



Project Access NOW

EXECUTIVE SUMMARY

2008-2010

PROGRAM EVALUATION

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Prepared by: Health Policy Research Northwest
Kenji Matsumoto, MPH
Heidi Hascall, MA
Ryan Burke, MPH
Jenny Hehnke, PhD
Anthony McParland
JP Sleeper, MPAc
Amanda Cobb, BA
Ian Cronin, BA
Erin Owen, MPH

Health
Policy
Research
Northwest

Evidence Serving Your Community's Health

University of Oregon Riverfront Research Park
1800 Millrace Drive
Eugene, OR 97403
541.431.1900
www.hprnw.org

Executive Summary

Background

Studies suggest that limited access to specialty care leads to poorer health outcomes for the underinsured.^{1,2} Lack of health insurance is the greatest risk factor associated with specialty care access problems.³ A gap in specialty care access is highlighted as a significant problem for uninsured and those covered by Medicaid.^{1,2} Uninsured and underinsured people are less likely to receive preventive care and more likely to be hospitalized or use emergency rooms, resulting in both poorer health outcomes and rising costs.⁴ Compared to patients with Medicaid, Medicare or private insurance, uninsured patients have greater difficulty obtaining access to off-site specialty services, including referrals and diagnostic testing.⁵

Given the absence of timely nation-wide solutions to these problems of specialty care access and increasing levels of specialty care need, many communities across the nation have initiated varied programs to meet the needs of the underinsured.^{1,15} Emerging research demonstrates that community-level approaches to healthcare can overcome access barriers for the uninsured,^{3,11} particularly for clients in need of specialty care services. Formal care coordination models not only report improved access to care but also better management of chronic diseases and cost-savings.¹⁵ Relying primarily on volunteerism, these programs face financial strain and barriers to community buy-in. Nearly 2,000 communities have implemented no- or low-cost clinics, referral networks, insurance coverage expansion, employer buy-in programs, hospital-driven approaches, and physician volunteerism with varying levels of success.^{1,15}

Project Access NOW is a broad based community initiative that builds access to health care for low-income and uninsured people in the Portland/Vancouver metropolitan area by coordinating a network of volunteer physicians, clinics and hospitals. Project Access NOW improves the health of the community by effectively linking those in greatest need with health care providers and organizations who have the ability to serve the uninsured. The collaboration initially included three programs, corresponding with the counties responsible for implementing the project in their regions: (1) Project Access Multnomah County (PAMC), Oregon; (2) Project Access Washington County (PAWC), Oregon; and (3) Project Access Clark County (PACC), Washington. In 2010, Project Access NOW (PANOW) added Clackamas County, Oregon to their portfolio of communities served.

The current program evaluation is limited to the three original counties served between 2008 and 2010. In 2009, the PANOW Board of Directors conducted the first comprehensive strategic planning process in which seven program goals, strategies to achieve the goals, and program and operational benchmarks were identified. Health Policy Research Northwest (HPRN) began working as an independent program evaluator for PANOW in 2008, prior to the completion of the FY 2009 – 2010 strategic planning process. The scope of work included directly addresses the strategies and benchmarks associate with *Goal #1: Low-income, uninsured individuals receive their care in the most effective, cost appropriate and timely way possible*. Included in the current report are the operational benchmarks that could be measured from data collected, aggregated, and/or analyzed by HPRN.

Methods

This report summarizes data collected from the first date of reported client service (March 2008) through January 2010.

Client Enrollment Information

When a client is enrolled in PANOW, basic demographic information is collected on the client (e.g., gender, age, etc.). This information is collected by PANOW staff via standard enrollment protocols. Clients are to be re-enrolled or exited from the program after six (6) months.

Client Surveys

For the purposes of this report, entry is defined as entry into PANOW for the first time (not a rescreen), and exit is defined as leaving the program after six months. Client entry and exit surveys include questions on access to healthcare, healthcare utilization, healthcare services needed and not accessed, overall health status and presence of mental health and dental health needs. Survey responses were cleaned and coded, then analyzed using SAS[®] version 9.0 (Cary, NC). Descriptive frequencies were generated for all survey responses. To assist in determining whether or not unmet need can be predicted, a multivariable logistic regression model was tested on each survey response that was potentially associated with unmet client need on the exit survey. The odds ratios (OR), 95% confidence intervals (CI), and p-values are reported. Finally, the survey responses were limited to only those clients with both an entry and exit survey (n=56) and were analyzed.

