

10. ACCESS TO QUALITY HEALTH SERVICES

Goal

Improve access to a continuum of comprehensive, high quality health care using both the public and private sectors in Kentucky.

Terminology

Activities of Daily Living: Personal care activities such as bathing, dressing, eating, toileting, transferring from bed to chair, and getting around (with special equipment, if needed) inside the home.

Adult Day Care: Center based services provided to individuals who are unable to be left alone while the primary caregiver is away from home. Basic services include meals/snacks; nursing and other supervision; scheduled daily activities; daily personal and health care needs; essential equipment and; incidental supplies. Other services that may be provided are Physical, Speech, and Occupational Therapy, and Respite.

Community-Based Services: Services, such as adult day care, social services, congregate meals, transportation and escort services, legal protective services, and counseling for clients as well as their caregivers.

Functional Assessment: An assessment of activities of daily living, instrumental activities of daily living, dementia, depression, other mental disorders, incontinence; the availability of support services (including caregivers, family, financial support and special equipment); and, care preferences of the person and the family.

Home-Based Services: Services provided in the person's place of residence, such as home health, personal care, hospice, homemaker and home delivered meals.

Home and Community Based Services (HCBS): Homemaker and personal care services to Medicaid eligible persons who meet nursing facility level of care needs but who choose to have services provided in the home setting. HCB services are provided only by a licensed home health agency.

Home Health Care: Intermittent skilled and para-professional services provided to the medically homebound person in their home.

Institutional Services: Structured settings such as nursing homes, rehabilitation hospitals, subacute care, hospice and assisted living facilities for the provision of long-term care services.

Instrumental Activities of Daily Living: Activities that enable a person to live independently in the community such as preparing meals, shopping, telephoning, taking medications, managing money, and performing light and heavy housework.

Long-Term Care: Health, personal care and social services delivered over a sustained period of time to persons who have lost or never acquired some degree of functional capability. Long-term care services cover a continuum of health and social services delivered in institutions, the community, and at home.

Polypharmacy: The use of many varied medications, both prescription and non-prescription. This is often the result of treatments from multiple care providers who use drug therapy to address a number of chronic physical and mental conditions.

Pressure Ulcer: Any lesion caused by unrelieved pressure that results in damage to underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed.

Rehabilitative Services: Services to restore specific skills, including overall physical mobility and functional abilities.

Urinary Incontinence: Incapability to control urinary function. While most commonly a medical condition, urinary incontinence may also result as a consequence of limitations in the ability to transfer from bed to chair in a timely manner.

Overview

Healthy Kentuckians 2000 included goals and objectives in the priority areas of Clinical Preventive Services and Health Services, which included both access and barrier issues in primary and preventive health care. *Healthy Kentuckians 2010* acknowledges those past efforts and looks at the many disparities remaining with the intent of eliminating as many of those disparities as possible in the arenas of Clinical Preventive Services, Primary Care, Emergency Medical Services, and Long-Term Care and Rehabilitative Services. The goals and objectives outlined focus on areas of large disparity where attention to prevention and quality can demonstrate improved health care delivery and outcomes.

Clinical Preventive Services

Access to high-quality clinical preventive care is an integral component of quality health care, and it is critical to achieving the goal of *Healthy Kentuckians 2010* of eliminating disparities in health outcomes. Individual clinical preventive services, which include on time age appropriate immunizations, screening tests, and counseling, have been demonstrated to have a substantial impact on morbidity and mortality. We must ensure

access to quality and preventive services that have been demonstrated to be effective in primary and secondary prevention.

Likewise, improving access to such services means removing or modifying barriers that exist at many levels, including those of the patient, provider, community, and system of care. Important patient barriers include lack of knowledge, skepticism, mistrust, lack of a primary care provider, or inadequate financial resource to pay for care. Provider barriers of importance include: lack of time, lack of training, perceived lack of effectiveness, and practice environments which are not conducive to preventive services. System barriers can include: lack of resources or insurance coverage, inattention to prevention, inadequate reimbursement from third party payers, and poor tracking systems for preventive services.

Primary Care

In view of changes occurring in the role of Kentucky health departments, Medicaid policy, and in the plan for insurance coverage it is timely to undertake an assessment of the availability of a source of ongoing primary care and estimates of access to the source.

