Project: EDC PATH2HEALTH RURAL SERVICES PROJECT
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Proposal Abstract

The EDC Path2Health Rural Services Project (project) will improve access to health care and health care coverage for eligible low-income rural residents of El Dorado County, California. The project assists the County in the effective implementation of a mandated Low Income Health Program (LIHP) and is consistent with federal and state goals for health care reform. The proposed project, with its countywide partnerships and coordination of safety net providers is complementary and essential to promoting the substance of the LIHP, particularly as it relates to rural populations.

The El Dorado County Health and Human Services Agency (HHSA) is pleased to serve as the fiscal intermediary on behalf of Access El Dorado (ACCEL). ACCEL is a nine-year old community-wide collaborative of public and private agencies working together to improve the coordination and delivery of care for the underserved in the County. This project will leverage ACCEL's partnerships, web-based care coordination technology and successful use of the Care Pathways™ Model. A promising practice for community care coordination, Care Pathways™ are standardized protocols for shared interagency case management and use health navigators to support at-risk individuals toward positive health outcomes.

El Dorado County, a mountainous region stretching across 90 miles of foothills, valleys and mountain peaks is home to 181,058 residents. More than 35% of the population lives in rural communities, and over 78% live in unincorporated areas. The County is a federally designated Health Professional Shortage Area (HPSA) for Mental Health and parts of the County are a Primary Care HPSA. Residents of the County's rural census tracts - the project's target population - are the most vulnerable to these shortages. Lack of access to health care services, limited capacity of current health care providers, and a diverse system of safety net providers pose serious barriers for clients seeking to obtain high quality, timely care.

Each year, on average, 240 participants will be helped with accessing health care coverage and/or a obtaining a medical home. Based on ACCEL's experience with contacting and helping vulnerable and rural populations overcome barriers to care, an estimated 60% of these will obtain coverage and 50% will obtain a medical home. Of those referred to specialized mental health services or to behavioral care services 60% will successfully obtain screenings for services. Referral completion rates will improve by 5% each project year and providers surveyed will report an 85% improved capacity to serve this target population. Of participants receiving at least three Health Navigator contacts, 80% will report receiving culturally competent assistance and 80% will indicate a greater ability to navigate the health care system on their own. Longer-term outcomes include the improved health status of low-income rural residents, stronger coordination between safety net providers and the institution of a replicable care coordination model.

HHSA is requesting Preference 1 Funding as the County is a HPSA for Mental Health and parts of the County are a Primary Care HPSA.

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1. INTRODUCTION

Background

As communities across the country prepare for health reform, there is much potential to reduce health disparities and improve health outcomes for rural populations. However, rural populations are often marginalized and outreach strategies are applied uniformly across populations, overlooking the unique needs of this patient population. In El Dorado County, the lowest income populations will become eligible for a new health coverage program and expanded benefits. This project focuses its activities on the County's rural populations to ensure adequate resources and appropriate strategies are developed to meet their needs.

Consistent with federal and state goals to improve coverage to the safety net population, El Dorado County will be implementing Path2Health, a Low Income Health Program (LIHP) in January 2012. For simplicity, this proposal will reference Path2Health as the "LIHP." As part of the County Medical Services Program (CMSP) network of 34 California counties, El Dorado County Health and Human Services Agency (HHSA) is mandated to implement this LIHP. It will provide coverage and expanded benefits for medically indigent adults (ages 19-64) such as mental health and substance use counseling services. For persons with incomes up to 100% of the federal poverty level (FPL), the LIHP will waive asset verification. Other goals of the program include: expand the network of primary and specialty care providers, promote linkages between primary care and behavioral health, and test enhanced the medical home concept for target groups. Lastly, the LIHP will serve as a bridge for the health reform changes set to take place in 2014. These goals align strongly with the proposed project.

Effective implementation of the LIHP will require countywide partnerships and coordination of safety net providers to meet the requirements of this new program. The proposed project is complementary and essential to promoting the substance of the LIHP, specifically as it relates to rural populations. Further, this project will augment the County's current service delivery system and partnerships so that providers of health and social services can more readily meet the health care changes set place to occur in 2014.

Our Proposal

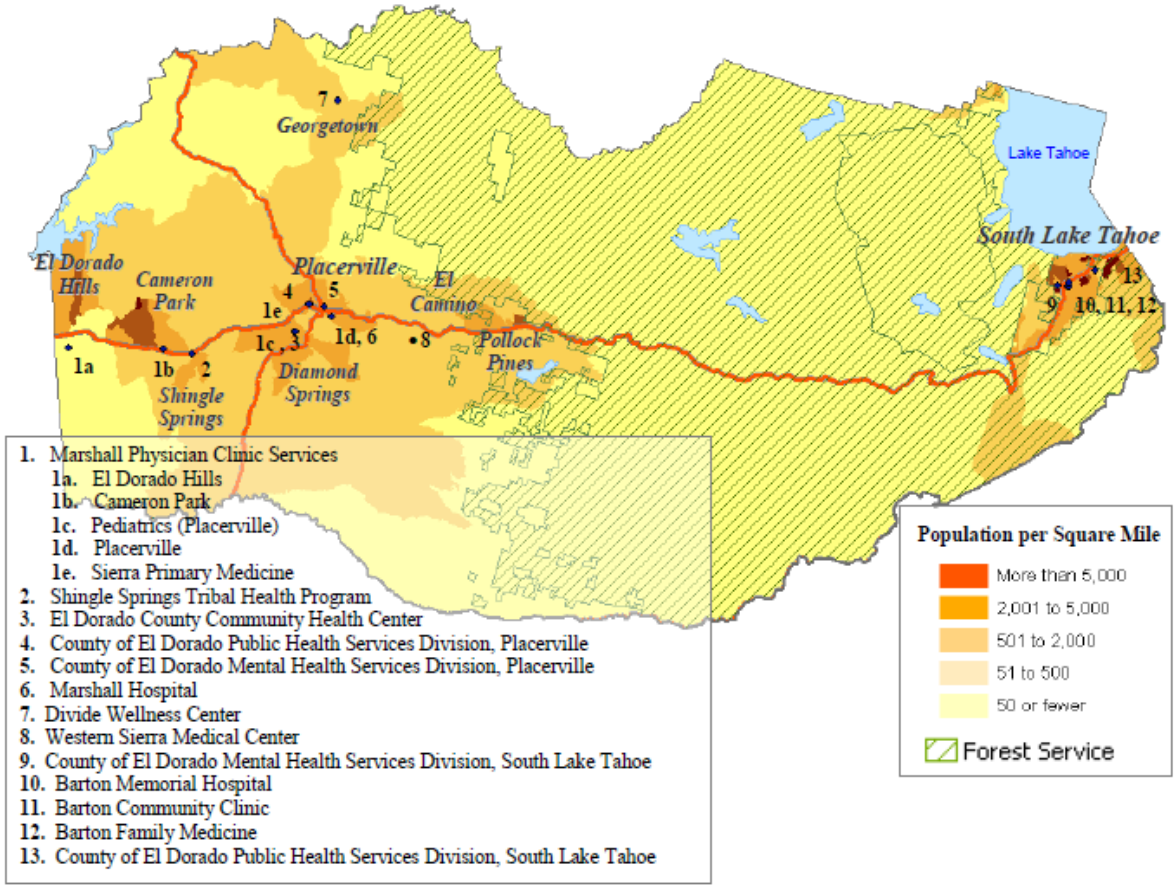
HHSA, on behalf of ACCEL (Access El Dorado), will serve as the fiscal intermediary for the El Dorado County Path2Health Rural Services Project (project). Formed in 2002, ACCEL has benefited from more than nine years of experience with its members successfully working across organizational boundaries to identify, understand, and resolve barriers to health care for the safety net population in El Dorado County. ACCEL is a public-private collaborative of the following organizations (Refer to Figure 1):

- El Dorado County Health and Human Services Agency, including Public and Mental Health Divisions
- Barton Health (hospital, rural clinic, primary care practices)
- Marshall Medical Center (hospital, rural clinic and primary care practices)

- El Dorado County Community Health Center (FQHC)
- Shingle Springs Tribal Health Program (health clinic with a focus on Native Americans)
- Western Sierra Medical Center (rural clinic)

Although disparate, and historically different, each ACCEL agency shares common care goals as described in more detail in Sections 5 and 6.

Figure 1. Map of ACCEL Agencies



In line with the goals of the LIHP, this project will provide the essential resources to deliver care coordination and case management services for the County's rural patients, particularly those with substance use, mental health or co-occurring disorders. This project enables a Health Navigator to support rural clients in obtaining LIHP coverage, establishing with a medical home and accessing mental health and substance use disorder providers more efficiently. In addition, this project will improve patient experience and strengthen their confidence in more effectively navigating the health care system.

This project will leverage ACCEL's existing community-wide partnerships of public-private agencies to implement the proposed project. ACCEL agencies have long recognized the value of and need to work together to meet the needs of the County's most vulnerable populations. ACCEL agencies are ready and willing to utilize its infrastructure to prepare the County's providers and patients for changes set place to occur in 2012 and 2014.

This project will also utilize the proven Care Pathways model, as described in detail below, which ACCEL has successfully integrated into its program for close to a decade. Specifically, ACCEL will build on its current Care Pathways that have historically focused primarily on children and families, to develop Care Pathways that target the needs of LIHP clients. We are confident our success with the Care Pathways model and spirit of collaboration will enable us to be successful, yet again, in this project.

