant opportunity to learn from other communities. With knowledge of specific community plans, the Montgomery County Healthcare Safety Net Task Force also reviewed various resources from the Health Policy Institute of Ohio.

The Montgomery County Healthcare Safety Net Task Force agreed to forward potential strategies for the Montgomery County Commissioners to consider studying further for possible implementation that include:

1. Strengthen and consolidate access to primary care.
2. Provide coverage for vulnerable populations under a managed care model.
3. Enhance outreach strategies to encourage eligible people to enroll in Medicaid.
4. Establish a community trust through a combination of new funding sources.
5. Investigate implementation of a community-wide electronic linkage between healthcare providers.
6. Enhance care coordination for vulnerable populations with chronic disease.
8. Encourage and support volunteerism in the healthcare community to provide care to vulnerable populations in a variety of settings.
9. Request the Montgomery County Cost Council examine the cost structure of providing care to vulnerable populations.

This report has been completed and reviewed by the Montgomery County Healthcare Safety Net Task Force for presentation to the Montgomery County Commissioners.

It is recommended that the Montgomery County Commissioners engage members of the Safety Net Task Force and other appropriate community stakeholders to further explore the viability and possible implementation of the above recommendations.
The group retained the services of The Lewin Group to complete an environmental scan documenting the extent of uncompensated care in Montgomery County and outline key environmental factors facing the community.

Key areas outlined include demographics, county economic trends, health status, characteristics of vulnerable populations, service delivery capacity, and safety net capacity and use. The scan included an analysis of public information, emergency department utilization and inpatient statistics, and results from thirty semi-structured interviews.

Demographic analysis of Montgomery County showed a larger African American population but smaller Hispanic population relative to Ohio and the nation (Chart 1). At the same time, the Hispanic population has grown considerably since 2000 (18.5 percent). The local poverty rate is similar to Ohio and the nation (Chart 2), although more concentrated among children and African Americans (Charts 3 and 4).

Montgomery County is facing challenges with the manufacturing sector continuing to weaken and little increase in non-manufacturing employment as experienced in other parts of the country. The unemployment rate has grown considerably since 2000, and manufacturing has experienced the greatest decrease in employment. This may result in an increase in vulnerable populations.

Montgomery County shows a similar decrease in mortality rates when compared to Ohio and the nation, although at a higher rate overall. Leading causes of death are comparable to Ohio and the nation. Chronic disease management was found to be a key health concern for community stakeholders.


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<thead>
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<th>Ohio</th>
<th>US</th>
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<td>65 years and over</td>
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<td>Under 18</td>
<td>23.7%</td>
<td>18.6%</td>
<td>17.6%</td>
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<td>Ages 18 to 64</td>
<td>13.0%</td>
<td>11.8%</td>
<td>11.1%</td>
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<tr>
<td>65 and Above</td>
<td>6.8%</td>
<td>8.4%</td>
<td>10.1%</td>
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<table>
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<th>Montgomery County</th>
<th>OH</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>10.1%</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>13.1%</td>
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</tr>
</tbody>
</table>
Approximately 60,300 or almost 11 percent of Montgomery County residents do not have healthcare insurance. This represents about 52,400 adults (12.6 percent of adults) and 7,900 children (5.8 percent of children), according to the Ohio Family Health Survey 2004 (Chart 5 and 6). The adult uninsured rate is similar to the State at 12.5 percent.

In September 2007, 84,082 individuals were enrolled in Medicaid. The percentage of Montgomery County residents receiving Medicaid increased from 12.2 percent in 2002 to 15.5 percent in 2007.

For Montgomery County residents with commercial insurance, the local payer market is concentrated primarily between Anthem and United HealthCare.

Most hospitals and safety net clinics are located in or near low-income areas of Montgomery County. The result is that current safety net clinics are doing some good in a lot of places, although access to these non-emergency services was found to be a concern by community stakeholders. The clinics provide care in limited hours and offer limited services.

