# Health Access Meeting

May 15, 2025

# Welcome to the Network

The Community Impact Network **builds equity** by serving those who create opportunities for people in the 24:1 community to learn, live and leave a legacy.

The Network serves its members by:

- **listening** to community stakeholders to shape how we serve and what we invest in;
- **collaborating** with others to align around shared objectives, craft solutions, and overcome challenges; and
- **investing** financial, strategic, and organizational resources in our priority areas.

The Network's meetings are:

- **A Place of Respect** — We show our respect for your time by starting on time and ending on time
- **A Place of Hospitality** — You're our guest and we welcome you to share with us all what's really going on
- **A Space for Relationships** — You are free to take new friends and new ideas with you

# Neosha Franklin

President and CEO

Community Impact Network

# Erin Murphy

Assistant Director of Clinical and Community Integration, Care Transition Initiatives
St. Louis Integrated Health Network

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# Care Transitions Initiative (CTI)

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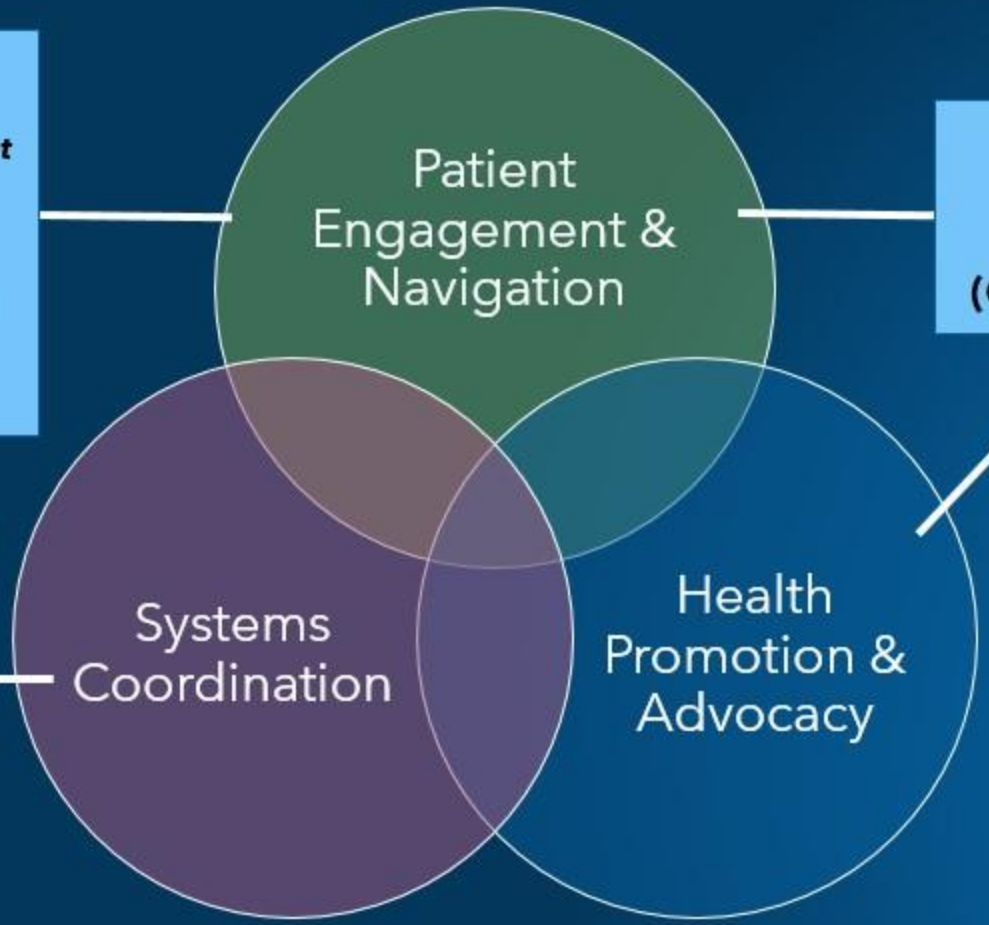
# Care Transitions Initiative

