

Better Health Takes More than Just Health Care

ANNUAL REPORT 2016

From the CEO



Judith Warren

Dear Friend,

Research has shown a strong connection between wealth and health. In a survey conducted by Harris Interactive in 2011, more than 4 in 5 physicians surveyed (85 percent) said unmet social needs are directly leading to worse health for all Americans. The 2013 Greater Cincinnati

Community Health Status survey found that 15 percent of Greater Cincinnatians said someone in their household did not receive a doctor's care because the household needed the money to buy food, clothing, or pay for housing. For those at 100% or less of the Federal Poverty Level, 1 in 3 (33 percent) said someone in their household did not get care for this reason, compared to only 6 percent of those at 200 percent of poverty or above. According to the 2013 State of American Well-Being from Gallup, our region ranks 142nd out of 189 in the nation.

Since 2009, Health Care Access Now (HCAN) has provided comprehensive care coordination and support to individuals who lack the social, emotional or financial resources to advocate for their own health and well-being. HCAN works with health plans, health systems, physicians and other service providers to achieve better health outcomes and lower costs. Our Certified Community Health Workers (CHWs) are on the front line, supporting our clients through regular contact and helping them navigate the health care system and social service systems so that they can overcome barriers to getting the right care and support. It's about going to the right place at the right time. This report provides a brief summary of the work of HCAN's care coordination programs for the 671 clients we served in 2016.

We thank our clients who give us the opportunity to serve them; our partners and collaborating agencies who come together so that we can maximize the use of resources; and our funders who invest in our work.

Judith Warren, MPH, CEO



The HCAN staff meets regularly to share insights to help them improve services to clients.

2016 FUNDERS

Bethesda Inc.
City of Cincinnati Health Department
Greater Cincinnati Foundation
Ohio Commission on Minority Health
PNC Community Development
Spaulding Foundation
United Way of Greater Cincinnati
The Wohlgemuth Herschede Foundation
Xavier University
Private Donors

BOARD OF DIRECTORS

Myrita Craig, Chairperson
Keith Caldwell, Treasurer
Karen Mueller, Secretary
Kim Patton
Robert Steven Kahn, M.D.
Robert Collins, M.D.
Penny Pensak
Gregory P. Rogers, Esq.

Pathways to Health: Transforming Chronic Care Coordination and Medical Education



Helen Koselka, M.D.

In 2016, Health Care Access Now received a \$1.75 million, 3-year grant from Bethesda Inc., a co-sponsor of TriHealth. HCAN will work in partnership with the TriHealth Good Samaritan Hospital Faculty Medical Center (FMC) in their Internal Medicine clinic, to improve chronic disease management in patients. The project also will work towards enhancing the quality of resident education both in the delivery of team-based primary care and in the outpatient management of medical conditions that account for increased health care costs and poor health status and quality of life.

Health Care Access Now has embedded a team of Community Health Workers (CHWs) to work with the medical residents rotating through the clinic. The attending physicians and designated physician leaders provide a valuable connection. The FMC identifies patients who need the support of the CHWs – those who have multiple chronic conditions and who have had frequent hospitalizations and emergency room visits within the last 12 months.

The program is still in its early stages. The first patients were enrolled in October 2016, and to date 75 clients are currently receiving care coordination services. The goal is to enroll 480 patients over the three-year period of the grant.

Key outcomes for FMC patients enrolled in the program include:

- Patients are linked with relevant social/community services to resolve risk factors/barriers to care.
- Patients will routinely use MyChart to access their medical records.
- Patients will reduce emergency room visits and hospitalizations.
- Residents learn how to work in an interdisciplinary team setting and understand the role of Community Health Workers as a community extension to their practice.

Helen Koselka, M.D., Executive Medical Director of Good Samaritan Hospital and Chair of the Department of Medicine, explains, "As much as our residents and physicians make the right diagnosis and prescribe the right drugs, we're not able to improve the overall health of our patients if they have socioeconomic needs that we can't fix." Embedding CHWs at the FMC to work directly with the residents and physicians enables a team approach to address all of the patient's needs. **"When we start meeting patients where they live and understand the situations they are in, we can then identify the barriers to care and find solutions."** Hopefully this will be how you actually finally move the needle in health care delivery and outcomes."



Angela C. Dawson (left), Executive Director of the Ohio Commission on Minority Health, and Judith Warren at the 2016 Minority Health Month Expo in Columbus.



The HCAN staff are the ones who make it happen for our clients.

