ENABLING SERVICES DATA COLLECTION IMPLEMENTATION PACKET

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Enabling Services Accountability Project

Updated October 2010

MISSION

To implement a standardized data collection system that improves the collection of enabling services data at health centers, and advocate for adequate reimbursement of these services so health centers can improve the health of medically underserved communities of color.

Accounts of Participating Health Centers

"The data from the project shows that our health center provides a great many services to patients and the community"

"The project was a good way to get national input"

"The project demonstrates that enabling services are the core of what makes quality care for our patients"

"We enjoyed meeting and joining forces with other health centers to show that enabling services are valuable to our vulnerable populations"

"The project was beneficial in terms of the possibility that we might incorporate enabling services data into federal reports for funding and to get an assessment of the enabling services activities provided by our health center to patients and to the community"

"The data will allow our managers to better assign staff and evaluate those activities which staff participate in. We will look at the outcome of sessions like nutritional counseling and the impact on patient health status"

ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

NEW YORK ACADEMY OF MEDICINE

Made possible with funding from:
Agency for Healthcare Research and Quality; The California Wellness Foundation; The MetLife Foundation; The Office of Minority Health

AAPCHO

Association Of Asian Pacific Community Health Organizations

Dear Community Health Advocate:

Thank you for your interest in the *Enabling Services Data Collection Implementation Packet*. Enabling services, non-clinical services such as interpretation, eligibility assistance, and transportation, play critical roles in increasing access and utilization of quality care, and are key components of the patient-centered medical home. They ensure that underserved patients obtain responsive, affordable, and culturally and linguistically appropriate health care by addressing the relevant health concerns of the local patient population. However, the lack of data on enabling services makes it challenging for health centers to demonstrate to payers and policymakers the value these services bring.

In an attempt to address this data collection issue, we have developed the *Enabling Services Data Collection Implementation Packet* to guide health centers in their data collection efforts. In collaboration with four of our member clinics, AAPCHO developed a standardized data collection model to improve data collection on these essential services, and better understand the services and their impact on health care access and outcomes.

The *Enabling Services Data Collection Implementation Packet* serves as a guide for health centers wishing to codify and track enabling services. Health centers may tailor many of the detailed demographic categories to their own health center needs, while keeping uniform, the broader categories for national health center aggregation purposes. The packet includes real-life sample encounter forms, protocols on data collection, a recommended work plan, project benefits and challenges, and fact sheets from actual data collected based on the enabling services data collection model. By building a larger, comparable dataset nationwide, we'll have a more comprehensive set of data that will more clearly show the value of enabling services. Additionally, costs and resource allocation needs can be better approximated which will strengthen health centers' ability to build a business case and obtain adequate funding for these critical services.

Since this packet is a "working" document that may be updated from time to time, please refer to the AAPCHO website for updated versions. To access the Enabling Services Implementation Packet online go to: **http://enablingservices.aapcho.org.** For additional information, contact Rosy Chang Weir or Hui Song. We also encourage you to send us your feedback or additional resources we may include in future updates.

Sincerely,

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ENABLING SERVICES DATA COLLECTION IMPLEMENTATION PACKET

ENABLING SERVICES ACCOUNTABILITY PROJECT

October 2010

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The project described in this report was funded in part by a grant from the Agency for Healthcare Research and Quality, under grant number 1 R03 HS013401, the California Wellness Foundation, the Metlife Foundation, and the Office of Minority Health (OMH), under a cooperative agreement #US2MP00004-05-0. The contents of this report are solely the responsibility of AAPCHO and NYAM and do not necessarily represent the official view of the grantors.

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Enabling Service Data Collection

Implementation Packet Description of Contents

Tool	Useful for	Purpose
Enabling Services Info Sheet	Management, Project coordinator	To provide information about the project purpose and goals.
Enabling Services Policy Brief	Management, Project coordinator	To highlight how AAPCHO is utilizing enabling services data collection to influence public policy.
Enabling Services Accountability Project FAQs	Management, Enabling service staff	To provide answers to commonly asked questions.
Enabling Services Needs Assessment Tool	Enabling service staff	To provide an assessment that helps organizations better understand its capacity and needs in collecting and reporting enabling services data.
Handbook for Enabling Services Data Collection	Enabling service staff	To provide detailed guidelines on how to collect enabling services data that is valid and useful.
Sample Encounter Forms	Project coordinator	To provide sample encounter forms that have already proved useful to community health centers.
Handbook Quick Reference Card	Enabling service staff	To provide an at-a-glance look at key enabling service definitions. This tool can be laminated and placed on a provider's ID tag or other suitable area.
Implementation Training Curriculum	Project coordinator	To provide a curriculum that helps train staff on enabling services data collection and implementation.
File Layout Manual	Data analyst	To provide a data layout that helps users organize data before it is entered. The tool includes instructions to import data from other databases, such as practice management systems.
Sample Enabling Service Database	Data analyst	To provide a sample database in which to enter data.
Data Evaluation Tool	Project coordinator	To provide a tool for evaluating data entry (by crosschecking data entry with completed encounter forms to detect rate of error) and recognize and resolving errors.
Data Collection Evaluation Tool	Project coordinator	To provide a tool that enables users to measure and monitor the progression of staff's data collection efforts.
Project Benefits and Challenges	Management, Project coordinator	To provide information about the project benefits and challenges.
Project Timeline	Management, Project coordinator	To provide a tool that enables users to create a timeline and monitor the progression of their project.
Enabling Services Accountability Project Fact Sheets	Management, Project Coordinator	To provide project outcomes from the Enabling Services Accountability Project.
Enabling Services Project Introduction	Management, Enabling service staff	To provide a sample introductory presentation, that includes an overview of the Enabling Services Accountability Project, the data collection process, the implications and importance of data collection, and the study findings.
Enabling Services References	Management, Project coordinator	To provide additional references on enabling services.

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Information Sheet

Enabling Services

Association of Asian Pacific Community Health Organizations

What are enabling services?

Enabling services are non-clinical services provided to health center patients that promote and support the delivery of health care and facilitate access to quality patient care.

They include case management, benefit counseling or eligibility assistance, health education and supportive counseling, interpretation, outreach, and transportation. These services are an essential component of quality comprehensive services provided by community health centers (CHCs) and are tailored to the unique needs of their patient populations.

Underserved minorities such as Asian Americans & Native Hawaiians and Other Pacific Islanders (AA&NHOPIs) face substantial financial, cultural, and linguistic barriers which prevent them from obtaining appropriate health care. Enabling services, aimed at increasing access to health care, are important to reducing health disparities and improving health for underserved populations. Despite their importance, these services are often inadequately funded. To improve overall health care for underserved populations, we need to recognize the value of enabling services and reimburse providers that deliver them.

Impact of enabling services

Enabling services are critical to improving health care access and health outcomes for underserved minorities such as AA&NHOPIs.

AA&NHOPIs, one of the fastest growing minority groups in the nation, face many barriers to care, including lack of insurance, culturally appropriate care, and limited English proficient (LEP) services. These barriers often prohibit many AA&NHOPIs from obtaining necessary health care services. Studies have reported AA&NHOPI underutilization of preventive and specialty care as well as mental health services compared to other racial groups. Furthermore, Native Hawaiians and other Pacific Islanders are less likely to get prenatal care in the first trimester, have higher infant mortality rates and have poorer quality care than whites.

The disparities are often magnified for patients who are also LEP. LEP patients are less likely to be given follow-up appointments than English-speaking patients. They also use fewer preventative services, such as mammograms and cervical screening, and often have little knowledge of the purpose of or need for these services. In addition, they are less likely to participate in health care programs in which they are eligible.

Participating Centers:

Charles B. Wang Community Health Center, New York, NY

International Community Health Services, Seattle, WA

Kalihi-Palama Health Center, Honolulu, HI

Waianae Coast Comprehensive Health Center, Waianae, HI

Made possible by grants from:

Agency for Healthcare Research and Quality

The California Wellness Foundation

The MetLife Foundation

The Office of Minority Health

Enabling services ensure that underserved patients can obtain culturally and linguistically appropriate health care. For example, enabling services such as interpretation services increase patient-provider communication and trust resulting in increased health visits and better health outcomes; eligibility assistance and enrollment in health insurance programs alleviate patient financial concerns. In addition, transportation services facilitate patient access to the clinic.

Overall, enabling services serve not only as an investment in preventive care by providing long-term cost savings, but they also reduce health disparities and result in improved health outcomes for underserved populations.

Growing need for enabling services

Many uninsured individuals often rely on community health centers (CHCs) as their only source of health care. The provision of enabling services at CHCs is becoming increasingly important to improving patient access to health care and health outcomes. In fact, the provision of enabling services is increasing at AAPCHO health centers and nationally despite financial pressures on CHCs. According to the Uniform Data System (UDS), CHCs reported that costs of different types of enabling services increased 61% nationally and 39% at AAPCHO health centers from 2000 to 2008.

Challenges providing enabling services

Enabling services are often not reimbursed or adequately funded

Despite their essential role in improving health outcomes, enabling services lack financial support. Adequate and consistent funding should be explicitly allocated to pay for these valuable enabling services to guarantee they are provided when necessary.

Even though states typically do not provide sufficient reimbursement for enabling services, many health centers understand their importance and absorb the difference in costs to providing these services to their patients. In addition, centers facing a growing number of uninsured patients are more likely to add rather than discontinue the provision of enabling services. If providers are to continue providing quality care to their patients, sufficient funding needs to be allocated and sustained to help them pay for these essential services.

As health centers face budget shortfalls, the uninsured population will increase and demand more enabling services

Studies suggest that greater attention be given to access barriers and the delivery of enabling services to underserved populations. America's uninsured population has grown by nearly 10 million since 1990; and in 2001, it reached 41.2 million or 14.6% of the total population. AA&NHOPIs with lower levels of education and higher rates of poverty, find it especially difficult to obtain insurance. According to recent studies, approximately 21% of AA&NHOPIs are uninsured. Other studies indicate that Chinese Americans have uninsured rates of 20%; Filipinos have rates of 20%; South East Asians, 27%; Japanese, 13%; South Asians, 22%; Korean Americans, 34%; and Native Hawaiians (in Hawaii) 7.5%.

As the uninsured population continues to grow, more low-income ethnic populations will rely on Medicaid and other insurance programs. With the rise in these programs, enabling services will play an increasingly important role in promoting access to health care and improving health outcomes for these high-risk populations. Financial support is essential to provide enabling services to the increasing number of vulnerable patients who require them.

Despite their importance, there is a lack of data on enabling services

Little is known about the utilization of enabling services, or the methods of delivery of these services and their impact on health outcomes. Moreover, a mechanism to track or evaluate the effectiveness of enabling services currently doesn't exist. For example, we currently do not know how many patients access this set of services, the types of patients who use them, how often patients require these services, and how many resources per individual patient are required to provide each service to each individual patient.

Documentation of enabling services is necessary to better understand their impact and contribute to the currently sparse data and research. By tracking enabling services and showing measurable results on health in AAPCHO's ongoing Enabling Services Accountability Project, we can begin to develop funding and reimbursement strategies to fund the cost of these essential services.

As budgetary crises ensue, it becomes especially crucial to document the importance of enabling services. Although many individuals believe that enabling services are cost-effective and improve health outcomes, we have no solid evidence to support this claim. The lack of data is a crucial barrier to securing financial support for these services. Currently, the services are not reimbursed or inadequately funded by the government; therefore health centers often must absorb these costs. The data can serve as evidence to the government and policy makers that these enabling services lead to improved health outcomes and necessitate reimbursement.

Enabling services definitions are not standardized

Because definitions of enabling services as well as a data collection protocol are not standardized, health centers face challenges in collecting the data. However, without data exemplifying that enabling services leads to positive health outcomes, funders are unwilling to reimburse centers that provide them. Both private and public payors are also more inclined to pay for services that are coded and documented. Thus, standardization of an enabling services data collection protocol will ensure that health centers have the tools they need to provide funding agencies with the information they require. Overall, the documentation and examination of enabling services will help support the delivery of health care that is culturally and linguistically appropriate, improve health outcomes and reduce health disparities for underserved populations.

Next Steps

Collect data on enabling services and illustrate the impact of enabling services on health outcomes

Enabling service data collection is crucial since funding agencies, when considering a reimbursement request, often require evidence illustrating the value of enabling services. The Enabling Services Accountability Project, a joint collaboration between AAPCHO and the New York Academy of Medicine, is currently collecting data from four health centers nationwide as a part of numerous studies that aim to illustrate the impact of enabling services on health outcomes.

