

# **ACCESS NEW HAMPSHIRE**

## **Year 1 Evaluation Report**

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## 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.

The purpose of the Project, funded in September 2004, is 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 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 Manchester Community Health Center (MCHC), 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 the community health center.
- *Activity B*, developing and implementing a web-based electronic communications mechanism to facilitate record sharing between the community health center 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 implementation and successes of the project in achieving the goals set out for the first year of the project, from September 1, 2004 through August 30, 2005. 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.

**Activity A. Develop & implement an electronic data link to facilitate patient information sharing between hospitals and the community health center**

In its first year, the Access NH project facilitated the establishment and strengthening of electronic linkages between hospitals and community health centers (CHCs) in Manchester and Nashua in order to improve the quality of care by making medical records exchange more efficient. During the period from September 1, 2004 through August 30, 2005, the following was accomplished:

- An agreement for the electronic data link between Manchester Community Health Center (MCHC) and Elliot Hospital was reached. Implementation has been delayed until after the hospital implements the electronic medical record (Epic) in October 2005.
- An electronic fax system was established that enables MCHC to receive incoming faxes, including patient records, electronically.
- An agreement for the electronic data link between the Nashua Area Health Center (NAHC) and Southern New Hampshire Medical Center (SNHMC) was reached. NAHC successfully installed its medical record system (Centricity) in June 2005. Implementation of the linkage between NAHC and SNHMC has been delayed until SNHMC is ready to proceed (tentatively, in January of 2006).
- In the White Mountains region, an agreement for the electronic data link was reached between Ammonoosuc Community Health Center and Cottage Hospital in Woodsville and work was begun to build the link.
- On the Seacoast, an agreement for the electronic data link was reached between Avis Goodwin Community Health and Frisbie Memorial Hospital in Dover and an agreement was signed with MedQuist, the provider of the information system for Frisbie.
- In the Lakes Region, an agreement for the electronic data link was signed between Health First and Franklin Regional Hospital.

While the original project work plan called for completion of the electronic links in Nashua and Manchester in Year 1 of the Project, internal issues and information systems schedules at Elliot Hospital and SNHMC have delayed this work. Both organizations have committed to implementing the link. With permission from the HCAP project officer, the project accelerated the Year 2 timeline for implementation of the data link in other parts of the state, allowing the project to complete the linkages in Manchester and Nashua in Year 2.

During Year 1, data were collected for several measures of success for Activity A. The methods used to collect these data differed in Manchester and Nashua due in large part to that fact that the community health center in Manchester successfully implemented an electronic medical record system earlier than in Nashua.

## ***Decrease costs associated with patient record keeping at community health centers***

This goal is to decrease the expenditures incurred by community health centers due to the handling of patient records. In collaboration with their directors of medical records, patient record transfer processes were observed directly at the community health centers in Manchester and Nashua. Because each agency had developed its own unique methods for processing patient records, each will be described separately, below.

### ***Manchester Community Health Center***

When we observed how the records were received and processed at the MCHC, we found seven basic processes:

1. Opening records received in mail
2. Transferring records into providers' envelopes
3. Delivering records to providers
4. Retrieving records from bins
5. Sorting records to be scanned
6. Scanning records
7. Importing scanned records

The Director of Medical Records then measured the time spent carrying out each of these processes during a typical week. Opening records received in the mail and scanning the records into the EMR were the two processes that took up the most time per day and per 100 records.

The projected savings in MCHC staff time for a given number of records that are transferred using either electronic faxing or automatic importing of patient records would be substantial. For example, if the MCHC receives 31,200 records in a given year, it would save nearly 800 hours in staff time through an electronic linkage with their health care partners. If the MCHC transferred 10,000 records per year through a linkage agreement that required staff to import the data into their EMR, the time savings would be estimated at 119 staff hours per year.