Kentucky uses the definition of “primary care” from the Institute of Medicine (IOM) report as follows:

“Primary care is the provision of integrated, accessible health care services by clinicians that are accountable for addressing a large majority of personal health care needs, developing sustained partnership with patients, and practicing in the context of family and community.”

Well-recognized correlations exist between primary care, wellness, and the cost of medical services and medical indigence. People who receive adequate primary care tend to be healthier and to require less use of expensive medical treatments. Conversely, those who cannot obtain adequate primary care or who otherwise decline to follow healthful lifestyle practices generally exhibit comparatively higher rates of preventable illnesses and disorders. This in turn leads to higher eventual utilization of costly hospital and specialist services – one of the factors contributing to escalation of medical prices – forcing more low income people into medical indigence.

Although there are only nine community health centers, Kentucky has a total of 87 licensed primary care centers. Nonprofit rural clinics and some health departments also provide a source of primary care. Several free clinics provide effective, but limited access to primary care for the indigent and uninsured.

Several groups currently are studying primary care accessibility in Kentucky. In the early 1990s, the Kentucky Department for Public Health, University of Kentucky, and University of Louisville created a Statewide Primary Care Coalition, an ad hoc group comprised of providers and advocates for primary care, to address Kentucky’s changing primary health care delivery system. Its various task forces made recommendations on

community health networks, transportation, special populations and the uninsured. The coalition has recently been reorganized into the Kentucky Rural Health Association, which held its first meeting in May 1999.

Emergency Services

In the 1998 fiscal year, Kentucky was served by 140 ground Basic Life Support (BLS) services, 110 ground Advanced Life Support (ALS) services and 13 specialized services. Thirty-six percent of these operated in urban areas, while 64 percent operated in rural areas. ALS services are not distributed evenly throughout the state: Eastern Kentucky and extreme Northern Kentucky are served almost exclusively by BLS services.

In Kentucky, as in most of the United States, objective data about Emergency Medical Services (EMS) have not been previously available. Through a contract with the Kentucky Injury Prevention and Research Center, the Kentucky Emergency Medical Services Branch has developed a data base of information from the ambulance run forms from each class I ground ambulance run conducted by every ambulance service licensed by the state. All ambulance service providers were required to begin providing the standardized data in the revised Kentucky Class I Ground Ambulance Provider Run Report Form by July 1, 1999. For the first time, Kentucky will have the capacity to analyze statewide EMS performance by such indicators as response times, type of injury or disease, regions, urban or rural areas, payment type and others. Services are being encouraged to submit run report data electronically, and to use electronic means of communication such as the Emergency Medical Services Branch (EMSB) website. The capacity to analyze performance of the system objectively and the increased capacity to communicate with services have profound implications on the ability of the EMSB to plan improvements and implement changes in the system.

Long-Term Care and Rehabilitative Services

The need for long-term care services will naturally increase as the population ages. With advances in medical technology and the utilization of preventive services people are living longer than ever before. Long-term care services, however, are utilized by persons of all ages, from those who experienced physical or mental limitations at birth or in their youth to those with diminishing functioning at an older age. Data from the Kentucky State Data Center show that in 1997, there were 34.1 million people in the United States over the age of 65. Since 1978, the percentage of age 85 and over population has grown from 1.0 million to 1.4 million in 1997. In Kentucky, the percentage population 65 and over is 12.5 percent (US 12.7 percent) and the percentage population 85 and over is 1.4 percent (US 1.4 percent).

In Kentucky, there are 326 Licensed Nursing Facilities with a total of 26,950 beds: 128 Licensed Home Health Agencies: 67 Licensed Adult Day Care facilities, and: 557 Other Licensed Residential Care for Adult/Aged. Kentucky rates over the National Average in Beds per 1000 population age 65 and over 55.1 (US 53.1) and age 85 and over 490.0 (US 468.1).

Home and Community Based Services are often the entry into the long-term care delivery system for the elderly and disabled. Services are chosen by the client as an alternative to Nursing Facility placement. As the client's physical and mental faculties decline the need for assistance increases to the point that care in the home is no longer appropriate to meet the need. Nursing Facilities are then faced with the need to care for sicker and more debilitated clients.

