Minnesota Department of
Human Services

09 - 0305

Health Care

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

Report to the Legislature

Primary Care Access Initiative: Progress Report and Recommendation

Laws of Minnesota 2007,
Chapter 147, article 5, section 3

February 2009

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The Primary Care Access Initiative: Progress Report and Recommendations

Executive Summary

The Primary Care Access Initiative (PCAI). Legislation passed in 2007 created a pilot project in Hennepin and Ramsey Counties to contain the program and resource costs resulting from inappropriate use of the hospital emergency departments (ED). Funding, in the amount of $725,000, was appropriated to develop and evaluate a "web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room". The project must identify uninsured patients who are potentially eligible for a Minnesota Health Care Program, and refer the patient for application.

The legislation requires the Department of Human Services (DHS) to conduct an evaluation of the program in consultation with the Minnesota Hospital Association (MHA). The evaluation shall: "compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and [calculate] an estimate of the costs saved from any documented reductions." DHS is required to submit the results of the evaluation to the legislature by January 15, 2009.

Purpose of this Report. The results of the evaluation are not yet available at this time, since the time span required by the legislation has not yet elapsed. Therefore, this report is an interim documentation of the implementation, current status, results obtained to-date, and recommendations to assure useful pilot Project results. DHS will submit an evaluation report to the Legislature in compliance with the Statute when this Project has been completed.

Project Implementation. DHS contracted with Data Futures, Inc. to implement this Project. Data Futures has taken a two-pronged approach, combining Care Scope, their innovative appointment management and scheduling software, with a project management, governance and on-site staffing structure necessary to assure positive outcomes. Implementation is being carried out locally by Data Futures' subcontractor, Quality First Healthcare Consulting, LLC. The Project is overseen by a Steering Committee composed of key leadership in the safety net community, MHA, Portico Healthnet, DHS, and the participating hospitals, St. John's and St. Joseph's in Ramsey County, and Hennepin County Medical Center (HCMC) in Hennepin County.

Present Status. The Primary Care Access Initiative (PCAI) went live in Ramsey County at St. Joseph's Hospital in St. Paul and at St. John's Hospital in Maplewood on November 3, 2008. Four primary care clinics are making appointments available to the patients referred from the hospitals' emergency departments (EDs).

The Project is scheduled to go live in Hennepin County at HCMC on January 13, 2009. Ten clinics have committed to making appointments available to referrals from HCMC.

In both counties, Portico Healthnet (a nonprofit organization that provides comprehensive enrollment assistance and advocacy support to low income people) is accepting referrals from the participating hospitals' EDs for patients who are potentially eligible for MHCP.

See Appendix F for examples of how PCAI has intervened with patients presenting at EDs during the first two months of implementation.

Results. The following results contain combined data collected during the first two months of implementation (November 3, 2008 through December 31, 2008). Note that only the Ramsey County sites were participating during these months.

Metric	***11/3/08 – 12/31/08***
Number of appointments available for scheduling by specialty *[1]*	
Medical	231
Dental	76
Podiatry	16
Mental Health	4
Total	327
Average length of time between scheduling referral and actual appointment scheduled date *[2]*	5.72 days
Number of patients referred	
Minnesota Health Care Programs recipients	111
Uninsured	261
Not known (information not available or data entry omission)	13
Total	385
Appointments resulting in completed visits	21% (13 of 63)
Patients continuing services with referring clinic	unavailable [3]
Patients screened and application assistance and/or follow-up monitoring provided by pilot project staff *[4]*	64 24.5%
MHCP applications submitted to DHS	15 23.4%
Patients enrolled in a MHCP	1 [5]

NOTES:

[1] All appointments are available irrespective of patient's insurance status or insurance type.

[2] Data limitations: Length of time for appointments may be dictated by type of appointment requested / needed and this is not currently reportable in data management system (e.g., ED physician discharge instructions for ED visit follow-up, new patient primary care visit, primary care visit-established, etc.).

[3] This data is reported quarterly.

[4] 100% of uninsured patients referred to PCAI by ED staff are screened for potential MHCP eligibility during assessment interview.

[5] Estimated completion time frame from application submission through completion and enrollment is 60 days.

Early reports from the ED staff at the hospitals are generally positive. Staff report they are able to easily use the software and the Project is of value to them.

No return on investment (ROI) can be projected at this time, due to the Project's early stage. DHS will complete an interim evaluation report with ROI projections in April 2009.

Issues. Technical issues relating to state budget regulations threaten to prematurely terminate this Project. DHS executed the contract with Data Futures May 2008. The contractor was granted a 6 month start-up phase during which it customized its software to DHS's specifications, recruited the participating hospitals, recruited the referral clinics, set up its relationship with the agency to which potential MHCP eligibles would be referred, hired local staff to manage the Project and provide the services in the EDs, and organized the Steering Committee and drafted its charter. The project went "live" at the Ramsey County ED sites on November 3, 2008, and will go live at the Hennepin County ED site on January 13, 2009.