**P.U.L.S.E.**
***Primary Care. Urgent Care. Live Well. Specialty Care. Emergency Care.***
**Educational Framework**




**Community Referral Coordinator (CRC) Program**

**Transitions of Care (TOC) Task Force**

## Care Transitions Initiative Goals

- Enhance access to a primary care home and health resources for all patients regardless of ability to pay
- Reduce non-emergent use of emergency departments and low acuity readmissions
- Enhance continuity of care
- Strengthen communications and processes among safety net providers caring for the same patients

# Core Services

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- The IHN Care Transitions Initiative is a three-tiered intervention for the health system comprised of three components comprised of three components:

| Systems Coordination Navigation (TOC) | Health Education (PULSE) | Patient Advocacy (CRC) |
|---|---|---|
| Population Health Management | Patient utilization across the care continuum | Payor Agnostic |
| Meaningful Use | Education and guidance around patient discharge and follow up care | Overcome barriers to patients access to care |
| Community Benefit | | Patient centered approach and neutral third-party navigators |
| Centralized Referral Data Repository | | |

# What is the Transitions of Care Taskforce (TOC)?

- Cross-functional group of providers and health leaders focused on strengthening collaboration by addressing policy and practice issues from a system's perspective to improve care transitions across the healthcare system.
- The goal of the TOC is to promote high-quality, safe, and efficient patient transitions of care between a hospital (inpatient or emergency department) and an outpatient setting including coordinated appointments and transfer of important clinical information.
    - The TOC has implemented ongoing qualitative efforts including:
        - Patient experience surveys regarding care transitions.
        - Improving communication via electronic means between providers.
        - Defining a TOC standard of care for the region.
        - Expanded to include Sickle Cell Disease Care Transitions between PCP, Specialist, and Hospital ED.

# P.U.L.S.E

**P.U.L.S.E.™ model:** Educational framework used to assist patients and community members to understand the levels of care available in the community and when and how to engage.

The P.U.L.S.E.™ acronym stands for: Primary Care, Urgent Care, Living Well, Specialty Care and Emergency Care.

# Who is a CRC?

- Patient-centered intervention where CRCs work with patients and community members to assist in understanding and navigating health and social services.
- CRCs connect patients from inpatient units and emergency departments of hospitals with a primary care home for follow-up and preventative care.
- The program focuses on serving underinsured and uninsured patients; however, it works with all patients in need of a medical home. Community Referral Coordinators are employees of the IHN who work on-site in the hospital.

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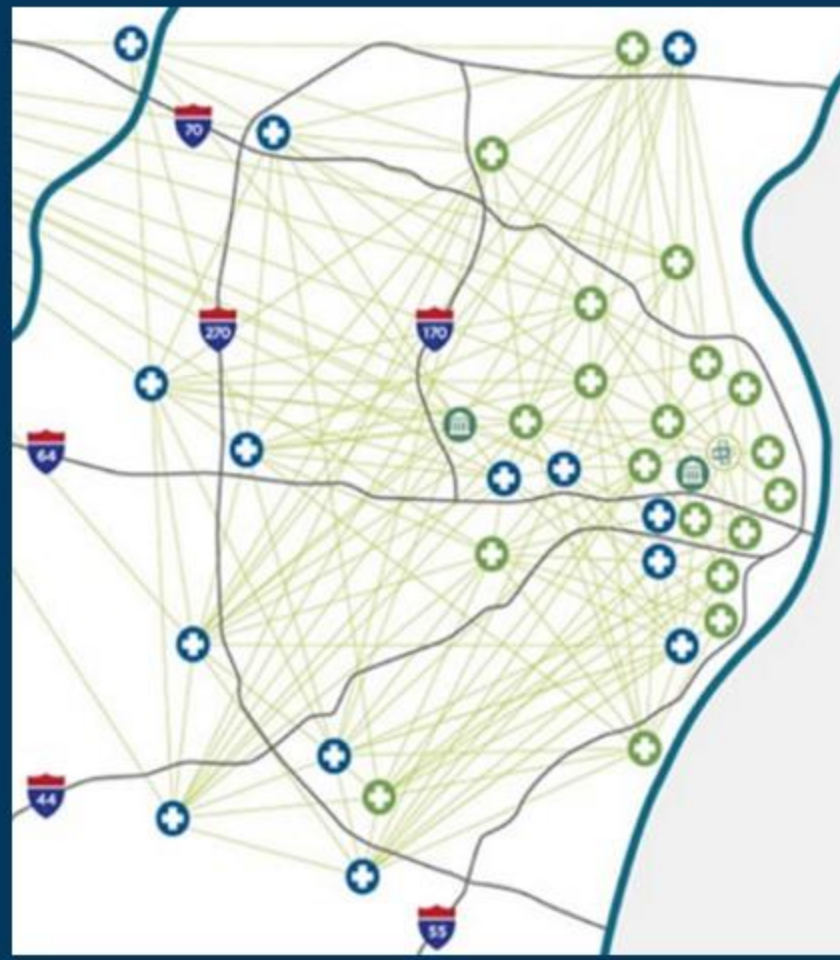