Administrative Data

Administrative (i.e., claims) data are collected by providers and submitted to track the scope and financial value of services delivered. Administrative data includes basic visit information (e.g. – date, place of service), a listing of procedures performed and services provided during the visit, the cost of those procedures, and codes describing the medical conditions or diseases the client is diagnosed with during the visit. Claims were available from March 11, 2008 to January 16, 2010. Data on population level diagnoses (ICD-9s) and procedures (CPTs, HCPCS) received are reported, in addition to cost data for charges submitted and equivalent Medicare Fee-For-Service fee schedule. In order to investigate potential predictors of future utilization at the time of enrollment, the outcome variables of interest were identified as very high, high and low encounter volume versus very low encounter volume. Independent variables that were examined as possible predictors included client demographics and select entry survey responses. The odds ratios (OR), 95% confidence intervals (CI), and p-values are reported.

Geographic Distribution

Geographic Information Systems (GIS) mapping was conducted for each county program as a means of assessing client distribution, income levels, and proximity to healthcare services (e.g., hospitals, community health centers), as well as dental and mental health needs of PANOW clients.

Provider Survey

The provider survey was developed and independently administered by HPRN using SurveyMonkey, a web-based survey administration service. The survey collected information on four main areas: respondent background (e.g., office title/role, length of time involved in PANOW), PANOW operations, referrals and medications, and PANOW value. A minimum of three attempts were made to contact each PANOW provider. Descriptive frequencies for each response are reported and comparisons between 2009 and 2010 provider survey responses are provided.

Results

Client Enrollment Information

A total of 2,515 clients were enrolled in a Project Access program from March 11, 2008 through Jan, 16 Jan, 2010. Assuming a steady rate of increased enrollment (181 clients per month), by June 30, 2010, the total program enrollment is estimated to be 3,694 clients. Clients who were enrolled once for fewer than 180 days accounted for 58% of clients. Clients varied significantly by county according to gender, homeless status, race/ethnicity, and age. Multnomah County enrolls the highest proportion of males (50.1%) and homeless clients (12.4%). Nearly half of all enrollment occurred in the Multnomah County program (46%), while Washington County accounted for 36% and Clark County 18%.

Approximately 386 volunteer provider groups provided services to 1,629 PANOW clients. Together, Tuality Community Hospital and OHSU accounted for nearly a quarter of all client encounters (23.8%).

Client Surveys: Entry and Exit

In total, 885 clients responded to the questions on the entry survey (at least one question) and 602 clients responded to the questions on the exit survey (at least one question), with 56 individuals responding to both an entry and exit survey (paired responses). Result highlights are provided for select survey responses.

“In the last six months, how many times did you go to the emergency room (ER)?”

- After adjusting for sample size, the number of clients who self-reported any ER visits in the past six months decreased 36% between program entry and exit.
- An estimated 143 ER visits were avoided between program entry and exit, at an estimated dollar value savings of \$54,769.
- The most frequent users of the emergency room at the time of enrollment were the PANOW population between the ages of 20-29 (42.4%) and 40-49 (42.5%). At the time of exit from PANOW, all age groups dropped in their ER use to 20% - 26%, accessing the ER in the last six months.

“In the last six months, did you go without care when you needed it?”

- 63% of clients reported going without care in the last six months at program entry.
- At entry, the primary reasons for going without care was money (92%); at program exit the proportion reporting money as a barrier dropped to 71%.

“In the last six months, how many times did you go without seeing a specialist when you needed specialty care?”

- After adjusting for sample size, there was a 53% decrease in the number of clients who went without specialty care in the past six months, by self-report between program entry and exit.



- Across all counties, the primary reason for going without needed medical or specialty care at the time of enrollment into PANOW was money (Clark County – 59%, Multnomah County – 58%, and Washington County – 44%). At the time of exit from PANOW, 11% - 39% still reported money as the biggest barrier to accessing medical or specialty care.

“In the last 6 months, has a doctor or specialist written a medication prescription for you?” and “Were you able to fill your medication prescription(s)?”

- There was no significant difference in the percent of clients with prescriptions written or filled between program entry and exit, by self-report.
 - Written: 76% entry (n=693); 79% exit (n=355)
 - Filled: 87% entry (n=508); 85% exit (n=273)
- When asked the reasons PANOW clients went without filling medication prescriptions at time of PANOW enrollment, 85% responded that money was the biggest barrier, while at exit, 69% reported cost was a barrier.