Emergency department visits increased 12 percent between 2000 and 2004. Vulnerable populations tend to be seen at Miami Valley Hospital, Dayton Children’s Medical Center, Good Samaritan Hospital, and Grandview Medical Center. Many stakeholders consider these visits inappropriate, and data shows an increase in Medicaid visits for less acute conditions. These visits should often occur with a primary care physician rather than an emergency department physician.
The Lewin Group completed a financial analysis of the healthcare safety net in Montgomery County. The analysis outlined the landscape of the healthcare safety net, stakeholder perceptions and opinions, and the financial profile of the safety net in Montgomery County. Primary sources of funding as well as uncompensated costs are documented.

The current healthcare safety net includes three major hospital systems: Dayton Children’s Medical Center, Kettering Health Network, and Premier Health Partners. As determined through the environmental scan, more than 20 clinics are dispersed throughout the County but are concentrated in low-income areas and provide limited services with limited hours.

Safety net provider concerns regarding the funding structure of the current safety net include the growth of uncompensated costs, relatively static payments from government sources, and erosion of Medicare and commercial payer reimbursement.

The current safety net is funded by a combination of higher insurance premiums, the Hospital Care Assurance Program (HCAP) and the Montgomery County Human Services Levy.

Uncompensated inpatient and emergency department care in the county totals more than $65 million annually (Chart 8), and uncompensated clinic care totals about $19 million annually (Chart 9). The majority of these services are provided by Premier Health Partners. Premier Health Partners incurs 73.5 percent of the inpatient, outpatient, and emergency department costs, Kettering Health Network incurs 18.3 percent, and Dayton Children’s Medical Center incurs 8.2 percent. Clinic safety net costs are similarly distributed. Premier Health Partners incurs 70.2 percent, Kettering Health Network incurs 25.8 percent, and Dayton Children’s incurs 4.0 percent.

Safety net hospitals in Montgomery County also report a $20 million Medicaid shortfall. Additionally, Premier Health Partners reports a cost of almost $21 million for emergency department call payments for specialists, and Kettering Health Network reports spending about $450,000 on the same expense.

The community faces an annual $126 million shortfall resulting from uncompensated care (Chart 7). The local hospital safety net system incurs this cost and relies on direct and indirect funding to subsidize the care to vulnerable populations. Direct funding is in the form of government reimbursement. Indirect funding occurs through cost shifting to commercial insurance, businesses, and employees through increased premiums and higher co-payments, deductibles, and premium sharing by employees. Both employers and employees have expressed concern about the increasing burden of financing the healthcare safety net.
With several local initiatives in place and many state initiatives beginning, there has been a significant opportunity to learn from other communities at the local, state, and national levels.

The Montgomery County Healthcare Safety Net Task Force examined various coverage and service models utilized in other communities. Although an overlap of best practice and communities with comparable characteristics was not found, the communities provided good examples with plans for expanding coverage for small business and individuals and for strengthening the existing safety net through re-aligning the infrastructure, expanding capacity, and improving coordination of care.

With knowledge of some specific community plans, the Montgomery County Healthcare Safety Net Task Force examined various reform options under development for Ohio.

Further, the Health Policy Institute of Ohio was instrumental in providing documentation about health reform issues at the local, state, and national levels.

Without a public hospital or federally qualified health center designation, it is difficult to compare, apply, and implement various safety net alternatives to Montgomery County; however, the lessons from other communities were used as a basis for Montgomery County recommendations.
Based upon Montgomery County’s unique characteristics and circumstances, data gathered, and a review of evidenced-based safety net systems in other communities, several strategies have been identified as opportunities to strengthen and improve the safety net system in Montgomery County.

Although it is believed these strategies individually or together may improve access and/or quality of healthcare available to the uninsured/underinsured in our community, the Montgomery County Healthcare Safety Net Task Force maintains that a long-term solution to serving vulnerable populations in Montgomery County will require involvement by state and/or national stakeholders.

The Task Force recognizes these strategies will require additional work on the part of various segments of the community including the healthcare system, government, and business. Resources, both financial and human, may be required and have not been scoped as part of the work of the Task Force. Funding for these strategies should neither be diverted from, nor jeopardize governmental funds that pay for access to healthcare services.

There are a number of community stakeholders that include businesses, hospitals, insurers, public agencies and governments who share a common concern about the costs related to healthcare coverage and services. The following recommendations must be sensitive to the financial impact to these various constituency stakeholder groups and should involve continued communication and input prior to the implementation of any specific or series of recommendations offered by the Montgomery County Safety Net Task Force.