### ***Nashua Area Health Center***

We conducted a similar analysis for Nashua Area Health Center, again in collaboration with their Director of Medical Records. For NAHC, we found nine processes in all:

1. Hospital and laboratory records are picked up from fax machines and from the health center's USPS mailbox

2. All incoming results are stamped with that day's date
3. Results from referred services are sorted and given to the referral specialist
4. The other results are sorted according to the patient's physician and placed in the appropriate physician's box.
5. For lab results, the patient's next appointment is noted on the lab result form
6. All of the records go out to the physicians for their signature
7. A cart goes around the NAHC, to pick up the results that physicians signed off on.
8. The records then come back to the medical records room and are put in the sorter
9. Records from the sorter are filed weekly, or whenever medical records personnel have additional time

Some of the processes require the same amount of staff time regardless of the number of records received. Staff spend approximately 10 minutes in a typical workday obtaining hospital and lab records from fax machines and the USPS mailbox. In contrast, sending records out to physicians for their signatures and then collecting the results after the physicians have signed them is much more time consuming, taking up to an hour and a half of staff time per day. The costs of other processes vary by the number of records received. For example, when records are returned after the physicians have seen them, they must be sorted and filed in the medical records room. This is the most time consuming of all the processes at NAHC, using about 80 minutes of staff time per 100 records received.

Analysis of the records review for NAHC revealed that the agency could save hundreds of staff hours by implementing an electronic link or electronic faxing with their health care partners. For example, if the NAHC received 27,560 records in a given year, it would save an estimated 617 hours in staff time through an electronic linkage and electronic faxing systems with their partners. If the NAHC also implemented a lab link that transferred 9,000 records per year, we would estimate the time savings associated with this linkage to be 106 staff hours per year.

### ***Decrease the delay in transferring records from hospitals to the community health centers***

This goal is to increase the proportion of records from hospital-based services that are promptly transferred to CHC primary care records via electronic linkages. Based on the medical records reviews, we estimated the average amount of time between when the community health center first requested patient hospital records and when these records were finally attached to the patient medical chart at the CHC.

#### ***Manchester Community Health Center***

The speed of patient record transfer was measured by a random audit of electronic medical records of the MCHC that dated between October and December of 2004. The audit assessed the date and time a service was performed at a given facility and the date and time that the record was imported into the MCHC EMR. Based on these two

dates and times, we estimated the average time interval for the speed of record transfer from their health care partners to the MCHC.

Analysis of our audit of nearly 200 records revealed that the most commonly requested records (e.g., those for imaging, emergency department and consultation records) were transferred to MCHC within ten days. The overall average time of record transfer between hospitals and MCHC was estimated at between 11 and 12 days. The distribution of the lag time was widely dispersed. The fastest 15 percent of the records were processed within two days of the MCHC request. At the other extreme, ten percent of the audited records took over 37 days to be transferred various health care partners to the MCHC EMR.

### *Nashua Area Health Center*

While based on a similar methodology, the data collection procedures were more complicated for the community health center in Nashua, coinciding with their paper records processes. To assess the speed of record transfer between hospital and community providers and the NAHC, an audit of their paper patient records in their record sorter was required. The dates and times of three data points were recorded for each record: when the service was conducted by the health care partner, when the record was received by the NAHC, and when the records were subsequently filed in the patient's paper charts – this last point marking the end of the transfer process. The time intervals associated with these processes were documented in this manner for 200 patient records.

The average time for record transfer at NAHC was nearly 20 days. The transfer time varied widely, regardless of the health care partner who was sending the records. The fastest ten percent of the records were transferred to NAHC within ten days. However, the slowest 20 percent of records took over 26 days to arrive from other providers and be filed in their respective medical charts.

The speed of records transfer did vary by the type of patient record requested by NAHC. Patient results from imaging and emergency departments were processed somewhat faster, averaging between 17 and 18 days, while consultation reports took the longest at nearly 24 days. When we examined the steps required in the transfer process at NAHC, we found that the average time between NAHC request and receipt of records was about 6 days, while the average time for internal processing of those records within NAHC took more than twice that amount of time.

**Activity B. Develop and implement a web-based electronic communications mechanism to facilitate record sharing between the community health center and community-based referral providers and agencies.**

The second component of the automation work involves developing web-based electronic communications for record-sharing between CHCs and community-based providers and agencies using high-quality communication software. During the period from September 1, 2004 through August 30, 2005, the following was accomplished:

- Software for electronic communication was selected (Clinical Messenger from Kryptiq Corporation) using an RFP process and the software was tested. However, the project encountered problems with the software and the loss of IT staff in the pilot phase at the Manchester CHC and correction of the problem was time consuming. Use of the software in Nashua has been postponed at the request of NAHC due to EMR installation activity.
- Interest by two other CHCs (Lamprey and Health First) resulted in agreements to pilot the software in those sites.

As with Activity A, the project accelerated the Year 2 timeline for implementation of the system in Newmarket and Franklin to accommodate the additional time needed in Manchester and Nashua.