“On a scale of zero to ten... ten being the best healthcare possible, how would you rate the care you received from your Project Access doctor?”

At program exit, PANOW clients rate quality of health care as an “8” or higher in:

Clark County; 86%
Multnomah County; 91%
Washington County 86%



“Do you currently have health insurance?”

At entry, 3% of clients reported having health insurance, compared to 11% at program exit (p<0.0001, entry n=872, exit n=584).

“How easy was it to understand the explanations that your Project Access doctor gave? Very easy, somewhat easy, somewhat hard, or very hard?”

- Across all counties, PANOW clients overwhelmingly reported “very easy” when asked about the ease of understanding PANOW doctor’s explanations (Clark- 78%, Multnomah - 70%, Washington - 80%).
- Only 2% of clients in Clark and Multnomah counties and 3% in Washington County reported it was “very hard” to understand PANOW doctor’s explanations.

“How often did your Project Access doctor listen to what you had to say? Never, sometimes, usually, or always?”

Across all counties, the majority of PANOW clients reported doctors “always” listened to what they had to say (Clark-81%, Multnomah-78%, Washington-83.6%).

“How easy was it to get an appointment with your Project Access doctor? Very easy, somewhat easy, somewhat hard, or very hard?”

Across all counties respondents reported getting an appointment with their PANOW doctor most frequently as “very easy” (Clark-47.5%, Multnomah 58.3%, Washington 72.3%).

“In general, how would you rate your overall health? Excellent, very good, good, fair or poor?”

Clients self reported health status at entry and exit as excellent (“1”) very good (“2”), good (“3”), fair (“4”) or poor (“5”). There was a significant improvement in mean health status from 3.60 to 3.33 between program enrollment and exit (two sample t-test of means, $p < 0.0001$). Significant differences in self-reported health status at entry and/or exit exist by gender, level of education and employment status.

“In the past 6 months, did you have any dental needs (i.e. tooth or mouth pain, bleeding, trouble chewing, broken or damaged teeth)?” And “In the past 6 months, did you see a dentist?”

- When asked about dental needs at the time of entry and exit, 66% reported having dental needs at entry and 63% at exit.
- When asked whether PANOW clients had seen a dentist in the last six months, 84% reported at entry that they had not seen a dentist and 81% of clients reported not having seen a dentist at exit from PANOW.

“In the past 6 months, have you felt stressed, anxious or depressed to the point that you wanted to talk to a professional counselor?”

- Across all counties, PANOW clients showed a decrease in feeling stressed, anxious, or depressed to the point of wanting to talk to a professional counselor at the time of exit (Clark- 13.3% decrease, Multnomah- 2.8% decrease, Washington- 6.6% decrease). However, at the time of exit from PANOW, 35% - 45% still reported feeling stressed, anxious, or depressed.
- Significant differences in self-report feelings of stress, anxiety or depression exist at entry and/or exit by gender and client age category.

Paired Survey Response Highlights (N=56)

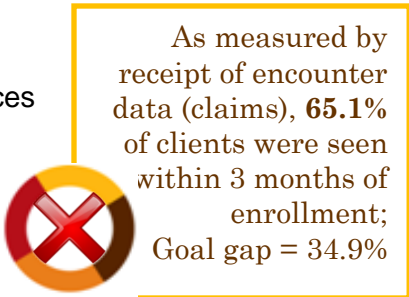
- There was no significant difference in the number of clients who self-reported going to the emergency room in the last six months by self-report, 34% at entry versus 30% at exit (n=50).
- When asked about going without care in the last six months, at entry 78% of clients stated that they had gone without care in the last six months, while 40% of the same respondents stated they went without care in the last six months at exit from PANOW (n=50, $p=0.0003$).
- A similar trend was noted in respondents reporting challenges accessing specialty care at program entry (70%), compared to program exit (30%) (n=47, $p=0.0003$).

