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100%
ACCESS
HEALTHCARE
INITIATIVE

EVALUATION OF THE
MEDICAL ACCESS PROGRAM PILOT: PHASE 1

Connecting the health services you need



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EXECUTIVE SUMMARY

Evaluation of the Medical Access Program Pilot: Phase 1

Background

The 100% Access Healthcare Initiative and Coalition were formed in 2005 after the 2004 United Way of Lane County Needs Assessment identified access to healthcare as the leading concern among Lane County residents, regardless of geography or socioeconomic status. The early work of the Initiative was divided into several Committees – Insurance and Enrollment, Outreach, Pharmacy Assistance, Chronic Disease Self Management, Healthcare Safety Net Collaboration, Medical Home, Information Technology and Metrics. For the first two years (2005 – 2007) the individual work groups defined and tested promising opportunities to increase access to care. As momentum grew around developing a coordinated access program for the uninsured, the work of each committee provided key pieces toward the development of a coordinated access program for the uninsured who did not qualify for government sponsored health insurance programs, such as the Oregon Health Plan (OHP).

In the summer of 2007, the Coalition leadership expressed a clear desire to take the work of each discrete Committee to the next level. The concept of the Medical Access Program (MAP) was developed initially by a committed group of stakeholders who set forth to create a system of care for the uninsured. Together, the scope of services desired, commitment to the medical home concept and ability to coordinate clients across medical, mental health and social services sectors, began to define a goal toward system's redesign that was potentially beyond the scope of other model programs to date. The Coalition wanted to "*provide better healthcare for more people at less cost,*" leveraging existing community resources to operationalize a pilot program. Coalition leadership asked for the program to be defined, piloted and implemented within three months (October 2007).

In July 2007, members of the Initiative's Executive Committee designated one individual from their organization to serve on the MAP Implementation team. The membership was empowered to make critical decisions about the programs infrastructure on behalf of their respective organizations. There was consensus from Coalition leadership and the Implementation Committee members that Phase 1 of MAP was a pilot – a tentative model for future experiment or development that would be redefined based on the program's initial experiences. In summary, the goals were to (1) test system-wide approaches to care delivery and cross-sector care coordination, (2) collect data on the program's successes and limitations and (3) use the pilot experience to inform the development of a comprehensive community access program, including innovative reimbursement reform at the local level (e.g. multi- or three-share models). Between 2005 and 2007, several criteria had been developed for MAP eligibility and benefits that built on the initial work of the Committees; however, in order to launch a pilot program, the program parameters needed to be better defined, the provider network established and each needed to integrate with a health information technology interface.

MAP is not an insurance program. Care for the pilot population was donated and the clients did not incur a cost for participation. The MAP Phase 1 model relies on the concept of a medical home in which the client establishes a relationship with a primary care provider (PCP - physician, physician assistant, nurse practitioner) and a MAP Care Coordinator. The PCP works

through the Care Coordinator to negotiate specialty care, hospital or surgery center procedures, expensive diagnostic labs or imaging, durable medical equipment, physical therapy, and any additional medical or psychosocial support the PCP needs to care for the client that are considered outside the scope of primary care services. Basic diagnostic labs and imaging are accessible to the client at the discretion of the PCP without prior authorization.

Phase 1 of MAP is defined as the pilot population enrolled between December 2007 and June 2008. The purpose of the current report is to focus on the key process outcomes for MAP and highlight a limited range of program outcomes related to Phase 1.

Methods

The evaluation for Phase 1 (population enrolled from December 2007 to June 2008) is divided into (1) a qualitative process evaluation based on focus group data and (2) quantitative data analytics based on data gathered during screening, enrollment, claims processing, and care coordination activities. Health Policy Research Northwest (HPRN) was one of nine institutions represented on the MAP Implementation Committee; therefore the qualitative process evaluation was sub-contracted to Susan Eliot, owner and lead qualitative researcher at Group Wisdom and Eliot & Associates, located in Portland, Oregon.

Process Evaluation

A qualitative approach was chosen to evaluate the process components of Phase 1 of the MAP demonstration project. Focus groups with four to six participants in each group were planned with three contingencies of the overall MAP coalition: (1) Executive Committee members, (2) Operations Committee members, and (3) end-users of the MAP system.