Attainment of the *Healthy People 2010* Objectives for long-term care will depend on overcoming a number of issues including but not limited to:

- Regulatory changes
- Financing
- Provider Education and Training in Assessment and Placement
- Staff to Client Ratios in Nursing Facilities

Future efforts in long-term care must address the total population at need, as well as the knowledge that the need will grow as the population ages. Techniques for functional assessments must address all areas of debility including nutritional and financial needs. Partnering and collaborative efforts between providers of care, regulators of care and reimbursement sources on behalf of the users of long-term care must be examined and developed. Efforts must be made to increase access to care and the quality of care in order to achieve these objectives by 2010.

Progress Toward Year 2000 Objectives

The Medicaid program was expanded to cover poverty level children 14 to 19 to 100 percent July 1, 1998. An additional K-CHIP Medicaid expansion took place on July 1, 1999 to cover targeted low-income children from one to 19 families up to 150 percent. On November 2, 1999, a Medicaid look-alike was implemented covering children from birth to 19 years of age up to 200% of the federal poverty level.

There are many agencies involved in the identification of adults and children with health needs. The Kentucky Department for Public Health has been the largest provider of direct patient care. Kentucky has nine Federally Qualified Health Clinics (FQHC) and one FQHC look-alike providing care for the medically needy. Eight of these centers provide outreach to assist with coverage and the two larger facilities have outreach workers. The Kentucky Physicians Care Program reaches many people in Kentucky without any type of health coverage by offering one routine, office visit by a volunteering primary care provider without charge as well as a limited pharmaceutical component.

2010 Objectives

Clinical Preventive Services

10.1 Reduce to zero the proportion of children and adults without health care coverage.

Baseline: In 1998, 14.3 percent of Kentuckians were uninsured. (BRFSS data)

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Sources: Medical Expenditure Panel Survey (MEPS), Agency for Health Care Policy and Research (AHCPR), Behavior Risk Factor Surveillance System (BRFSS)

Implementation Strategy:

Lack of insurance remains a major determinant of access to necessary health services, including preventive care, primary care, tertiary care, and emergency care. Uninsured patients are less than half as likely to have a primary care provider, to have received appropriate preventive care such as recent mammograms or Pap smears, or to have had any recent medical visits. Lack of insurance also affects access to care for relatively serious medical conditions. There is evidence that lack of insurance over an extended period significantly increases the risk of premature death and that mortality rates among hospitalized patients without health insurance are significantly higher than among patients with insurance. A recent study of National Health Interview Survey (NHIS) data has demonstrated that increases in the proportion of a state's population eligible for Medicaid are associated with lower child mortality rates. The disparity in utilization of needed clinician services between the insured and uninsured is particularly acute for those with chronic health problems.

10.2. (Developmental) Increase the proportion of patients who have coverage for clinical preventive services as part of their health insurance.

Baseline: Data Not Available

Potential Data Sources: BRFSS, Kentucky Department of Insurance; Legislative Research Commission, Medical Expenditure Panel Survey, Insurance Tables.

Implementation Strategy:

- Develop baseline data.

- Work with the Kentucky State Legislature to mandate that Kentucky based health insurers provide information as part of a survey regarding services covered by policies.
- Survey the Kentucky health insurance companies regulated by the Department of Insurance on current mandates.
- Develop additional questions for the BRFSS regarding adequacy of preventive healthcare insurance coverage.

10.3. (Developmental) Increase the proportion of current smokers and problem drinkers who report being counseled about smoking and alcohol use at the last visit to their health care provider.

Baseline: Data Not Available.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Sources: BRFSS, Youth Risk Factor Surveillance System (YRBSS), National Health Interview Survey (NHIS)

Implementation Strategy:

- Develop baseline data.
- Develop assessment tools to be used within the communities to identify current smokers and problem drinkers.
- Utilize the Health Risk Assessment at the initial visit to the local health department and every three years thereafter as directed in the Public Health Practice Reference.
- Update information with appropriate counseling at each visit to the health department.
- Provide appropriate education for nurses on smoking cessation and alcohol abuse to assure knowledge of the latest statistics and management options that will be used in counseling clients.
- Write and utilize additional questions as needed for BRFSS.
- Assess smoking and problem drinking among 18-24 year olds.

