Access New Hampshire

Final Evaluation Report

Introduction

Established by the U.S. government in 2002, the Healthy Communities Access Program (HCAP) provides grant funding to assist communities to develop or strengthen integrated community health care delivery systems. The purpose of the project is to bridge the organizational, financial, and service delivery gaps that fragment the systems of health care for the uninsured and underinsured. This effort strives to improve the effectiveness, efficiency, and coordination of services, resulting in higher quality of care at a reduced cost, especially for the uninsured and underinsured with chronic health conditions.

Funded in September 2004, New Hampshire's HCAP program is known as the *Access NH* Project. The project strives to highlight and support the community health center as the medical home of choice for the uninsured, to reduce barriers to health services, and to facilitate patient navigation among various community health care providers. The consortium of community partners for the project is the Medical Interpretation Advisory Board (MIAB) specifically the Community Linkages Subcommittee that was created to minimize the fragmentation of separate community initiatives. Members of the subcommittee include the Community Health Access Network (CHAN), the New Hampshire Minority Health Coalition (NHMHC), the Southern New Hampshire Area Health Education Center (SNHAHEC), and the Foundation for Healthy Communities (FHC). The project focuses on five activities.

- *Activity A*, developing and implementing an electronic data link to facilitate patient information sharing between hospitals and community health centers.
- *Activity B*, developing and implementing a web-based electronic communications mechanism to facilitate record sharing between community health centers and community-based referral providers and agencies.
- *Activity C*, facilitating communication between consumers and health care providers to overcome cultural and language access barriers to care.

- *Activity D*, implementing a system for patient eligibility determination for free/discounted health services from community providers of emergency care, primary care, specialty care, and in-patient care.
- *Activity E*, facilitating enrollment in Medication Bridge pharmacy assistance programs.

This report documents the second and final year of the project that spanned from September of 2005 through August of 2006. The report draws on quarterly activity reports compiled by program partners and evaluation data collected by, or with the support of, the NHMHC research and evaluation group.

Activities A and B: Develop and implement electronic linkages and communications to facilitate patient information sharing between community health centers, hospitals, and other community-based providers

In the second year, the *Access NH* project expanded activities for strengthening electronic data linkages between community health centers (CHCs), hospitals and pharmacies into new geographic areas in the state. The goal continues to be to improve the quality of patient care through more informed medical decisions with input from electronic medical records (EMR) from various health care partners and community-based providers (e.g., pharmacies) using secure communication software. To evaluate these two project activities, interviews were conducted with directors and information technology professionals from CHCs and their hospital partners who lead these efforts in their communities.

Linkages between CHCs and hospitals

Community Health Center directors reported many benefits from the electronic linkages they have made with their local hospitals. Had it not been for grant support from the *Access NH* project, they said, the information technology support necessary to create these linkages would not have been available. The most valuable patient information now accessible to CHCs from hospital records include:

- Patient laboratory test results from hospitals, now shared in a more timely manner to better inform clinical decisions made by the primary care physician (PCP) at the CHC
- Radiology results, especially imagery files, which can be linked directly into the patient's EMR in Centricity or Logician systems
- Urgent care visits to the emergency department, which the PCP may not be aware of without notification through the EMR.

Importing data from hospital records, especially recent test results, allows primary care physicians at the CHC to access patient information more quickly. For example, as one hospital IT professional explained, the "infomatic physician" can now view a recent image from an MRI – not just the text of the radiologist's report but the image itself – simply by selecting the document in the patient's EMR. The physician can be notified by email when the document is available, and such documents can be copied into the EMR (using the familiar "click and drag" mouse maneuver) via a virtual private network created for this purpose.

Patient case management and communications

Community health centers are also developing innovative ways to use electronic medical records to improve the care of patients with chronic diseases such as diabetes. A disease management specialist uses data from the EMR to track the patient's hemoglobin A1C blood sugar results, for instance, and can alert the PCP and the patient if the levels are outside the specified range. Two of the CHC partners in *Access NH* are also participating in pilot projects to promote a diabetes care model that encourages patient self-management in consultation with the primary care physician. With support from health information systems, collaborations with visiting nurse associations, hospitals, and other clinicians the CHC can provide more coordinated care to patients with diabetes. Electronic sharing of patient records, with the proper data sharing agreements to ensure continued HIPAA compliance of all partners, enables more efficient information exchange all the more crucial for patients with chronic health conditions.

Beyond sharing among health care providers, some CHCs are expanding to include the patient in the stream of information exchange. With so much medical information available as electronic data, patient health reports can be automated and provided to patients on a routine basis. CHCs use EMR data to track health status over time, such as patient weight, blood pressure, glucose or asthma test results. This information can be displayed in charts or simple tables that the patient is taught to read during a routine office visit.

