TAP

The Access Partnership Research Discussion

March 24, 2011

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MEDICINE

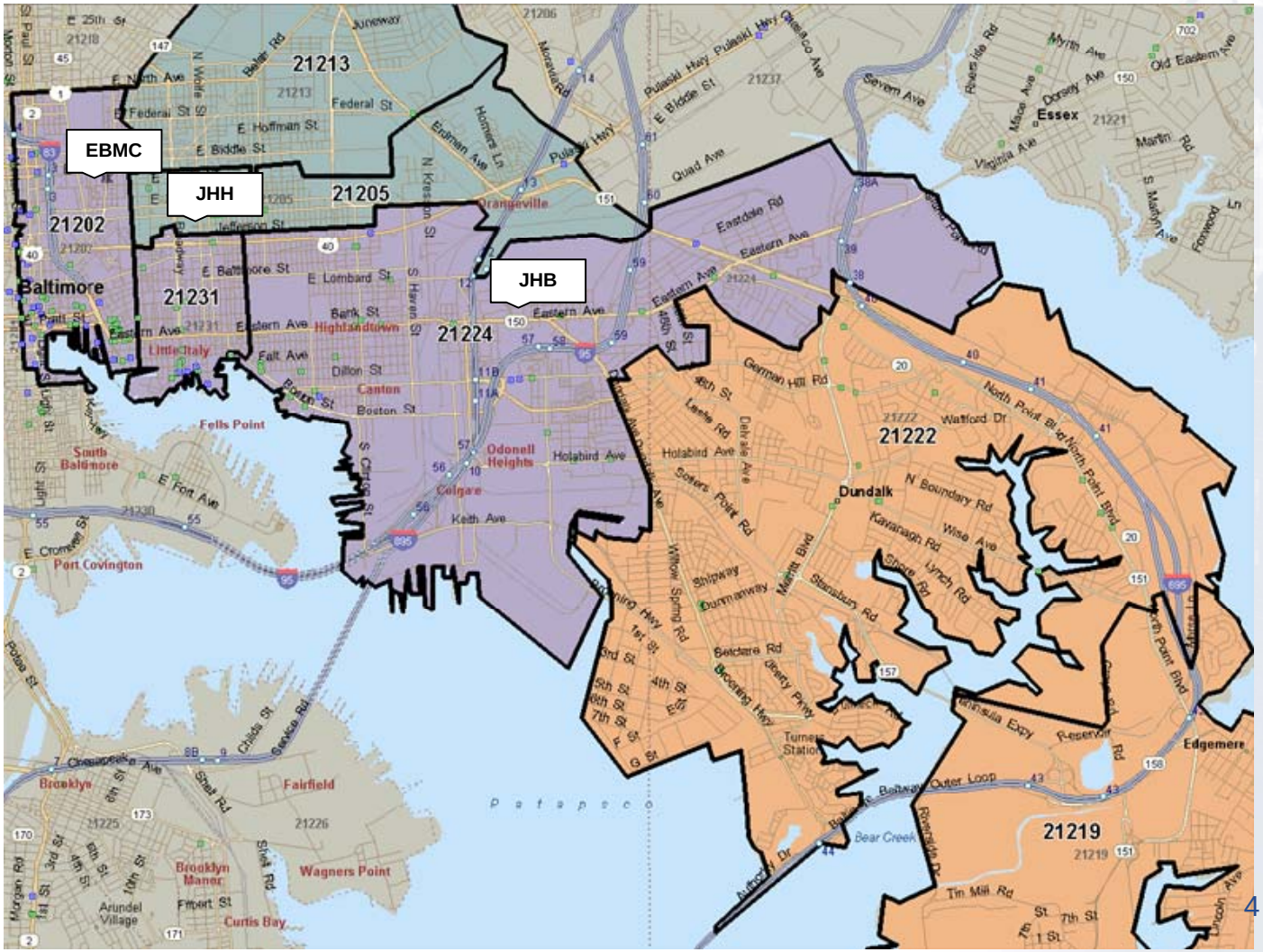
TAP Mission

To improve access to effective, compassionate, evidence-based health care for uninsured and underinsured patients in our community with demonstrated financial need.

Who is eligible?