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

In the first year of the project, relationships have been established between *Access NH* partners and health care providers to offer cultural competency training and support for medical interpretation. The project will continue to promote efforts to increase awareness about the importance of cultural competency and medical interpretation for improved patient-provider relationships. In addition, *Access NH* also sponsors consumer education for those with limited English proficiency (LEP) to teach them how to navigate the U.S. health care system.

SNHAHEC and NHMHC have joined forces to ensure increased access to health care for those who face cultural or language barriers to accessing health care in the target areas. The primary tasks under Activity C of the project include:

- increasing the size and quality of the medical interpreter workforce through medical interpreter training and scholarships to those who speak priority in-demand languages;
- increasing the number of consumers (especially those with limited English proficiency) who understand the U.S. health system and how to access health care by using a home-based peer education model; and
- increasing the number of providers and provider organizations that are culturally competent by providing a resource guide, training, and technical assistance.

***Medical Interpreter Training***

During the first project year, 44 medical interpreters graduated from the medical interpreter training program (20 in Fall 2004 and 24 in Spring 2005), representing 12 non-English languages. Eight training scholarships (3 in Fall 2004 and 5 in Spring 2005) were made available to individuals who speak languages that are in high demand such as Kurdish, Arabic, Russian, Dinka, Swahili, Kionh, and Kinyarwanda. The End of Course Survey completed by participants showed that most participants attended the course to become a medical interpreter or improve their medical interpretation skills. Open-ended comments indicate that the training has enabled interpreters to be more professional and effective in their current position.

Work to test a pilot program of a reimbursement mechanism for interpreters through Medicaid was completed. This pilot involved Dartmouth Hitchcock Medical Center (DHMC) and included updating billing codes, revising encounter forms, and enrolling more medical interpreters into Medicaid. Results were presented to the MIAB, who will continue this work in the second year of the project.

A medical interpretation resource guide for providers was developed and disseminated on the SNHAHEC website with live links. An informational webpage on medical interpretation and webpage advertising materials (bookmark and post-it-notes) have been developed and disseminated at educational events and meetings.

### ***Consumer Education***

In the first year of the project, 91 small group educational sessions were held with consumers to inform them about how the health care system works in the United States, their role in their own self-care, and their right to an interpreter. Between February 4 and August 30, 2005, consumer education was provided to 318 individuals with the following characteristics:

- *Gender* — both men and women attended the groups in roughly equal numbers.
- *Age* — about half of the participants were under 30 years of age.
- *Race/ethnicity* — over two thirds of participants were Latinos, while another fourth were of African descent.
- *Country of birth* — participants came from many different countries, most commonly, from Mexico. Other Latin immigrants were from the Dominican Republic, Puerto Rico, and Columbia. African immigrants who participated in consumer education were from Somalia, Liberia, and the Sudan, among others.
- *Time in the United States* — about one in ten had been in this country for less a year, while about half have been here from one to 5 years.

### ***Health Care Provider Training***

Technical assistance was provided to nine organizations including two hospitals (one in Manchester and one in Nashua), NAHC, the media, and a medical practice (in Manchester). This support involved advice related directly to medical interpretation, as well as cultural competency overall in health care settings. In support of medical interpretation, advice was offered to assist in enrolling medical interpreters in Medicaid; writing job descriptions and hiring medical interpreters and managing interpreter lists. Language proficiency tests for health care providers were also sponsored by the project, as was a mentoring program to improve bilingual staff's medical language skills. Regarding cultural diversity and competency, support involved helping to establish diversity committees and promote more appropriate language and around medical interpretation and cultural competency within health care organizations.

During Access NH's first year, 688 people participated in 16 provider trainings on the following topics:

- Cross Cultural Skills in Health Care (2 trainings)
- Working with Interpreters (9 trainings)
- Spanish for Health Care (1 training)
- Cultural Beliefs and Customs on Death & Dying (2 trainings)
- Preventing and Managing Diabetes in Culturally Diverse Populations (1 training)
- Cultural Viewpoints on Dealing with Emergencies (1 Culture Forum)

Participants were overwhelmingly favorable in their voluntary course evaluations completed at the end of each training session. The vast majority reported that they gained the specific knowledge and skills they had hoped to receive from the training. Open-ended comments indicate that participants in these trainings obtain skills that will apply to their current work.

The trainings in which participants reported having the least knowledge of the subject matter beforehand were *Spanish for Health Care Professionals* and *Introduction to Mental Health Interpretation*. Most of the participants in the training reported having “little” or “no” knowledge prior to the training and gaining “some” or “great” knowledge of the learning objectives after the training.