It is the hope of the Task Force members that the Montgomery County Commission will review this report and move forward with efforts to further explore and encourage, and where appropriate, lead efforts to implement the strategies summarized below.

Nine local strategies are recommended and described below.

1 **Strengthen and consolidate access to primary care.**

Currently, there are more than twenty clinics in Montgomery County that focus on providing primary care, other services, and serving indigent populations. Many of the clinics provide specialized services such as prenatal, HIV, or immunizations. Although most of these clinics are located in or near low-income communities, many are under utilized, not cost-effective, and do not provide access at appropriate times to those in need of medical care. Commercial insurance does not exceed 20 percent at any site. Medicare and Medicaid are the most common payor, and sites report 55 percent to 90 percent of volume from these payors. Fee-for-service reimbursement rates for Medicare and Medicaid average less than $50.00 per encounter.

The Montgomery County Safety Net Task Force recommends strengthening and consolidating primary care access points in the County. A collaborative effort between hospital systems and Public Health — Dayton and Montgomery County is underway to address consolidation. Initially, three hospital-operated clinics (Corwin Nixon Health Center, Drew Health Center, and East Dayton Health Center) will be rolled into Community Health Centers of Greater Dayton, a nonprofit organization designated as a federally qualified health center (FQHC).

By achieving FQHC designation through an application process, the clinics would dramatically improve their reimbursement for both Medicaid and Medicare patients. For example, Ohio FQHC average reimbursement rates per encounter are $110.00 for Medicaid and $118.73 for Medicare compared with reimbursement mentioned above. This occurs through enhanced Medicaid reimbursement and Medicare cost based reimbursement. FQHC designation will require extension of hours of operation and meeting standards for visits/encounters. FQHC designation should allow these clinics to expand services, and improve efficiency and access for patients.
While this strategy does not provide additional coverage to vulnerable populations and does not fully address serving more uninsured patients, it significantly strengthens the safety net system in Montgomery County. It is hoped that it will provide patients who access the clinic system with better quality of care by improving the amount of preventative and follow-up care. The application for FQHC was submitted in December 2007.

**Provide coverage for vulnerable populations under a managed care model.**

With 12.6 percent of adults in Montgomery County uninsured, the Montgomery County Healthcare Safety Net Task Force recommends providing healthcare coverage options to components of vulnerable populations under a managed care model. The individual coverage plan should target individuals over the age of 19 who are uninsured, whether employed or unemployed, and living below 200 percent of the federal poverty level (FPL) and are not eligible for Medicaid or SCHIP coverage (Chart 10). This plan would offer a limited ambulatory benefit package aimed at service coverage that is not available in the community through the existing safety net. Additionally, an employer participation plan with an enhanced benefit package should be offered which would allow employers to offer affordable coverage to low income workers and participate in the premium of the plan. Select benefits would be offered in both plans, which focus on promoting a cost-effective primary care medical home model of care promoting preventative and early intervention care.

<table>
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<th>ASSISTANCE GROUP SIZE:</th>
<th>50% Monthly FPG</th>
<th>100% Monthly FPG</th>
<th>135% Monthly FPG</th>
<th>150% Monthly FPG</th>
<th>175% Monthly FPG</th>
<th>185% Monthly FPG</th>
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Through promotion of using primary care physicians, the healthcare safety net can be significantly improved. An anticipated outcome and strategic goal of this model would be a reduction of inappropriate emergency department and inpatient hospital usage and improvement in prevention and wellness interventions, and the management of chronic conditions such as asthma, diabetes, and various heart conditions.

Benefits are focused in both plans on ambulatory primary care services include primary physician care, gynecology services, specialty care, limited drug coverage and limited outpatient care to include lab and radiology services. Limited inpatient, outpatient, emergency and urgent care are also part of the employer plan. Benefits do not include ambulance, dental or behavioral health services for either plan. The plans will offer first dollar coverage up to an annual benefit limit of $30,000.

