

May 1, 2001

Attn: CFDA #93.252
HRSA Grants Application Center
1815 North Fort Meyer Drive
Suite 300
Arlington, BA 22209

Dear Grant Reviewer:

I am pleased to submit the Nashville Consortium of Safety Net Providers' application for funding under the Community Access Program. The Consortium consists of providers that serve the uninsured and underinsured in the target area: Davidson County, Tennessee. The purpose of this grant will be to implement the Consortium's "Bridges To Care" program. The total amount of funding requested for the project is \$1,080,819.

The lead organization is the Metropolitan Health Department of Nashville and Davidson County, Tennessee. The contact person for this grant application is:

Stephanie B.C. Bailey, MD, MSHSA (at the letterhead address)
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This application is being submitted as part of the unified submission of Ascension Health for Community Access Program funding. Ascension Health will match approved CAP funding over later years of the project. The contact person for Ascension Health is:

Susan Nestor Levy
Telephone: (314) 253-6466 Fax: (314) 253-6807
Email: slevy@ascensionhealth.org

Thank you for your consideration in this process.

Sincerely,

Stephanie B.C. Bailey, MD, MSHSA
Chairperson, Nashville Consortium of Safety Net Providers and
Director, Metropolitan Health Department of Nashville and Davidson County

NASHVILLE CONSORTIUM OF SAFETY NET PROVIDERS

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3. Community Profile

4. Project Abstract

This application is being submitted on behalf of the Nashville Consortium of Safety Net Providers as part of the unified submission of Ascension Health for Community Access Program funding.

Applicant Community: The Nashville Consortium of Safety Net Providers (Consortium) is pleased to submit this proposal to solidify the infrastructure to improve care to the uninsured and underinsured in Metropolitan Nashville and Davidson County, Tennessee. Joined in this unique partnership are public, private and teaching hospitals, one of the nation's four historically Black medical colleges, the public health department, all the County's federally qualified health centers, clinics for the poor sponsored by the faith community, dental providers, substance abuse treatment centers, and community mental health centers. Historically, these partners have served the region's growing uninsured population mostly isolated from each other's efforts. In 1999, the landmark alliance between Vanderbilt University and Meharry Medical College spawned dialogue with other prospective Consortium members that culminated in the formation of the Consortium. Since January 2000, they have been creating a coordinated system of care to improve health care and the health status of the county's uninsured. Plans include enhancing developing information system that links the uninsured to needed care and integrating the county's mental health and substance abuse providers into the Consortium's clinical practices. This collaboration presents an unprecedented opportunity to weave private provider support with the historical commitment of Nashville's traditional public safety net to create a coordinated system of care for the vulnerable population of the state's capital.

Target Population: The Consortium proposes to target the growing number of uninsured and underinsured persons living in the Nashville/Davidson County area. The uninsured population is predominantly African-American with the numbers of Latinos growing considerably due to the continuing influx of large numbers (446.4% increase in the past decade) whose English proficiency is limited and who cannot obtain health insurance.

Current Delivery System for the Uninsured and Underinsured: There are 22 organizations currently within the Nashville/Davidson County area that serve the uninsured population. These include community organizations that operate primary care, mental health, and substance abuse clinics, the public health department, the county owned public hospital, and other hospitals that serve uninsured patients primarily through their emergency departments. Some utilize a sliding fee schedule for those who do not have insurance or the financial means by which to pay for their care. Others attempt to collect what they can but must write off many of these bills as uncompensated care.

Goals and Projected Results: The Consortium's goal is to improve and expand access to medical, substance abuse, mental and dental health services for all of the County's uninsured and underinsured by creating an integrated, coordinated, culturally sensitive system of care among the county's major providers of health care. It will create Bridges To Care, which will link 4,000 uninsured patients and their families to appropriate "medical homes" and provide them with care management, increase number of presently uninsured patients who are assessed for eligibility in government sponsored health plans, provide transportation and prescription medications for uninsured patients and family members, and institute an aggressive, culturally sensitive

information campaign for patients (especially for those whose English proficiency is limited) and providers about the services available for the uninsured and underinsured. The result will be a coordinated care management system for the uninsured and underinsured featuring accessible, cost-effective services in appropriate clinical settings, and a diminished health status gap between the insured and the uninsured and underinsured.

Activities that the Grant Would Support: The grant will support the enhancement of the “Bridges To Care” infrastructure to improve the delivery of quality, coordinated patient care services to the target population by the partners of the Nashville Consortium. Bridges To Care will build upon existing and developing MIS and programmatic infrastructure among some partners of the Consortium, linking the entire group of Consortium providers into a care management network.

Year 1: The Consortium will enhance its basic electronic Management Information System (MIS) that will link public and private safety net providers. With this enhanced system, program Care Managers will link uninsured emergency patients to “medical homes”, scheduling them for follow-up appointments and other medical, dental, mental health, and substance abuse treatment in more appropriate settings. Care Managers will also screen for transportation and prescription drug needs, making appropriate referrals. Individual care management plans will be developed and patients will be screened for TennCare and other insurance programs. An aggressive, culturally sensitive outreach program will inform the target population about Bridges To Care.

Year 2: Bridges To Care will continue to serve the target population. Using the report capacity of the MIS, the Consortium will monitor the need for additional resources to support its goals, emphasizing the special needs of the Limited English Proficiency patients, shortages of primary and specialty care, and the integration of mental health and substance abuse services with primary care providers. The Consortium will continue to identify and solicit additional resources to address these concerns.

Partners Collaborating in the Project: The Bridges To Care collaborators are the current members of the Nashville Consortium of Safety Net Providers: Metropolitan Health Department of Nashville and Davidson County, the Metropolitan Nashville General Hospital, the Matthew Walker Comprehensive Health Center, United Neighborhood Health Services, Faith and Family Health Clinic, Meharry Medical College, Vanderbilt University Medical Center, Saint Thomas Health Services, Tennessee Christian Medical Center, Baptist Hospital, Centennial Medical Center, Comprehensive Care Center, Centerstone Community Mental Health Centers, Mental Health Cooperative, Buffalo Valley Treatment Center, Samaritan Recovery Community, Pathfinders, and Foundations, Inc. The Consortium also includes a Community Advisory Board with representatives from a variety of public and private community organizations. Ascension Health, parent of St. Thomas Health Services, will provide a financial match for any CAP grant to provide funding over three additional years, and is also a collaborator in this project.

5. Community Needs Assessment

The Nashville Consortium of Safety Net Providers proposes to target the uninsured population of the Nashville/Davidson County area by building upon current collaborations between area providers.

Description of Current Delivery System: The uninsured and underinsured of Nashville/Davidson County are largely dependent on charity and uncompensated care provided by Consortium members. Some specific populations qualify for TennCare, Tennessee's Medicaid managed care demonstration. The Metro Indigent Care Fund also covers some services for qualified patients at Metro Nashville General Hospital. However, significant numbers of low-income patients are not enrolled in these programs.

The predominant providers of care to the uninsured include the Metropolitan Health Department (MHD), which operates a primary care clinic for the homeless and provides a variety of preventative health services for children and adults, and the Matthew Walker Comprehensive Care Center, which provides a full range of primary care, dental and pharmacy services. United Neighborhood Health Services runs six Nashville clinics, and the Siloam Family Health Center also serves the uninsured. Both of these organizations offer a full range of primary care and pharmacy services. The Interfaith Dental Clinic provides preventative and restorative dental care services. Clinics sponsored by Vanderbilt University, Meharry Medical College, St. Thomas Hospital, and Metro Nashville General Hospital also care for the uninsured. A new center, the Faith and Family Health Clinic, scheduled to open in July 2001, will serve the working uninsured. Providers participating in a recent survey reported a total of 96,720 annual patient visits from uninsured patients in 2000.

Substance abuse and mental health service providers also serve Nashville's uninsured. Six Nashville organizations provide alcohol and drug treatment programs. These providers offer residential and outpatient programs for adolescents and adults. Several of these organizations also offer mental health services. Three other organizations provide mental health services for the uninsured and underinsured, treating a range of disorders for people of all ages. All of Davidson County's providers of substance abuse treatment and mental health care for the uninsured are members of the Consortium.

Despite the breadth of services offered to Nashville's uninsured, the absence of a coordinated referral system, lack of information about what is available, and transportation barriers make it difficult for patients to access available services. Consequently, a large proportion of Nashville's uninsured receive most of their medical care at one of the area's hospital emergency departments. In 2000, six Nashville emergency departments saw 26,854 uninsured patients. The Consortium will remedy this by creating an integrated network that will help the uninsured and underinsured receive care in appropriate settings.

Barriers and gaps to care in the current delivery system include:

- Lack of health insurance
- Lack of transportation
- Inadequate information about where the uninsured can receive care

- Inability to afford medications
- Inadequate identification of mental health and substance abuse problems
- Inability to afford specialty care
- Language barriers for non-English speakers

Target Population: Bridges To Care targets uninsured residents of Davidson County (map attached in Appendix 1). On average, Davidson County is more racially diverse than the state of Tennessee. Minorities compose 33% of the population of Davidson County. Just over 25% of the county's residents are African-American, and the 2000 Census reports that 4.6% are Hispanic, although it is likely that this number does not include the rapidly growing number of undocumented Spanish-speaking immigrants.

Nashville has the second highest uninsured rate in the state of Tennessee. Of the 569,891 Davidson County residents, approximately 45,591 (or 8%) are uninsured. Davidson County's uninsured residents tend to be younger (59% are age 14-44) and less wealthy (70% with household incomes less than \$40,000) than their insured counterparts. Bridges To Care would potentially affect all of the uninsured in the area.

A 1996 telephone survey conducted by the Social Science Research Institute and the University of Tennessee identified some of the reasons why residents do not have insurance coverage. One reason is that they work with employers who either do not offer insurance or who require employee contributions that workers cannot afford. Other uninsured residents do not realize that they qualify for TennCare, or earn too much to qualify but are still unable to afford private coverage. Undocumented immigrants migrating into the area face substantial challenges in obtaining insurance both because they often do not qualify for government plans and because they have difficulty gathering information about how to obtain coverage.

Nashville faces new challenges because of the substantial demographic transition that Davidson County is undergoing. Many of the county's previous residents have left the area, and individuals who are demographically dissimilar are replacing them. A substantial proportion of Davidson County's new immigrants are Latino or Hispanic. The 2000 census shows that there are 26,091 Hispanics in Davidson County. This represents a 446.4% increase in Nashville's Hispanic population in a decade. A recent article in The Tennessean quotes representatives of the Hispanic community who claim that the actual number is 45,000, which is 172% of the census estimate. National surveys suggest that Hispanic workers are disproportionately likely to work in jobs that do not offer health benefits. In addition, Nashville's Hispanic population must overcome communication difficulties, cultural health beliefs, immigration status, and lack of transportation as they attempt to access medical care. Bridges To Care will open access to these individuals by providing transportation and making care management available in Spanish.

Projection of Potential Changes in Insurance Coverage: Nashville's uninsured population is projected to grow significantly in the coming years for several reasons. As individuals who are currently covered by TennCare undergo reverification of their eligibility, it is likely that many of them will lose TennCare coverage. Reductions in TennCare enrollment are likely because the TennCare Bureau has finally received permission from the federal court to verify the eligibility of its TennCare enrollees that are covered under the "uninsured" and "uninsurable" categories. There has been no verification of eligibility for this population since 1994. Many of these

persons, especially those covered under the uninsured provisions, will no longer meet these criteria and will be dropped from coverage, largely because their financial and employment situations have changed since enrollment. Moreover, it is clear to the Consortium that TennCare will not be able to keep up with Davidson County's future insurance demand.

Increasing unemployment is also likely to increase the number of uninsured. According to a March 27, 2001 New York Times article, the "slowing economy and renewed double-digit inflation in health insurance costs are all but certain to cause an increase in the uninsured later this year and next, in the view of experts from foundations, business and consumer groups and the insurance industry." These factors will swell the ranks of uninsured and underinsured patients who look to Consortium providers for medical care.

Assessment of Most Urgent Needs: During a series of planning meetings on the problems faced by the uninsured and underinsured in Nashville, the Consortium identified most urgent needs. Listed not in order of priority, they are as follows:

1. Large numbers of potentially eligible persons are not enrolled in TennCare or the Metro Indigent Care Fund.
2. A high number of uninsured persons do not have a "medical home" for primary care treatment. Consequently, they are going from one health care setting to another with little continuity of care or seeking primary care at hospital emergency departments.
3. The uninsured have limited access to primary care providers because of inconvenient hours, lack of information, and transportation barriers, and a lack of provider capacity among those who see uninsured patients.
4. Many uninsured persons have unidentified and untreated mental health and substance abuse problems.
5. Access to preventative and restorative dental care is an urgent need. MHD and United Neighborhood Health Services have been forced to cut a total of 7000 patient visits annually from their dental programs, intensifying the need for dental care for the uninsured.
6. Uninsured people are foregoing care due to difficulties finding transportation to health care providers or a lack of money to pay for prescription drugs.
7. Uninsured people in Davidson County have inadequate information about what services are available for the uninsured.
8. Language and cultural differences are major barriers to health care for large numbers of new immigrants to Nashville.
9. Financial barriers prevent the uninsured from accessing specialty care providers.

This proposal targets those needs that can be effectively addressed by the Consortium consistent with the goals of the CAP program.

6. Evidence of Progress Towards Developing an Integrated System of Care for the Target Population

Evidence of Community-wide Collaboration: The Nashville Consortium of Safety Net Providers is not aware of any other CAP grantees or applicants in Nashville/Davidson County. Through Bridges To Care, the Consortium serves a population that has not previously been targeted by a CAP program and offers this group access to a comprehensive network of medical care, dental care, substance abuse and mental health providers.

History and Progress of Collaboration: While the Consortium did not become a formal entity until May 2000, there is a long history of collaboration among these providers to improve the delivery of care to the uninsured in Nashville. These include the formation of the regional Community Health Agency (CHA) created with state support to bring together safety net providers, health educators and social services. The Davidson County CHA conducted some of the first studies on the uninsured in Nashville and the capacity of available services in the early 1990's before being replaced by an agency focused on regional children's services. In 1992, United Neighborhood Health Services, Inc., and Meharry Medical College developed an affiliation that placed the Family Practice Program Residents at a UNHS clinic site, increasing the care to the uninsured and assuring community-based training. In 1995, United Neighborhood Health Services, Inc., Matthew Walker Comprehensive Health Center and Meharry Medical Foundation developed an integrated service network, developed joint protocols and assured community health center users of specialty referrals.