Goals and Expected Outcomes

In alignment with the County's mandate to implement the LIHP, this project seeks to achieve the following goals:

1. Increase access to health care services for selected, rural LIHP-eligible clients
2. Improve health outcomes for rural LIHP-eligible clients and build local capacity to prepare for future health care reform changes

The project seeks to achieve the following outcome objectives:

- Increase the number of rural LIHP-eligible candidates that secure LIHP coverage;
- Increase the number of rural LIHP-eligible candidates that obtain a medical home;
- Improve coordination between primary care providers (PCPs) and mental health and substance use disorder services;
- Increased client self-efficacy and engagement in managing their own health care; and,
- Institution of a replicable care coordination model that improves local capacity and strengthens the coordination of care among safety net providers.

The project will focus on selected rural clients over the three-year project period. An emphasis will be on serving those with mental health, behavioral health or co-occurring disorders. A Health Navigator will assist a yearly average of 240 clients with obtaining LIHP and/or access to health care services. Each year, on average, 240 participants will be helped with accessing coverage and/or obtaining a medical home. Based on ACCEL's experience with contacting and helping vulnerable and rural populations overcome barriers to care, an estimated 60% of these will obtain coverage and 50% will obtain a medical home. Successful screenings for services will be achieved by 60% of those referred to specialized mental health services or to behavioral care services. Referral completion rates will improve by 5% each project year and providers surveyed will report an 85% improved capacity to serve this target population. Of participants receiving at least three Health Navigator contacts, 80% will report receiving culturally competent assistance and 80% will indicate a greater ability to navigate the health care system on their own. Longer-term outcomes include the improved health status of low-income rural residents, stronger coordination between safety net providers and the institution of a replicable care coordination model.

Baseline Measures

ACCEL recognizes that measuring project progress and impact is important. Below are key baseline measures that will facilitate this process. The full list is in Attachment 12.

- Demographics of Participants (Clients);
- Unduplicated Number of Participants Served;
- Number and Type of Services Received;
- Number/Percentage of Participants that Report Receiving Culturally Competent Services;
- Number/Percentage of Participants that Report Being Better Able to Manage Their Own Health Care Needs;
- Number and Listings (Rosters) of Stakeholders that Participate in Meetings and Forums;
- Surveys of Service Recipients and Stakeholders;
- Percentage Increase in Successful Completions of Referrals; and,
- Completion and Integration of Four Electronic Health Care Pathways.

Project Impact

The impact of the project will be significant and numerous. First, the project will help to improve the health status of rural residents and reduce health care costs. Many studies have shown patients with health insurance and a PCP experience improved health outcomes and are less likely to use the emergency room (ER) for non-urgent cases, reducing overall system costs. Further, through help with obtaining coverage and services, health education and care coordination, these clients will be more engaged with their care and confident in overcoming barriers to care. The project will also strengthen the coordination and delivery of care within the County. This is critical as providers are forced to do more with less. Like many providers across the country and in rural areas, El Dorado County providers are facing reduced reimbursement, and limited staff resources while also investing in activities to meet the health care reform mandates of 2014, including electronic medical record adoption. The project will provide the support to augment and expand the County's current partnerships to effectively deliver high quality care to its rural populations.

Promising Practice

ACCEL will build upon its use of the Pathways™ Model (Care Pathways) of community-based care coordination, developed by Drs. Mark and Sarah Redding in Ohio. ACCEL has developed and successfully implemented eight Care Pathways as described later in the proposal. This promising practice provides a framework of standardized interagency processes to support patients in connecting to health care services and achieving positive health outcomes. Care Pathways is a structured and collaborative approach to help ensure patients do not fall "between the cracks," particularly as patients move from one health care setting to another. This is particularly useful for transient, rural patients. Furthermore, the model makes use of Community Health Workers (also known as Health Navigators or promotoras) to support clients in accessing needed social and health care services in a culturally competent manner.[i]

2. NEEDS ASSESSMENT

Program Development/Target Population Involvement

Engaging target populations throughout a project's life cycle is key to developing and maintaining a program that is relevant and addresses the population's needs. ACCEL members

participated in a variety of activities to help gain stakeholder input regarding the health care and health care coverage needs of low income rural residents. Participation included involvement in:

- California Behavioral Health Services Needs Assessment and Services System Plan
- California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative
- Mental Health Stigma and Discrimination Initiative
- County Mental Health Services Act (MHSA) community program planning
- El Dorado County MHSA Innovation Work Plan
- CMSP Innovation Planning: State and County
- ACCEL monthly meetings and ad hoc convenings
- El Dorado County Community Health Clinic needs assessment processes
- Other nonprofit, regional planning efforts

Participation included heavy involvement by stakeholders and subject matter experts, such as those providing the services within ACCEL. Discussions with CMSP staff, who regularly conduct, review and analyze CMSP data, also helped to inform the goals and activities of the project. These activities help to ensure the project employed strategies to help address challenges of rural LIHP-eligible clients including ways to overcome geographic, cultural and language barriers, limited social service resources, and lack of access to high quality health care, mental health and substance use disorder services.

Methods used to gather information included public meetings, focus groups, key informant interviews, surveys/questionnaires and information published on websites and in newspapers with requests for comments. Participants have included service providers and other government, nonprofit, Tribal and faith-based entities as well as individuals who could be service recipients and their families or significant others.

Over the course of the grant, the project will continue to seek guidance and feedback from a multiple perspectives. Feedback from client and patient surveys, community forums, and meetings with community-based organizations will provide important information to help adjust and improve the project over time. Monthly ACCEL Safety Net Provider Workgroups will help give clinical insight. In addition, a leadership perspective will be gained from participation in ACCEL Steering Committee meetings, which includes senior leadership from the County's major safety net provider groups.

Target Area Details

El Dorado County, a mountainous region stretching across 90 miles of foothills, valleys and mountain peaks is home to 181,058 residents. More than 35% of the population lives in rural communities, and over 78% live in unincorporated areas. With elevations ranging from 200 feet at the western border in the Central Valley of California to 10,881 feet at the highest peak in the majestic Sierra Nevada Mountains, the climates vary from warm, dry summers in Placerville to snowy winters in South Lake Tahoe.

Many rural patients must travel long, mountainous routes to obtain health care and social services and at times, face adverse weather conditions. Residents that live in very remote locations must travel up to an hour to obtain care. Highway 50 is the County's only major transportation artery. All other routes are winding two lane roads that can be icy or snow-clogged in the winter. The only public transportation is by local buses in Placerville and South Lake Tahoe. Residents in Georgetown, a rural town in the northern part of the County are roughly 40 minutes from the closest hospital in Placerville, and must travel a two-lane, winding road lining the Sierra Nevada range to access care not provided at the local clinic. For more specialized services, patients must travel anywhere from 50 minutes to Davis (UC Davis Medical Center) to up to four hours to the Bay Area (UC San Francisco, Stanford Medical Center). For many rural clients, this means finding reliable transportation and missing at least a day of work, often times losing associated pay.

The topography and microclimates within El Dorado County have had an important impact on the evolution of care systems in the County. The County, unlike many in the state, is bisected by the Sierra Nevada mountain range creating a dichotomous health care system that is important to consider when meeting the needs of rural residents. Historically, there is little crossover of patients between the two regions known as the Western Slope (west of the Sierra Nevada) and the Tahoe Basin (east of the Sierra Nevada).

The rural focus of this project will target areas that are located on both sides of the slope. As shown on the map below (Figure 2), the project's service area encompasses the majority of the County except for a small urban area (El Dorado Hills and Shingle Springs area). Specifically, the target population service area is within four rural Medical Service Study Areas (MSSAs). HRSA formally recognizes California MSSAs as the Rational Service Area (RSA) for medical service for California. The target census tracts, as referenced as eligible for this funding opportunity, are within these MSSAs.

Target Population Details

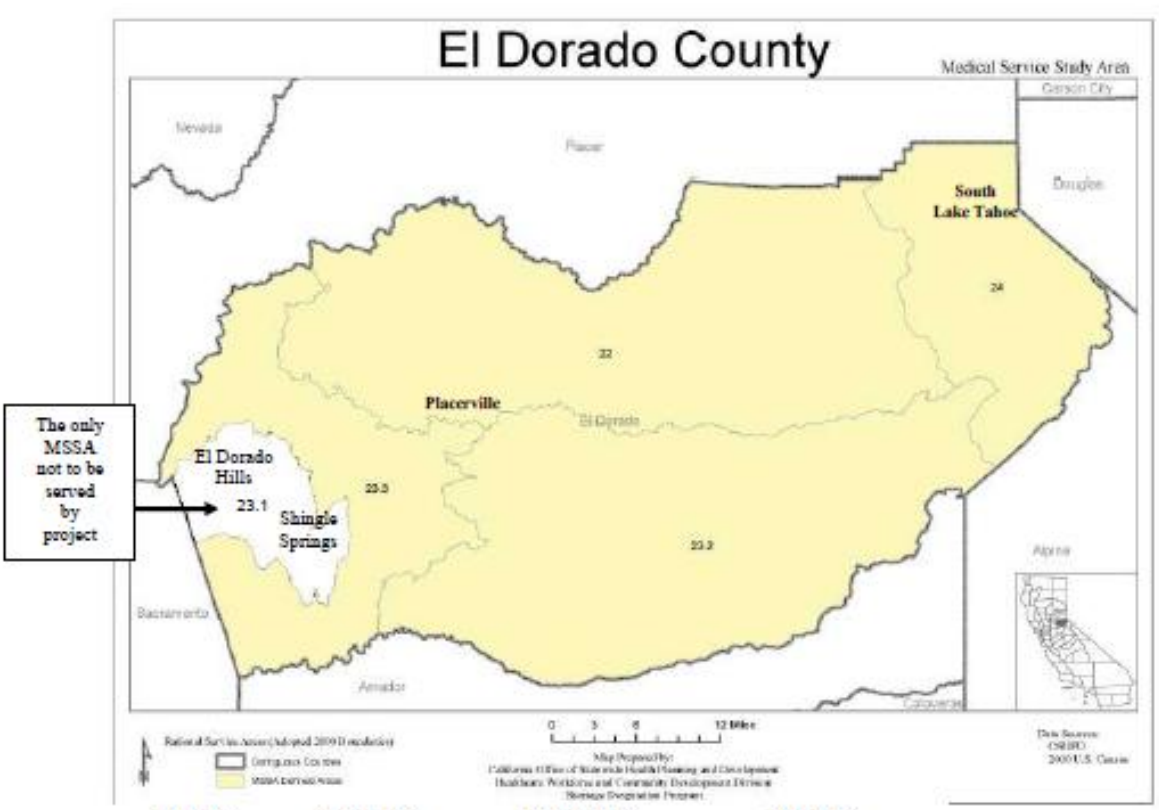
The target population will be individuals that are eligible for the LIHP and that live in the rural census tracts depicted in Figure 2. Specific LIHP requirement include:

