

A background image of a water splash against a blue sky, with the splash itself appearing as a dark, textured shape at the bottom of the splash.

**CHOICE Regional Health Network**

# Impacts of the Regional Access Program

**Drops in the bucket towards achieving 100% Access for 93,000 low-income neighbors**

**CHOICE Regional Health Network  
2409 Pacific Avenue SE**

**Olympia, WA**



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# Piecing Together the Broken System to Reduce Uncompensated Care

## Executive Summary of RAP Impacts

Because of our work through the Regional Access Program (RAP), we find ourselves in a unique position to see access trends and system meltdowns. In March 2001, the CHOICE Board used this knowledge to launch the 100% Access Project to fundamentally restructure the finance and delivery of health care in our region (see separate report). Within the framework of 100% Access, Access Coordinators have continued to be invaluable as:

- A source of information on access barriers at the local level
- Community ambassadors with seven-year strong relationships with local leaders
- A source for client stories that are effective for putting a face on the problems as we advocate for change

RAP gives the 100% Access Project greater legitimacy with consumers and is of visible value within each community. At the December 2002 Board retreat, CHOICE was instructed to integrate RAP into the 100% Access Project according to the approved three-year business plan. This integration was complete in July 2003.

Over the span of seven years, the Regional Access Program (RAP) has provided access to health services to over 17,000 people who have limited incomes (36% of the low-income uninsured in our five-county region; although some of these 17,000 people are repeat clients)<sup>1</sup>. When fully staffed, it costs CHOICE about \$570,000 a year to provide this service. The largest expense is compensation for nine (9) FTEs, primarily Access Coordinators who work locally in each service area. Fifty-six percent (56%) of paid RAP staff is bilingual Spanish speakers. RAP FTEs have fluctuated over the years, tied to volume. In the last few months, with a Basic Health waitlist, we have reduced our staffing by 2.5 FTEs by not filling vacancies. In addition, we use 14 volunteers (through SHIBA/HelpLine) to augment paid resources.

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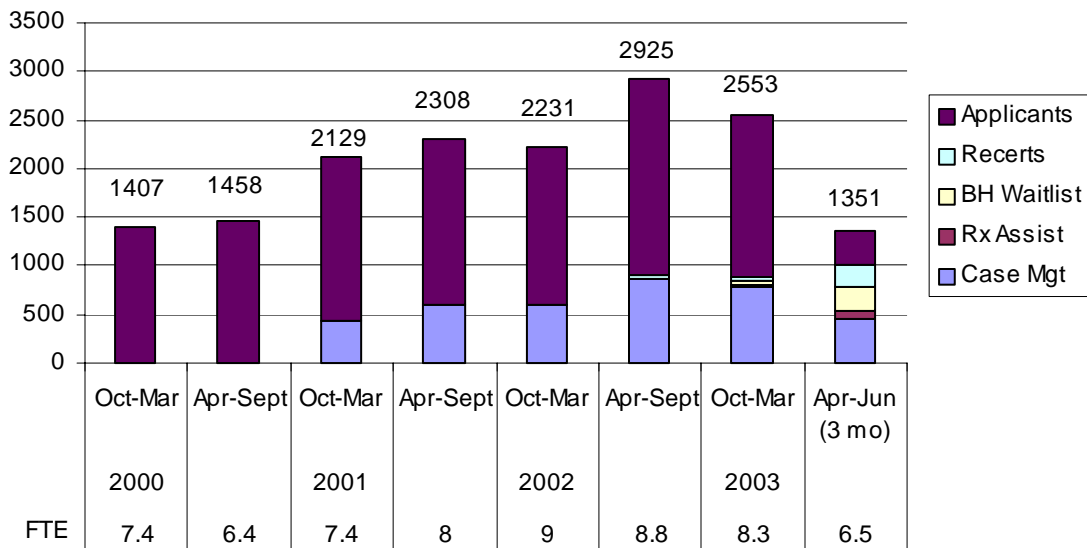
<sup>1</sup> Our client tracking system for the last seven years has been a low-cost Microsoft Access database that does not track our clients over time. Recently, this database crashed due to size and instability. We are in the process of finding the funding to purchase a new, more robust tracking system that will track changes in client's status over time. Until we have this new client tracking system, we do not have data on "repeat clients" although a time study has shown that 3% of our clients have applied through us before and dropped their coverage or disenrolled unnecessarily as a result of inaction or competing priorities for their premium payments in a given month.

## Access to What?

Access Coordinators continue to facilitate access to health insurance, medical homes (even for Medicaid enrollees), prescription drugs, and specialty consultations. We also provide connection and navigation to a wide range of human services in support of personal health responsibility. With the cuts in Basic Health, Access Coordinators are currently focusing on finding and enrolling eligible children in Medicaid and keeping Basic Health members from being disenrolled. Access Coordinators also serve as community liaisons, directing clients to other medically related or appropriate community based resources.

## RAP Volume Overview: Caseload and Staffing

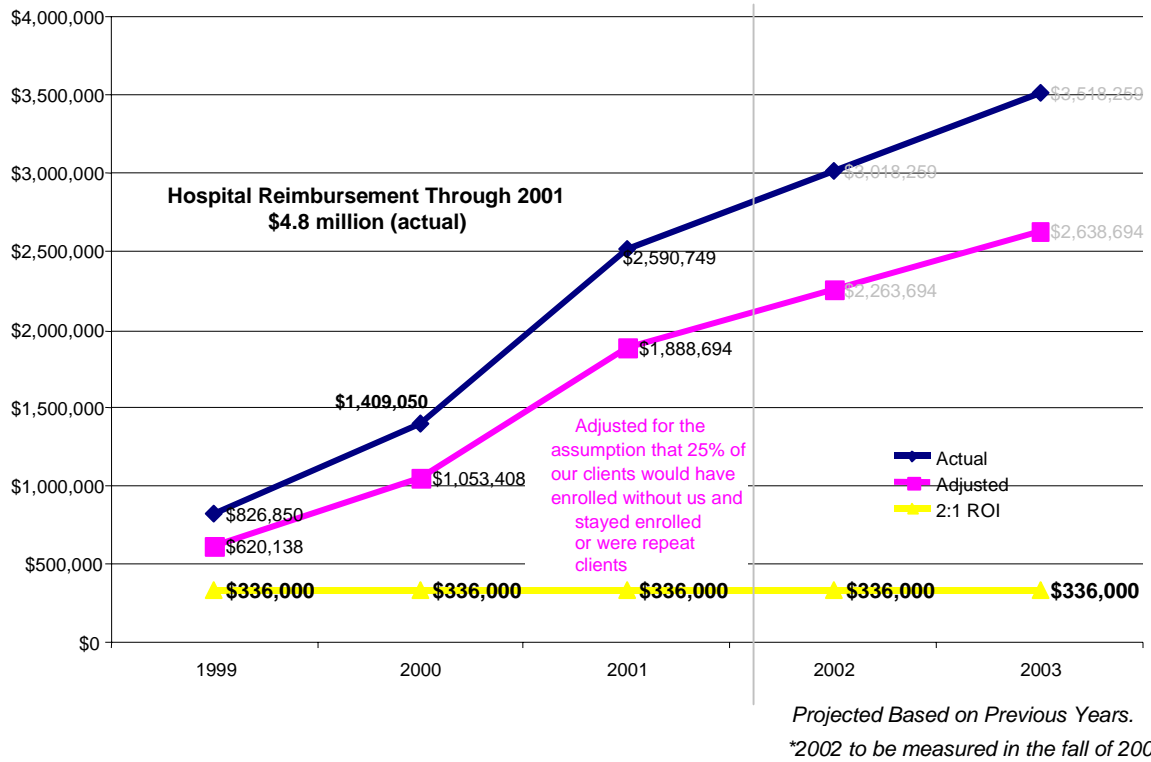
### Caseload Over Time For the Region



## Impact on Reimbursement to Hospitals

Access Coordinators enroll uninsured people into state-subsidized coverage; a subset (63.8%) of whom needed hospital services between October 1998 and September 2001, which resulted in health plan reimbursement to all seven hospitals of \$4.8 million. Reimbursement amounts varied significantly among hospitals, logically related to the size of the hospital and scope of services each hospital provides. The average return on investment for all hospitals for 1999 was 9.13:1, for 2000 it was 11.40:1, and for 2001 it was 20.96:1. It is reasonable to expect that additional

reimbursement between October 2001 and September 2003 will follow comparable trends (although the ROI may be lower in the future given Basic Health waitlist and cuts to the Medically Indigent Program).



