

General Session 5: Best Practices in Addressing Health Inequities

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Faculty Disclosures

- Lauren Kelley, MSW, MPA, has nothing to disclose. She does not intend to discuss any non-FDA-approved or investigational uses of products/devices.
- Adrienne Lofton, RN, MSN, has nothing to disclose. She does not intend to discuss any non-FDA-approved products or devices.

Objectives

- Provide an overview of Project Access-New Haven - a community-based program that uses a best-practice model to increase access to care for underserved patients and reduce health disparities in New Haven, CT
- Explain how patient navigation is implemented in PA-NH
- Outline the barriers that affect PA-NH patients
- Explain the benefits of PA-NH to the underserved
- Discuss program monitoring and evaluation strategies and review data that demonstrate program impact

Project Access-New Haven Background

Lauren Kelley, MSW, MPA

Project Access-New Haven

- Increases access to healthcare for low-income, uninsured and underinsured residents of the Greater New Haven area by using patient navigation to coordinate the provision of donated medical care and services to this population
- Facilitates timely delivery of quality, comprehensive, compassionate care
- Reduces health disparities in the community
- Fosters the efficient and effective utilization of local healthcare resources

Project Access-New Haven

- Founded in 2009 by physicians who sought to address health concerns and inequities identified within the New Haven community:
 - A growing number of uninsured within the Black, Latino and immigrant communities
 - A shortage of specialty physicians who would see uninsured patients
 - A lack of care coordination disproportionately affecting individuals from cultural minority groups and those with low health literacy

Project Access-New Haven

- Stakeholder input:
 - Primary care available through local community-based FQHCs and hospital-based PCCs
 - Access to specialty care and ancillary services more limited
 - Result: long wait-times for appointments, disease advancement, over-utilization of hospital EDs and inpatient services

Project Access-New Haven

- Program model
 - Developed in 1996 in Asheville, NC
 - Replicated in 50+ communities across the U.S.
 - Local physicians and healthcare providers come together to provide care to the underserved
 - Volunteer provider network

Project Access-New Haven Program Overview/Use of Patient Navigation

Adrienne Lofton, RN, MSN

Project Access-New Haven

- Core program components
 - 300+ volunteer physicians donate their time
 - Yale-New Haven Hospital (YNHH) and the Hospital of Saint Raphael (HSR) donate all inpatient and outpatient medical services
 - Business community also contributes (e.g., Metro Taxi)
 - PA-NH coordinates delivery of donated care and services using patient navigation

Project Access-New Haven

- Eligibility
 - Greater New Haven area resident
 - Under 250% Federal Poverty Level (household)
 - No insurance (expanding to underinsured)
 - Urgent need for specialty care (expanding to primary care & chronic conditions for frequent ED users)

Project Access-New Haven

- Referral Sites
 - 2 community-based FQHCs
 - 2 hospital-based PCCs
 - 2 EDs
 - Other: hospital inpatient services, urgent care centers, community outreach van, physician offices, etc.

Project Access-New Haven

- Patient Navigation
 - 1 RN Nurse Navigator (full-time)
 - 3 “Lay” Navigators (2 full-time, 1 part-time)
 - Coordinate the delivery of care in a timely manner
 - Ensure that patients are able to access care provided through PA-NH
 - Help patients navigate a complex, confusing, and often intimidating healthcare system

Project Access-New Haven

- Patient Navigator functions:
 - Facilitate referrals
 - Conduct intake interviews
 - Work with providers to determine health needs and develop individual care plans
 - Identify and address barriers to care – e.g., by coordinating translation or transportation services
 - Coordinate delivery of care and services – e.g., schedule and remind patients of appointments, follow-up with patients/providers after appointments to determine follow-up plans, services, etc.

Project Access-New Haven

- Patient Navigation
 - Bilingual patient navigators
 - Face-to-face with a navigator
 - Establish “confianza”

Project Access-New Haven

- Patient responsibility
 - Meet with patient navigator
 - Maintain regular communication with navigator
 - Keep all appointments
 - Inform PA-NH of changes in insurance status, income or address
 - Give back

Project Access-New Haven

- Patient barriers to accessing care
 - Language
 - Financial
 - Transportation
 - Prescriptions
 - Child care

Project Access-New Haven

- PA-NH resources used to help patients overcome barriers to care
 - Yale New Haven Hospital translator service
 - Metro Taxi
 - Patient Assistance Program-Rx assist
 - Yale Surgical Company

Project Access-New Haven

- Benefits to patients
 - Care is provided free of charge
 - Medical care provided in a timely manner
 - Patient care is coordinated
 - Low no show rate
 - Eliminate or reduce Emergency Department visits