A key event occurred in 1997 with the formation of the Meharry-Vanderbilt Alliance, a unique partnership between Meharry Medical College and Vanderbilt University Medical School. This Alliance eventually led to Metropolitan Nashville General Hospital contracting with Vanderbilt for its CEO, COO, and CFO while Meharry continued to provide its clinical services. Beginning in 1999, the Alliance undertook several projects focusing on diabetes. One that is funded by Nashville Memorial Foundation, links community-based treatment centers that provide care to minority and low income patients with diabetes in Middle Tennessee. Meharry Medical College Ambulatory Care Clinic, Matthew Walker Health Center, United Neighborhoods Health Center, Vanderbilt University School of Nursing Clinics, The Vanderbilt Clinic, Metropolitan Hospital and clinics, St. Thomas Family Health Center, and the Metropolitan Health Department are working collaboratively to meet project goals. Based on established chronic disease management and quality improvement models, the program will rely heavily on nurse educators to provide state-of-the-art care for patients with Type 2 diabetes. MVA has also undertaken additional projects aimed at diabetes treatment and prevention.

The organizations that became involved in care management projects through the Meharry-Vanderbilt Alliance have now taken that experience and are applying it to the specific needs of Nashville residents through the Consortium. For the last two years several original members of the Consortium have also collaborated on the CDC funded REACH 2010 Project to reduce the incidence of cardiovascular disease and Type 2 diabetes in Nashville's African American population. Through this project, Consortium members have gained experience in working together with community members to improve the health of a largely low-income and often uninsured population. The Meharry-Vanderbilt Alliance and REACH 2010 Project demonstrate that Consortium members are eager to put their experience and expertise to use in

serving the uninsured by creating more far-reaching and comprehensive projects than any one provider could undertake alone.

An integrated infrastructure would allow Consortium members to draw on each other's strengths and mutual commitment to improve care for the uninsured and underinsured. It was this vision that led the Consortium to develop the Bridges To Care program. The Consortium's Board of Directors, Executive Committee, and Community Advisory Board have all been meeting regularly during the last year to plan and begin implementing Bridges To Care. Attendance at these meetings has been excellent and the Consortium partners have exhibited commitment to working together to coordinate care for the uninsured.

The Consortium's first project has been to link its members together through an Internet based patient referral and service tracking system. The system was designed by representatives of the participating partners who met regularly during the fall of 2000. The preliminary design was then reviewed and modified through onsite meetings with administrative and clinical staff at each of the hospital emergency departments and clinics. A software development firm is now writing the application. This basic MIS system will be fully implemented among all participating Consortium partners by September 2001. The cost of this project has been absorbed by Metro Health Department. (See Appendix 3 for a description of the system.)

During the first year of its formal existence, the Consortium added seven new participating partners. Chief among these have been all of the mental health and substance abuse agencies in Nashville who provide services to those without insurance regardless of their ability to pay. Also joining the Consortium has been the Comprehensive Care Center, a community based organization that serves patients with HIV/AIDS, and the Faith and Family Medical Clinic, a new primary care clinic that focuses on the working uninsured. The Consortium is in discussions presently with the few remaining organizations that serve the uninsured and hopes to have them become formal partners in the near future.

Formal Arrangements Already Established within the Community: The members of the Nashville Consortium of Safety Net Providers have signed a Memorandum of Agreement committing them to participate in the Bridges To Care electronic patient referral and service tracking system. They have also adopted a set of by-laws that demonstrate their commitment to a long-range collaboration aimed at creating an integrated system of care for the uninsured. These documents, and the Meharry-Vanderbilt Alliance bylaws, are attached in Appendix 2.

Capacity to Assume Grant: The lead organization of Bridges To Care is Metro Health Department (MHD). MHD is a functional unit of the Metropolitan Government of Nashville and Davidson County, a political subdivision of the State of Tennessee. MHD operates under the auspices of the Metropolitan Board of Health as authorized by the Charter of the Metropolitan Government of Nashville and Davidson County.

The annual operating budget for MHD exceeds \$28 million with more than \$10 million of the total budget received from grants. Some of the grants currently received by this department are listed in Table 6.1.

As a local government entity, MHD is a participant in the Single Audit process, which involves an annual review of the fiduciary practices and policies of all departments within the Metropolitan Government of Nashville and Davidson County. Purchases and other expenditures are executed in accordance with the established policies of the Metropolitan Finance Department.

MHD has experience managing and administering substantial grants and the Metropolitan Government oversees its fiscal accountability. All Consortium members have agreed that MHD will serve as the fiscal agent of the Consortium, and will be responsible for the receipt and dispersal of any Consortium funds (See Consortium Bylaws, art. III § 6, attached in Appendix 2).

Table 6.1 Grants Managed by the MHD, FY 2001

Name	Source	Amount
Supplemental Food – WIC	US Dept. of Agriculture	\$ 1,453,600
Supplemental Food – CSFP	US Dept. of Agriculture	\$ 208,200
Air Pollution Control	Environmental Protection Agency	\$ 857,758
Health Care for the Homeless	US Dept. of Health and Human Services	\$ 647,174
Children Special Services	US Dept. of Health and Human Services	\$ 628,300
Family Planning	US Dept. of Health and Human Services	\$ 319,000
Grant-In-Aid	US Dept. of Health and Human Services	\$ 749,474
Sexually Transmitted Disease	US Dept. of Health and Human Services	\$ 540,000
Tuberculosis Control	US Dept. of Health and Human Services	\$ 384,000
AIDS Prevention	US Dept. of Health and Human Services	\$ 455,000
Adolescent Pregnancy Prevention	Tennessee Department of Health	\$ 51,000
Community Development	Tennessee Department of Health	\$ 155,000
Families First	Tennessee Department of Human Services	\$ 211,200
Renal Intervention	Tennessee Department of Health	\$ 50,000
TennCare Eligibility/Reverification	Tennessee Department of Finance and Administration	\$ 1,304,800
Healthy Start	Tennessee Department of Health	\$ 442,800
Nashville REACH 2010	US Dept. of Health and Human Services via Matthew Walker Comprehensive Health Center	\$ 156,636
Mobile Clinic	United Way of Middle Tennessee	\$ 294,000

7. Statement of Project and Budget

Statement of Project: The underpinnings of care for the uninsured and underinsured in Nashville and Davidson County, Tennessee have shifted markedly in the past 15 years due first to expansion of the Medicaid program then to the introduction of mandatory managed care for the Medicaid population (TennCare). While the former changes meant increased rates for Medicaid providers enabling traditional safety net providers to cost shift uncompensated care to Medicaid, the implementation of TennCare expanded coverage initially to many previously uninsured but reduced payments and the ability of traditional safety net providers to shift costs.

As a result, MHD closed six of its neighborhood primary care clinics and declined to continue as a Medicaid provider under TennCare. Metro Nashville General Hospital, Davidson County's public hospital, relocated to the campus of Meharry Medical College. These and other shifts in financing, location, and eligibility made the search for services more confusing and difficult for those in need. When Nashville's traditional safety net providers and others formed the Nashville Consortium of Safety Net Providers, they knew the first priority was to identify and sort out services that are available for the uninsured and underinsured, coordinate them, identify urgent gaps in these services, and attract resources to supply urgent needs. Their goal is to create a system of care for the uninsured and underinsured to improve their quality of care and health outcomes.

After a year spent developing the Consortium and identifying the best ways to address the urgent needs of the target population, the Consortium concluded that the large numbers of uninsured patients seeking non-emergent care at the county's hospital emergency departments suggested that the system had several flaws. The uninsured's pattern of seeking primary care in emergency rooms indicated that they lacked information about the availability of primary care at community health centers and other primary care providers, lacked transportation to those sites, and lacked insurance to choose other providers. The Consortium developed Bridges To Care to address those urgent needs and provide the community with the information and infrastructure to adjust as needs change.

Bridges To Care has four objectives:

- Link 4,000 uninsured patients and their families to appropriate "medical homes" and provide them with care management services;
- Increase the number of presently uninsured patients who are screened for eligibility for TennCare and the Metro Indigent Care Fund;
- Provide transportation and prescription medications for uninsured patients and family members enrolled in Bridges To Care; and
- Institute an aggressive, culturally sensitive information campaign for uninsured patients, especially for those whose English proficiency is limited, and for providers about the services available for uninsured and underinsured patients.

Care Management - Bridges To Care will improve the health of uninsured and underinsured patients by coordinating their medical care. The current fragmented system does not holistically address the medical, mental, dental, and substance abuse needs of uninsured patients because

complete care assessment is not available for the uninsured and underinsured in Davidson County. Bridges To Care will link them to primary care providers and make referrals to dental, mental health, and substance abuse services if needed.

An uninsured person who receives treatment at a hospital emergency room will be invited to meet with a Bridges To Care Care Manager. The Care Manager will assess the patient's medical care, mental health, substance abuse, and dental health needs. Using the information gained through this assessment, the Care Manager will develop a care plan with the patient. The care plan will identify the most appropriate primary care "home" and all other providers necessary to meet the needs of the patient. Along with contact and demographic information, the Care Manager will enter this care plan into the Management Information System (MIS). Using the MIS, the Care Manager will be able to schedule appointments in real time with participating Consortium partners. The Care Manager will also use the MIS to screen the patient for insurance eligibility and for the pharmacy and transportation programs. This process is depicted in Chart 8.2: "Bridges To Care Patient Services Flow" on page 32.

Because of resource limitations it will not be possible to have a Care Manager stationed in each hospital 24-hours a day. Instead, Care Managers will primarily be scheduled to work in the evenings and on weekends, the time when the uninsured are more likely to come to the hospital seeking non-emergency primary care. If an uninsured patient arrives when a Care Manager is unavailable, hospital emergency department staff will have access to the MIS system, will be able to enter the patient's contact information into the Bridges To Care database, and can schedule the patient to meet with a Care Manager at a convenient time.

The Consortium intends to contract with a private community-based organization to provide case management and outreach services for Bridges to Care. Through a competitive bidding process, the Consortium will identify an organization that has demonstrated a history of providing case management to low-income patient populations and to those whose English proficiency is limited. There are at least four Consortium members that could provide this service.

Screening for TennCare Eligibility - One part of the patient's interview with the Care Manager will be a screen for insurance eligibility. Information entered into the MIS will allow the Care Manager to determine whether the patient is eligible for TennCare or for the Metro Indigent Care Fund. If the patient qualifies for TennCare, the Care Manager will prepare the TennCare application. If the patient qualifies for the Metro Indigent Care Fund, the Care Manager will certify the patient for that program. If the patient is ineligible for either of these programs, they will then be invited to enroll in Bridges To Care.

Transportation and Prescription Drugs - Bridges To Care will meet the need for transportation and prescription drugs by expanding currently existing programs. MHD presently manages a transportation program for 116,800 TennCare enrollees in Davidson County. The Consortium will expand this program to cover Bridges To Care enrollees who have transportation needs, who are not covered by TennCare, and who have an appointment with a medical provider within the Consortium system. This transportation service will encourage patients to join Bridges To Care because enrolling will qualify them for transportation, and it will

help retain patients in appropriate care programs because they will have a means of traveling to their appointments.

Metro Nashville General Hospital operates a prescription drug program for qualified indigent, legally documented, residents of Davidson County. Metro General's prescription program takes advantage of pharmaceutical manufacturers' support for programs for low-income patients, thereby reducing costs substantially. The Nashville Consortium will extend this program to Bridges To Care enrollees. However, the financial eligibility requirements will be based on the federal poverty guidelines and undocumented residents of Davidson County will be eligible. Like the transportation program, this prescription drug program will help encourage patients to join the Bridges To Care network and will help to fulfill their medical needs.

Information Campaign - Bridges To Care will provide uninsured Nashville residents with information about how and where they can obtain medical care, mental health services, substance abuse treatment, and dental care. The Bridges To Care information campaign will inform uninsured residents not only about Bridges To Care, but also about other medical and social services for the uninsured and underinsured. A key component of the campaign will be the distribution of a comprehensive, printed and Internet based Resource Directory. The directory will enable uninsured residents and their social service and health care providers to determine the location and availability of services and the eligibility criteria.

A second component of the campaign will be radio announcements, brochures, posters, flyers, and other public media that will promote the Bridges To Care phone number to call for information about available services. Information materials will be available in both English and Spanish so that as many of Nashville's uninsured as possible will be able to learn how to access the care that they need. Finally, Bridges To Care staff will visit community leaders and make presentations to community organizations to promote the program and build relationships and trust among the African American, Latino/Hispanic and other minorities that have large numbers of uninsured persons.

Relationship of Objectives to Community Needs Assessment – Bridges To Care will meet several of the most urgent needs of the Nashville/Davidson County uninsured population by linking each patient to a medical home for primary care and making referrals to other needed providers along the medical/psycho/social continuum. It will address patients' uninsured status directly by screening them for TennCare and the Metro Indigent Care Fund. Bridges To Care will confront the needs for transportation and prescription medication by expanding currently existing programs to offer these services to the uninsured and underinsured. The Bridges To Care information campaign will help fill the need for information about services that are available to the uninsured. Meeting these objectives will advance the primary mission of Bridges To Care: improving the health status of Nashville/Davidson County's uninsured.