State budget regulations prohibit the carry-forward of the funds currently appropriated for this Project to SFY 2010. Therefore, if the Project is to run for 12 months, as envisaged in the enabling legislation, and as necessary for a robust program evaluation, additional funds will be needed for the period July 1, 2009 to January 15, 2010. The estimated cost is $271,750.[1]

This project represents an effective collaboration among the participating hospitals, the MHA, the safety net clinics, the non-profit eligibility assistance organization, and DHS. The contractor has delivered its products on specification, per the agreed-upon schedule. As of January 2009, the collaborators have produced a viable infrastructure to reduce inappropriate ED use in Hennepin and Ramsey counties. It is crucial that this infrastructure be given a full year in which to demonstrate its value.

The Commissioner will review the progress and results of this Project in April 2009. If the results are positive, the Commissioner will prioritize the extension of this Project when considering the status of unexpended SFY 2009 funds.

Recommendations

RECOMMENDATION 1: The Commissioner recommends that the authority to implement this initiative should be extended to January 15, 2010.

RECOMMENDATION 2: The Commissioner recommends that the Legislature's due date for the evaluation results be rescheduled to February 15, 2010.

[1] This figure includes the additional costs associated with modifying the software, the cost of additional interfaces due to the inclusion of additional clinics, and the higher labor costs in the Minneapolis/St. Paul labor market not anticipated by the contractor in their original proposal.

The Primary Care Access Initiative: Progress Report and Recommendations

I. Introduction

The Primary Care Access Initiative (PCAI) is a pilot project to reduce inappropriate emergency department (ED) use. It is currently operating in two hospitals, with a third to be added January 13, 2009. The Department of Human Services (DHS) is required by the enabling legislation to conduct an evaluation of the program in consultation with the Minnesota Hospital Association (MHA) and present the results to the legislature on or before January 15, 2009. However, the results of the evaluation are not yet available at this time, since the time span required by the legislation has not yet elapsed. Therefore, this report is an interim documentation of the implementation, current status, results obtained to-date, and recommendations to assure useful pilot project results. DHS will submit an evaluation report to the Legislature in compliance with the Statute when this Project has been completed.

II. Background

Non-emergency utilization of emergency room resources. A recent study[2] noted that, "It is believed by some that Medicaid beneficiaries often use EDs for their primary care needs, which increase the cost of such programs." There is little data in the literature that quantifies the cost of inappropriate ED use. However, DHS has an estimate of Minnesota's public health care programs' costs based a projection made for a 2005 study.

At the direction of the Legislature, DHS conducted an extensive study of its Minnesota Health Care Programs[3] (MHCP) in 2004 and 2005[4]. One phase of the study was to identify services delivered that are not needed and produce no benefit to the patient. The study examined the programs for opportunities for cost savings based on empirically-based research. Within the MHCP budget, inappropriate emergency department (ED) use was cited as one area of opportunity. According to one researcher cited in the DHS report, "20% of patients coming to the ED did not have conditions requiring emergency care, and another 20% had urgent conditions that could have been treated in a primary care setting."[5] By applying this figure to calendar year 2003 MHCP data on fee-for-service claims and managed care encounters, the DHS study's author projected estimated payments in excess of $26.2 million for inappropriate ED use by MHCP recipients on a state-wide basis.[6]

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[2] Handel DA et al., "How Much Does Emergency Department Use Affect the Cost of Medicaid Programs?", *Annals of Emergency Medicine*, May 2008, p. 614.

[3] The Minnesota Health Care Programs are the publicly-funded Medical Assistance Program, the General Assistance Medical Care Program, and the MinnesotaCare Program. Information about these programs can be found at DHS's web site: www.dhs.state.mn.us

[4] Minnesota Department of Human Services, "Health Care Services Study: Findings and Strategies for Savings, January 2005, Report to the Minnesota Legislature," available at www.dhs@state.mn.us

[5] Regenstein M et al., "Walking a Tightrope: The State of the Safety Net in 10 U.S. Communities." The George Washington University Medical Center, May 2004.

[6] Minnesota Department of Human Services, p. 19.

Redirecting Medicaid patients from inappropriate ED use to primary care clinics has proven to be a formidable task. A study published in 2008[7] summarizes previous research studies that highlight the crux of this issue:

- only 34% of nonemergent ED patients complied with outpatient referral;
- only 28% of all discharged ED patients completed an outpatient follow-up appointment;
- only 47% of patients were able to get appointments within three days of the recommended date;
- only 56% were able to complete an appointment within one month.

Reasons for noncompliance were "multifactorial", and included lack of insurance, lack of childcare, transportation difficulties, and lack of ability to make an appointment. However, a 1996 article documented a 67 percent rate of successful follow-up when the majority (92 percent) of patients were given a confirmed appointment.[8]

Legislation. PCAI is authorized by legislation passed in 2007 (see attachment A). The pilot project is to be implemented in Hennepin and Ramsey counties to address the inappropriate use of the hospital EDs. Funding, in the amount of $725,000, was appropriated to develop a "web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room".

