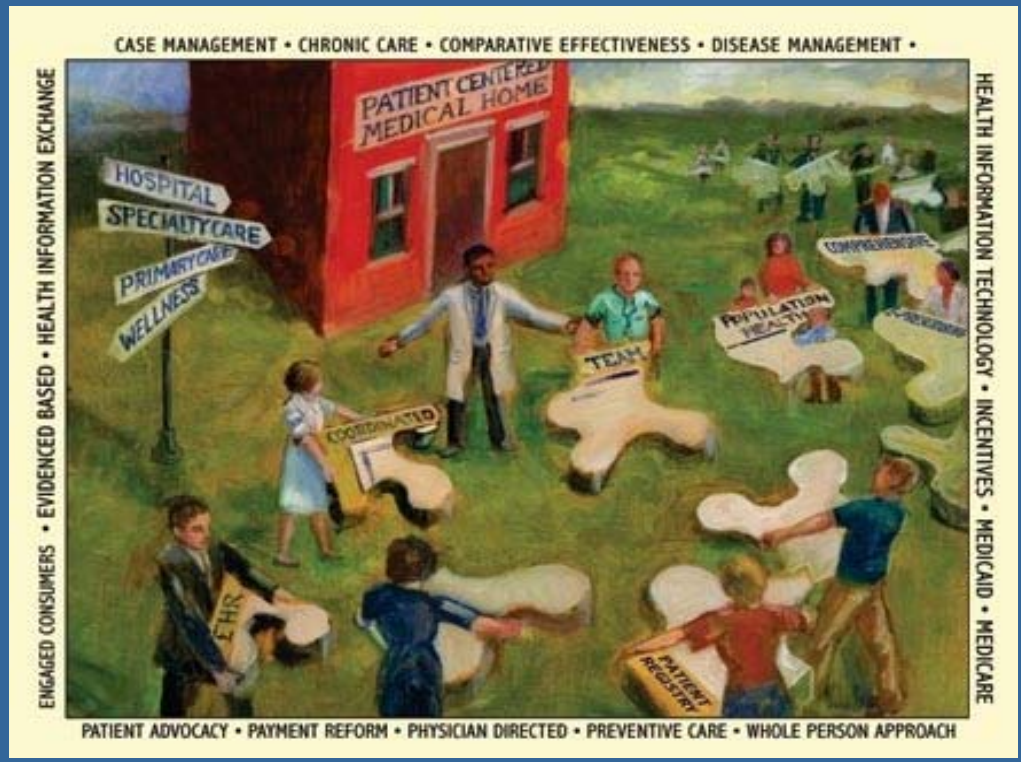
Emerging Roles for Non-Clinical Workers in the Medical Home Team



Medical Home Audioconference
Thursday, May 28, 2009
Sherry E. Gray, M.A.
Director: Rural and Urban Access to Health
St. Vincent Health

RUAH History

- RUAH Partnership initiated: 2000
- Partners:
  - **SV Health**
    - *In patient, Out patient, Community Based Care*
  - **Indiana Health Centers, Inc.**
    - *Federally Qualified Health Care Center (FQHC)*
  - **Health and Hospital Corporation of Marion County**
    - *County Health Department*
  - **ADVANTAGE Health Plans, Inc.**
    - *Insurance Provider (public and private plans)*
  - **Butler College of Pharmacy**
    - *PharmD students*
    - *Pharmaceutical Assistance Program (PAP) Consultation*
    - *Project Management/Oversight*
  - **Community "Interface" Groups:** local partner groups responsible for program implementation.
    - *Health centers, health departments, physician offices, civic groups, and health, human and social service agencies*

Initial Funding
(HRSA, Ascension Health, SV Health, Founding Partners)

- Funding Request Submitted to HRSA: May, 2001
- Funding Award to SV Health: HCAP – Healthy Communities Access Program in October 2001 for three years
  - Completed Fall, 2004 = $1 million
- Matching Dollars from Ascension: 2001 through 2005
  - Completed Fall, 2005= $1 million
- SV Health Based Program as of July, 2005

Initial Program Goals

- Assure a continuum of quality health and health-related services to the un and underinsured population at community-based primary care sites.
- Improve the ability of providers to address the cultural and linguistic issues occurring due to a fast growing Hispanic population.
- Provide access to free or reduced cost prescription drugs for the un and underinsured.