Health information can flow both to and from the patient. Patients with diabetes can submit daily blood glucose test results via a secure server to the disease management specialist who supports their care. This information is then, in turn, incorporated into the patient's EMR for review by the PCP or other clinicians who treat the patient. Rather than using the telephone, technically-minded patients may also submit questions of a general medical nature or requests for prescription refills electronically.

Linkages between CHCs and other providers in the community

During the second year of *Access NH*, two software solutions by Kryptiq were launched: secure electronic messaging with ClinicalMessenger® and access to patient records via CareCatalyst®. Once various barriers were overcome (see the following section for details), the systems now interface well with the Centricity® systems of the CHCs. The PCP can generate a referral to a specialist, for example, using the EMR orders module. The system notifies the referral physician who then clicks on a hyperlink in the alert email to go to the secure server to read the full email and access the patient's records. Similarly, the PCP can order a prescription by clicking on the appropriate pharmacy in Logician which then sends an electronic fax of the order.

Even with hospitals or other health care providers whose patient records continue to be on paper, CHCs are able to send out patient referrals and prescriptions directly from the Centricity EMR via electronic fax. Providers at the CHCs reportedly appreciate the added convenience of the integration of all medical orders in the EMR, and filling prescriptions is easier for patients using this paperless system.

Organizational Barriers

CHC directors all agreed that electronic linkages were much more difficult to implement than they had anticipated. To be successful, a broad array of obstacles had to be overcome. In addition to the technical issues that were to be expected, directors also emphasized how they had to address strong resistance from within the healthcare institutions. Those in the position to approve electronic exchanges with outside providers had to be convinced that the linkages would be secure. For instance, board members of a community hospital were reportedly "scared to death" that outsiders would be able to see patient records, one CHC director said. After many meetings and consultations with IT professionals, affiliate agreements were devised to be HIPAA compliant and more secure than paper records.

Since ordinary interagency data sharing agreements were not sufficient to ensure HIPAA compliance, all sharing partners had to agree to abide by stipulations in the affiliate agreements:

- All sharing partners must collectively agree which elements of the patient's EMR will be shared, and that none will be shared outside the group
- Confidentiality and patient consent forms must give the patient the option of choosing to whom their records (if any) will be shared

Technical Barriers

Some CHC directors reported that they had to invest time in order to reach an understanding with staff from other HCOs about what exactly would be exchanged in the linkage, and how the exchange of EMR data could be secure. Many staff have a limited understanding of how the EMR system works, as they rely solely on the Centricity query tool or on Crystal Reports to access their EMR data. Since they "never look at the back end of the Oracle database," they may not clearly understand the infrastructure of their patient data or how to share EMR data with others electronically.

Other HCOs may have electronic data, but continue to use older software than Centricity. For example, one VNA is still using FoxPro to enter and manipulate their patient data. The only way they can import data from another system is as a flat ASC-II

file that is comma and space delimited. This antiquated format is incompatible with the HL7 medical record export format required by Centricity and other more modern systems.

Rural issues also have a technical aspect in that some communities have absolutely no access to high-speed internet service. One provider in the Northern part of the state still has to use dial-up service with a transmission rate of 1/16th of DSL and 1/50 the speed of a T-1 cable connection. The only way data can be exchanged over such a slow connection is to login to the system at the end of the work day and let the patient records download overnight. As one CHC director sympathized: "You could sit there and knit a sweater while the system transmits one patient record"

Benefits from HCAP

A hospital IT professional emphasized the benefits of the project particularly for rural health providers. Before the *Access NH* project, a PCP who practices in a rural area would drive to the hospital, sometimes an hour or longer, in order to view a patient's test results. Now, the same "infomatic" physician can simply click on the results from any desktop computer with an internet connection. While many of the *Access NH* partners described earlier attempts to create these linkages, all agreed that the project served as a crucial catalyst to actually implement these connections between HCOs. As one CHC director explained,

> "None of us as separate CHCs could have gotten these systems up and running without CHAN. The HCAP grant provided the needed infrastructure that none of us could have developed alone…the only way this could have been accomplished is collectively."

Activity C. Facilitate communication between consumers and health care providers to overcome cultural and language access barriers to care

In the second year of the project, HCAP partners continued to promote efforts to increase awareness about the importance of cultural competency and medical interpretation among healthcare providers in order to improve patient-provider relationships. In addition, *Access NH* also sponsored consumer education for those with limited English proficiency (LEP) to teach them how to navigate the U.S. healthcare system.

Cultural Competency Training to Providers

As an *Access NH* partner, the NH Minority Health Coalition provided cultural competency training to enhance the ability of healthcare providers to communicate effectively with a diversity of patients. In the second project year, 26 training programs for cultural competence were offered to a total of 603 individuals across the state.