The focus groups were designed to evaluate the development of the following program components by the Executive and Operations Committee members: client eligibility determination, client screening and enrollment, provider recruitment, provider relations, determination of the map scope of services, and program administration. The evaluation also includes an assessment of committee components such as leadership, commitment, and group process. The primary aim was to detail the key program decisions and lessons learned during Phase 1.

A question guide was developed in advance in collaboration with HPRN. Focus groups were conducted by phone while a live captioner created a word-for-word transcript of each focus group. Transcript data from both focus groups and written responses from the two end-users were collated and entered into an Excel spreadsheet for coding and categorization. Major themes and sub-themes were identified and data grouped accordingly. To the extent possible, exact participant quotations are used throughout the qualitative section of the report to capture exact sentiments. To establish anonymity, participant names and group identities are not attached to any quotations or summary findings.

Focus group participants were asked to describe the perceived level of development for each program component on a scale of 1-10, with 10 representing highly developed. Additionally they were asked which components proved the most difficult to operationalize, what compromises or revision needed to be made to operationalize each component, and to what extent they were satisfied with each of the finalized components.

Quantitative Program Evaluation

Quantitative outcomes were compiled from a variety of sources:

- Screening and program eligibility;
- Geographic distribution;
- Encounter (administrative claims) data submitted by providers; and
- Activity log entries made by Care Coordinators and/or MAP staff.

Screening and Program Eligibility

When a client is screened for MAP, basic demographic information is collected and stored about the client. Data may be entered directly into the MAP website (www.mapcard.org) or captured on paper enrollment forms, then entered into the MAP website. Screening data is captured for all potential enrollees following a documented client consent process and execution of required forms (client rights and responsibilities, HIPAA notice and agreement, charitable immunity waiver).

Geographic Distribution

Geographic Information Systems (GIS) mapping was used to geocode the residence location of MAP clients. Two maps were created to demonstrate the MAP enrollment density in each census tract – one for Lane County and a second map for the Eugene-Springfield metropolitan area. Finally, census tracts in the Eugene-Springfield metropolitan area were coded with a gradient shading scheme to reflect the percent of households with combined incomes less than 200% of the federal poverty level according to 2000 Census data – the reference population of potentially qualifying clients for MAP.

Encounter (administrative claims) submitted by providers

Administrative (i.e. claims) data are information collected by providers and submitted to the patient's insurance company for reimbursement of services. Administrative data includes basic patient information, a detailed listing of procedures performed and services provided to the patient during the visit, the cost of those procedures, and codes that describe the diseases or conditions the patient is diagnosed with during the visit. Submission of MAP enrollees' encounter data to Lipa is optional; therefore, analysis of encounter data is limited to providers who submitted claims. Claims were available for the pilot population enrolled between December 2007 and June 2008. Claims analyses were extended through claims received before June 2009 due to the small population sample size (46 clients enrolled).

Variable definitions are included in the associated *Results* section to lend clarity to each analysis and aid in interpretation. Two definitions of "encounters" are provided; count of all encounters (claims) and the count of defined episodes of care.

A time trend histogram was created to examine utilization of services during enrollment over time. For each member, the time elapse is limited to the first six months of enrollment, corresponding with the initial eligibility period for MAP.

Activity log entries made by care coordinators and/or MAP staff

The client's care coordinator or MAP staff member that interacts with the client, or with other agencies or providers in the community on behalf of the client, is responsible for documenting each interaction on the "Activity Log" tab of the MAP website. The "notes" field was left

purposefully as open-ended text in order to capture the scope of coordination activities provided to MAP clients. The open-ended string variables were reviewed by two HPRN staff members independently and validated by a third.

The scope and intensity of care coordination activities required to serve MAP clients is a key consideration when considering program sustainability and scalability. Clients were categorized into “high intensity” clients or “low intensity” clients, using a 50% break for the count of activity log entries. Separately, two time trend histograms were generated to compare the utilization trends of “high intensity” versus “low intensity” clients over the first six months of enrollment.

Results

The current evaluation is not intended to provide feedback on the Coalition’s processes, previous programmatic efforts or work as a whole. An evaluation of the strength and effectiveness of the collaborative was completed in the summer of 2008 by an independent contractor hired by United Way of Lane County. Some results of the qualitative process evaluation suggest the line between the Coalition’s and MAP’s activities may be blurred. Participants’ comments extend into phase 2, rather than limiting the scope of feedback and reflection to Phase 1.