Project Access-New Haven

- Goals
 - Reduce health inequities
 - Increase access to medical care for the uninsured
 - Improve health outcomes
 - Reduce the cost of care

Case Study

December 2010

- 46 year old Hispanic female presents with 9cm x 11cm right sided neck mass
- No other symptoms
- No relevant medical history

December 2010

(Continued)

- Referral made to PA-NH
- Patient was screened by patient navigator at
PA-NH
- Consult appointment scheduled with
participating Project Access New Haven ENT
physician

January 2011

- Open neck biopsy by ENT physician at Hospital of Saint Raphael's

- Biopsy positive for lymphoma

January 2011

(Continued)

- Medical oncologist/lymphoma specialist agrees to see the patient
- CT and PET scan ordered for staging
 - Large lymph nodes in upper body and lower body
 - Nodules in liver and lungs

February-March 2011

- Consults with medical oncologist and radiation oncologist
- Care plan formulated, more ambulatory surgery
- Chemotherapy begins

April-August 2011

- Chemotherapy every other week
- Radiation
- Weekly appointments/labs
- Consults with nephrologist/cardiologist

September-November 2011

- Restaging PET scan shows no lymphatic disease and no lung lesions
- Patient express feelings of being overwhelmed and depressed
- Patient connected with CancerCare

Current

- Monthly appointments and labs with primary oncologist as well as quarterly PET scans to monitor any potential developments
- Patient Navigators remain actively in touch
- Total cost of donated services through March 2012- \$405,588.07

Project Access-New Haven Monitoring & Evaluation

Lauren Kelley, MSW, MPA

Research & Evaluation

- Goals
 - Evaluate program impact on patients and local healthcare system
 - Assess applicability to larger/broader populations
 - Measure patient & provider satisfaction
- Tools/data sources
 - PA-NH Program/Operational Data
 - Baseline Patient Survey
 - Follow-up Patient Survey
 - Provider Survey
 - Yale-New Haven Hospital Data

PA-NH Program Data

- Ongoing collection of key program metrics:
 - Referrals rates by date (e.g., month) and source
 - Wait time from referral to screening/intake
 - Wait time from intake to specialty/ancillary visits
 - No-show rates to physician appointments
 - Extent and type of PN services provided
 - Amount, type, and value of services provided

PA-NH Program Data

- September 2010 – July 2012
 - 416 patients enrolled
 - Median wait from referral acceptance to enrollment: 6 days
 - Median wait from enrollment to specialty/ancillary visit: 16 days
 - 6-8 weeks in local hospital specialty clinics
 - No-show rate: 3%
 - ~34% in specialty clinics
 - ~\$2.5 million in donated services

Baseline Patient Survey

- Completed by PN at program enrollment/intake
- Measures:
 - Demographics
 - Health status & history
 - Quality-of-life
 - Health service utilization
 - Access/barriers to care
- To-date, n=154 (included in analysis)

Baseline Patient Survey

- Demographic Characteristics
 - 61% female
 - Mean age 44 years
 - 71% Hispanic/Latino, 12% black, 12% white, 5% other
 - 49% non-English speaking
 - 41% married or living with a partner
 - Many undocumented

Baseline Patient Survey

- Health Literacy
 - Mean REALM score (English-speakers) = 5.8*
 - *Scores in the 4-6 range indicate a 7th-8th grade literacy level and suggest that patients will struggle with most patient education materials*
 - Mean SAHLSA score (Spanish-speakers) = 40.6*
 - *Scores in the 0-37 range indicate inadequate health literacy*

**Note: Some early tests not completed because patients had very low literacy or were illiterate (should have been scored 0), so scores likely slightly inflated*

Baseline Patient Survey

- Education, Employment & Income
 - Most (76%) had a high school education or less
 - 43% HS/GED, 20% some HS, 13%> HS
 - Approximately half (53%) were employed
 - 37% part-time, 16% full-time
 - 11% of those employed had employers that offered health insurance
 - Most (80%) had a monthly household income <\$2100
 - Average household: 3 individuals (adults, children and patient) and 1 child

Baseline Patient Survey

- Insurance status & history
 - 46% insured in the past
 - 46% employer-based, 42% government-based
 - Most common reasons for not having insurance
 - “Can't afford premiums” (53%)
 - “Not working” (33%)
 - “Employer doesn't offer insurance” (31%)