Further, the project would identify uninsured patients who are "potentially eligible for a Minnesota health care program,"... and "connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process."[9] The legislation requires the Department of Human Services (DHS) to conduct an evaluation of the program "in consultation with" the Minnesota Hospital Association (MHA). The evaluation shall: "compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and [calculate] an estimate of the costs saved from any documented reductions." DHS is required to submit the results of the evaluation to the legislature by January 15, 2009.

Federal and state efforts. The Centers for Medicare and Medicaid (CMS) has devoted considerable attention to reducing inappropriate ED use in the Medicaid program. Most recently, CMS has made a total of $50 million available to the states for projects. In April 2008, CMS awarded twenty grants to twenty states for two year projects with the goal of reducing use of hospital emergency rooms by Medicaid beneficiaries for non-emergent

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[7] Vieth, TL and KV Rhodes, "Nonprice Barriers to Ambulatory Care After an Emergency Department Visit," *Annals of Emergency Medicine*, May 2008, p. 607.

[8] Ibid.

[9] The Minnesota Department of Health estimates that over 50 percent of uninsured Minnesotans are eligible for a Minnesota Health Care Program but have not enrolled

reasons. The anticipated outcomes of these grant-funded projects are improved access to, and quality of, primary healthcare services, improved beneficiary health status and demonstrated program cost savings.

III. Implementation

Procurement. DHS issued the Request for Proposals (RFP) for the PCAI on September 17, 2007. DHS received two proposals in response. An evaluation team composed of DHS staff and outside experts and stakeholders reviewed the proposals and made recommendations to the Department. DHS entered into a contract to implement the Project with Data Futures, Inc. on May 1, 2008. The Project budget allots funding for the software licensure, project management, and personnel costs for on-site Project staff.

Project Description. The contractor's approach to this Project is two-tiered, combining "high tech" with "high touch":

- a technical component that links hospitals and clients with primary and specialty care safety net providers for appointment scheduling, care coordination resources, community service referral tracking, and comprehensive performance measurement;
- a care navigation system that guides the patient into a primary care health care home.

A key feature of this approach is the recognition of the critical need to fully engage the community in developing the program structure. Data Futures' project team invested considerable front end work with safety net providers in Hennepin and Ramsey County over a five month period to ensure the development, deployment and implementation of a positive solution, acceptable and effective for each of the community participant providers.

The entry portal for the program is the emergency room. Uninsured individuals and Minnesota Care Health Program subscribers receiving care for non-emergent conditions are referred by hospital staff to onsite PCAI care managers and care navigators. PCAI staff complete an electronic screening interview for MHCP eligibility and assessment of "at risk" factors that may prevent an individual from establishing a primary care medical home. Upon establishing the need for a primary care appointment, the patient is assigned an appointment at a time and place that is accessible to the patient. The patient is given a document that lists the time and place of the appointment, and the public transit lines that serve the clinic site. The document is printed in the patient's primary language.

The appointments are available for assignment by the care navigators through a software package that is accessible in the ED. The appointments have been set aside for PCAI by the participating clinics, and are stored in an inventory available through Data Futures' Care Scope software.

PCAI staff act as liaisons beyond the emergency room encounter for individuals and safety net providers by establishing trusting relationships, and use of efficient and effective language and culturally sensitive communication techniques and tools to resolve identified actual and potential restricting "at risk" factors. See Appendix F for examples

of how PCAI has intervened with patients presenting at EDs during the first two months of implementation.

Project Participants. Data Futures assigned responsibility for recruiting the participating hospitals and clinics to its subcontractor, Quality First Healthcare Consulting (QFHC). Recruiting was targeted at those hospitals serving large numbers of uninsured and low income patients. Ultimately, three hospitals were selected for participation: St. Joseph's Hospital, St. Paul, St. John's Hospital, Maplewood, and Hennepin County Medical Center, Minneapolis. A fourth hospital, Regions in St. Paul, determined that they were unable to participate at this time due to other commitments, but asked to remain on the Project Steering Committee to keep abreast of the Project.

The clinics were recruited based on their relationships with the participating hospitals. By and large, they are safety-net clinics whose missions are to serve uninsured and low income patients. See Appendix D for a list of the participating clinics.

Portico Healthnet facilitates the Project's responsibility to identify uninsured patients who are potentially eligible for a Minnesota Health Care Program, and refer the patient for application. Portico is a nonprofit organization, funded largely by hospitals, that provides comprehensive enrollment assistance and advocacy support. Potentially eligible patients identified during the screening process are referred to Portico for assistance.

All Project participants have signed informal participation agreements, acknowledging their support and participation in the Project as safety net providers.

Project Management and Oversight. Daily operations of the Project are the responsibility of the Project Manager. The Project Manager has been hired by QFHC. The Project Manager was hired locally and has considerable experience in and knowledge of the Twin Cities healthcare community. The Project Manager reports directly to QFHC.