- Up to 100% FPL
- Asset waiver
- Deficit Reduction Act level documentation for citizenship and identity
- Ages 19-64
- 6-month enrollment term (including 10-day pre-enrollment period for emergency services)

The CMSP Governing Board, which oversees the LIHP program for all 34 counties, estimates there will be roughly 3,500 LIHP-eligible clients in El Dorado County. A review of zip codes of CMSP clients reveal that roughly half of CMSP clients are from rural areas. Based on this, it is estimated that about half of LIHP-eligible clients, or 1,750 will be the target population that may be eligible for this project. This project will particularly focus our efforts on rural clients that suffer from mental health, substance use and/or co-occurring disorders. By focusing on a specific

patient population, we believe the project will demonstrate the use of Care Pathways as an effective and innovative model of care for rural, LIHP clients.

Figure 2. El Dorado County's Rural Census Tracts and the Project's Target Service Area



EDC Path2Health Rural Services Project
Target Census Tracts in the Rural Medical Services Study Areas

Selected County Health Data

While El Dorado County shows mid-range values for many chronic conditions[1], there are pockets of high chronic disease rates. For example, compared to a regional rate of 7.88, asthma hospitalizations were 9.73 and 11.69 per 100,000, respectively in Diamond Springs and Pollock Pines, according to a 2010 Community Needs Assessment.[ii] The County has higher death rates in

cancers and strokes compared to other California counties. Hepatitis C and Chlamydia are the two most common reportable diseases in El Dorado County. Chronic Hepatitis B and C rates continue to climb.[iii]

Substance Use/Abuse: The percentage of residents that drink excessively exceeds that of the national benchmark of 8% provided by Healthy People 2020. Nineteen percent of El Dorado County residents drink excessively. Liver disease, often associated with substance use/abuse, is the third leading cause of premature death in El Dorado County.[iv] The admission rate for Alcohol and Other Drug (AOD) use/disorders was higher (by up to 20%) than the State for five of the eight years between 2000 and 2008. The rate of admission to AOD treatment in El Dorado County is 708 per 100,000 people is significantly higher than the State rate of 592 per 100,000 people. The death rate due to alcohol and drug-related causes in El Dorado County is almost double the rate of the State (19/100,000 compared to 11/100,000).

Rural Differences: El Dorado County rural residents often suffer disproportionately from chronic illness and overall poor health. The Rural Assistance Center (RAC) notes that geographic isolation, socio-economic status, health risk behaviors, and limited job opportunities contribute to health disparities in rural communities. The figures below, derived from the Behavior Risk Factor Survey (2007-2009) reveal depict some of these differences - including a greater percentage of current smokers in rural areas than in urban areas, and a higher percentage of poor health days.

Figure 3. Percentage of Smokers and Chronic Risk of Alcoholism in Rural vs. Urban County in California

California Rural and Urban Counties	2008 Rural	2008 Urban	2009 Rural	2009 Urban
Current smokers	15.55%	12.14%	14.75%	10.33%
Chronic risk of alcoholism	4.99%	3.93%	5.24%	4.56%

Figure 4. Percentage of Self-Reported Poor Health Days in Rural vs. Urban Counties in California

Self-Report of Poor Health Days, Rural and Urban Counties in California	2007 Rural	2007 Urban	2008 Rural	2008 Urban
Cannot work, go to training or school due to				
Physical Issues	13.79	10.95	15.4	12.02
Mental Issues	3.87	3.82	5.68	4.69

Ethnic/Cultural Differences: El Dorado County is roughly 80.0% White, 12.1% Hispanic or Latino origin and the remainder representing other minority populations.[2] While the county is predominately White, ACCEL's focus on vulnerable populations presents a more diverse patient

[2] These include Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander or persons reporting two or more races

pool, serving over three times more patients from Hispanic and minority backgrounds compared to overall County statistics. Similarly, in South Lake Tahoe, a greater proportion of residents are Hispanic and of minority backgrounds as they help to meet the demands of a predominantly service-related and gaming industry. The target area's demographic breakdown reveals similar patterns.(See Attachment 14).

Insurance Coverage Differences: A strong link exists between health insurance coverage and access to preventive care, primary care, acute care, chronic illness management, and mental healthcare.[v] Between calendar years 2004 and 2009, a greater proportion of California' rural residents report no health insurance compared to residents of urban counties. This trend is reflected in the fact that between 2008 and 2009, the percent of rural residents below the FPL increased from 19% to almost 22%. [vi] Even when coverage was available through CMSP, (2009-2010) only 62.5% used it.[vii]

CMSP Recipients (Target Population)

In 2008-2009, acute injuries (e.g. fractures) accounted for 13% of outpatient expenditures. Chronic diseases including diabetes, hypertension, atherosclerosis or COPD accounted for 4.6% of expenditures.[viii]

Barriers/Challenges

This project is a critical and essential piece to helping rural clients effectively obtain and use the LIHP. Specifically, this project will provide resources to overcome challenges commonly faced by the County's rural populations. Specific barriers include:

Too Few Health Care Resources: There are limited health care resources within the County for rural, publicly insured patients. As a result, patients often face long wait times to see a provider or deal with long travel times to get to the provider. Access to mental health and substance use disorder services and their capacity to meet the needs of LIHP clients are another major concern. In South Lake Tahoe, there are no substance abuse treatment centers that take CMSP. CMSP coverage for behavioral health care has always been limited. Yet, a 34-County analysis of CMSP claims data revealed that more than a third of the total cost for the program was for beneficiaries who had behavioral health (mental health or substance abuse) conditions.[ix]

After review of the current health care services in the County, it is not surprising, therefore, to see that El Dorado County is a Health Professional Shortage Area (HPSA) for Mental Health and parts of the County are a Primary Care HPSA. Three of the service area census tracts are also designated as Medically Underserved Areas. Residents of the County's rural census tracts are most vulnerable to these shortages. Figure 5 helps to show the limited quantity of available health care providers that accept CMSP and are expected to accept LIHP coverage.

Inappropriate Use of Healthcare Resources: CMSP data suggest that the project's target clients do not have or utilize their PCP effectively. Instead, many are using the ER to fulfill immediate and emergency medical needs, in particular serious needs requiring hospitalization. Of 742 CMSP enrollees seen in Placerville through the Marshall Medical Center system between

February and July 2010, 61% of those were treated as inpatients and 72% of recipients seen in the ER had no primary care physician.[x] Within 60 days, 40% of CMSP patients discharged from the Marshall ER came back for a non-emergency visit (2009-2010 CMSP data).

Care Coordination/Collaboration Needs Improvement: Care coordination, health education and case management help is also limited. The clinics and hospitals have disparate computer systems with varying applications and no interoperability. Information about patient services provided at one site is not readily available to other providers at another site. Coordination of care, clinical decision-making based on complete information, and elimination of costly duplications is currently difficult. From the patient's perspective, additional aspects are similarly disorganized. Finding a "medical home" is a difficult and disheartening system of trials and errors for the patient and family. Clinics open and close operations. Practices are closed to new patients—or to publicly insured ones—and there is no source of accurate information about practices with openings for new patients. This project will provide a Health Navigator to support clients in more effectively navigating the local health care system. Further, it will utilize ACCEL's Safety Net Provider Workgroup to foster discussion of these barriers to care.

Lack of Patient Confidence and Engagement in their Care: Rural clients suffering from mental and/or substance use disorders, or co-occurring diseases, may not have the tools and knowledge to cope with the many barriers that they face. They may not know how to comply with the requirements for insurance, overcome transportation barriers, or have limited or no money to pay for services. Some may also feel fear or anxiety about attending a medical appointment and not feel "wanted" or "welcomed" by their providers. Other personal and family issues such as lack of childcare, no sick leave and language and cultural barriers can only compound these problems. These barriers provide insight as to why many low-income rural residents seek help through the emergency room rather than a PCP.

Health Care in Service Area

As shown Figure 5, rural LIHP clients have access to only four outpatient clinics on the Western Slope and one in the Tahoe Basin. It should be noted that all these entities are ACCEL agencies and will participate in this project.