Health plan reimbursement to hospitals for clients enrolled by CHOICE averaged 48.55% of billed charges between October 1998 and September 2001 and declined a couple of percentage points each year with some variation across hospitals (see table on page 28).

### Impact on Reimbursement for Other Providers

The amount of additional reimbursement to primary care and specialist providers resulting from increased enrollment is not quantified because we don't have easy access to data from over two hundred private practices in the region (although we plan to barter deals to collect this data in the future). If we extrapolate the experience of the Providence Health and Education Center (PHEC) and Mark Reed Rural Health Clinic (MRHC) (which have comparable practitioner FTEs and about the same reimbursement), we estimate an additional \$800,000 - \$900,000<sup>2</sup> reimbursement is generated per year as a result of RAP for primary care safety net practices in the region.

<sup>2</sup> 82.5 primary care safety net practitioners at \$10,778 additional reimbursement per FTE (based on PHEC and MRHC actuals).

## **Brief History of the Regional Access Program (RAP)**

RAP originally started in three rural counties (Grays Harbor, Pacific and Mason counties) for the purpose of paying (sponsoring) uninsured residents' BHP premiums. As a direct result of the leadership and sponsorship of the public and nonprofit hospitals in the region, the services we provide through RAP have significantly expanded over time (both in terms of geography and scope) and continue to show a strong return on investment for hospitals and an unquantified, but assumed positive return for the community. In 2000, we responded to the demographics of our caseload by creating the capacity to serve Limited English Proficient (LEP) Latino clients (31% of our clients are Latinos compared to 5% of the region's total population). Two years ago our client caseload grew in size and experience so that 42% of Access Coordinators' time is now spent on keeping people enrolled and case management of clients with complex health needs. While the amount of on-site application assistance time has not decreased, Access Coordinator spend over 20% recertifying families we've previously enrolled (or transferring undocumented children from Medicaid to Basic Health). Since case management is an increasing part of what an Access Coordinator does (coupled with a caseload of increasing severity of need), we need to have clearer boundaries about the level of case management to invest in and better outcome measures to evaluate impacts in service to the six principles of the 100% Access Project and returns for our investors; particularly safety net providers who will disproportionately be impacted by recent budget cuts.

## **Access Coordinators – Getting and Keeping People Enrolled in Coverage**

Without CHOICE, we know that some percentage of the uninsured clients we helped enroll in state subsidized coverage may have enrolled successfully on their own. This is probably truer of children enrolling in Medicaid than for Basic Health because of the simplicity of the application, although uninsured children usually live in a house with uninsured adults. This results in multiple applications to get the entire family covered. Data we have received from the Health Care Authority for Basic Health Plan applications show that:

- 98% of CHOICE applications result in enrollment compared to 40% of people who enroll on their own.
- 96% of clients we enrolled were still enrolled in insurance (90% still enrolled in Basic Health) up to three years later compared to 40% who enrolled on their own.

This creates a multiplier effect in two ways: 1) There are higher rates of disenrollment in other parts of the state creating more slots in a managed enrollment situation that our region disproportionately fills; and 2) Access Coordinators have more time to spend on enrollment assistance for new uninsured clients.

## **Access Coordinators – Providing Case Management**

In addition to enrolling uninsured families in state-subsidized programs and working to keep them enrolled, RAP staff provide case management and care coordination for a growing caseload, and more recently, enroll clients in pharmacy assistance programs.

There is national evidence that reducing fragmentation within the health care system through case management for low-income patients reduces the average annual cost of care per person

from \$4,000 to \$3,000<sup>3</sup>. While we don't have local data to quantify the actual savings resulting from RAP's case management services, if we apply national data to the 3,500 clients each year we case manage, this generates annual savings to the theoretical "health system" of \$3.5 million. It is unclear how much (if any) of these savings accrue to local providers or reduce emergency rooms' uncompensated care, but it most likely does reduce some of the stress on the safety net since the majority of our case management referrals come from the hospital ER or primary care practices.

## **Access Coordinators – Reaching the Hard to Find**

In order to reach the uninsured, CHOICE staff make hundreds of outreach contacts with local organizations and participate in a multitude of community events each year. The number of our clients below 65% of federal poverty has grown the last two years, indicating that we are increasingly reaching the "hard to reach" uninsured with complex problems.

## **RAP Fees Leverage More Money Into our Region**

The seven hospitals and Grays Harbor and Mason County (on behalf of Mason County Children's Dental Coalition) Public Health Jurisdictions paid CHOICE \$160,000 to fund RAP this year. This has leveraged an additional \$138,000 in Medicaid match plus \$272,000 in grants and SHIBA/HelpLine (for a revenue multiplier of 2.57). Therefore, CHOICE member RAP fees fund 28% of RAP expenses and the rest (72%) is new revenue that would otherwise probably not flow into our region. Of all sources of revenue, member dues and fees are the most flexible sources for federal Medicaid match.

## **Impacts of RAP fees in 2003**

For an investment of \$570,000 this year (28% paid by CHOICE member organizations):

- Hospitals are estimated to receive \$2.5 million additional reimbursement from health plans based on previous years actuals.
- Mark Reed Rural Health Clinic and PHEC are estimated to receive \$30,000 each.
- The health system saved \$3.5 million through lower direct care costs.
- 190 pharmaceuticals valued at \$11,000 were provided for free to 94 patients in need (in operation only five months this year; annualized amount is \$26,400).

So far this year (nine months), 2,011 uninsured people were assisted with state-subsidized insurance, 260 were recertified in order to continue coverage and 94 clients received pharmacy assistance. An additional 2,126 existing clients received case management, resulting in 4,991 people touched by RAP staff. This translates into a cost per person served of \$85.65 or \$270.06 per application processed.

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<sup>3</sup> David P. Rogoff, Measuring the Return on a Community's Investment Resulting from Providing Access to Affordable Health Coverage; Bureau of Primary Health Care, Health and Human Services July 2003.

Most national research shows a link between having access to coverage and improving self-reported health status from poor or fair to very good and excellent. Studies also show that moving from poor to very good health status increases earning power by 15 – 20%<sup>4</sup>. If you apply a conservative multiplier of 5% in increased earnings, an additional \$4.4 million in buying power was generated to stimulate local economies.

## **Issues Affecting the Future**

CHOICE's number one priority is to expand access to services for 93,000 limited-income residents of our region. Expanding access in an environment of eroding coverage is challenging and the financial impact on public and nonprofit hospitals is a large and looming concern.

### **Basic Health Plan**

Enrollment is currently open for foster parents, Personal Care Workers (COPES) and children, but there is a waitlist for everyone else (started in January 2003). In March 2003 we stopped scheduling Basic Health application assistance appointments, unless we are helping the client apply for pharmacy assistance or sliding fee scale services and need proof they've attempted to enroll in some sort of coverage. We currently have over 500 people on an internal waitlist, 30% of whom we've assisted with pharmacy assistance programs. Statewide, there is a disenrollment rate of 4-5% and with Basic Health's rigorous recertification policy, it is predicted by the Health Care Authority that "a bunch" of new slots will open in November. Access Coordinators are also taking advantage of a small loophole in the Basic Health Plan that allows family members to be enrolled at open enrollment if the children are enrolled in Basic Health Plus. This may be one way for uninsured adults to enroll sooner if the waitlist is not lifted. We have been contacting families on our waitlist to assist them in transitioning their children to Basic Health Plus if they want to take advantage of this opportunity.