To better assess the effectiveness of *Access NH*'s cultural competency training program, training assessment data from the second half of the project year (from March through August of 2006) were collected and analyzed. Participants reported statistically significant improvement on the learning objectives of all but one of the sessions. The most general of the sessions, Culture and Cultural Competence Training was only offered once to what was described by one participant as "a quiet group" of 12 people. Most of them reported some knowledge of culture and cultural competence both before and after the program. Participants in all of the other *Access NH* cultural competency trainings showed significant improvement based on the learning objectives.

Cross Cultural Skills in Health Care

The most popular course, Cross Cultural Skills in Health Care, was also the most effective. Assessment forms from three sessions of this course, from a total of 99 participants, were analyzed for this course. With a sample of this size, chi-square tests are appropriate to assess participant reports of their knowledge and skills before and after the training sessions. While improvements were reported in all seven of the course objectives, some appeared to be more difficult to achieve than others according to the participants. With three of the objectives, participants reported some knowledge prior to the training, while most reported little or knowledge of the other four.

The three objectives that were apparently more attainable were as follows:

- Define culture and cultural competency, identifying similarities and differences across cultural groups;
- List at least three health care disparities among racial groups; and
- Describe barriers to cross cultural communication and discuss methods for bridging those barriers.

Between 54 and 59 participants reported "some" or "great" knowledge of these three objectives prior to the training and 28 to 38 of them reported improvement from some to great knowledge of them after the session.

The remaining four course objectives tended to be less familiar to participants as they began the course. The most typical improvement was to move from "little knowledge before the training to some knowledge after the session for the following four objectives:

- Integrate concepts regarding cultural competency into clinical practice…;
- List components of an explanatory model which supports the provision of providing culturally sensitive care;
- List at least three cultural/group norms for people from generational poverty; and
- Identify best practices for working with medical interpreters.

While less than ten participants reported great knowledge of any of these 4 objectives prior to the training, 35 to 46 people reported great knowledge of them afterwards, demonstrating that they believed they had learned a great deal from the training. Specifically, 29 participants reported little knowledge of how to integrate cultural competency into clinical practice before the training, but then reported they had gained some knowledge about this objective from the training. Likewise, 19 participants improved from some knowledge beforehand to great knowledge of this objective afterwards. A similar pattern emerges when examining the other three more difficult objectives.

Apart from the before and after questions dealing with the learning objectives, the assessment forms also ask open-ended questions about what participants will do differently as a result of this training. Analysis of the write-in answers to this question revealed three common themes. Many said they were more aware of the importance of respecting diversity among patients, some saying they would incorporate cultural differences into their treatment plans. Participants also learned how cultural influences communication in the clinical encounter and stated their intention to listen to patients

with a more open mind in the future. Several specifically mentioned the vital role of medical interpreters and their resolve to "advocate for patients – encourage the use of trained interpreters" as one participant wrote.

Medical Interpreter Training

During the second project year, two groups total 45 people and speaking 13 different foreign languages, graduated from the medical interpreter training program (19 in Fall 2005 and 26 in Spring 2006). Focus groups were conducted with program graduates to obtain their feedback about the Bridging the Gap curriculum and to learn about their experiences as medical interpreters.

Program graduates who participated in the focus groups speak a wide variety of languages (in addition to English) including Spanish, Portuguese, French, Bosnian, Servo-Croation, Russian, Arabic, Dinka, Kinyarwanda, and Kirundi. They interpret for healthcare providers, health education organizations, and refugee centers. They may offer interpretation at their healthcare work place or as free-lance consultants.

When asked if the training met their expectations, graduates collectively agreed that they learned more than they anticipated. They generally expected most of the training sessions to be about medical terminology. Participants were surprised to learn about other these other subjects as well:

- patient's rights,
- the medical interpreter code of ethics, and
- effective ways to communicate with patients and healthcare providers during interpretation.

As one focus group participant explained:

> "The program was about doing it the proper way. Do you hold their hand or don't? Ask questions or don't? That is what made a big difference. When I go into a hospital or clinic, I know exactly what to do."

Graduates also expressed that the course helped them avoid common interpretation mistakes such as using the third person when speaking and interjecting their own opinion in the message.

One participant described her experience this way:

> "I came to America and was called to interpret for families. I was doing interpretation, but I was doing it wrong. I directed people what to say to the doctors. I didn't know the rules and didn't follow the rules. The class helped."

When asked about the benefits of the training program, focus group participants emphasized gains in confidence and professionalism. Many reported that the training offered them more credibility in the eyes of healthcare professionals they work with, as well as with patients. Patients with concerns about revealing their private health information were reassured when they learned their interpreter was trained and bound to a code of ethics. As one graduate explained:

> "The person is concerned that you will talk about her outside the doctor's office. You say you are a trained interpreter. When you say that, they are more confident."