Figure 5. Summary of Primary Health Care Service Options for LIHP Clients

Area	Agency	Description
Western Slope	Shingle Springs Tribal Health Program	SSTHP is located about 10 miles west of Placerville and served 168 CMSP enrollees in 2010. SSTHP recently built a new clinic that will increase its ability to see new patients.
	El Dorado County Community Health Center (EDCCHC)	EDCCHC provides primary care for more than 46% of CMSP enrollees in the Western Slope and is the County's only FQHC. Their Integrated Behavioral Health program serves patients whose behavioral health problems affect their ability to adhere to medical treatment plans. This is the only behavioral health services to CMSP patients at this time. EDCCHC also provides podiatry and Hepatitis C care.

Area	Agency	Description
	Western Sierra Medical Center (WSMC)	WSMC is a rural health center located 10 miles east of Placerville in Camino. It served 128 CMSP patients in 2010.
	Divide Wellness Center	Divide Wellness is a rural health center in northwestern El Dorado County in Georgetown. Divide is part of Marshall Medical Center's network of providers and served 137 CMSP members in 2009-10.
	Marshall Orthopedics	ACCEL facilitated CMSP availability for these services
Tahoe Basin	Barton Community Clinic	Primary clinic for LIHP clients in South Lake Tahoe.

3. METHODOLOGY

Goals and Objectives

The project seeks to achieve the following goals:

1. Increase access to health care services for selected, rural LIHP-eligible clients
2. Build local capacity and improve health outcomes for rural LIHP-eligible clients

Using ACCEL's collaborative approach and proven Care Pathways model, the project will produce significant outcomes for the County's rural patients and develop a model that can be replicable by other rural networks in the country. Specifically, the project seeks to achieve the following objectives:

Objective 1	Increase in the number of rural LIHP-eligible candidates that secure LIHP coverage
Objective 2	Increase in the number of rural LIHP-eligible candidates that obtain a medical home
Objective 3	Improve coordination between primary care providers and mental health and substance use disorder services
Objective 4	Increase client self-efficacy and engagement in their health care
Objective 5	Increased client confidence in navigating the health care system more effectively
Objective 6	Institution of a replicable care coordination model that improves local capacity and strengthens the coordination of care among safety net providers

The project will focus on selected rural clients, with an emphasis on serving those with mental health, behavioral health and/or co-occurring disorders. Through the use of a Health Navigator, a yearly average of 240 clients will be assisted with obtaining LIHP coverage and/or accessing health care services. Based on ACCEL's experience with contacting and helping vulnerable and

rural populations overcome barriers to care, an estimated 60% of these will obtain coverage and 50% will obtain a medical home. Successful screenings for services will be achieved by 60% of those referred to specialized mental health services or to behavioral care services. Referral completion rates will improve by 5% each project year and providers surveyed will report an 85% improved capacity to serve this target population. Of participants receiving at least three Health Navigator contacts, 80% will report receiving culturally competent assistance and 80% will indicate a greater ability to navigate the health care system on their own. Longer-term outcomes include the improved health status of low-income rural residents, stronger coordination between safety net providers and the institution of a replicable care coordination model.

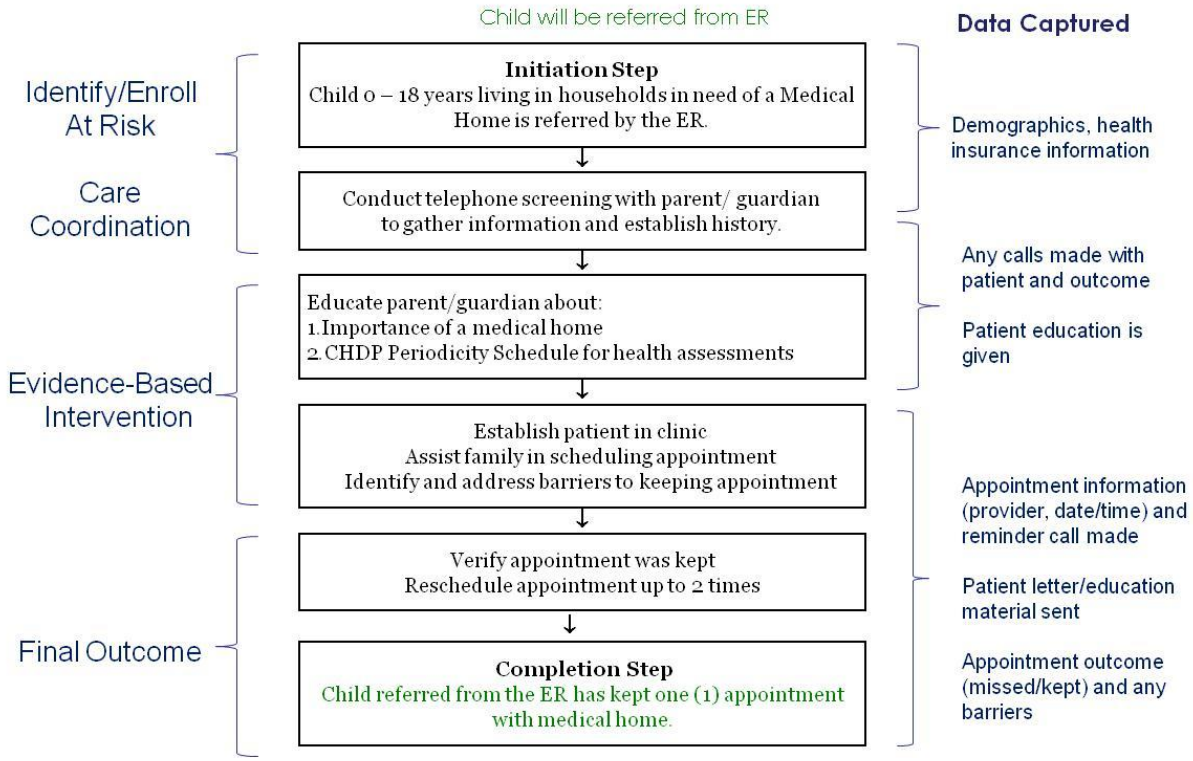
Program Goals and Healthy People 2020 Initiative

The goals and objectives correspond to several Healthy People 2020 objectives. These include: ***Access to Health Services:*** AHS–1: Persons with health insurance, AHS-3: Increase the proportion of persons with a usual PCP. AHS-5: Increase the proportion of persons who have a specific source of ongoing care. AHS-6: Reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care or prescription medicines. ***Mental Health:*** MHMD–9: Increase the proportion of adults with mental disorders who receive treatment. MHMD–10: Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders. ***Substance Abuse:*** SA–8: Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year.

Evidence/Based Promising Practice Model

The Project employs the Pathways© Model of community-based care coordination developed by Drs. Mark and Sarah Redding of the Community Health Access Project (CHAP) in Mansfield, Ohio. This model, herein referred to as "Care Pathways," has been used successfully for more than 10 years in diverse environments throughout the country. This model identifies a basic client need to be addressed and provides measureable steps to help move patients toward a positive outcome. Care Pathways are jointly developed by a cross-agency team and are designed to leverage resources. A Health Navigator assists each client, acts as a personal guide and advocate, helps determine eligibility, links patients to resources, provides health information and works with the medical system on the client's behalf. The desired results include supporting patients to achieve positive health outcomes and fostering patient confidence in navigating the health care system and engagement in their own health care. Care Pathways are built from an endpoint or Completion Step, the successful resolution of an identified problem. The Completion Step documents that the client has achieved all requirements for resolution or at least improvement of the problem identified in the Initiation Step. Success in using a Care Pathway is measured by counting the number of completed Care Pathways. Outcomes are tracked at the level of the individual being served. This outcome must be easily measured and based on accepted criteria. Figure 6 shows ACCEL's "Obtaining a Medical Home (OMH)" pathway targeted at chronic users of the ER.

Figure 6: ACCEL's OMH Pathway



With the support of Drs. Mark and Sarah Redding, ACCEL was among the first sites in the country to successfully adopt the Care Pathways model. Further, ACCEL was the first to develop a pediatric mental health pathway, one of the most complex pathways due to the sensitive conditions of patients and hesitation by providers to treat these patients. This pathway facilitates a more transparent and structured referral process for PCPs to make direct referrals to the County Mental Health Division for Medi-Cal or Healthy Families. Since 2002, ACCEL has developed and implemented eight Care Pathways aimed at increasing access to care. Examples of our Care Pathways include: securing health insurance for newborns and young children, ensuring that insurance coverage is maintained over time, obtaining a medical home for newborns and children, and facilitating referrals between primary care practices and pediatric mental health services and specialty care services. The pathways were created alongside ACCEL strategies to expand PCP supply and access to needy populations.

Each ACCEL agency provides resources and agrees upon a shared process to manage patients, Since August 2009, with this support, ACCEL Care Pathways have made measurable progress including: connecting over 6,646 children and 600 newborns to health care coverage; assisting 526 (93 percent) children to re-enroll into health insurance programs; assisting 140 newborns in obtaining well-baby exams and immunizations; successfully establishing a medical home for 355 (83 percent) of children seen in the Marshall ER, (thus reducing the use of the ER for primary care needs); and, connecting over 456 publically insured adults to Orthopedic specialty care since August 2009.

ACCEL recently launched a Pain Management telemedicine pathway in partnership with UCDMC. Over the past two years, we successfully held five community-wide provider education sessions (one for continuing medical education credit) via telehealth for both Pain Management and Orthopedic specialties. Roughly 40 providers across disciplines attended each session. Care Pathways has served as a standardized framework to address access and enhanced coordination cross ACCEL agencies. This project will benefit from our experience and success in these pathways, reducing the time needed for design and implementation of the proposed pathways.