Initial Program Target Population Information

- The population in the original RUAH target sites was 171,191 with 54,961 or 32% living at less than the 200% poverty level.

- Approximately 75% of these people were not being served by safety net providers.

- Special emphasis was placed on the Hispanic population in the Central Indiana area where St.Vincent Health Ministries were located.

HCAP Becomes RUAH

Rural
Underserved
Access
to Health

Rural
Urban
Access
to Health

The word *ruah*, in yiddish means

“Breath of Life”

The Goal?

…to breathe new life into a dying

health care system trying to serve our most vulnerable community members

Current Service Areas:

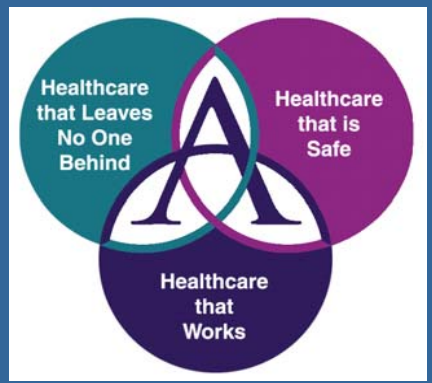
- **Clinton County**
  - *St.Vincent Frankfort **
- **Howard County ***
  - *St. Joseph Hospital*
- **Madison County**
  - *St. Vincent Mercy **
  - *Saint John's Health System*
- **Randolph County ***
  - *St.Vincent Randolph*
- **Clay County**
  - *St.Vincent Clay*
- **Jennings County**
  - *St.Vincent Jennings*
- **Fountain and Warren Counties**
  - *St.Vincent Williamsport*

* *Original CAP grant program sites*

Adding four additional program Sites increased the targeted Population to Approximately 106,000 additional Hoosiers

RUAH Today:

Purpose: *To connect our friends, family, and neighbors to a comprehensive, integrated delivery network of health, human and social services resulting in improved access and removal of barriers to needed resources.*



Focus Areas:

- **Health Access Workers–*client*** *advocates & system navigators*
- **Pharmacy** – *access to low or no cost drugs*
- **Creation of "Primary Care Homes" for the underserved**
- Access to **Specialty Care** for the underserved
- **Program enrollment** (*financial resource review and application assistance)*
- Reduction of inappropriate **Emergency Room utilization**
- Assistance with **supportive social services** ("wrap around")
- **Diversity** – *translation of core documents, medical interpretation, key signage, development of diversity councils, LEP Assessment*
- Sustainability

Health Access Workers (HAWs)

- Develop, maintain and encourage referral initiatives
  - establish a format to obtain and direct client referrals
- Complete initial assessment on each referral
  - “Global needs assessment”
- Assist with access to services
  - **Assist with and “negotiate” initial primary care home appointments and ultimate establishment of “medical homes”**
  - Complete referrals to area resources
  - Assist with public/private program applications
  - Provide follow-up as appropriate/necessary
- Work toward reduction of inappropriate use of the ER
  - Assists clients in finding “medical homes”
  - Encourages holistic care at the appropriate point of entry

HAW's as Medical Home Advocates:

- Work between, among, and across all appropriate community facilities, providers and programs/agencies, etc.
- "Connect the dots" between social issues, provider preferences and requests, and applicable program requirements (i.e. payer source requirements, provider/practice requirements, etc.)
- Negotiates through and around barriers, the ultimate goal:
  - *A primary care appointment and subsequently, follow up based on the outcome of that appointment "experience"*
  - *May revise based on outcome (or lack of); or use of ER for primary care home (both prior to 1st contact and subsequent to 1st contact)*
- "Juggles" the varied goals, challenges and expectations of the community providers
- Keeps the patient as the focus