Graduates benefited from being placed on a distributed list of interpreters and learning about business tips, such as getting a fax machine and business cards. One person did note that having certificate of training attendance would also be useful to build their credentials in the workplace. Networking opportunities and career related information were common desires for many people. Graduates enjoy the job-postings trainers send by e-mail and many were interested in joining a professional interpretation organization. They expressed a need for a home-base for their work. They expect such an organization might provide a platform for information sharing and networking as well as helping them establish rules for fair compensation.

When asked what they would like to change about the class, the graduates most frequently mentioned the length of class and the homework. A common complaint was that the class was too short for the amount of information covered; being rather dense in material, some people had a hard time keeping up. Graduates disagreed on whether they would like more medical terminology during the course. Some would like to have more terminology in future classes while others thought learning terminology should be done as homework or independent study.

Graduates suggested that future classes have more practice sessions, more time for presentations, more visual aids and demonstrations, and smaller class sizes. One person suggested holding classes on weekends. Graduates expressed interest in further professional development workshops on subjects such as:

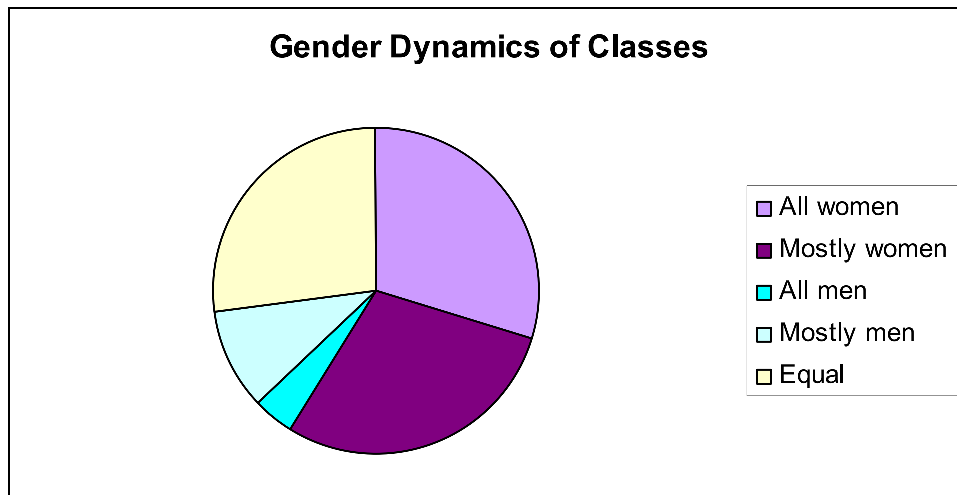
- health insurance policies and prescriptions;
- mental and behavioral health,
- diseases such as cancer and diabetes, and
- cultural beliefs and traditional healing practices.

Overall, focus groups revealed that graduates found the Bridging the Gap curriculum to be very useful, and they are interested in continuing their professional development as medical interpreters. Several graduates requested further assistance in career building such as resume writing and marketing strategies for building a consulting practice. Many also expressed an interested in joining a professional organization, under the leadership of SNHAHEC, to promote medical interpretation in New Hampshire.