Baseline Patient Survey

- Health status & quality-of-life
 - Poor overall health (vs. general U.S. population)
 - 19% poor (4%), 35% fair (11%), 32% good (30%), 9% very good (35%), 5% excellent (20%)
 - Most (70%) said their health prevented them from working or doing usual activities during the past 30 days
 - 45% 1-14 days;
 - 25% 15+ days
 - Chronic illnesses
 - 20% hypertension, 18% high cholesterol, 12% diabetes, 6% asthma, 6% heart disease, 4% cancer, 10% depression, 2% stroke, 3% COPD

Baseline Patient Survey

- Healthcare Utilization
 - 81% had a usual source of care
 - 75% used a clinic or health center
 - 13% hospitalized within the past year
 - 43% visited an ED within the past year

Baseline Patient Survey

- Health Service Utilization/Barriers to Care
 - 64% wanted to see a doctor but didn't in the past year
 - 84% “could not afford”
 - 12% “could not get timely appointment”
 - 80% avoided getting health care because of cost
 - 43% did not take prescribed medication because of cost
 - 60% said it was “hard” or “very hard” to get care

Baseline Patient Survey

- Health Service Utilization/Barriers to Care
 - Barriers to attending medical appointments
 - 56% cost
 - 26% transportation
 - 20% language
 - 19% work schedule conflicts
 - 9% childcare
 - 5% not sure of how to get an appointment
 - 63% requested interpreter services (99% for Spanish)

Follow-Up Patient Survey

- Completed by a PA-NH staff or volunteer approximately one year post-enrollment
- Measures:
 - Health status
 - Quality-of-life
 - Health service utilization
 - Access/barriers to care
 - Program satisfaction
- To-date, n=66