Project Management Matrix:

Objective 1: Link 4,000 uninsured patients and their families to appropriate 'medical homes' and provide them with care management.			
Action Steps	Timetable for Each Action Step	Responsible Organization or Person	Anticipated Results
<i>A. Staff Recruitment and Hiring</i>			
Action Step 1: Recruit, hire, and orient Bridges To Care (BTC) administrative staff (Project Director, MIS Manager, and Administrative Assistant).	September – October, 2001	Consortium Board, Metro Health Department	BTC staff in place, ready to begin implementing the program by November 1
Action Step 2: Develop RFP, receive proposals and select BTC Contractor (for care management and community outreach activities).	July - September, 2001	Consortium Board, Metro Health Department	BTC Contractor identified, contract terms approved, Contractor ready to begin recruitment of staff by October 1, 2001
Action Step 3: Recruit, hire, and orient BTC program staff (Care Management Supervisor, Administrative Assistant, Care Managers, Community Outreach Director).	October – December, 2001	Project Director and BTC Contractor	All BTC program staff in place by January 1, 2002
<i>B. Install Patient Screening, Medical Care Plan and Extracted Clinical Record Modules</i>			
Action Step 4: Establish Joint Application Design (JAD) Teams to develop specifications for MIS expansion modules: patient screening, care plan, and extracted clinical record.	November 2001	Project Director and MIS Manager	JAD Teams for screening modules and the extracted clinical record in place and meeting by November 15, 2001
Action Step 5: JAD Teams meet to develop the protocols for medical, mental health, alcohol and drug, and dental screening and design the care plan format.	November – December, 2001	Project Director, MIS Manager, MIS Consultant, Legal Consultant, JAD Teams	Screens designed and fields defined for the screening modules and the care plan module by December 15, 2001

Action Step 6: JAD Teams meet to determine the fields to be included in the extracted clinical record based on an assessment of each Consortium partner's MIS system.	November – December, 2001	Project Director, MIS Manager, MIS Consultant, Legal Consultant, JAD Team	Extracted clinical record fields defined for inclusion in the Consortium MIS database by December 15, 2001
Action Step 7: Develop, review, modify, approve, then test and install patient screening and extracted clinical record modules. Train Care Managers to use the new modules.	December 2001- February, 2002	MIS Manager, MIS Consultant, Legal Consultant, JAD Teams	Patient screening, care plan and extracted clinical record modules are ready for use by BTC Care Managers and Consortium partners by March 1, 2002
Action Step 8: Based on HIPAA regulations, including privacy regulations and other considerations, develop and test appropriate BTC patient consent and authorization protocols, notices of privacy practices, business associate agreements, bilingual forms and other materials.	January – February, 2002	Project Director, Legal Consultant, BTC staff, MIS Consultant, Consortium Board	MIS security protocols in place to assure adherence to patient privacy regulations; patient forms tested by actual patients for usability; care management privacy protocols in place
Action Step 9: Implement use of patient screening, medical care plan, and extracted clinical record modules.	March 2002	Care Managers, MIS Manager	BTC enrollees assessed and care plans designed using care management modules
Action Step 10: Conduct survey of BTC enrollees and Consortium provider staff to measure satisfaction with the BTC care management program.	April and August, 2002	Evaluation Team	Feedback from target population is used to modify program structure/design as appropriate
<i>C. Install Patient Appointment Scheduling Module</i>			
Action Step 11: Assess scheduling systems at each Consortium site	January - February, 2002	MIS Manager and MIS Consultant	Scheduling needs for MIS system determined

Action Step 12: Determine requirements for report generation (“Printing”) and facilities interface for Consortium sites, Care Managers and care providers.	March, 2002	Project Director, MIS Manager, MIS Consultant, JAD Team	Detailed design of reports and interface completed
Action Step 13: Develop Printing and Facilities Interface components for patient scheduling, facility scheduling, and administration components.	April-May, 2002	MIS Manager and MIS Consultant	Patient and facility scheduling systems and administration component ready for testing
Action Step 14: Test and install patient scheduling module and train staff to operate it.	June -August, 2002	MIS Manager	Technical difficulties resolved; and staff members ready to use the patient scheduling system
Action Step 15: Implement use of patient scheduling module.	September 1, 2002	Care Managers, MIS Manager	BTC enrollees scheduled for appointments by Care Managers using scheduling system
Objective 2: Increase number of presently uninsured patients who are assessed for eligibility in TennCare and Metro Indigent Care Fund.			
Action Step 1: Develop, review, modify, approve, then test and install eligibility determination screens (Part of Obj. 1, Action Step 7).	December, 2001-February, 2002	JAD Team, MIS Manager, MIS Consultant	TennCare and Metro Indigent Care Fund eligibility screening modules ready for approval and implementation
Action Step 2: Implement use of TennCare and Metro Indigent Care Fund eligibility determination screens.	March - September, 2002	Care Managers, MIS Manager	Uninsured patients screened for TennCare and Metro Indigent Care Fund by Care Managers using eligibility determination screens

Objective 3: Provide transportation and prescription medications for uninsured patients and family members enrolled in Bridges To Care.			
Action Step 1: Negotiate and sign an agreement with Metro Nashville General Hospital for implementation of the pharmacy program.	October 1, 2001	Consortium Board, Metro Health Dept, Metro Nashville General Hospital	Contract for BTC pharmacy program established
Action Step 2: Develop transportation screening and pharmacy screening modules for BTC MIS system.	December 2001 - January 2002	MIS Manager, MIS Consultant	MIS transportation screening module ready for approval and implementation
Action Step 3: Review, modify, approve, install, and train staff on pharmacy and transportation screening modules.	February, 2002	MIS Manager, MIS Consultant, JAD Team	BTC enrollees assessed for transportation needs, provided services if eligible
Objective 4: Conduct an aggressive, culturally sensitive information campaign for uninsured patients, especially for those whose English proficiency is limited, and for providers about the services available for uninsured and underinsured patients.			
Action Step 1: Survey Consortium providers, social services agencies to compile data for BTC Resource Directory	November – December, 2001	Project Director	Care Managers have Resource Directory to assist in making care plans for BTC enrollees
Action Step 2: Develop, test and implement online public Bridges To Care website.	January - February, 2002	Project Director, MIS Manager, MIS Consultant	The uninsured/underinsured, providers, Care Managers, social workers, others will have online access to BTC Resource Directory and other useful information
Action Step 3: Develop a public information campaign including brochures, radio announcements/interviews, flyers, posters, presentations to community groups, etc.	December 2001 - January 2002	Project Director, Community Outreach Director	Public information materials are ready for distribution at appropriate time

<p>Action Step 4: Visit community leaders, community organizations, African American, Latino/Hispanic and other targeted community groups to develop relationships and build trust.</p>	<p>November 2001 - September 2002</p>	<p>Project Director, Community Outreach Director</p>	<p>Increased awareness and support of BTC program among community groups and target population; community group feedback into BTC program design</p>
<p>Action Step 5: Public information campaign is implemented.</p>	<p>February - September 2002</p>	<p>Community Outreach Director</p>	<p>Increased awareness of BTC benefits among uninsured/underinsured, providers, policy leaders, potential and outside funders</p>

Management Information Systems: The Bridges To Care Management Information System is a critical component in the Consortium’s efforts to integrate care for the uninsured. It will connect BTC Care Managers to patient information, provider resources and social services, enabling them to schedule appointments for the uninsured in “medical homes”, assess the patient medical/psycho/social status, and refer them for transportation, prescription drug assistance and other services as needed. This proposal requests funds to expand the base MIS system. The base MIS simply captures the place and date of service and diagnoses. Please see Appendix 3 for a detailed description of the Management Information System.

Organizational Structure and Accountability: Bridges To Care will be managed and overseen by the Consortium. The Consortium is composed of the safety net providers in Davidson County. Each of these providers is represented on the Consortium’s Board of Directors. The Consortium’s Board of Directors meets once every two months, and more often if necessary. During the months that the Board does not meet, a smaller Executive Committee convenes to keep track of Consortium projects. In addition to the Executive Committee, the Board of Directors has four standing committees. The Program Committee oversees the design and implementation of Consortium Projects, such as Bridges To Care. The Fund Raising Committee pursues opportunities for funding Consortium programs through private and government sources and the Finance Committee oversees Consortium finances. Funds from the Community Access Program grant, for example, would be managed by Metro Health Department with oversight by the Finance Committee. Finally, the Clinical Quality Committee ensures to the Board that Consortium projects provide quality care that will improve the health status of the uninsured.

The Consortium also has a separate Community Advisory Board composed of other community organizations and patient advocates. This Advisory Board seats five representatives on the Consortium’s Board of Directors. An Evaluation Committee that is part of the Community Advisory Board assesses the effectiveness of Consortium projects. A diagram of the Consortium’s Structure is attached in Appendix 4-A.

Bridges To Care is accountable to the Consortium’s Board of Directors. Staff provided as an in-kind donation by the Metro Health Department will provide overall management for the program. Accountability for the Bridges To Care’s care management, community outreach, and expanded MIS components rests with the Project Director. The Project Director will oversee the MIS Manager, the Care Management Supervisor, and the Community Outreach Director and will work to ensure that these services are integrated. The Consortium will contract with a local community based organization to employ the Care Management Supervisor, the Care Managers, the Community Outreach Director, and the Administrative Assistant.

In addition to care management, community outreach, and MIS expansion, another major function of Bridges To Care is the provision of transportation to qualified patients. The TennCare Transportation Director, whose services are also an in-kind donation from MHD, and a Transportation Clerk will operate the Transportation Program. Together, they will work to make sure that Bridges To Care patients have the

transportation that will allow them to attend their appointments and thus receive the benefits of the Bridges To Care initiative.

The Pharmacy Program will be operated through a contract with the pharmacy program at Metro Nashville General Hospital. The Director of Community Assessment and Health Promotion at Metro Health Department will coordinate this contract.

Evaluation of the Bridges To Care program will be conducted under the direction of the Evaluation Committee of the Consortium’s Community Advisory Board. MHD’s Director of Research and Evaluation and the staff of this division will carry out the research and analysis functions associated with the evaluation.

The Bridges to Care Organizational Chart is attached in Appendix 4-B.

Budget Plan:

This itemized Budget breaks down the CAP funds requested for implementation of Bridges To Care.

PERSONNEL:¹

Project Director (1.0 FTE)	\$59,583
Manager Consortium MIS (1.0 FTE).....	45,833
Research Analyst for Evaluation (0.5 FTE).....	16,271
Transportation Clerk (0.33 FTE).....	5,500
Fringe Benefits (@ 34 %)	43,244

TOTAL: PERSONNEL \$170,431

EQUIPMENT:

Desktop computers/software (1,100 per 2 units)	\$2,200
Desktop printers (250 per 2 units).....	500
Uninterruptable power supply units (85 per 2 units).....	170
Ergonomic workstations (1500 per 2 stations).....	3,000
Cell phones (150 per 2 units)	300
Purchase of server	25,000
Fees for setup and maintenance of MIS server	2,400
Computer equipment upgrades at Consortium sites.....	20,000

TOTAL: EQUIPMENT \$53,570

¹ Assumes staff are employed by beginning of second month of the grant year.

SUPPLIES

Office and printing supplies at MHD \$2,860
Telephone (3 phones @ \$30/month)..... 990
Cell phone charges (2 phones @ \$30 /month) 660

TOTAL: SUPPLIES \$4,510

TRAVEL

Project Director (1500 x 2 trips to HRSA)..... \$3,000
Local travel (.32 x 1200 miles rate per year x 2 people)..... 704

TOTAL: TRAVEL..... \$3,704

CONTRACTUAL

Bridges to Care contractor (see detail on page 25) \$468,647
Legal consultant 20,000
Pharmacy benefit with Metro Nashville General Hospital (for
medications and a dispensing fee @ \$4 per prescription) 120,000
MIS Consultant 180,000

TOTAL: CONTRACTUAL \$788,647

OTHER

Evaluation Program (see detail on page 25)..... 29,957
Transportation for Patients 30,000

TOTAL: OTHER \$59,957

TOTAL: ALL BUDGET \$1,080,819

BRIDGES TO CARE CONTRACTOR EXPENSE BUDGET DETAIL

BTC Personnel (assumes staff employed beginning in the 4th month of the grant year)

Care Management Supervisor (100% @ \$50,000/yr).....	\$41,667
Administrative Assistant (100% @ \$25,000/yr).....	20,833
Care Managers (8 @ \$32,500/yr).....	195,000
Community Outreach Director (100% at \$32,500/yr)	24,375
Fringe Benefits (0.23)	63,394
Total Personnel.....	\$345,269

BTC Equipment

8 Notebook computers (\$2,700 per unit)	\$21,600
8 Notebook printers (\$300 per unit).....	2,000
3 Desktop computers (\$1,100 per unit).....	3,300
3 Desktop printers (\$250 per unit)	750
3 Uninterruptable power supply (485 per unit).....	255
9 Cell phones (\$150 per unit).....	1,350
3 Ergonomic work stations (\$1,500 per station)	4,500
Total Equipment.....	\$33,755

BTC Supplies

Internet service (22 per month x 11 users).....	\$2,178
Office and printing supplies (10 people @ 20 per week).....	7,800
Cell/telephone charges (11 phones @ 30 per month)	2,970
Space/utility cost for 3 persons (1000 sq. feet x 15)	11,250
Total Supplies	\$24,198

BTC Travel

Care Management Supervisor (1500 x 2 trips to HRSA).....	\$3,000
Local travel (.32 x 1500 miles per year x 10 people).....	3,600
Total Travel	\$6,600

Administrative Overhead (12% of salary expense) \$33,825

Community Outreach Campaign \$25,000

TOTAL at Contractor \$468,647

EVALUATION PROGRAM EXPENSE BUDGET DETAIL

Field supervisor (420 hours at \$18.75 per hour).....	\$7,875
Telephone Interviewers (1600 hours at \$10.71 per hour).....	17,136
CATI Programming (100 hours at \$27.46 per hour).....	2,460
Supplies and printing.....	2,200

TOTAL: Evaluation Program..... \$29,957

Although the Nashville Consortium has made great strides in building the partnership among Nashville's safety net providers and developing its basic MIS, additional funds are necessary to implement Bridges To Care. The basic MIS does not support comprehensive health needs assessment, development of care plans, scheduling referral appointments, determination of eligibility for TennCare or the Metro Indigent Care Fund, or sharing extracted clinical records among providers. The Consortium has no assets of its own. Although all Consortium partners are contributing to this project through participation in planning and in-kind donations, these resources are not sufficient to construct the infrastructure that will allow Bridges To Care to operate. CAP funding would allow the Consortium to install infrastructure that will support the delivery of health care services to the uninsured and underinsured of Davidson County long after the funding period has passed.

If the Consortium is awarded year one funding for this proposal under the CAP program, it intends to use the funds for the infrastructure and care management programs specified in this proposal. The Consortium will not use the funding to supplant existing funding for services to the uninsured.

8. Scope and Quality of Services

Collaboration Among a Range of Providers in the Community: Bridges To Care links uninsured and underinsured patients to the broad and comprehensive range of providers that are a part of the Nashville Consortium of Safety Net Providers. Any provider who serves the uninsured may join the Consortium upon approval of the Board of Directors. Consortium members include medical, mental health, substance abuse, and dental providers. (Please see Fig. 8.1).

**Table 8.1 Nashville Consortium of Safety Net Providers Membership List
(As of 4/3/01)**

Member Organizations	MC	MH	AD	DT
Baptist Hospital	X			
Buffalo Valley Treatment Center			X	
Centennial Medical Center	X	X		
Centerstone Community Mental Health Centers		X	X	
Comprehensive Care Center	X			
Faith and Family Health Clinic	X			
Foundations, Inc.		X	X	
Interfaith Dental Clinic				X
Matthew Walker Comprehensive Health Center	X			X
Meharry Medical College	X	X	X	X
Metro Health Department	X	X	X	X
Mental Health Cooperative		X		
Metro Nashville General Hospital	X	X		
Pathfinders			X	
Samaritan Recovery Center			X	
St. Thomas Health Services	X			
Tennessee Christian Medical Center	X	X	X	
United Neighborhood Health Services	X			
Vanderbilt University Medical Center	X	X	X	

(MC = Medical Care; MH = Mental Health; AD = Alcohol/Drug; DT = Dental)

Of the nineteen Consortium members, twelve offer general medical care, nine provide mental health services, nine provide alcohol and drug treatment, and four offer dental care. Ongoing discussions with the few remaining safety net providers are likely to expand Consortium membership in the near future. The broad range of service providers represented in Consortium membership will allow Bridges To Care to offer uninsured and underinsured patients a comprehensive, integrated network that will meet their medical, mental health, substance abuse treatment, and dental health needs.