10.4 (Developmental) Increase the collection and reporting of information on delivery of recommended clinical preventive services, by provider group, health plan, health system, and payer status.

Baseline: Data Not Available.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Sources:

- Medicare Health Maintenance Organizations (HMO)

- Medicare Fee for Service (FFS)
- KCHIP
- Medicaid
- Local Health Departments
- Health Plan Employer Data and Information Set (HEDIS) measures
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Managed Care Organizations
- Private Health Insurers
- BRFS
- Kentucky Department of Insurance

Significant progress in the delivery of Clinical Preventive Services (CPS) is unlikely without appropriate data systems to allow providers and administrators to identify those services and populations most in need of better delivery. Currently Kentucky has data regarding the number of primary care providers per population and geographic area, but there is no specific source with which to link CPS. There is a body of evidence that suggests that audit and feed back to individual providers and groups can improve rates of immunization and screening tests, but this is a challenge outside of centralized health systems with stable populations. Measuring how well preventive care is provided under different systems is an essential first step to motivating those systems that are not performing well to develop the information, tools, and incentives to improve care. (*Healthy People 2010*)

- 10.5. (Developmental) Increase the proportion of physicians, physician assistants, nurses, and other clinicians who receive appropriate training to address important health disparities: disease prevention and health promotion, minority health, women’s health, geriatrics.**

Baseline: Data Not Available

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Sources:

- Healthy People 2000 Medicare Review and 1995 Revisions
- Guide to Clinical Preventive Services, 1996
- IOM: Primary Care: American’s Health in a New Era
- IOM: Association of American Medical colleges, Medical School Graduation Questionnaire, 1997
- Pew Health Professions: Health Care Workforce Recommendations

Implementation Strategy:

- Develop baseline data.

- Identify core faculty to expand curricula in health professions education with emphasis on primary, preventive and public health care.
- Increase faculty understanding of the state needs for achieving this objective.
- Offer statewide continuing education with emphasis on disease/prevention and health promotion.
- Offer statewide continuing education to retool the health provider workforce.
- Develop partnerships between communities, public health, managed care, and health professions schools to provide education to meet the targeted needs of the state.
- Work with curricula committees of all health provider programs to develop course content that will incorporate the above concepts.
- Work with Area Health Education Centers (AHEC) to expand practice opportunities in all areas identified.
- Increase the capacity for graduate training in these areas.
- Establish a database of activities with the health profession's schools.

Primary Care

10.6. Increase to at least 90 percent the proportion of people who have a specific source of ongoing primary care.

Baseline: Data Not Available.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Source: BRFSS

Implementation Strategy:

- Develop baseline data.
- National data indicate that those “under age 65 who were uninsured were substantially more likely to lack a usual source of health care (38 percent) than those who had either private (15 percent) or public insurance (13 percent)” (MEPS Highlights, October 1997, #3, p.2). Since availability of insurance is a key determinant of having a usual source of care, achievement of these objectives is tied to achievement of an objective on health insurance.
- Since the availability of primary care services is an issue in Kentucky, particularly in rural and underserved areas, achievement of these objectives is contingent upon improving the availability of services.
- In view of the suggested emphasis on children, attention should be given to alternatives such as school-based clinics. For young adults, insurance coverage is likely an issue. Thus attention to insurance, college-based, and work-place initiatives (education and service) should be considered.

10.7. Increase to at least 95 percent the proportion of children 18 years and under and who have a specific source of primary care.

Baseline data: The Kentucky Health Interview and Examination Survey (KHIES), conducted in 1993 and published in 1995, indicated that 76.2 percent of children are checked at least once a year with 83 percent checked by their own physician, 5.3 percent checked in a clinic, 10 percent checked in a health department, and 1.6 percent checked in a hospital. Other data showed that 36 percent of all children go to a private doctor for routine care but receive immunizations at the health department. This suggests that payment issues are involved and, given multiple sources of care, there are challenges in assuring continuity of care.

Target Setting Method: With the inception of the KCHIP Medicaid plan, every child 0 to 19 under 200 percent poverty level should qualify to receive state funded health coverage.