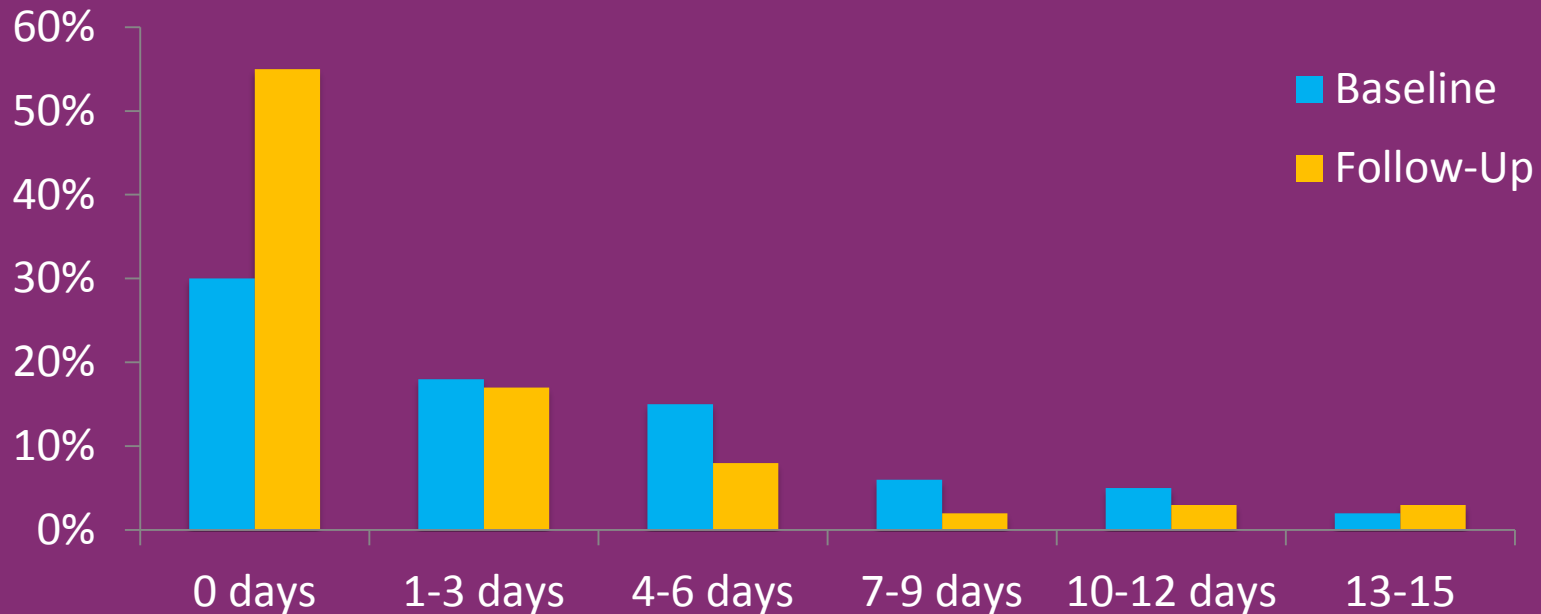
Follow-Up Patient Survey

- Patient self-report of overall health



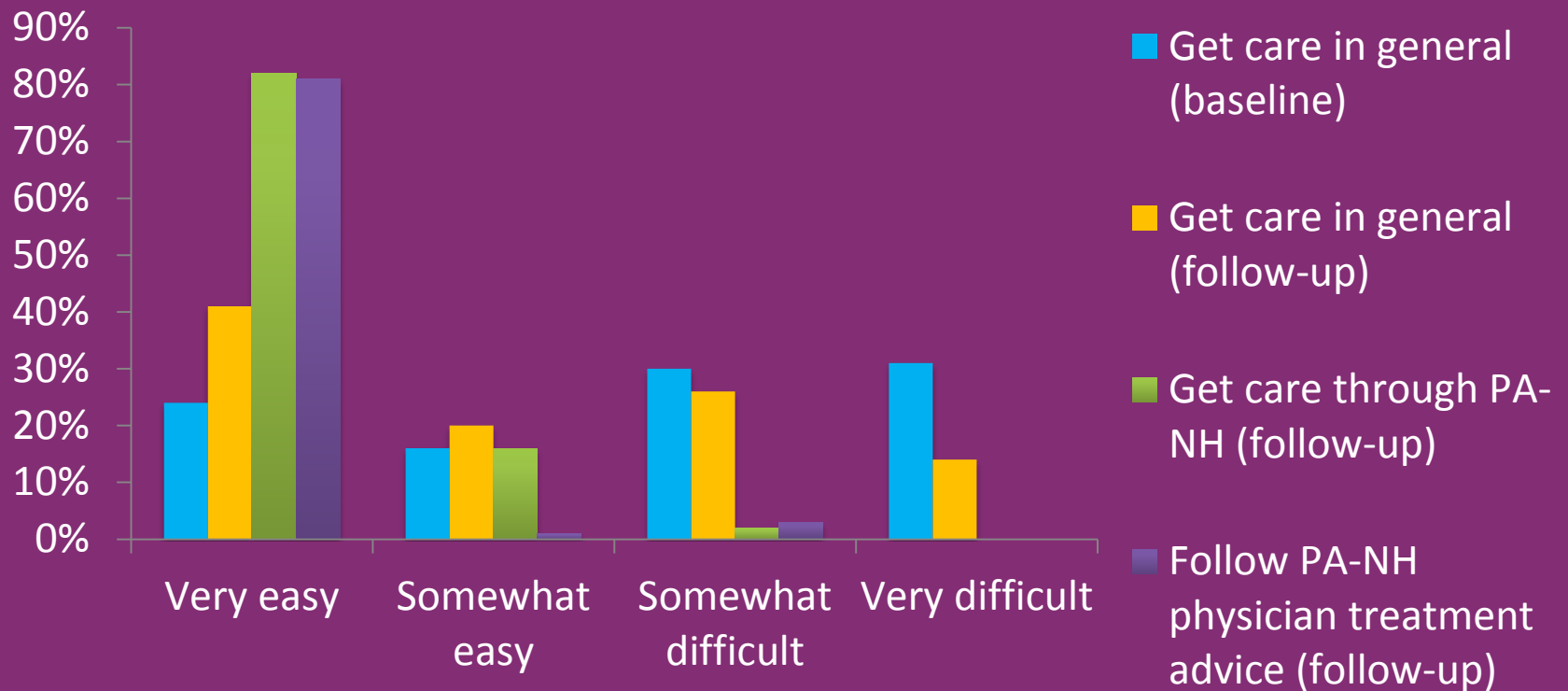
Follow-Up Patient Survey

- # last 30 days physical/mental health prevented patient from working or doing usual activities