Since benefits and cost-sharing change significantly next year for Basic Health enrollees, we anticipate receiving a large volume of calls for assistance from our current clients during open enrollment (Oct and Nov). It will be very important that clients continue to understand the value of their benefits and remain enrolled.

### **Medicaid Healthy Options**

As of April 1, 2003, Medicaid began requiring a signature to be on file for all their applications and proof of income. We are no longer able to enroll children over the phone and must fax the application before it will be processed. This has created much more follow-up for staff to ensure clients are enrolled.

As of July 1, 2003, Children's Medical no longer has 12-month continuous eligibility. Clients' eligibility is now reviewed every six months. This process will increase the amount of staff time required to keep clients enrolled.

### **Medically Indigent Program**

As of July 1, 2003, there is no longer a Medically Indigent Program. Enrollment in the Medically Indigent Program accounts for 6% percent of the application assistance we provide so this will have little impact on our volume, although it will result in less revenue for hospitals, which in some areas will be offset by a new grant program.

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<sup>4</sup> Jack Hadley, "Sicker and Poorer – The Consequences of Being Uninsured; The Urban Institute, June 2003.

## Impacts of Loss of Medically Indigent Program

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	Estimated MI Cuts 2004	Estimated Grants 2004	Net Loss/Gain
Mason General	\$165,004	\$181,063	\$16,059
Morton General	\$31,108	\$34,136	\$3,028
Providence Centralia	\$309,408	\$160,401	-\$149,007
Providence St. Peter	\$1,256,468	\$651,370	-\$605,098
Grays Harbor Community	\$464,524	\$240,816	-\$223,709
Mark Reed	\$14,519	\$0	-\$14,519
Willapa Harbor Hospital	\$55,653	\$61,070	\$5,417
Capital Medical Center	\$251,821	\$130,547	-\$121,274
TOTAL	\$2,548,506	\$1,459,403	-\$1,089,103

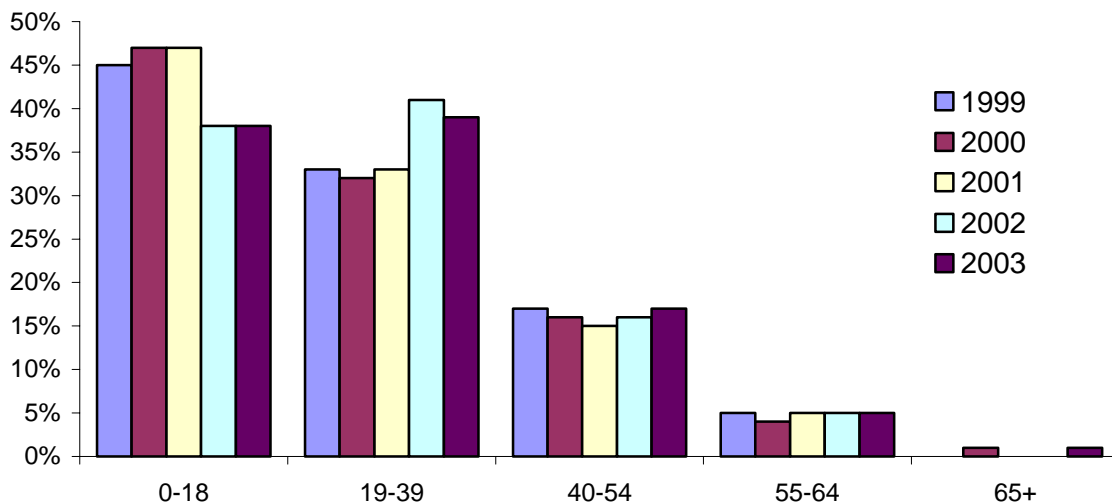
# Who RAP Serves

## Client Demographics

Over time we're seeing slightly more adults as a percentage of total clients, which is probably a direct result of the economic downturn. Of interest is the 19 to 39 year olds who are typically labeled the "young immortals" that won't purchase health care coverage. Our enrollment data consistently shows over time that this is false. We also know that most of them are employed in low-wage jobs that offer unaffordable or no coverage.

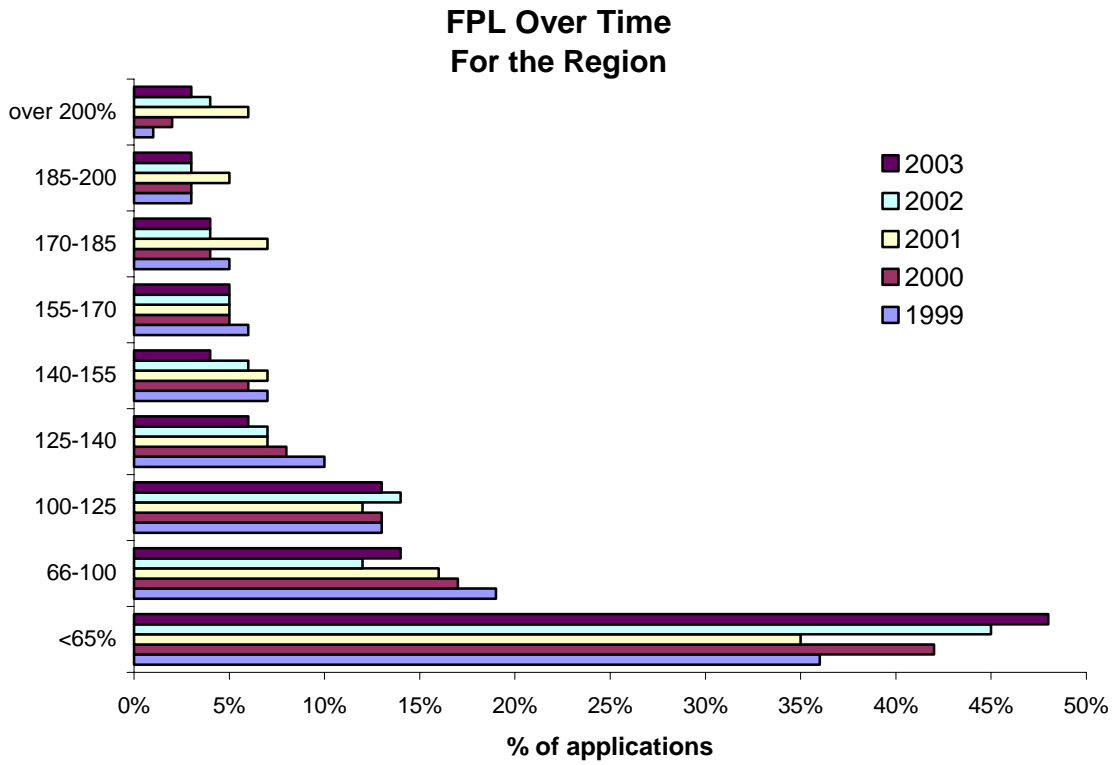
### Age

**Age of Applicants Over Time  
For the Region**



## Need

Almost half of our clients have incomes below 65% of FPL. We've seen a fairly significant increase in the number of very low-income clients in the past year especially in Lewis and Mason counties.