Provide a model of data collection for health centers including feasible tools to help health centers begin implementation

The Enabling Services Accountability Project developed an Enabling Service Data Collection Implementation Packet which includes standardized definitions of enabling services, a handbook on data collection procedures, and sample encounter forms that health centers can use in their data collection. AAPCHO can also provide technical assistance services. The packet is designed to help health centers collect their own data and use it to advocate for enabling services funding, as well as for their quality management purposes. Health centers may also work with AAPCHO to compile their data with other health centers to advocate for funding.

Advocate for adequate reimbursement and appropriate funding for research on enabling services

With the data collected by health centers, AAPCHO can begin to provide data to policymakers illustrating the value of enabling services to the health and well-being of underserved minorities. The data will also provide crucial information, such as the cost and level of resources required to provide the services, and justify the need for adequate funding of these critical services.

AAPCHO
Association Of Asian Pacific Community Health Organizations

2010 POLICY ISSUE BRIEF

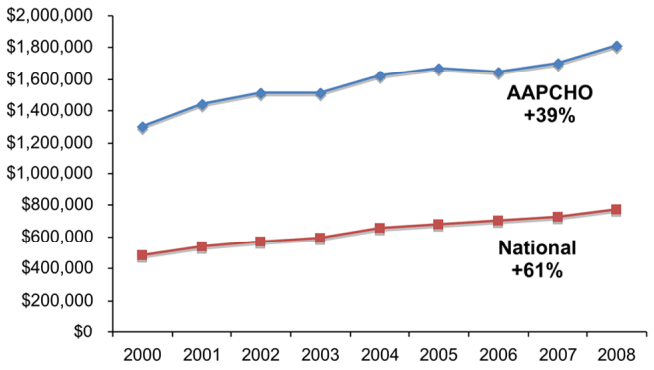
Enabling Services

Enabling services are non-clinical services (e.g. case management, benefits counseling or eligibility assistance, health education and supportive counseling, outreach, interpretation, and transportation) provided to patients to support health care delivery and facilitate access to quality care. They are an essential component of community health center's (CHC) quality, comprehensive services that are uniquely appropriate to their patient populations.

Enabling services (ES) are critical to improving health care access and outcomes for underserved minorities. AAPCHO research demonstrates their critical role in reducing health disparities:

- CHC ES are likely to prevent acute episodes and promote better management of chronic disease.
- ES users have better outcomes for diabetes and immunization measures.
- Increased use of ES, such as health education, can lead to improved HbA1c levels for diabetic patients.

Enabling services are an investment in health and preventive care.



Source: BPHC UDS 2000-08 Data

The average cost of providing enabling services at AAPCHO and national health centers has increased significantly since 2000. The amount of resources dedicated to these services at CHCs is indicative of their importance.

Establishing a National Enabling Services Standard

Enabling services are often jeopardized by political and financial pressures because they are non-reimburseable services and are funded through disjointed and term-limited grants. Data collected to understand the scope and impact of enabling services at CHCs is limited without a nationally standardized defnition and data collection protocol. Comparable data is needed to justify these CHC services on such issues as universal health coverage, maintaining prospective payment systems, and negotiating roles and responsibilities with managed care organizations. Establishing a nationally recognized standard is an essential step in determining the quantitative value of enabling services for health care delivery and outcomes.

AAPCHO implemented findings from the Medical Group Management Association (MGMA)/ National Association of Community Health Centers, Inc. (NACHC) Health Center Enabling Services Validation Report and developed an enabling services data collection model, which has been used at CHCs nationwide. Additionally, the NACHC Board of Directors voted to support a national standard definition of enabling services and a tracking system based on AAPCHO processes. AAPCHO is working with NACHC to establish, develop, and issue guidance on nationally recognized standards for enabling services and data collection.

Recommendations

AAPCHO believes the national health care home -- especially for providers serving a low-income, underserved community -- should include enabling services. This is not likely to occur unless we:

- Establish a nationally recognized ES definition
- Standardize ES data collection protocols at CHCs

Uniform enabling services data will help us understand their role and impact in improving access to and quality of care. Replicating data collection efforts at CHCs nationally and additional research studies will better inform policy makers and providers on how to reduce health disparities and improve quality for all, particularly the most vulnerable populations.

ENABLING SERVICES ACCOUNTABILITY PROJECT

Enabling Services Data Collection
Frequently Asked Questions

1. What are Enabling Services?

Enabling services are non-clinical services that facilitate the delivery of health care and access to quality patient care for health center patients. They include case management, benefit counseling or eligibility assistance, health education and supportive counseling, interpretation, outreach, and transportation. These services are an essential component of quality comprehensive services provided by community health centers (CHCs) and are appropriate to the unique needs of their patient populations.

2. What is the Enabling Services Accountability Project?

The Enabling Services Accountability Project is a collaborative effort between the Association of Asian Pacific Community Health Organizations (AAPCHO), four of its member clinics, and the New York Academy of Medicine. The purpose of the project is to develop a model that improves data collection on enabling services and to describe how these services impact health care access and outcomes. Overall, the project aims to provide a better understanding of the role of enabling services in health care access, utilization, and outcomes for Asian Americans, Native Hawaiians, and Pacific Islanders, and useful information to appropriately address their needs.

3. How will data collection of enabling service assure quality delivery of care for patients?

Enabling services ensure that underserved patients can obtain culturally and linguistically appropriate health care. For example, enabling services such as interpretation services increase patient-provider communication and trust resulting in increased preventive health visits and better health outcomes. Eligibility assistance and enrollment in health insurance programs alleviate patient financial concerns. In addition, transportation services facilitate patient access to the clinic. Overall, enabling services serve not only as an investment in preventive care by providing long-term cost savings, but they also reduce health disparities and result in improved health outcomes for underserved populations.

4. How do enabling services fit with trends in health care?

The challenge in health care is to reduce costs while simultaneously improving patient care. Implementation of enabling services allows for this. Simple enabling services such as transportation and interpretation services can significantly increase access to preventive care and can have a significant impact on patient outcomes. For example, increased access to preventive health care can reduce the number of costly Emergency Room visits.

5. Who can participate in Enabling Services Data Collection?

Any health center can participate. One of the goals of the Enabling Services Accountability Project is to expand data collection efforts to other health centers so we can collectively document and improve the approaches used by health centers to address the health care needs of underserved populations. The data can be used to advocate for adequate reimbursement of these essential services.

6. Why should we participate in enabling services data collection?

The following are a list of reasons that health centers participate in enabling services data collection:

- To prove that enabling services are an integral component of positive health outcomes at my health center
- To support and advocate for adequate reimbursement rates and appropriate funding for enabling services for my health center
- To obtain a better understanding of enabling services utilization, encounters, and how it affects health care at my health center
- To track the time my clinic staff spends on enabling services to support quality management efforts, to evaluate services, and to design interventions. For example, the data can be used as a management tool by showing patient utilization patterns and use of resources.
- To improve patient care by exchanging ideas and sharing best practices with other CHCs nationwide.

Overall, implementing this process can lead to improved patient care & outcomes, decreased costs and increased patient, provider, and staff satisfaction.

7. How does the data collection differ from other data collection systems such as the Bureau of Primary Health Care Uniform Data System (UDS)?

The UDS does not provide comprehensive data on enabling services. For example, it only provides utilization data on select categories of enabling services and the data is not linked to health outcomes, thus preventing the ability for detailed analysis. In addition, the UDS does not provide disaggregated data on races, such as AA&NHOPIs.

8. How much will this cost the clinic? Is there funding available to implement the data collection project?

The costs can vary. Most of the clinic costs involve staff time and energy. There is no direct federal funding to conduct the work, although the costs of training sessions, phone conferences, meetings, and technical support may be considered for funding by AAPCHO. AAPCHO will also consider additional funding requests depending on availability of funds.

9. How much time is involved in the data collection process? What is the time commitment necessary to be successful?

There are no exact time measurements for this process. Initially, setting up the team and learning the process requires more time. Teams should be given time weekly to meet for planning, implementing testing processes, data entry, and communicating results.

10. What are the resources available to implement the data collection? What training, resources, and tools will I be provided?

AAPCHO can provide resources depending on availability at the time of need. Enabling services database software can be provided, along with handbooks on procedures for data collection, encounter forms, and other materials. On-site training can also be provided by AAPCHO depending on available resources. Teams also participate in quarterly telephone conferences to support their efforts.

11. How sophisticated should the Information System staff be to participate?

IS staff should be able to install/uninstall programs, set file permissions, move files around on a network, be familiar with backing up data, know how to use and link data on Access and Excel, and understand the meaning of terms such as: RAM, CDROM, 1GHz, 256Mb, etc. In addition, staff must be able to send and receive e-mail, as filing reports and other communication is done electronically.

12. What are the key elements to assure success in the data collection?

The key elements to assure success are Senior Leadership and management of the project, staff involvement in the data collection, and an enthusiastic staff champion and creative team. Regular meetings are also very important to ensuring success.

13. What are other health centers' experiences participating in enabling services data collection?

The following are accounts of health centers in the enabling services data collection project:

- "The project demonstrates that enabling services are the core of what makes quality care for our patients"
- "The project was a great way to share ideas and get national input. We enjoyed meeting and joining forces with other health centers to show that enabling services are valuable to our vulnerable populations"
- The project was beneficial in terms of "the possibility that we might incorporate enabling services data into federal reports for funding and to get an assessment of the enabling services activities provided by our health center to patients and to the community"
- "The data will allow our managers to better assign staff and evaluate those activities which staff participate in. We will look at the outcome of sessions like nutritional counseling and the impact on patient health status"

14. How easy is it to obtain technical support if needed?

Participants can obtain technical support by contacting Hui Song at 510-272-9536 x119 or hsong@aapcho.org, or Rosy Chang Weir at AAPCHO at 510-272-9536 x107 or rcweir@aapcho.org.

Enabling Services Needs Assessment Tool

Enabling Services Accountability Project

Purpose of Needs Assessment:
To better understand your capacity and needs in collecting and reporting enabling services data at your health center.

Purpose of Project:
The purpose of the project is to track enabling services to gain a better understanding of how they affect health care for underserved populations. As we know, enabling services are very important to your patients' medical care. These services increase access to health care and improve outcomes of treatment, but are not part of the actual medical encounter. Unfortunately, health centers often have little information on how these services work, even though they are very important to health care. Once we have measurable information on these services, we can begin to demonstrate how they can improve health.

General Questions

1. Please list the types of enabling services your health center provides to patients.

_____
_____
_____

2. Do you currently collect data or information on the enabling services provided by your health center? [] yes [] no

   2a. IF YES, what information does your health center currently collect (e.g, type of enabling service, provider of service, etc.)? Please specify category and category choices if appropriate. If possible, please attach encounter form(s).

_____
_____
_____
_____
_____
_____

3. Do you currently collect registration/patient information on the patients to whom you provide enabling services (e.g. insurance, race/ethnicity, language spoken)? [] yes [] no

   3a. IF YES, please specify category and category choices if appropriate. If possible, please attach registration form(s).

_____
_____
_____
_____
_____
_____

4. IF YOU ANSWERED YES TO QUESTION 2 OR 3: Are data for enabling services available in electronic format (i.e. entered into a database)? [] yes [] no

4a. IF YES, what data or fields are inputted?

_____
_____
_____

4b. IF YES, can your enabling service database be linked to other databases using patient identifiers (e.g. claims data, encounter data)? [] yes [] no

4bi. IF YES, please specify which databases:

_____
_____
_____

5. Does your health center routinely monitor prevalence rates for specific conditions such as diabetes, asthma or cardiovascular disease (including those from health collaboratives)?

[] yes [] no

5a. IF YES, please list below or attach sheet.

_____
_____
_____
_____

5b. IF YES, how often are they reported or recorded?

_____
_____

6. Does your health center routinely calculate quality/performance measures such as proportion of women who have had a mammogram in the last 2 years, or use of appropriate medications for people with asthma? [] yes [] no

6a. IF YES, please list below or attach sheet.

_____

_____

6b. IF YES, how often are they reported or recorded?