Gerald Lowe

On his way to better health management

Gerald Lowe is 73 years old and started the Pathways to Health program in November. He has congenital heart failure, a pacemaker, vascular disease and other health issues. "His doctor recommended him to be in the program," says his wife Mary. His doctor is Angel Mena, M.D., at Good Samaritan Hospital. "It is really helping," he says.



Shane Satterfield (left), talks with Gerald and Mary Lowe about how things are going with Mr. Lowe in Pathways to Health.

As part of the program, Shane Satterfield, one of HCAN's Chronic Care Coordination Supervisors, calls Mr. Lowe every two to three weeks and does monthly face-to-face visits. During one home visit, he learned that Mr. Lowe was not taking a prescription medicine because his insurance wouldn't cover the cost. Satterfield worked with Mr. Lowe's doctor to get medication that was covered. Satterfield learned that a home visit for a wound dressing was scheduled for weeks later than needed, so he worked with the provider to get the visit moved up to a more appropriate time frame.

Before joining the program, Mr. Lowe went through a period where he kept falling and was going to the emergency room weekly for care. Since he has moved to a better home and been working with the program, "I'm doing a lot better," he says. Satterfield says, "Often folks 'run into a wall' when trying to work with providers. We teach them how to work with their providers so they stay engaged in their care. We walk them through the steps, not just giving them the information and telling them to go do it. We get them to the point where they know how to help themselves." Says Mr. Lowe, "Shane is doing a great job."



Xavier University's MHA graduate students selected HCAN to develop a proposal on behalf of HCAN's Pregnancy Care Coordination Program for the purchase of portable cribs. Thanks to these students, HCAN was awarded a \$1,000 grant! Pictured are Lauren Sweeny, Joe Hayden, Caren Burger (HCAN), Rachel Helt, Shan Qureshi and Angela Sims.



HCAN partners with the YMCA in the D4P program.

Diabetes Care Coordination:

D4P: Targeting consumers at risk for diabetes and D5Alive!: Improving diabetes management for those with diabetes

Health Care Access Now offers two programs that focus on decreasing the impact of diabetes among adults: D4P, which focuses on prevention and reducing risks of developing diabetes, and D5Alive!™, which focuses on diabetes self-management. In 2016, 47 clients participated in the D5Alive! program; 96 clients participated in D4P.

In D5 Alive! HCAN's Community Health Workers provide education and coaching; assist with finding medical & community resources and go to doctor appointments with clients as needed. Community Care Coordinators work with physicians, certified diabetes educators, social workers and other agencies to bridge the gap in understanding diabetes and make sure that consumers are actively involved with their care. Clients are referred by the UC Health – Hoxworth Clinic. Chief Resident Nabeela Siddiqi, M.D., says the program benefits the residents who care for the clients as well as the clients.

"The residents get a chance to be involved in the patient's care outside of the office through the program. The patients are able to get assistance with their disease in their daily lives and have someone who can spend some more time with them and help them with community resources to manage their diabetes."

HCAN's D4P program refers individuals to the YMCA's Diabetes Prevention Program (DPP), an evidence-based community health program offered in Ys across the U.S. Program benefits include enrollment in the YMCA's DPP and a 6-month YMCA membership to help clients meet their program goals. The program is facilitated by trained YMCA Lifestyle Coaches. Clients attend weekly Healthy Lifestyles group sessions at one of the YMCA

branch locations. Kiana Trabue, M.P.H., Executive Director of Community Health for the YMCA of Greater Cincinnati, says of HCAN's participation in D4P, "We know diabetes is an epidemic nationwide, statewide and in our local community, so it's important for us to provide resources for people so they can prevent diabetes." The benefit of working with HCAN in this effort, she says, is "The Community Health Worker provided by HCAN adds an additional layer of support and another resource that is not part of our program, allowing individuals to be more successful." Results for 2016 clients show that more than half of the clients (58 percent) have lost weight in the program, and after 9 months, more than 8 in 10 (86 percent) reported 90 minutes or more of physical activity each week.

D4P is funded by the Ohio Commission on Minority Health. D5Alive! is funded by United Way of Greater Cincinnati.