# RAP Services

## What RAP Staff Do

### Enrollment Assistance

- New applications completion, processing and follow-up
- Recertifications and open enrollment
- Pharmacy assistance
- Connection to medical home

### Case Management and Care Coordination (pilots)

- Connection to medical home and other providers
- Complex casework
- Community Resource Referrals (light case management through customer service)

### Marketing and Outreach

- Children's campaign
- Immunization clinics
- Health fairs

### Health Education and Training

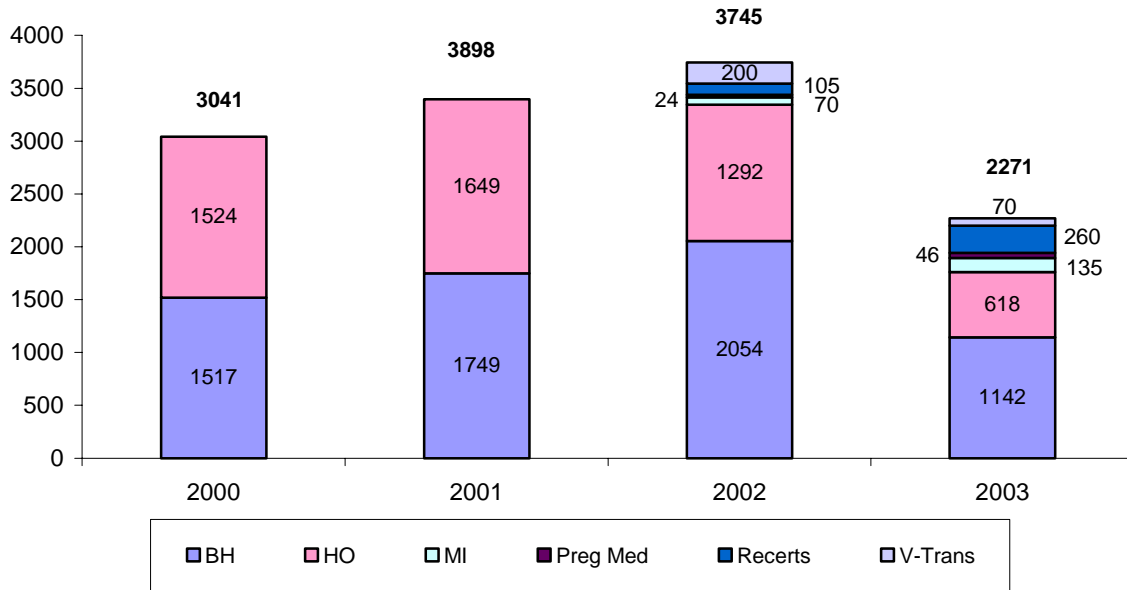
- System navigation
- Chronic disease management
- Cultural competency

## Enrollment Assistance

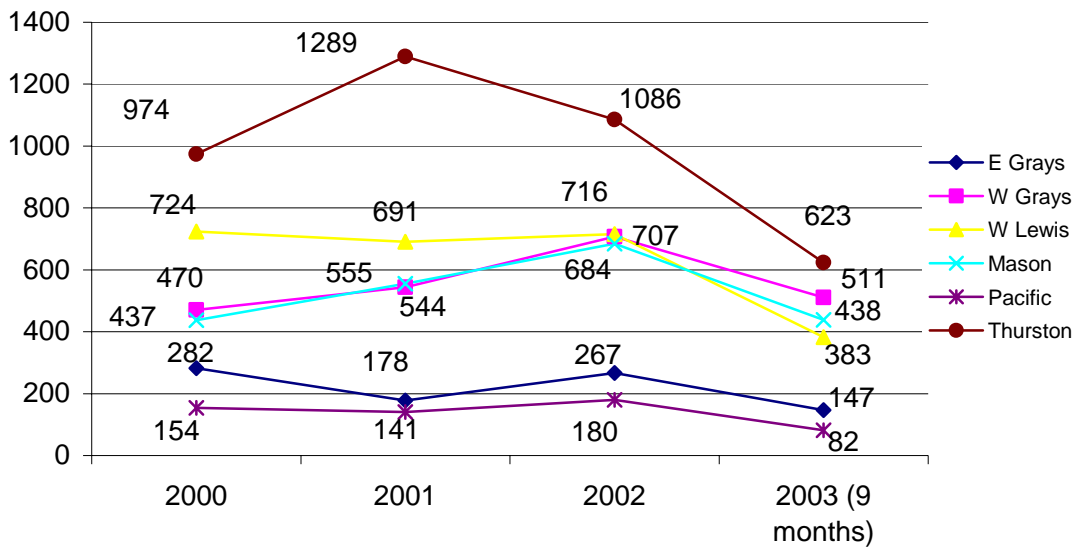
The mix of programs we enroll the uninsured in has changed slightly over time, with Basic Health applicants peaking in 2002. Total applicants are down for 2003 by about 18% (even after adjusting for it only being nine months into the fiscal year). The Healthy Options clients have slightly decreased over time, although we are currently focusing on outreach to uninsured children. The diversity of types of application assistance we do has significantly increased since 2002.

## New Application Assistance Volume

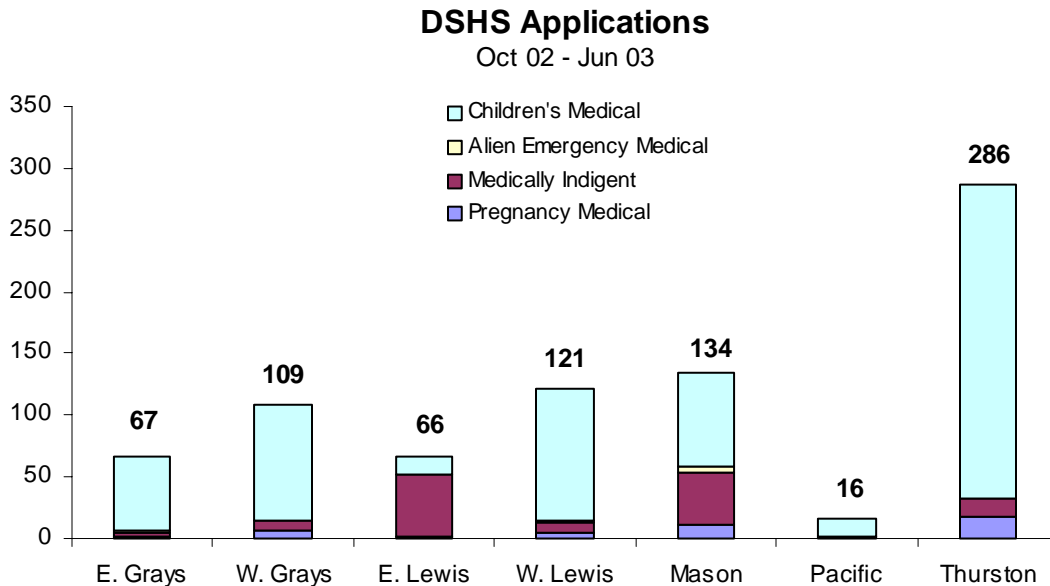
### Applicants Over Time For the Region



### All Applicants Over Time by Site



## Medicaid Applications by Type (a subset of all applications above)



\*E. Lewis tracking began in February

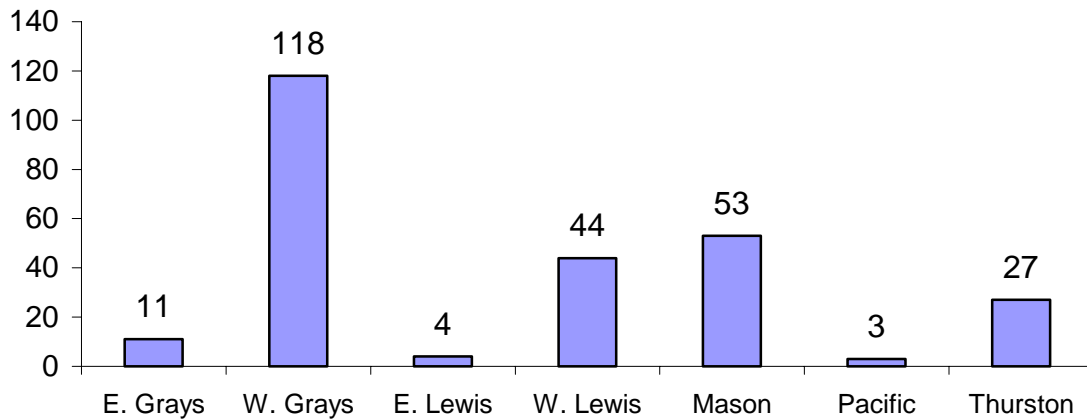
## Keeping people enrolled (recertifications)

We know that to sustain good health measures, those who have insurance must continue to stay enrolled. Access Coordinators work with clients to assure they have followed all the rules to stay enrolled in Basic Health and Medicaid. We track estimated enrollment dates and three months out contact our clients and let them know if they “receive a packet in the mail with flower on it” that it is important and if they want our help with recertification for Basic Health they can call us for an appointment. For Medicaid, we contact clients 45 days prior to their eligibility review date to remind them how important it is to submit the paperwork and offer our assistance if needed.