Co-payments for both plans are minimal for “desirable” care received from an in-network primary care physician and for generic prescriptions. In the employer plan, co-payments for “undesirable” emergency room care will be significantly higher. Requiring co-payments will promote a level of personal responsibility among plan members.
Funding for this individual benefit plan with an estimated premium of $90.00 per member per month will be subsidized by a community trust with a premium share for the individual based on a sliding fee scale. The employer plan will follow the “three-share” model. The approximate monthly cost of $150.00 is divided three equal ways. The community trust will fund a portion, a qualified employer will fund a portion, and the employee will contribute a portion.

This strategy has been utilized in many communities with varying degrees of success. CareSource patterned the benefits and cost-sharing proposals after those in place in multiple counties across Michigan, specifically the Ingham County Health Plan that covers over 16,000 previously uninsured residents with both an individual coverage plan and a three-share employer plan. The successful enrollment penetration rates among the uninsured and maintaining a manageable cost will be key to the success of any proposed plan in Montgomery County. The Task Force believes Montgomery County is uniquely positioned to pilot this type of managed care program for the uninsured due to the existence of CareSource in the community. CareSource’s experience in managed care for vulnerable populations (Ohio Medicaid and Medicare participants), non-profit status, low administrative cost structure, and comprehensive provider network makes it uniquely qualified to assist Montgomery County in developing a pilot that could eventually serve as a model statewide.

Funding for this initiative should neither be diverted from, nor jeopardize governmental funds that pay for access to healthcare services.

Enhance outreach strategies to encourage eligible people to enroll in Medicaid.

Over the five-year period from September, 2002 to September, 2007, all major categories of Medicaid enrollment have grown in Montgomery County. When compared to Montgomery County’s population as given by the 2000 census and the 2006 population estimate, the percentage of Montgomery County residents receiving Medicaid increased from 12.2 percent in 2002 to 15.5 percent in 2007. In September 2007, 84,082 residents in Montgomery County were enrolled in Medicaid (Chart 11). The Montgomery County Healthcare Safety Net Task Force recommends enhancing outreach strategies to further promote enrollment in Medicaid. Montgomery County Department of Job and Family Services (MCDJFS) should initiate this effort by initially determining how many residents are eligible for Medicaid programs under current and potential eligibility standards but are not enrolled. Through collaboration with key stakeholders, MCDJFS should identify enrollment strategies based on best practices that prevent barriers to enrollment and enrollment maintenance problems. MCDJFS can be a leader in the state and results could be replicated statewide.

**CHART 11: Medicaid Recipients in Montgomery County (2002 & 2007)**

<table>
<thead>
<tr>
<th>Categories of Medicaid enrollment (2002 and 2007)</th>
<th>In Numbers of Persons:</th>
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<td>Healthy Start = 9,015</td>
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<tr>
<td>Ohio Works First and Related = 42,156</td>
<td>80,000</td>
</tr>
<tr>
<td>Disabled = 11,506</td>
<td>90,000</td>
</tr>
<tr>
<td>Blind = 39</td>
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<tr>
<td>Aged = 5,662</td>
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<td>Healthy Start = 12,106</td>
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<tr>
<td>Blind = 31</td>
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</tr>
<tr>
<td>Aged = 7,365</td>
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</tr>
</tbody>
</table>

In 2002: (68,378 Recipients)
In 2007: (84,082 Recipients)
Establish a community trust through a combination of new funding sources.

Recognizing implementation of strategies to improve the safety net system will require significant funding, the Montgomery County Healthcare Safety Net Task Force recommends the establishment of a community trust through a combination of new funding sources. Several funding strategies were examined, and the group believes the community trust is the best approach to this community issue. Funding for this trust should neither be diverted from, nor jeopardize governmental funds that pay for access to healthcare services. Sources of funding could be local charitable donations, contributions from local healthcare organizations, national foundations, and the local, state, and federal governments. This trust should be used to investigate, develop, and/or implement any proposed recommendations including the managed care program outlined in Recommendation 2. Further, the new funds should also be utilized to leverage additional state and national funding. It is also suggested that the administration of the trust should have representation from key stakeholders in the safety net healthcare issue.

Investigate implementation of a community-wide electronic linkage between healthcare providers.