- Hopkins primary care patient
  - Until recently this meant EBMC; with expansion this includes JHOC GIM, Bayview GIM, CMP and CCP
- Uninsured or Underinsured
  - Underinsured primarily means PAC
- Demonstrated financial need
- Reside in zip code:
  - 21202, 21205, 21213, 21219, 21222, 21224, 21231.

Eligible Residents



Zip Codes:

21202
21205
21213
21219
21222
21224
21231

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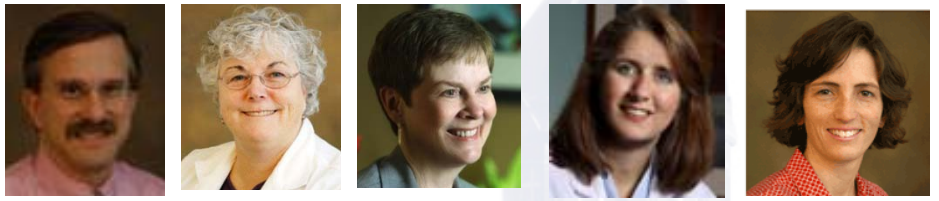
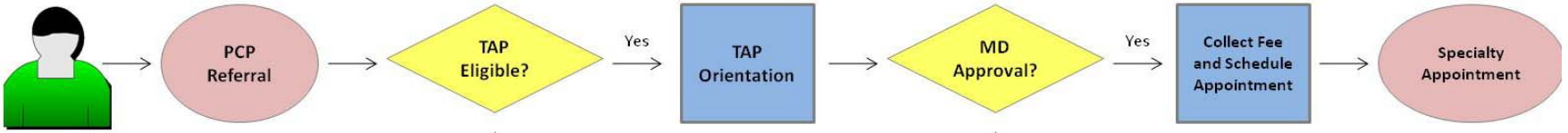
Key Components

- Navigator: TAP removes financial barriers to care and provides assistance and support to patients in scheduling and attending appointments.
- TAP fee: All patients commit to the process by paying $20 upon enrollment.
- Medical Director: reviews all referrals to ensure that care is delivered in the most appropriate setting

TAP Process





Hopkins Primary Care Patient
Uninsured/PAC
Seven Zip Codes

East Baltimore Medical Center
JHB Children's Medical Practice
JHB Comprehensive Care Practice
JHH General Internal Medicine
JHB General Internal Medicine