We also appeal state agency decisions regarding a client's coverage. Over the last six months Basic Health recertified all of their 130,000+ enrollees. This process, combined with a reduction in force, created a processing backlog for the Health Care Authority. Letters of disenrollment were automatically and accidentally sent out to clients who may have already sent in their information but had not been entered into HCA's system due to the backlog. This created a flood of phone calls from panicked clients. We also assist clients in appealing actual disenrollments due to missed payments or lack of understanding.

## Recertifications

Oct 02 - Jun 03



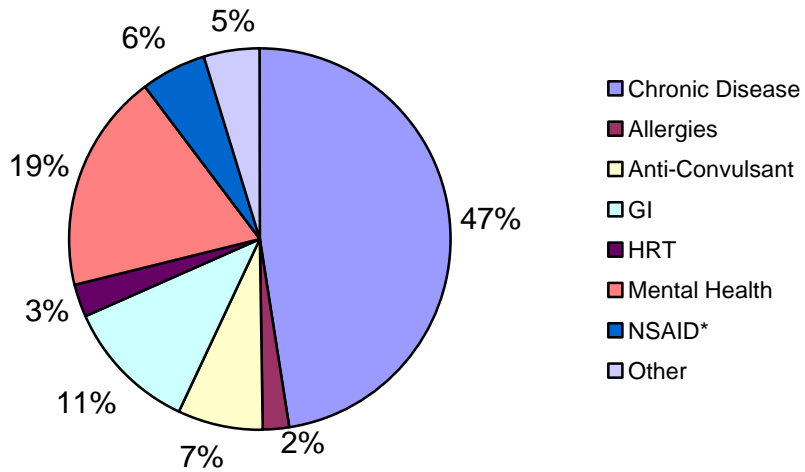
Our best guess for the fluctuation of recertification assistance among service areas is the ratio of Latinos to program enrollment combined with the ratio of program enrollment to total population. The ratio of program enrollment to total population is self-explanatory, but the reason the ratio of Latinos is relevant is that people enrolled without social security numbers are being targeted for recertification.

## Pharmacy Assistance

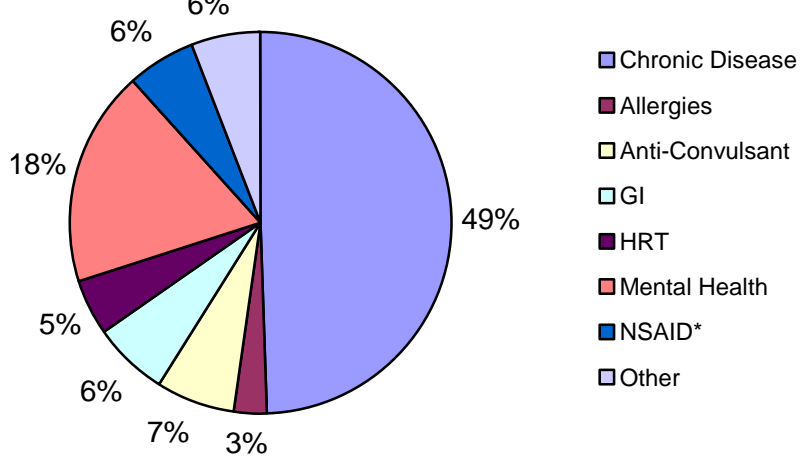
A growing number of uninsured clients are unable to find affordable prescription drugs. Pharmaceutical companies have programs for free or reduced price drugs, but the application process varies by each company and is long and cumbersome for both physicians and clients. Since each client to date has had an average of over two prescriptions to fill (and some have up to 14) Access Coordinators do the administrative work to complete the different manufacturer forms, procedures, requirements and then coordinate with the physician to complete the application. In the last five months we've assisted with applications for 190 prescriptions for 94 clients and a market value of over \$11,254. Most of these are for chronic conditions, and many pharmaceutical companies require that clients reapply every three months creating a need to actively manage a growing caseload.

The most common prescriptions we help clients fill are for cardiac, mental health, diabetes, and asthma diagnosis. In total these account for 67% of the prescriptions. In most cases, the client's inability to pay for these medications would seriously compromise their health and possibly result in an emergency room visit.

### Prescription Value by Type of Medication



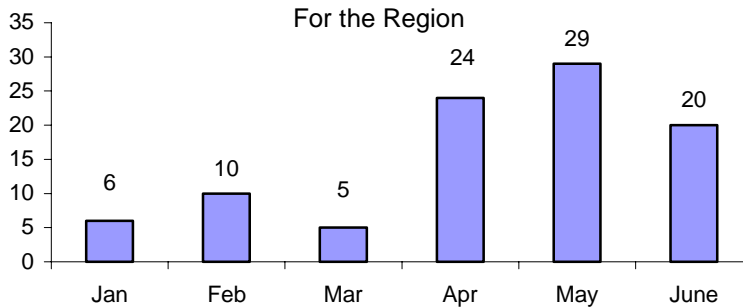
### Health Condition



\*Non-steroid anti-inflammatory drugs

### Rx Assistance

Client Volume by Month  
For the Region



## CHOICE Rx Assistance

January 24 thru June 30, 2003

Prescription Cost	Grays Harbor	Lewis*	Mason	Pacific	Thurston	Region
Allergies	\$118.00		\$59.00	\$38.00	\$38.00	\$253.00
Anti-convulsant	\$342.00		\$12.00	\$32.00	\$429.00	\$815.00
Asthma	\$84.00		\$384.00		\$784.00	\$1,252.00
Cardiac	\$581.00	\$265.00	\$428.00	\$251.00	\$608.00	\$2,133.00
Diabetes	\$586.00	\$364.00	\$421.00	\$74.00	\$515.00	\$1,960.00
GI	\$225.00		\$110.00	\$152.00	\$779.00	\$1,266.00
HRT	\$92.00	\$35.00	\$86.00		\$114.00	\$327.00
MH	\$1,063.00		\$302.00	\$163.00	\$560.00	\$2,088.00
NSAID	\$332.00		\$167.00	\$40.00	\$93.00	\$632.00
Other	\$39.00		\$99.00	\$50.00	\$340.00	\$528.00
Grand Total	\$3,462.00	\$664.00	\$2,068.00	\$800.00	\$4,260.00	\$11,254.00

\*PHEC does Rx assistance for their patients.

No. of Prescriptions	Grays Harbor	Lewis*	Mason	Pacific	Thurston	Region
Allergies	2		1	1	1	5
Anti-convulsant	4		1	1	7	13
Asthma	3		7		12	22
Cardiac	13	5	8	5	11	42
Diabetes	9	5	7	2	7	30
GI	3		1	1	7	12
HRT	3	1	2		3	9
MH	17		7	2	9	35
NSAID	5		3	1	2	11
Other	4	1	1	1	4	11
Grand Total	63	12	38	14	63	190

## Connecting and Stabilizing Medical Homes

With a dwindling number of providers accepting patients with public health insurance or no insurance, Access Coordinators continue to be successful in linking clients to a medical home. This task is becoming more difficult as the number of uninsured clients grows.

