2016 Evaluation Results

Overview

The Network uses the Results Oriented Management Accountability (ROMA) logic model to evaluate our programs. We compute program data and compare the results to parameters within the logic model to determine program outcomes and then utilize our findings as a baseline for future strategic plans. We also constantly measure our progress as an organization by using community needs assessments commissioned by both the Network and other community agencies.

We track our program evaluation through:

- Demographic data at intake;
- Follow-up surveys; and
- Summary tracking data indicators

Evaluation Capacity

In 2012, the Network purchased a data tracking system, ClientTrack, which has helped us better measure programmatic impacts and improve our organizational efficiency by reducing staff time that would otherwise be spent computing data results. We worked with ClientTrack developers over the course of six months to create a custom database to meet our program needs.

Additionally, the Network uses the Patient Activation Measure (PAM) from Insignia Health, an evidence-based evaluation tool to quantitatively measure patient empowerment as a result of the Patient Navigator Program. Our program policy is to administer a PAM survey to clients at the onset of our patient navigation services, and every three months thereafter for high touch cases (one or more touches a week), every six months for low touch cases (one touch a month), and at close of the case.

Organizational Impact

In 2012, the Network served 258 unique clients through our programs.
In 2013, the Network served 365 unique clients, a 41% increase over 2012.
In 2014, the Network served 487 unique clients, a 33% increase over 2013.
In 2015, the Network served at least 391 unique clients. Due to data extraction complications at Middle Park Medical Center, exact numbers are unclear.

In 2016, the Network served 448 clients, collaborating with over 45 partners. Clients fall into the following categories and some clients fall into more than one category:

ACHES & PAINS: 125 clients, 148 vouchers
Gas & Pharmacy Voucher Program: 73 clients, 126 vouchers
Patient Navigator: 250 clients (59 complicated cases, 191 simple cases)

Volunteer Hours for 2016 – 434 hours of volunteer involvement including Board participation and special events. An additional 55 hours were contributed by our transportation volunteers for a total of 498 hours.

PATIENT NAVIGATOR PROGRAM RESULTS – 2016

The Network has decided to distinguish our cases into two categories: complicated and simple.

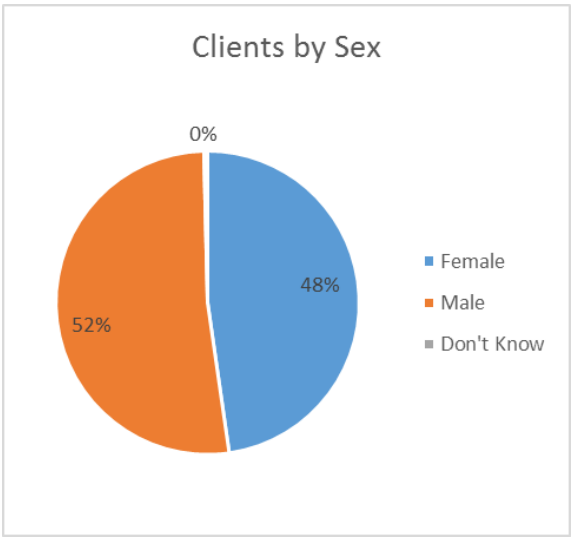
- Simple cases involve between one to two easy-to-address barriers to care and require a large amount of client involvement at the onset. Meeting the needs of these clients usually takes one to two hours of staff time.
    - For these clients, we track basic demographic data and statistics on barriers to care and referrals.
- Complicated cases involve clients with multiple diagnoses, multiple significant barriers to care, and/or a mental health diagnosis. Staff time varies based on each case.
    - We track the following case statistics: detailed demographic data; statistics on barriers to care, referrals, ER visits and hospitalizations during the prior six months and during the active case navigation; primary care provider (PCP) information before, during and after program (e.g., PCP before compared to after; regular usage of PCP to manage chronic illness), etc.
    - All clients receive a follow-up survey every six months and/or at the close of their case.
    - All clients receive a PAM survey at intake, every three months thereafter, and/or at close of case.