The Montgomery County Healthcare Safety Net Task Force recommends investigating the implementation of a community-wide electronic linkage between healthcare providers. Tracking the medical care of vulnerable populations at safety net sites is key to improving the healthcare safety net system in Montgomery County. This type of health information exchange (HIE) is not new to Montgomery County; however, exchanging information about the medical care of vulnerable populations would be a new and targeted focus. It would allow medical personnel and social services personnel to access a portable electronic medical record. This would improve care coordination and minimize duplicative services across hospital systems and clinics. Ultimately, a community-wide electronic medical record system would allow social and medical conditions to be addressed together with better outcomes. Montgomery County has experienced positive results from this type of community-wide data sharing in other settings, and the Task Force recommends the same approach to improve the safety net system.

Enhance care coordination for vulnerable populations with chronic disease.

Peer-reviewed medical journal articles indicate patients with chronic disease account for 75 percent of healthcare system costs. To address the needs of our vulnerable populations with chronic diseases such as diabetes and heart disease, the Montgomery County Healthcare Safety Net Task Force recommends enhancing care coordination in the safety net system for vulnerable populations with chronic disease. The greatest healthcare costs can be reduced with extensive care coordination, including screening, early detection, education, treatment and follow-up. Uninsured individuals could also benefit from intensive case management as they utilize safety net hospital emergency departments, because social and medical conditions could be addressed. In conjunction with a community-wide electronic linkage between healthcare providers, enhanced care coordination could maximize outcomes for vulnerable populations.
Explore U.S. Department of Health and Human Services demonstration projects.

With the groundbreaking work of the Montgomery County Healthcare Safety Net Task Force, opportunities may exist to secure support from the United States Department of Health and Human Services. The Healthcare Safety Net Task Force recommends exploring United States Department of Health and Human Services demonstration projects. Serving as a demonstration site for a key segment of our vulnerable populations could have a lasting impact. Health Resources and Services Administration (HRSA) grants exist for service expansion projects, and the Miami Valley has been successful in securing these awards in the past. The Task Force recommends exploring a Medicare buy-in program, allowing people younger than 65 who have retired the opportunity to access the Medicare system.

Encourage volunteerism in the healthcare community to provide care to vulnerable populations in a variety of settings.

The Montgomery County Healthcare Safety Net Task Force recognizes the impact of volunteerism through programs like Reach Out of Montgomery County. Healthcare providers throughout the community should be encouraged to volunteer in an effort to meet the needs of our vulnerable populations. By working together, physicians, nurses, and others can help identify and provide medical homes for Montgomery County residents.

Request the Montgomery County Cost Council examine the cost structure of providing care to vulnerable populations.

The total cost of providing care to vulnerable populations in Montgomery County is truly a community issue. The Healthcare Safety Net Task Force recommends that the $126 million cost be examined further including the impact on employer costs, the impact on recruiting family practice physicians and specialists, future implications, and distribution of uncompensated care among healthcare providers. The Montgomery County Cost Council should continue its current membership of insurers, business groups, governments, hospitals, and other interested stakeholders.
**Montgomery County**

**HEALTHCARE SAFETY NET TASK FORCE ROSTER**

**Task Force Co-Chairs:**

- **Mike Ervin, MD**  
  Community Leader
- **Kathy Hollingsworth**  
  CEO  
  Innovative Interchange

**Task Force Members:**

- **Gary Auman**  
  Director  
  Dunlevy, Mahan, and Furry
- **Thomas G. Breitenbach**  
  President and CEO  
  Premier Health Partners
- **Deborah Feldman**  
  Administrator  
  Montgomery County
- **Rich Gunza**  
  Executive Director  
  Anthem
- **Thomas Hardy, DO**  
  Vice President of Medical Affairs  
  Grandview Hospital
- **David Kinsaul**  
  President and CEO  
  The Children’s Medical Center of Dayton
- **Gary LeRoy, MD**  
  East Dayton Health Center
- **Marc Levy**  
  President and CEO  
  United Way of Greater Dayton Area
- **Terry Lindquist**  
  Vice President of Network  
  United Healthcare
- **Heath MacAlpine**  
  Assistant Director  
  Montgomery County Job and Family Services
- **Pat Meadows**  
  Executive Director  
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