A Snapshot of St. Louis Health Care in 2003

HEALTH OUTCOMES

Key Findings from 2003 “Building a Healthier St. Louis” Report

- Persons living in St. Louis City and pockets of St. Louis County – especially the northern portions of the county – had particularly poor health outcomes
- Health disparities were clearly linked to socioeconomic status and race. African Americans had poorer health status than whites for most clinical outcomes
- Disparities were greatest for birth-related indicators such as lack of early prenatal care and low infant birth weight:
  - Lack of early prenatal care carries a risk for prematurity and low birth weight.
  - Premature and low birth weight infants are at substantially higher risk for long-term mental and physical handicap as well as early death
- Other areas of notable disparity between African Americans and whites in our region included the death rates from diabetes and prostate cancer

SAFETY NET ORGANIZATION

Key Findings from 2003 "Building a Healthier St. Louis" Report

- In 2003, 307,000 people in St. Louis City and County were either uninsured or covered by Medicaid (1 in every 5 citizens)
- Limited collaboration and care coordination existed among safety net providers in our community
- The complex and fragmented nature of the health care safety net made it difficult for both patients and providers to navigate, thereby creating barriers to access and contributing to health care disparities
- The health care safety net was under-funded. Barring intervention, this problem would worsen as $23 million per year in current funding would be lost due to expiration of Disproportionate Share Hospital (DSH) payments tied to the former St. Louis Regional Hospital

ACCESS TO CARE

Key Findings from 2003 "Building a Healthier St. Louis" Report

- Safety net primary care sites were broadly distributed geographically, providing access within 20 minutes travel time for the vast majority of uninsured and underinsured patients living in St. Louis City and County
- Patient appointments for preventive and routine primary care were generally available within 14 days of request which was comparable to the private health care sector; however, hours of operation were largely restricted to weekdays between 8:30a.m.–5p.m.
- Despite adequate primary care capacity, many patients utilized hospital emergency departments for non-emergent medical concerns:
  - Non-emergent conditions accounted for 32% of all emergency department visits. Non-emergent visits were equally prevalent among commercially insured, Medicaid, and uninsured patients
  - Nearly half of patients with non-emergent concerns arrived in the emergency department before 4p.m.
- Appointment wait times for subspecialty care were excessive, extending to 3 months or greater for uninsured and Medicaid patients, and there was a projected unmet need for up to 246,400 additional subspecialty visits per year for these populations

ACCESS TO CARE (continued)

Key Findings from 2003 “Building a Healthier St. Louis” Report

- A significant shortage of dentists and behavioral/mental health services for the uninsured and underinsured was reported in the St. Louis region in 2003
- In addition, limited coordination existed between the behavioral health care system and the physical health care system in the region
- Other key barriers to care included:
  - Lack of information about available safety net services
  - Lack of awareness about the importance of preventive and primary care services
  - Lack of insurance, the cost of care, and medical debt
  - Cultural and linguistic barriers for minorities and new Americans
  - Stigma associated with safety net care and perceived lack of provider sensitivity

MAJOR PRIORITIES MOVING FORWARD

Recommendations from 2003 “Building a Healthier St. Louis” Report

Based on the key findings published in the 2003 “Building a Healthier St. Louis” report, the RHC developed 95 specific short-term, intermediate-term, and long-term recommendations focused on the following 5 major priorities:

1) An umbrella organization should be established to create a standing forum that would allow safety net providers to better coordinate and integrate the delivery of primary care and specialty care health services to the uninsured and underinsured
2) Specialty care capacity and referral processes should be enhanced to ensure more timely delivery of specialty care services
3) Strategies and tactics should be developed for reducing cultural and other barriers to care
4) Strategies and tactics should be developed to strengthen behavioral health care capacity and coordination
5) The RHC should work with State and Federal officials to preserve the $23 million per year in transitional DSH funding that helps support safety net care in our community