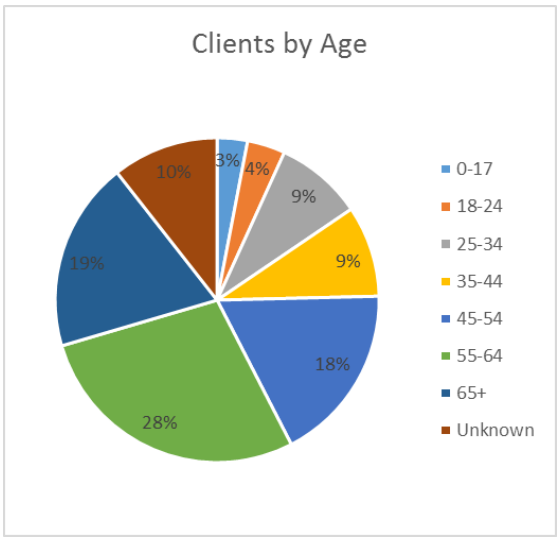
Total Clients

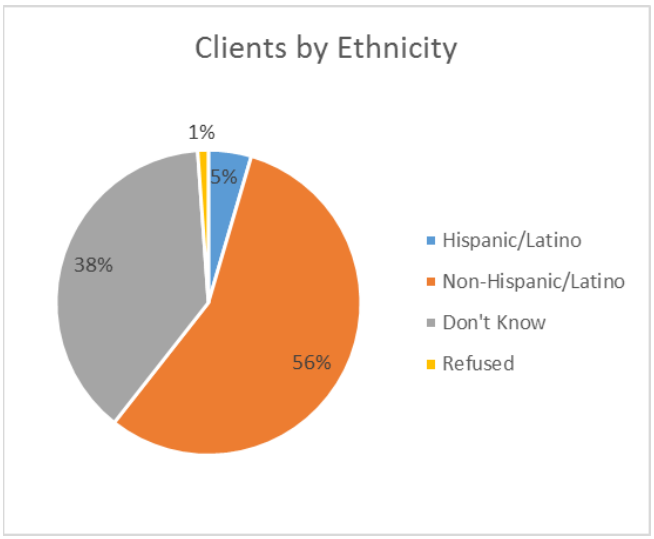
- In 2016, we served at least 250 unique clients, including both complicated and simple cases. Clients may enter our program as a simple case, sometimes more than once. Depending on their individual situation, they may also become a complicated case or receive services at GCRHN and MPMC.
- Cases were divided across our two service locations as follows:
    - GCRHN: 110 total – 30 complicated cases
    - MPMC: 154 total – 22 complicated cases (Note: During January and February 2016 we were unable to collect full data from Middle Park Medical Center due to technical issues so total client numbers may be higher for the year.)
- Among these cases, 7 were also medical transport clients. An overview of our volunteer medical transportation services are as follows:
    - We have provided 10 total transport trips.
    - Our volunteers have driven 1,660 miles.
    - We have used the services of 4 volunteer drivers.
    - Our volunteers have donated 55 volunteer hours.

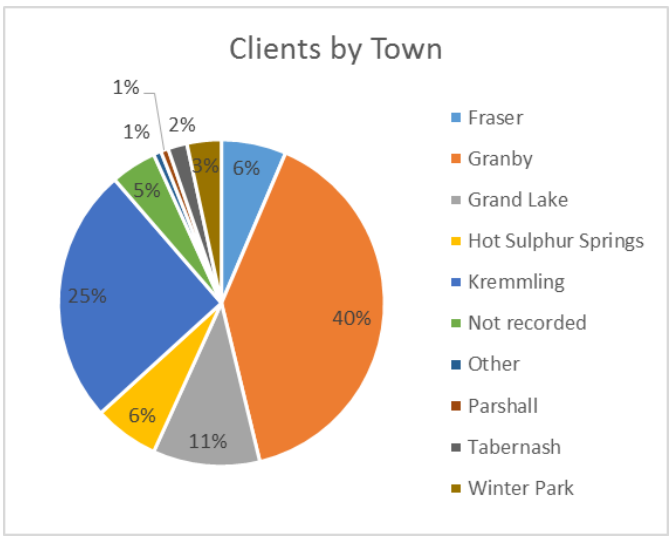
2016 Demographic Data:

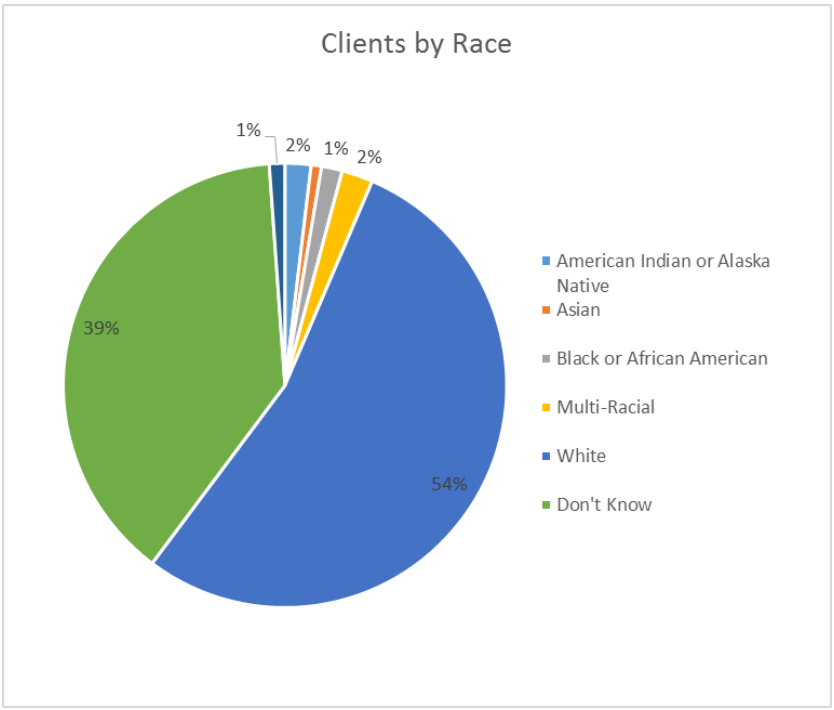
For all Patient Navigation cases – complicated and simple











Patient Activation Measure (PAM) Data:

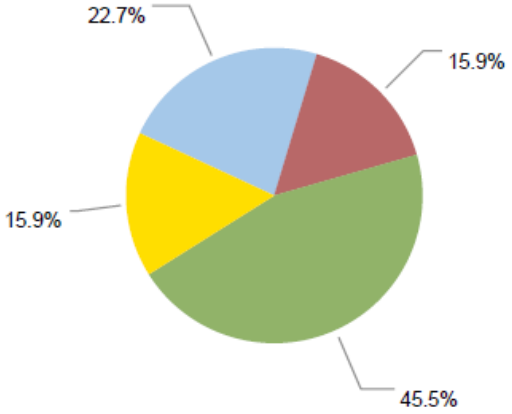
We purchased and implemented the Patient Activation Measure™ (PAM)™ survey in the Summer of 2012. This tool is a scientifically validated measure that assesses three core domains – knowledge, skills and confidence, which drive health behavior for managing one's own health and healthcare. With the ability to measure patient activation and uncover related insights into patient self-management competencies, care support and education can be more effectively tailored to help individuals become more effective members of their own healthcare team.

The PAM survey instrument assigns an individual to an activation level (1 – 4) based on a numeric score (0 – 100). Most individuals score between 30 and 80. Ten to twelve points separate activation levels. Each level provides insight into a wide array of health-related characteristics including attitudes, motivators, behaviors and outcomes. This evidence-based guidance helps to identify behavior change opportunities that are realistic and achievable, and which allow an individual to progress on a journey of increasing activation. Research has shown that patients with high PAM scores are significantly more likely to perform self-management behaviors, use self-management services, and report high medication adherence, compared to patients with the lowest PAM scores. Research has also shown that patients in the two lowest activation levels are at significant risk for hospital readmission and unnecessary emergency department visits.

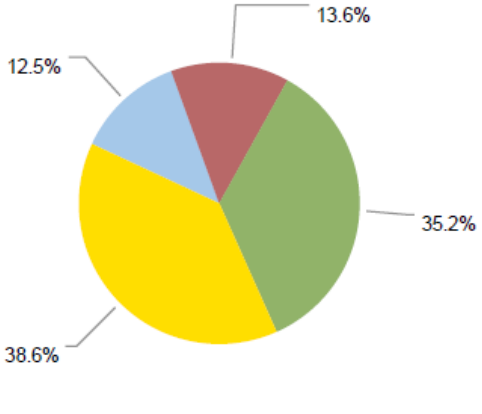
The complimentary tool, Coaching for Activation, gives navigators and staff tools to tailor their individualized education on several different topic areas to the patient's activation level. This tool basically supports the RNs intuition on topics that meet patient education needs and how to do so.