### Providers Accepting New Patients

	Healthy Options				Basic Health				Medicaid
	CHP	Molina	Premera	Regence	CHP	GHC	Premera	Regence	
East Grays Harbor	5	3		1	6			8	7
West Grays Harbor	8	5		16	12			12	22
Lewis	21	31			30			25	34
Mason	24	7			24				24
Pacific		6	6	7			9	5	9
Thurston	10	10			10				24

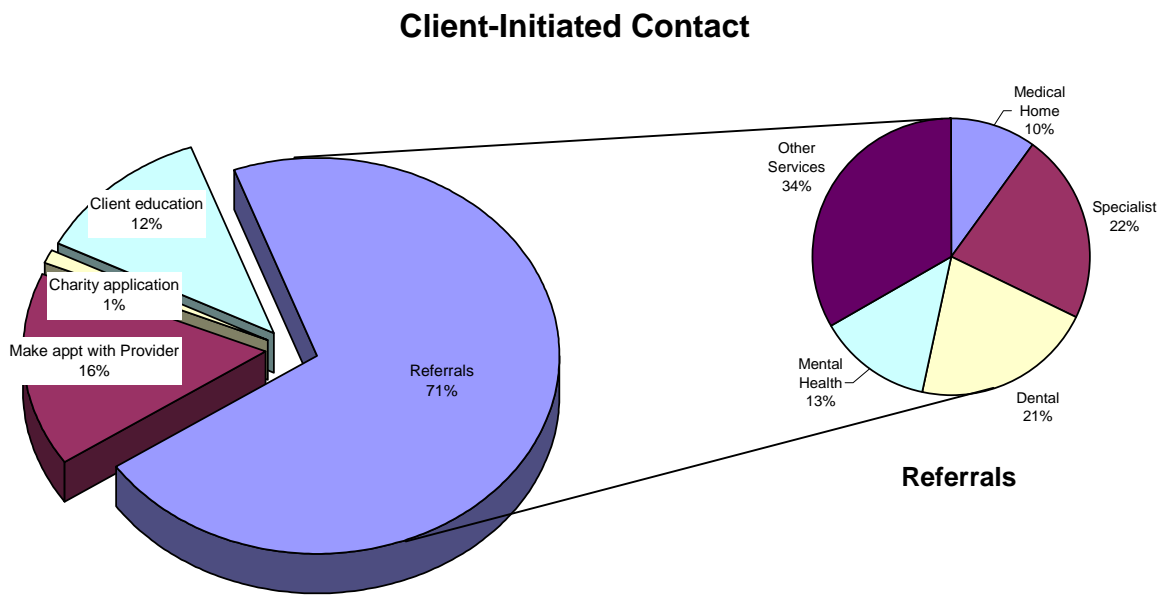
### Providers Accepting Uninsured on a Sliding Fee Scale

West Grays Harbor	Peninsula Clinic
Lewis	Pope's Kids Place Providence Health and Education Center Randle Clinic
Pacific	Willapa Family Medicine
Mason	Health Care Center North Mason Medical Clinic Olympic Physicians Shelton Family Medicine
Thurston	Clinic at West Olympia* Sea Mar Community Clinic

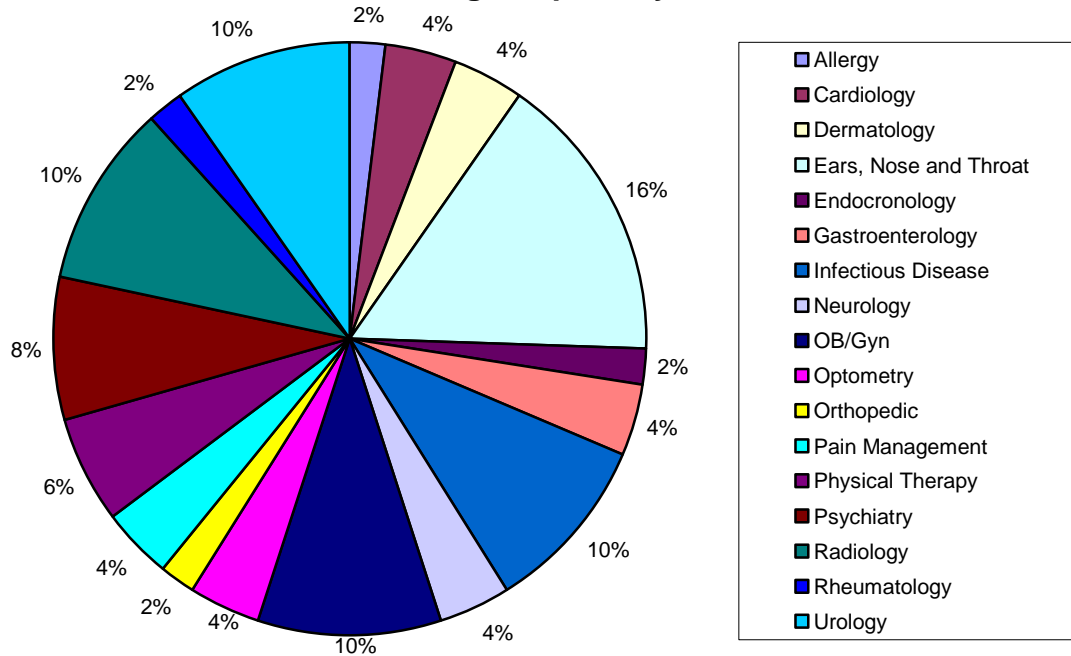
\*offer cash discount

## Case Management and Care Coordination (pilots)

Almost a quarter of all Access Coordinators' time is currently spent on case management. Typical case management facilitates access to direct services such as: finding a primary care provider or specialist, making appointments for medical appointments, reminder calls to go to an appointment, linking clients to interpreting services and in some cases, being the interpreter. Access Coordinators also help clients with other social needs that may be interfering with their health. These services include: finding housing, food, employment, and referrals to other community organizations.



## Arranged Specialty Referrals



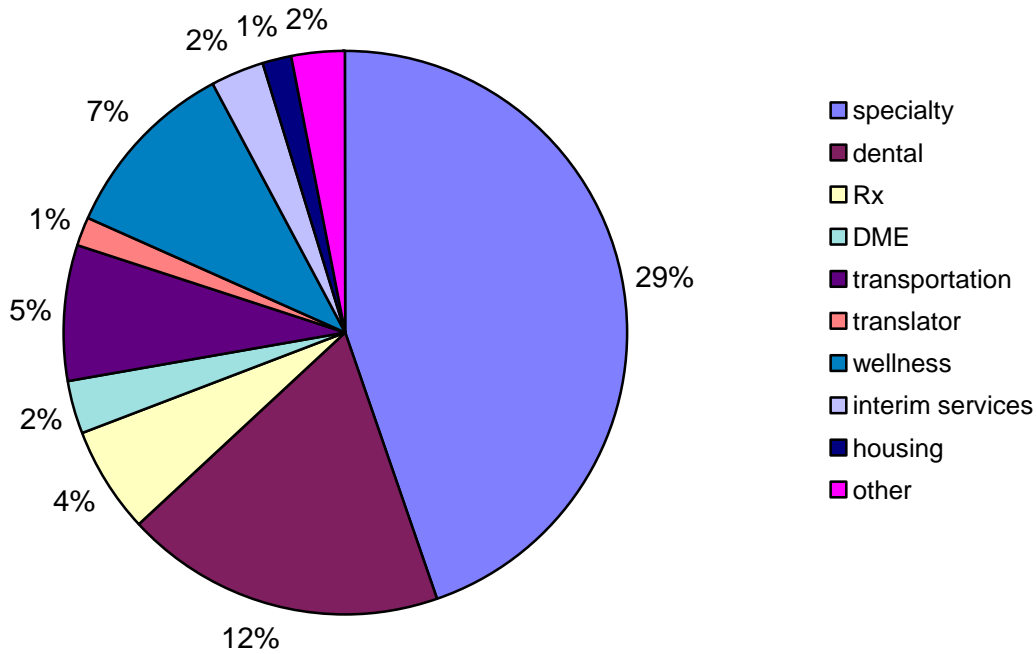
## Care Coordination Pilots

### Care coordination pilots have been educational

Since the Care Coordination program began in December 2001 at five of sites in four of counties, we have learned much that is being used to shape our recommendations for future work in this area to support the 100% Access Project. The Care Coordination pilot phase has ended, and we have incorporated the value-added services into our regular work.