Process Evaluation (from the Group Wisdom Report)

Client Eligibility

Good overall development; eligibility guidelines possibly too restrictive; non-representative pilot population; more work to be done. According to focus group participants, client screening and enrollment is one of the most well-developed of all MAP components. On a scale of 1 to 10 their collective score was a “9.” “As far as the elements that are out there, it’s probably one of the stronger,” said one participant.

Scope of Services Determination

Non-representative scope of services; need for expanded services (dental, mental health, social services); expense of expanded services. For the most part, focus group participants felt that the scope of services component was well-developed: “I think we did very well designing and recruiting and trying to flush out those services. There’s still a couple of them that need to be rejuvenated again...” Some focus group participants felt that the current scope of services was inadequate for the type of individual being enrolled. In particular, dental and behavioral health services presented a higher demand than anticipated. Not unexpectedly, the dynamic need for services created tension between those attempting to supply the services (Executive Committee) and those attempting to respond to the demand for services (Operations Committee). On average, participants gave it an “8” on a scale of 1 to 10.

Provider Recruitment and Relations

Less than ideal provider relations; disengagement of Medical Society; need to identify barriers to recruitment. Poor communication with providers and the inability to fully engage the local Medical Society plagued development of the provider recruitment component: “I felt like we could have communicated a little more on an ongoing basis with the PCPs to let them know how our process had been.” “...I think one of the flaws we have in our system is we didn’t acknowledge the existing pro bono work by lots of docs out there doing this.” Someone mentioned the fact that physician recruitment was not supposed to be part of the original scope

of work, perhaps contributing to the challenge in its development: “[Recruitment] wasn't necessarily in the scope of the assignment that the MAP committee was supposed to have. Initially they said you decide the program and we'll bring the docs...” Another observed: “The providers are experiencing stress from a number of different angles right now, economic stress in particular. For us to expand capacity or even create any kind of capacity, we're going have to have some sort of provider relations mechanism that's much better than what we've done in the past.” Overall, the development of the physician recruitment component scored a “6” on average.

MAP Project Administration

Complex structures and decision-making processes; inconsistent participation; driven by minutiae; diluted vision. Nearly every participant acknowledged the complexity of administering the project. “...I guess I would say the lines of authority and decision-making and who was doing what were just not well defined. I think that added to the confusion and the lack of smooth program administration.” On the other hand, some individuals embraced the complexity: “My sense is we did as good as a job as we possibly could have done at operationalizing each area...even the program administration which [we] agree wasn't thought out all the way. But it was a pilot program.” Another stated: “I'm pretty satisfied with how it's gone considering the complexity of the decentralized system we wanted to set up. I suppose it would have been easier if we just found a huge funding source and built a central administration.”

“I think we're still building on our greatest strength – the collective strength of all the members of this coalition. And that's an insight we need to keep in front of us and capitalize on.”

Focus Group Participant

Group Processes

Good processes and leadership; not always on the same page. Both groups applauded their internal processes and leaders. Participants from both committees mentioned problems with keeping the whole group on the same page. One Operations Committee member stated: “It felt like in the planning phase, the first phase, we had pretty good group process. Everybody participated. Everybody was willing to kind of step back and kind of look at the big picture... how are we going to continue to keep that momentum going...” The Executive Committee seemed to have a similar issue: “There may be occasions, and I'm speculating here...that we need to do a better job of making sure we're on the same page and thinking of the same thing as we're walking out with the agreements that we have.”

Leadership

Lack of leadership at the top; no continuity of leadership; confusion regarding leadership. “I think that's one area we (Executive Committee) haven't done as well: structur[ing] the committees, creating leadership in those committees, giving them their marching orders, that sort of thing.” Another, however, said: “We had some leaders that we asked to do some things [but] they didn't get a lot of strategic direction. So I don't know they navigated some of the land mines as deftly as they could have.” The need for leadership at the program's current stage is especially acute for those attempting to implement the program: “I would think if there would be an area for improvement it would be more clarity on who ultimately absolutely is in charge...”

Mission and Vision

Confusion regarding conflicting purpose, vision, provider recruitment, client eligibility, and scope of services. Initially, it seemed, project developers embraced a clear purpose. As the project moved forward, however, the initial resolve dissipated: “It was about the time we [were] coming out of the pilot and going into a broader community enrollment and involvement and so forth that a whole lot of other cooks in the kitchen started to dump things into the soup. And it got a little messy at that point. Things got more disorganized.”