According to Insignia Health, as of December 31, 2016, our patient navigator program has increased PAM scores from the baseline to second survey by 7.4 points, from baseline to fourth survey by 14.2 points, and from baseline to most recent survey by an average of 8.5 points. These increases are higher than most other programs in the country which average a 4 point increase from first to second survey.

PAM Trend from first to most recent survey: Increase of 8.5 points



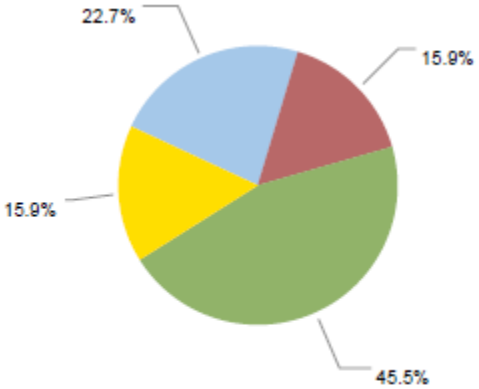
Baseline PAM Score Mean: 58.6



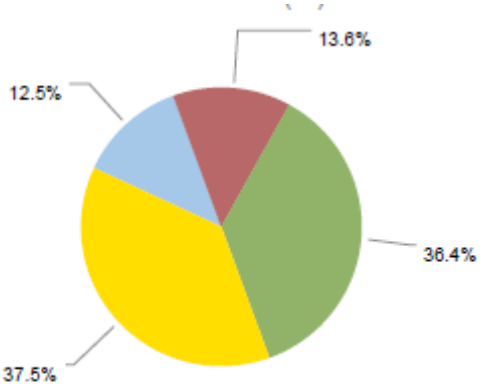
Selected PAM Score Mean: 67.1

Baseline score (left bar) vs. most recent survey (right bar).

PAM Trend at second survey: Increase of 7.4 points

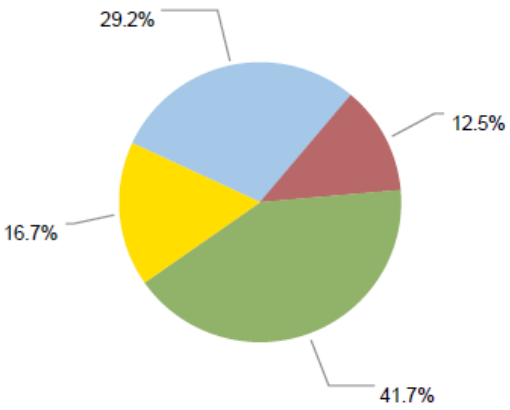


Baseline PAM Score Mean: 58.6

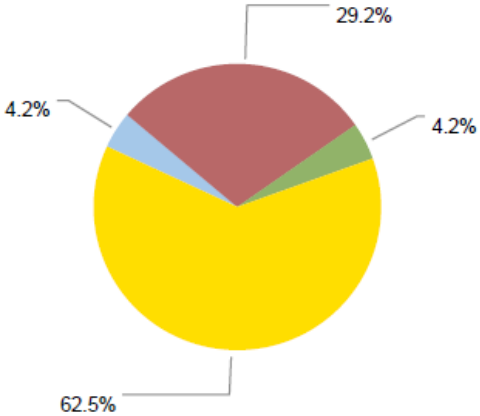


Selected PAM Score Mean: 66.0

PAM Trend at fourth survey: Increase of 14.2



Baseline PAM Score Mean: 58.4



Selected PAM Score Mean: 72.6

2016 Program Outcomes:

The following represents client perceptions during the regular follow-up survey this year:

- 100% of surveyed clients were linked to necessary resources to get the care they need
- 83% felt the resources/referrals met their needs
- 100% of surveyed clients found the program valuable in reducing barriers to care
- 100% of surveyed clients now have a primary care provider, compared to 61% at enrollment.
- 78% of clients had a better understanding of their chronic illness, with 22% giving a neutral response
- 78% of clients surveyed feel better equipped to manage their chronic illness than before entering the program, with 22% giving a neutral response.
- 94% of clients surveyed are very satisfied with the program
- 88% of clients surveyed are very satisfied with the patient navigators
- 94% would recommend the service to others
- On a scale of 1 to 5, with 5 being most satisfied, the average program satisfaction score is 4.8.