_____

_____

Questions about Enabling Services at your Health Center
(for Enabling Services Providers)

7. How many total FTE's of enabling service staff do you have at your health center? _____

8. How many total hours of enabling services does your health center provide on average per day at your health center?

_____

9. For how many average total patients per day do you provide enabling services?

_____

10. How often do you provide more than one enabling service to the same patient per day?

[] never [] rarely [] some of the time [] most of the time [] always

11. How much time do you typically spend with each patient on enabling services per day? ____min

11a. Do you document all the enabling services you provide?

[]yes []no

If yes, which ones? Please list:

_____

_____

12. If you provide more than one service, how is this documented using your current procedures, if applicable? Do you document multiple services on multiple forms (A) or do you document multiple services on the same form (B)?

[] A. multiple forms [] B. same form []C. not applicable/do not document

13. After the patient visit, when is the encounter documented, if at all? Check, if not documented →[]

_____

_____

14. Does your health center conduct data analyses or reports on the enabling service data? If possible, please attach sample.

[] yes [] no []not applicable/do not collect enabling service data

Thank you for your participation.

AAPCHO Enabling Services Encounter Form

Note: Fields in Red are optional

Service Date	Provider ID	Patient ID	Patient DOB	Patient Gender ☐ M ☐ F	Pt. Zip Code

Encounter Type (check only one):	☐ Face to Face	☐ Telecommunication	☐ Off-site
Appointment Type (check only one):	☐ Scheduled	☐ Walk-in	
Group or Individual (check only one):	☐ Group	☐ Individual	

B. Payor Source at time of service (check)			
A. Managed Care ☐ Y ☐ N		B. Sliding Fee ☐ Y ☐ N	
C. Carrier at time of service (check only one)			
☐ Medicaid	☐ Medicare	☐ Other Public including Non-Medicaid CHIP	
☐ Private	☐ Self-pay	☐ Other (please specify):	

D. Ethnicity (check only one)

☐ Hispanic or Latino ☐ All others including unreported ☐ Not used

E. Primary Language (check only one)			F. Race (check only one)		
☐ English ☐ Cantonese ☐ Hmong ☐ Japanese ☐ Khmer ☐ Korean ☐ Laotian	☐ Mandarin ☐ Samoan ☐ Spanish ☐ Tagalog ☐ Tibetan ☐ Thai ☐ Tongan	☐ Vietnamese ☐ Visayan ☐ Other (please specify): _____	☐ Asian Indian/ South Asian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian	☐ Native Hawaiian ☐ Guamanian/ Chamorro ☐ Samoan ☐ Other Pacific Islander	☐ White ☐ Black/ African American ☐ American Indian/ Alaskan Native ☐ Mixed – AAPI ☐ Mixed – Other ☐ Other (Please specify): _____

Check if applicable:

☐ *Cannot read/write primary language*

☐ *Service provided in language other than English*
Specify language _____

F. Place of Birth (check only one)			G. Job Type (check only one)		
☐ U.S. ☐ Pacific Islands ☐ China ☐ Taiwan ☐ Japan ☐ Korea ☐ Cambodia	☐ Laos ☐ Philippines ☐ South Asia ☐ Thailand ☐ Vietnam ☐ Other Asian Country ☐ Europe	☐ Africa ☐ Latin, Central, or South America ☐ Other Place of Birth (Please specify) _____	☐ General Enabling Services Provider ☐ Case Manager ☐ Eligibility/Financial Worker ☐ Health Educator ☐ Counselor/Therapist ☐ Interpreter ☐ Outreach Worker ☐ Transportation Provider ☐ Volunteer	☐ Administrator/Clerk/ Facility Staff ☐ Community Health Worker ☐ Counselor/Therapist (certified or licensed) ☐ Dental Personnel ☐ Medical Assistant ☐ Nurse (NP, RN, LVN, Midwife) ☐ Nutritionist ☐ Pharmacist	☐ Physician (MD or DO) ☐ Physician's Assistant ☐ Social Worker (certified or licensed) ☐ Traditional Healer ☐ Other (please specify) _____

H. ENABLING SERVICE	CODE	MINUTES (Circle one or specify in Other if > 120 minutes)												Other
Case Management – Assessment	CM001	10	20	30	40	50	60	70	80	90	100	110	120	
Case Management – Treatment and Facilitation	CM002	10	20	30	40	50	60	70	80	90	100	110	120	
Case Management – Referral	CM003	10	20	30	40	50	60	70	80	90	100	110	120	
Financial Counseling/ Eligibility Assistance	FC001	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education/ Supportive Counseling	HE001	10	20	30	40	50	60	70	80	90	100	110	120	
Interpretation Services	IN001	10	20	30	40	50	60	70	80	90	100	110	120	
Outreach Services	OR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation	TR001	10	20	30	40	50	60	70	80	90	100	110	120	
Other: describe services below _____	OT001	10	20	30	40	50	60	70	80	90	100	110	120	

Sample Health Center
Enabling Service Encounter Form

Service Date (M/D/Y)	Provider ID	Patient ID	Pt. DOB (M/D/Y)	Pt. Gender e **M** e**F**	Pt. Zip Code

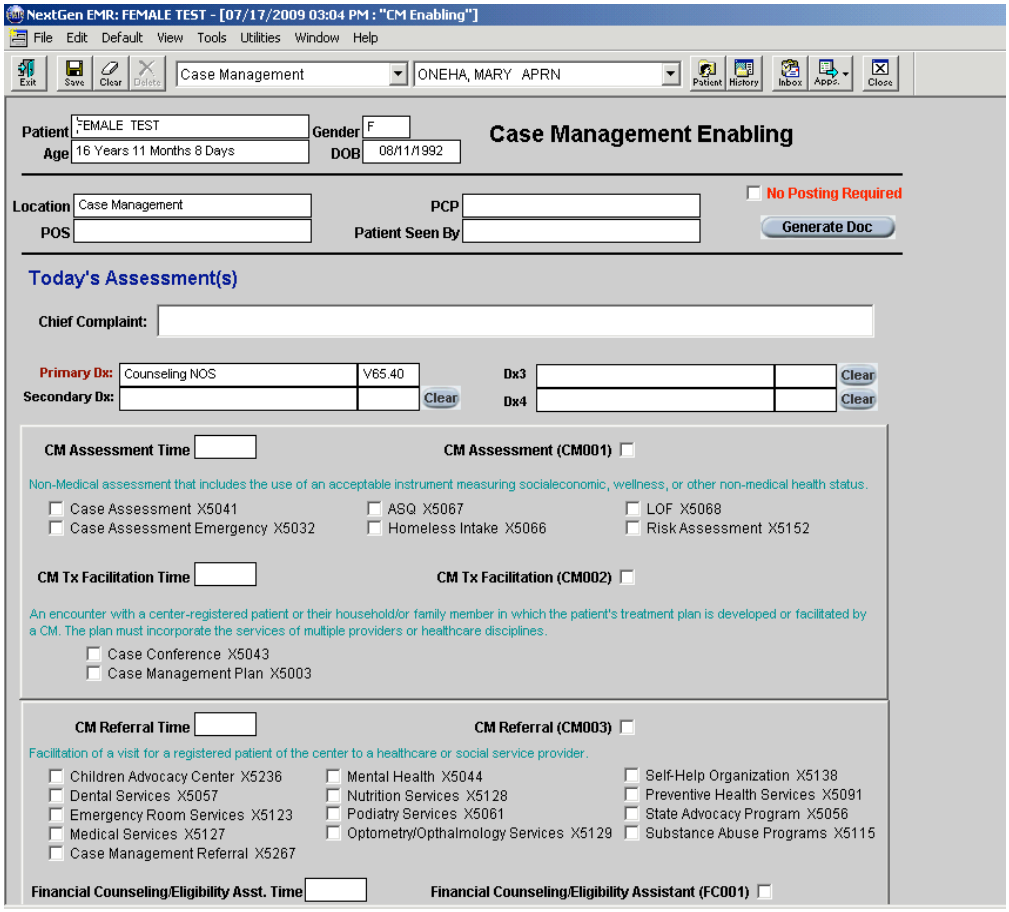
Encounter Type (check one): e**Face to Face** e**Telephone** e **Off-site**

e **Service provided in language other than English – specify language _____**

ENABLING SERVICE	CODE	MINUTES (circle one)												Other
Case Management – Assessment	CM001	10	20	30	40	50	60	70	80	90	100	110	120	
Case Management – Treatment & Facilitation	CM002	10	20	30	40	50	60	70	80	90	100	110	120	
Case Management – Referral	CM003	10	20	30	40	50	60	70	80	90	100	110	120	
Financial Counseling / Eligibility Assistance	FC001	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education / Supportive Counseling	HE001	10	20	30	40	50	60	70	80	90	100	110	120	
Interpretation Services	IN001	10	20	30	40	50	60	70	80	90	100	110	120	
Outreach Services	OR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation	TR001	10	20	30	40	50	60	70	80	90	100	110	120	
Other Enabling Service	OT001	10	20	30	40	50	60	70	80	90	100	110	120	

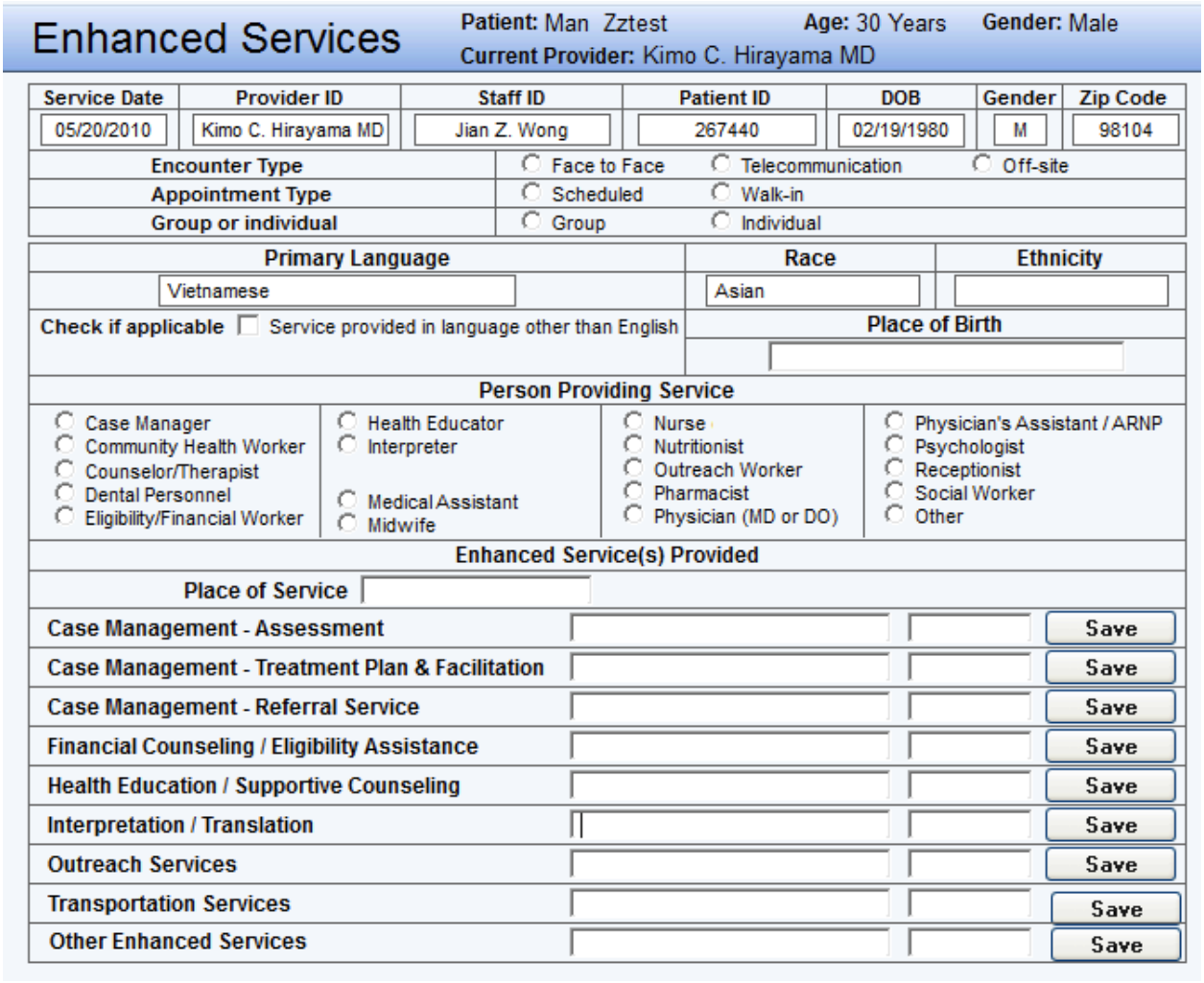
Describe Other Enabling Service:

Sample EMR Encounter Form



Developed by Waianae Coast Comprehensive Health Center.

