

# 2011 Evaluation\* and Highlights of the Medical Access Program

The Medical Access Program (MAP) was developed in 2007 as a pilot project to create a system of care for the uninsured by leveraging community resources. In Phase 2, initiated in the spring of 2009, MAP sought to improve the system of care through enhanced collaboration, care coordination and technology.

Phase 2 of MAP was supported, in part, by grants from the Department of Health and Human Services and the Northwest Health Foundation.

## Success

More than half of the clients reported that they were “always able to get care for urgent issues when they needed it” and 98% claimed that they had a “personal doctor.” The return on community investment (ROCI) was calculated at **313%**; in other words, for every dollar spent, **\$3.13** is generated back to the community.

## Value of Care

Encounter data for MAP clients is limited to providers who submitted claims; claims submission is optional as this is a voluntary program. The value of care provided to MAP clients was estimated using the March 2010 Oregon Medicaid fee schedule. In the first three years of the program, \$392,000 of donated care was provided; the median sum per client was approximately \$510; and the per-member-per-month value was stated as \$112.

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## Care Coordination

The goal of care coordination is not only to connect patients to medical care and provide guidance while navigating the health system, but to also aid in removing or lowering the social barriers to accessing care. After six months of enrollment in

the program, only 19% reported “finance” as still being a barrier (43% reported this as a barrier during the enrollment screening) and 63% of clients

stated they were “able to see a doctor more than three times for the same condition” (an increase of 24%). This latter statistic illustrates behavior consistent with the use of a medical home. According to the program evaluation, MAP clients are 80% less likely to seek medical care at the emergency room.

The intensity of care coordination is defined by the number of encounters the care coordinator has with a client. Out of 273 enrolled clients, 119 of them are considered to be “high intensity” and 63 are considered “low intensity.” Over time, both the high and low intensity clients demonstrate a need for fewer encounters with client coordinators. This is a key indicator for program sustainability and its ability to serve the uninsured in an effective and scalable manner. As of January 2011, 705 lives have been impacted by the MAP program. 273 clients were fully enrolled into the program and 428 clients were connected to care through MAP.

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\*Evaluation conducted by Health Policy Research Northwest, April 2011



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## Collaboration

MAP is built on the foundation of collaboration in that every available service is either donated or discounted. A large portion of the program infrastructure, including the care coordination, is embedded in existing organizations; the participating

physicians are seeing patients at no cost; and Lane

Individual

Practice Association processes the claims received for services in order to assist MAP in tracking the scope of medical care utilization and the financial value of services provided.

MAP relies heavily on community partners, including our hospitals, medical practitioners, safety net clinics, insurance companies, government agencies, private businesses and non-profit organizations to keep this program growing and thriving.

*98% of MAP clients claimed that they had a "personal doctor."*

*MAP clients are significantly less likely to report emotional problems or pain that interfere with work and/or getting things accomplished after enrollment into MAP.*

## Technology

The MAPCard website is a central community database with full client demographic and provider/care coordinator activity information. Built specifically for this program, it is utilized as the care coordinator software system. This website helps facilitate meaningful connections to healthcare and non-healthcare needs as well as eligibility management, provider tracking and medical home assignment, diagnosis management, prescription list management, and activity log entries.

In the spring of 2010, the MAPCard website was expanded to incorporate a "registrant module" called *Coalition Services*, used to track program referrals of clients who are not eligible for MAP but need community resources such as healthcare safety net clinics, the Chronic Disease Self-Management Program, prescription assistance programs, addiction and chemical dependency treatment, housing, transportation, food security, mental health, and emergency dental services.

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## Challenges

MAP is not an insurance plan; it is a coordination of donated services. To that end, MAP does not process claims or reimburse for clients, therefore, the provider network as well as access to certain types of services or resources is not as robust as it would be if it were an actual insurance plan.



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