Data Sources: BRFSS, NHIS

Implementation Strategy:

- Actively support more school based clinics for low income families.
- Increase locations, such as school based clinics, health departments and civic organizations for eligibility determination for KCHIP.
- Increase marketing and development of KCHIP Medicaid Plan. In view of the suggested emphasis on children, attention should be given to alternatives such as school-based clinic.

10.8. Reduce to no more than 7 percent, the proportion of individuals/families who report that they did not obtain all of the health care that they needed.

Baseline: Data Not Available

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Sources: BRFSS

Implementation Strategy:

- Include a question on the BRFSS pertaining to this variable in order to develop baseline data and to follow progress.
- Assure that health care providers understand the importance of validating with the patient their perception of the care received at the conclusion of an encounter. This may involve statewide training in the delivery of primary care.

- Establish quality assurance measures related to client perception of completeness of care and conduct evaluations at exit from service or in immediate period following care.
- Take other appropriate actions based on survey results.

10.9. Reduce the percentage of population reporting no type of health insurance to 10.0 percent.

Baseline: 14.3 percent in 1998 (BRFSS data)

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Source: BRFSS

Implementation Strategy:

- Increase incentive programs to attract primary health providers to underserved areas.
- Continue to provide education regarding Medicaid benefits, particularly for children, and work with small businesses and other employers to help provide health insurance benefits to their employees.

10.10 Reduce by 25 percent the number of individuals lacking access to a primary care provider in underserved areas.

Baseline: An estimated 987,322 people lacked access to primary care providers in underserved areas in 1997.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Source:

The Bureau of Primary Health Care Shortage Designation database provides estimates of the number of people who lack access to a primary care providers in underserved areas; HRSA.

Implementation Strategy:

- Implement a State Loan Repayment Program using federal and local funding.
- Monitor use of International Medical Graduates in underserved areas.
- Coordinate free health clinic programs, Kentucky Physicians Care Program, and other mechanisms to low cost or free care to those who cannot afford care.

10.11 Increase by 2.0 percent the proportion of all degrees in the health professions and allied and associated health professions fields awarded to members of under represented racial and ethnic minority groups.

Baseline: Not available.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Sources:

Data for public institutions on minority graduates may be obtained from the Council on Post-Secondary Education. Data for graduates of private institutions may need to be collected by survey from individual institutions that have health professions programs. New registration data may be a proxy measure for health professions graduations.

Implementation Strategy:

- Determine geographic distribution of minority populations in Kentucky and target recruitment accordingly.
- Identify minority health professionals to serve as role models for potential students.
- Enlist support of school, community and educational groups to integrate recruitment efforts into other educational enhancement/enrichment programs.
- Collaborate with existing school districts, guidance counselors and other community leaders.
- Produce a statewide brochure that is culturally appropriate and identifies the benefits of careers in health.
- Support continuation of existing minority recruitment and retention activities, e.g., Robert Wood Johnson 3000X2000 project at the University of Louisville.
- Work with professional organizations to spearhead minority recruitment and retention efforts. (e.g. Kentucky Medical Society, Kentucky Nurses Association, Kentucky Hospital Association and other allied health organizations).

10.11. Increase the proportion of individuals from underrepresented racial and ethnic minority groups enrolled in Kentucky schools of nursing.

Baseline: Data Not Available.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Sources: Enrollment data from Schools of Nursing, Bureau of health Professions, HRSA.

Implementation Strategy: Same as for Objective 10.10

10.12. Reduce preventable hospitalization rates by 25 percent for chronic illness for three ambulatory care sensitive conditions - pediatric asthma, immunization-preventable pneumonia and influenza in the elderly, and diabetes - by improving access to high-quality primary care services.

Baseline:

- Pediatric asthma, 31.2 admissions per 10,000 population under age 18 years;
- Immunization-preventable pneumonia and influenza in the elderly, 1.61 admissions per 10,000 population aged 65 years or older;
- Diabetes, 18.7 per 10,000 population aged 18 years or older.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Sources: The Health Care Cost and Utilization Project (HCUP), Hospital discharge databases.