The collaboration that the Consortium has developed in building the Bridges To Care program has inspired providers to work together on a variety of other projects. For example, the Consortium plans to establish a subgroup of the Program Committee that will focus on integrating mental health and substance abuse services. This group will

develop strategies for integrating mental health providers more closely to the Consortium's primary care sites, rather than simply making referrals. Centerstone Community Mental Health Centers has already expressed an interest in placing its mental health staff in Consortium primary care sites, and the Consortium anticipates that this effort will become a key component of Bridges To Care as it develops in next few years.

System Coordination: Bridges To Care Care Managers, who will be supervised by the Care Management Supervisor, will coordinate services for the patients targeted by this project. Care Managers will evaluate the medical, mental health, substance abuse and dental needs of Bridges to Care participants, and will link patients to the services that they need. The Care Manager will coordinate services by developing a care plan with the patient and making referrals to Consortium providers. Care Managers will use the Consortium's Management Information System (MIS) to monitor services provided.

Chart 8.2 illustrates the process by which uninsured patients will be linked to a medical home and enrolled into Bridges To Care.

All Consortium providers will be linked to the Consortium's Internet-based MIS system. The Bridges to Care Care Managers and other authorized personnel at the Consortium partners' sites will have access to the confidential patient information in the Consortium's database. Included in this database are the patient's contact information, demographic information, and service history with Consortium providers. This information will be maintained and used in compliance with state and federal privacy requirements. Thus, whenever an uninsured patient presents seeking care at one of the Consortium sites, their information is immediately available to admission and clinical staff. Admission staffs do not have to ask patients to complete registration forms a second time and clinical staff will have important service history without depending upon the patient's recall.

In addition, with the enhancements to be developed with the requested CAP funds, the MIS system will enable the Care Manager to schedule appointments on line at participating Consortium clinics. The enhancements also include a module to extract more extensive clinical information from the Consortium partners' electronic medical records, i.e., CPT codes, lab results, prescriptions, etc. All of these MIS functions will significantly improve the Care Managers ability to monitor and coordinate the care of uninsured patients.

Bridges To Care will coordinate services at a technical level through the MIS system, and at a personal level through the Care Managers. This coordination will allow the target population to receive the care that they need in the most appropriate manner. Currently, a large portion of the target population seeks treatment at hospital emergency rooms for non-emergency needs. Bridges To Care will provide an alternative to this system by linking patients to a medical home and referrals to the medical, dental, substance abuse and mental health services that they require.

Clinical Quality: The Consortium is concerned with ensuring that participants in Bridges To Care receive high quality medical care. To this end, it has established a

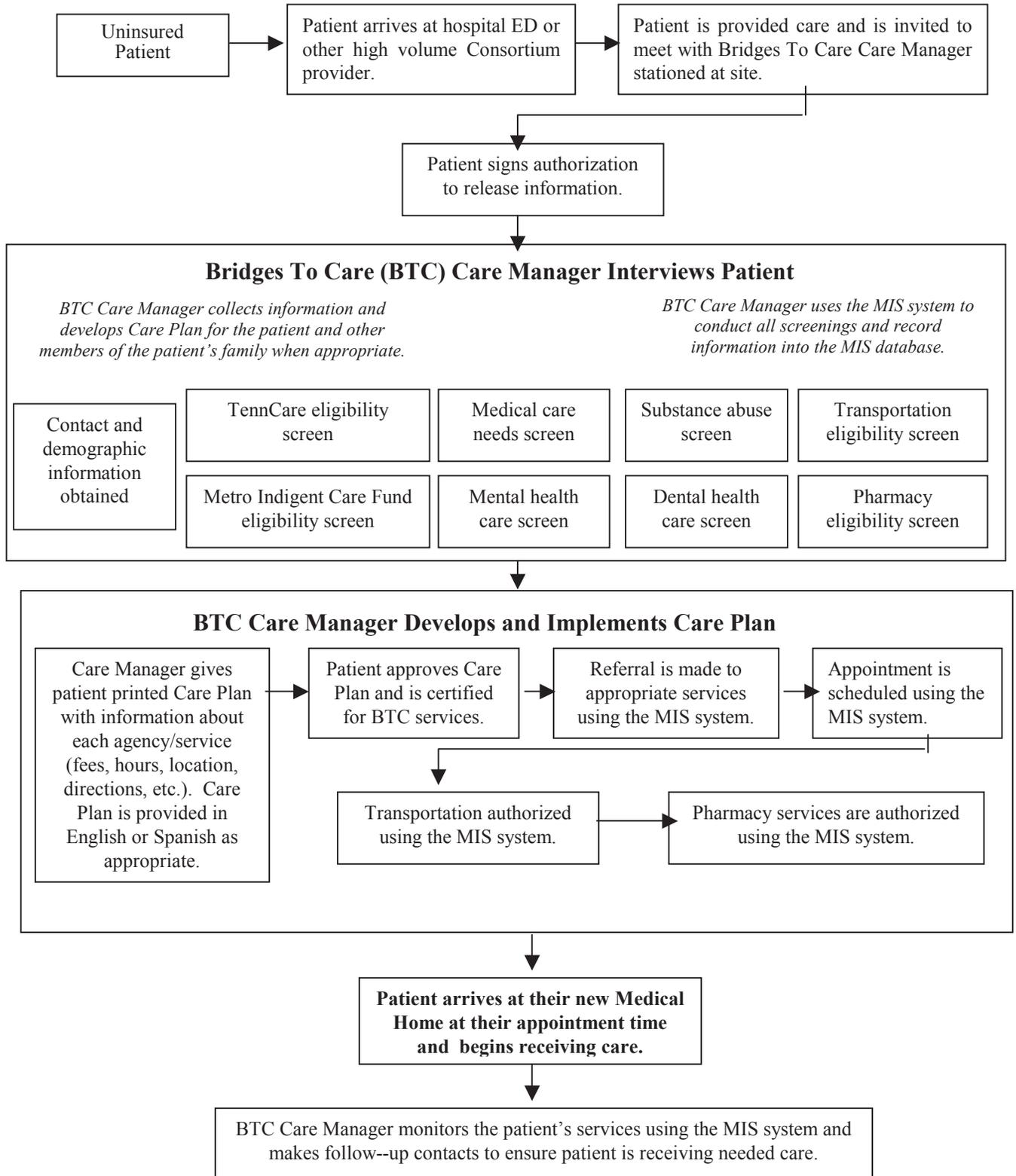
Clinical Quality Committee that reports to the Board of Directors. This Committee is composed of clinical staff from the Consortium providers and will perform several functions. It will identify measures of quality, develop strategies for collecting data, analyze and evaluate results, develop recommendations for improvement, assist with the implementation of improvement measures and report to the Board. The Meharry-Vanderbilt Alliance (MVA) has been formally engaged to assist the Consortium in providing medical quality improvement services to the Nashville Consortium. MVA will work with the Consortium through the Clinical Quality Committee to assure that proven quality models are incorporated into disease management protocols for Bridges To Care patients.

Cultural and Linguistic Competency: The Consortium’s Community Advisory Board will review all materials and program components to ensure that they are multi-lingual and appropriate for the target population. All informational materials will be printed in both English and Spanish, and many of the Care Managers will be fluent in both English and Spanish. Meetings held with community members, including individuals who do not speak English, will help the Consortium identify those areas where Bridges To Care services need to be improved to provide full access to patients who do not speak English.

The Consortium is committed to promoting appropriate multicultural and multilingual services to community residents. Several Consortium providers currently have translation services available, but these services often need to be reserved in advance. Bridges To Care MIS will allow Care Managers to specify the need for translation services when making appointments for patients. Additionally, Bridges To Care will identify the necessary translation services for patients who need assistance communicating with their health care providers.

Links to Social Services: The Consortium’s Community Advisory Board contains representatives from several social service agencies that will be an invaluable resource for helping Bridges To Care link patients to other social services. The Consortium intends to collaborate with these and other Davidson County social services providers in the implementation of Bridges To Care. The Consortium will develop the Bridges To Care Resource Directory, a reference guide to community services that are available to the target population. This publication will be printed in both English and in Spanish, and will be accessible online at the Bridges To Care public website. Care Managers will be able to use the guide to connect Bridges To Care patients with social services that will help them receive financial assistance, job training, English lessons, and a variety of other social services offered in Nashville. Copies of the guide will also be available for patients to take with them and share with other members of their communities.

CHART 8.2: BRIDGES TO CARE PATIENT SERVICES FLOW



9. Community Partnerships and Sustainability

Community Involvement: The network of the Nashville Consortium of Safety Net Providers who designed Bridges To Care were assisted by members of the Consortium’s Community Advisory Board. The organizations represented on the Community Advisory Board span a wide range of community interests. Charitable organizations, patient advocacy groups, the public school system, the Chamber of Commerce, religious organizations, and the state and local governments are all involved in advising the Consortium through the Community Advisory Board. They were an integral part of the process of designing Bridges To Care, and will continue to assist in its implementation. The Community Advisory Board will evaluate the program to make sure that the services and information provided are culturally and linguistically appropriate, and will examine whether Bridges To Care is meeting its goal of improving the health of the uninsured in Nashville/Davidson County. The Consortium’s Community Advisory Board includes representatives from:

- Alcohol and Drug Council of Middle Tennessee
- Alive Hospice
- Campus for Human Development
- Catholic Charities of Tennessee, Inc.
- Comprehensive Care Center
- Council of Community Services
- Hispanic Family Resource Center
- Interdenominational Ministers Fellowship
- Meharry Vanderbilt Alliance
- Metropolitan Nashville Public Schools
- Nashville Academy of Medicine
- Nashville Area Chamber of Commerce
- Partnership for Hispanic Health
- Nashville Cares
- Nashville Project REACH
- Office of the Mayor, Nashville and Davidson County
- Siloam Family Health Center
- Tennessee Department of Finance and Administration
- Tennessee Department of Health
- Tennessee Health Care Campaign
- The Mental Health Association of Middle Tennessee
- United Way
- Vice Mayor, Nashville and Davidson County
- World Relief
- YWCA

Commitment to the Community and the Population: All Consortium members have demonstrated their commitment to the uninsured by providing extensive services over a number of years. Examples of this dedication to the target population of Bridges To Care are provided below.

Baptist Hospital: Baptist Hospital is a not-for-profit hospital in the central city area that provides care for the uninsured through its emergency department. It has also donated a facility to house the newly established Faith and Family Health Clinic.

Centennial Medical Center: This for-profit central city hospital cares for the uninsured in its emergency department.

Centerstone Community Mental Health Centers, Inc.: Centerstone is a network of seven mental health and substance abuse treatment centers. The centers provide mental health services and alcohol and drug treatment for TennCare and uninsured patients in Davidson County.

Interfaith Dental Clinic: The Interfaith Dental Clinic provides comprehensive preventative and restorative dental care services for working low-income adults and their children, many of whom are uninsured.

Matthew Walker Comprehensive Health Center: The Matthew Walker center, a federally qualified health center, provides a full range of services for children and adults regardless of their ability to pay including preventative and primary care, dental care and pharmacy services. Historically, the Matthew Walker center has been a significant source of care for Nashville/Davidson County's uninsured population.

Meharry Medical College: Meharry operates a clinic that is adjacent to Metro Nashville General Hospital. This clinic provides primary care services to TennCare patients and others who are certified as indigent by Metro Nashville General Hospital. Services include family and internal medicine, pediatrics, obstetrics/gynecology and surgery specialties. Meharry also operates the Elam Center, an Alcohol and Drug Abuse Program that provides detoxification, residential treatment and counseling for adolescents and adults.

Mental Health Cooperative: This non-profit agency serves as the gatekeeper and care manager for individuals with serious and persistent mental illness covered by TennCare.

Metropolitan Health Department of Nashville and Davidson County: The Metro Health Department (MHD) provides preventative health care and dental services for children and adults, and primary care services for homeless persons regardless of their ability to pay. Preventative services include free immunizations for children, family planning services for women, and testing, treatment and counseling for persons with sexually transmitted diseases and tuberculosis. Dental services include adult emergency services, oral surgery, comprehensive care for the homeless, and a dental sealant program in local schools. MHD also operates "Opening Doors" a program that provides intake, assessment, referral to treatment, and care coordination to persons with alcohol or other drug problems who have no means of paying for treatment services. All MHD services are provided without regard for insurance status.

Metropolitan Nashville General Hospital: A significant portion of Nashville's uninsured residents seeks inpatient and outpatient medical care at Metro Nashville General Hospital, the county-owned hospital. Metro General also runs a Primary Care Center that provides primary care and pharmacy services for children and adults regardless of ability to pay. A large portion of patients at the Primary Care Center is homeless persons. Metro

General also runs a Maternal Infant Care Clinic that offers comprehensive family planning, prenatal and pediatric care without regard for ability to pay.

Pathfinders: Pathfinders provides residential and outpatient substance abuse treatment for adolescents and adults.

Saint Thomas Health Services: In addition to serving uninsured patients through its emergency room, this not-for-profit hospital funds and operates a Family Health Center. There, St. Thomas provides comprehensive preventative and primary health care for children and adults regardless of their ability to pay. The Family Health Center is located near several public housing communities. St. Thomas also funds the NeighborCare Mobile Clinic and the DePaul Dispensary a dispensary of medications for those who cannot afford them.

United Neighborhood Health Services: United Neighborhood Health Services, a federally qualified health center, provides preventative and primary care, pharmacy services, prenatal care and birthing services in six locations around Nashville. This full range of services for children and adults is provided without regard for ability to pay.

Vanderbilt University: The Vanderbilt University Medical Center is a not-for-profit hospital that treats many uninsured patients in its emergency room for episodic primary care and is a major provider of outpatient and inpatient care for indigent patients in Nashville. The Vanderbilt University School of Nursing also runs a clinic that provides comprehensive preventative and primary health care to uninsured patients on a sliding fee scale. The clinic is located in a public housing community. The Vanderbilt Medical Center also runs a Community Mental Health Center that provides outpatient diagnostic and treatment services for adults, children and adolescents.

Funding Support and Sustainability: If Bridges To Care is to be successful in the long run, it must be sustained and expanded to serve more uninsured and underinsured individuals. Bridges To Care is currently and will continue to be strongly supported by the Consortium and the community. The start up effort has been directly underwritten by MHD, which has spent significant staff time and more than \$75,000 to support the development of the base MIS system. HRSA funds and other support will be needed to complete the implementation of Bridges To Care, and Consortium members have already pledged significant monetary and in-kind support.

Because of its serious commitment to sustain and expand Bridges To Care, the Consortium has developed four strategies to develop future funds:

1. Secure future funding from Consortium members. To this end, the Consortium has already received pledges of significant continued in-kind support from MHD, including staff, space, furniture and fixtures. As significantly, Ascension Health System, parent of St. Thomas Hospital, has pledged matching funds equivalent to the amount of the first year of HRSA support to finance the next three grant years. Using the Ascension Health pledge as inspiration, the Consortium is approaching the other hospital systems in the Consortium (Baptist Hospital, Centennial

Medical Center, Tennessee Christian Medical Center, and Vanderbilt University Medical Center) to ask them to match the Ascension Health/St. Thomas Hospital pledge. If successful, this strategy will result in 133% of the equivalent of HRSA's first year funding for each of the next three grant years.

