Touchette Regional Hospital

Transformation Impact

Good morning and thanks for allowing me to present to you today. Last year when I presented it was solely about our Hospital, Touchette Regional. Today I feel it is imperative that I share who we are as a health care provider in whole and why that has helped in past transformations, is part of our future changes, and why our role as a key regional access provider is necessary in our region. Our network is a true safety net with a legal structure that includes SIHF Healthcare, Touchette Regional, and Life Links. We also maintain several partnerships in our respective care locations.

INTRODUCTION TO OUR SYSTEM

SIHF Healthcare is one of the nation's largest Federally Qualified Health Centers serving over 105,000 patients across southern Illinois of which over 88% are at 200% of poverty and below. Life Links is our affiliated community mental health center that we have started integrating across our FQHC locations for counseling services. And Touchette Regional is our safety net hospital located in Centreville, IL a city which happens to be the most impoverish city in the United States of America. Centreville is actually part of the greater East St. Louis area which actually would have three of the poorest communities except two of the cities were excluded do to data concerns. Touchette sits in the heart of this severely impoverish area along with a number of our FQHC locations. We employ 530 people at a hospital and another 660 across Life Links and SIHF. I share this brief overview as you will hear we have always maintained a focus to adapt to the needs of the underserved and I hope you gain the insight that our importance to the region is greater than what alone as a sole hospital may appear.

KEY FORMATIVE TRANSFORMATIONS

Let me start by highlighting some of the key milestones for past transformation that has formed our service model and then transition into current initiatives that has created who we are:

1. In 1993 Touchette became a controlled affiliate of SIHF after transitioning from a tax based township hospital to a not-for-profit,

2. In late 2003 TRH was directed by regional and statewide leaders to step in and implement a transition for St. Mary's Hospital in East St. Louis after it was announced they were closing. This transition became official in 2004 and the coordinated plan with the state of Illinois and Ancilla (St. Mary's ownership) to ensure services are maintained in the East St. Louis region commenced over the next eight years with early funding support from HFS. We transitioned services into Touchette and continued to re-build the behavioral health, specialty services, home health, and emergency services.

3. This move started a pathway for Touchette Regional Hospital to become the primary delivery source for Behavioral Health services. And in 2016 TRH became the only inpatient behavioral health facility in the St. Clair County and the only Intensive Outpatient Programs in the region. We accomplished this through a past partnership with HSHS St. Elizabeth's Hospital in Belleville who was terminating their BH services and agreed to guarantee a loan for TRH to expand our 12 bed unit to a new 30 bed unit and expanded IOP programs.

TRANSFORMATION CONSIDERATIONS

I share this because as leaders in our communities the transformation we undertake is just as much about the circumstances and needs that are presented to us by our communities and region for our actions and not what we seek to dictate the needs to be. This is what makes our community assessments a living document as to how we address the region underserved health needs and the services needed and not just for a community assessment document to sit on a shelf.

1. So my first recommendation for transformation is for the use of the community assessments for measureable changes with actions that improve the health in our communities. The health conditions of our communities along with the position of other providers often challenge our actions. For example:
    a. The reduction in inappropriate ER utilization. SIHF teamed with TRH to change the behavioral use of ER by opening two convenient care structures in our FQHC locations in the East St. Louis area to serve the lower acuity needs of patients during evening, weekend, and late hours.

This has allowed us to guide over 100 patients weekly into our convenient care/primary care location and away from the TRH emergency room. We are now working with two of our Medicaid MCO's to place a similar model in the west end of Belleville to divert this same lower acuity traffic away from another local emergency room.

b. We designed and have the only special needs dental program for children in our area with the FQHC providing the preventative and screening, SIU School of Dentistry providing partial sedation, and Touchette providing full sedation.

c. To address the disparity of Breast Health in our area we commenced a program with the Komen Foundation that has educated over 20,000 at risk African American women of which 14,000 whom attained mammograms for the first time. An impact that has seen our deaths from breast cancer in our primary service area drop from 14 in 2008 to 4 annual cases today.

d. In 1998 we pursued and were award a Healthy Start grant to target African American women and families. This is a $650,000 funding stream that utilizes targeted care management services linking the community and medical issues in a manner that reduces the disparity with African American women of child bearing age by improving pregnancy outcomes through reduction efforts. Our program is funded for 500 women which 50% (250) must be pregnant.

	2005-2007	2011-2013	2014--2016
LBW	10.2%	6.8%	5.5%
First Trimester	53.8%	67.8%	72.6%
Postpartum	56.90%	66.50%	71.2%

This investment has returned an estimated reduction in cost of over $1.3 million annually as a result of improving the birth outcomes of which now has nearly eliminated the disparity between African American and white births. In 2019 we will be submitting a grant to HRSA to expand this service to serve 800 women, of which 400 must be pregnant.