## the focus areas

- 4 FQHC Systems
- 2 Public Health Departments
- 2 Medical Schools
- 3 Major Hospital Systems
- 1 Partner Member
- 2 Technical Advisors

SERVING 90% OF ST. LOUIS HEALTHCARE MARKET

## the partners

- Affinia Healthcare
- BJK People's Health Center
- Family Care Health Centers
- CareSTL Health
- St. Louis University School of Medicine
- Washington University School of Medicine
- St. Louis County Department of Public Health
- BJC Healthcare
- Mercy Hospital St. Louis
- SSM Health
- St. Louis City Department of Health
- St. Louis Community Health Worker Coalition
- Missouri Primary Care Association
- Regional Health Commission

# Evolution of the CRC Program

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**2007:**

CRC Program is grant funded. Starts off in two hospitals with two CRCs.

Barnes Jewish Hospital → 1 ED

St. Mary's Hospital → 1 ED

**2011**

Expansion to Inpatient.

**2012:**

CHCs move to PCMH model; CRC emphasis placed on established CHC patients.

**2014:**

CRC Program moves from grant-based funding to hospital contracts.

**2016:**

CRC tracking of SDOH factors identified during encounter; impacts focus of TOC and development of additional referral partners.

**2019:**

Addition of community based CRCs.

**2025:**

**BJC Barnes Jewish Hospital** (1 Inpatient CRC)

**BJC St. Louis Children's** (1 ED CRC)

**BJC Christian Hospital** (1 NW ED CRC & 0.5 CRC NE ED CRC)

**BJC Memorial Hospital** (1 Inpatient CRC & 1 ED CRC)

.

**2025 (cont.):**

**SSM Health St. Mary's Hospital** (1 ED CRC & 1 Inpatient CRC)

**SSM Health DePaul Hospital** (1 ED CRC & 1 Inpatient CRC)

**SSM Health St. Louis University Hospital** (1 ED CRC & 1 Inpatient CRC)

**SSM Cardinal Glennon Hospital** (1 ED CRC)

**2 Float CRC** (ability to move between sites to provide coverage)

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# Referral Process

Patients Referred to CRC:

a. Patient with no PCP

b. Patient with no insurance or Medicaid

c. Established FQHC patient

d. ED high utilizer

Referrals come from Care Management, Social Work, CHWs, Providers.

Is patient established with FQHC or has PCP…

**YES…**

CRC will notify patient *in person* that an appointment will be set up and gets preferences for appt.

If unable to meet patient in person, CRC will encounter patient via telephone.

Is patient established with FQHC or has PCP…

**NO…**

YES (patient is interested):

CRC schedules appointment with the FQHC contact according to the health center's preferred protocol or with a PCP per patient's request.