2. Solicit additional funding from state and local government. The Consortium intends to solicit additional funding from the Metro Nashville government. Presently, both Metro Health Department and Metro Nashville General Hospital have made significant in-kind and cash contributions to establish the Consortium and build the initial MIS system. The Director of the Health Department and the Director of Metro General Hospital have announced to the Consortium Board their intention to request additional dollars from Metro Government in their budget expansion requests for fiscal year 2003 to support the on-going activities of the Bridges To Care program. The Consortium also plans to solicit support from the State of Tennessee's Departments of Health and Mental Health and Mental Retardation.
3. Solicit additional funding from private foundations. The Consortium has identified local foundations to which it will submit funding proposals. These include: Nashville Memorial Foundation, HCA Foundation, Frist Foundation, Nashville Community Foundation, and United Way of Middle Tennessee.
4. The Consortium will apply for continuation funding from HRSA. If such funding continues to be available through HRSA under the Community Access Program or a successor or similar new program, the Consortium intends to apply for continuation or new funding as appropriate.

To implement these strategies and develop additional ones, the Consortium has formed a standing Fund Raising Committee.

Reinvestment in the Community: Bridges To Care will create cost savings by providing patients with care where they can be served most efficiently. Consortium members are strongly committed to ensuring that Bridges To Care remains operational, serving the uninsured and will use the savings realized from increased efficiencies to expand the number of uninsured patients who receive care management and medical, mental health, substance abuse and dental services.

10. Evaluation Plan

Self Evaluation Plan: The Nashville Consortium of Safety Net Providers has an established Evaluation Committee composed of representatives of the Consortium provider agencies and members of the Community Advisory Board. The Evaluation Committee is responsible for evaluating the projects of the Consortium. The Director of Evaluation of the Nashville Area Chamber of Commerce chairs the Evaluation Committee. The Director of the Research and Evaluation Division of the Metropolitan Health Department is the staff director of the Evaluation Committee.

Process Evaluation - The evaluation staff, under the leadership and guidance of the Consortium Evaluation Committee, will implement a process and outcome evaluation program designed to monitor the Consortium's progress in implementing the CAP grant funded activities, and measure the Consortium's success in achieving its goals and objectives as outlined in the logic model. The process evaluation will consist of three components: monitoring project implementation, measuring patient satisfaction, and measuring provider satisfaction.

Monitoring Project Implementation - The Evaluation Team will track implementation progress through the collection and assessment of three primary data sources:

- Official minutes of the Consortium Board of Directors and its program implementation committees,
- Formal monthly reports submitted by the Bridges To Care management staff using a form developed by the Evaluation Team, and
- The Consortium Management Information System.

The Evaluation Team will prepare detailed reports every two months depicting the progress of project implementation and submit these to the Evaluation Committee, Board of Directors, and other committees of the Consortium as appropriate. These reports will keep the Consortium informed about the project so that any problems can be solved in a timely fashion.

Measuring Patient Satisfaction - The Evaluation Team will develop, implement, and analyze results of a patient satisfaction survey with a sample of uninsured persons enrolled in Bridges To Care. Elements to be measured include perceptions of service delivery, access, quality of care, and self-perceived health status. Aspects that pertain to cultural sensitivity of Bridges To Care staff and Consortium provider staff will be included. It will be administered once after the first month of implementation of the Care Management program and once at the end of the sixth month of operation. The sample size for both assessments is 300 completed surveys. Detailed reports of both surveys will be produced that depict patients' perceptions. These reports will inform the Consortium of problems and strengths of the Care Management program so that improvements, if needed, can be made.

Measuring Provider Satisfaction - The Evaluation Team will develop, implement, and analyze results of a satisfaction survey with all Consortium provider participants.

Persons to be interviewed are the administrative and clinical staff at the Consortium agencies that are using the Consortium Management Information System for patient screening, referral, service tracking, etc. The sample size of this telephone survey is projected to be 150. The survey will address perceptions of the Bridges To Care Care Management program, ease of use of the MIS, the value of the MIS in referring and tracking patients, etc. This survey will be implemented at the end of the first year and on an annual basis thereafter. A detailed report will be produced that depicts the level of satisfaction with the program and identifies areas for improvements.

Outcome Evaluation - The outcome evaluation will measure the project's success in achieving its stated goals and objectives as outlined in the logic model. The Bridges To Care MIS system will be the primary source of data. The following aggregate data will be collected from the MIS database and analyzed on a monthly basis:

- Number of uninsured and underinsured patients screened for TennCare and the Metro Indigent Care Fund;
- Number of patients screened for medical and dental care, mental health and alcohol and drug problems and the number of referrals to these providers;
- Number of patients linked to a medical home and enrolled into Bridges to Care program;
- Demographic characteristics and primary diagnoses of the patients;
- Number of patient visits by provider site for Bridges To Care patients; and
- Number of transports provided and prescriptions filled for Bridges To Care patients.

The Evaluation Team will produce monthly progress reports summarizing these data and distribute these to the Consortium Evaluation Committee, Board of Directors, Program Committee, and others as appropriate.

In addition, at the beginning of the project year, the Evaluation Team will survey the Consortium hospitals to determine the number of uninsured primary care patient visits that occurred in the previous twelve months at their Emergency Departments. The same survey will be conducted at the end of the project year to determine if there has been an increase or a decrease in these inappropriate Emergency Department visits.

Finally, the Evaluation Team will develop, implement, and analyze results of a telephone survey to determine the success of the Bridges To Care program to inform the public and medical providers about how to access services for the uninsured and underinsured in Davidson County. Those surveyed will be a random sample of uninsured and underinsured persons in the Consortium MIS database and a random sample of medical and social service providers in Davidson County. The goal will be to obtain 300 completed surveys from each group. The survey will measure the respondent's knowledge of the service system for uninsured patients, their use of the Bridges To Care web based Resource Directory, their knowledge of the Bridges To Care care management program, etc. Added to these data will be information about the actual number of times the Bridges To Care Resource Directory pages have been accessed. The Evaluation Team will produce a report of the findings of the survey and distribute to the Consortium

Evaluation Committee, Board of Directors, Program Committee, and others as appropriate.

Experience in Applied Health Services Evaluations

Bridges To Care evaluation staff has extensive experience in research and evaluation. This is detailed in the resumes included in Appendix IV.

National Program Evaluation: The Nashville Consortium of Safety Net Providers and its coordinating agency, the Metropolitan Health Department of Nashville and Davidson County (MHD) is committed to participating in the national program evaluation of the Community Access Program. It is willing and capable of collecting data required by the Secretary of HHS.

Bridges To Care's base Management Information System collects information about each uninsured patient that is served by the Consortium's providers. Included in that database are contact information, demographic information, and service information including primary diagnosis. The base MIS is now being developed and will be in operation in September, 2001. During the project year, the Consortium will enhance this base MIS system with components necessary to implement Bridges to Care care management program including patient screening, the scheduling of appointments, and an enhanced extracted clinical record.

The Consortium's MIS will provide the information necessary to produce reports on the number of uninsured and underinsured who receive care through the Consortium's Bridges to Care project. The MIS is collecting this information each day as patients visit the Consortium clinics and hospital emergency departments. Thus, the database can be queried and reports produced that compare changes in these two measures overtime. The Consortium will be able to provide interim and final program reports as required as a part of the national program evaluation.

Logic Model for Nashville CAP Grant

	Resources	Activities	Outputs	Outcomes	Impact
Component 1: Link 4,000 uninsured patients and their families to appropriate “medical homes” and provide them with care management.					
Definitions	What you need to carry out program activities:	What you do with those resources in order to achieve program goals:	What you expect those activities to produce:	What benefits or changes you expect to see happen as a result of the outputs:	What fundamental changes you are seeking in the long term:
Descriptions	<p>Funding from HRSA grant.</p> <p>In-kind and cash funding from the Consortium members.</p> <p>Project administrative staff.</p> <p>Contract MIS consultant.</p> <p>BTC contractor with bilingual Care Managers and outreach director.</p> <p>Consortium staff experts to serve on MIS Joint Application Design (JAD) Teams.</p> <p>Legal Consultant engaged.</p>	<p>JAD Teams design screening modules, care plan, and extracted clinical record components of the enhanced Consortium MIS.</p> <p>JAD Team designs the patient appointment scheduling module.</p> <p>MIS contractor develops, tests, and installs the Internet based application and database for these four new modules.</p> <p>BTC Care Managers and Consortium partners’ clinical and administrative staff are trained to use the new MIS modules.</p>	<p>Internet based application that supports linkage of uninsured patients with a medical home and on-going care management.</p> <p>Real time scheduling of uninsured patients for medical appointments at safety net providers by remote Care Managers.</p> <p>Comprehensive extracted clinical record of uninsured patients available across the network of safety net providers.</p> <p>Patient privacy and patient data security</p>	<p>4,000 or more uninsured patients successfully linked to a “medical home”.</p> <p>More uninsured patients being screened and referred for mental health, alcohol and drug, and dental care services.</p> <p>Comprehensive care plans developed for uninsured patients.</p> <p>On-going care management provided to 4,000 uninsured patients and their families.</p> <p>Reduction in costly and inappropriate use of</p>	<p>More uninsured patients are receiving the services they need and have better health status.</p> <p>Resources supporting care for the uninsured are used more efficiently and effectively.</p>

	Resources	Activities	Outputs	Outcomes	Impact
		<p>MIS modules. Screening and care management is provided to uninsured patients.</p> <p>JAD team, with legal advice, develops consent and authorization forms to support HIPAA privacy, security rules.</p>	<p>protocols.</p> <p>Patient consent and authorization forms, notices of privacy practices in English and Spanish.</p> <p>Negotiated business association agreements.</p>	<p>hospital EDs for non-emergency primary care.</p> <p>Patient privacy is protected.</p> <p>MIS database is secure.</p>	
Assumptions	<p>Funding will be available to maintain and upgrade the system.</p> <p>Consortium partners continue to participate in the MIS.</p>	<p>Consortium partners can reach consensus on protocols to be used in the screenings.</p> <p>Consortium partners will continue to have access to the Internet.</p>	<p>An Internet based application can be developed that can communicate effectively with the Consortium partners' MIS systems.</p> <p>Consortium partners will allow the scheduling of patient appointments at their clinics by BTC Care Managers.</p>	<p>Uninsured patients will sign a release allowing their information to be shared across a network of safety net providers.</p> <p>Consortium clerical and clinical staff will use the information available through this system for registering and serving their uninsured patients.</p>	<p>Improved screening and care management will result in more uninsured patients receiving the services they need.</p>
Measures of Success	<p>Funding sources identified.</p> <p>BTC administrative and contract staff employed.</p>	<p>Screening modules, care plan, and extracted clinical record components of the enhanced Consortium MIS system.</p>	<p>Number of BTC Care Managers using the Internet tools.</p> <p>Number of Consortium partners' clerical and</p>	<p>Number of uninsured patients linked to "medical homes" as documented through the MIS.</p>	<p>% of uninsured patients who report improved health status through survey.</p>

	Resources	Activities	Outputs	Outcomes	Impact
	<p>employed. Contract with MIS consultant in place. Consortium staff experts participating on JAD Teams.</p>	<p>MIS are developed and operational. Extracted clinical record and patient appointment scheduling modules are developed and operational.</p>	<p>clinical staff using the Internet tools.</p>	<p>% of patients who report satisfaction with the services received from the BTC program. % of Consortium partners' staff who report satisfaction with the Internet tools. Number of uninsured primary care visits to hospital EDs.</p>	
Component 2: Increase number of uninsured patients who are assessed for eligibility in TennCare and Metro Indigent Care Fund.					
<p>Descriptions</p>	<p>Those described for Component 1. Representative of TennCare Bureau on JAD Team.</p>	<p>JAD Team designs the eligibility determination screens. MIS contractor develops, tests, and installs the eligibility determination screens in the Consortium Internet based MIS.</p>	<p>Internet based application to screen uninsured patients for eligibility for TennCare and the Metro Indigent Care Fund.</p>	<p>More uninsured patients being screened for TennCare and the Metro Indigent Care Fund.</p>	<p>Limited resources for serving uninsured patients being used most effectively.</p>
<p>Assumptions</p>	<p>Same as Component 1.</p>	<p>Same as Component 1.</p>	<p>BTC Care Managers will use the application to assess eligibility for TennCare and the MICH.</p>	<p>Uninsured patients will participate in the assessment process.</p>	<p>Assessing uninsured patients for TennCare and MICH eligibility will result in more being certified.</p>

Measures of Success	Same as Component 1. TennCare Bureau representative participates on JAD Team.	Eligibility screens are developed and operational.	Number of BTC Care Managers using the assessment tool.	Number of uninsured patients assessed for eligibility for TennCare and MICF.	Number of uninsured that become eligible for TennCare and MICF.
Component 3: Provide transportation and prescription medication for uninsured patients and family members enrolled in Bridges To Care.					
Descriptions	Those described for Component 1. Metro Health Department's existing TennCare transportation program. Metro Nashville General Hospital's existing Indigent Drug Pharmacy program.	Consortium Board, MHD, and MNGH sign agreement for pharmacy program. Transportation and pharmacy screening modules designed by JAD Team. MIS contractor develops, tests, and installs the eligibility screens in the Consortium MIS.	Internet based application to screen uninsured patients for eligibility for the BTC transportation and pharmacy program.	Uninsured patients being provided transportation to medical services. Uninsured patients receiving otherwise unavailable prescription medications.	More uninsured patients are receiving the services they need and have better health status.
Assumptions	Same as Component 1.	Same as Component 1.	BTC Care Managers will use the application to assess eligibility for BTC transportation and pharmacy services.	Uninsured patients will participate in the BTC sponsored services.	Transportation and pharmacy services will improve health status of uninsured patients.
Measures of Success	Same as Component 1.	Transportation and pharmacy eligibility screens are operational.	Number of BTC Care Managers using the assessment tool.	Number of transports provided and prescriptions filled.	% of uninsured patients who report improved health status through survey.