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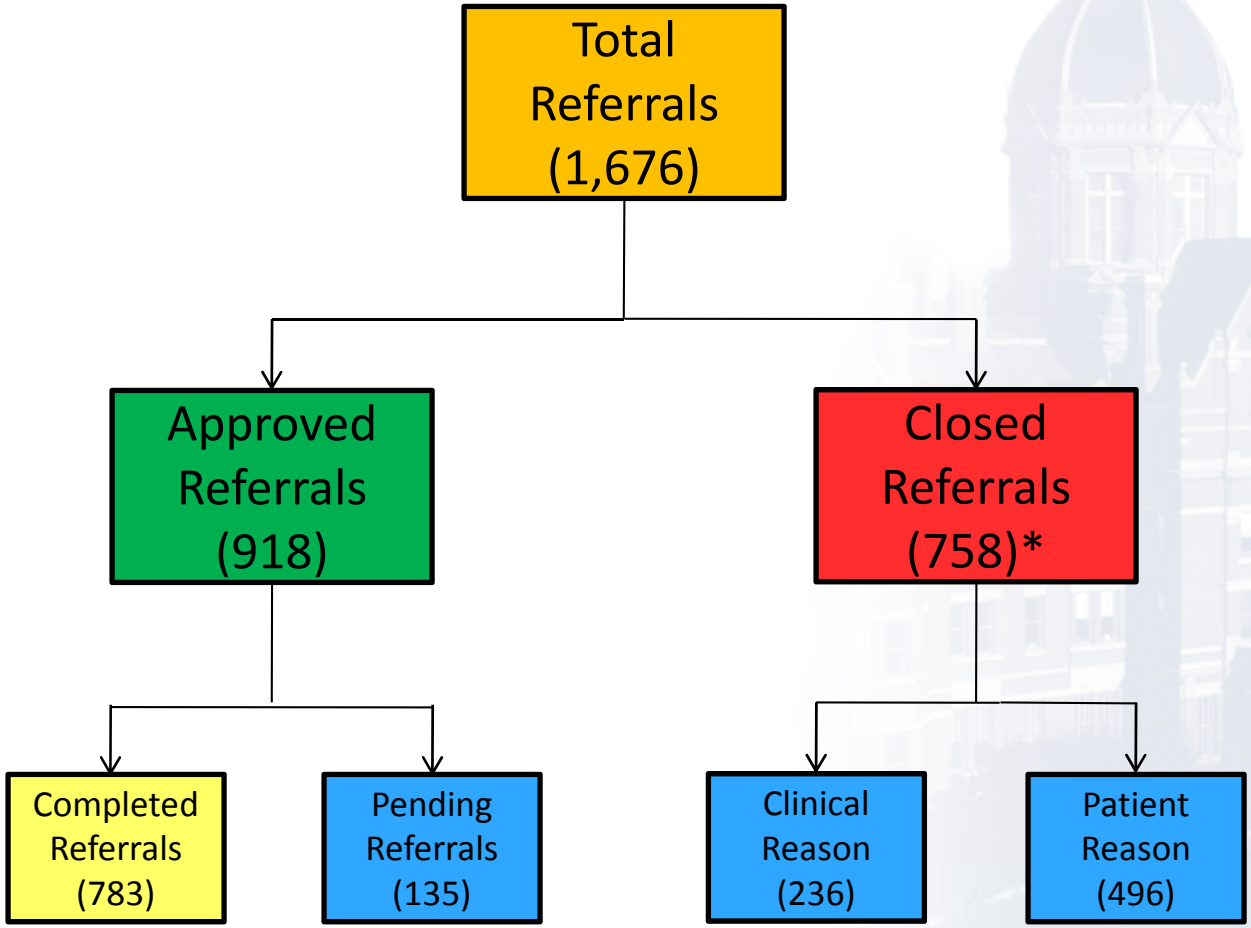
Specialty Referrals

May 1, 2009 through February 28, 2011



* There are 26 referrals that remain to be classified as a 'clinical reason' or 'patient reason.'

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TAP Unique Patients

May 1, 2009 through February 28, 2011

Description	Count
Patient with Completed Referrals	347
Patient with Closed for Patient Reason Referrals	204
Patient with all Pending Referrals	87
Patient with Closed for Clinical Reason Referrals	52
Total Unique Patients	**690**

TAP Charges

May 1, 2009 through February 28, 2011

Specialty	Hospital	CPA	Total
Surgery Subspecialties	354,098	219,269	573,367
Medicine Subspecialties	263,677	105,252	368,929
Radiology	151,849	115,984	267,833
Anesthesiology	14,201	97,914	112,115
Ophthalmology	31,795	17,077	48,872
Lab and Miscellaneous	3,471	29,524	32,995
Physical Medicine and Rehab	18,853		18,853
Psychiatry	10,148	1,034	11,182
Total	**848,092**	**586,054**	**1,434,146**

*As of March 22, 2011

Administrative Measures

- Referrals by specialty and disposition
- Number of unique patients, by zip code
- No-show rate and follow-through rate
- Patient demographics
- Stability of residence and insurance status of the TAP population
- Types of conditions/medical status

Key Evaluation Questions

- Does TAP improve access to outpatient specialty care?
- Does access to outpatient specialty care
  - improve health,
  - reduce overall health care costs,
  - reduce ED use in the enrolled population?
- Does TAP change health care utilization patterns overall?

Impact on Patients and Physicians

- Does the program
  - improve clinician and patient satisfaction,
  - change referral patterns, and
  - strengthen the relationship between the provision of primary and specialty care?
- Does participating in the program change the practice patterns of primary care physicians?
- Does TAP attract patients to primary care?

Finance-related questions

- What is the net financial impact of this program on each hospital (JHH and JHBMC)? On the JHU CPA? On each clinical department?
- What is the incremental change in charity care?
- Who bears the costs of the program? If there are savings, who benefits (patients, physician practice plan, the hospital)?