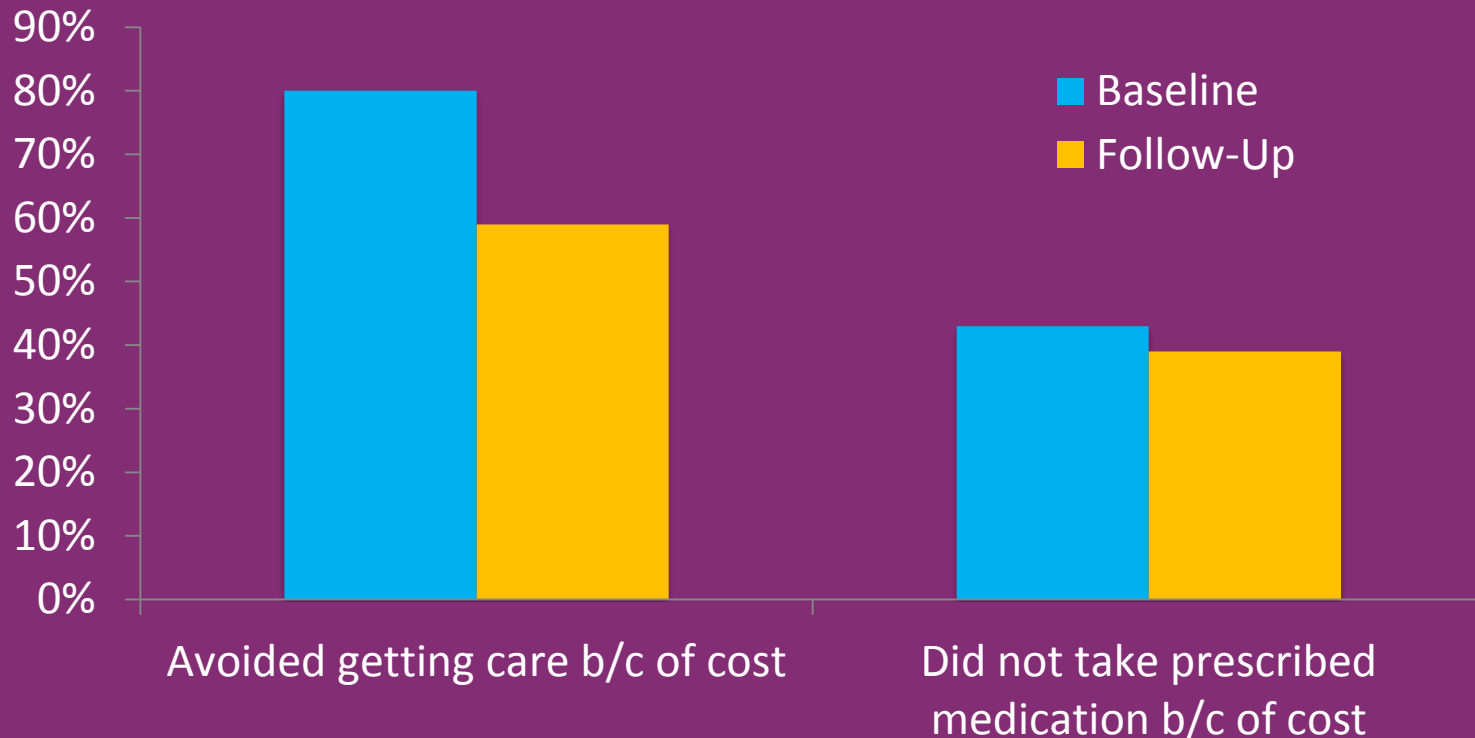
Follow-Up Patient Survey

- Ease of getting needed care & following treatment



Follow-Up Patient Survey

- Indicators of healthcare access (past year)



Follow-Up Patient Survey

- Additional indicators of success and satisfaction
 - 90% reported improved access to care
 - 89% said PA-NH was “very helpful” in getting needed care
 - 74% rated care as “excellent”
 - 80% “very satisfied” with overall experience
 - Net promoter score: 89%

Follow-Up Patient Survey



Provider Survey

- First annual survey – September 2012
- Measures:
 - Program satisfaction
 - Willingness to participate in Medicaid if patient navigation were offered

Yale-New Haven Hospital Data

- Hospital (YNHH and HSR) clinical/operational data
 - Health service utilization and cost
 - PA-NH patients and matched control cohorts (e.g., historical uninsured group, Medicaid population)
 - Data collection underway; data extraction and analysis not yet initiated

Summary

- PA-NH uses a community-based program model and intensive patient navigation to increase access to medical care and services for underserved patients in New Haven, CT, reduce health disparities in the community, and improve health system efficiency
- Key data are collected to monitor and evaluate the program and demonstrate program impact on patients and the local healthcare system

Thank You

- PA-NH Board of Directors
- PA-NH Staff: Christopher Borgstrom, Giselle Carlotta-McDonald, Juan Carmona, Darcey Cobbs-Lomax, Edna Cruz-Cedeño
- PA-NH Volunteers
- PA-NH Partners & Funders: Yale-New Haven Hospital, Hospital of Saint Raphael, Community Foundation of Greater New Haven, Aetna Foundation, CVS Caremark Charitable Trust, CT Department of Public Health, CT State Medical Society, New Haven County Medical Association, NewAlliance Foundation, Webster Bank, MetroTaxi, Blue State Coffee