Component 4: Conduct an aggressive, culturally sensitive information campaign for uninsured patients and for providers about the services available for uninsured and underinsured patients.					
Descriptions	<p>Those described for Component 1.</p> <p>English to Spanish translators.</p> <p>Organizations representing African Americans, Hispanics and other ethnic and cultural groups in the community to advise in the development and execution of the campaign.</p>	<p>Survey Consortium providers and social service agencies to compile information for BTC Resource Directory.</p> <p>Produce copy for printed and Internet versions of the Resource Directory.</p> <p>MIS contractor develops, tests, and installs the Internet version of the Resource Directory into the Consortium Web Site.</p> <p>Print and distribute Resource Directory.</p> <p>Design and produce brochures, radio announcements, flyers, posters, etc. for information campaign.</p> <p>Implement public information campaign.</p> <p>Visit community leaders, community organizations, African American,</p>	<p>Printed version of the Resource Directory for uninsured persons.</p> <p>Internet version of the Resource Directory for uninsured persons.</p> <p>Public media (radio ads, brochures, posters, flyers, etc.) to distribute information about services for the uninsured.</p>	<p>Uninsured persons have information about how to obtain needed services.</p> <p>Health care and social service providers have information about how to obtain needed services.</p> <p>Uninsured persons seek out the assistance of BTC Care Managers to obtain health care services.</p>	<p>More uninsured persons are receiving the services they need and have better health status.</p>

Assumptions	<p>Those in Component 1. English to Spanish translators are available and affordable. Organizations representing the ethnic and racial minorities are available and willing to advise the Consortium.</p>	<p>Latino/Hispanic and other targeted community groups to develop relationships and build trust.</p> <p>Health and social service agencies will provide the information needed for the resource directory. Community leaders and organizations will be receptive to requests to meet and discuss the work of the Consortium.</p>	<p>Radio stations, health and social service agencies, businesses and community groups will cooperate in the distribution of the campaign materials.</p>	<p>Consortium partners' clerical and clinical staff, the BTC Care Managers, other health and social services providers, and the general public will have access to and use the Internet version of the Resource Directory.</p>	<p>Effective, culturally appropriate information about services will improve access to care.</p>
Measures	<p>Those in Component 1. Translators are employed to translate the copy. Organizations work with the Consortium.</p>	<p>Copy written for Resource Directory. Public information campaign materials produced.</p>	<p>Number Resource Directories distributed. Visits to Internet Resource Directory. Number public media distributed and visits/presentations to community groups.</p>	<p>% of uninsured patients and safety net providers who express satisfaction with the Resource Directory through a telephone survey.</p>	<p>% of uninsured patients reporting improved health status through survey.</p>

APPENDIX 1

Map of the Services Area

APPENDIX 2

Memoranda of Understanding and Bylaws

APPENDIX 3

Description of Management Information System (MIS)

The proposed MIS system enhancements will further the goals of the project by enabling Bridges To Care Care Managers to assess the medical/psycho/social condition of uninsured patients who present in Davidson County hospital emergency departments for non-emergent conditions using the MIS system screens. After making the assessment, the MIS will assist them in developing care plans for using up-to-date information supplied via the Resource Directory housed on the MIS system public web pages. Then, uninsured patients may be scheduled for appointments by the Care Managers at appropriate primary care and other provider sites before they leave the emergency department.

Immediate assessment, care plan development and scheduling creates the possibility that the uninsured patients enrolled in Bridges To Care will become linked with appropriate medical homes, locate transportation as needed, and offset the cost of prescription drugs as needed for their care. The MIS system's reporting capability will enable the Bridges To Care professional staff to evaluate the effectiveness of the program in meeting the needs of the target population, enabling them and the Board of the Consortium of Safety Net Providers to continuously improve the quality of the program.

Existing MIS Environment

The base MIS system has been designed at the time of this application, and will be tested at selected Consortium provider sites in June 2001. It will be installed in remaining sites during July and August 2001. Plans are to have the base MIS system fully operational at all participating Consortium provider sites by September 1, 2001. The remainder of this section describes the base MIS system.

The MIS consultant under an existing contract with Metro Health Department is developing and installing the system. The system is web based and accessed via the Internet. The application and databases will be stored on a server at Metro Government's Information System Department, a facility that features 24 hour a day, seven day a week security and supervision. The base MIS system consists of the following functions and components:

- Patient registration – contact and demographic information
- Patient referral – date, need, referral source and referral destination information
- Patient service tracking – service provider, diagnosis and services provided information
- Aggregate and custom reports

Core components will consist of any database design and front-end development in which subsequent modules share data elements. The data elements will embrace an existing protocol classification taxonomy such as DRGs, ICD9s and their associated

groupings. The Wizards will be the primary tool for accessing these elements from the interfaces and will be instrumental in making the application easy to use.

The application database is built on Microsoft SQL Server 2000. MHD's IS Department will manage the application and database. Information will be encrypted during storage and transmission. Public pages will be accessible by the general public ("Resource Directory"). Private pages will be accessible only by authorized Consortium staff, and this will include patient information and aggregate reports. Patient information will be password protected, and will be updated to prevent access upon the withdrawal or expiration of patient authorization. Originating Consortium members can control access to patient information.

The application is being written to leverage the benefits provided by a classic N-Tier architecture. The client application will require no more than Internet Explorer as a browser that will interface with Internet Information Server (IIS). The middle tier will consist of IIS and the middleware developed by the MIS Consultant. This middleware is being developed with Microsoft's Visual Studio using Visual C++ and Visual Basic as programming languages. The database software serving as the third tier will be Microsoft SQL Server 7 or Microsoft SQL Server 2000. A clustered arrangement of multiple databases servers may be necessary depending on load and the middle tier (IIS servers) may require a clustering setup as well.

Network Design and Security

Each site participating in the overall system will be expected to have an Internet connection and browser software (Internet Explorer) installed on all machines that will interact with the user interface (web) portion of the system. Virtual private network (VPN) software will be used to insure secure transmission between each participating site and the application servers. Each consortium sites' network personnel will be actively involved in the setup effort to insure that security standards for each individual site are not breached and the application's security is maintained.

Application Security Design

The application will have a robust security model designed into the system to give maximum flexibility in security arrangements. Security levels, managed primarily by MHD and secondarily by each site's security administrator, will insure that indigent care recipient data is protected from unauthorized personnel. In addition, specific data elements in the database will pass through an encryption scheme, using PGP, to store encrypted indigent care data. This will maximize the protection of sensitive indigent care information should database security ever be compromised. The hosting facility's firewall/security protocols supports 128 bit-secure socket layer (SSL) extensions through VeriSign certificates, and Raid-5 level intrusion protection.

Proposed Enhancements

Additional modules for the base MIS system will be developed and implemented during the first grant year. These will consist of patient screens (TennCare, Metro

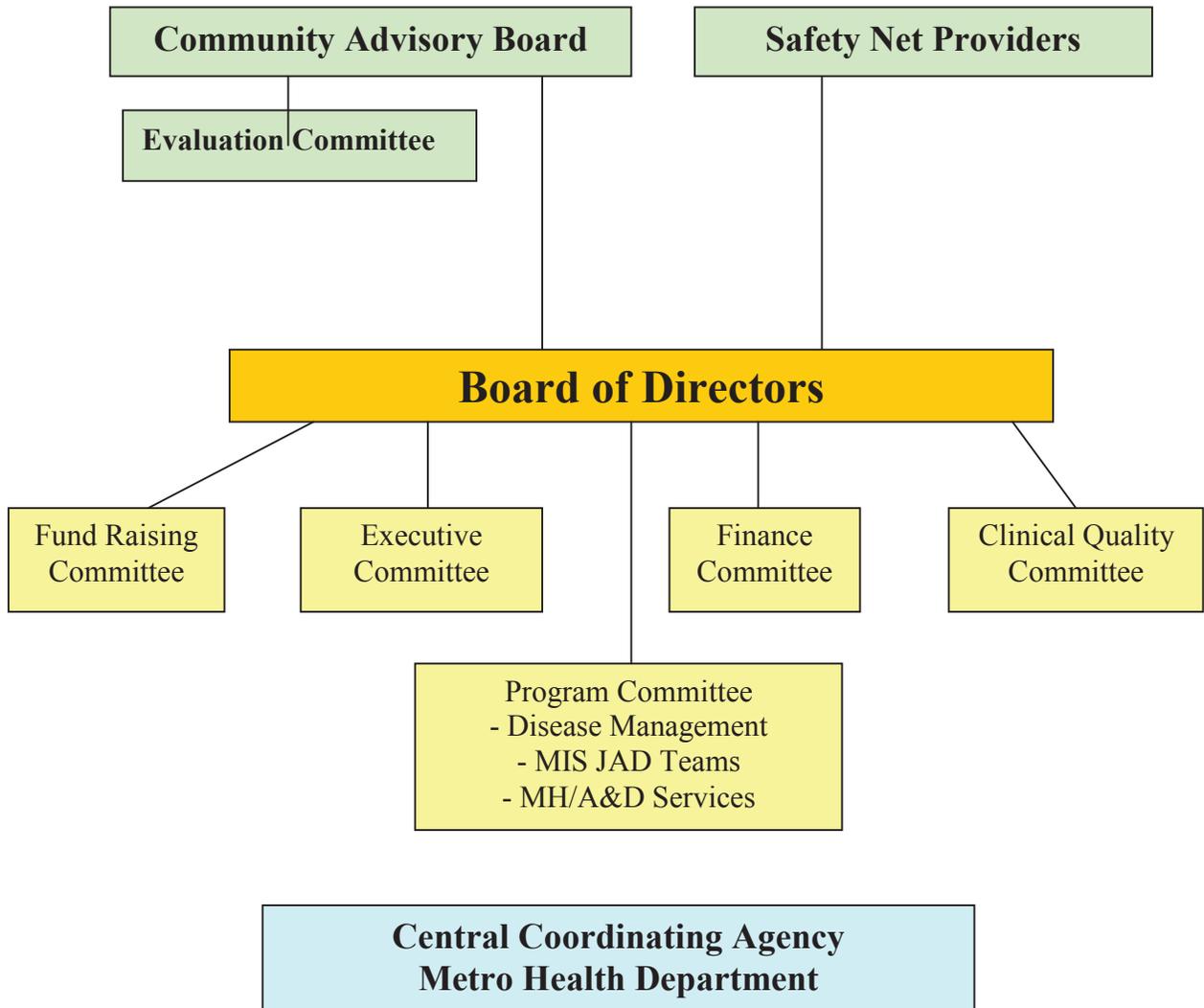
Indigent Care, Primary Medical Care, Dental Care, Mental Health Care, Substance Abuse Care, Prescription Drugs, and Transportation); extracted clinical record (CPT codes for treatment, lab results, for example; and Consortium appointment scheduling system.

Joint Application Design (JAD)

A Joint Application Design (JAD) process will assure and manage input from the Consortium needed to define in detail any design issues surrounding the overall development effort. These sessions will have at least four members of the MIS Consultant's technical team in attendance in order to insure that a complete range of skill sets involved in the design, development and implementation effort is represented. In addition, a decision maker for the MIS consultant will often be in attendance to provide direction when issues are encountered requiring elevation to a project controller. Managerial staff and Board Committee representatives will represent the Consortium. Legal consultation will provide the JAD with guidance on privacy consideration, such as preventing inappropriate access, and denying access to patient records when patient authorization is withdrawn or expires.

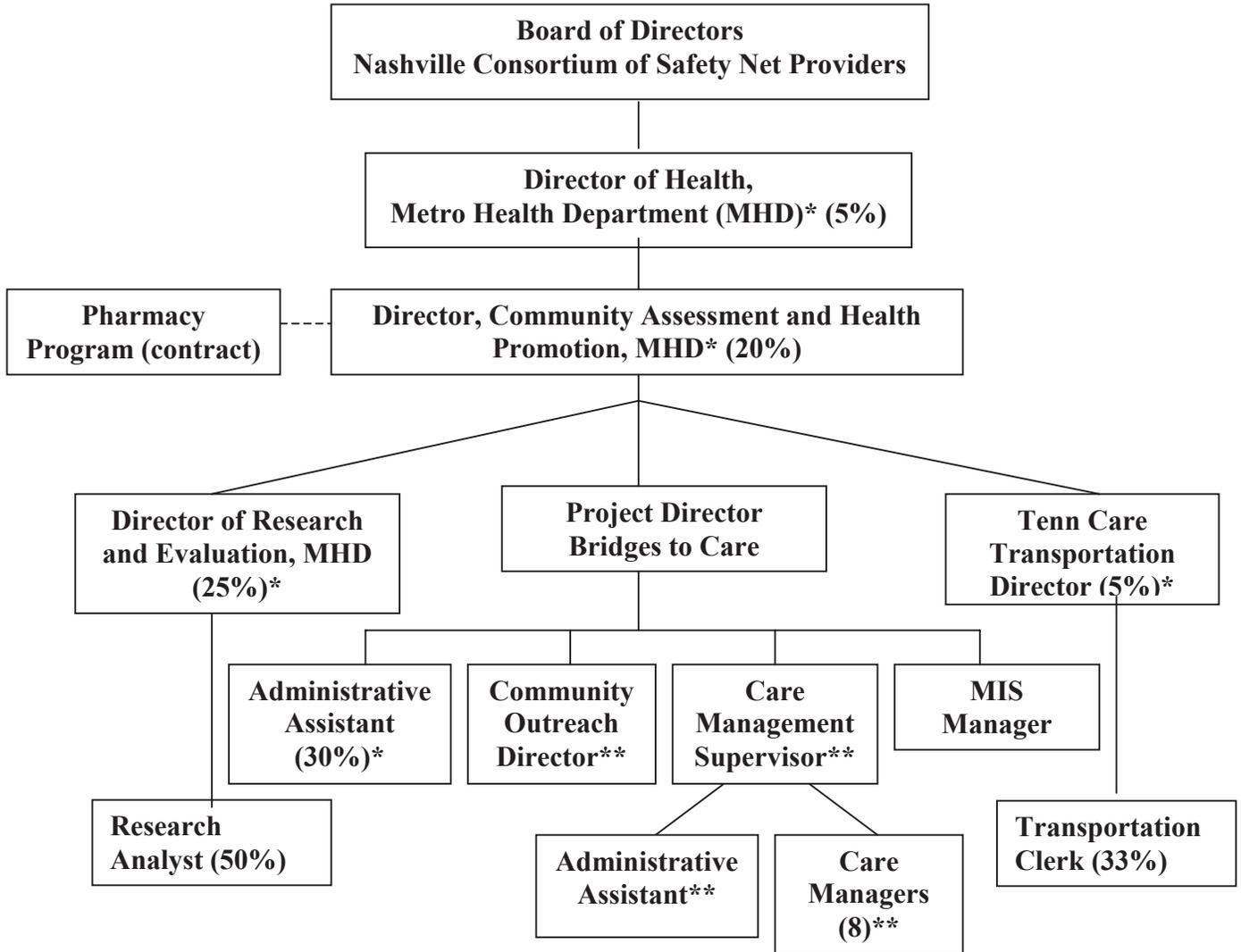
APPENDIX 4-A

Nashville Consortium Organizational Chart



APPENDIX 4-B

Bridges to Care Organizational Chart



* In-kind staff

** Staff at BTC contract agency

APPENDIX 4-C

Resumes and Position Descriptions

STEPHANIE B. COURSEY BAILEY, MD
8340 RIVER ROAD PIKE
NASHVILLE, TN 37209
(615) 356-6012

EDUCATION:

- 1993 **College of St. Francis**, Joliet, Illinois
M.S.H.S.A.
- 1976 **Meharry Medical College**, Nashville, Tennessee
M.D.
 - Residency – Internal Medicine
Grady Memorial Hospital/Emory University, Atlanta, Georgia
- 1972 **Clark University**, Worcester, Massachusetts
Bachelor of Arts in Psychology

EXPERIENCE:

- 1981-Present **Metropolitan Health Department of the Metropolitan Government of Nashville and Davidson County**
- May 1995-Present **Director of Health**
 - Chief Administrative Officer of the Board of Health
 - Responsible for the administration and execution of Board policies
 - Exercises executive management and control of all divisions of the Health Department
 - Develops and oversees annual budget of over \$27,000,000 and a staff of 507 employees
 - Chairs the Nashville/Davidson County Child Death Review Team
- January 1995-May 1995 **Acting Director of Health**
- 1988-1995 **Medical Director and Director of Bureau of Health Services**
 - Responsible for overall supervision and management of six divisions, which provide direct health care services
 - Divisions were primary Care Clinics, Communicable Disease Control, Health Services to the Homeless, Pharmacy and Indigent Prescription Program, Correctional Health Services, Dental Services
 - Designated Medical Officer for Metro Nashville and Davidson county for Communicable Disease Control
- 1981-1988 **Public Health Medical Doctor**
 - Responsible for delivery and oversight of primary health care at East Nashville Public Health Center
 - Supervised practice of Health Department Nurse Practitioners and develop protocols

1978-1981

National Health Services Corps

- Physician responsible for the development and delivery of health care in rural areas

MEMBERSHIPS:

National

- American Public Health Association, 1994-present
- American Medical Association, 1994-present
- National Association of County and City Health Officers
 - President, Board of Directors, 1999-2000
 - President Elect, 1998-1999
 - APEXPH Work Group, 1996
 - Nominations Committee, 1996
 - Governing Board of NACCHO, 1996-present
 - Chair – Comprehensive Environmental Health Assessment Work Group, 1995-present
 - Consultant – Influenza Pandemic Preparedness Work Group, 1996
- National Tuberculosis Controllers' Association
 - Executive Committee, 1994-present
- Centers for Disease Control and Prevention (CDC), 1996
 - Advisory Council for the Elimination of Tuberculosis (ACET), May 1999-present
 - Taskforce on Public Health Workforce Development, Co-Chair, June 1999-present
 - Advisory Committee to Director of the CDC, May 1999-present
- University of Illinois (Grant to School of Public Health through CDC) Key Informant for the Development of a Research Framework for Public Health Performance

State

- Tennessee Public Health Association, 1998-present
 - Legislative Committee, 1994-1997
 - Chairman, 1995-1996
 - Physicians Section President, 1994-1995
 - Exhibit's Committee, 1993
 - Program Committee, 1992, 1994
 - Scholarship Committee, 1993-1994
- Tennessee Medical Association, 1994-present

Local

- Partners for a Healthy Nashville (Nashville Healthcare partnership)
 - Executive Committee, 1995-1999
 - Vice Chairman, 1996-1999

CELIA O. LARSON, Ph.D.
2403 OAKLAND AVENUE
NASHVILLE, TN 37212
Home: (615) 269-6561 Office: (615) 340-2129
e-mail: celia_larson@mhd.nashville.org

EDUCATION:

- 1984 **Texas Christian University**, Fort Worth, Texas
Ph.D. in Experimental Psychology
- 1983 **Texas Christian University**, Fort Worth, Texas
Master of Science in Experimental Psychology
- 1980 **Murray State University**, Murray, Kentucky
Bachelor of Science in Psychology

EXPERIENCE:

- 1995-Present **Director of Research & Evaluation**, Bureau of Assessment and
Evaluation, Metropolitan Nashville/Davidson County Health
Department, Nashville, Tennessee
- 1994-1995 **Associate Director**, MEDTEP Research Center
Associate Professor, Department of Family and Preventive
Medicine, Meharry Medical College, Nashville, Tennessee
- 1988-1995 **Adjunct Professor**, Department of Psychology
Tennessee State University, Nashville, Tennessee
- 1992-1994 **Director of Quality Measurement and Analytic Studies**, Quality
Resource Group, Columbia/HCA Healthcare Corporation,
Nashville, Tennessee
- 1987-1992 **Director of Statistics and Basic Research**
NCG Research Inc., Nashville, Tennessee
- Research Consultant**, Quality Resource Group
Hospital Corporation of America, Nashville, Tennessee
- 1985-1987 **Assistant Professor**, Department of Psychology
Middle Tennessee State University, Murfreesboro, Tennessee
- 1985 **Assistant Professor**, Department of Psychology
Murray State University, Murray, Kentucky
- 1981-1984 **Research Assistant/Instructor**, Department of Psychology
Texas Christian University, Fort Worth, Texas

SELECTED PUBLICATIONS & REPORTS:

- Larson, C.O., Colangelo, M., Goods, K. (1998). Black-white differences in health perceptions among the indigent. The Journal of Ambulatory Care Management, 21:1, 35-43.

TECHNICAL REPORTS:

Metropolitan Davidson County Health Department

- Voice of the Homeless: Nashville/Davidson County, 1999.
- TennCare and Presumptive Eligibility: Health Status and Birth Outcomes, 1997.
- TennCare and Patient Satisfaction, 1996.
- TennCare and Enrollee Cost Sharing: A Survey of the Previously Uninsured and Uninsurable Enrollees in Davidson County, 1996.

Hospital Corporation of America

- Batalden, P., Larson, C.O. (1993) Hospital Quality Trends: 1992 Annual Report.
- Nelson, E.C., Larson, C.O. (1992) Hospital Quality Trends: 1991 Annual Report.
- Nelson, E.C., Larson, C.O. (1991) Predictors of Billing Satisfaction.
- Nelson, E.C., Larson C.O. (1990) Benchmarking: The Best of the Best.
- Nelson, E.C., Larson, C.O. (1989) Customer Judgments of Importance vs Performance.

PAPER PRESENTATIONS:

- Okpaku, S., Larson, C., Stroebel, C., Hynes-Gagne, L. Health Status and Needs Assessment: A Focus on the Hispanic Community. American Psychiatric Institute, New Orleans, November, 1999.
- Larson, C.O. A Model for Evaluating Patient Outcomes. MEDTEP Summer Institute, Meharry Medical College, Nashville, TN, July, 1994.

BART N. PERKEY

EDUCATION:

- 1974 **University of Louisville**, Louisville, Kentucky
Kent School of Social Work
Master of Science in Social Work
- 1970 **Southern Baptist Theological Seminary**, Louisville, Kentucky
Master of Divinity
- 1967 **Carson-Newman College**, Jefferson City, Tennessee
Bachelor of Arts in Philosophy

EXPERIENCE:

- February 1992-
Present **Bureau Director**, Metro Health Department of Nashville and Davidson County
- Direct the Bureau of Community Assessment and Health Promotion
- October 1989-
January 1992 **Executive Director**, Mid-Cumberland Community Health Agency
- Chief executive officer of a quasi-public agency with a staff of 70 persons who provided services for low income, medically underserved persons in middle Tennessee
- September 1986-
October 1989 **Principal Investigator**, RWJF Funded Health Care for the Uninsured Project, Tennessee Primary Care Association
- Directed a research and demonstration project which developed and marketed a low-cost health insurance plan for employees of small firms who had no health insurance
- June 1984-
September 1986 **Policy Analyst**, Office of Policy and Planning, Tennessee Department of Mental Health and Mental Retardation
- Conducted studies and staffed special task forces on public mental health policy
- November 1982-
May 1984 **Director of Planning**, East Tennessee Baptist Health Care System
- Worked with the Chief Executive Officer and Board to ensure the long term viability of the hospital and its subsidiaries
- October 1980-
October 1982 **Senior Planner**, Kentucky Health Systems Agency-West
- Developed regional health plans (including mental health and mental retardation services)

- Conducted a study of health care reimbursement systems
- August 1978-
September 1980 **Director**, Mental Retardation Services, Kentucky Department for Human Resources
 - Chief administrator of the state’s institutional and community services for persons with developmental disabilities
- August 1975-
July 1978 **Assistant Professor of Social Work**, Southern Baptist Theological Seminary
 - Taught courses in social policy, planning and gerontology
- May 1974-
July 1975 **Senior Research Analyst**, Human Services Coordination Alliance
 - Directed team of three consultants who developed health programs for older persons in Louisville, Kentucky
- June 1970-
August 1971 **Associate Pastor**, Smithwood Baptist Church, Knoxville

SELECTED PAPERS AND PUBLICATIONS:

- “Health Pulse: A Report on the Health Status of Music City”, February, 1998.
- “The Health Status, of Davidson County’s Fourteen Planning Districts, 1990-1996”, February, 1998.
- “Davidson County Natality Report, 1996” November, 1997.
- “Davidson County Mortality Report 1995: An Analysis of Deaths, Death Rates and the Ten Leading Causes of Death Among Davidson County Residents”, August, 1997.
- “TennCare and Enrollee Satisfaction: A Survey of TennCare Enrollees in Davidson County and Their Satisfaction With Medical Care and the Managed Care Organization”, December, 1996.
- “TennCare and Presumptive Eligibility: A Survey of Expectant Mothers in Davidson County and Their Experience with the TennCare Presumptive Eligibility Program”, November, 1996.

AFFILIATIONS AND AWARDS:

- **Board of Directors**, Mental Health Association in Nashville, 1987-1998
- **Board of Directors**, Tennessee Primary Care Association, 1990-1998
- **Board of Directors**, Dede Wallace Mental Health Center, 1992-1993
- **Board of Directors**, Tennessee Health Care Campaign, 1987-1989

- **Public Service Award**, Mental Health Association in Nashville, 1986
- **Community Leadership Award**, Mental Health Association in Nashville, 1990
- **Charles E. Darling Award**, Tennessee Primary Care Association, 1991

BRIDGES TO CARE PROJECT DIRECTOR

JOB OBJECTIVE

Provides administrative guidance and technical support for the Bridges To Care Program created by the Nashville Health Care consortium of Safety Net Providers. Oversees the effective operation and sustainability of the Bridges To Care Program.

JOB DESCRIPTION

MAJOR JOB RESPONSIBILITIES

- Must be thoroughly familiar with all participating agencies and programs' services, eligibility criteria and limitations. Must continually keep this information updated in order to orient and train Bridges To Care employees.
- Acts as a liaison to all participating agencies and acts as communication facilitator between agencies where appropriate relationships between the agencies.
- Develops and coordinates all staff training.
- Develops protocols for provider utilization (e.g., when to use ER/urgent care vs. office visit).
- Responsible for maintaining protocols and procedures for system.
- Prepares monthly reports as required by the grant/agency. Submits reports to appropriate coordinating body within the organization.
- Develops and maintains a manual of resources, updating frequently to assure currency.
- Coordinates staff activities and ensure that referrals are processed in an appropriate manner.
- Initiates conferences with all team members on a regular and as-needed basis.
- Maintains regular communication.
- Develops quality control and performance improvement plan to ensure effective and efficient functioning of program.

EMPLOYMENT STANDARDS

EDUCATION AND EXPERIENCE

- Masters of Public Health, Masters of Social Work, or Masters of Public Administration with strong community health experience or other health-related field.
- Proven ability to work with a variety of health care providers and/or disciplines as well as the general public.
- Demonstrates ability to be proactive and work independently to achieve designated goals.
- Experience in analyzing and assessing complex data, and interpreting data to ensure program goals are being met.

Bridges To Care Project Director (cont'd)

- Demonstrates effective oral and written communication skills. Bilingual skills (Spanish/English) are considered an asset to, but not a requirement of this position.
- Proven community and professional presentation and staff-training skills.
- Demonstrates ability to supervise staff at multiple work sites within the system.

PERFORMANCE STANDARDS

- Strong decision-making ability when presented with multiple options.
- Excellent communication and interpersonal skills.
- Ability to work independently with minimal supervision.
- Displays a genuine concern for the clients served.
- Ability to establish and maintain effective working relationships.

ANNUAL SALARY

\$65,000 plus fringe benefits

BRIDGES TO CARE MIS MANAGER

JOB OBJECTIVE

Performs professional duties involved in planning and overseeing Bridges To Care integrated web system plan. Performs related duties as required.

JOB DESCRIPTION

MAJOR JOB RESPONSIBILITIES

Oversees and participates in the management and operation of a major section of information technology services.

- Meets with Consortium provider sites and Bridges To Care staff.
- Conducts feasibility studies and makes cost estimates.
- May write documentation for systems.
- Investigates and solves system problems.
- Provides technical problem-solving support to Consortium provider sites and Bridges To Care staff.
- Evaluates and recommends information technology products and procedures.
- Ensures optimum utilization of resources.
- Performs various supervisory duties.
- Trains and/or establishes training requirements for employees.
- Performs various administrative duties.
- Develops, implements, and revises work standards and procedures.
- Prepares written and oral reports as needed.
- Provides technical consultation services to management.
- May review and make recommendations on Bridges To Care Project.
- Keeps abreast of current technical advances and industry changes.
- Attends meetings, workshops and training classes as needed.

SUPERVISION EXERCISED/SUPERVISION RECEIVED

This classification reports to the Bridges To Care Project Director who assigns and outlines the goals and objectives for projects and assists with any unusual or exceptionally difficult problems.

WORKING ENVIRONMENT/PHYSICAL DEMANDS

The work environment involves the everyday risks or discomforts which require normal safety precautions typical of such places as offices, meeting and training rooms, etc. The work area is adequately heated, lighted, and ventilated.

Bridges To Care MIS Manager (cont'd)

This classification typically works in an office environment within an information technology environment. Employees may be on call to assist with any emergencies or problems beyond the scope of the staff, but working hours are typically regular and stable. There may be some walking, standing, bending, carrying of light items, etc. No special physical demands are required to perform the work.

EMPLOYMENT STANDARDS

EDUCATION AND EXPERIENCE

Any combination of education and experience that would prepare the incumbent to perform the duties of the position at the appropriate level. Employees would typically have some supervisory or significant project management experience.

PERFORMANCE STANDARDS

- Thorough knowledge of NT system.
- Thorough knowledge of existing information technology.
- Thorough knowledge of the most efficient ways to utilize computer systems.
- Thorough knowledge of information system resource requirements and costs.
- Knowledge of the principals and practices of customer service.
- Knowledge of supervisory principles and practices.
- Knowledge of departmental rules, policies, and procedures.
- General knowledge of the budgetary process.
- Skill in investigating and resolving complex problems.
- Skill in evaluating situations.
- Ability to manage projects.
- Ability to make recommendations.
- Ability to train others.
- Ability to analyze needs or specifications to determine the best approach to meeting those needs.
- Ability to install and maintain information technology systems and software.
- Ability to analyze data and prepare reports.
- Ability to communicate effectively, both orally and in writing.
- Ability to evaluate employee performance.
- Ability to establish and maintain effective working relationships.