D5ALIVE! OUTCOMES:

Clients Enrolled More than 3 Months

	At least 1 ED visit/ hospitalization 3 months BEFORE enrollment	Fewer ED visits/ hospitalizations AFTER enrollment	No ED visits/ hospitalizations AFTER enrollment
Impact on Emergency Department Visits	88%	75%	46%
Impact on Hospitalizations	73%	54%	67%

For clients enrolled in the D4P program for more than three months, we have seen a consistent decrease in A1c levels:

D4P STATISTICS:

Clients Enrolled More than 3 Months*

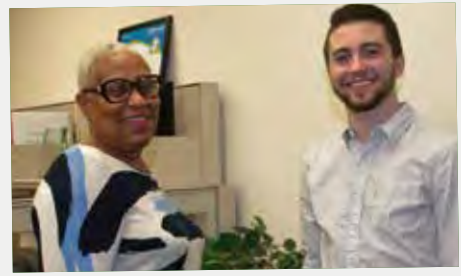
	3 months	6 months	9 months
Number of clients who decreased A1C	16	14	4
% who decreased A1C	52%	82%	67%

**National data document that for every 1 percent decrease in A1C, there is a significant decrease in the likelihood of acute and long-term health conditions such as stroke.*

Gwendolyn Madaris

A D4P Champion

Gwendolyn Madaris completed the D4P Chronic Care Coordination Program recently after joining with her cousin a year ago. Everyone in the group had been diagnosed with pre-diabetes. Once joining the program, they met monthly with a care coordinator who helped them understand diabetes and encouraged them to get actively involved in their care. Tim Frey, HCAN's Community Care Coordinator, said, "Gwendolyn was already doing a great job when I started working with her in September. But we worked together and I tried to be a support system for her, and I've enjoyed seeing her continue to be successful, because she's made permanent changes in her life."



Gwendolyn Madaris with Community Care Coordinator Tim Frey.

Ms. Madaris started to get sick after a cruise. After tests, she was diagnosed with sarcoidosis on her lung and liver. As a result of the sarcoidosis, she now has rheumatoid arthritis, as well as other health issues. She weighed 257 pounds initially and wore size 22, and at one point swelled up to 300 pounds. Her weight was also affecting her health. Now she's down to about 200 pounds and very happy with her body. Her blood pressure has become more consistent and her last A1C level was a 5.6%, below the pre-diabetes range that she started in.

The program taught her how to eat differently. She said, "I took pop out of my life for the past year. I watch my fat intake, calories and sodium. I always drank water, but I drink even more now. I allow myself to eat sweets, but in moderation." As part of the program, participants join the YMCA, where Ms. Madaris worked out and did water aerobics. Now she tries to be active whenever she can.

Ms. Madaris loved the program so much she's referred several people who have joined and has re-enrolled herself. "The program has done wonders for me," she said, "and I'm really motivated to keep up my good habits so I will continue to look good!"

Larry McKay

Overcoming the challenges of diabetes

Larry McKay, 64 years old, is part of HCAN's D5Alive! Program. He was referred to the program by his doctor at UC Health, David Foote, M.D., after being diagnosed with diabetes last year. Choya Key, HCAN Community Care Coordinator, worked with Larry to help him set goals: eating better, giving up alcohol and finding an apartment.



Choya Key visits with Larry McKay as he prepares to move to his own apartment.

Larry has a bad heart and high blood pressure, and has been at Oak Pavilion Nursing Care Center since last summer. When he found out he had diabetes, his glucose levels were in the 300s; now he's down to 100. Larry gets regular injections of insulin and soon will be doing those himself. Choya connected him with Home Choice, and now he's getting ready to move into his own apartment. His blood pressure is lower now, too.

Larry says, "I make sure I take my medicine the way I'm supposed to every day, and I'm eating better, too. Choya talks to me about how to make healthier decisions and how to take care of my body." Key says, "I've also gone to a few of his doctor's appointments to help him communicate with the doctors."

Getting physical therapy for a bad leg also helped his everyday life. He's no longer in therapy and is getting diabetic shoes to help him walk better.

Larry is very happy with his results so far and feels that his attitude about taking care of himself has really improved. He plans to stop drinking alcohol and hopes to continue his good eating habits once he's on his own and in his new home. Choya will remain in contact with him on a monthly basis to make sure he's settled into his apartment and is setting self-management goals that are practical for him.

Pregnancy Care Coordination: Achieving Better Birth Outcomes in Hamilton/Butler County



Angela Nowden (right), CHW at Crossroad Health Center, and Pregnancy Care Coordination client review educational information.



Caren Burger, RN and CHW at HCAN (left), conducts a home visit with client.



Charlessa Davis (right), Pregnancy Care Coordination client, and her daughter Kimirra.

In 2016, 501 clients were part of the Pregnancy Care Coordination program, and 346 gave birth during the year. Working in partnership with Healthy Moms and Babes, the City of Cincinnati Health Department and Crossroad Health Center, we target neighborhoods in Cincinnati/Hamilton County, and Butler County (West Chester, Fairfield and Hamilton) where infant mortality and preterm births average more than twice the state or national average.