Sample EMR Template



Enhanced Services

Patient: Man Zztest **Age:** 30 Years **Gender:** Male
Current Provider: Kimo C. Hirayama MD

Service Date	Provider ID	Staff ID	Patient ID	DOB	Gender	Zip Code
05/20/2010	Kimo C. Hirayama MD	Jian Z. Wong	267440	02/19/1980	M	98104

Encounter Type	○ Face to Face	○ Telecommunication	○ Off-site
Appointment Type	○ Scheduled	○ Walk-in	
Group or individual	○ Group	○ Individual	

Primary Language	Race	Ethnicity
Vietnamese	Asian	

Check if applicable ☐ Service provided in language other than English

Place of Birth

Person Providing Service

○ Case Manager	○ Health Educator	○ Nurse	○ Physician's Assistant / ARNP
○ Community Health Worker	○ Interpreter	○ Nutritionist	○ Psychologist
○ Counselor/Therapist		○ Outreach Worker	○ Receptionist
○ Dental Personnel	○ Medical Assistant	○ Pharmacist	○ Social Worker
○ Eligibility/Financial Worker	○ Midwife	○ Physician (MD or DO)	○ Other

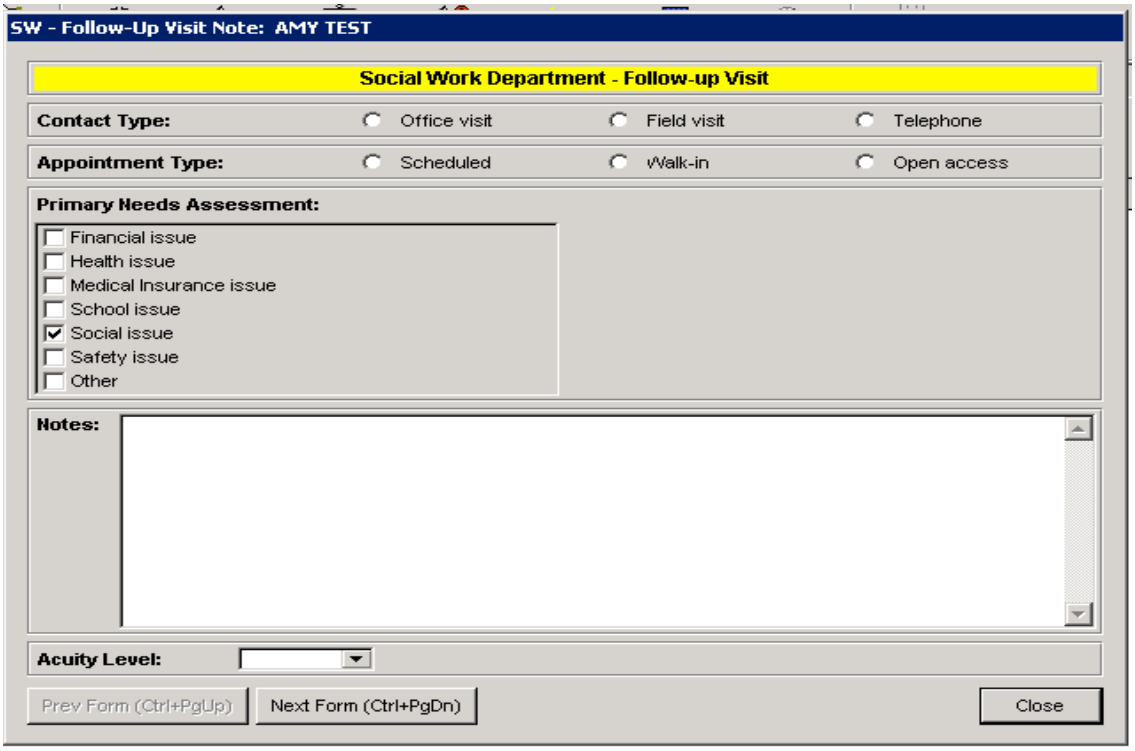
Enhanced Service(s) Provided

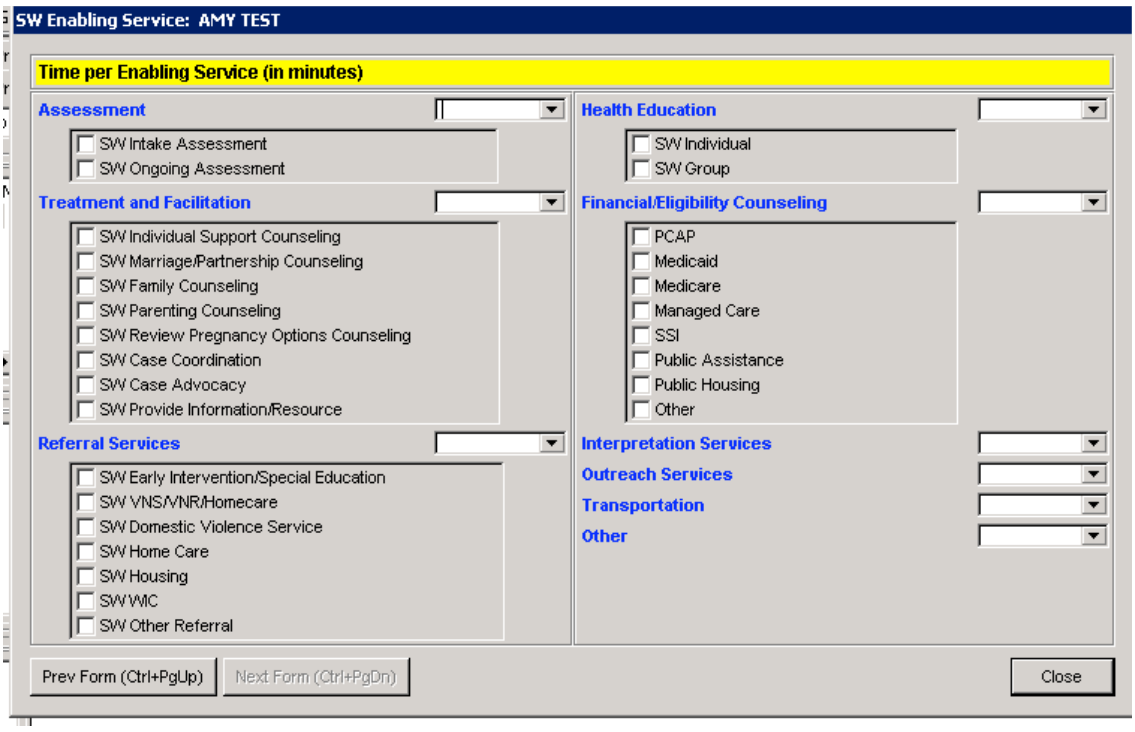
Place of Service

Case Management - Assessment			Save
Case Management - Treatment Plan & Facilitation			Save
Case Management - Referral Service			Save
Financial Counseling / Eligibility Assistance			Save
Health Education / Supportive Counseling			Save
Interpretation / Translation			Save
Outreach Services			Save
Transportation Services			Save
Other Enhanced Services			Save

Developed by International Community Health Services

Sample EMR Templates





Developed by Charles B. Wang Community Health Center

Enabling Services Accountability Project
Handbook Quick Reference Card

Enabling Services Data Collection
Training Curriculum

Preparation: Ask the clinic for examples of enabling services within their daily practice, or obtain the information from the needs assessment. Use the information to provide examples of how these services should be coded when explaining the protocol definitions.
Objectives for Session: By the end of the session, you will be able to:

- Understand requirements for documentation of enabling services.
- Identify nine (9) types and examples of enabling services.

Time: 30-40 minutes
Considerations for Facilitator: Must have familiarity with enabling services data collection protocol.
Evaluation: Participants will be presented with scenario in protocol booklet and asked to fill out encounter form.

Activity 1: Introduction to Enabling Services Project.
Overall Description: Mini-lecture

Time	Methodology/Steps and Content	Materials
5 min	I. Introduce self II. Explain collaboration A. Project developed out of collaboration between AAPCHO, four of its member centers (WA, HI, NY), and NYAM. III. Explain purpose of data collection project A. To track the time clinic staff spend providing enabling services. B. Define enabling services: services that "enable" your patients to access and receive culturally appropriate and high quality health care (e.g., interpretation, transportation). C. Making a case for reimbursement: The services are often non-reimbursable by payors; therefore health centers often have to absorb these costs. Our goal is to demonstrate to payors and policy makers that these enabling services are key components of health care homes and contribute to high quality care provided by health centers; they need to be reimbursed so that health centers can sustain the valuable services and continue to improve health and reduce health disparities for patients. . The first step in trying to demonstrate the value of the services is to track them uniformly nationally to make the case more robust and meaningful. IV. Explain purpose of training A. To explain to you the procedure we will use to track the time you spend providing enabling services. B. Explain materials: instruction manual and encounter form. V. Explain project plan A. This is the initial phase of the project 1) Collect enabling services data for 4 months beginning _____.	Enabling Services Protocol, Enabling Services Encounter Form

	2) After 4 months, we would like to obtain your feedback on the process to see what worked and what didn't work in efforts to make the process more effective and feasible. 3) The plan is for you to incorporate data collection into your clinic's daily practice. VI. Explain benefits - what we will gain 1) Better understanding of enabling services utilization, encounters, how it affects health care 2) Policy paper to guide policy and help secure funding for enabling services 3) Highlight importance and need for enabling services and more attention to comprehensive and quality care for vulnerable and diverse health center patient populations	
Activity 2: Explain requirements for documentation of enabling services. Overall Description: Mini-lecture in larger group.		
Time	Methodology/Steps and Content	Materials
5 min	1) Service must be linked to provision of medical services. 2) Service must be provided by a staff member or volunteer at your health center. 3) Service must be linked to a registered medical patient at your health center. 4) Service must last 10 minutes or greater.	Handout or write on display board
Activity 3: Definition and identification of the nine (9) types of enabling services. Overall Description: Mini-lecture in larger group.		
Time	Methodology/Steps and Content	Materials
10 min	1) Mini-lecture on enabling services • Define and describe examples of enabling services. Use examples from clinic daily practice when possible. • Highlight important points on protocol (e.g., record in 10 minute increments, rounding)	Enabling Services Protocol
Activity 4: Evaluation. Overall Description: Participants will be presented with scenario in protocol booklet and asked to fill out encounter form.		
Time	Methodology/Steps and Content	Materials
5 min	1. Present enabling services scenario (in handbook or make up appropriate scenario depending on participants) 2. Invite participants to individually fill out encounter form. 3. Invite participants to share their answers. Ask other participants for their reactions, questions.	Enabling Services Encounter form
Activity 5: Questions and Answers Overall Description: Questions and Answers		
5 min	1. Invite participants to ask questions. 2. Disseminate contact info.	RCW, HS contact info

Hawaii Patient Accounting Services

AAPCHO Enabling Services File Specifications

August 2010

Version 2 (08/24/10)

Table of Contents

Overview

This document provides specifications to community health centers (CHCs) participating in the Enabling Services Accountability Initiative on the procedures to be followed in the electronic submission of enabling service encounter information to AAPCHO. Data submitted will be edited and then merged into the AAPCHO Enabling Services Database (AESDB) for subsequent analysis.

The encounter file submitted must be a "flat" ASCII file. It must consist of fixed-length 320-character records with no linefeed/carriage return (CRLF) record terminators, no CTRL-Z end-of-file character, and no embedded control characters. The total number of characters/bytes in the file should be the product of the number of records in the file and 320, the length of each record.

The content of the file has been kept simple. Each file contains one File Header record (Record Type "00") as the first record in the file. The header record is followed by an indefinite number of Service Records, one for each enabling service provided (Record Type "10"). After all the Service Records, and the last record in the file, is the File Trailer record (Record Type "99").

In order to enhance the quality of data entered into the AESDB, all files received from participating CHCs will be edited prior to entry into the AESDB. The edit process will check the logical integrity of the file contents and produce a report. If errors are found, the file and the edit report will be submitted to the originating CHC for correction. Sample edits performed on the file are included later in this document.