2. So this leads me to my second recommendation and that is to allow entities like our to propose the integration of value based services in direct grants or

through payment structures like what is in the Integrated Health Homes (IHH) model. These types of care management services bring the value we need to reduce our health care spend, improve outcomes, reduce the disparities among our impoverished communities, and brings value models to our current health care focus versus volume and rates.

a. The IHH model which includes billing codes for Comprehensive Care Management, Care Coordination and Health Promotion, Transitional Care, Patient and Family Support, and Referral to Social Services brings some of these much needed integrated services.
b. These functions along with items like integrated outpatient clinical pharmacy are critical to generating better health. We have imbedded three part time pharmacists from SIU School of Pharmacy into our clinical schedules to focus on diabetes and pain management. They have provided improved clinical outcomes and help allocate the care team patient distribution more effectively. Today, we actually give up revenue on this service as we cannot be reimbursed for this service in our outpatient FQHC.

3. Let me provide a brief list of our current and planned transformations with some recommendations:
    a. This year we became the primary delivery source for St. Clair County Corrections inmates for inpatient and outpatient services. We are now designing an IOP program for inmates that are within their final 60 days prior to release. This is to assist with continuity of health care as they transition back into the community.

    b. In 2019 we plan to apply for and build the first of 50 units of permanent supportive housing. This will assist inmate discharge and for our behavioral health program participants as it provides an option for continuum of care needs.

    c. This will be coordinated with the first phase of our vocational programming that we plan to start in January 2019 through a Youth Build grant for 18-24 year old adults. Programs for medical assistants and traditional trades are planned in partnership with the Urban League and Ranken Technical College.

d. We have contracted with the St. Clair County Housing Authority to begin replacing over 300 units of housing in the Centreville area.
    i. ASK: To assist our external development team with tax credit support.

e. While these are not traditional health care services, these are community needs for our region. We know if we are to have a greater transformation impact in such an impoverished area these actions are necessary.

f. So for health care services,

g. We are actively modeling a partnership with AT Still to start a Psychiatry residency at TRH starting in 2020.

h. Opened an outpatient sleep study center in July that welcomes Medicaid and uninsured as there are no such service in our region for these patients;

i. We have started our transition out of Labor & Delivery services with a partner who has agreed to absorb this service as that can make a profit from this service, but we need support in changing the current reimbursement model that links all of our add on payments to our DSH and L&D services.
    - ASK for OB DSH condition – payment models include all add-ons linked to this single classification. Ask for two modifications 1) to create regulatory reform to ensure the our plan to transform out of OB does not force to loss of these necessary payments; and
    - That we push to have federal changes in the law to have BH as a DSH designated service category so we can retain this classification to ensure access to the 340B program.

j. We are expanding our inpatient behavioral beds from 30 to 40.

k. We are expanding our IOP services to 2-3 new communities this year and another 2-3 communities next year.

l. We continue to expand our specialist access by adding Dermatology, ENT, cardiology, pulmonology, Ophthalmology, others.

m. However, this leads me to my last recommendation and that is for an uncompensated care program to be established for safety nets like TRH. Why I ask this is because when I sat here last time you asked about our uncompensated care spend and I noted it was around $4.5 million a year with our self-pay being 4%. As of this June, TRH's self-pay was at 9% and we have already incurred nearly $3.2 million in uncompensated care cost and project we could exceed $8 million for the year. We see this trend growing to nearly 11% by the end of this year. The reason is linked SIHF who has seen a 32% growth in self-pay patient volume through June and behavioral health referrals. This growth and the inability to acquire access for services for many of our self-pay and Medicaid has pushed TRH to become even more of a regional safety net. SIHF now has over 12,000 unmet referrals for our Medicaid patients and another 2,300 for self-pay. And unfortunately barriers are being presented in gaining necessary access. (Share Statements on circumstances).

n. I highly recommend that current funds for TRH be allowed to be sustained for the services necessary for the regional population we care for within a proposed model of care that supports our underserved patients. This would include replicating key components of the IHH for the uninsured, expanding outpatient services imbedded in our FQHC's, and growing access across the region for the underserved in a valued based approach.

I thank you for your time and willingness to hear our issues and recommendations.

GENERAL SUPPORTING DATA

Touchette Regional Hospital's primary service area is composed of:

	Primary Service Area	**Secondary Service Area**
Total Population	58405	237439
		(BH reach)
Race		
% African American	82%	16%

% Caucasian	15%	79%
% Other	3%	5%
Income		
Below Poverty (<100%)	42%	14%
100-200% of poverty	28%	17%
Over 200% of poverty	30%	70%
Education		
Below High School	42%	
College Graduate	7%	
Unemployment		
Total rate of unemployment	19-22%	8%

TRH and our related system is a true Safety Net provider for some of the most vulnerable. TRH payer mix has always been on the

i. 2014 and prior it was 16-24% uninsured; 55% Medicaid
ii. Today 9% uninsured and another 62-64% Medicaid
iii. Over the last 3 years we will have expended $4.8 – $5.4 in charity and uncompensated care. Proportion much higher than other local hospitals. In 2018 this amount is likely to exceed $8 million.