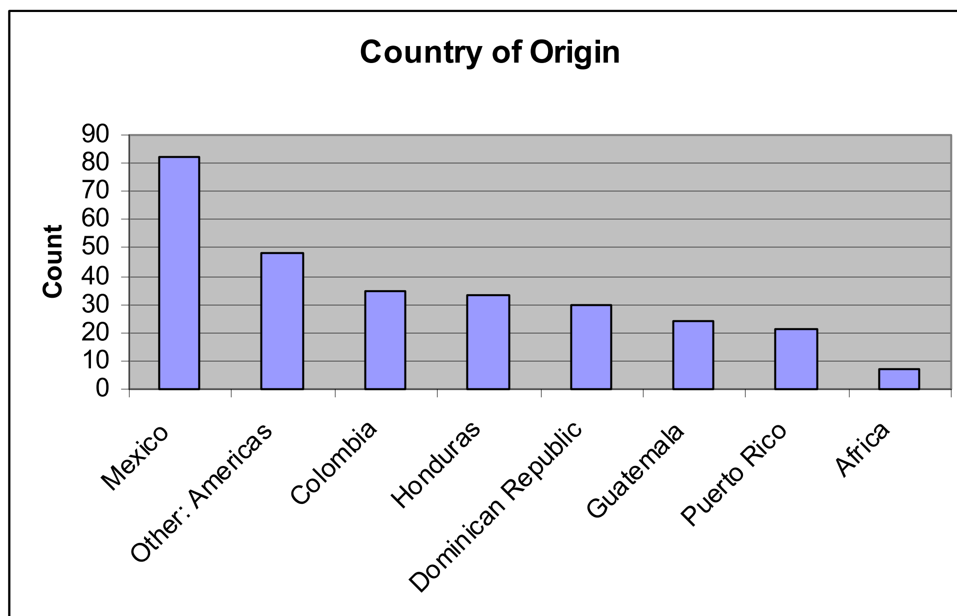
Consumer Education

In the second year of the project, over 250 small group educational sessions were held with more than 900 people with limited English proficiency. Sessions informed consumers about how the health care system works in the United States, their role in their own self-care, and their right to an interpreter. Health educators collected basic demographic information from 258 of the sessions regarding 887 participants. Educators made some tallies by sight or with a show of hands to give the evaluation a general description of the group composition of the classes.

Typically, classes consisted of four participants. As with most health education programs, women were about twice as likely to participate in *Access NH* consumer education as men. The pie chart on the following page illustrates that nearly two thirds of the sessions had a majority of women in attendance.

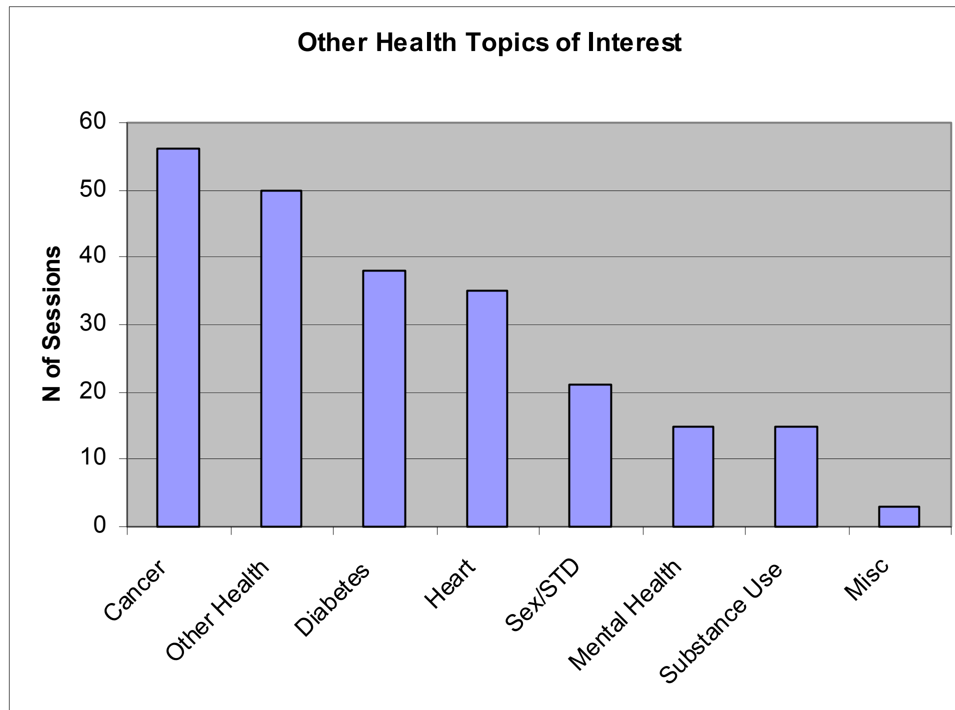


Since the goal of the classes was to educate those with limited English proficiency about the healthcare system in the United States, it is not surprising that most sessions were held in Spanish. Typical of Southern New Hampshire, about a third of the classes included participants from Mexico (82 of the 256 classes).



In addition to the U.S. healthcare system, a few classes covered another topic such as addiction, domestic violence, sexual health, or exercise and nutrition. Addiction was taught more frequently than any other supplementary topic. Exercise and nutrition was the next most popular topic discussed in addition to the healthcare system.

At the end of the sessions, consumers were asked about other health topics they would be interested in learning more about in the future. Consumers were interested in a broad range of health care issues, including cancer in various forms, diabetes, and heart disease. In addition, other health problems were also mentioned by some consumers including asthma, obesity, prostate health, and pneumonia. Interestingly, different topics appealed to different audiences. Groups that were attended predominantly by women were more likely to be interested in learning more about cancer, while predominately male and mixed gender groups tended to ask questions about other health concerns. The chart below shows how often each topic was raised at the end of the classes.



Activity D. Implement a system for patient eligibility determination for free/discounted health services from community providers of emergency care, primary care, specialty care and in-patient care.