NO (patient is not interested):

No appointment is scheduled for the patient

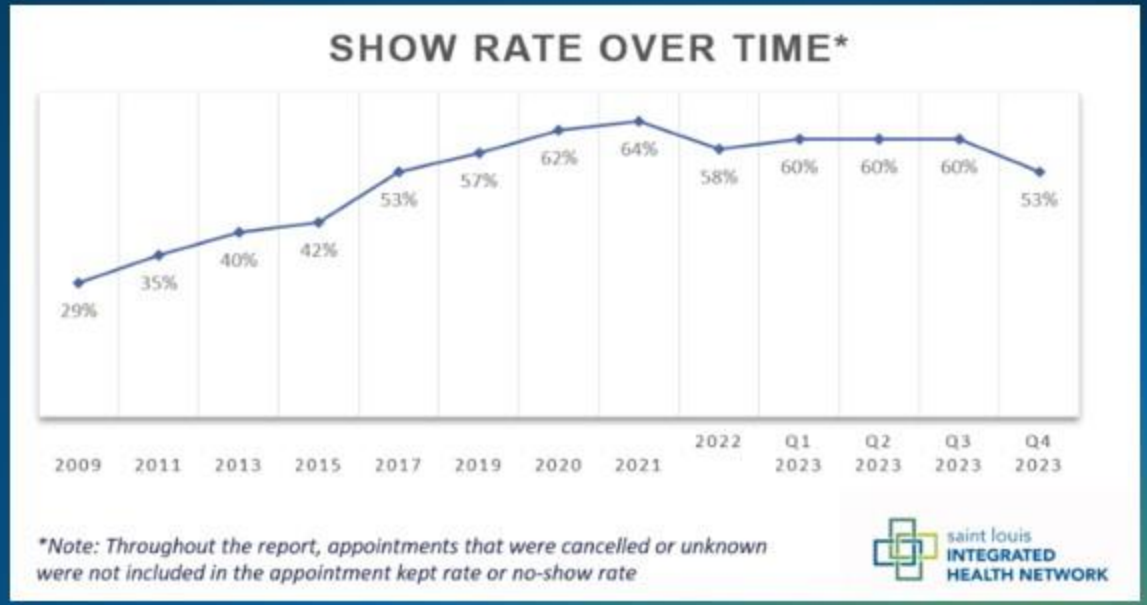
CRC educates patient on the importance of a PCP follow up appointment

CRC sends password protected Word Document with appointment request via encrypted email to FQHC contact. FQHC contact responds within 24-48 hours with appointment information. CRC faxes discharge paperwork to FQHC.

CRC reaches back out to patient to confirm appointment, CRC will reschedule appointment if needed and remind patient as appointment gets closer.

# Impact

- IHN's community referral coordinators have helped thousands of patients and community members get connected to primary care services since the program's inception in 2007. The program surpassed 200,000 patient encounters in 2022. In 2023, community referral coordinators scheduled over 2,330 appointments at the four community health center partners.
- Compared with traditional ED diversion programs that focus on avoidable 90-day readmissions, IHN's model centers the process of connecting patients to medical homes (predominantly community health centers), thereby providing greater access to comprehensive care and wrap-around and preventative services.
- By anchoring patients to community health centers and addressing social determinants of health factors, community referral coordinators achieve higher than average show rates at community health centers and a 21% reduction in avoidable hospital readmissions.
- The Transitions of Care Taskforce has been instrumental in helping build the capacity necessary to connect more patients to a community health center. By bringing community health centers and hospital systems to the same table, the group facilitates important cross-organizational discussions on how members of the St. Louis safety net can support each other and contribute to better strategic alignment.



# Aja La’Starr Owens

Advocacy and Mobilization Manager
Community Health Commission

The Community Health Commission of Missouri (CHCM) is a group of

# Radical Collaborators

achieving ZERO HEALTH DISPARITIES through equity-centered, trauma-informed practice.