The Project is governed by a Steering Committee composed of representatives of the Project's component organizations. The purpose of the Steering Committee is to "provide proactive leadership, maintain grass-roots credibility and demonstrate community commitment" to the Project. The Committee provides oversight of the project manager and provides "direction, perspective and inspiration to the Project".[10]

The Committee's responsibilities and duties include:

- Approve community policies and protocols
- Review State-mandated progress and outcome reports
- Approve PCAI agreements and contracts
- Make recommendations to Project policy and protocol initiatives
- Review Project Manager reports to evaluate progress
- Support the Project Manager to facilitate forward progression
- Provide oversight to the Project Manager

[10] PCAI Steering Committee Charter, July 18, 2008

The Committee meets on a monthly basis. Its meetings are hosted by the Minnesota Hospital Association. See Appendix B for a listing of Steering Committee members. See Appendix C for a timeline of the Project's major milestones.

IV. Evaluation and Quality Improvement

DHS and MHA have developed a Project evaluation plan to measure the Project's success and potential for permanent implementation. The evaluation will examine DHS claims data, MHA hospital data, and data collected by Data Futures. Per contract, Data Futures is gathering data on the following metrics and reporting them to DHS on a quarterly basis.

Metric 1: The total number of appointments available for scheduling by specialty
Metric 2: The average length of time between scheduling and actual appointment;
Metric 3: The total number of patients referred and whether the person was insured or uninsured;
Metric 4: The total number of appointments resulting in visits completed;
Metric 5: The number of patients referred for MHCP eligibility determination;
Metric 6: The number of eligibility determinations completed (applications submitted to DHS for processing);
Metric 7: The number of eligibility enrollments completed; and
Metric 8: The number of patients continuing services with the referring clinic.

Data Futures has established a continuous quality improvement process for the Project. Through this process, Data Futures monitors performance metrics 1- 7 above on a monthly basis. The purpose is to track and monitor trends, to identify opportunities to improve and proactively implement improvement activities that increase overall Project performance.

V. Results To-date

The following table summarizes key metrics of the Project for the first two months of its operation (November and December 2008). The numbers reflect activity only at the Ramsey County Project sites, since implementation is not scheduled to begin in Hennepin County until January 13, 2009. See Appendix E for the demographics of the persons served by the Project to-date.

Metric	***11/3/08 – 12/31/08***
Number of appointments available for scheduling by specialty *[1]*	
Medical	231
Dental	76
Podiatry	16
Mental Health	4
Total	327
Average length of time between scheduling referral and actual appointment scheduled date *[2]*	5.72 days
Number of patients referred	

Minnesota Health Care Programs recipients	111
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[2] Data limitations: Length of time for appointments may be dictated by type of appointment requested / needed and this is not currently reportable in data management system (e.g., ED physician discharge instructions for ED visit follow-up, new patient primary care visit, primary care visit-established, etc.).

[3] This data is reported quarterly.

[4] 100% of uninsured patients referred to PCAI by ED staff are screened for potential MHCP eligibility during assessment interview.

[5] Estimated completion time frame from application submission through completion and enrollment is 60 days.

Appointment Scheduling Detail Report 11/3/08 – 12/31/08	
Appt Status	**Result**
Appts Available	327
Appts Scheduled	63
Appts Completed	13
Appts Pending	16
Appts Canceled	14
No Show	20
Percent of no shows	32%
Percent of no shows/cancels	54%
Percent of appts scheduled	19%
Percent of appts completed	21%

This project represents an effective collaboration among the participating hospitals, the MHA, the safety net clinics, the non-profit eligibility assistance organization, and DHS. The contractor has delivered its products on specification, per the agreed-upon schedule. The result is a viable model that is testing the cost-effectiveness of reducing inappropriate ED use.

VI. Issues

Technical issues relating to state budget regulations threaten to prematurely terminate this Project. State budget regulations prohibit the carry-forward of the funds currently appropriated for this Project to SFY 2010, so the current contract terminates June 30, 2009.

DHS executed the contract with Data Futures May 2008. The contractor was granted a 6 month start-up phase during which it customized its software to DHS's specifications, recruited the participating hospitals, recruited the referral clinics, set up its relationship with the agency to which potential MHCP eligibles would be referred, hired local staff to manage the Project and provide the services in the EDs, and organized the Steering Committee and drafted its charter. Services began at the first two hospital sites on November 3, 2008. Services are scheduled to begin at the third hospital site on January 13, 2009. Therefore, if this Project is to run for the full 12 months envisaged in the enabling legislation, additional funds will be needed for the period July 1, 2009 to January 15, 2010. The estimated cost is $271,750.[11]

VII. Conclusions and Recommendations

As of January 2009, a viable infrastructure has been set up to reduce inappropriate ED use in Hennepin and Ramsey counties. It is crucial that this infrastructure be given a full year in which to demonstrate its value to its stakeholders. The Commissioner agrees with the Steering Committee's assessment that this pilot Project should operate for the full 12 months specified in the Legislation. Twelve months is a minimal length of time to obtain useful data to assess the efficacy of this model. This data will be useful to the State, as well as to managed care organizations and to individual hospitals in developing strategies to prevent inappropriate emergency room use. If the evaluation proves positive and the ROI is favorable, the infrastructure created through the Project can continue to serve the three pilot hospitals, and can be a foundation for expansion to additional hospitals in the state.