Record Type: File Header (00)

Position	Size	Field Name/Remarks	Status	Type	Justify
1-2	2	**Record Type** Must be “00”.	Req	N	
3-8	6	**Source ID** Unique ID assigned to each participating AAPCHO health center, as follows: CBWCHC: 1 ICHS: 2 KPHC: 3 WCCHC: 4	Req	A/N	Left
9-16	8	**File creation date** Date the enabling services activity file was created, in YYYYMMDD format.	Req	N	
17-320	304	Blank			

Record Type: Service Record (10)

Position	Size	Field Name/Remarks	Status	Type	Justify
1-2	2	**Record Type** Must be “10”.	Req	N	
3-10	8	**Service Date** Date the enabling service was rendered, in YYYYMMDD format.	Req	N	
11-18	8	**Provider ID** Unique ID assigned by the reporting clinic to the rendering provider.	Req	A/N	Left
19-28	10	**Patient ID** Unique ID assigned by the reporting clinic to the patient served.	Req	A/N	Left
29-36	8	**Patient DOB** The patient’s birthdate, in YYYYMMDD format.	Req	N	
37	1	**Patient Gender** The patient’s gender (M:Male; F:Female).	Req	A	
38-42	5	**Patient Zip Code** The 5-digit USPS zip code of the patient’s residence.	Req	N	
43	1	**Encounter Type** F: Face to face encounter T: Telecommunication encounter O: Off-site encounter Blank: Not reported	Opt	A	
44	1	**Appointment Type** S: Scheduled W: Walk In Blank: Not reported	Opt	A	
45	1	**Scope of Encounter** G: Group encounter I: Individual encounter Blank: Not reported	Opt	A	
46	1	**Managed Care Indicator**	Req	A	

Position	Size	Field Name/Remarks	Status	Type	Justify
		Y: Patient is covered by a managed care plan			
		N: Not managed care			
47	1	**Sliding Fee Indicator**	Req	A	
		Y: Patient visit was covered by sliding fee			
		N: Not sliding fee			
48	1	**Insurance Carrier Category**	Req	A	
		A: Medicaid			
		B: Medicare			
		C: Other Public (incl non-Medicaid CHIP)			
		D: Private			
		E: Self-Pay			
		F: Other carrier at time of service (specify in next field)			
49-68	20	**Name of Other Insurance Carrier** Free text name of other insurance carrier. This field is REQ if the Insurance Carrier Category field above contains an “F”. Otherwise, this field should be left blank.	Cond	A/N	Left
69	1	**Primary Language**	Req	A	
		A: English			
		C: Cantonese			
		D: Hmong			
		E: Japanese			
		F: Khmer			
		G: Korean			
		H: Laotian			
		I: Mandarin			
		J: Samoan			
		K: Spanish			
		L: Tagalog			
		M: Tibetan			
		N: Thai			
		O: Tongan			
		P: Vietnamese			
		Q: Visayan			

Position	Size	Field Name/Remarks	Status	Type	Justify
		Z: Other Primary Language (specify in next field)			
70-89	20	**Name of Other Primary Language** Free text name of other primary language. This field is REQ if the Primary Language field above contains a "Z". Otherwise, this field should be left blank.	Cond	A/N	Left
90	1	**Literacy Challenge** Y: Cannot read/write primary language N: Can read/write primary language Blank: Not reported	Opt	A	
91		**Ethnicity** A: Hispanic or Latino B: All others including unreported C: Not used	Req	A	
92	1	**Race** A: Asian Indian/South Asian B: Chinese C: Filipino D: Japanese E: Korean F: Vietnamese G: Other Asian H: Native Hawaiian I: Guamanian/Chamorro J: Samoan K: Other Pacific Islander L: American Indian/Alaskan Native M: White N: Black/African-American	Req	A	

Position	Size	Field Name/Remarks	Status	Type	Justify
		O: Mixed - AAPI P: Mixed- Other Z: Other Race/Ethnicity (specify in next field)			
93-111	19	**Name of Other Ethnicity** Free text name of the other ethnicity. This field is REQ if the Ethnicity field above contains a "Z". Otherwise, this field should be left blank.	Cond	A/N	Left
112-116	5	**Enabling Service Code** CM001: Case Mgmt Assessment CM002: Case Mgmt Treatment & Facilitation CM003: Case Mgmt Referral FC001: Financial Counseling/Eligibility Assistance HE001: Health Education/Supportive Counseling IN001: Interpretation Services OR001: Outreach Services TR001: Transportation Services OT001: Other Enabling Service	Req	A/N	
117-196	80	**Name of Other Enabling Service** Free text name of other enabling service. This field is REQ if the Enabling Service Code field contains "OT001". Otherwise, this field should be left blank.	Cond	A/N	Left
197-199	3	**Minutes** Total minutes spent rendering enabling service (in multiples of 10 only: 10, 20, 30, etc).	Req	N	Right
200	1	**Job Type** A: General Enabling Services Provider	Req	A	

Position	Size	Field Name/Remarks	Status	Type	Justify
		B: Case Manager			
		C: Eligibility/Financial Worker			
		D: Health Educator			
		E: Counselor/Therapist			
		F: Interpreter			
		G: Outreach Worker			
		H: Transportation Provider			
		I: Volunteer			
		J: Administrator/Clerk/Facility Staff			
		K: Community Health Worker			
		L: Certified or Licensed Counselor/Therapist			
		M: Dental Personnel			
		N: Medical Assistant			
		O: Nurse (NP, RN, LVN, Midwife)			
		P: Nutritionist			
		Q: Pharmacist			
		R: Physician (MD or DO)			
		S: Physician's Assistant (PA)			
		T: Certified or Licensed Social Worker			
		U: Traditional Healer			
		Z: Other Job Type (specify in next field)			
201-220	20	**Other Job Type** Free text name of other job type. This field is REQ if the Job Type field above contains "Z". Otherwise, this field should be left blank.	Cond	A/N	Left
221	1	**Enabling Service Provided in Language Other than English** Y: Enabling Service provided in language other than English. *Specify language in next field.* N: Enabling Service provided in English language Blank: Not reported	Opt	A	

Position	Size	Field Name/Remarks	Status	Type	Justify
222	1	**Non-English Language Used** B: Cantonese D: Hmong E: Japanese F: Khmer G: Korean H: Laotian I: Mandarin J: Samoan K: Spanish L: Tagalog M: Tibetan N: Thai O: Tongan P: Vietnamese Q: Visayan Z: Other Non-English Language (specify in next field)	Cond	A	
223-242	20	**Other Non-English Language Used** Free text name of other non-English language used to conduct encounter. This field is REQ if the Non-English Language above contains a "Z". Otherwise, this field should be left blank.	Cond	A/N	Left
243	1	**Place of Birth** A: United States B: Pacific Islands C: China D: Taiwan E: Japan F: Korea G: Cambodia	Opt	A	

Position	Size	Field Name/Remarks	Status	Type	Justify
		H: Laos I: Philippines J: South Asia K: Thailand L: Vietnam M: Other Asian Country N: Europe O: Africa P: Latin, Central, or South America Q: Other Place of Birth (specify in next field) Blank: Not reported			
244-263	20	**Name of Other Place of Birth** Free text name of other place of birth. This field is REQ if the Place of Birth field above contains "Q". Otherwise, this field should be left blank.	Cond	A/N	Left
264-320	57	Blank			

Record Type: File Trailer (99)

Position	Size	Field Name/Remarks	Status	Type	Justify
1-2	2	**Record Type** Must be “99”.	Req	N	
3-8	6	**Source ID** Unique ID assigned to each participating AAPCHO health center.	Req	A/N	Left
9-16	8	**File creation date** Date the enabling services activity file was created, in YYYYMMDD format.	Req	N	
17-24	8	**Service Record Counter** Number of Service (“10”) Records in the file	Req	N	Right
25-320	296	Blank			

File Transmission Instructions

WHEN TO SUBMIT DATA:

Data should be submitted monthly for the services posted between the beginning and ending of the previous month. Note there is a distinction between visits POSTED the prior month and those with SERVICE DATES the prior month. Please send us data for all services posted the previous month only.

Please submit the data posted during the previous month within two weeks of the following month. Because each pilot site will have different start dates, schedules will be distributed once the data collection begins at each participating health center. Timelines for submitting data may be adjusted if necessary as long as all data are received within two weeks of the end of the four-month data collection period. Please contact Hui Song before you begin data collection (see contact info below) should you require an adjusted timeline.

Each participating health center is required to submit data for a total of four months during the initial phase of the project.

FORMAT:

Data files must be submitted in a flat file format (e.g., .txt format).

Instructions for submitting data via e-mail:
It is highly recommended that health centers submit data via email. If this is not possible, please see instructions for submitting data via compact disc (below).

Data files via email should be submitted to hsong@aapcho.org.

File Compression:
The data file may be zipped using compression utilities in order to reduce the amount of time required to transmit the file.

Instructions for submitting data via Compact Disc:
Data should be mailed to the following address:

Hui Song
Research Manager
Association of Asian Pacific Community Health Organizations
300 Frank H. Ogawa Plaza, Suite 620
Oakland, CA 94612

Copies of compact discs will be retained unless specifically requested otherwise in writing. Please remember to label the compact disc with the appropriate file name (see section below).

LABELING FILES:

Use the naming convention of:

hc#_momoyr.txt

where # stands for the number assigned to your health center followed by the months of data submitted followed by the year. For example, International Community Health Services (assuming #2 assigned to health center) submitting data for the months of April through May 2003 would create a file named hc2_040503.txt.

In your submission (email or CD), please specify the number of cases in your submitted dataset.

Please crosscheck your dataset with the file layout manual to ensure that all the appropriate database fields are included in the submission. All files received will be checked via an editing process (see sample file edits section in this document). If errors are found, the file and the edit report will be submitted to the originating health center for correction.

BACKING UP DATA:

Please remember to keep backup copies of your dataset to prevent data loss.

QUESTIONS:

If you have any questions about the data submission, please contact Hui Song at (510) 272-9536 x119, or by e-mail at hsong@aapcho.org, or Rosy Chang Weir at 510-272-9536 x107, or by email at rcweir@aapcho.org.

Sample File Edits

- The first 2 characters of every record must be either “00”, “10”, or “99”
- The first record in each file must be a 10 record
- Any record other than the first or last must be a 10 record
- The last record in each file must be a 99 record
- The 00 record Source Id must be valid and match the sender
- The 00 record File Creation Date must be a valid date within the last 90 days
- The 00 record positions 17-80 must be blanks
- The 10 record Service Date must be a valid date within the last year
- The 10 record Patient DOB must be a valid date prior to the File Creation Date
- The 10 record Patient Gender must be M or F
- The 10 record Encounter Type must be F, T, O, or blank
- The 10 record Appointment Type must be S, R, W, or blank
- The 10 record Scope of Encounter must be G, I, or blank
- The 10 record Managed Care Indicator must be Y or N

Requirements for Documentation of Enabling Service

1) Service must be linked to provision of medical services.

2) Service must be provided by a staff member or volunteer at your health center.

3) Service must be linked to a registered medical patient at your health center.

4) Service must last 10 minutes or greater.

Instructions for importing data to AAPCHO Enabling Services database

If you are using a version of MS Access other than Access 97, convert database upon initial entry. After conversion, exit database and re-enter. This will force a re-compilation of the database.

To import records to the Patient table:
Be sure that data is plain text and comma or tad delimited.
Fields must be passed in order, type, and format as specified. If fields are not correct, your export file will not be correct. Any fields that are not required, still need a blank entered for them. In those cases, the file should contain first a comma, then a space, and then another comma prior to the next field being imported.

If field headings are used on import, they must match those described below.