# CHCM Advocacy Efforts


- Community Listening Sessions
- Youth Ambassador Program
- Show Me Advocacy
- Advocacy Days
- Engaging Legislators
- Town Hall Meetings
- Provide Testimonials before Elected Body
- Voter Education Outreach

# Community Listening Sessions

# Youth Ambassadors Program

# Show Me Advocacy

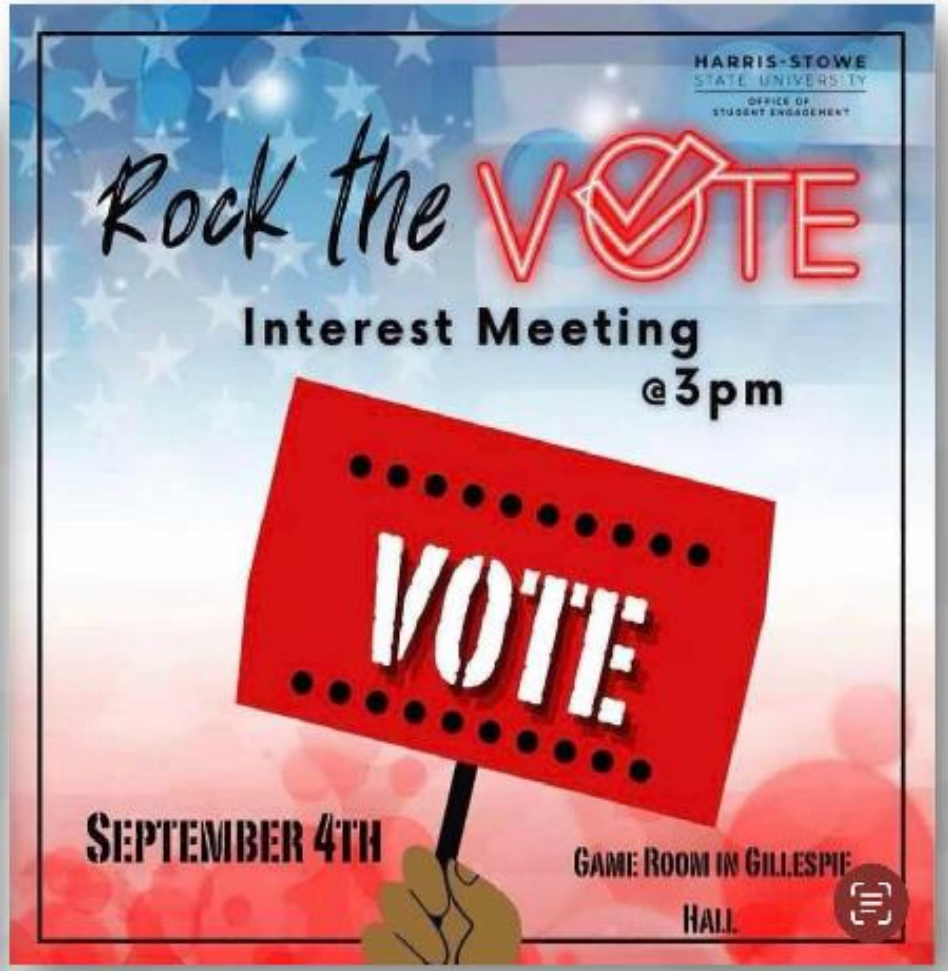
# Advocacy Days at the Capitol


# Engagement with Legislators

# Town Hall Meetings

# Provide Testimonies During Board Meetings


# Voter Education Outreach




# Questions & Feedback

## Aja Owens, MBA

Advocacy Mobilization Manager

Community Health Commission of Missouri

# Michael Quinn

PhD, President and CEO

Autism Support Now

# Roy Whitley

President and CEO

Rx Outreach

# Rx Outreach®

America's Nonprofit Pharmacy


314-222-0472 or 888-796-1234

RxOutreach.org

questions@rxoutreach.org

Rx Outreach Headquarters
3171 Riverport Tech Center Dr
Maryland Heights, MO 63043