The Commissioner will review the progress and results of this Project in April 2009. If the results are positive, the Commissioner will prioritize the extension of this Project when considering the status of unexpended SFY 2009 funds.

RECOMMENDATION: The Commissioner recommends that the authority to implement this initiative should be extended to January 15, 2010.

RECOMMENDATION: The Commissioner recommends that the Legislature's due date for the evaluation results be rescheduled to February 15, 2010.

[11] This figure includes the additional costs associated with modifying the software, the cost of additional interfaces due to the inclusion of additional clinics, and the higher labor costs in the Minneapolis/St. Paul labor market not anticipated by the contractor in their original proposal.

Appendix A. Legislation

Minnesota Session Laws 2007 - Chapter 147, ARTICLE 5, Sec. 3. PRIMARY CARE ACCESS INITIATIVE.

Subdivision 1. Establishment. (a) The commissioner shall award a grant to implement in Hennepin and Ramsey Counties a Web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. The grantee must establish a program that diverts patients presenting at an emergency room for nonemergency care to more appropriate outpatient settings. The program must refer the patient to an appropriate health care professional based on the patient's health care needs and situation. The program must provide the patient with a scheduled appointment that is timely, with an appropriate provider who is conveniently located. If the patient is uninsured and potentially eligible for a Minnesota health care program, the program must connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process. The program must also ensure that discharged patients are connected with a community-based primary care provider and assist in scheduling any necessary follow-up visits before the patient is discharged.

(b) The program must not require a provider to pay a fee for accepting charity care patients or patients enrolled in a Minnesota public health care program.

Subd. 2. Evaluation. (a) The grantee must report to the commissioner on a quarterly basis the following information:

(1) the total number of appointments available for scheduling by specialty;

(2) the average length of time between scheduling and actual appointment;

(3) the total number of patients referred and whether the patient was insured or uninsured; and

(4) the total number of appointments resulting in visits completed and number of patients continuing services with the referring clinic.

(b) The commissioner, in consultation with the Minnesota Hospital Association, shall conduct an evaluation of the emergency room diversion pilot project and submit the results to the legislature by January 15, 2009. The evaluation shall compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and an estimate of the costs saved from any documented reductions.

Appendix B. Steering Committee Membership and Staff

Member's name	Representing
Walter Cooney	Neighborhood Health Care Network
Rhonda Degelau	Minnesota Association of Community Health Centers
Thomas Fields	Minnesota Department of Human Services, Health Services & Medical Management Division
Shawntera Hardy	Regions Hospital
Michael Harristhal	Hennepin County Medical Center
Debra Holmgren / Chris Bargeron	Portico HealthNet
Joseph Schindler	Minnesota Hospital Association
Pennie Viggiano	HealthEast (St. John's & St. Joseph's Hospitals)

Chair: Joe Schindler, Minnesota Hospital Association
Staff: Bill Juergens, Quality First Healthcare Consulting
Contract Manager: Tom Fields, DHS

Appendix C. Project time line

Milestones	Responsibility	Completion Date / *Target Date*
Contract Executed	DHS & Data Futures (DF)	May 1, 2008
Detailed Implementation Plan completed and approved	DHS & DF / Quality First Healthcare Consulting (QFHC)	June 16, 2008
Software customized	DF	May 5, 2008
Steering Committee convened	QFHC	June 2, 2008
Pilot Sites (Hospitals) Identified	QFHC	June 16, 2008
Relationships established with primary care and specialty clinics referring sites	QFHC	July 14, 2008
Primary care appointment inventories and sub-inventory established	QFHC	October 13, 2008
Evaluation protocol agreed upon	DHS, MN Hospital Association (MHA) & DF / QFHC	September 30, 2008
Patient assistance & eligibility referral begins at St. Joseph's Hospital (go-live)	Hospital project site	November 3, 2008
Patient assistance & eligibility referral begins at St. John's Hospital (go-live)	Hospital project site	November 3, 2008
Patient assistance & eligibility referral begins at Hennepin County Medical Center (go-live)	Hospital project site	January 13, 2009
Preliminary report to Legislature: progress to-date, evaluation results to date	DHS / SC	January 15, 2009
Interim report to Legislature: evaluation results to date and recommendations	DHS / MHA	*April 1, 2009*
Project status beyond 6/30/09 is determined	DHS / Potential funders	*April 1, 2009*
Contract terminates	DHS & Data Futures	***If Project not extended: June 30, 2009*** ***If Project extended: January 15, 2010***
Evaluation completed	DHS / MHA	***If Project not extended: July 30, 2010*** ***If Project extended: February 15, 2010***
Final Report results and final recommendations completed	DHS	***If Project not extended: July 30, 2010*** ***If Project extended: February 15, 2010***

Appendix D. Participating Clinics, January 2009

Hennepin County:

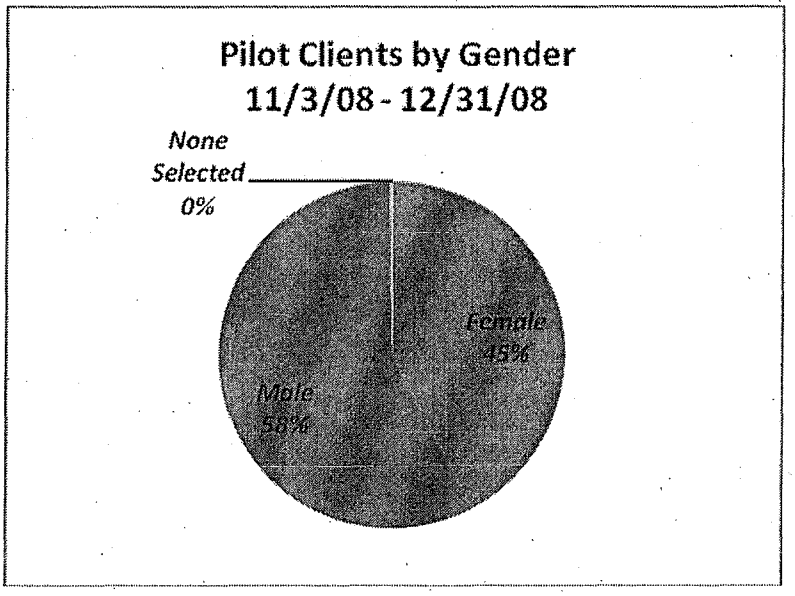
- HCMC / Hennepin County North Clinic
- HCMC / Medicine Clinic
- HCMC / Family Medical Center
- HCMC / Hennepin County East Lake Clinic
- HCMC / Hennepin County South Clinic
- Community – University Health Care Center
- Fremont Clinic
- Fremont / Central Avenue Clinic
- Fremont / Sheridan Avenue Clinic
- Indian Health Board

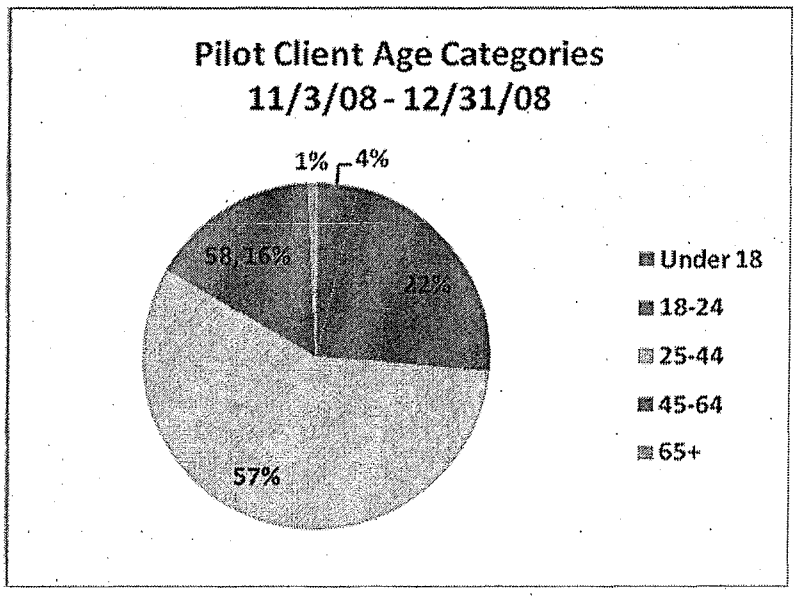
Ramsey County:

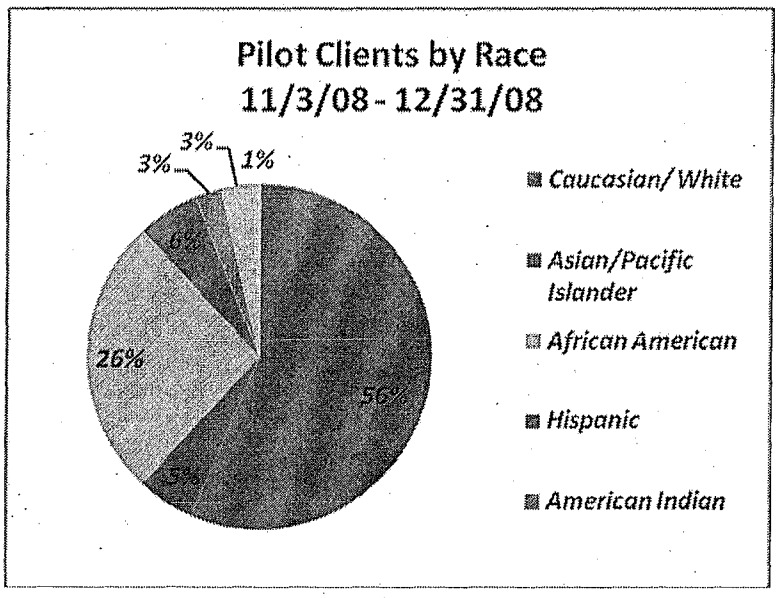
- Bethesda Clinic
- Phalen Village Clinic
- Open Cities Heath Center / Dunlap Clinic
- Open Cities Heath Center / North End Clinic