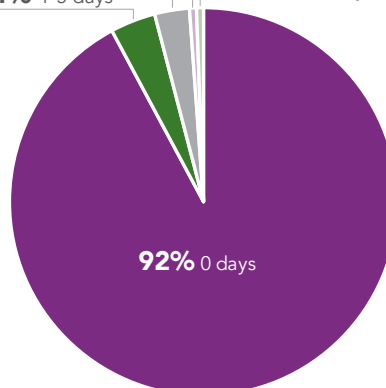
HCAN offers a consistent approach for care coordination provided by Certified CHWs who are employed by our Care Coordination partner agencies, using a nationally recognized approach, known as pathways, that targets the social, environmental and financial barriers that result in delays in seeking care early and consistently. The CHWs provide essential support for moms, addressing the medical and social determinants that can severely hamper a pregnant woman's ability to concentrate on having a healthy baby. HCAN coordinates case management connections with the Medicaid Managed Care Plans to ensure that moms access plan benefits. HCAN also facilitates referrals from prenatal providers when they identify patients who are missing appointments or lack a support system during their pregnancy. After delivery, CHWs remain connected with moms to verify that mom and baby have a medical home.

Pregnancy care coordination outcomes demonstrate positive results. **Our clients average 10 prenatal visits, and nearly 8 in 10 established a medical home for the baby after birth.** Our goal is to connect with moms during the first trimester... get care early and often! Of the moms who delivered in 2016, 84 percent of the babies born were normal weight, and 85 percent were full-term births.

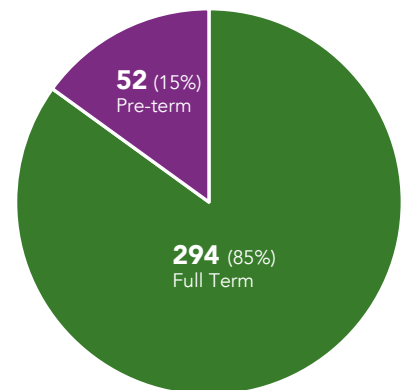
We also recognize the importance of mental health and well-being. All clients are screened for depression and substance abuse, and connected to local counselors and therapists if necessary.

NICU Days 2016

3% 6-20 days
0.6% 21-45 days
4% 1-5 days
0.6% 46-90 days



Birth Outcomes 2016



PROGRAM PARTNERS



Charlessa Davis

Working towards a healthy baby and well-being

Charlessa Davis, mother of a school-age daughter, is four months pregnant and in the Pregnancy Care Coordination Program. She was referred through her clinic at The Christ Hospital. Ella Thomas, Care Coordination Supervisor, is her community care coordinator. Thomas provides support and assists her with finding resources that will help her through her pregnancy. Thomas first met with Ms. Davis at home. Now they have monthly visits where Ella goes over important information and checks in with Ms. Davis' providers regarding her care.



Ella Thomas (left) and Charlessa Davis are working together to ensure Charlessa has a healthy newborn.

Ms. Davis says, "During my first pregnancy, I didn't know I was pregnant until my fifth month. My blood pressure was sky high. I also have a manic-depressive disorder that I have to monitor.

This pregnancy, I'm trying to stay healthy and keep my blood pressure down. And I know that if I have a problem or need to talk, I can give Ella a call. I feel very comfortable talking with her."

"Pregnant women need to know it's OK to put themselves first," Thomas says, "We provide them with support and encourage them to invest in themselves, and that is what Charlessa is doing. She is focused on meeting her goals, taking care of herself and her family and getting ready to go back to school for her GED."

Although her daughter Kimirra was hoping for a baby sister, she's excited for her baby brother, and said, "Mama, I'm gonna love him like you love me."

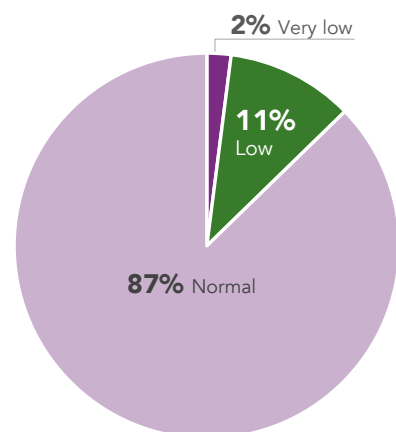
HCAN Collaboration with Cradle Cincinnati/ Ohio Department of Medicaid Partnership

Health Care Access Now (HCAN) will serve as the community hub for referral distribution of clients received from centralized intake for four medical and social service providers and United Way 211 to recruit and enroll women in HCAN's Pregnancy Care Coordination services. A key asset of our Pregnancy Care Coordination is a centralized information management and reporting system that is designed to track service activities, client progress and outcomes data. This feature of the county initiative will offer a secure and streamlined process to achieve the best in care coordination and quality assurance.