Patient Table

PatientNbr	10 character text, must have leading zeroes
LastName	25 character text
FirstName	15 character text
DOB	Date/Time, yyyymmdd format
Gender	1 character text, value either M or F
ZIPCd	5 character text, 00000 format
PlaceofBirth	All entries must meet data specifications laid out for field with the AAPCHO Enabling Services File Specifications dated August 2010 Version 2
Ethnicity/Race	All entries must meet data specifications laid out for field with the AAPCHO Enabling Services File Specifications dated August 2010 Version 2
PrimaryLanguage	All entries must meet data specifications laid out for field with the AAPCHO Enabling Services File Specifications dated August 2010 Version 2.
WRPrimary Lang	All entries must meet data specifications laid out for field with the AAPCHO Enabling Services File Specifications dated August 2010 Version 2
OtherPOB	All entries must meet data specifications laid out for field with the AAPCHO Enabling Services File Specifications dated August 2010 Version 2
OtherEthnicity	All entries must meet data specifications laid out for field with the AAPCHO Enabling Services File Specifications dated August 2010 Version 2
OtherPrimLang	All entries must meet data specifications laid out for field with the AAPCHO Enabling Services File Specifications dated August 2010 Version 2

Provider Table

ProviderID	8 character text, must have leading zeroes
LastName	25 character text
FirstName	15 character text
MI	2 character text

Enabling Services Data Collection
Implementation Readiness Assessment

Enabling Services Accountability Project

1. Do your senior leaders, MIS, and enabling service staff know about your plans to collect enabling services data? [] YES [] NO
   Do you have their support (time and resources)? [] YES [] NO

Comments:

_____

_____

2. Who will be designated as the Project Coordinator, Data Collection Coordinator, and System Administrator for the Enabling Service data collection project?

Project Coordinator: _____
Data Collection Coordinator: _____
System Administrator: _____

3. How will the enabling service data collection be implemented in daily flow and practice?

_____

_____

_____

_____

4. Which departments and which staff at your center will collect the enabling services data?

Department(s): _____
Staff: _____

5. Do you plan on using the provided Enabling Service Encounter Form or do you have your own Encounter Form or other alternative for data collection of enabling service data?
   - [] Use provided encounter form
   - [] Use own encounter form
   - [] Use both

Comments:

_____

_____

6. How will the encounter forms be collected from the enabling service staff (e.g. how often, by whom)?

_____

_____

7. Do you plan on using the provided Enabling Service Database or do you have your own practice management system or other alternative for data entry and management of enabling service data?
   - [] Use provided Enabling Service Database
   - [] Use own database system
   - [] Use both

Comments:

_____

_____

8. Do your computers meet the following requirements for hardware and software specifications? (Please check)

Hardware

[] Processor Speed:	1 GHz (gigahertz)
[] Hard Drive:	5 Gb of free space
[] Memory (RAM):	128 Mb
[] External/Iternal Drive:	CD-RW (CD-ROM re-write - for backup purposes)
[] Monitor	1024x768 Pixels

Software:

[] Operating System:	Windows 98, 2000, XP, or ME
[] Application Software:	Microsoft Office 2000 or more recent version (Word, Excel, Access)

9. Who will have access to the enabling service data?

Read-only Access: _____
Read/write Access: _____

10. Who will input the enabling service encounter form data?

_____

_____

11. Will you import existing data from your health center databases (e.g. patient demographic data) into the Enabling Service Database? [] YES [] NO

IF YES, will you be able to review and verify that the import went smoothly and the data appears to be accurate? [] YES [] NO

Comments:

_____

_____

12. Will you be able to monitor the enabling service data collection? [] YES [] NO

IF YES, how will the accuracy of the data entry be monitored (e.g. with encounter form audits?)

_____
_____

13. Do you have on-site IS support at your center? [] YES [] NO
14. Do you have off-site IS support at your center? [] YES [] NO

15. How will electronic patient data be kept confidential?

_____
_____

16. Do you have other concerns/comments?

_____
_____
_____
_____
_____
_____
_____
_____

Enabling Services Data Evaluation
Enabling Service Accountability Project

Purpose of Data Evaluation:

The purpose of the data evaluation is to ensure that the data completed on the encounter form correctly matches the data entered into the database. The evaluation process can also determine the consistency between data entry and coding in the health center database. For example, you can crosscheck the error rate of data entry and coding of completed enabling service encounter forms to identify potential errors in the process of transferring data from the encounter form into the database. Overall, the data evaluation process can prevent errors and increase the accuracy of the data reports.

Useful Tips When Doing Your Data Crosscheck

- It is very important to understand exactly how your data was created (how it was entered, whether your codes matched with the source's codes, and if not, how were they translated or cross-linked). Such information can vary from site to site and will determine for you which entries are correct and incorrect.

- Randomly select the encounters to be crosschecked. Be sure to select encounters from different service dates to avoid systematic forces affecting data entry and to ensure adequate representation of the crosschecks. You may want to avoid the first month of data or perhaps do a comparison between the first and later-month data.

- Organize your encounter forms and database to match with sequence and entry before you begin. This keeps you from having to look up each encounter and facilitates a faster crosscheck.

- Number the crosschecked encounters, so you can easily refer back to the same database entry and/or encounter form when necessary.

- Document everything. If an entry is entered incorrectly, do not just designate it as incorrect. Note what should have been entered and what was entered instead. This can show trends in the erroneous entries and help you identify the problem.

- Note missing encounters not found in the database.

- Please see the attached sample of a data crosscheck used for data evaluation.

Enabling Services Accountability Project
Sample Data Crosscheck

CROSSCHECK RESULTS

Variable Name	Variable Label	Error Rate per variable	Notes
ServiceDate	Service Date	N/A	Used to identify patient.
ProviderID	Provider ID	N/A	Used to identify patient.
PatientID	Patient ID	N/A	Used to identify patient.
InsuranceCarrierCategory	Insurance Carrier	71.4%	Possible systematic errors. "C" was consistently entered as "B" in database.
EnablingSvcCode	Enabling Service	14.3%	Looks to be a random error.
OtherEnablingSvcCode	Other Enabling Service	0.0%	
Minutes	Minutes	28.6%	

SAMPLE CROSSCHECK – Errors Shaded – Correct Entry in Parentheses

Crosscheck Number	ServiceDate	ProviderID	PatientID	InsuranceCarrier	EnablingService	OtherEnablingService	Minutes
1	8/22/2003	98765321	123456789	A	CM003		10 (20)
2	8/25/2003	98765322	123456780	A	FC001		20 (40)
3	6/12/2003	98765323	123456781	B (C)	CM003		20
4	8/18/2003	98765324	123456782	B (C)	CM003 (CM001)		10
5	8/25/2003	98765325	123456783	B (C)	CM001		20
6	8/18/2003	98765326	123456784	B (C)	OT001	ANTICOAGULATION	60
7	8/19/2003	98765327	123456785	B (C)	CM001		20
Total Incorrect	**NA**	**NA**	**NA**	**5**	**1**	**0**	**2**
Error Rate	**NA**	**NA**	**NA**	**71.4%**	**14.3%**	**0%**	**28.6%**

ENABLING SERVICES DATA COLLECTION PROJECT

YOUR JOB TITLE: _____ DATE: _____

INSTRUCTIONS - Please fill out all 10 questions on BOTH sides of this form. Your responses will be used to improve the data collection process and will be kept confidential and anonymous. Results will be reported in aggregate and individuals will not be identified.

SECTION A: PERSPECTIVES

Please share your perspectives on the data collection for enabling services at your health center.

1. How difficult is it to fill out the enabling services encounter forms?
[] Very difficult [] Somewhat difficult [] Somewhat easy [] Very Easy

2. How often are you able to categorize the enabling services you provide into one of the eight main categories?
[] Always [] Most of the time [] Some of the time [] Rarely/never

3. On average, how often do you use the "other" category?
[] Always [] Most of the time [] Some of the time [] Rarely/never

4. On average, how often do you provide services in less than 10 minutes?
[] Always [] Most of the time [] Some of the time [] Rarely/never

5. What proportion of the direct patient services that you provide is captured on your encounter forms?
[] All or most services [] Half my services [] Less than half my services [] Very few of my services

If you checked "very few of my services," please explain why: _____

_____

SECTION B. SCENARIOS

This section provides two different scenarios. Please read carefully, and then describe the service as indicated.

6. A 42-year-old male patient, whose primary language is Korean, has an appointment with a physician at your health center. First, you spend 23 minutes translating between the physician and patient during the exam. He is diagnosed with hypertension and is prescribed medications. After the appointment, you spend another 18 minutes explaining a brochure on hypertension that is written in English, discussing the condition and treatment in more detail. **DESCRIBE THIS SERVICE BY CHECKING ONE ITEM IN EACH CATEGORY.**

A. Service Type:

[] Case mgmt – assessment	[] Financial counseling/eligibility assistance	[] Health education/ supportive counseling
[] Case mgmt – treatment & planning	[] Interpretation	[] Outreach
[] Case mgmt – referral	[] Transportation	[] Other: _____

B. Time: [] 10m [] 20m [] 30m [] 40m [] 50m []60m [] other: _____

C. Service Type:

[] Case mgmt – assessment	[] Financial counseling/eligibility assistance	[] Health education/ supportive counseling
[] Case mgmt – treatment & planning	[] Interpretation	[] Outreach
[] Case mgmt – referral	[] Transportation	[] Other: _____

D. Time: [] 10m [] 20m [] 30m [] 40m [] 50m []60m [] other: _____

7. A 55-year-old female patient has been a patient with the health center for 5 years. She has had several conditions, including diabetes. You developed an ongoing care management plan for her during a previous visit, and today you follow up on her plan and arrange a referral to a podiatrist. The encounter, during which you telephone the provider to arrange the visit, takes you approximately 15 minutes. **DESCRIBE THIS SERVICE BY CHECKING ONE ITEM IN EACH CATEGORY.**

Question 7 continued →

ENABLING SERVICES DATA COLLECTION PROJECT

A. Service Type:

[] Case mgmt – assessment	[] Financial counseling/eligibility assistance	[] Health education/ supportive counseling
[] Case mgmt – treatment & planning	[] Interpretation	[] Outreach
[] Case mgmt – referral	[] Transportation	[] Other: _____

B. Time: [] 10m [] 20m [] 30m [] 40m [] 50m []60m [] other: _____

8a. In the space below, please describe briefly the LAST enabling service encounter **you** conducted. Please include sufficient detail for coding in part b.

_____

_____

_____

_____

8b. Now, please show how you would code this service on the following example of an encounter form:

ENABLING SERVICE	MINUTES (circle one)												Other
1- Case Management – Assessment	10	20	30	40	50	60	70	80	90	100	110	120	
2- Case Management – Treatment & Planning	10	20	30	40	50	60	70	80	90	100	110	120	
3- Case Management – Referral	10	20	30	40	50	60	70	80	90	100	110	120	
4- Financial Counseling / Eligibility Assistance	10	20	30	40	50	60	70	80	90	100	110	120	
5- Health Education / Supportive Counseling	10	20	30	40	50	60	70	80	90	100	110	120	
6- Interpretation Services	10	20	30	40	50	60	70	80	90	100	110	120	
7- Outreach Services	10	20	30	40	50	60	70	80	90	100	110	120	
8- Transportation	10	20	30	40	50	60	70	80	90	100	110	120	
Other Enabling Service:	10	20	30	40	50	60	70	80	90	100	110	120	

SECTION C: CONCLUDING QUESTIONS

9a. Please check which of these eight services you provide at your health center. **CHECK ALL THAT APPLY.**

[] Case mgmt – assessment	[] Financial counseling/eligibility assistance	[] Health education/ supportive counseling
[] Case mgmt – treatment	[] Interpretation	[] Outreach
[] Case mgmt – referral	[] Transportation	

9b. Which of the above enabling services do you most commonly provide? _____

10. Please check this box if you are a certified or licensed social worker. → []

Use the space below for comments on how we can improve the encounter form or the process of using the forms:

_____

_____

****** Thank you for your participation ******

ENABLING SERVICES ACCOUNTABILITY PROJECT
Benefits and Challenges

Project Benefits to Health Centers

- Better understanding of the nature of enabling services (e.g., volume, time spent)
- Increased capacity to advocate for enabling services reimbursement
- Increased capacity to collect enabling services data for research & reimbursement purposes
- Ability to evaluate staff activities and allocate resources more effectively
- Empowerment of enabling service staff through documentation of their important work
- Increased capacity to demonstrate quality of care and services

Project Benefits to the Community

- Provides general health assessment of underserved patients at health centers
- Highlights diverse needs of community and challenges for healthcare providers
- Provides comprehensive data on underserved patients (e.g., disaggregated data, language data)
- Provides model for other organizations serving culturally diverse populations
- Increases capacity of community to conduct research on underserved populations

Project Challenges for Health Centers

- Staff time for training on the importance of enabling services data collection & research
- Lack of participation of all direct enabling service providers in data collection
- Lack of space on practice management system for adding enabling service data fields
- Implementation of successful data collection often requires more resources than anticipated

For more information regarding project benefits & challenges, please contact:

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Activity Timeline for Implementation of Enabling Services Data Collection Project

Enabling Services Accountability Project

Activity	Approximate Timeframe	Available Resources
Complete enabling services needs assessment	1 week	Fact sheets, FAQs, Needs assessment tool
Presentation to key staff to obtain buy-in	1 month	ES project introduction ppt
Develop enabling services encounter form	1 week	Sample encounter forms
Prepare enabling services database	1 month	Sample database, File layout manual
Train enabling service staff to collect data	1 month	Fact sheets, Implementation training protocol, Handbook for enabling services data collection
Train data analysts to enter, code, and clean datasets	1 month	Handbook for enabling services data collection
Complete enabling services implementation readiness assessment	3 weeks	Implementation readiness assessment tool
Implement pilot data collection	4 months	Handbook for enabling services data collection, Handbook quick reference card
Evaluate data entry	3 weeks	Data evaluation tool
Evaluate implementation process	1 week	Implementation evaluation tool
Analyze data	2 weeks	Sample Analysis & Report
Report data	1 week	Sample Analysis & Report
Total Approximated Timeframe	*11 months*	

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Examination of Health Conditions of Enabling Service Users

Enabling Services Accountability Project

Association of Asian Pacific Community Health Organizations
New York Academy of Medicine

INTRODUCTION

Enabling services (ES), nonclinical services that facilitate access to care, are believed to improve health outcomes for underserved minority patients. They also help to prevent acute episodes and promote better management of chronic diseases. Moreover, culturally and linguistically appropriate enabling services are integral components of health care that reduce barriers to care and health disparities for AAPIs and other vulnerable populations. However, there is no solid evidence to support this claim, as there is a current lack of data on enabling services. In addition, these services are not reimbursed or adequately funded by payors; the lack of data is a crucial barrier to securing financial support for these essential services at Community Cealth Centers (CHCs).

