Access to Care

Annual Work Plan

FY 2016-2017

Focus Area: Access to Care						
Goal 1	**Improve knowledge of health service options available and appropriateness of each**					
Objective 1.1	Sustain a collaboration of community health partners for the purposes of remaining aware of ongoing access-to-care issues in El Dorado County and influencing positive change.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
1.1.A Access-to-Care CHIP team regularly convene to share knowledge about access to care issues and solutions	12/2016	ongoing	Nancy Williams	Team members Guest speakers Meeting room Food	≥ 4 meetings per year; ≥ 4 attendees per meeting on average; ≥6 entities (associations, agencies, etc.) represented;	Met target measures and will continue indefinitely. During first year, met nearly every month; Average attendance has had at least 4 participants at each meeting, often more; Regular participation during the first year from: HHSA Public Health and Behavioral Health, ACCEL, El Dorado County Community Health Center, Marshall Medical, Barton Hospital/Foundation, and less frequent or recent participation from others; Meeting room provided by HHSA-PH; Food provided by team leader.

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Objective 1.2	Advocate to develop a sustainable comprehensive reference guide of information about health services provided by the main health plans available in El Dorado County (to improve both community member and agency/service-provider knowledge)					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
1.2.A Seek people well versed in health plans, health services; use their expertise to help develop guide	6/2017	12/2018	Nancy Williams	Iveeth Bannister (plan eligibility & benefits) Katy Eckert (knowledge of other counties' 2-1-1 system s)	Identification of experts in these areas	Experts (or future experts) have been identified; Relatively new HHSA-PH grant program focusing on CMSP eligibility is staffed by Iveeth, who is quickly becoming familiar with the various government-sponsored health-plan options available to our county residents, including CMSP; Katy has shared her knowledge of the function and benefits of 2-1-1 and will keep the team posted on progress toward establishing a system within HHSA (not driven by this team)
1.2.B Invite reps from main health plans to meet with / educate Access-to-Care CHIP team about their plans, patient navigation, and how team can partner with them to reduce barriers in accessing care.	6/2017	5/2018	Chris Weston; Nancy Williams	Medi-Cal managed-care plans (California Health and Wellness, Anthem / Blue Cross, and possibly Partnership HealthPlan of California)	Meetings held	Partially complete. Two representatives from California Health and Wellness spoke at a team meeting in July 2017; Plan to schedule visit by Anthem / Blue Cross representatives in early 2018, during year 2; Note: Other counties in our region with the same two Medi-Cal managed care plans are discussing the possibility of converting their counties' plans to one run exclusively with Partnership HealthPlan of California. This team will keep abreast on that progress during year 2.
1.2.C Develop guide described in Key Action 1.2.A and a system for maintaining it with updated information	1/2018	Ongoing	Iveeth Bannister; Katy Eckert; Others TBD	If 2-1-1 system adopted, the County of El Dorado would be responsible	Provider directory available; 2-1-1 system implemented	Not started.

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Objective 1.2, continued	Advocate to develop a sustainable comprehensive reference guide of information about health services provided by the main health plans available in El Dorado County (to improve both community member and agency/service-provider knowledge)					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
1.2.D Utilize welldorado.org website to disseminate current access-to-care resources for community members, agency partners, healthcare providers, and others.	7/2018	Ongoing	Nancy Williams	Iveeth Bannister	List of resources posted; List of dates of posted resources to indicate their currency	Not started.

Objective 1.3	Educate community members (users of health services) on availability of services and which are appropriate for which situations					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
1.3.A. Perform targeted education to frequent ambulance-service and ED users about early symptom recognition, preventive care, options available.	Already ongoing at start of Year 1; expanded in 2017	Ongoing	Marshall Medical Center (MMC)	MMC resources, including: patient advocates; Community volunteers; 1 MD; 2 social workers; 1 dietitian; (enabled by ACA incentives)	# of referrals to establish medical homes; % who still have medical homes after 1 year	Started. Method of measurement TBD.

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Objective 1.3, continued	Educate community members (users of health services) on availability of services and which are appropriate for which situations					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
1.3.B Public Health Nurses & Community Health Advocates identify EDC families with access issues, educate and refer.			HHSA – Community Hubs / Amber Burget (Supervising Public Health Nurse)	HHSA Community Hub staff (education), County libraries (for connecting people to Hub staff, disseminating educational materials)	# of community members educated about services; # of referrals made for insurance; # of community members assisted in finding providers	Hub staff (Community Health Advocates) educated many community members, individually and in groups, about many services, including insurance eligibility (specific numbers not recorded). They recorded 24 insurance-linkages requests for April-June, 2017, and 29 insurance-linkage requests during July-August, 2017, for a total of 53. They also assisted clients in accessing providers: 52 Requests for medical providers and 92 Requests for dental provider.

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Focus Area: Access to Health Services						
Goal 2	**Increase timely access to health-service providers**					
Objective 2.1	Increase proportion of patients/clients with medical homes.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
2.1.A See Key Action 1.3.A			(Marshall – see Key Action 1.3.A)			(see Key Action 1.3.A)
2.1.B Develop and/or expand care-management services	1/2017	Ongoing	Marshall	Marshall's patient navigators; donations of gas, cars, drivers	# of hired staff; # of patients served	Marshall increased number of navigators in cancer program to transport patients to support groups and to expedite scheduling their appointments. (Example: policies were changed that allow patients to see general surgeons more promptly for biopsies.)
2.1.C Outreach & marketing to community members to recruit new enrollees for any medical plan	Ongoing	Ongoing	EDCCHC – Terri Stratton	EDC's patient advocates, HHSA funding	# of outreach activities; surveying patients about how they heard of EDCCHC	Outreach activities have been done at the following locations: Kids' Expo, food truck events, National Night Out, movie theater ads, billboards, dental-van clients, Marshall's 'Affair of the Heart' event, and others. Future plans include establishing other opportunities for key actions that can/will be taken to link more people with medical homes.
2.1.D Expand clinic hours	3/1/2017	6/1/2018	EDCCHC – Terri Stratton	EDC staff; insurance reimbursement	TBD	Hours have been expanded. Future: try to determine whether the additional people seen at EDCCHC would have gone to the ER had EDCCHC not been an option.
2.1.E EDCCHC to take patients referred from Marshall ED with active drug withdrawal symptoms	8/2017	Ongoing	EDCCHC; Marshall ED	EDC staff, insurance reimbursement	# of referrals accepted	Process started; future: design method to track progress.