In contrast, about half of the participants in the *Cross Cultural Skills in Health Care* trainings reported they had “some” or “great” knowledge of the specific learning objectives prior to the training. Even more participants (70-90 percent, depending on the objective) said they were knowledgeable about the learning objectives for the training, *Working with Medical Interpreters*. The only learning objective that was not achieved for a sizable portion of participants was one regarding cross cultural skills, to “define culture and cultural competency, identifying similarities and differences across cultural groups.” About a fourth of all participants in the sessions on *Cross Cultural Skills in Health Care* still reported “little” knowledge of how to do this after the training.

**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 New Hampshire Health Access Network (NHHAN) is a voluntary effort by health care providers in New Hampshire to improve access to health care for low-income children and adults. Patients apply for financial eligibility status for the NHHAN program at a number of sites in the community. Once the patient is found eligible for financial discount, he/she is provided with a NHHAN card that will then be accepted at all participating health providers in the state.

The funding enabled NHHAN to expand the number of provider organizations, thereby increasing access to health care. NHHAN also provided training and technical assistance to new sites, laminated ID cards, and translated outreach materials. During the period from September 1, 2004 through August 30, 2005, the following was accomplished:

- Establishment of an NHHAN User's Group to plan training, and provide technical support to other NHHAN members.
- Development and dissemination of translated outreach materials for use in the Nashua area, including NHHAN application and cover letter materials, a brochure on NHHAN services, and a brochure to help inform people about what to do if they lose their health insurance coverage. Forms were also translated into Indonesian.
- Completion of a consumer survey to collect information about how to improve NHHAN application procedures.
- Implementation of common eligibility formula and application procedures in four Manchester and Nashua hospitals.
- Addition of 24 new primary care practice sites (19 from the Elliot Physician Network and 5 from Catholic Medical Center physician practices) and one new specialty practice in Manchester. Enrollment procedures were developed and staff were trained.

#### **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 manufacturers. The program keeps updated 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. enables the Medication Bridge Program to expand enrollment by increasing the number of enrollment sites in Manchester and Nashua. The primary component of this work is to establish new health care and non-health care sites by identifying locations, setting up procedures, and recruiting and training staff. During the period from September 1, 2004 through August 30, 2005, the following was accomplished:

- Five new sites were started (one health-care facility and four non-healthcare related). A new site was approved for Nashua.
- Revised procedures to adjust to new Medicare drug benefit were developed and 13 education sessions were held in Manchester and Nashua on the Medication Bridge program and the new part D Medicare program. The Medication Bridge brochure was updated and a Spanish version of it was printed. More than 950 organizations were sent the new brochure.
- Held two quarterly meetings of the Medication Bridge User's Group

- Started working with a Nashua community organization to develop a local training program for Medication Bridge sites

## Summary and Conclusions

To understand the collective work of the partners more fully, individual interviews were conducted with each of the partners. The purpose of these interviews was to gather each Partner's perspective on the accomplishments, challenges, and planned activities in the area in which he/she is working; and to obtain each Partner's perspective on how involvement with has enhanced her/his work and potential future opportunities for collaboration.

While the activities of were already underway to varying extents prior to this project, Partners described the HCAP funding as a “catalyst” that enabled Partners to collaborate strategically. Under, they were able to accelerate timelines for some activities, intensify activities in the state's most populous geographic region; and identify new opportunities to foster innovation. Specifically, Partners pointed to the following accomplishments during the first year of :

- Established a new pilot program to support health care providers as they improve their ability to better communicate with LEP patients by improving their language skills.
- Fostered the NHHAN program, particularly in Manchester, including successfully recruiting Elliot Hospital as a participating provider.
- Secured more Medication Bridge sites in Manchester and Nashua, in the face of reduced support from drug companies.
- Accelerated implementation of electronic linkages in Manchester and Nashua.
- Discovered the potential of electronic fax as a way to share information in the face of delayed automation and different information systems in organizations.
- Taught hundreds of consumers about the U.S. health care system and how to access it.
- Increased awareness about language and cultural competency issues among provider organizations.

While acknowledging that a causal relationship is hard to establish, one Partner contrasted provider organizations before and after the implementation of the project as follows:

We see cultural competency more on the radar screen... There is more attention paid to meeting the needs of different groups. It is also coming from a higher level in these organizations—coming at a strategic level in the organizations. Within organizations, CEOs are paying attention.