Commitment

Dedication; persistence; common purpose; stepping up to the plate. Despite confusion and differences of opinion, the dedication, persistence, and resolve of those involved transcended the rough spots and carried people forward. One individual remembered a specific situation: “I’m not sure we ever got to a revision that everybody was really happy with. So, you know, we continued to move ahead largely because of people’s dedication and devotion to what we were trying to accomplish.” And people stepped up to the plate again and again: “Different people on the group volunteered again and again to call up so and so and see if they could get what felt like 50 doctors to sign up to do this.”

Quantitative Program Evaluation

Screening and Enrollment

In total, 46 clients were enrolled between December 2007 and June 2008: 17 clients from Head Start (37%), 15 clients from the Department of Human Services OHP eligibility office in west Eugene, following confirmation of OHP denial (33%), nine were enrolled following a targeted outreach effort conducted in partnership with the Bethel School district (20%), and five from other methods (11%). The high school graduation rate among MAP enrollees (65%) is less than the high school graduation rate in the Eugene/Springfield metropolitan area reported in 2000 (82%). The majority (80%) of participants screened received a Full MAP Card (six month eligibility term) at the time of initial screening, all of whom had an OHP denial letter or were assumed ineligible for OHP due to known eligibility restrictions.

Encounter (administrative claims) submitted by providers

A total of 40 clients (87%) enrolled accessed services for which claims were submitted between December 2007 and June 2009. When reporting episodes of care, which more accurately reflects the access point for a single care event, two-thirds of MAP encounters occurred in the office setting. In addition, 11% of care delivered was accessed through the emergency department; 9% through independent laboratories; 8% through outpatient hospital services; 3% were admitted to the hospital (inpatient); and less than 1% accessed ambulance services.

Medical charges submitted totaled nearly \$139,000 (mean per enrollee \$3,474; median \$1,115). Dental charges submitted totaled \$8,882 for four MAP Phase 1 clients for whom a claim was received. The total charges were cross-tabulated with the demographic characteristics in an attempt to identify utilization cost trends that may be important to program planning and implementation: 20% of enrollees were undocumented residents of Lane County, but only accounted for 4% of the charges generated; 60% of enrollees were self-identified as White, Non-Hispanic, but 87% of charges were generated by this race/ethnicity; and 58% of enrollees were unemployed at the time of initial screening, but this population generated 83% of charges generated.

In the MAP, no reimbursement is provided; however, Current Procedural Terminology (CPT) codes, the HCFA Common Procedural Coding System (HCPCS) codes, and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD9) procedure codes are still submitted to quantify the scope of services utilized by MAP Phase 1 clients.

Among the 40 MAP Phase 1 enrollees who accessed services between December 2007 and June 2009, 588 procedures were performed. Nearly half (49%) of procedures were related to an evaluation and laboratory chemistry and hematology, procedures common when performing a routine physical examination. Among members with claims submitted, the majority of procedures were diagnostic in nature, as compared to high cost treatment or hospitalizations. Using a standardized coding methodology (Clinical Classification System), the disease categories and conditions that were present in one out of every three (33%) enrollees included: injury and poisoning; endocrine, nutritional, and metabolic diseases and immunity disorders; diseases of the nervous system and sense organs and mental health. Symptoms and ill-defined conditions were the most frequent diagnoses among Phase 1 enrollees (55% of clients). These ill-defined conditions include symptoms such as abdominal pain, nausea and vomiting, malaise and fatigue, and fevers of unknown origin.

Disease-specific coding algorithms, which may be more accurate for capturing a more narrow set of conditions, result in similar prevalence estimates for mental health (33%). Less than 10% of clients have encounter data documenting a dental, alcohol-related, asthma-related or drug-related condition. Although a small sample, 15% of Phase 1 enrollees have at least one diagnosis reported for diabetes (Type I or Type II); 138% higher prevalence than the statewide prevalence reported for adults in 2006 (6.3%).¹