ACCEL has received national attention for its Care Pathways work. For example, ACCEL was selected to participate in a *Community Care Coordination Learning Network* (CCCLN). Established by AHRQ's Health Care Innovations Exchange Initiative, CCCLN includes 17 Care Pathway Hubs (including ACCEL) representing 12 states. As part of this initiative, AHRQ supported the development of a manual to assist service providers and community organizations in creating a hub to coordinate delivery of health care and social services using the Pathways model. This guide can be found at http://innovations.ahrq.gov/content.aspx?id=2956.

Another area where Care Pathways and ACCEL are highlighted is a National Institutes of Health study. The study, *Community Care Coordination Performance Measures*, expands upon work in health disparities and access with the CCCLN. It is developing and testing performance measures designed to assess improvements in health outcomes associated with community care coordination services. This two-year community-based participatory research effort is studying five sites across the nation that uses the Pathways Model, including El Dorado County via ACCEL. While the five sites differ in its target population focus, all five sites use the Care pathways approach. This vital work is geared to research and make determinants in areas such as the development of performance evaluation measures and assessment instruments uniquely designed for local collaborative care networks. [xi]

Care Pathways has also been proven in other rural locales in states such as Ohio, Kentucky, Indiana and Oklahoma.[xii] In Ohio, Pathstone implemented Care Pathways using migrant farm workers as Community Health Workers. Casa de Salud, through Pathways to a Healthy Bernalillo County (KY), has three Health Navigators that assist clients with health and social services, especially focusing on reducing medical debt for uninsured clients who have received large bills from ER or hospital visits.[xiii] In a growing Hispanic community, the Rural and Urban Access to Health in Indiana serves individuals primarily with incomes below 200 percent of the FPL. The Central Oklahoma Project Access works with the homeless, underserved, and uninsured populations. [xiv]

Sustainability Approach

Continued support for the project, during and beyond the HRSA funding period, will help us achieve the following sustainable impacts:

- Continuation of Activities and Services - ACCEL's longevity speaks to the ability of the consortium to support continued activities and services, even as funding streams have changed. ACCEL's partners are committed to the continued success of the collaborative

and its projects as demonstrated by both financial and in-kind contributions by each ACCEL agency to sustain program operations.

- Patient Empowerment and Engagement in their Care - The institution of pathways for selected LIHP clients will help change how clients access and use resources. This project will not only assist clients in accessing services but also provide critical education and support tools to empower patients to engage in the management of their own care and more effectively navigate the health care system.

- Strengthened Community Coordination and Capacity – The project will provide the resources to educate providers and facilitate discussions about the LIHP and broader health care changes in general. The ability to bring stakeholders together in focused way will allow the community and its providers to identify challenges and gaps in the health care delivery system as it relates to rural populations and to discuss systematic solutions to overcoming these barriers.

This project will provide the funding necessary to help El Dorado County providers prepare for the changes brought upon by the LIHP and 2014. ACCEL will develop and implement a Sustainability Plan well before the third year of the project that accounts for the health care changes set place to occur in 2014 and beyond. HHSA and other ACCEL partners recognize the importance of planning for sustainability, including anticipating changes in how a project is funded. We anticipate employing multiple strategies to ensure the project's initiatives not only continue, but also expand. These include:

- Build upon the strength of ACCEL's current infrastructure and on collaboration among ACCEL member organizations and the target community;
- Expand community connections and referral processes between health care agencies
- Adding additional community "champions" who invest in the success of the project;
- Inform and educate key influencers about the project;
- Promote knowledge sharing around the operational, technological and reimbursement strategies and challenges with ACCEL agencies and the broader community;
- Maintain and build quality improvement (QI) practices, including data collection, service delivery monitoring and problem solving through collaboration and capacity building;
- Identify opportunities to leverage resources among ACCEL agencies;
- Explore diverse revenue streams to support ACCEL operations, including third-party reimbursement, consortium financial contributions, etc.; and,
- Support integration of project activities into existing organizational procedures, operations and budgets.

The focus on collaboration and ACCEL's integrated team approach (County, agencies and communities) is intended to establish the knowledge, skills and capacity to continue this work

independent of this grant. In addition to serving as an educational resource for LIHP, the Project Team will help to identify and support community champions who can serve as resources for LIHP activities beyond the grant period. Community champions may be individuals from community-based organizations, natural leaders in the community, County or provider staff, or a combination of the above. By employing these combined strategies, ACCEL is confident the project funds will continue to make an important impact for El Dorado County patients beyond the grant period.

Work Plan

Key elements of the Work Plan are described below. This is followed by a tabular summary of the Work Plan. Outcome measures are summarized in the table. Attachment 12 provides more details regarding the key process and outcome measures to evaluate the project.

Design and Implement Care Pathways: Building on ACCEL's success with the Care Pathways model, four pathways will be designed and implemented. The pathways will be designed and programmed into ACCEL's Care Coordination system (iREACH) to facilitate interagency care coordination and more effective information sharing and patient tracking across agencies.

Pathway	Description	Comments
Securing Health Care Coverage (SHCC)	Works to assist LIHP-eligible clients (MIAs under 100% of the FPL) with obtaining LIHP coverage. Health Navigator helps each client complete the application packet and other necessary documents to ensure a successful insurance coverage outcome. This pathway is considered successful when the client has obtained health care coverage. Health Navigator will contact client before coverage expires to assess if client needs further assistance with renewal of the application. Education and assistance overcoming barriers is provided and documented by the Health Navigator.	With a current focus on infants and other children <18, this pathway is already in ACCEL's iREACH technology. Project Team will modify it (without IT programming costs) to serve target LIHP-eligible clients.
Obtaining a Medical Home (OMH)	Helps selected LIHP clients obtain a medical home. County eligibility staff and/or other community organizations may refer individuals to ACCEL when a LIHP-eligible client lacks a medical home. Health Navigator first assesses client for health care coverage then matches them with an ACCEL PCP. The Health Navigator also provides health education services and assistance working through any barriers that might inhibit the client from successfully establishing with the medical home. Confirmation of the primary care visit is the outcome measure.	With a current focus on newborn infants and other children <18, there is a similar pathway programmed into iREACH. Some customization is necessary. Project Team will modify it to serve LIHP-eligible clients.

Pathway	Description	Comments
Assessment for Specialty Mental Health Services (SMHC)	Strengthens referral process between PCP or Behavioral Health Provider (BHP) and the County Mental Health division. PCP or BHP identifies an adult (18 years+) requiring assessment for Specialty Mental Health services with County Mental Health. Health Navigator will assist client in successfully scheduling and attending assessment for specialty mental health. Education and assistance overcoming barriers is provided and documented by the Health Navigator.	Similar paper-based pathway is in use. Programming into iREACH is required. ACCEL Project Team will review lessons learned and customize as necessary.
Assessment for Behavioral Health and Substance Use Disorder Services (BHH)	Strengthens referral process between PCP or Behavioral Health Provider (BHP) and County Mental Health. County Mental Health Division identifies an adult (18 years+) in need of a primary behavioral health home. Health Navigator will assist client in successfully scheduling and attending assessment for behavioral health services in a primary care setting. Education and assistance overcoming barriers is provided and documented by the Health Navigator.	Similar paper-based pathway is in use. Programming into iREACH is required. ACCEL Project Team will review lessons learned and customize as necessary.

Utilize Web-Based Technology to Facilitate Patient Information Across Settings: The project will make use of a shared, enabling technology utilized by all ACCEL agencies. The web-based application (iREACH) allows users in multiple locations to track, share, and update patient progress through a Care Pathway more efficiently and be held accountable for their part in the care coordination process. The Care Pathways developed in this project will be integrated into the current technology system to allow for real-time, efficient communication across agencies and standardized methods for patient-system navigation.

Strengthen and Promote Community Capacity Building: The project will leverage ACCEL's private-public partnerships and standing ACCEL workgroups to convene key stakeholders. Public forums will also be held. Specifically:

- *ACCEL Steering Committee:* ACCEL's steering committee includes senior leadership from each ACCEL agency and is pivotal in providing the strategic guidance for all ACCEL operations. This committee meets at least quarterly and will act as an important forum to discuss overall project activities, providing feedback in overcoming challenges and guidance in maximizing the impact of the project from a community-wide perspective. This Committee will also serve as the Project Advisory Team. Additional individuals may also be identified during the course of the project to serve on an advisory capacity, as appropriate.

- *ACCEL Safety Net Provider Workgroup:* This monthly group includes key provider champions from ACCEL agencies and will provide a regular forum to review the project and assess its progress from both an operational and clinical perspective. Project stakeholders will be invited to attend these meeting as appropriate.

- ACCEL Quality Assurance (QA) Workgroup: This quarterly workgroup is a multi-disciplinary group that includes community and mental health workers, physicians, information technology (IT) staff, funders, clinic staff and program staff to review and assess ACCEL projects and activities. This group will provide an additional medium to review proposed Care Pathways from an operational and front-line perspective and ensure effective implementation of the pathways.

- The Project will hold two public kick-off forums open to the public (one on the Western Slope and one in the Tahoe Basin). The forums will invite community organization, rural residents, and other interested parties to learn more about the LIHP, implications to the County and solicit feedback about the proposed project.

Improve patient experience and build patient confidence in accessing health care services and navigating the health care system. In addition to supporting clients in accessing health care services, the Health Navigator will provide critical educational support and tools in a culturally sensitive manner to improve patient experience and confidence in navigating the health care system. This support and educational piece is an important tool in empowering clients to proactively engage in their own care.