Better Care: Staying Current

Starting in 2017, HCAN will coordinate and offer continuing education (CE) workshops to ensure that CHWs maintain and enhance their professional skills and knowledge. Our goal is to promote professional or technical development that ensures CHWs are recognized as an integral part of improving the health and well-being for our region's under-resourced consumers.

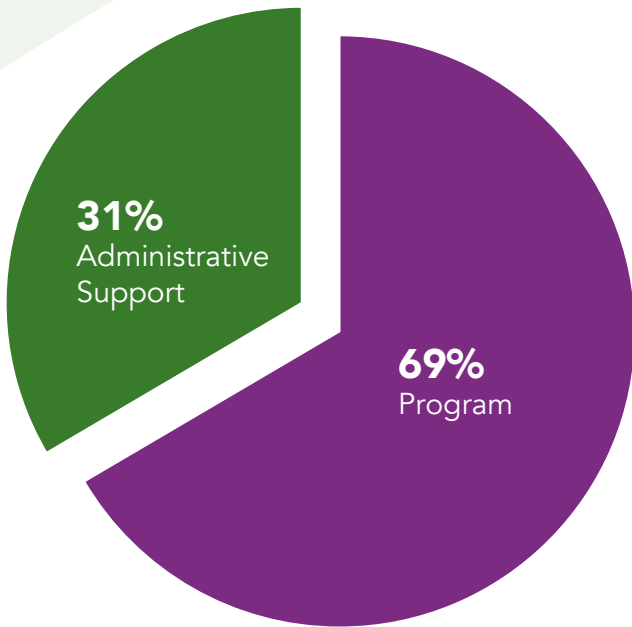
Birth Weights 2016



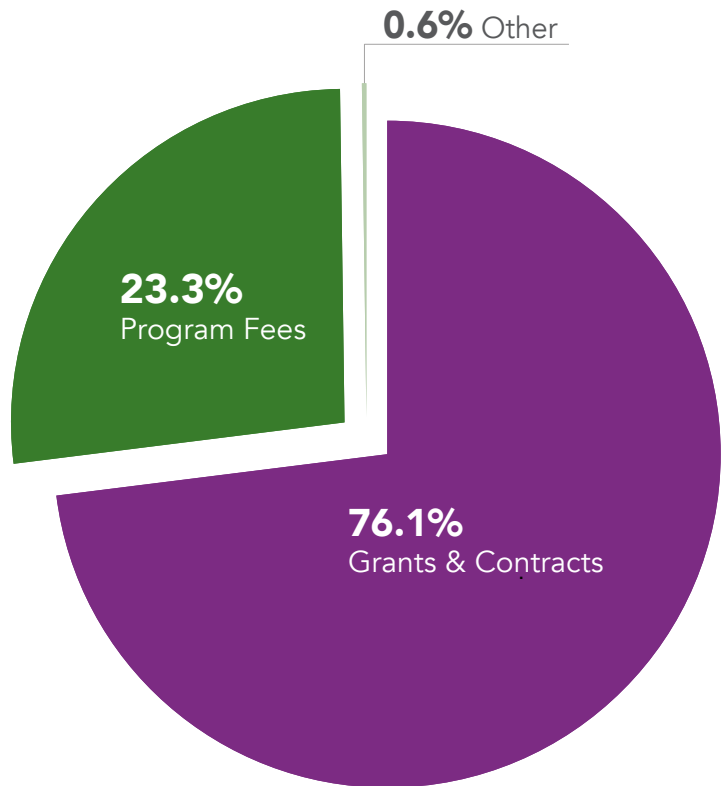
Note: This chart includes all babies, including twins, etc. For singleton births, 91 percent of babies were normal weight.

Financials


Total Expenses: \$1,036,650



Total Revenue: \$1,045,239



Health Care ✓
Access Now

 Like us on Facebook at:
www.facebook.com/healthcareaccessnow

 Follow us on Twitter at
<http://twitter.com/hcancincy>

7162 Reading Road, Suite 1120 | Cincinnati, OH 45237
www.healthcareaccessnow.org | 513-707-5696