LICENSES REQUIRED

A valid driver's license is required for this position.

ANNUAL SALARY

\$50,000 plus fringe benefits

BRIDGES TO CARE RESEARCH ANALYST

JOB OBJECTIVE

Performs professional duties involved in analyzing and designing research studies and implementing ways of measuring efficiency and effectiveness of administrative and operational problems, programs or policies related to the Bridges To Care Program. Performs related duties as required.

JOB DESCRIPTION

MAJOR RESPONSIBILITIES

Under supervision of the Bridges To Care Project Director:

Analyzes administrative or operational problems, programs or policies.

- Identifies data to be collected and determines data collection methods.
- Collects and analyzes assorted data manually or by using a computer.
- Details problems, provides supporting evidence and makes recommendations to appropriate personnel.
- Determines appropriate presentation methods to disseminate data.
- Writes reports detailing methods, conclusions and recommendations of the study.
- Presents and defends findings to department management.
- May assist management with the implementation of adopted recommendations.
 - Performs related administrative duties.
 - Assists with the installation of management control procedures and participates in their initial installation.
 - Devises office forms for measurement, control, and cost analysis.
 - Maintains close liaison with analysts in the fields of planning, personnel, and budgeting.
 - Studies requests to resolve specific administrative or operational problems.
 - Maintains confidential records and files.

Attends meetings and workshops as needed.

SUPERVISION EXERCISED/SUPERVISION RECEIVED

This is a non-supervisory classification.

This classification receives general supervision and reports to the Bridges To Care Program Director who is consulted on unusual or complex matters.

WORKING ENVIRONMENT/PHYSICAL DEMANDS

This classification works primarily in an office setting under generally favorable working conditions. Work is sedentary, however, there may be some walking, standing, bending, carrying of light items, etc. No special physical demands are required to perform the work.

Bridges To Care Research Analyst (cont'd)

The work environment involves the everyday risks or discomforts that require normal safety precautions typical of such places as offices, meeting and training rooms, etc. The work area is adequately lighted, heated and ventilated. Some positions may be required to perform observations, studies, or related tasks in the field.

EMPLOYMENT STANDARDS

EDUCATION AND EXPERIENCE

Bachelor's Degree from an accredited college or university and two (2) years experience in operations research and analysis techniques.

OR

Master's Degree in Business or Public Administration, Education, Psychology or a related field of study from an accredited college or university.

PERFORMANCE STANDARDS

- Thorough knowledge of the principles and techniques of organizational management/efficiency studies.
- Must have knowledge of basic computer word processing and spreadsheet programs including, but not limited to, Word, WordPerfect and Excel. Must be comfortable with communicating and accessing records and files using web-based technology.
- Thorough knowledge of statistics and statistical applications.
- Working knowledge of the various types of analyses used in operational studies and the appropriate circumstances in which to use them.
- Basic knowledge of the overall organizational structure of the department.
- Basic knowledge of departmental rules, policies and procedures.
- Skill in working with the public.
- Skill in collecting information from various types of research materials.
- Ability to analyze administrative problems and recommend improvements.
- Ability to use personal and/or mainframe computers to facilitate analysis and implementation.
- Ability to communicate effectively, both orally and in writing.
- Ability to train other staff members as directed by immediate supervisor.
- Ability to establish and maintain effective working relationships.

LICENSES REQUIRED

Valid driver's license may be required for some positions in this classification.

ANNUAL SALARY

\$35,000 plus fringe benefits

BRIDGES TO CARE TRANSPORTATION CLERK

JOB OBJECTIVE

Performs scheduling, organizational and administrative duties related to facilitating the transportation needs of clients served by the Bridges To Care Program.

JOB DESCRIPTION

MAJOR JOB RESPONSIBILITIES

Under supervision of the coordinator of the Transportation Program or their designee:

- Assists clients with accessing appropriate transportation to medical appointments as needed within the Bridges To Care system.
- Maintains all client records in web-based computer system.
- Reports all transportation problems within the system to immediate supervisor.
- Participates in secondary administrative tasks such as filing, faxing and answering telephones, as designated by supervisors of the program.

EMPLOYMENT STANDARDS

EDUCATION AND EXPERIENCE

High School Diploma or GED

LICENSES REQUIRED

Valid driver's license with no violations or restrictions.

PERFORMANCE STANDARDS

- Demonstrate the ability to work with a variety of individuals from healthcare providers to the general public with sensitivity to multi-cultural issues.
- Bilingual (English/Spanish) oral and written communication skills.
- Ability to assess problem areas and identify appropriate solutions.
- Ability to work on a computer and accurately enter client data in web-based program.
- Ability to establish effective working relationships.

ANNUAL SALARY

\$18,000 plus fringe benefits

CARE MANAGEMENT SUPERVISOR

JOB OBJECTIVE

Provides daily administrative guidance and direction to the Bridges To Care Program overseeing activities of Case Management and Community Outreach.

JOB DESCRIPTION

MAJOR JOB RESPONSIBILITIES

- Must be thoroughly familiar with all participating agencies and programs' services, eligibility criteria and limitations. Must continually keep this information updated in order to orient Bridges To Care employees.
- Acts as a liaison to all participating agencies and as communication facilitator between agencies where appropriate relationships between the agencies, as designated by the Project Director.
- Assists the Project Director in developing and coordinating Bridges To Care staff training.
- Assists the Project Director in developing protocols for provider utilization (e.g., when to use ER/urgent care vs. office visit).
- As directed by the Project Director, prepares monthly reports as required by the grant/agency. Submits reports to appropriate coordinating body within the organization.
- Under the direction of the Project Director, develops and maintains a manual of resources updating frequently to assure currency.
- Assist Project Director in the supervision of the Community Outreach Coordinator and other subordinate positions within the organization. Oversees and coordinates all volunteer staff activities.
- Participates in all conferences with team members as designated by Project Director.
- Maintains regular communication.
- Assists the Project Director in developing a quality control and performance improvement plan to ensure effective and efficient functioning of program.
- Under the direction of the Project Director, acts as a liaison with other programs and with officials and lay groups and agencies, with specific responsibility for the administrative functions.
- Initiates and/or assists in preparing plan material, periodic and special reports, and other written material.
- Assists in planning and carrying out a program of staff development; assists in transmitting and makes recommendations for improving administrative policies and procedures.
- Represents the Project Director at meetings and conferences.

Care Management Supervisor (cont'd)

EMPLOYMENT STANDARDS

EDUCATION AND EXPERIENCE

- Bachelors degree in public administration, business administration, public health administration, public health sanitation, public health nursing, public health education, social work, or other appropriate field from an accredited (4) four-year college or university – Master's Degree preferred.
- Bilingual skills (Spanish/English) strongly encouraged for this position.
- Three (3) years of progressive, responsible, full-time paid employment in public administration, business administration, public health administration, public health sanitation, public health nursing, public health education, or other appropriate field, of which one (1) year within the past three (3) years must have been in an administrative or supervisory capacity.
- One (1) year of successfully completed graduate study in public health administration, public administration, or health education may be substituted for one (1) year of the required general experience.

PERFORMANCE STANDARDS

- Strong decision-making ability when presented with multiple options.
- Excellent communication and interpersonal skills.
- Ability to work independently with minimal supervision.
- Displays a genuine concern for the clients served.
- Ability to establish effective working relationships.
- Demonstrates strong community-relations skills including sensitivity to cultural diversity.

ANNUAL SALARY

\$50,000 plus fringe benefits

ADMINISTRATIVE ASSISTANT

JOB OBJECTIVE

Performs a variety of professional level administrative duties for a program or division manager. Performs related support duties as required by the Project Director.

JOB DESCRIPTION

MAJOR JOB RESPONSIBILITIES

Performs professional level administrative work.

- Gathers statistical, financial, and related data used in planning and decision making for a specific program or project.
- Develops and recommends courses of action open to the department and analyzes their probable consequences.
- Prepares concise reports on programs or projects.
- Interprets policies, rules and regulations as required.
- Assists in improving work flow in office operations.
- May assist in budget preparation.
- May interview job applicants, conduct orientation of new employees, and plan training programs.
- Implements and/or oversees implementation of projects.
- Provides direct support for a program or a division manager.
- May act as a liaison for the program/division manager in routine administrative matters.
- Prepares directives and difficult correspondence.
- Follows up on the implementation of directives.
- Participates in management staff meetings.
- Schedules appointments/meetings for the manager.
- Maintains records and disseminates information as necessary.
- May oversee and participate in the work of a clerical staff.

SUPERVISION EXERCISED/SUPERVISION RECEIVED

This classification may exercise supervisory responsibility over clerical support personnel.

This classification receives general supervision and reports to a designated supervisor who assigns and reviews duties and provides guidance and/or assistance with unusual or complex matters.

Administrative Assistant (cont'd)

WORKING ENVIRONMENT/PHYSICAL DEMANDS

The work environment involves the everyday risks or discomforts that require normal safety precautions typical of such places as offices, meeting and training rooms, etc. The work area is adequately lighted, heated, and ventilated. Overtime work may occasionally be required.

This classification works primarily in an office setting under generally favorable working conditions. Work is sedentary, however, there may be some walking; standing; bending; carrying of light items, etc. No special physical demands are required to perform the work. Local travel to attend meetings may be required.

EMPLOYMENT STANDARDS

EDUCATION AND EXPERIENCE

High School Diploma and four (4) years of administrative experience.

PERFORMANCE STANDARDS

- Knowledge of modern office practices and procedures.
- Knowledge of budgetary practices and procedures.
- Knowledge of the organization, function, goals and objectives of the department.
- Knowledge of general management theory and practices.
- Knowledge of current practices in the preparation of municipal government reports and correspondence.
- Knowledge of department rules and procedures.
- Skill in formulating ideas and presenting them in an effective manner.
- Skill in handling inquiries and dealing with problems.
- Skill in working with the public.
- Ability to use independent judgement and discretion to analyze and resolve problems.
- Ability to gather and interpret a wide variety of data.
- Ability to communicate clearly, concisely and convincingly, both orally and in writing.
- Ability to plan, organize and coordinate the work of others.
- Ability to analyze situations and written materials.
- Ability to maintain accurate records.
- Ability to use office equipment and personal computer.
- Ability to establish and maintain effective working relationships.

LICENSES REQUIRED

Valid driver's license may be required for some positions in this classification.

ANNUAL SALARY

\$25,000 plus fringe benefits

BRIDGES TO CARE CARE MANAGER

JOB OBJECTIVE

Links medically uninsured individuals, as identified by designated referral sources to appropriate health care services in the Nashville area through the Bridges To Care Program.

JOB DESCRIPTION

MAJOR JOB RESPONSIBILITIES

- Receives referrals by fax or phone from designated community-based referral sources. Must assure accuracy and completeness of referral information and be able to request additional information when necessary.
- Responsible for data search and updating into the system as needed.
- Identify barriers to accessing care, and communicate access issues to appropriate community-based or healthcare provider and Bridges To Care, Care Management Supervisor.
- Responsible for assigning referrals to appropriate medical programs or agency and tracking the progress of referrals after they have been made. Referrals will be monitored by Bridges To Care, Care Management Supervisor.
- Be aware of eligibility criteria for and refer uninsured residents to enrollment in TennCare, Metro-Indigency, and/or Bridges To Care programs as appropriate.

EMPLOYMENT STANDARDS

EDUCATION AND EXPERIENCE

- Bachelor's of social work or related field.
- Knowledge of and/or experience with community resources, both medical and non-medically related. Experience in working with uninsured or traditionally underserved populations within the community.
- Must demonstrate the ability to assess and “triage” client needs, assisting with both medical and non-medical needs of client, and appropriately deal with crisis situations as they arise.
- Must have knowledge of basic computer and spreadsheet programs including, but not limited to Word, WordPerfect and Excel. Must be comfortable with communicating and accessing records and files using web-based technology.
- Preferred applicants will be Bilingual (English/Spanish) and able to demonstrate cultural sensitivity in dealing with the diverse patient population who use the Bridges To Care Program.
- Must have a valid driver's license and be able to demonstrate that they have their own reliable transportation.

Bridges To Care Care Manager (cont'd)

PERFORMANCE STANDARDS

- Requires skilled decision-making ability when presented with multiple health issues and intervention options.
- Requires excellent communication and interpersonal skills.
- Requires the ability to work independently with minimal supervision.
- Must display a genuine concern for the clients served.
- Must demonstrate the ability to establish effective working relationships within the organization and networking skills with other organizations.

ANNUAL SALARY

\$32,500 plus fringe benefits

BRIDGES TO CARE COMMUNITY OUTREACH DIRECTOR

JOB OBJECTIVE

Working closely with other Bridges To Care staff members, designs and implements community-specific outreach/media campaigns consistent with the goals of the Bridges To Care Program.

JOB DESCRIPTION

MAJOR JOB RESPONSIBILITIES

- Must be thoroughly familiar with all participating agencies and programs' services, criteria and limitations and continually keep this information updated in order to assist the Project Director in developing and implementing Bridges To Care staff training.
- Acts as a liaison to all participating agencies and as a communication facilitator between agencies where appropriate relationships between the agencies as designated by the Project Director.
- Designs and implements culturally sensitive community outreach campaigns publicizing the mission, goals and activities of the Bridges To Care Program paying close attention to the needs of the traditionally underserved/uninsured populations of the Nashville area.
- Designs and implements media campaign publicizing the mission, goals and activities of the Bridges To Care Program.
- Supervises and trains all Bridges To Care volunteers who will be representing the organization at health fairs, church events and other community functions.
- Assists the Project Director in preparing monthly reports as required by the grant/agency.
- Assists other Bridges To Care staff members in referring clients to appropriate programs.
- Initiates conferences with all team members as needed.
- Communicates with all members of the team by phone, e-mail or face-to-face, on an as needed basis.
- Participates in all regularly scheduled staff meetings as required by Project Director.

EMPLOYMENT STANDARDS

EDUCATION AND EXPERIENCE

- Master-level candidate with degree in social work or related field with strong community health experience.
- Ability to work with a variety of health-care providers or disciplines and the public.
- Ability to work independently, as well as part of an implementation team.
- Ability to interpret and organize data.

Bridges To Care Community Outreach Director (cont'd)

- Demonstrate strong community-relations skills and sensitivity to cultural diversity.
- Bilingual (English/Spanish) communication skills are essential, including but not limited to oral and written communication, as well as presentation and training skills.
- Extensive knowledge of the Nashville/Davidson County area.

PERFORMANCE STANDARDS

- Strong decision-making ability when presented with multiple options.
- Excellent communication and interpersonal skills.
- Ability to work independently with minimal supervision.
- Displays a genuine concern for the clients served.
- Ability to establish and maintain effective working relationships.

ANNUAL SALARY

\$32,500 plus fringe benefits

APPENDIX 5

Letters of Support