Evaluate the Components of TAP

- Do the key components of TAP—medical review, navigator support, and/or paying $20 up front—improve patient attendance and engagement in health care? (see no-show and follow-through rates)

TAP Evaluation

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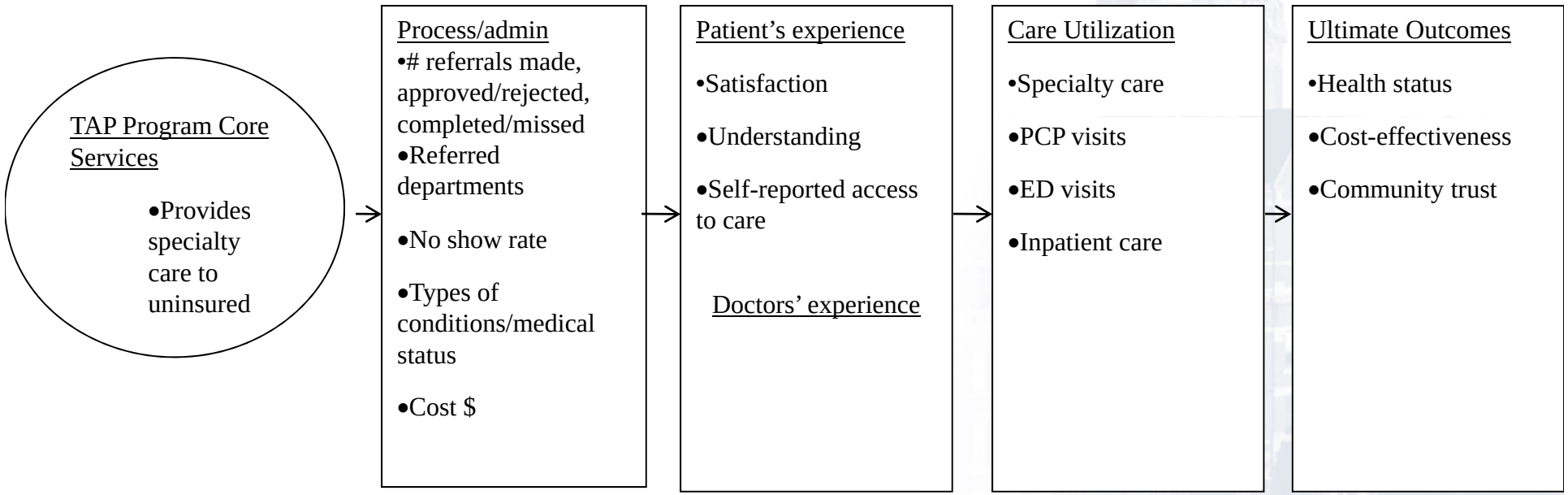
Evaluation Framework



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Outcome Evaluation Research Objectives

- Evaluate TAP impact on access and utilization of care
- Create and test evaluation tools for annual evaluation
- Assess TAP sustainability and generalizability

Outcome Evaluation Research Questions

- How effective is TAP in improving patients' **access** to, **understanding** of, and **satisfaction** with care?
- How effective is TAP in improving the **efficiency** of the system, measured by the **follow-through rates** at specialty appointments and monthly **ED utilization**?
- Is TAP effective at lowering ED utilization at the **population** level?

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Outcome Evaluation: Goals

Paper #1

Pre vs. Post TAP
- Survey
- Administrative
  - Follow-thru
  - Primary care
  - ED utilization