The partner who leads this activity for *Access NH* is the New Hampshire Health Access Network (NHHAN) via the Foundation for Healthy Communities, who seeks to improve access to health care for low-income families through the volunteer efforts of over 200 health care providers from across the state of New Hampshire. According to their website, NHHAN follows four guiding principles:

1. Maintaining an open door to healthcare by providing dependable access to care for vulnerable community residents;
2. Offering levels of free and discounted care that meet or exceed eligibility thresholds adopted collaboratively through the Network;
3. Network members collaborate to reduce or eliminate access barriers ; and
4. Network members also work collaboratively to enhance the continuity and coordination of care statewide.[1]

Analysis of the geographic distribution of the NHHAN volunteer healthcare providers confirmed that practices offer free or discounted care through the program to residents from all regions of the state. As of the summer of 2006 participating sites included:

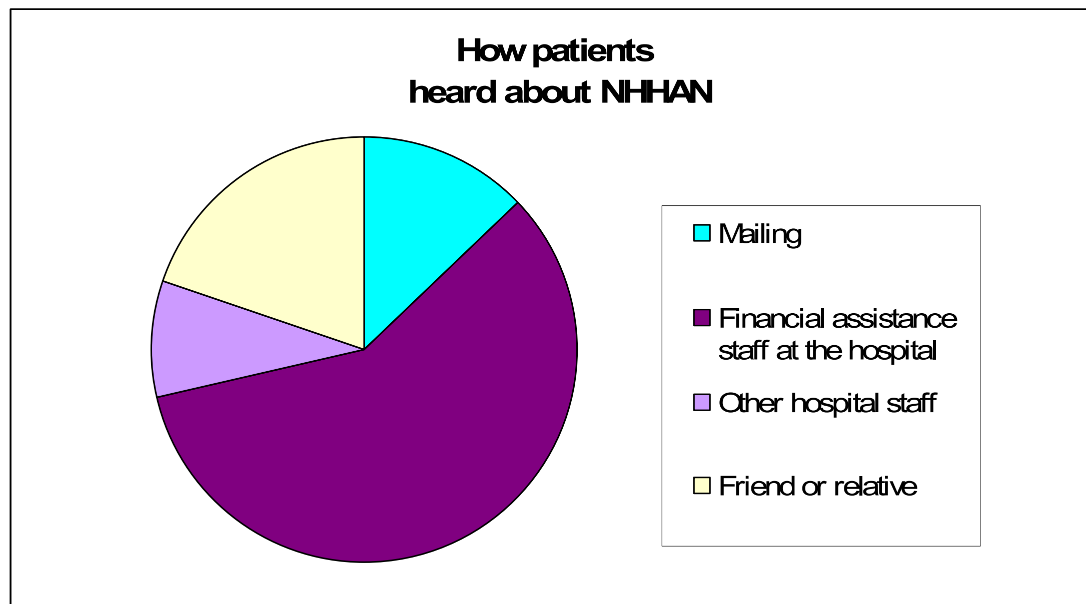
- 6 from the North Country,
- 8 from the White Mountains region,
- 7 from the Lakes Region,
- 11 from the Mount Sunapee area,
- 11 from the Monadnock region, and
- 17 participated from the Seacoast.

[1] Program descriptions for Activities D and E were drawn from the Foundation for Healthy Communities website at www.healthynh.com and from in-person interviews with foundation staff who manage the NHHAN and Medication Bridge programs.

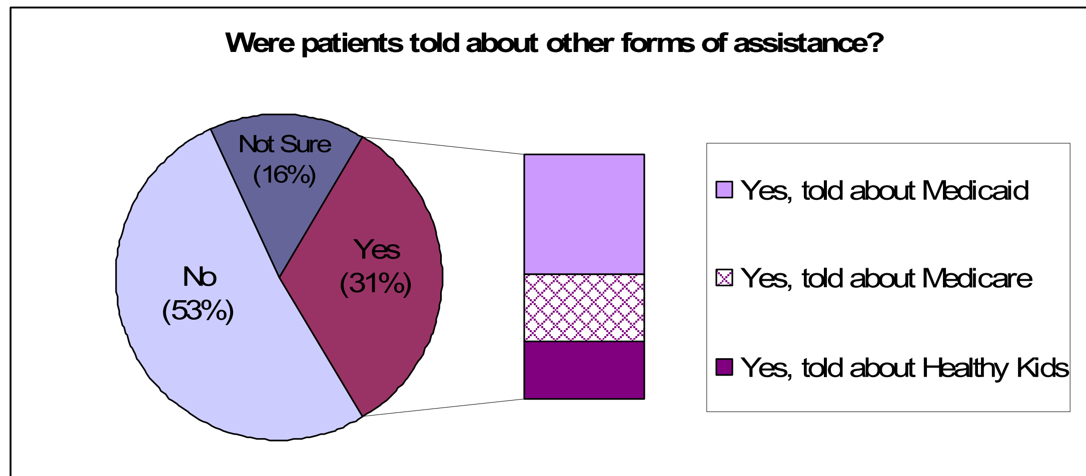
Primary care providers are active partners in the Network, as are all 24 community hospitals in New Hampshire. Participating healthcare practices also include a wide array of specialties ranging from pediatrics and gynecology, to cardiology and pulmonology, to surgery and internal medicine, among others.