# Do you know someone who has challenges affording and managing their medication needs?

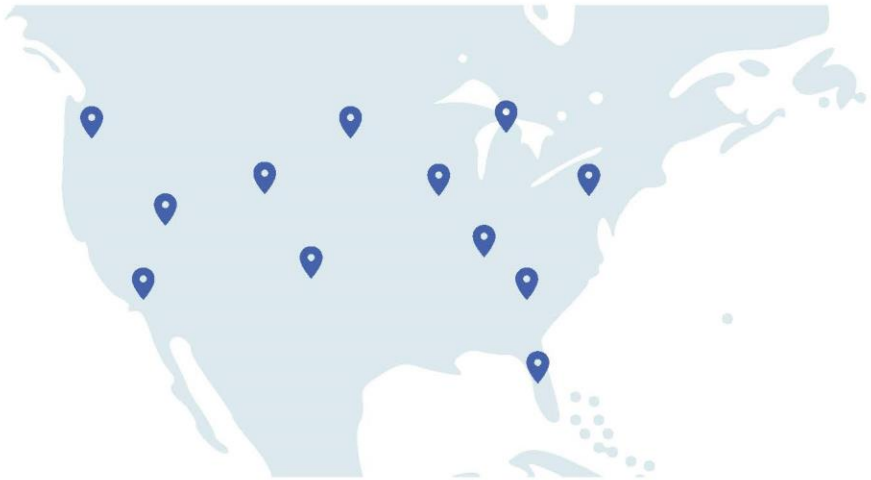
**Of course! We all do.**

This is why Rx Outreach exists.

# Our Mission

**Rx Outreach is the only nation-wide nonprofit pharmacy** that assists patients, prescribers, and partners in reducing **financial, geographic, and social barriers to health** through patient advocacy, community partnerships, and medication access.

# By the Numbers



Since 2010, Rx Outreach has served **over 600,000 patients, saving them over $1B** on prescriptions. RxO provides access to over **1000 medications**, covering most chronic conditions, with shipping and **service to all 50 states and major US territories.**

**600K+ Patients**

**Over $1B Saved on Medications**

**Nearly 4M Prescriptions Filled**

# Who We Serve

Rx Outreach believes all people deserve access to safe and affordable medications, regardless of income, ethnicity, age, or where they live.

All prices are listed on our website. Price includes shipping.
No hidden fees, coupon cards, or memberships required.

We do not run insurance at Rx Outreach.

# Three Primary Programs

## Patient-Centered Affordable Medication Program

**Open to Everyone.**
**No Memberships.**
**No Eligibility Rules.**
**Web/Phone Service.**
**Shipped to Home.**

## Community Partner Network

Clinics & Community Organizations.
Added discount.
Payment & Shipping Options.

## Fill the Gap Medication Assistance & Support Program

Free Medications.
Health Education.
12-Month Enrollment.
Eligibility Requirements.

# Patient-Centered Affordable Meds

## Did you know?

Most people come to Rx Outreach for this program because they're **uninsured or under-insured.**

## Buy a Med, Give a Med?

Patients that use Rx Outreach even if they are not struggling to afford their medications can **still benefit from our prices AND help offset costs for patients** served through our Community Partner Network.

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# Community Partner Network

## Did you know?

Rx Outreach works with **hundreds of Network members** across the United States, providing an added discount for all prescriptions they request.

## What about insurance?

In the St. Louis region, Rx Outreach can **serve both your patients with and without insurance** in one easy process!

The **Dellwood Community Pharmacy by Rx Outreach** is able to use Medicaid, Medicare, and private insurance plans.