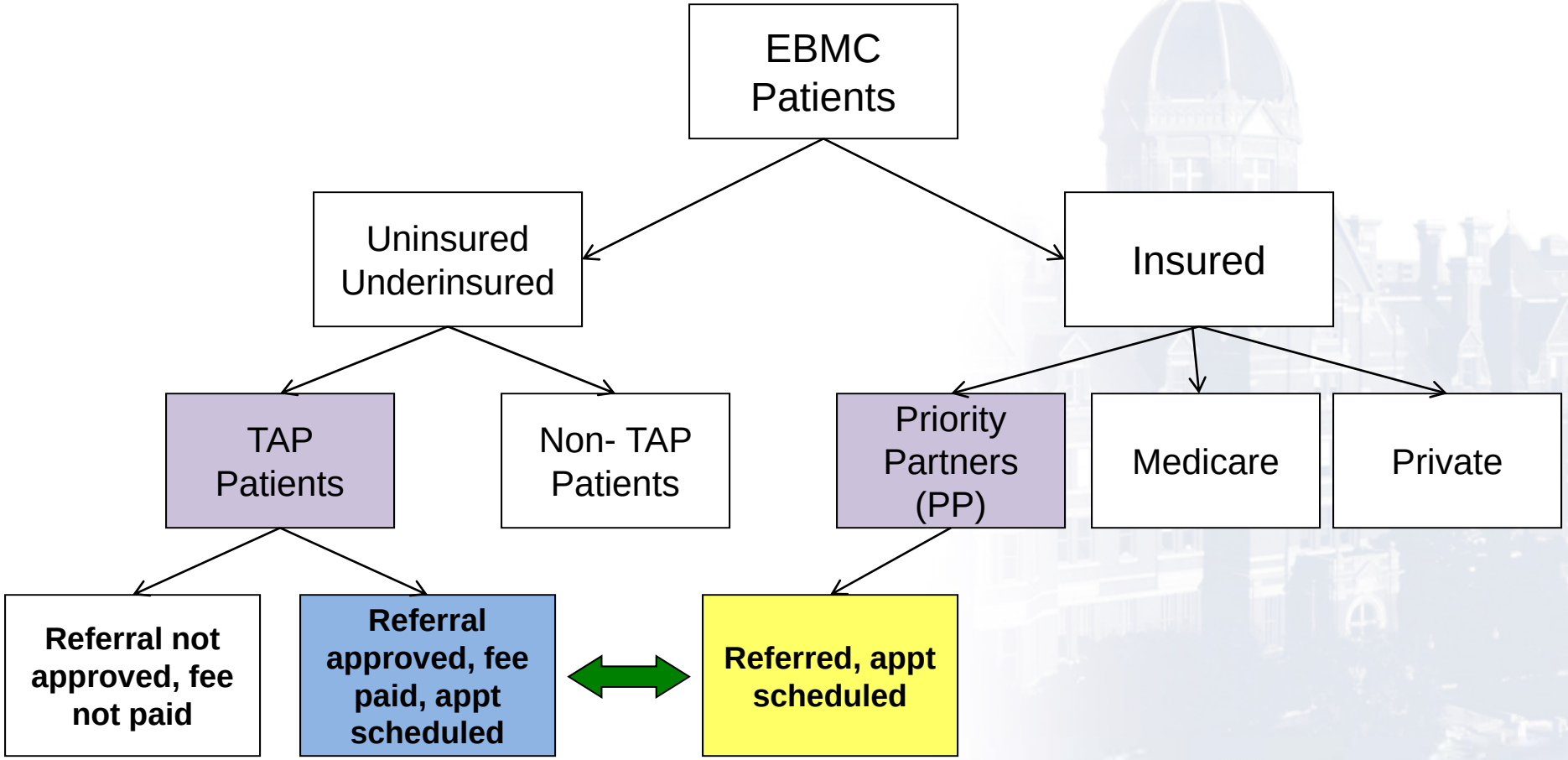
Paper #2

TAP vs. comparison
- Survey
- Administrative
  - Follow thru
  - Primary care
  - ED utilization