WORK PLAN -YEAR ONE

Objective						Activity	Quarter	Lead	Measure
1	2	3	4	5	6	Project Management			
X	X	X	X	X	X	Kickoff Mtgs: Convene PT, review/discuss Proj. timeline and activities	1	PM	Roster, agendas, # mtgs. held
X	X	X	X	X	X	Complete contracting process with HRSA, complete subcontracts (Eval. Team, IT)	1	PM	Completed Contracts
X	X	X	X	X	X	Create Mgmt and QA/QI plan to ensure scope of work & other grant req'mts are met	1	PT	Work plan developed
X	X	X	X	X	X	Develop strategy to integrate project into ACCEL framework (management, services) and begin integration process	1	PT	Strategy developed
X	X	X	X	X	X	Hold, participate in meetings, share info, gain feedback, problem solve [Monthly: Safety Net Provider (SNP); Quarterly: Steering Committee (SC)]	1-4	PT	Mtg data, materials produced/ rec'd

YEAR ONE, continued

Objective						Activity	Quarter	Lead	Measure
1	2	3	4	5	6	Pathway Implementation			
X	X					Plan and implement SHCC, OMH Pathways	see below	see below	see below
X	X					Convene Project Team to design pathway. Review projects and lessons learned that may inform design and implementation of the pathways	2	PT, HN	Pathway developed
X	X					Develop Pathway steps, responsibilities, Integrate Pathway into existing web-based care coordination system	2	HN, IT	Integrated into iREACH
X	X			X		Design and implement outreach plan to appropriate stakeholders (service providers, potential service recipients)	2	OC/HN	Mtgs, materials created
X	X					Develop client education handouts/tools	2	HN	Materials developed
X	X			X	X	Implement pathway	2	PM, HN	# Clients referred, # referrals
X	X			X		Regular QA and reporting, monitor and optimize, update SC and QA groups	2-4	PT	Updates provided
						Plan and implement SMHC, BHH Pathways	see below	see below	see below
		X	X			Convene Project Team to design pathway. Review projects and lessons learned that may inform design and implementation	3	PT, HN	Pathway developed
		X	X			Develop Pathway steps, responsibilities, Integrate Pathway into existing web-based care coordination system	3-4	HN, IT	Integrated into iREACH
		X	X	X		Design and implement outreach plan to appropriate stakeholders (service providers, potential service recipients)	3-4	OC/HN	Mtgs, materials created
		X	X			Develop client education handouts/tools	3-4	HN	Materials developed
		X	X	X	X	Implement pathway	3-4	PM, HN	# Clients referred, # referrals
				X	X	Regular QA and reporting, monitor and optimize, update SC and QA groups	3-4	PT	Updates provided

YEAR ONE, continued

Objective						Activity	Quarter	Lead	Measure
1	2	3	4	5	6	Pathway Implementation			
					X	For all Care Pathways, provide education and support to strength client's ability to more confidently connect to health care services and effectively navigate the health care system (self-efficacy)	2-4	OC	Data from iReach
1	2	3	4	5	6	Project Evaluation			
				X	X	Quarterly data collection to assess project impact	1-4	EV	iReach data,
				X	X	Develop and distribute patient and provider surveys	4	EV	Survey summaries
				X	X	Mid-year reports re activities to date, project data, progress and lessons learned	4	PM, EV	Reports
				X	X	Yearly reports required by grant contract	4	PM, EV	Reports

WORK PLAN -YEARS TWO AND THREE

Objective						Activity	Quarter	Lead	Measure
X	X	X	X	X	X	Continue with meetings and operational activities, including discussions regarding project sustainability.	1-4	PM	Roster, agendas, # mtgs. held
X	X	X	X	X	X	Development of a sustainability plan	1-4	PT	Sustainability Plan
X	X	X	X			Continue with serving clients through the four health care pathways developed	1-4	PM, HN	# Clients referred, # referrals
X	X	X	X			Maintain IT system for pathways as needed	1-4	IT	Service reports
				X	X	Continue with education and outreach	1-4	OC	Materials produced, roster, etc.
		X	X			Continue with client education handouts/tools	3-4	HN	Materials developed
				X	X	Continue with client and participant surveys	4	EV	Survey summaries
				X	X	Regular QA and reporting, monitor and optimize, update SC and QA groups	1-4	PT, IT	Updates provided
				X	X	Yearly reports required by grant contract	4	PM, EV	Reports

WORK PLAN**,** continued (Year Three)

Objective						Activity	Quarter	Lead	Measure
X	X	X	X	X	X	YEAR THREE: Final Report summarizing activities to date, project data, progress and lessons learned	4	PM, EV	Reports
X	X	X	X	X	X	YEAR THREE: Dissemination of outcomes. Dissemination of project impact, lessons learned as outlined in proposal	4	PM, EV	Reports

Impact

Between 2012 and 2014, El Dorado County providers must be ready for the changes set place to occur. In 2012, the lowest income patients will become eligible for new coverage and expanded services through the LIHP. In 2014, broader and complex health reform changes will take place.

While ACCEL has the infrastructure, workgroups and history of collaboration to prepare for these changes, limited resources and staff remain as substantial barriers to maximizing ACCEL's partnerships. This grant will provide the critical funding to utilize ACCEL's infrastructure to prepare for the LIHP and to support ACCEL agencies in preparing for the health reform changes in a collaborative, systematic way. It will provide the staffing and technology to design and execute the substance of the LIHP.

The project will help improve the health status of rural residents by supporting clients in enrolling in the LIHP and assisting them with obtaining a medical home. Many studies reveal that patients with health insurance and a PCP experience improved health and well-being, have better health outcomes and are less likely to use costly ER visits for care, reducing overall costs. A study of ACCEL's Obtaining a Medical Home (OMH) pathway that targets children and chronic users of the ER, reveal a 43% reduction in the number of high and moderate-frequency[3] ER users. These results suggest that the OMH pathway reduces children's overutilization of the ER. Further, based on a 2005 Rand Study of average marginal costs, the pathway saved the local hospital ER $95,213 in one year, which represents a 40% reduction in cost compared to what would have been spent had these 288 patients not obtained a medical home.

This project will also empower and inspire clients to be more proactive about managing their health. They will develop more confidence in their ability to overcome barriers when seeking care. The education and tools provided to patients will also help to promote the use of less costly primary and preventative services. Patients will be less likely to use expensive and limited ER resources for non-urgent cases, reducing overall system costs.

The project will further strengthen the coordination and delivery of care within the County. This is critical as providers are faced to do more with less. Like many providers across the country and in rural areas, El Dorado County providers are facing reduced reimbursement, limited staff

[3] Moderate users: 2 visits/year. High users: 3+ visits/year

resources and investing in activities to meet the mandates of 2014, including electronic medical record adoption. The need to leverage one another's resources and identify synergistic partnerships will be key as the safety net providers seek to maximize its resources. This project will provide the support to augment and expand the County's current partnerships to effectively deliver high quality care to its rural populations. Lastly, it will provide the resources to enable the County's safety net partners to prepare for, in a systematic and collaborative way, the health reform changes set place to occur in 2014.

Potential Challenges: Without this project, existing providers may continue to find it difficult to serve the target population. Rural clients may not obtain LIHP coverage or take advantage of its benefits. Further, rural, LIHP clients may continue to utilize the ER without a better understanding of the cost implications or the benefits of accessing primary care and preventative services. Additional work is needed to determine whether the current providers can accommodate the increase in services that will be made available through the LIHP. This project will help facilitate discussion on how to more effectively overcome those challenges. For example, providers may look to telemedicine to help bridge the geographic gap. In addition, the process and details to contract with the CMSP Plan Administrator, Anthem Blue Cross is not clear, affecting the ability of providers to be ready to serve clients in 2012. While some very limited sessions have been conducted by ACCEL to "spread the word" about the LIHP and health reform in general, its current capacity is not sufficient to coordinate the focused countywide effort that is truly needed. This project is essential in providing the resources for the County and patients to begin a focused discussion and effort to implement the LIHP and begin, in a collaborative and meaningful way, preparations to meet health reform changes as a community. This opportunity will enable the County to address the unique challenges of rural residents while helping improve service provider efficiency for all potential clients.

Why this Grant Opportunity is the Best Choice: HHSA and ACCEL maintain a current awareness of grant opportunities. This opportunity is the only one that currently was available to address the specific needs of the target population. This grant program is the most appropriate to address the gaps in service to the rural community as it supports and will augment the already successful efforts of the existing ACCEL collaborative.

Replicability

As the nation seeks to achieve health care reform goals and objectives, this project will serve as a model for local and rural communities throughout the United States. For example, there is growing need for organizations to collaborate and leverage each other's resources to maximize limited resources. The Care Pathways model can be applied to guide interagency work and partnerships within a rural setting, particularly for a shared patient. In general, Care Pathways is a model that can and has been adapted, to multiple settings and communities, as well as target populations.

In addition, this project will produce important outcomes that will assist other rural communities as they prepare for health reform. For example, this project will emphasize the importance and value of existing community-wide partnership and infrastructures. This project will also develop detailed Care Pathways that can be modified for other rural settings. Lastly, this project is in line

with the current movement for a stronger integration between primary care and mental health/behavioral health services, making it more relevant and appealing for other communities. The project is designed for replicability and will be compelling for adaptation by other jurisdictions.