Financial Assistance for 2016:

The following includes information collected from all of our simple and complicated cases in 2016 including our Gas & Pharmacy Voucher Program (Changes) funding:

Direct Funds: $22,297.03

Types of assistance -

- rent and utilities
- immediate prescription need
- co-pay assistance
- medical equipment & devices
- past due medical and dental bills
- gas money
- hotel stays prior to surgery
- caregiver fees

Indirect Funds: $1,000.00

Types of assistance -

- Medical bill reduction

Financial assistance not measured in dollars

- Clients awaiting disability approval
- Medical bill organization and review
- Assistance in requesting charity care
- Assistance in arranging payment plans

Funding partners include:

- Mountain Parks Electric Charitable Trust
- Grand Angels
- Fraser Baptist Church / Changes Thrift Store
- Mountain Family Center

ACHES and PAINS PROGRAMS:

In collaboration with Grand County Public Health, the Network developed stop-gap community-health voucher programs, A.C.H.E.S. and P.A.I.N.S., which provide access to limited healthcare to the uninsured, low-income population. Through community partnerships, the Network provides ten points-of-entry at eighteen healthcare providers throughout the county, allowing for more accessible care. Program data shows this delivery model improves access to care and reduces healthy life years lost.

The Network conducts follow-up surveys with clients to determine qualitative impact.

2016 ACHES and PAINS program results illustrate that the programs continue to improve self-sufficiency, provide timely intervention, reduce healthy life years lost, and improve chronic illness management:

- 81% of clients spent $10 or less on their or their child's healthcare issue.
- 51% of clients were able to see a provider either the same or next day upon receiving the voucher.
- 32% of clients missed one day or less of work due to their or their child's illness.
- 20% of children missed less than one day of school due to their illness, illustrating the A.C.H.E.S. program positively affects the child's quality of life and ability to learn.
- 1 adult was diagnosed with a previously unidentified chronic illness and received referrals and adequate follow-up.

ACHES PROGRAM RESULTS

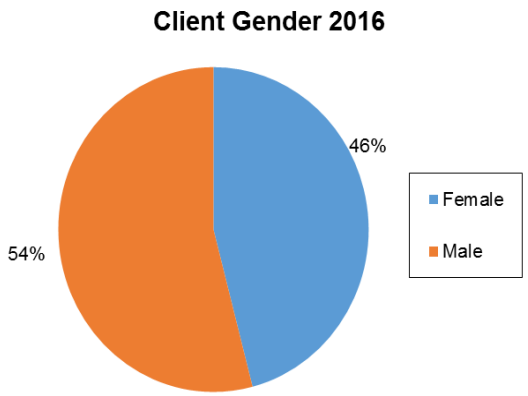
The A.C.H.E.S. program provides vouchers for healthcare to uninsured, low-income children. Our program offers both acute care vouchers and preventative/well-child vouchers for medical, dental, and mental health. The majority of our vouchers for children continue to be issued for Well-Child exams – a total of 63% of all vouchers issued in 2016. This is attributed to a 2015 initiative by Grand County's health care providers, who all chose to only administer sports physicals during well-child exams. Well-child exams provide more comprehensive screenings than a sport physical, including age-appropriate developmental, behavioral and mental health screenings; chronic-disease management; and preventative health counseling on diet, exercise, nutrition, peer pressure, drug and alcohol use, and sexual health.

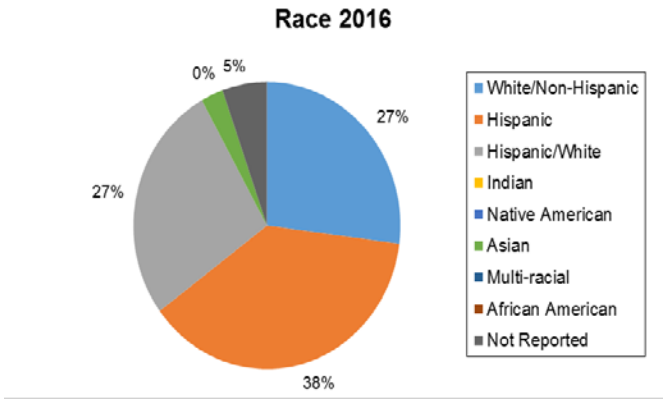
ACHES Acute & Preventative Care:

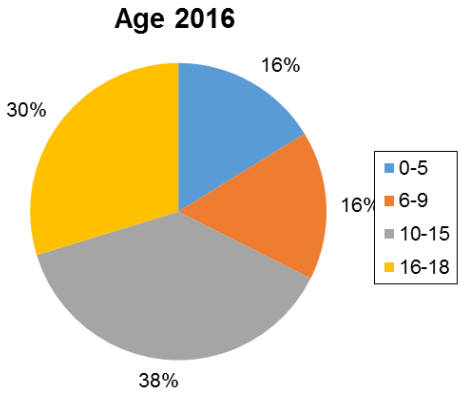
Total Clients:

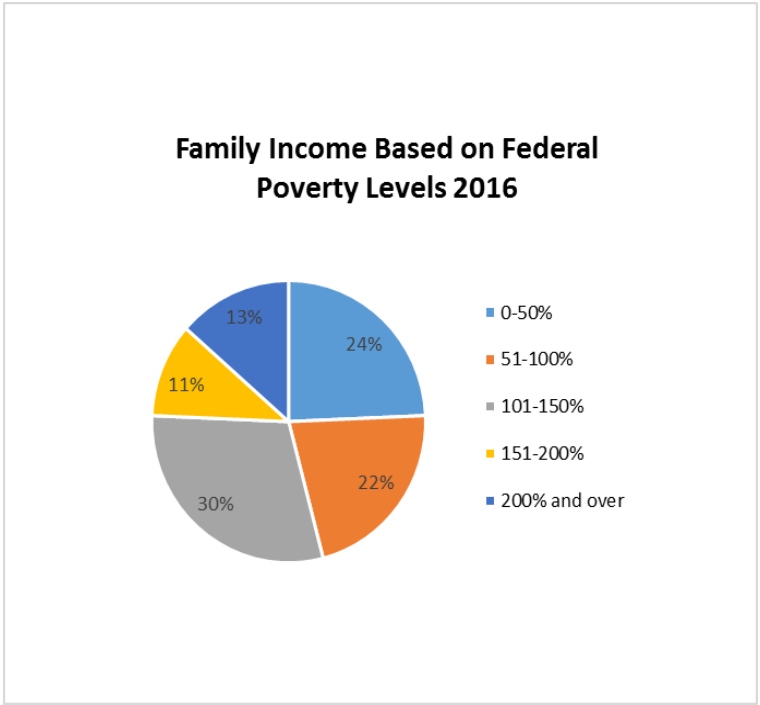
- 37 unduplicated clients, (1 seeing a mental health provider)
- 46 total vouchers (17 acute, 29 preventative)

ACHES Demographic Data:









PAINS PROGRAM RESULTS

The PAINS Program provides vouchers for acute medical, mental health, and pharmaceutical needs to uninsured, low-income adults. In 2013, we also expanded through a monthly corporate donation to include pharmaceutical vouchers and gas vouchers for medical transportation needs.

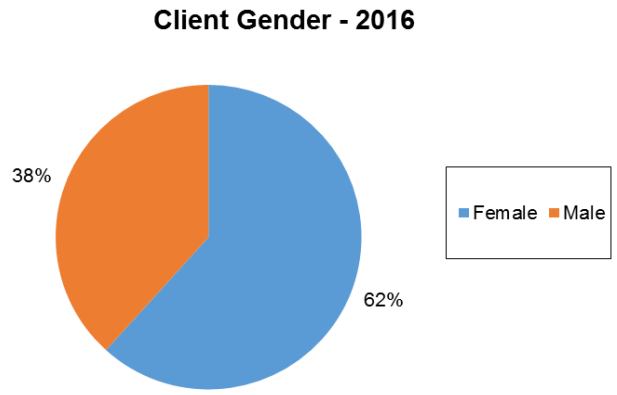
Total Clients – Acute Vouchers:

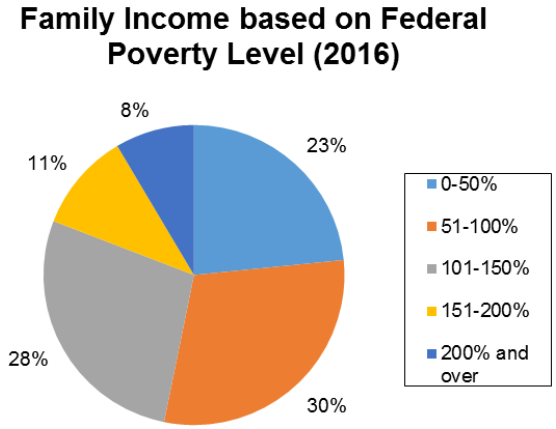
- 88 unduplicated clients, (8 seeing MH providers)
- 102 acute vouchers

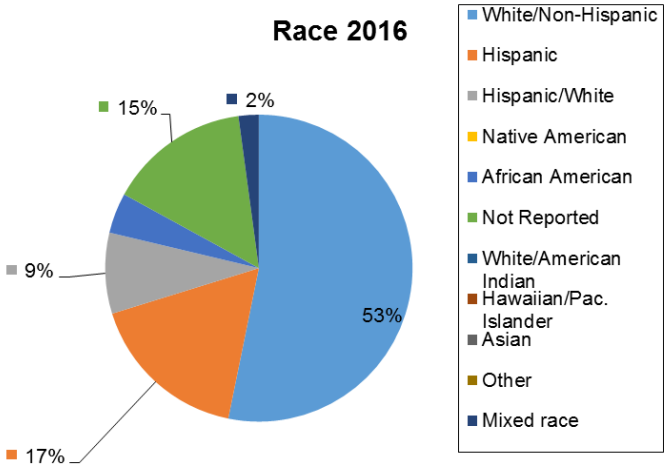
Total Clients – Pharmaceutical and Gas Vouchers

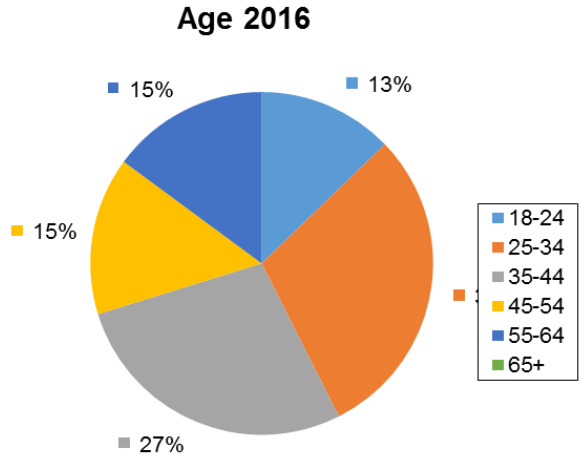
- 73 unduplicated clients
- 126 total vouchers

Demographic Data for P.A.I.N.S. Acute Vouchers Only:









Health Coverage Guides

Our Health Coverage Guide program provides individual and family education and assistance in enrolling in the Connect for Health Colorado insurance marketplace for Grand and Jackson Counties. This program is made possible through a partnership with the Northwest Colorado Community Health Partnership.

Due to the nature of the program, it is extremely difficult to track the number of people the Health Coverage Guides helped enroll. Therefore, we review the trend of enrollment in both Connect for Health CO and Medicaid, knowing that our Health Coverage Guides assisted only a portion of the people enrolled.

The following illustrates the number of enrollments for 2013-2017 open enrollment period with the Connect for Health Colorado exchange. (Data from: http://connectforhealthco.com/resources/stay-informed/metrics/ - Annual End of Open Enrollment Reports.)

County	**2013 Covered Lives**	**2014 Covered Lives**	**2015 Covered Lives**	**2016 Covered Lives**	**2017 Covered Lives**
Grand	589	516	625	869	855
Jackson	37	40	49	71	80

For reference Medicaid and CHP+ enrollments for 2012-2016 (per CHI and HCPF reports).

Medicaid (monthly average)	**2012 (pre-ACA)**	**2013**	**2014**	**2015**	**2016** (Dec. data)
Grand	857	993	1,827	2,242	2,140
Jackson	135	187	285	319	308

CHP+	**2012** (Q4 avg.)	**2013** (Q4 avg.)	**2014** (monthly average)	**2015** (Dec. data)	**2016** (Dec. data)
Grand	260	190	186	152	187
Jackson	NR	32	32	NR	NR