Example:

- HAW meets client through a weekly “rounding” at the local subsidized housing unit
- Client reports needing medication, but has no provider: goes to the ER when “it gets really bad”
- HAW goes through “global assessment” with client:
  - Assists with Healthy Indiana Plan (HIP) application
    - *HIP = new Indiana-specific plan for those previously uninsured*
  - Assists with appointment to local clinic
    - *Local clinic has a Medication Access Coordinator (MAC): so medication assistance will be provided at the appointment*
  - Contacts local community group for transportation assistance
- HAW follow’s up with client at next “rounding” visit

Medication Access Coordinators (Mac's)

- Receive requests for prescription assistance
  - establish a format to communicate between the community, the client and the physician
  - *(help with Primary Care Home establishment)*

- Complete medication assessment on each referral
  - Review financial status/means
  - Evaluate: eligibility criteria
  - Search data base: medications covered

- Assist with access to services
  - Complete applications to prescription assistance programs
  - Provide follow-up as appropriate/necessary
    - Refills
    - Change in prescription
    - Develop or access additional PAP programs

Diversity:

- **LEP (Limited English Proficiency) plan**
  - **CLAS standards**
  - **Internal/External relationships; services; etc.**
- **Language Access Project:**
  - **Assessment**
  - **Action Plans**
    - ***Providing trained interpreters and/or interpretation by phone for non-English speaking patients especially for primary care appointments.***
  - **Auditing**
- **Health Access**
  - **Migrant Councils**
  - **Local communities**
  - **Promotores**
- **NCI contract**
- **Immigration Issues**

Program Outcomes:
(*Program "Start up" to Date…)*

- Four community programs grown to Eight community programs
- Additional private sector funding obtained
  - *Anthem Foundation*
- 28,181 client encounters
- 54,810 referrals, including
  - Primary Care Home appointments
  - Government program applications (Medicaid & SCHIP, etc.)
- $16.1 million worth of low/no cost drugs provided
- More than 800 HIP applications

National Access Outcome Measures Initiative (NAOMI)

1	Demonstrate an increase in the number of individuals in the targeted population with funded healthcare by increasing enrollment in public funded healthcare programs (i.e. Medicaid, State Children's Health Insurance Program, existing State and Local coverage initiatives).
2	Demonstrate an increase in the number of individuals in the targeted population with funded healthcare by increasing enrollment in private funded healthcare programs for the uninsured.
3	Demonstrate access and assignment to a medical home as evidenced by a documented visit to a primary care physician.
4	Demonstrate the impact of pharmaceutical assistance programs by the percentage of unduplicated people who receive pharmaceutical assistance.
5	Demonstrate the impact of pharmaceutical assistance programs by the retail cost of drugs obtained.
6	Demonstrate a reduction in unnecessary emergency room visits in the targeted population.
7	Demonstrate a reduction in unnecessary hospitalizations in the targeted population.
8	Diabetes: Demonstrate an improved health status of diabetic clients who are enrolled in care management programs.
9	Asthma.
10	Hypertension.
11	Demonstrate a reduction in the cost of unnecessary emergency room visits.
12	Demonstrate a reduction in the cost of unnecessary hospitalizations.

ASCENSION HEALTH

United States Department of Health & Human Services

AHRQ HEALTH CARE INNOVATIONS EXCHANGE

The Pathways Model (PM) is a strategy to establish measurable positive outcomes for populations most at risk in the community, develop action steps to accomplish those outcomes, and track progress at the level of individuals. The purpose of this Learning Network is to bring together sites that have expressed interest in implementing this innovative model in their communities. Through this Learning Network, the sites have an opportunity to share information on their individual settings, learn the strategies and techniques needed to implement the Pathways Model, and benefit from each others' experiences.

CHAP
COMMUNITY HEALTH ACCESS PROJECT

RURAL AND URBAN ACCESS TO HEALTH
RUAH
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St.Vincent
HEALTH
100% Access To Healthcare
No Closed Door