Paper #3

ED utilization at population level

Outcome Evaluation Comparison Populations



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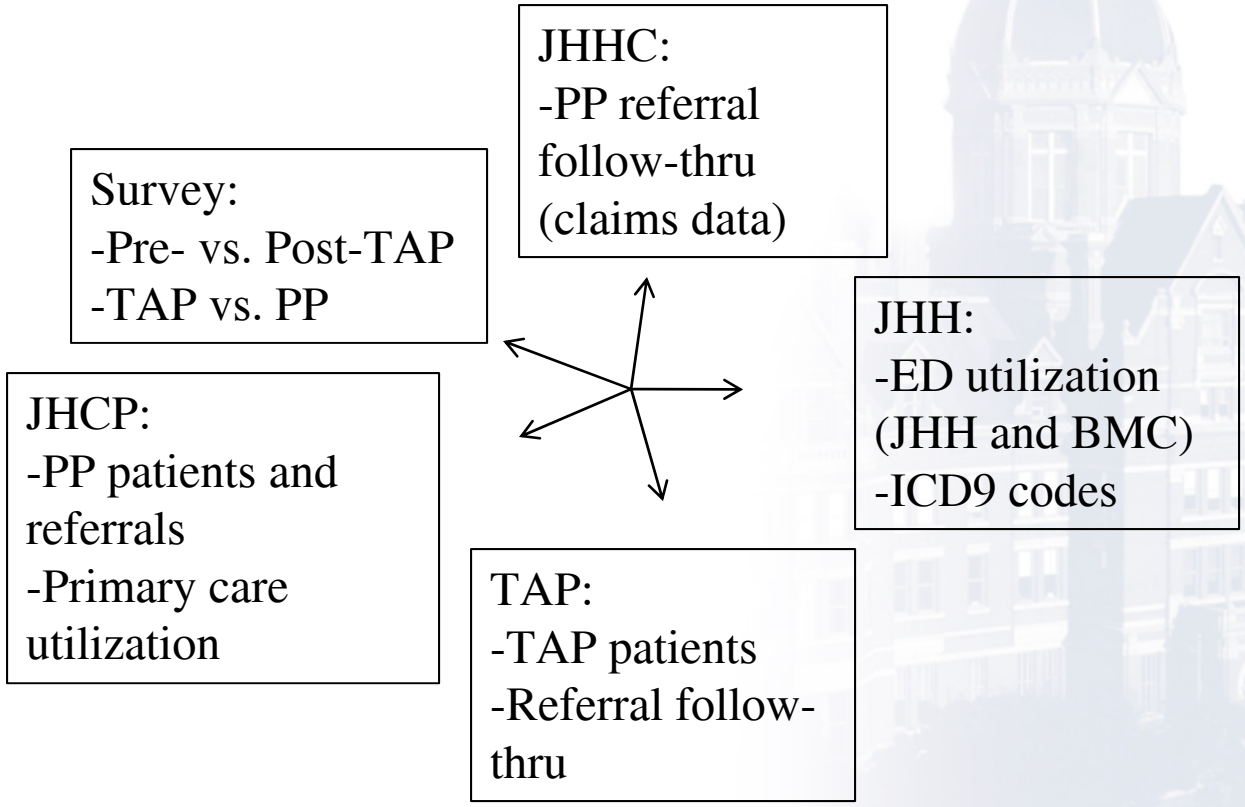
Outcome Evaluation
Risk Adjustment