Dissemination Plan

Information regarding project challenges and achievements will be disseminated to a variety of partners including ACCEL's Steering Committee and workgroups as well as any participating project agency. As described above, ACCEL is also connected to a nationwide network of care coordination sites (CCCLN) interested in addressing health care problems through care coordination and will share what was learned in this project with those partnering agencies. HHSA also envisions sharing project outcomes with groups such as the Mental Health Services Act (MHSA) Advisory Board, Mental Health Commission, County management and local collaboratives.

4. RESOLUTION OF CHALLENGES

There are numerous challenges that this project may face:

- ***Local capacity to meet expanded LIHP client benefits*** (mental health, substance abuse disorders, dental, primary care in South Lake Tahoe). As mentioned earlier, there is a serious lack of capacit***y*** to meet the expanded benefits available to LIHP clients. Capacity of service providers to treat LIHP clients is affected by multiple factors outside of this project's scope including reimbursement, difficulty in recruiting and retaining providers, staff turnover and limited resources (e.g. funding, physical space, etc.)

- ***Timing of provider contracts*** may affect a provider's ability to contract with CMSP's plan administrator, Anthem Blue Cross. This may impede access to care for LIHP clients. Furthermore, the LIHP will require new procedures for processing billing for the new services that will be covered. It is unclear what steps participating providers will need to take to ensure they are prepared for these changes.

The ability to overcome these challenges will require a larger effort than any one organization. ACCEL's collaborative approach and history of overcoming barriers to care will be important tools to helping address these challenges. ACCEL has used a number of important and effective strategies that may be applied in this project. For example:

- **Standardize work processes:** Standardized systems, processes, responsibilities and accountabilities across agencies improve efficiency and enhance the program's ability to provide services to all clients.

- **Leverage IT to create more efficient processes and facilitate information sharing across agencies:** Technology allows patient handoffs (care transfer/sharing) to occur in real time, helps ensure that all necessary reference information is readily available and enables staff to easily document completion of services.

- **Ongoing QA and QI activities:** Regular QA and QI activities help to identify and resolve issues in a timely manner, ensure high quality services are being delivered, identify opportunities for improvement and allow regular feedback of activities from project stakeholders.

- **Public-private partnerships and ongoing workgroups** (e.g. Safety Net Provider Workgroup and Steering Committee). These standing workgroups and relationships are critical forums that allow for discussion and feedback of community-wide issues.

5. EVALUATION AND TECHNICAL SUPPORT CAPACITY

Logic Model

The Logic Model is provided in Attachment 11 and illustrates the inputs, activities, outputs, outcomes, and impact of the project.

Project Monitoring

Monitoring and tracking will be provided throughout the grant period. QA/QI methodologies are already in place and integrated into ACCEL's existing infrastructure. These will be used to assess and improve project activities and the proposed Care Pathways.

The project will utilize ACCEL's three-tiered Quality Assurance model to help ensure data and process integrity across its program and to support continuous QI efforts. QA Level 1 focuses on providing robust support and monitoring to new members of ACCEL and iREACH users; QA Level 2 empowers each organization to manage and provide feedback to their own users; and QA Level 3 consists of a multi-disciplinary workgroup that reviews care pathway data, identifies cross-agency trends and helps to resolve community barriers.

Quantitative and qualitative data will be used to inform project development and service delivery as well as to support replication and sustainability. This project will include use of quarterly data collection efforts to help monitor its pathways and project activities, as well as utilize patient and provider surveys to assess the effectiveness of its work.

Evaluation

Mission Analytics Group, LLC (Mission) will act as the evaluator of the EDC Path2Health Rural Services Project. Mission staff are familiar and experienced with ACCEL's work and provided evaluations for previous federal and state grants. As an independent evaluator, Mission will ensure that evaluation methods are rigorous and lead to unbiased findings.

The evaluation will assess two facets of the project. First, to help the program better achieve its goals, Mission will evaluate project activities and processes and provide recommendations for improvements. To complete this part of the evaluation, Mission will track project outputs, challenges, and successful strategies through continual communication with the Project Manager,

by attending project meetings and community forums, and by conducting semi-structured interviews with project implementers. Second, Mission will evaluate whether the project is meeting its goal of improving access to health care. To do so, Mission will collect and analyze pathways data – calculating metrics on the number of pathways opened and completed successfully over time. In addition, Mission will survey providers to understand their engagement with the program and willingness to accept LIHP patients. Finally, through client surveys, Mission will capture client experience with the Health Navigator and the pathway's ability to connect the patient to health care in a culturally competent manner. Evaluation findings will be summarized in semiannual reports, so project implementers receive continual feedback on program progress and recommendations for change. The Final Report will target a wider audience with the goal of promoting replicability. The evaluation plan is provided in Attachment 13.

Resources/Capabilities

The project proposes the following staffing plan:

The **Project Manager** (Christine Sison) will have overall responsibility for the Project Team, grant and budget management and overall project development and execution. Activities will include overseeing Care Pathways development and implementation, education and outreach activities, as well as coordination with other community partners. The Project Manager will work closely with the Project Team to help build local capacity by attending ACCEL's Safety Network Provider Workgroup and ACCEL's Steering Committee meeting. The Project Manager will also serve as a LIHP educational resource for the community and provide regular updates to consortium members and project partners. The Project Manager will ensure compliance with all grant-related reporting requirements. 0.25 FTE is proposed for year 1 and 0.20 FTE for years 2 and 3. Additional time is expected to occur during year 1 of the project to account for upfront project planning and launch activities, Pathways design and development, community outreach activities and training needs.

In partnership with the Project Manager and Health Navigator, the **Community and Outreach Coordinator** (Kirsten Rogers) will lead community outreach and education efforts, support local capacity building efforts and serve a LIHP educational resource for project partners and the community. This role will also research and identify appropriate project partners and community resources, help to convene local and public forums to discuss project goals, activities and progress. She will also provide guidance on Care Pathways development and the development of outreach, training and educational materials as appropriate. She will report to, and provide regular updates to Project Manager and consortium members and project partners, as requested. 0.30 FTE is proposed for year 1, and 0.15 FTE is proposed for years 2 and 4. Additional time is expected to occur during year 1 of the project to support activities related to upfront project planning and launch activities, Pathways design and development, community outreach efforts and training needs.

The **Health Navigator (HN)** (Randy Austin), will assist selected clients in navigating local health systems and providing care coordination and support services. The HN will provide education to community coalitions and organizations regarding LIHP activities; conduct and/or

participate in community needs assessments and developing strategies to address identified patients needs. HN will also assist in coordinating project activities, developing and implementing proposed Care Pathways, quality assurance efforts and developing outreach and education materials. HN will report to, and provide regular updates to Project Manager and consortium members and project partners, as requested. 0.45 FTE is proposed for year 1, 0.95 FTE for year 2 and 0.85 FTE is proposed for year 3. HN efforts are weighted more heavily toward Years 2 and 3 as direct client work will be less intense due to the activities required to design, program and implement pathways. As pathways are implemented, HN work will increase to provide the care coordination and educational support to support each client and their needs.

The integration of the proposed Care Pathways into iREACH requires critical support by **Infocom**, the iREACH vendor for ACCEL, and a local IT contractor. Infocom will provide the Care Pathways Programming, Integration and Maintenance services required to embed new pathways into current system. Infocom will report to, and provide regular updates to Project Manager. Roughly $3K-$5K will be required for pathway development and 15% maintenance. The exact duration of pathway programming is dependent on complexity and requirements of each pathway however we estimate between 2-4 weeks to program each pathway into iREACH.

Once a Care Pathway is built into the system, the Project Team will work with a local IT vendor (**Trever Lee**) to assist in customizing the pathway. We estimate most programming costs will occur during the first year of the project. Additional time is allocated in the following years for help-desk support functions and assistance. We estimate up to roughly five hours per month the first year and two hours per month the following years.

HHSA will contract with a **Project Evaluator** (Mission Analytics Group, LLC) who will conduct a quantitative and qualitative evaluation of the project's impact and report to the Project Team. The Project Evaluation will conduct quarterly data collection and evaluation activities, provide annual reports for years 1 and 2 and a Final Report summarizing the project's activities, impact and lessons learned. Evaluation activities may include but not limited to, regular data collection activities, data analysis, interviews, development and implementation of surveys, and summary of findings to the project team. The Project Evaluator will provide regular updates to the Project Team. We estimate evaluation work to occur more intensely during the first and third years of the project to account for additional time to collect and analyze data for pre- and post-project impact.

As discussing above, the project will also utilize ACCEL's existing workgroups, specifically the ACCEL Steering Committee, ACCEL Safety Net Provider Workgroup and Quality Assurance Workgroup as resources to the project. Together, these workgroups will provide a diverse and robust resource for the project. Additional individuals or organizations may be identified during the project to serve in an advisory capacity and requested to attend one or more of the ACCEL workgroup meetings.

6. ORGANIZATIONAL INFORMATION

Formed in 2002, ACCEL is a community-wide collaborative among public and private agencies that 1) seeks to create healthier communities, especially within vulnerable populations, 2)

identifies specific barriers to a healthy community, and 3) studies, develops and implements systematic improvements that include all partners and serve our entire community. This collaborative approach helps create a stronger, better coordinated community health system for the people who live in El Dorado County.