Predictors of Unmet Need at Program Exit

- The adjusted odds of a client self-reporting going to the ER in the past six months at program exit were 1.75 times higher among clients that self-reported feelings of anxiety, stress or depression compared to clients that did not report potentially depressive feelings ($p < 0.01$).
- The adjusted odds of a client having gone without specialty care in the past six months at program exit were 2.14 times higher among clients with feelings of anxiety, stress or depression compared to clients without any self-reported depressive feelings ($p < 0.001$).
- The adjusted odds of a client having gone without specialty care in the past six months at program exit were 1.92 times greater among clients that self-report unmet dental needs compared to clients that did not self-report unmet dental needs ($p < 0.01$).
- The adjusted odds of a client having an unmet dental need at program exit were 0.59, or 41% less times among clients that self-report being employed compared to clients that reported being unemployed ($p = 0.03$).
- The adjusted odds that a client had unmet dental needs were 2.03 times greater among clients with self-reported feelings of anxiety, stress or depression compared to clients without depressive feelings ($p < 0.001$).
- Having dental needs appeared as a significant predictor for having feelings of anxiety, stress or depression at program exit (adjusted OR = 2.02), compared to clients who did not report having dental needs at program exit ($p < 0.001$).

Administrative Data (Medical Encounters)

Claims were available for dates of service beginning March 11, 2008 through January 16, 2010. Of the 2,515 clients that were enrolled in PANOW, a total of 1,629 (64.8%) had received services by January 16, 2010. Out of three counties, Washington County showed a significantly higher percent of clients receiving services ($p \leq 0.0001$). Of those who enrolled in the program once, the mean and median of medical encounters were 9.7 and 6.0, respectively.



As measured by receipt of encounter data (claims), 65.1% of clients were seen within 3 months of enrollment; Goal gap = 34.9%

Claims data showed that of the three counties, Washington County had the highest utilization, with 72% of clients accessing services, compared to 64% and 60% in Clark and Multnomah Counties, respectively. In total, 65% of clients in all three counties accessed care within the first three months of enrollment. Utilization was highest for clients 50-59 years of age, which is anticipated due to the more complex health needs of that age group compared to younger clients.

Utilization is associated with client education level and whether or not the client had received needed medical care in the prior six months. A backwards elimination model was used to determine possible predictors of increasing medical care utilization in an ordinal regression model. After adjusting for level of education, the odds of having higher medical encounters was 1.61 times greater among clients that self-reported not having any medical care in the past six months compared to clients that reported having prior care. The same model also revealed that after adjusting for whether or not a client had medical care in the six months prior to enrollment,

the odds of having higher medical encounters were 1.68 times greater and 1.71 times greater among clients who self-reported completing high school / GED and more than high school, respectively, compared to clients with an education less than high school.

The most frequent services provided to clients were diagnostic in nature; 82% of clients received evaluation and management services, and 36% of clients receiving laboratory services. The most frequent client diagnoses (37%) were in the category of symptoms and ill-defined conditions, which explains why the majority of services were evaluative. In comparison to the interim report, diagnostic procedures were more heavily utilized (33.9% versus 22.4%),

Nearly one in five clients received at least one diagnosis classified as “factors influencing health status.” This category includes a general classification for mental and behavioral conditions. Mean charges for all clients with mental illness diagnoses were nearly three times that of clients with no mental illness diagnosis, at \$17,398 versus \$6,106, respectively. Of the 1,482 PANOW clients for whom homeless status was known, 5.7% were homeless, but these clients made up a much higher proportion of clients with mental illness (11.6%), injury and poisoning (11.2%), and skin disease (11.1%).

Overall gross charges for the time period totaled \$11.9 million. Overlaying the 2008 Medicare fee schedule for Oregon, the total estimated cost to the program would have equaled \$2.7 million. This value represents the base Medicare reimbursement rate. Commercial rates are estimated to be 20% higher (minimum); therefore if PANOW contracted with the same providers for the services that were rendered between 2008 and 2010, the amount of medical expenditures paid is estimated between \$3.2 million and \$11.9 million. Due to the chronic conditions/diseases that occur later in life, the highest median charge was among those clients 60 years and over with \$3,155; followed by the 20-29 year-old clients (\$2,624).

Race/ethnicity and spoken language also showed statistical difference in medians of charges. Clients who speak Russian as a primary language (\$5,360) and Non-Hispanic AI/AN (\$3,108.53), followed by Non Hispanic White (\$2,995), had the higher median charges. This is attributable to Washington County having the lowest median cost per client of \$1,385; as well as having the highest percentage of Hispanic clients at 65% and overall enrollment at a little over a third of total PANOW enrollment. Finally, the median total charges over the evaluation period for clients with a mental health diagnosis were highest among the top four diagnoses (ill-defined, circulatory diseases, digestive diseases, and endocrine/metabolic diseases) and nearly four-fold the charges incurred by clients without a mental health diagnosis.