Dellwood
COMMUNITY PHARMACY
BY Rx Outreach

# Three Primary Programs

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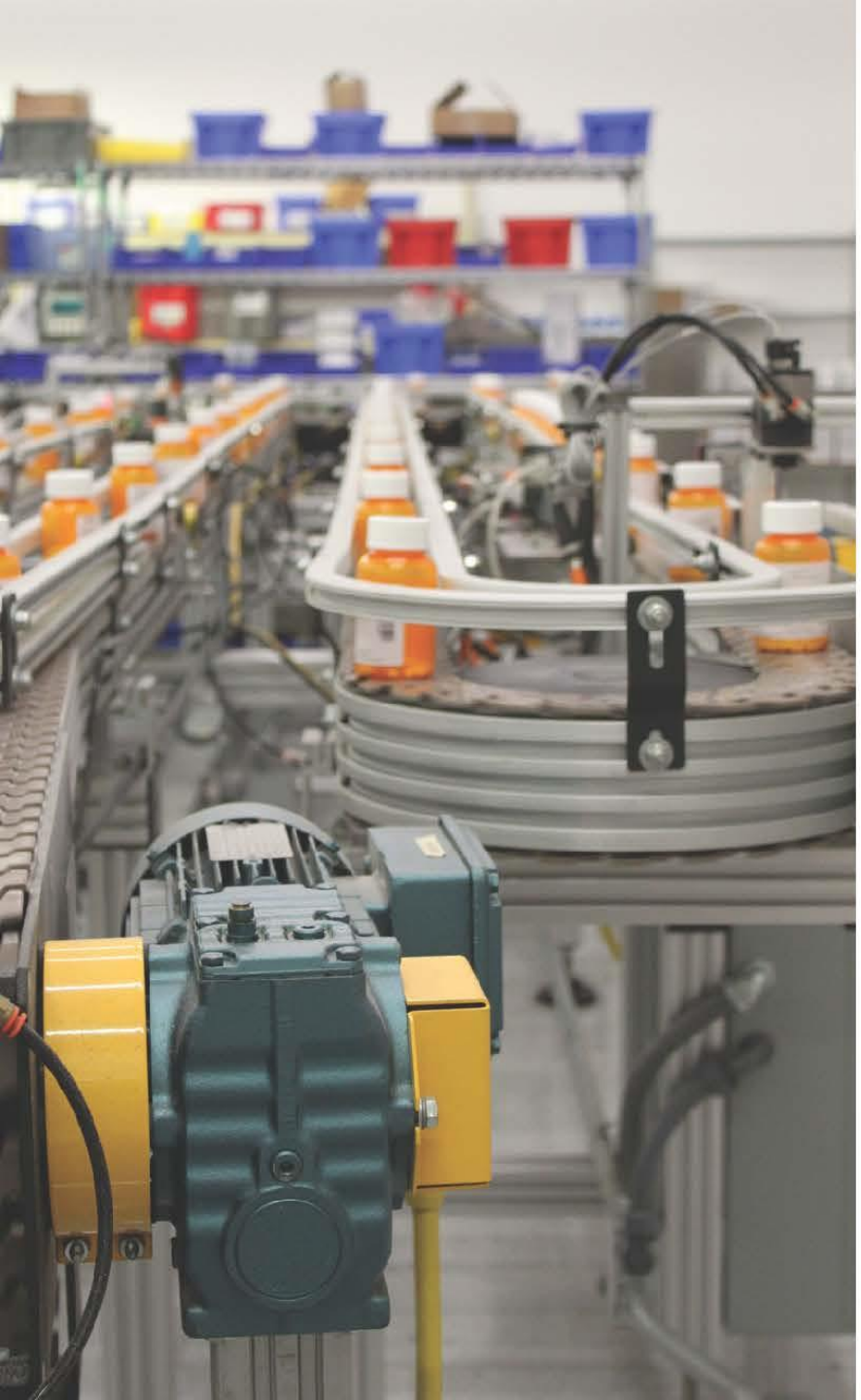

# Fill the Gap

## Did you know?

As Rx Outreach's newest program, **Fill the Gap launched in February 2025.**

## Eligibility Requirements?

To enroll in the Fill the Gap pilot program, a patient must be:

- Between **55-65** years old
- Living **under 300%** of the Federal Poverty Level (approx. $47,000)
- Have medication needs in **cardiovascular, diabetes, or asthma/allergy**
- Live in the **St. Louis** Metro Area

# Thank You


Roy Whitley

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# Health Access Panel

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# Thank you for attending!

To serve you better in future meetings and the rest of 2025, we would love your feedback and suggestions.