Activity Log Entries Made by Care Coordinators and/or MAP Staff

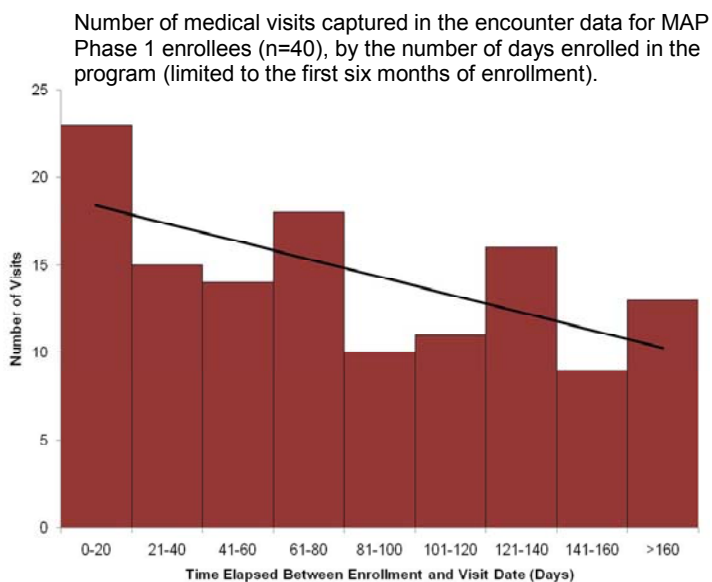
There were 707 activity log entries captured by the MAP website between December 2007 and June 2009, limited to the Phase 1 population: 84 appointments; 75 referrals; 41 entries related to PCP assignments; and 403 open-text comments. The remaining entries were auto-generated by the MAP website upon screening, rescreening or receipt of a claim (n=104). In total, 43 members had care coordination notes documented in the activity log. The open-ended text comments represented the largest proportion of entries within the Phase 1 clients' activity logs (58%). Out of 403 open-ended comments, 50% were related to client contact, care coordination and administrative activities (n=93, n=36, and n=72, respectively).

The median number of activities documented between December 2007 and June 2009 per client was nine; therefore "high intensity" clients are defined as Phase 1 enrollees with more than nine activities (> 9) and "low intensity" clients are defined as Phase 1 enrollees with nine or less activities (≤ 9). Citizenship (US versus other) (p=0.001), race/ethnicity (p=0.01), and the MAP referral source (p=0.02) were significantly different between "high intensity" and "low intensity" clients. More high intensity clients were US citizens and White, Non-Hispanic. There were significantly more episodes of care (encounters) and procedures performed among the "high intensity" clients compared to "low intensity" clients (both measures p=0.001, non-parametric Mann-Whitney U test). Finally, "high intensity" clients had a higher prevalence of alcohol-related diagnoses (not significant – small sample size), dental-related diagnoses (not significant – small sample size), diabetes (not significant – small sample size) and mental health-related diagnoses (p=0.03). Patterns detected in the Phase 1 population will need to be validated in a larger population.

¹ The Burden of Diabetes in Oregon: Surveillance Report. Oregon Department of Human Services, Public Health Division, Health Promotion & Chronic Disease Prevention. March 2008.

Intensity and Duration of MAP Service Utilization: A Preliminary Assessment

The figure to the right reports the utilization of medical services, as captured in the encounter data (claims) for the 40 Phase 1 clients with medical claims submitted. The time elapse for each member is limited to the first six months of enrollment, corresponding with the initial eligibility period for MAP. The measure of interest is the number of visits to medical providers (y-axis) over time. Note the dark trend line – a preliminary assessment of utilization over time. This measure may demonstrate that as the length of MAP enrollment time increases, the utilization of medical services decreases.



A similar methodology can be applied to the “high intensity” care coordination clients and the “low intensity” care coordination clients, where intensity level is measured by the count of activities documented by the client’s care coordinator and MAP staff. The resulting trend is the same – utilization decreases in both groups over the duration of the first eligibility term (six months).

Recommendations and Next Steps

A comprehensive program evaluation of the three year program (December 2007 – December 2010) will provide stakeholders important feedback and help determine key program features that will impact the scalability and sustainability of MAP. The timeframe is consistent with the work defined in the grant received from the Oregon Department of Health and Human Services.

The quantitative program evaluation is limited by the lack of consistent and systematic data collection throughout Phase 1. The small population sample size presents known challenges to an effective program evaluation; however, incomplete data capture in the Phase 1 population introduced additional bias.