This collaborative study between the Association of Asian Pacific Community Health Organizations (AAPCHO) and the New York Academy of Medicine, addresses this information gap and takes a closer look at CHC patients who utilize enabling services. The CHCs in this study are Bureau of Primary Health Care federally qualified health centers (FQHC) located in Hawaii, New York, and Washington. Each AAPCHO CHC serves predominantly Asian Americans, Native Hawaiians, and Pacific Islanders. Patient diagnoses were categorized into ambulatory care sensitive conditions (ACSCs). Nine different enabling service categories were included in the analysis to better examine the differences in patient health conditions by enabling service use. (See Methods section)

Overall, this study provided an overview of the health conditions of enabling service users as well as an examination of patients with comorbidities, or simultaneous conditions. This study provides an essential foundation for future enabling service studies that examine health outcomes for specific conditions. By examining enabling services and their measurable effects on health, we can begin to develop funding and reimbursement strategies to pay for these essential and currently non-reimbursed services at CHCs nationwide.

METHOD

Sample

- Setting: Three federally qualified health centers located in Chinatown New York City, NY, Seattle, WA, and Waianae, HI
- Sample:
  - Enabling Service Users (N=2656): Patients who used at least one enabling service and had a primary care visit in June 2004.
  - Non-Enabling Service Users (N=2190): Patients who had a primary care visit in June 2004. Patients were excluded if they used enabling services during varying health center data collection periods between May 2003-June 2004.

Measures

- Demographic: Gender, Age, Ethnicity, Insurance
- Enabling services categories: case management assessment, treatment, and referral; eligibility assistance; health education or supportive counseling; interpretation; outreach; and transportation services. Please contact AAPCHO for definitions and data collection protocol.
- Primary diagnosis of all primary care visits from 6/1/02-6/30/04

Analysis

- Diagnoses were coded as Ambulatory Care Sensitive Conditions (ACSCs) (Falik et al, 2001; Billings, et al. 1993). ACSCs are medical conditions for which timely effective outpatient care can prevent hospitalization or ER visits.
- Chi square and t-test analyses were used to examine differences between enabling service Users and Non-Users.

Table 1:
Patient Demographics of ES Users and Non-Users

	ES User		Non-ES User		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Total	2,656	100	2,190	100	4,846	100
Gender*						
Female	1,809	68	1,255	57	3,064	63
Male	847	32	935	43	1,782	37
Ethnicity*						
Chinese	1,150	43	779	36	1,929	40
Filipino	165	6	231	11	396	8
Korean	107	4	38	2	145	3
Vietnamese	307	12	307	14	614	13
Other Asian[a]	137	5	120	5	257	5
Native Hawaiian	469	18	318	15	787	16
Samoan	66	3	40	2	107	2
Other Pacific Islander	29	1	37	2	66	1
Total AAPI	2430	92	1870	86	4300	88
White	132	5	138	6	270	6
Other Race/Ethnicity[b]	92	3	180	8	272	6
Insurance Carrier*						
Medicaid	1,004	38	976	45	1,980	41
Medicare	337	13	251	11	588	12
Other Public	505	19	272	12	777	16
Private	285	11	358	16	643	13
Self-Pay	525	20	326	15	851	18
Other Carrier	0	0	6	0.3	6	0.1
Age*						
Younger than 1	72	3	137	6	209	4
1-4	154	6	195	9	349	7
5-14	174	7	298	14	472	10
15-24	390	15	240	11	630	13
25-44	687	26	488	22	1,175	24
45-64	687	26	501	23	1,188	25
Older than 64	492	19	331	15	823	17

*p <.05

[a]Includes Japanese and Asian Indian
[b]Includes American Indian/Alaska Native, African -American, Hispanic/Latino, Mixed -AAPI, and Mixed Other

RESULTS

Analyses indicated that ES Users and Non-Users significantly differed in gender, ethnicity, insurance, and age (p<.05). See Table 1. ES Users were more likely to be female, AAPI, uninsured, and older (mean=40 vs. 34 years). ES Users had a higher incidence of chronic conditions

Table 2: Chronic & Acute Ambulatory Conditions of ES Users and Non-Users

	ES User		Non-ES User		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Chronic Conditions						
Asthma	127	2	144	3	271	2
Epileptic Convulsions	17	0.3	12	0.2	29	0.3
Cellulitis	160	3	95	2	255	2
Diabetes	324	5	209	4	533	5
Heart Failure	71	1	26	1	97	1
Hypertension	108	2	109	2	217	2
Iron Deficiency	12	0.2	11	0.2	23	0.2
Pulmonary Disease	174	3	135	3	309	3
Total	993	17	741	15	1734	16
Acute Conditions						
Bacterial Pneumonia	3	0.1	2	0.04	5	0.05
Dehydration	5	0.1	2	0.04	7	0.1
ENT	667	11	693	14	1,360	12
Gastroenteritis	36	1	81	2	117	1
Hypoglycemia	7	0.1	1	0.02	8	0.1
Kidn/Urinary Infection	163	3	89	2	252	2
Pelvic Inflammatory Disease	3	0.1	2	0.04	5	0.05
Failure to Thrive	14	0.2	22	0.4	36	0.3
Pulm Tb	3	0.1	1	0.02	4	0.04
Other Tb	1	0.02	0	0	1	0.01
Immunization	0	0	3	0.1	3	0.03
Total	902	15	896	18	1798	16
Reproduction & Dev	917	15	720	14	1,637	15
Routine Care	874	15	773	15	1,647	15
Other	2,307	38	1,956	38	4,263	38
Total	5,993	100	5,086	100	11,079	100

whereas Non-Users had a higher incidence of acute conditions. For both ES Users and Non-Users, the most common chronic and acute conditions were Diabetes and Ear, Nose, & Throat (ENT) Infections, respectively. See Table 2. The most common diagnosis was ENT for both ES Users (11%) and Non-Users (14%). The average number of ACSCs per user was 1.5. Upon further analysis (see Table 3), we found that ES users had a higher percentage of visits for genitourinary disorders, conditions in the urinary or genital organs such as prostate disease, (7 vs. 4%) and a lower percentage of visits for respiratory disorders (12 vs. 15%). For more information, see Table 3 below.

Analysis by Enabling Services

Analysis of financial counseling, case management combined with health education, and interpretation use also yielded interesting results. Patients with diabetes used more interpretation (10% vs. 4-6%) while asthma patients used more case management and health education (5% vs. 2-3%). Patients with chronic conditions were less likely to use financial counseling (17%) than patients with acute conditions (22%). Patients diagnosed with chronic compared to acute conditions may be less likely to require financial counseling due to their comprehensive and planned medical care.

CONCLUSIONS / IMPLICATIONS

- This study provided preliminary evidence that ES Users, compared to Non-Users, are more likely to be from a minority background, uninsured, older in age, and have a greater need for enabling services. Patients with genitourinary disorders may also be more likely to require enabling services.

- Enabling services provided at CHCs are likely to prevent acute episodes and promote better management of chronic diseases. Health outcomes for specific diseases, such as diabetes, the most common chronic condition observed in this study, will be analyzed in future studies.

- Enabling services data can be used to examine how enabling services at CHCs improve quality of care and reduce health disparities. These services can be further studied and tailored to specific AAPI populations and health conditions. The research can also demonstrate the impact of these services on health, and be used as a tool to advocate for reimbursement of these services.

Table 3: ICD-9 Diagnoses of ES Users and Non-Users

	ES Users		ES Non-Users		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Infectious Diseases	550	4	519	5	1,069	4
Neoplasms	73	1	43	0.4	116	0.5
Metabolic and Immune Disorders	974	7	689	6	1,663	7
Blood Diseases	93	1	81	1	174	1
Mental Disorders	320	2	202	2	522	2
Neurological Disorders	501	4	517	5	1,018	4
Circulatory Disorders	912	7	707	7	1,619	7
Respiratory Disorders	1,559	12	1,587	15	3,146	13
Digestive Disorders	493	4	437	4	930	4
Genitourinary Disorders	891	7	480	4	1,371	6
Complications Of Pregnancy	375	3	64	1	439	2
Skin/Subcutaneous Diseases	695	5	603	6	1,298	5
Musculoskeletal Diseases	1,046	8	764	7	1,810	8
Congenital Anomalies	17	0.1	16	0.1	33	0.1
Perinatal Conditions	35	0.3	43	0.4	78	0.3
Ill-Defined Conditions	1,551	12	1,405	13	2,956	12
Injury And Poisoning	406	3	384	4	790	3
Factors Influencing Health Status and Access	2,841	21	2,199	20	5,040	21
Total	13,332	100	10,740	100	24,072	100

LIMITATIONS

- Although the health centers used a standard protocol for data collection, they used different methods to provide enabling services. Enabling services data thus reflects those services captured through each center's protocols. For example, one health center implemented the project in one department, while other health centers achieved varying organizational levels of implementation.

- Services less than 10 minutes are not captured. Thus, some patients in the non-user group may have used a number of enabling services that were each less than 10 minutes.

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An Examination of Enabling Services at Charles B. Wang Community Health Center (CBWCHC) 2004 - 2007 Enabling Services Accountability Project

Association of Asian Pacific Community Health Organizations

INTRODUCTION

Asian Americans, Native Hawaiians and Pacific Islanders (AAPIs), especially those that are medically underserved, face substantial financial, cultural, and linguistic barriers that prevent them from obtaining appropriate health care. Enabling services (ES), non-clinical services such as interpretation and financial counseling, aimed to increase access to health care, are believed to improve health outcomes for underserved minority patients. They also help to promote better management of chronic diseases. However, there is little evidence to support this claim, as there is currently limited data on enabling services. In addition, these services are not reimbursed or adequately funded by payors. The limited data is a crucial barrier to securing financial support for these essential services at Community Health Centers (CHCs) such as Charles B. Wang Community Health Center (CBWCHC) in Chinatown, New York City.

The Enabling Services Accountability Project, which is a collaborative effort between the Association of Asian Pacific Community Health Organizations (AAPCHO) and its member clinics, aims to fill this information gap by developing an enabling services data collection model, and examining the impact of these services on health care delivery and health outcomes. Four AAPCHO community health centers serving primarily AAPIs, including CBWCHC, are participating in this project and utilizing this ES data collection model.

This fact sheet provides an overview of enabling services utilization at CBWCHC for the years 2004-2007 that includes data collection methods, patient type, encounters, and provider type. AAPCHO is assisting these health centers as they document enabling services utilization so we may provide much needed data on this topic, and better understand the impact of these services on access to care and quality of care for medically underserved AAPIs. The information is also useful for health centers in their efforts to secure staffing, funding and added resources that support enabling services provision, as well as to support advocacy efforts for enabling services reimbursement and funding. Overall, the documentation and examination of enabling services supports the national efforts to improve cultural and linguistic appropriate health care delivery and reduce and eliminate health disparities for underserved AAPI populations.