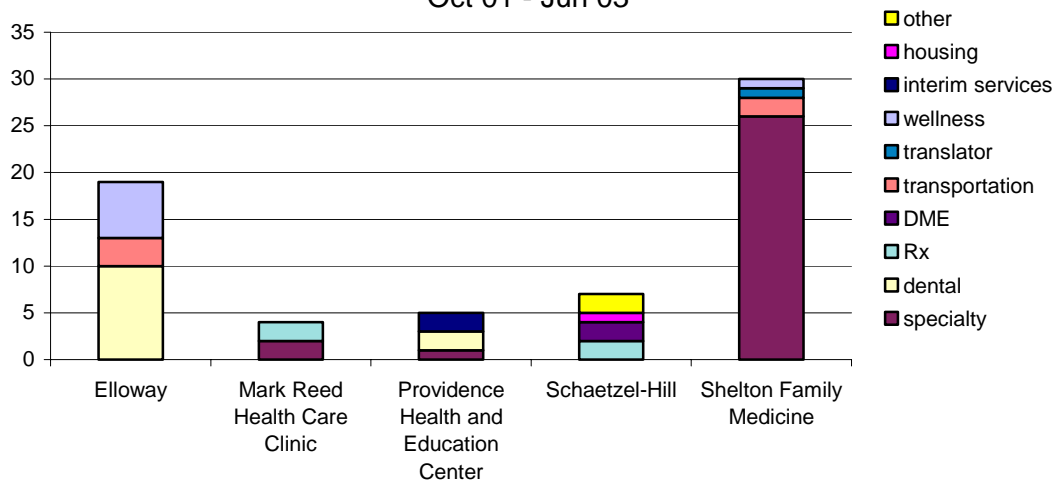
Each of the care coordination sites generated an expanded volume of application assistance referrals but we removed this data since it is part of our routine business and not part of care coordination activities. Specialty referrals make up the largest percentage of referral types. We were able to find specialists for all but one of the specialty referrals (to an orthopedist). Some specialists were out of the region (i.e. Tacoma, Bremerton or Seattle). All dental referrals received services, although some options were distant (i.e. a Lewis or Grays Harbor county client might have to travel to Olympia, Shelton or Tacoma). We also linked clients to support groups, respite care, diabetes education and pain clinics. One client was linked to a computer generated morning telephone call to remind her to take her medications.

### Referral Types for Region



### Referrals by Care Coordination Pilot

Oct 01 - Jun 03



Between December 2001 and April 2003 we received referrals of 148 uninsured patients who use PHEC as their medical home. Access Coordinators were able to complete applications for over

one-third of these referrals. The percentage is low because patients are used to getting free care, which makes it more difficult to convince them to pay a premium even if it is for more comprehensive coverage. However, this work increased PHEC's reimbursement by an estimated \$36,000 (based on prior years actuals).

## **Marketing and Outreach**

Access Coordinators work and live in the communities they represent. In addition to seeing clients at the hospitals and public health departments, they attend meetings with WorkSource, school districts, community service offices (CSOs), civic organizations, Hispanic roundtables, and many more. In addition, Access Coordinators staff special community events such as church-sponsored events, back-to-school activities, booths at community fairs, public health immunization clinics and many other events.

We have recently launched an intensive outreach campaign to enroll children. We contact every school district; distribute local flyers at each school, reach-out to Head Start, and daycares. We also work to get messages about kid's enrollment in hospital invoice statements, and are planning major back-to-school events, including immunization clinics. We have begun a teen outreach program that uses teens to help design materials and get the message out to their peers. We have yet to see whether this campaign is effective in increasing volume. While hard to know, we may have already begun to "saturate the uninsured children market".

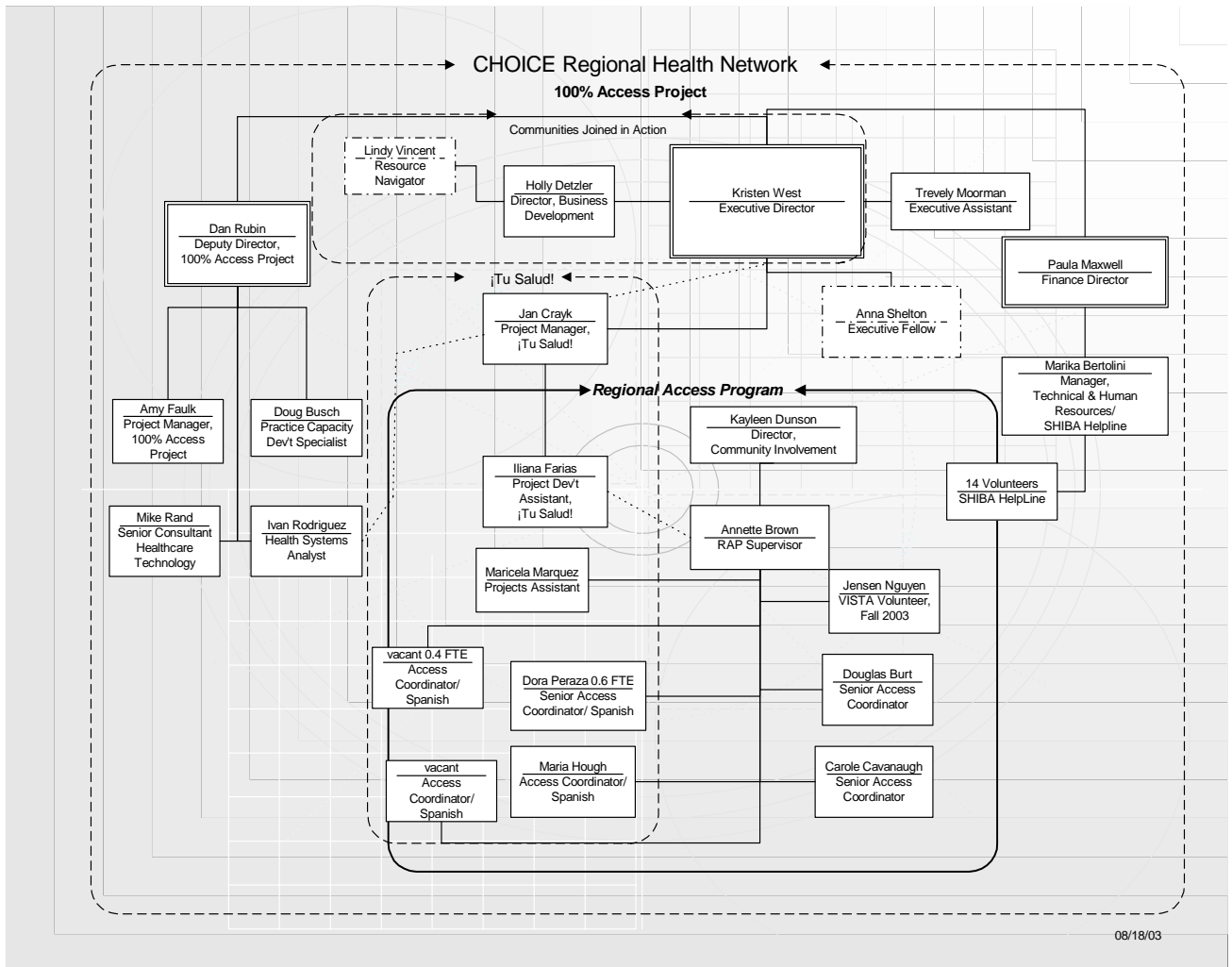
## **Health Education and Cultural Competency**

We know that in order to make any headway in creating healthier communities, people need more education about their own health and how to take responsibility for it. We have made modest investments in providing health education to community members. Our Access Coordinators receive SHIBA volunteer training and provide health information to all clients. We also trained seven lay workers and forty low-income clients about chronic disease management and 253 health care staff in cultural competency.

Because of the relationship that clients establish with their Access Coordinators, it is common for clients to call asking whether they should go to the emergency room given x, y or z symptoms. In the past these were referred to the RAP Program Manager who was a Registered Nurse, or forwarded to Nurse Plus. CHOICE no longer has a clinician on staff and Nurse Plus ceased operations on May of 2003. We now redirect these calls to the client's primary care provider office or other nurse advice lines.