Implementation Strategy:

While factors in addition to access and quality also influence admission rates (prevalence of disease, co-morbidities, physician practice style, psychosocial factors, hospital bed supply), it has been shown that disparities in preventable hospitalization persist after controlling for prevalence of underlying conditions, health care seeking behavior, and physician practice style. In addition, disparities exist even in states with relatively low rates of admission for these conditions. The fact that sociodemographic characteristics also influence admission rates indicates that integration of clinical and public health interventions will be needed to reduce preventable hospitalizations in underserved populations.

Emergency Services

10.13. (Developmental) Increase the proportion of all individuals who have access to rapidly responding pre-hospital EMS.

Baseline: Data Not Available

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Source: The run form data base now being created through a contract with the State Injury Prevention Program (SIPP) will provide a source of information about emergency response times.

Implementation Strategy:

- Use a database of ambulance run form information to determine the current average response times for rural and urban areas, as well as for regions.

- Develop percentage goals based on the information provided from the ambulance run form database.
- Analyze the data to develop strategies for improving response times, such as increasing First Responder programs.
- Measure progress toward the percentage goals through continuous monitoring of the ambulance run form database.
- Revise strategies, if necessary.

10.14. (Developmental) Increase the proportion of patients whose access to EMS when and where they need them is unimpeded by their health plan's coverage or payment policies.

Baseline: Data Not Available

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Source: The ambulance run form database now being created through a contract with the SIPP will provide a source of information about payment plans being accepted by ambulance service providers.

Implementation Strategy:

- Use a database of ambulance run form information to analyze the payment plans now being accepted for emergency runs.
- Design and implement a survey to determine how people perceive their coverage of EMS. This will provide an estimate of the proportion of people who do not call an ambulance because of the cost.
- Develop percentage goals based on the information provided from the ambulance run form database and the survey.
- Devise strategies to increase the proportion of patients whose access to emergency services is unimpeded by their health plans' coverage or payment policies.
- Measure progress toward the percentage goals established through continuous monitoring of the ambulance run form database and, if appropriate, a second survey.
- Revise strategies as necessary.

10.15. Partner with the Kentucky Regional Poison Center to facilitate establishment of 1-800-POISON for 24-hour access and to reduce the incidence of poisoning incidents in Kentucky.

Target Setting Method: 1-800-POISON will be available on a 24-hour basis and the incidence of poisoning will be reduced throughout Kentucky by the year 2010.

Potential Data Source: The Kentucky Regional Poison Center records will be consulted to determine the change in the numbers of calls made to the Center.

The ambulance run form database will be utilized to determine the changes in the number of ambulance runs resulting from poisonings.

Implementation Strategy:

- Continue to support the implementation of statewide access to 1-800-POISON by subsidizing the operations of The Kentucky Regional Poison Center.
- The Kentucky Regional Poison Center educator will be asked to provide a training session at the Kentucky EMS Conference and Trade Show in September 1999.
- Kentucky Emergency Medical Technicians (EMTs) will provide public education about the Kentucky Regional Poison Center, 1-800-POISON and how to reduce the incidence of poisonings.
- Coordinate with the Kentucky Regional Poison Center to track numbers and types of calls made to the center.
- Track the numbers of ambulance runs resulting from poisonings.
- Adjust strategies according to data.

- 10.16.** (Developmental) **Assess the proportion of eligible patients with acute myocardial infarction (AMI) who currently receive clot-dissolving therapy within an hour of symptom onset, and establish a realistic plan for improvement.**

Baseline: Data Not Available

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Source: The Operation Heartbeat program will provide information about the proportion of eligible patients with AMI who receive clot-dissolving therapy within an hour of symptom onset.

Implementation Strategy:

- Utilize contacts with individuals administering the Operation Heartbeat program to assess the proportion of eligible patients with AMI currently receiving clot-dissolving therapy within an hour of symptom onset.
- From the base-line data, develop percentage goals for improvement.
- Develop a plan of action for achieving the established percentage goal.
- Measure progress toward the percentage goal through periodic querying of the Operation Heartbeat program personnel.
- Revise strategies as necessary to obtain positive results.

- 10.17.** (Developmental) **Assess the proportion of persons with witnessed, out-of-hospital cardiac arrest currently receiving their first therapeutic shock within 10 minutes of collapse recognition, and establish a realistic plan for improvement.**

Baseline: Data Not Available

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Source: The new ambulance run form data base will contribute information about the proportion of persons with out-of-hospital cardiac arrest who receive their first therapeutic shock within 10 minutes of collapse recognition.