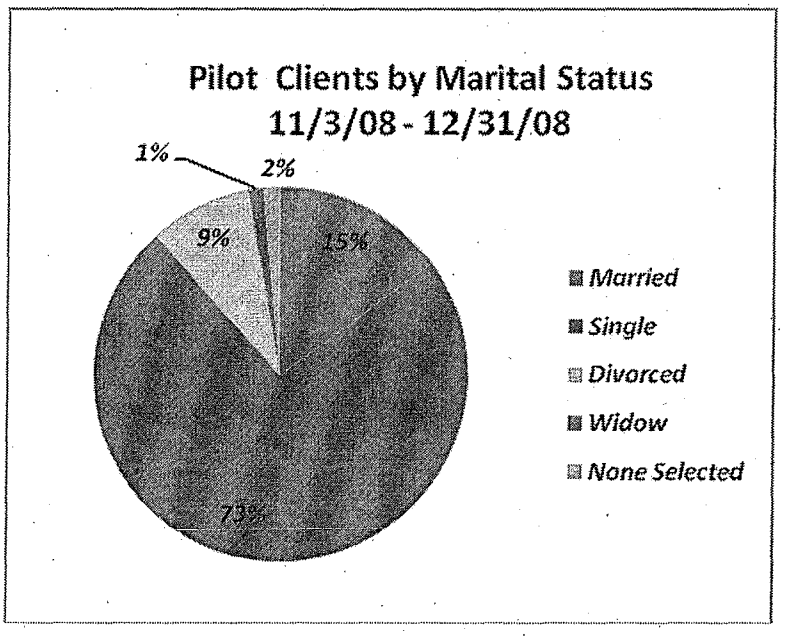
Appendix E. Program Demographics 11/3/08 – 12/31/08

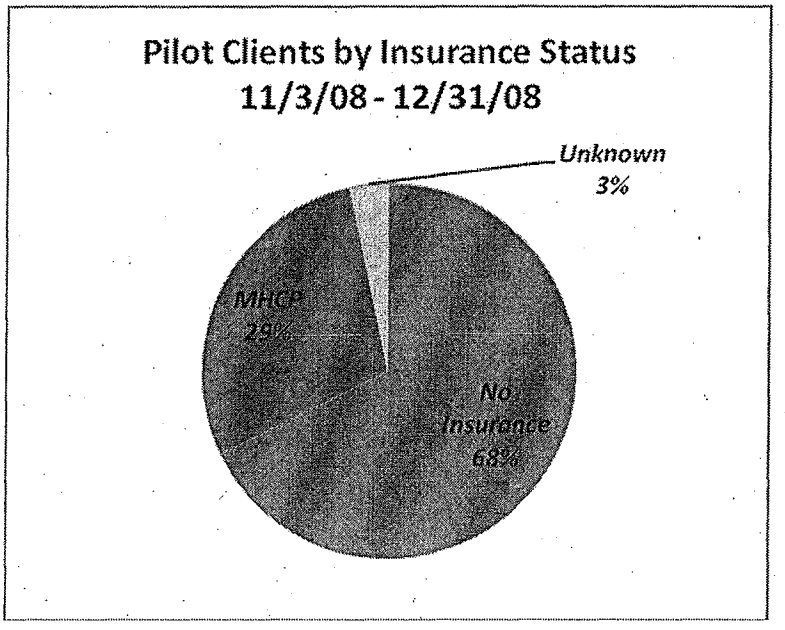
Findings: The PCAI pilot population during the first two months of program operations in Ramsey County are predominantly single, uninsured, Caucasian males, ages 25-44, residing in Ramsey County.

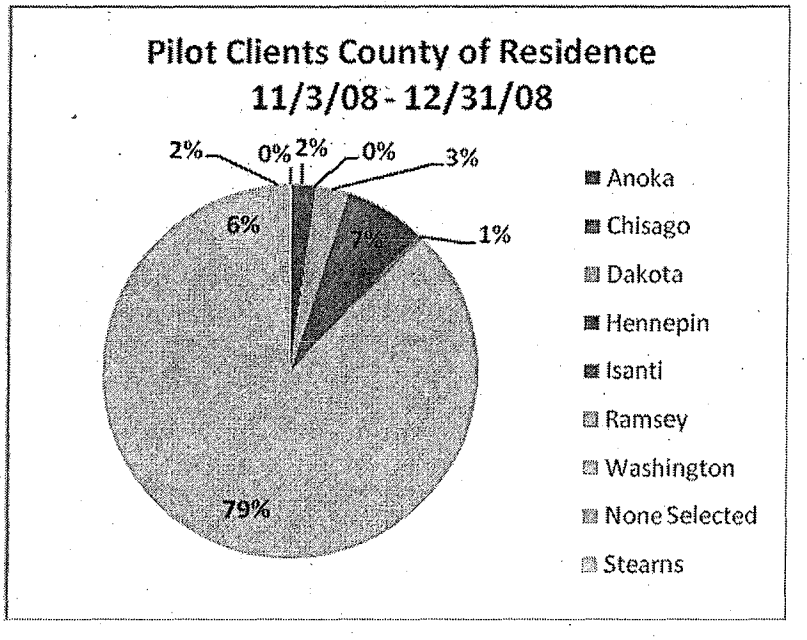





Pilot Clients by Race
11/3/08 - 12/31/08
3%
3%
1%
6%
26%
56%
5%
Caucasian/ White
Asian/Pacific Islander
African American
Hispanic
American Indian