# RAP Staffing Patterns

## Current Organizational Chart



## How RAP Staff Spend Their Time

### Customer Service Center Volume and Type of Calls

Most of the uninsured make their first contact with us by calling one of our 1-800 telephone numbers. During normal work hours, we have a customer service receptionist to answer these calls in person, including someone who speaks Spanish. Our call center sees moderate fluctuations in volume and types of calls. As our cumulative caseload grows, case management

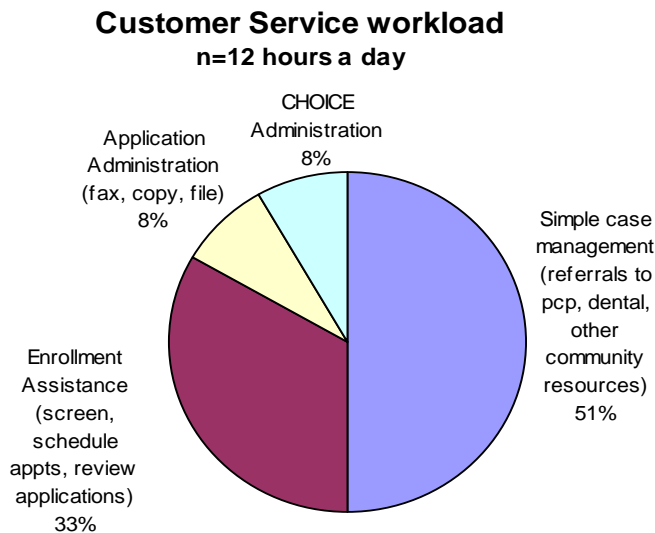
calls continue to rise and 10% of our calls are from LEP-Spanish speakers. Customer Service Representatives spend about two-thirds of their time dealing directly with clients, primarily over the phone at CHOICE (although there are a growing number of “drop ins” at the CHOICE office). Over 30% of their time is spent on enrollment and administrative activities in support of Access Coordinator’s application assistance activities. Less than ten percent of their time is spent on general reception for the entire CHOICE office.

Given how small our call center is a spike of an additional 20 calls in a day can overwhelm our capacity if not actively managed. We try to staff our call center for low to moderate volume, and during volume spikes, Access Coordinators and all CHOICE employees sign up to take shifts for phone coverage until the calls slow down. It’s a corporate norm that answering the phones is the highest priority and that we all need to pitch in if it’s a high volume period.

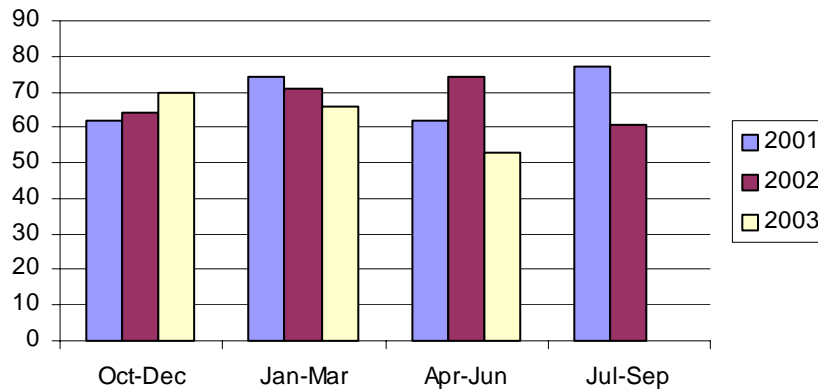
Our largest referral source continues to be “word of mouth” which is effective, but hard to control and grows as our penetration rate increases over time. Some volume spikes are predictable because they are tied to outreach activities initiated by us (such as post cards sent home in children’s backpacks through the schools three times per year). Other volume is generated by the actions of other agencies (sometimes coordinated with us, sometimes not). For instance, during re-certification time; our call center is flooded with requests for assistance.

Seven calls a day continue to be from uninsured adults seeking Basic Health coverage. As of March, we are not scheduling appointments to complete Basic Health applications unless we are enrolling them in a pharmacy assistance program, but we do take client’s contact information and offer to call them when slots become available. We also ask if they have an immediate health issue that we might be able to help with. About 75% do have a health issue that we assist with (such as finding a doctor who will see them on a sliding fee scale and/or arranging for free or low-cost prescription drugs for chronic diseases).

While we are not marketing the pharmacy assistance program until we have the operational systems in place to handle high volume, word of mouth is increasingly generating call referrals specifically for enrollment in pharmacy assistance programs.



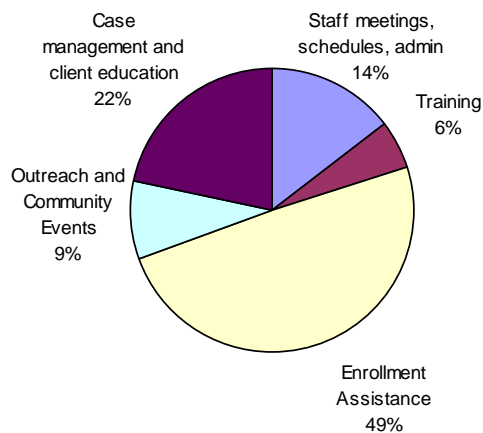
### Call Volume Over Time Average per day



### Access Coordinator Activities

Access Coordinators spend 71% of their time dealing directly with clients in the community. They spend an additional 9% of their time in the community doing outreach. About 20% of their time is spent “in-house” at CHOICE on operational duties (weekly staff meetings, field coverage scheduling, case notes, data entry, replenishing materials and continuing education on state programs).

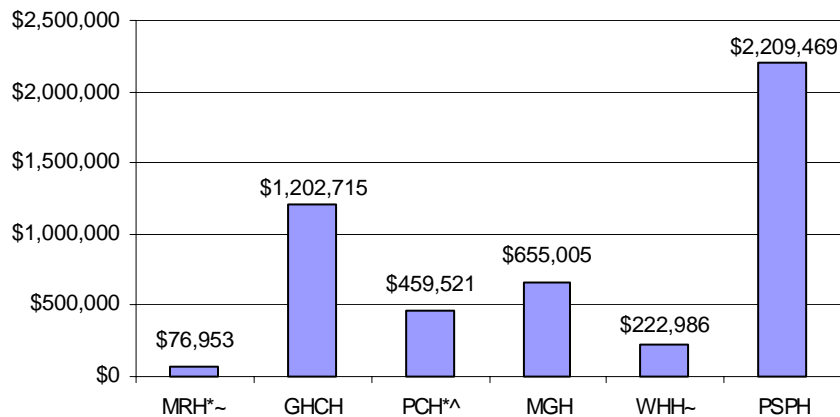
### Access Coordinator workload N=40 hrs a day



# Hospital Return on Investment

While all hospitals have realized the promised 2:1 return on investment, Providence St. Peter Hospital (as the tertiary referral center) has seen the greatest return. Grays Harbor Community Hospital is second (despite its smaller size), because it chose to make an additional investment to expand the level of effort in Grays Harbor County in partnership with the public health jurisdiction.

**Reimbursement by Hospital  
1999-2001**



\*Of the total, \$29,703 reimbursement was to Mark Reed Health Clinic (MRHC) and \$27,019 to Providence Health and Education Center (PHEC).

~No data for 1999.

^The year 1999 was based on seven months of data.

Morton General Hospital has been on sabbatical the last two years.

The 2002 ROI measurement for (October 2001-September 2002) will be done in the late fall of 2003. This allows hospitals up to one full year from date of service to bill and receive payment from state and federally subsidized programs and health plans.

## Reimbursement as a Percent of Billed Charges

	1999-2000	2000-2001
Grays Harbor Community Hospital	46.85%	46.26%
Mason General Hospital	41.84%	46.24%
Willapa Harbor Hospital	46.05%	46.43%
Providence St. Peter Hospital	48.68%	51.48%
Mark Reed Hospital	40.62%	18.88%
Mark Reed Health Clinic	34.44%	41.22%
Providence Centralia Hospital	87.63%	39.32%
<b>Average</b>	<b>49.55%</b>	<b>47.65%</b>