Implementation Strategy:

- Use the data being compiled by the new run form database to determine the proportion of persons with out-of-hospital cardiac arrest who currently receive their first therapeutic shock within 10 minutes of collapse recognition.
- From the baseline data, develop percentage goals for improvement.
- Develop a plan of action for achieving the established percentage goals. The plan will include promulgating regulations to require automatic external defibrillators (AED) to be placed in all BLS ambulances and supporting legislation to encourage AED program development in communities.
- Measure progress toward the percentage goals through continuous monitoring of the run form database.
- Revise strategies as necessary to obtain positive results.

10.18. (Developmental) Incorporate “model” pediatric ALS and BLS protocols into a comprehensive set of protocols for both adults and children. Facilitate implementation and use of comprehensive protocols through use of the Internet and monitor usage.

Target Setting Method: Comprehensive protocols will be developed and monitoring will have begun by the year 2010.

Potential Data Source: Medical Standards/Delegated Practice Committee (MS/DPC) of the Kentucky EMS Council, Kentucky Board of Medical Licensure (KBML)

Implementation Strategy:

- Develop a protocol template and a comprehensive list of conditions for which protocols must be written.
- Utilize members of the MS/DPC and others with recognized expertise in pre-hospital clinical care to review existing protocols in use, training and practice standards for EMTs and paramedics, and other “model” protocols.
- Develop for each medical condition one or more adult and pediatric protocols. The different protocols for each condition will take into account varying

degrees to which physician medical directors are willing to authorize procedures or drugs to be utilized without specific “on-line” authorization.

- Obtain approval from the KBML for local physicians and ambulance services to use these protocols as written without separate approval for each service.
- Establish a means, through the Internet or similar mechanism, for local medical directors to view the protocols, download copies, and notify the EMS Branch and KBML of their local usage.
- Periodically review and revise each protocol to keep current with medical practice.

10.19. (Developmental) Develop and implement a voluntary program to identify hospitals that are prepared and committed to provide emergency treatment for children. Disseminate information about such hospitals to ambulance services and the public.

Target Setting Method: The program will be developed and the information disseminated by December 2001.

Potential Data Sources: Medical professional associations state emergency medical service organizations, the EMS for Children Committee of the Kentucky EMS Council, Kentucky hospitals

Implementation Strategy:

- Obtain “model” standards and guidelines for pediatric emergency medical facilities from professional associations, other states, and other sources.
- Using the EMS for Children Committee as a core group, analyze the standards and guidelines to develop a consensus set of Kentucky guidelines for pediatric emergency facilities addressing minimum staffing, training, equipment, supplies, transfer and triage protocols.
- Disseminate the standards and guidelines to Kentucky hospitals and invite each hospital to perform a self-assessment of its capacity compared to the standards.
- Consider the need for an outside verification procedure after a hospital has completed its own self-assessment.
- Determine which hospitals meet the minimum guidelines and establish a procedure for identifying and recognizing each hospital through certificates of recognition, public service announcements, publications and dissemination of lists, and other means.

Long-Term Care and Rehabilitative Services

10.20. (Developmental) Increase the number of primary care providers who routinely provide or refer potential long-term care patients for a functional assessment.

Private Physicians
Primary Care Centers
Rural Health Clinics
Hospitals

NOTE: Currently functional assessments are conducted by Rehabilitation Centers, Home Health providers, Home and Community Based providers, Area Development District In-Home Care and Aging Service providers and Nursing Facilities (includes Intermediate Care for the Mentally Ill and Residential Care), Adult Day Care, and Support for Community Living services.

Baseline: Data Not Available.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Source: Cabinet for Families and Children/Division for Aging Services, Cabinet for Health Services/Division of Licensing and Regulations, Primary Care Providers Survey.

Implementation Strategy:

- Develop educational materials for distribution at potential referral sites.
- Develop a sample functional assessment tool for use by primary care providers.
- Provide potential referral resource lists for use by primary care providers.