Patient eligibility and referrals

Patients apply for financial eligibility status for the NHHAN program at a number of sites in the community. The current standard adopted by the Network matches the federal eligibility requirements to receive care from community health centers. Once found eligible, the patient can seek free or discounted care from any participating NHHAN health provider in the state. To assess consumer satisfaction with the NHHAN program, the Foundation for Healthy Communities conducted a mail-in survey in the fall of 2004. Over 1,000 surveys were mailed to patients from 24 hospitals and clinics around the state with an offer of a $50 incentive for those who replied via the self-addressed stamped envelope that was also enclosed. Surveys were received from 336 patients, yielding a response rate of just over 30 percent. As displayed in the pie chart below, most of the patients heard about the program from hospital staff, principally from the hospital financial assistance department. If not from hospitals, 19 percent of respondents said they had heard about the program from a friend or family member, and another 16 percent reported receiving a mailing about NHHAN.



Very few consumers reported any difficulty in applying for the program, and most reported receiving assistance in completing the NHHAN application from hospital staff. About a third of patients also reported they had been informed about other programs such as Healthy Kids, Medicare, and Medicaid (see chart below for details).



Provider survey results

The Foundation for Healthy Communities also conducted a survey of the 24 participating hospitals in each of three years from 2002 through 2004. Hospital staff collected data from all the paper applications received in September of each year for the survey. This paper survey has since been replaced by an online data system that was launched in the summer of 2006. Key data elements have been incorporated into NHHAN's online assistance application which will enable the program to report findings on a routine basis. Unfortunately, data from the online system was not available in time for this report.

Based on the most recent paper survey conducted in September of 2004, hospitals reported receiving over 1,900 applications during that month alone. Most were for out-patient or clinic-based services, with just 8 percent of the requests for in-patient care. Over 1,100 of the applicants were uninsured. Seventy percent of all applicants were deemed eligible for NHHAN in September of 2004.

Activity E. Facilitate enrollment in the Medication Bridge pharmacy assistance programs

Begun in 1999, the Medication Bridge Program facilitates patient applications to obtain discounted drugs offered by pharmaceutical companies with an emphasis on medications to treat chronic health conditions. The program currently works with seventy sites across NH to provide this assistance including hospitals, community health centers, physician offices, senior housing, and non-profit organizations. The program keeps up to date on the discounted drug plans that are offered by manufacturers and trains personnel at different sites on how to assist consumers in applying for the benefits.

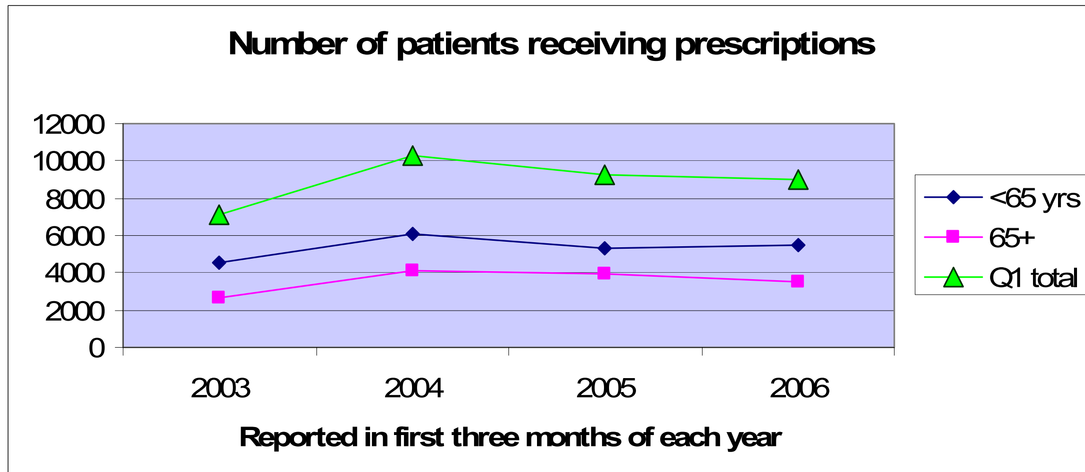
To publicize the availability of this assistance, the program has distributed over 18,000 copies of the "NH Prescription Assistance Guide." This brochure lists the NH Medication Bridge sites, as well as all state programs that can assist with the cost of prescriptions, along with each program's eligibility requirements.