Pilot Clients by Marital Status
11/3/08 - 12/31/08
1%
2%
9%
15%
73%
Married
Single
Divorced
Widow
None Selected


Pilot Clients by Insurance Status
11/3/08 - 12/31/08
Unknown
3%
MHCP
29%
No
Insurence
68%


Pilot Clients County of Residence
11/3/08 - 12/31/08
2%
0%
2%
0%
3%
6%
7%
1%
79%
Anoka
Chisago
Dakota
Hennepin
Isanti
Ramsey
Washington
None Selected
Stearns

Appendix F. Examples of PCAI Intervention

The following are actual examples of the intervention provided by the PCAI at St. John's and St. Joseph's Hospitals in November and December 2009.

1. A 44 year old woman presented in the emergency department with severe leg pain. The patient reported she is married and has 2 children. The patient complained of severe leg pain that had persisted for some time. The patient said she and her husband have Medical Assistance, but have never used it before because the spend down is $489.00 a month and she must pay that fee every month before her coverage would begin. In addition, her husband had just had a heart attack in June and they were paying $250.00 a month out of pocket for 5 medication prescriptions that her husband needed. Patient could not afford spend down and thus was not getting the care she needs.

A PCAI Care Manager collaborated with the hospital financial counseling office and the county financial worker in finding a solution to the client's financial constraints. Solution: Client and family were transferred onto Minnesota Care for a premium fee of $165.00 a month for coverage for the entire family, with co-pays for medications only costing $3.00 a piece. With affordable coverage now the family is receiving the medical care they need and continues to work with the PCAI staff to establish a primary care medical home for the entire family.

2. A 25 year old uninsured man presented in the emergency department (ED) after a severe seizure and a fall resulting in a displaced shoulder. Patient has been epileptic since childhood and has not been on seizure medication or seen by a primary care physician for more than 5 years. The client reported he has not had medical insurance for more than 5 years. After the ED visit a PCAI Care Manager (CM) scheduled a meeting with the client and his girlfriend to assess for potential barriers to completing post ED care with a neurologist and an orthopedic surgeon. Barriers to care were identified as inability to pay the required combined specialty physician visit fees of $350. In order to afford the fees the family disclosed they would have to use part of the rent money. The PCAI CM worked with the client and facilitated access to specialty care by acting as a liaison on behalf of the client with the specialist office's to reduce his combined visit fee to $100 to be paid through a payment plan. Other service navigation services provided to this client by PCAI staff was assistance with completing an application for Minnesota Health Care Programs. The client acknowledged plans to continue communication with PCAI staff once enrolled in MHCP to find a primary care medical home.

3. 47-year-old man enrolled in the Medical Assistance program presented in the emergency room for abdominal pain and was referred to PCAI staff at time of discharge for a primary care appointment. A PCAI Care Navigator (CN) scheduled an appointment for him at a participating clinic. A follow-up call made by the PCAI CN found the client was satisfied with the experience he had at primary care clinic and indicated he planned to schedule another appointment for some preventive care. He was planning on scheduling another appointment for a flu shot there.

4. A 22-year-old man presented in the Emergency Department (ED) for leg pain due to a snowmobile accident that occurred earlier this year. He was on transitional MinnesotaCare after his snowmobile accident but it stopped and he has not been on health insurance for the last four months. He was given pain medication for the next couple of days. He came back to the ED five days later and needed more medications for his pain. He was told by the ER doctor that his medical needs could be better addressed by a primary care physician and was referred to the PCAI program.

A PCAI Care Navigator (CN) met with the client several times and on the last visit a MHCP application was completed. When speaking with the client about establishing a primary care medical home the client told the PCAI CN he had been turned away from doctor's offices in the past because of his inability to pay and he was hesitant to make an appointment but did allow the CN to schedule an appointment with one of the participating clinics. Understanding the client's reserve the CN provided the client with information about what to bring to the appointment to apply for the clinic's sliding fee scale, provided him with a contact at the clinic to speak with, provided him PCAI program contact information, and forwarded information to the clinic to begin the administrative process ahead of the client arriving for his appointment.

During a post appointment follow-up call by the PCAI CN the client verbalized his satisfaction with the care he received at the clinic and the ease in completing the sliding fee paperwork. The client expressed appreciation about the help he received through the PCAI program in getting immediate care, and in restoring his coverage so he would be able to have surgery on his leg and get physical therapy. The MHCP application was submitted to DHS for processing and the client is waiting for a decision.