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Objective 2.1, continued	Increase proportion of patients/clients with medical homes.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
2.1.F EDCCHC to take referrals from probation and jail	Ongoing	Ongoing	EDCCHC	EDCCHC staff, insurance reimbursement	# of referrals accepted.	Process started; future: design method to track progress.
2.1.G Enroll homeless referred by Sheriff's Homeless Outreach Team	7/2017	Ongoing	EDCCCHC; Sheriff's "HOT" team	EDCCHC staff, insurance reimbursement	# of referrals accepted	"HOT" team was established in 2017. EDCCHC already accepted referrals of homeless persons; HOT team serving as new referral source. Means for tracking needs to be developed.
2.1.H Identify other ways medical homes are being established and track	1/2018	12/2018	CHIP team members	TBD	Increase in numbers of patients with medical homes at EDCCHC, Barton, other providers	Not started

Objective 2.2	Increase the numbers and availability of medical care providers in El Dorado County					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
2.2.A. Marshall to recruit additional specialists to its network	1/2017	12/2020	Marshall Medical Center		# of new LCSW; # of new clinical psychiatrists; # of new GI physicians;	New psychiatrist (1), new GI physicians (2); new primary care physicians (5, including one Spanish-speaking). Referrals being accepted, including from Tribal health and EDCCHC. Recruitment continues.
2.2.B EDCCHC to recruit primary-care practitioners	Ongoing	TBD	EDCCHC – Terri Stratton	New staff hired by EDCCHC	Increase in # of providers	Number has increased. Measurement pending.

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Objective 2.2, continued	Increase the numbers and availability of medical care providers in El Dorado County					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
2.2.C Barton to recruit additional specialists to its network	Ongoing	Ongoing	Barton	Barton Hospital / Barton Foundation	Increase in # of providers	19 new on-site physicians 32 new telemedicine physicians
2.2.D Explore feasibility of recruiting specialists to donate after-hours/weekend services to patients unable to access through normal insurance channels	1/2019	12/2019	CHIP team members, Marshall, Barton, others	Providers, medical facilities, liability insurance coverage, administrative support, meds & supplies, advice from SPIRIT program	# of specialists contacted about potential volunteering; # of hours/year of donated hours in El Dorado County, by specialty; # of specialty areas that have volunteers	Not started
2.2.E.a Increase awareness of existing resources for teen reproductive health services on Western Slope	6/2017	12/2017	El Dorado Progressives' Health Action Committee	Margaret Madams, Maureen Dion-Perry	Creation and distribution of wallet cards (WS);	Cards to be printed and distributed late 2017
2.2 E.b Increase awareness of existing resources for teen reproductive health services in South Lake Tahoe	9/2017	12/2020	Barton Foundation and HHSA	Barton Foundation subcommittee members, Michael Ungeheuer and Chris Cifelli (HHSA)	Determination of whether feasible; establishment of services if so	Not started

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Objective 2.2, continued	Increase the numbers and availability of medical care providers in El Dorado County					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
2.2.F Explore need to increase teen-friendly providers on Western Slope and South Lake Tahoe	1/2019	12/2019	TBD	TBD		Not started.
2.2.G Explore opportunity to promote CMSP loan-reimbursement opportunity to new providers	1/2019	12/2019	Iveeth Bannister		TBD	Not started

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Focus Area: Access to Health Services						
Goal 3	**Assess transportation barriers, educate on available options, and advocate for improvements**					
Objective 3.1	Disseminate information about existing transportation options.					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
3.1.A Distribute HHSA transportation brochure to clients/patients with transportation needs	10/2017	Ongoing	Nancy Williams	HHSA transportation brochure; Iveeth Bannister; Star Walker; Hub staff	# of locations / agencies receiving paper brochures; Electronic availability of brochure on various partner websites (links to master), including welldorado.org (master)	Not started.
3.1.B Brain-storm new ideas for client/patient transportation services; assess basic feasibility; seek champions	1/2018	6/2018	Access-to-Care CHIP team (initial brainstorming) / specific member(s) to do assessment , seek champions	TBD	# of ideas proposed during brainstorm session; # of ideas assessed; # of ideas deemed feasible; # of ideas forwarded to champions	Not started.

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Objective 3.2	Investigate feasibility of providers traveling to locations accessible to patient/clients with transportation challenges					
Key Actions	**Timeline**		**Responsible Parties**	**Resources**	**Measures**	**Status (Insert after year one)**
	Start	**End**				
3.2.A Research possible remote sites for use by providers	7/2019	6/2020	TBD	TBD	TBD	Not started
3.2.B Research the availability of providers willing to travel to nontraditional sites to provide care	7/2019	6/2020	TBD	TBD	TBD	Not started
3.2.C Research feasibility of telemedicine for patients unable to access care due to transportation issues	7/2019	6/2020	TBD	TBD	TBD	Not started.