ACCEL has 13 agency sites, which include governmental agencies, rural health centers, a federally qualified health center, a tribal clinic, several private clinics, and two rural hospitals. Although disparate, and historically different, each ACCEL agency shares common care goals. ACCEL agencies represent two separate health care communities, bisected by the Sierra Nevada mountain range. Located on the "Western Slope" of the County, near Placerville, are: Shingle Springs Tribal Health Program (SSTHP), El Dorado County Community Health Center (EDCCHC), Western Sierra Medical Center, and Marshall Medical Center (Marshall) affiliates including Marshall Hospital, Marshall Physician Clinic Services in Placerville, Cameron Park, El Dorado Hills and Divide Wellness Center in Georgetown. South Lake Tahoe members on the "eastern slope" include: Barton Health affiliates including Barton Memorial Hospital, the Barton Community Clinic and Barton Family Medicine. HHSA including the Public Health and Mental Health Divisions, has sites on both slopes.

ACCEL agencies have worked collaboratively to improve the flow of information within and across agencies for the benefit of the underserved in El Dorado County. Through a series of successful efforts, both IT and non-IT, ACCEL has established greater inter-partner communication, and a pride of ownership in our successes that position us well to implement the proposed project activities for our rural populations. Two successful initiatives highlight our effectiveness as a collaborative and give credence to our belief that we will be successful yet again. These efforts are outlined below:

- *Care Pathways:* ACCEL develops and coordinates Care Pathways, a set of standardized protocols for interagency shared case management that connects patients to health care services. The adoption of the Pathways model came as a result of a search by ACCEL representatives for a way to organize the collaborative's activities and facilitate clarity in coordination and handoff among participating institutions; the model was seen as a tool that could enable ACCEL to accomplish this goal. As mentioned above, ACCEL has developed and implemented eight Care Pathways aimed at increasing access to care. Concurrently, in order to enable sharing of information across agencies, ACCEL developed HIPAA compliant consent language and common notification of privacy practices that meet all ACCEL agency requirements and have since been incorporated into each agency's patient consent forms.

- *Centralized Patient Registry and Pathway Management Application:* With a grant from AHRQ, ACCEL engaged in a rigorous process to research, plan and implement a centralized and shared web-based application to monitor and track ACCEL patients through a Care Pathway. The application (iREACH) allows ACCEL agencies in multiple locations to track, share and update patient progress more efficiently. With the exception of ACCEL's Orthopedic and Pain management pathways, all Care Pathways are electronic and can be initiated and monitored through this tool. The use of technology has allowed for real-time, efficient communication across agencies and standardized methods

for patient-system navigation. All ACCEL agencies are utilizing the web-based application and users are provided with formal one-on-one or group training. Through an electronic tool, we have the ability to extract data more efficiently to guide our QA efforts, evaluate the effectiveness of a Care Pathway, and identify barriers to success and community-wide trends. Our collective experience with this shared and electronic application gives substantial insight into the pitfalls and challenges going forward with health information exchange's (HIEs) and broader health care collaborations.

In 2011, ACCEL was selected by UC Davis and the California Telehealth Network to be one of 15 "Model e-Health Community" grant recipients. The grant seeks to support select communities across the state to become best-practice examples in the use and integration of technology to improve health and health care for its residents. ACCEL will be implementing diverse e-Health applications such as remote specialty and critical care consultations between local health providers and specialists affiliated with academic medical centers; health education for consumers and continuing education for health care professionals, as well as health care workforce development programs.

Together, these efforts are stepping stones towards ACCEL's vision of a more coordinated care delivery system. ACCEL's experience with interagency collaborations, implementation of Care Pathways, shared health IT platform and community-wide telehealth clinic, position ACCEL to support the countywide scope of the Project.

Each agency, though diverse in nature and each facing their own organizational challenges, contribute and are committed to, the ongoing success of ACCEL and serving the County's most vulnerable and rural populations. Despite the economic recession of 2008, ACCEL agencies continue to support the standing workgroups and Care Pathways developed by the program. ACCEL agencies commit senior leadership to serve on the ACCEL Steering Committee group which meets at least quarterly to provide strategic guidance on the program and make critical business decisions necessary for the success of ACCEL projects and activities. In addition, ACCEL agencies contribute physician time and staff to attend ACCEL's monthly Safety Net Provider Workgroup group and quarterly Quality Assurance Workgroup. These workgroups provide unique community-wide forums to help identify gaps in care, inform systematic solutions to improve the delivery of care in El Dorado County and provide ongoing feedback on existing and new ACCEL initiatives. Each ACCEL agency also commits staff time to help support and manage the Care Pathways within their organization. Specific to this project, ACCEL agencies are pleased to continue their joint support for the proposed project and agree to:

- **Provide advisory support** in areas such as implementing local-level care management, continuity of care, linkages to enabling services, building local provider capacity, advocacy and outreach approaches;
- **Provide a forum for discussion** of the grant and its activities. Examples may include ACCEL's quarterly Steering Committee and monthly Safety Net Provider Workgroup meetings;
- **Interagency collaboration** to include working together to identify mutually acceptable, efficient methods for referring and managing patients; and

- **Service linkages** that connect patients with needed resources through the project's referral pathways.

This project team will utilize ACCEL's existing workgroups and reporting mechanisms to solicit feedback and guidance, discuss solutions to overcoming project barriers and identify opportunities that complement project activities. Specifically, the Project Manager will provide the ACCEL Steering Committee quarterly project updates. The Project Team will attend ACCEL's monthly Safety Net Provider and quarterly Quality Assurance Workgroups to provide project updates, solicit feedback, and obtain guidance on project activities. The breadth of disciplines represented at ACCEL workgroups (e.g. executive, providers, technology staff, clinical staff, mental and community health workers) provide a unique and ready forum to obtain project feedback and discussion. Feedback from ACCEL agencies and its workgroups will be used to inform improvements to the project.

ACCEL's current infrastructure and workgroups enable project-related activities, such as progress reporting, feedback, and monitoring to occur without the need for additional resources and time from ACCEL agencies. This is particularly important as ACCEL agencies continue to face dwindling resources and reduced reimbursement during these tough economic times. Further, many ACCEL agencies are currently implementing or have recently implemented, electronic medical records further stretching both staff and economic resources. Concurrent activities and competing priorities are realities ACCEL must face as a collaborative. Despite some of these barriers, ACCEL agencies continue to value the collaborative spirit and partnership ACCEL provides. ACCEL agencies recognize the need to work together to address the needs of the County's rural and vulnerable population. It is through these synergistic partnerships that ACCEL has been able to make real progress over the past eight years.

If awarded, authority and grant-related decision making will adhere to ACCEL's current governance agreement. ACCEL is the umbrella collaborative whose operations and oversight are guided by a common memorandum of understanding (MOU) and Governance Agreement signed by all ACCEL agencies, including HHSA. The members agree as a matter of policy that all funding obtained for the development, implementation or administration of ACCEL programs shall be managed by the applicant. Consequently, all grant-related activities, policies for handling funds and other decision-making processes will be subject to the policies applicable to the County.

HHSA

HHSA, on behalf of ACCEL, is pleased to serve as the fiscal intermediary for the project. HHSA has a mission and history of successful activities to help the uninsured and underserved rural populations. These demonstrate HHSA's capacity to be successful in meeting our project's goal.
HHSA manages the County's public welfare programs as well as CMSP and disability enrollment programs. Within HHSA, the Health Services Department houses all of the functions normally found in such a department (e.g. public health, alcohol and drug and mental health programs. In 2004, Public Health, now a division under HHSA, secured a Healthy Communities Access Program grant of $1.8 million from the federal Health Resources and Services Administration (HRSA) to improve access to medical care.

Project: EDC PATH2HEALTH RURAL SERVICES PROJECT

The Public Health Division of HHSA has served as the lead applicant for other ACCEL initiatives, including multiple projects to improve health care access. These include: developing and implementing a campaign to encourage parents to enroll children in existing health coverage plans and a plan to introduce CalKids in El Dorado County. The two entities also: worked together providing information on health insurance options and additional ways for businesses to support their employees health; increased the service capacity of the Community Health Center and rural clinics; and developed community health workers to assist children and families to access and navigate the health system.

Most recently, the Public Health Division of HHSA managed and provided oversight to ACCEL's Specialty Care Initiative grant. During the course of this two year grant, Public Health helped to support the development and implementation of two specialty care referral pathways for the County's publicly insured. These specialty care pathways in Orthopedics and Pain Management continue have continued beyond the grant period and serve as critical access points for the County's Medi-Cal and CMSP patients.

Note: Due to the timing of the project, HHSA will be seeking approval by the Board in December. The project will not be considered binding until ratified by the Board. We have already taken steps to obtain approval and will provide minutes of the meeting once approved.

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[i] 330A Outreach Grant Program: Making an Impact in Communities
[ii] *www.healthylivingmap.com/CNA%20Report%20**2010**.pdf*
[iii] http://www.edcgov.us/Government/PublicHealth/2010_Morbidity_Report,_El_Dorado_County.aspx
[iv] http://www.edcgov.us/Government/PublicHealth/2010_Morbidity_Report,_El_Dorado_County.aspx
[v] Hoffman CB, Paradise J. Health insurance and access to healthcare in the United States. Ann N Y Acad Sci. 2008;1136:149-60. [PubMed]
[vi] California State Rural Health Association Collaboration in Challenging Times The Rural Advantage November 10, 2010
[vii] CMSP data report, February 2011.
[viii] CMSP data report, February 2011.
[ix] CMSP Pilot Proposal, EDCCHC
[x] CMSP data report, February 2011.
[xi] https://www.cccperformancemeasures.com/About-the-Program/Overview.aspx
[xii] http://www.innovations.ahrq.gov/content.aspx?id=2040
[xiii] http://www.casadesaludnm.com/projects/pathways/
[xiv] http://www.peninsulafap.org/documents/NICHQ_Innov_Profile_Report_6-09.pdf