10.21. (Developmental) Increase the proportion of primary care providers who routinely evaluate, treat, and, if appropriate, refer their long-term care patients to subacute rehabilitative and other services to address:

- **Physical mobility**
- **Urinary incontinence**
- **Polypharmacy**
- **Communicating and hearing disorders**
- **Depression**
- **Dementia**
- **Mental disorders, including alcoholism and substance abuse.**

Baseline: Data Not Available.

NOTE: This objective focuses specifically on the long-term care population and on conditions and limitations that are common to this population. For example, urinary incontinence, instead of being a health problem may in fact be the consequence of limitations in the ability to transfer from bed to chair. In Kentucky 13.2 percent of the residents in Nursing Facilities were reported to be bedbound in 1997 compared to the national average of 7.9 percent. The number of

residents reported to be chairbound was essentially the same as the national average at 48.1 percent.

Polypharmacy often occurs in the long-term care population due to their treatments from multiple care providers who use drug therapy to address a combination of chronic physical and mental conditions.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Source: Primary Care Providers Survey, Department for Public Health, Division for Aging Services, University of California San Francisco Department of Social and Behavioral Sciences.

Implementation Strategy:

- Develop educational materials addressing need for and benefit of subacute rehabilitative services for long-term care patients.
- Educate the general population with focus on those seeking long term care services in regards to
 - The need and benefit of rehabilitative and other services
 - The potential impact of polypharmacy
 - The need to be knowledgeable about medications and their actions in the long term care population
- Educate potential primary care providers regarding rehabilitative needs and potential impact of polypharmacy on the long term care population.

10.22. (Developmental) Assure that every person with long-term care needs has access to the continuum of long-term care services, especially:

Nursing home care

Home health care

Adult day care

Assisted living

Baseline: Data Not Available

NOTE: State Health Planning Officials indicate there is an over supply of Nursing Facility beds available. However, many times the available beds are in an area of the state far removed from the area of need. Other access barriers may include high intensity care needs, multiple medical conditions, special care needs such as blindness or deafness or severe dementia. Often nursing facility placement for men is more difficult because of the higher ratio of elderly women to men (there may be an available bed but it may be in a room with a woman). Regulatory restrictions and financial issues are the most frequent barriers to access for home health and home and community based services.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Sources: National Long-Term Care Survey, Medicare Beneficiary Survey, HCFA, Department for Public Health, Cabinet for Families and Children/Division for Aging Services.

Implementation Strategy:

- Educate legislators and regulatory bodies of the need for equitable access for long term care services to those with needs.
- Investigate potential financial and provider avenues to expand current services and/or develop new services to allow access to the long term care continuum for those in need.

10.23. (Developmental) Reduce to no more than 6.0 per 1,000 the proportion of nursing home residents with pressure ulcers at stage 2 or greater.

Baseline: 7.4 percent per 1,000 in 1997.

Target Setting Method: While the number of Nursing Facility residents reported to be bedfast has risen from 6.6 in 1994 to 13.2 in 1997, the percent of residents with pressure ulcers has dropped from 9.4 in 1994 to 7.4 in 1997. Contributing factors include an increase in the percent of residents receiving special skin care, an increase in the number of special equipment items for pressure relief, i. e. gel mattresses, air flotation devices and water beds. The National average of residents with pressure ulcers is 7.0. Given the significant decrease in pressure ulcers reported up to 1997, it is conceivable that with increases in quality of care and staff to client ratios, nursing facilities in Kentucky can reduce the incidences of pressure ulcers to 6.0 per 1,000 residents by the year 2010.

Potential Data Source: Long-Term Care Minimum Data Set, National Nursing Home Survey, University of California San Francisco Department of Social & Behavioral Sciences, Department for Public Health, Cabinet for Families and Children/Division for Aging Services.

Implementation Strategy:

- Educate providers regarding available resources for new and innovative skin protective supplies and equipment for use with bedridden residents.
- Include advanced skin care techniques and preventive interventions in the orientation and training of nursing facility personnel.
- Explore methods to provide incentives for staff retention, i.e. salary and/or benefits to achieve improved staff to client ratios. (Current regulations do not encourage staff retention in regards to nurse aide training costs. Redirecting the cost of multiple trainings into staff retention initiatives could potentially assure improved quality of care activities and staff to client ratios.)

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