Screening and Enrollment

The populations identified for MAP Phase 1 enrollment were selected purposefully to test three different eligibility determination models. “Client is known not to be eligible for OHP” was a status adopted by the Implementation Committee to ease the screening process for clients who were assumed not to be categorically eligible for OHP. The proportion of clients in this category who had (1) ever applied to OHP or (2) who may have qualified for OHP had the application been completed is unknown. With the expansion of OHP eligible populations in late 2009, clients with this designation may now qualify for Medicaid benefits. Screening and enrollment into government-sponsored programs was identified as a primary goal of Phase 1. Should this strategy be pursued moving forward, a defined effort to screen and enroll eligible populations may be warranted.

Encounter (Administrative Claims) Data Submitted by Providers

Submission of claims was requested of participating providers, but not necessarily mandated during Phase 1. The encounter data is the most standardized and valid assessment of the scope and financial value of services provided to MAP enrollees. In addition, the claims data can be most easily compared to other jurisdictions. Furthermore, physicians cannot be easily acknowledged for care delivered that the program is not aware of, nor can the Care Coordinator intervene to manage utilization issues in a timely manner. Moving forward, a clear and systematic effort should be made to capture administrative billing claims on all services provided to MAP clients.

Assessment of Care Coordination Intensity May Tie to the Equitable Distribution of Donated Care

Equitable distribution of services, with particular attention paid to the distribution of primary care services, was a key consideration in the assignment to the client's medical home. In addition, the Care Coordinator made a documented effort to distribute specialty care services among affiliated groups and independent providers. The clients' activity logs were analyzed in order to identify "high" versus "low" care coordination intensity clients. The pilot data suggests it may be possible to "tier" clients and predict utilization patterns based on demographics, case complexity and medical necessity in the future should the enrollment numbers be scaled sufficiently. Should the program parameters and data capture support this approach, standardized policies and procedures may be created to develop an accountable and transparent client distribution.

Activity Log Entries Made by Care Coordinators and/or MAP Staff

More clients (n=43) have documented activities by the Care Coordinator in the client's activity log compared to the number of clients with medical claims (n=40). Part of the goal and intent of MAP is to coordinate and assist clients in navigating services across the medical, mental health, dental, and social services sectors; therefore, the MAP's success is not entirely dependent upon encounters with medical care providers.

Focused attention should be given to documenting the full scope of care coordination activities required to provide cross-sector case management and support systems navigation. The entries captured in the clients' activity logs appear to be terminal events and do not capture the sequence of events required to reach the end-point. We have demonstrated that the activity log can be combined with other data streams, such as the encounter (administrative) data to support program and policy decision-making.

Intensity and Duration of MAP Service Utilization: A Preliminary Assessment

Data sources were combined to create a time-trend histogram of medical service utilization over the first six months of client enrollment. These data results are encouraging and will prompt further investigation. Regardless of the client care coordination intensity level (high versus low), medical service utilization decreased over time. The goal of the analysis is to begin to predict or profile clients based on anticipated need, which may translate directly into care coordination and program staffing levels required to effectively case manage enrollees. Increased submission of encounter data (claims) and increased documentation of care coordination activities are needed to assess the accuracy of this observation.

Next Steps toward Ensuring Measurable Outcomes

In June 2009, enrollees began completing a series of two standardized questionnaires at enrollment and rescreening. These data may add significant insight and guide program planning in the future. Results from the surveys will be reported in February 2011.

The Phase 1 qualitative focus groups were unable to recruit clinician participation. The time commitment required (90 minutes), lack of knowledge about MAP, and not recognizing that care had been provided to a MAP Phase 1 client were barriers to participation. The Coalition may consider offering an incentive to increase the clinician response rate.

The results of the qualitative focus groups and the quantitative program evaluation both highlight the need for a strategic, organized approach for advancing the goals of MAP. The evaluation results suggest the momentum achieved in the development of Phase 1 is difficult to sustain. While Phase 1 relied predominantly on volunteer resources from a few key agencies, the realities of operationalizing a collaborative health services delivery project may necessitate an investment in organizational infrastructure to ensure:

- Program parameters are well defined;
- Provider recruitment, engagement and recognition strategies are developed and sustained;
- Program documents are utilized appropriately and distributed consistently (e.g. informational packets, agreements to participate, client and provider handbooks); and
- Quality management processes are completed routinely.

Program administration in Phase 2 has not been optimized, as highlighted in the qualitative process evaluation. Results of the Phase 1 evaluation provide an opportunity to inform and enhance Phase 2. The magnitude of decision-making that the three year program evaluation can inform is dependent upon the Coalition addressing the limitations highlighted.