Demographics
- Age
- Gender
- Zip Code

Referral types
- Therapeutic
- Diagnostic
- Pain
- Ancillary

Comorbidities
- Charlson Co-morbidity Score

Outcome Evaluation Data Sources

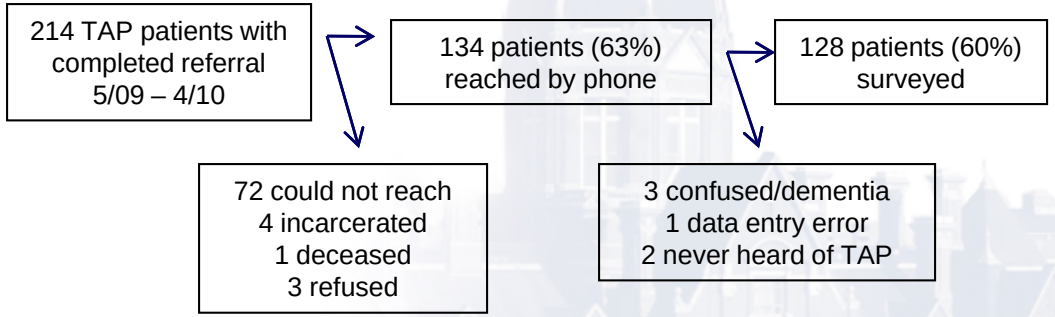


Outcome evaluation
Survey data

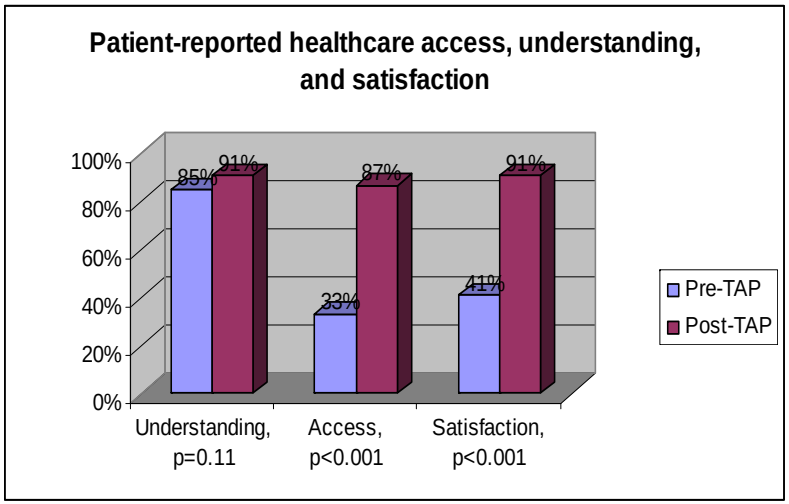
Surveyed patients, N = 128

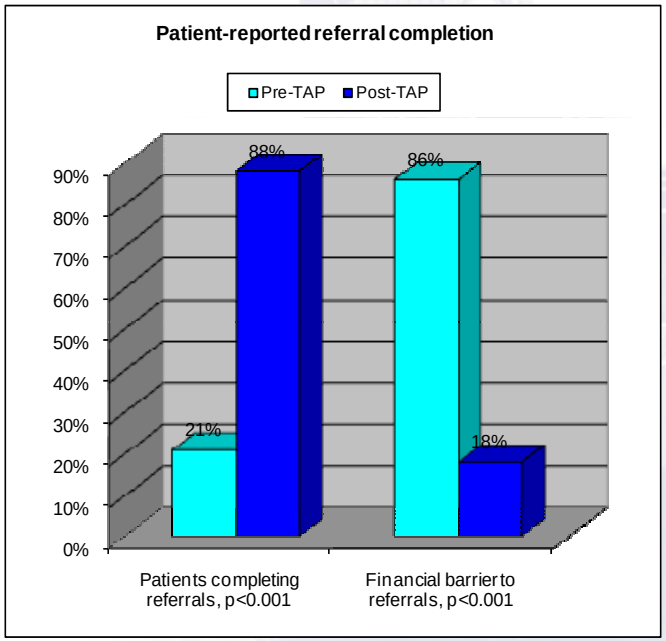
		N	%
Gender	Female	69	54 %
	Male	59	46 %
Age	Average	48	
Mean number of referrals	Per patient	2	
Top 3 departments for referral	Radiology	75	22 %
	Ophthalmology	37	11 %
	Cardiology	33	10 %
Referral types	Diagnostic	128	35 %
	Therapeutic	180	49 %
	Ancillary	31	8%
	Pain	31	8%

Survey flowsheet



Outcome evaluation
Patient-reported data

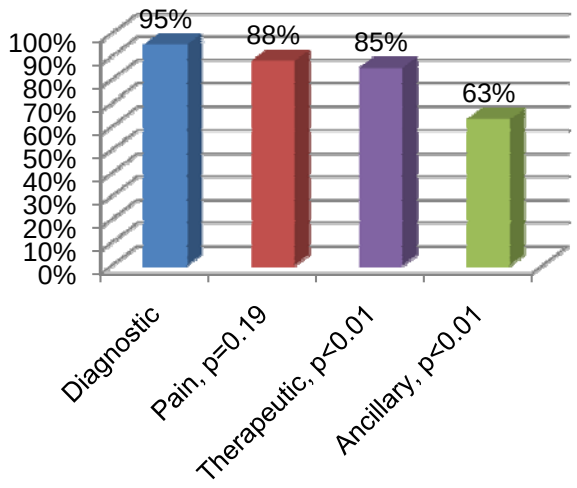




Outcome evaluation
Administrative data

Overall 90d follow-through rate: 89%

Follow through by referral type, relative to diagnostic, N=605 referrals



ED utilization, reported vs. admin data, N=204 patients

	Pre-TAP	Post-TAP	p
Reported visits/month	0.18	0.09	<0.001
ED visits, admin data	191	148	0.08
Inpatient stays	52	36	0.11

Outcome evaluation Limitations/problems

- Recall bias
- Comparison data
- Short-term data

Outcome evaluation
Next steps

- Analysis of comparison group data
- Primary care utilization evaluation
- Survey of those patients who refuse TAP
- Assessment of heavy ED users
- Population-level assessment of ED use