Geographic Distribution

In Clark County, client distribution and utilization was most heavily concentrated in the Vancouver area. The concentration of poverty is distributed throughout Multnomah County, with a greater concentration in downtown Portland and along the I-5 corridor. PANOW provider locations are more concentrated and are located almost exclusively adjacent to hospitals within the northwestern region of the county. When compared to Clark County, Washington county appears to have fewer clusters of concentrated high-poverty areas.

Provider Survey

There was a 32% response rate with 67% of providers belonging to a specialty group, and the majority (40%) having been involved with PANOW for 1-2 years. An additional 28% of providers became involved with PANOW in the last year. A majority (59%) of providers surveyed either strongly agree or somewhat agree that clients enrolled in PANOW have timely access to specialty medical care.

A large portion of providers (45%) do not use or know what is contained in the PANOW manual and therefore could not state whether it contained information they needed. A majority (76%) of providers responded not applicable, neutral, or don't know when asked if the PANOW website is easy to navigate. In addition, nearly half of all providers surveyed (47%) are either neutral or without sufficient knowledge to say whether the PANOW claim submission process is easy, and 48% did not know how many claims had been submitted to PANOW. When asked about the ease of communicating with the prescription referral networks and the ease of clients getting the medications that are prescribe by the providers, nearly half (49% and 50%, respectively) of providers also answered "I don't know."

In 2009, providers responding to questions about the PANOW manual, case managers, and administrators strongly agreed that each met their needs (76%, 88%, and 82% respectively), however, when providers were asked the same question in 2010, the percentage that strongly agreed declined to 35%, 49%, and 52%, respectively. Overall, the majority (79%) of providers surveyed claimed they had not experienced any problems with PANOW programs. Two out of 10 providers; however, did report problems with PANOW such as:

- Enhanced communication with Primary Care Providers (PCPs);
- Better coordination between programs and providers;
- Reduction of paperwork associated with PANOW. (Nearly as many providers expressed the ease in which they see PANOW clients, as those who expressed what they perceive to be a paperwork burden associated PANOW programs); and
- Timely provision of cards to clients.

When asked about the value of PANOW, 45% of the providers surveyed either strongly agree or somewhat agree that PANOW has added value to their practices (an increase of 3% since 2009), while 35% responded neutrally to the same statement. Eighty-three percent of providers surveyed at least somewhat agree that PANOW has had a positive or favorable impact on participating clients (also an increase of 3% over 2009). A majority (88%) of the providers surveyed either strongly agree or somewhat agree that PANOW has added value to the community, a decrease of 5% since 2009.

Discussion

Program Benchmarks

The current report provides baseline data that can drive PANOW program and policy development to meet the needs of the uninsured in four northwest counties; Clark, Multnomah, Washington and more recently, Clackamas county. PANOW has already achieved significant milestones that demonstrate program impact in a relatively short timeframe (2008 – 2010). However, there are also key benchmarks that have yet to be achieved which are highlighted in the full report. PANOW's structure allows for participating counties to operate with a large degree of independence, while adhering to core program principles and procedures. The data suggest there are key differences in population of clients served by each county; therefore, the ability of PANOW to demonstrate impact at the organizational level is significant.

Population Health

Compared to patients with Medicaid, Medicare or private insurance, uninsured patients have greater difficulty obtaining access to off-site specialty services, including referrals and diagnostic testing.⁵ A recent study reports lack of health insurance as the greatest risk factor associated with prescription drug and specialty access problems, heightening concerns about the adequacy of the safety net system.³ After adjusting for sample size, there was a 53% decrease in the number of PANOW clients who self-reported going without specialty care between enrollment and program exit. Although the reduction clearly demonstrates program impact, a little more than one out of four enrollees (27%) report having gone without needed specialty care in the past six months upon exit from PANOW. Nationally, 49% of uninsured adults, ages 18 – 64 years report they have problems seeing a specialist in the prior 12 month.¹⁷

Keeping individuals from accessing the emergency room (ER) unnecessarily is a common goal of community based programs that aim to increase access for the uninsured. Compared to self-reported ER use at program entry, the number of clients who reported using the ER in the past six months declined by 36%. The trend toward decreasing ER use was reported across all three counties. The reduction in ER utilization realized by PANOW may be a proxy for potential system-wide cost savings that is more difficult to measure – the estimated 75% of national expenditures that are associated with chronic disease care.²¹ In addition, it is also difficult to measure the cost-savings for providing timely treatment for each specialty care treatment episode among the uninsured.