Patient eligibility requirements for the Medication Bridge in general are:

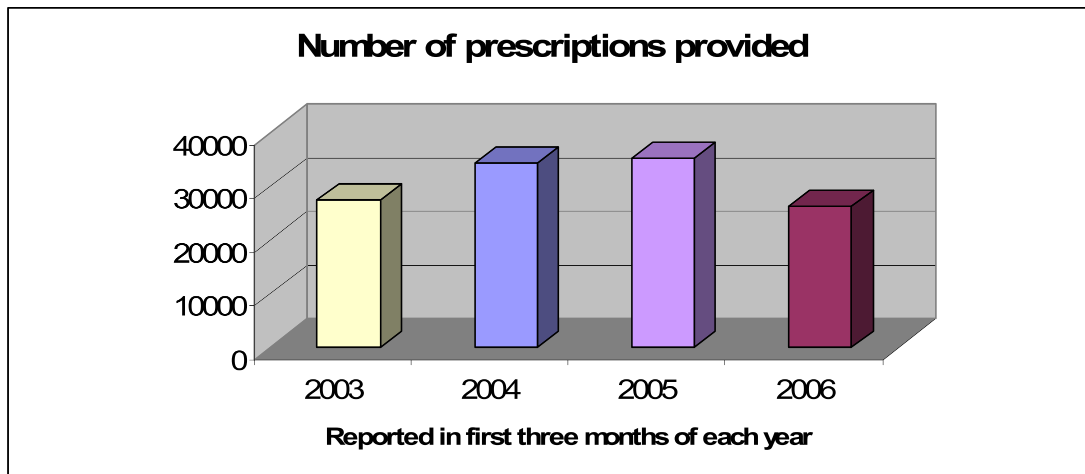
- The patient must be a U.S. resident.
- The patient must not have any other type of prescription coverage, including Medicaid, Veteran's Administration benefits, and private insurance.
- Household income generally must be less than 200% of poverty level, though this may vary according to the pharmaceutical company providing the assistance.

The first year of the *Access NH* project enabled the Medication Bridge Program to increase the number of enrollment sites in Manchester and Nashua. The second project year expanded enrollment statewide. While the number of enrollment sites has reportedly remained stable this year, the number of patients receiving assistance (and the number of prescriptions made available) from the Medication Bridge program has declined due to the new Medicare Part D prescription drug plan.

The chart below illustrates how the number of patients receiving prescription drug assistance from the Medication Bridge program has declined since it peaked in 2004, particularly among those who are 65 years and older.



Similarly, the number of prescriptions provided by the program has also declined as patients enrolled in the Medicare Part D plan, thereby withdrawing from the Medication Bridge program.



Summary and Conclusions

In summary, the *Access NH* project, with the support from the Healthy Communities Access Program, has succeeded in strengthening the infrastructure of community health centers across the state, educating consumers and healthcare providers to improve cross-cultural communications in clinical settings, and providing free and discounted care and prescriptions to thousands of New Hampshire residents. The evaluation report from the first year of the project demonstrated the substantial cost savings associated with electronic transfers of patient medical records between CHCs and other healthcare providers. To complement the evaluation of the first year, the current report has focused on assessing the consumer and provider education activities of the project, in addition to describing further progress on the others accomplished in the second grant year. We have documented important lessons learned by the CHCs as they implemented electronic data linkages with local hospitals and other healthcare partners.

The cultural competency program has been shown to be effective in achieving the learning objectives of the courses offered through the *Access NH* project. Based on participants self-reports, they learned a great deal about such important topics as cultural diversity, health disparities, cross-cultural communication barriers, and how to offer more culturally sensitive care to patients from different cultural groups. Many also noted on the assessment form that they had a newly found appreciation of the critical role fulfilled by medical interpreters in providing quality care.

Focus group participants were similarly enthusiastic in their endorsements of the Bridging the Gap medical interpretation program. Graduates of the program appreciated both the curriculum content and the teaching approach taken by the instructors. Many hope to continue to build their careers together in some form of professional organization with the assistance of the SNAHEC. Graduates are also interested in continuing their professional development through workshops on various health topics.

The many collaborative partners of the project view the HCAP funding as a catalyst that enabled innovative efforts to improve community health to advance among community health centers, local hospitals, and other healthcare providers across the state. Under *Access NH*, they were able to intensify activities in the state's most populous geographic region in the first year and then to spread these innovations in the second year to other regions of New Hampshire. Based on accounts from the full gamut of partners and program participants – from hospital administrators and IT professions, to community health center directors, to clinicians and patients – the *Access NH* program has been a success.