There are a number of instances in the PANOW data that may indicate that PANOW is helping to narrow gaps in health status between genders, levels of education and employment status. For example, at program entry, a significantly higher percent of females self-report “fair” or “poor” health status; however, at program exit, there is no significant difference between genders. For future evaluations, a strategy to target increasing the number of clients that can be paired (have both entry and exit surveys), would assist in better capturing improvements in self-reported health status as a program outcome.

There is increasing need to better understand the uninsured population requiring specialty care treatment and to identify opportunities in which better coordination could increase impact and enhance return on investment. Recent literature suggests there is growing evidence of the link between oral health and general health status.²²⁻²³ The adjusted odds of having gone without specialty care in the prior six months at program exit are 1.92 times greater (92% greater) among clients that self-report unmet dental needs compared to clients that do not self report

unmet dental needs ($p < 0.01$). Improved oral health status results in less healthcare dollar expenditures.²¹ In the total PANOW population that responded to the entry and exit surveys, 66% reported having dental needs at entry compared to 63% at exit. The non-significant change may suggest that enrollment in PANOW does not improve connections to needed dental care (directly or indirectly). Efforts to directly connect clients to dental care may produce a return on investment for the healthcare provided through PANOW.

Similarly, having self reported feelings of stress, anxiety or depression in the past six months (at program exit) to the point that he or she wanted to talk to a professional counselor was significantly associated with all of the following in the prior six months: (1) having gone to the ER at all, (2) having gone without any care, (3) having gone without specialty care, (4) having unmet dental needs. In addition, clients who report going without medical care in the past six months at program entry have 60% higher odds (adjusted OR 1.61, 95% CI 1.10, 2.35) of having an increased number of medical encounters while enrolled in PANOW. The cumulative impact of this evidence points to the potential benefit that may be realized from developing policies, programs and systems to address the unmet mental health needs of the PANOW client population. In the PANOW population, mean healthcare charges were \$9,178 (median \$4,100) more among clients with a mental health diagnosis compared to clients without a mental health diagnosis as captured in encounter (claims) data.

PANOW Volunteer Providers

Clients across all counties expressed overall satisfaction with the health care received from PANOW volunteer providers. Across all three counties, at least seven out of 10 clients indicated that it was easy to understand the explanations their PANOW doctor gave. When asked to rate the quality of healthcare received, across all counties, 86%-91% of clients indicated the quality of care as an “8” or higher, where “10” is the highest quality care. These ratings are higher than somewhat comparable national data in which only 77% of uninsured respondents rate the quality of healthcare received in the past 12 months as a “7” or higher.¹⁷

Provider satisfaction and willingness to continue to provide donated care is a key consideration for the program’s scalability and sustainability. Most of the providers surveyed self-identified as being involved with PANOW for more than one year (72%). Nearly eight out of 10 volunteer physicians report no problems with PANOW operations (79%). Many of the providers were unable to respond to questions about PANOW’s provider support functions. These data suggest that it may be more beneficial to target some questions to medical office staff, rather than the providers specifically, as staff may have increased knowledge about the ease of working with PANOW to deliver efficient and effective care for clients.

The trends between 2009 and 2010 provider responses may be concerning. The 2010 data shows a marked percent decrease (30%-41%) in the proportion of providers who responded favorably (agreed or strongly agreed) to questions regarding program administration, case management and suitability of the provider manual. Sample sizes in 2009 were smaller ($n=38$ to $n=40$) and response bias (those who choose to respond to the survey versus not) may have been introduced, particularly given the relative infancy of PANOW. In 2010, the response size was larger ($n=102$) for these three operational questions.

Of great importance are providers’ impressions on the value PANOW adds to their practice, community and to the uninsured clients. In contrast to the operational questions, the percent of providers who report PANOW has added value to his/her practice (agree or strongly agree) has

increased marginally from 41% in 2009 to 45% in 2010. Also encouraging is the proportion of providers who report a favorable opinion of the value PANOW has added to the community is relatively constant and high (93% in 2009 and 88% in 2010). Most importantly, 83% providers strongly agree or somewhat agree that PANOW is having a favorable impact on participating clients, an increase of 3% compared to 2009 data.

Health Policy Research Northwest is pleased to have the opportunity to provide the PANOW Board of Directors, program staff and community partners with this 2008 – 2010 comprehensive evaluation report. The analysis completed on the data available provides information that will allow PANOW to identify a core set of realistic and actionable items for planning the next phase of program development.