METHOD

Enabling Service Data Collection Procedure

(1) Define enabling service measures & data collection variables
(2) Develop enabling service encounter form & data codebook
(3) Develop data collection protocol and assess face and content validity
(4) Conduct enabling service data collection and assess inter-rater reliability

Please contact AAPCHO for definitions and data collection protocol.

Enabling Services Measures

- Case Management (CM) Assessment, Treatment, and Referral
- Eligibility Assistance
- Health Education or Supportive Counseling
- Interpretation
- Outreach
- Transportation
- Other Enabling Services

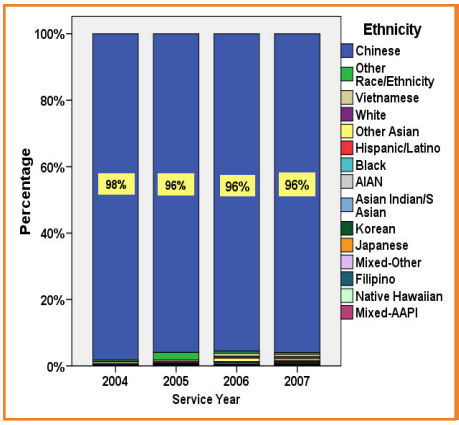
Enabling Service Patients Comparisons 2004 - 2007

	# of Patients	# of Services	Average Age	% Female
2004	2,410	9,885	27	69%
2005	4,540	32,825	32	65%
2006*	3,224	11,845	35	71%
2007	5,043	23,773	33	71%
Average**	3,998	22,161	32	69%

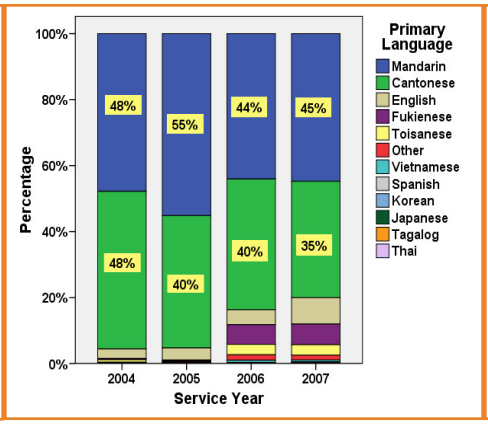
*Data from Apr - Dec 2006; Jan - Mar 2006 data was not available
** Yearly Average for 2004, 2005 and 2007

RESULTS

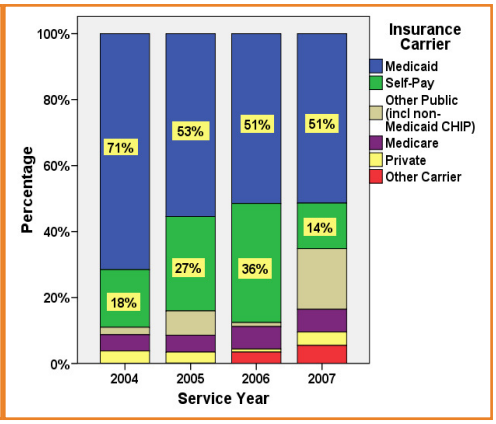
Enabling Service Patients: 2004 - 2007



Chinese comprised the majority of the patient population.



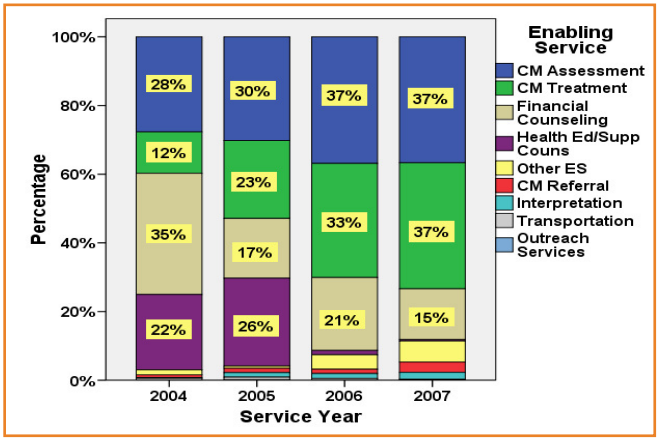
Mandarin and Cantonese were consistently the most common languages spoken.



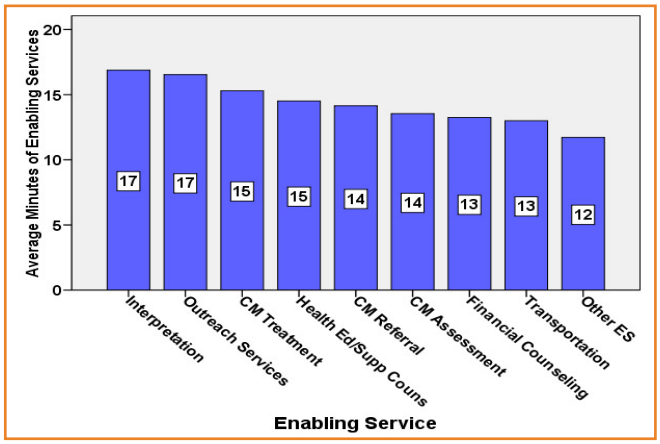
Medicaid was consistently the primary insurance source.

Examination of Enabling Services at CBWCHC

Enabling Services: 2004 - 2007

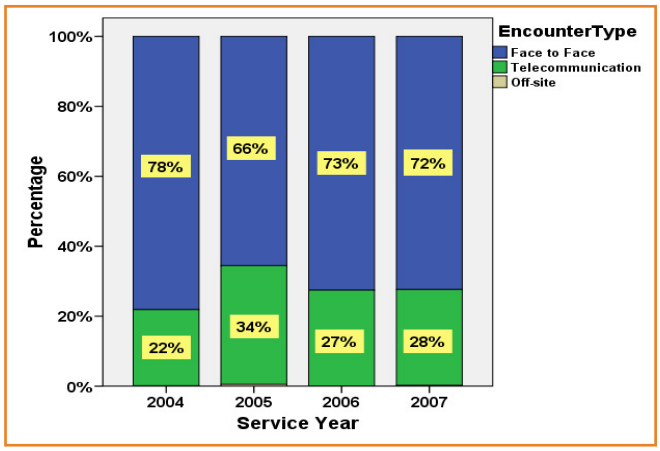


There was an increase in CM Treatment, and a decrease in Health Education/Supportive Counseling from 2004-2007.

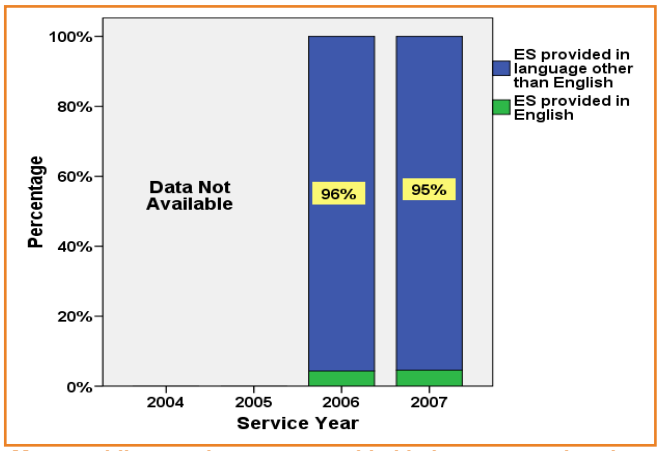


Interpretation (17 min.) and Outreach Services (17 min.) averaged the longest time.

Enabling Service Providers: 2004 - 2007



Most enabling services were Face-to-Face.



Most enabling services were provided in languages other than English.

SUMMARY

- The majority of enabling services patients were female (69%).
- The average age of enabling services patients was 32 years old.
- The most common ethnicity served at CBWCHC was Chinese (96%).
- The most common primary languages spoken were Mandarin (48%) and Cantonese (41%).
- The most common insurance source was Medicaid (57%).
- There was an increase in CM Treatment, and a decrease in Health Education/Supportive Counseling from 2004-2007.
- Interpretation (17 minutes) and Outreach Services (17 minutes) averaged the longest service time.
- Most enabling services were Fact-to-Face (72%).
- Of the reported cases, most cases were Walk-ins (61%).
- Most enabling services in 2007 were provided by Case Managers (76%) and Licensed Social Workers (24%).
- Most enabling services were provided in languages other than English.

CONCLUSIONS

Culturally and linguistically appropriate enabling services are essential to Asian Americans, Native Hawaiians, and Pacific Islanders and other underserved minorities that receive health care services from community health centers nationwide, such as Charles B. Wang Community Health Center.

By documenting enabling services and examining health outcomes through AAPCHO's Enabling Services Accountability Project, we demonstrate to policymakers the value of enabling services in improving access to care and quality of care to underserved minorities.

Overall, enabling services reduce health disparities and result in improved health outcomes for underserved populations. They are a vital investment in preventive care and reduce emergency room utilization.

For further information, please contact Rosy Chang Weir at AAPCHO,
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An Examination of Enabling Services at International Community Health Services (ICHS) 2004 - 2007

Enabling Services Accountability Project

ICHS
www.ichs.com

Association of Asian Pacific Community Health Organizations

INTRODUCTION

Asian Americans, Native Hawaiians and Pacific Islanders (AAPIs), especially those that are medically underserved, face substantial financial, cultural, and linguistic barriers that prevent them from obtaining appropriate health care. Enabling services (ES), non-clinical services such as interpretation and financial counseling, aimed to increase access to health care, are believed to improve health outcomes for underserved minority patients. They also help to promote better management of chronic diseases. However, there is little evidence to support this claim, as there is currently limited data on enabling services. In addition, these services are not reimbursed or adequately funded by payors. The limited data is a crucial barrier to securing financial support for these essential services at Community Health Centers (CHCs) such as International Community Health Services (ICHS) in Seattle, Washington.

The Enabling Services Accountability Project, which is a collaborative effort between the Association of Asian Pacific Community Health Organizations (AAPCHO) and its member clinics, aims to fill this information gap by developing an enabling services data collection model, and examining the impact of these services on health care delivery and health outcomes. Four AAPCHO community health centers serving primarily AAPIs, including ICHS, are participating in this project and utilizing this ES data collection model.

This fact sheet provides an overview of enabling services utilization at ICHS for the years 2004-2007 that includes data collection methods, patient type, encounters, and provider type. AAPCHO is assisting these health centers as they document enabling services utilization so we may provide much needed data on this topic, and better understand the impact of these services on access to care and quality of care for medically underserved AAPIs. The information is also useful for health centers in their efforts to secure staffing, funding and added resources that support enabling services provision, as well as to support advocacy efforts for enabling services reimbursement and funding. Overall, the documentation and examination of enabling services supports the national efforts to improve cultural and linguistic appropriate health care delivery and reduce and eliminate health disparities for underserved AAPI populations.

METHOD

Enabling Service Data Collection Procedure

(1) Define enabling service measures & data collection variables
(2) Develop enabling service encounter form & data codebook
(3) Develop data collection protocol and assess face and content validity
(4) Conduct enabling service data collection and assess inter-rater reliability

Please contact AAPCHO for definitions and data collection protocol.

Enabling Services Measures

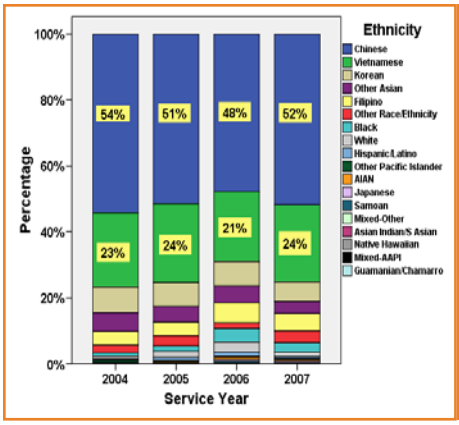
- Case Management (CM) Assessment, Treatment, and Referral
- Eligibility Assistance
- Health Education or Supportive Counseling
- Interpretation
- Outreach
- Transportation
- Other Enabling Services

Enabling Service Patients Comparisons 2004 - 2007

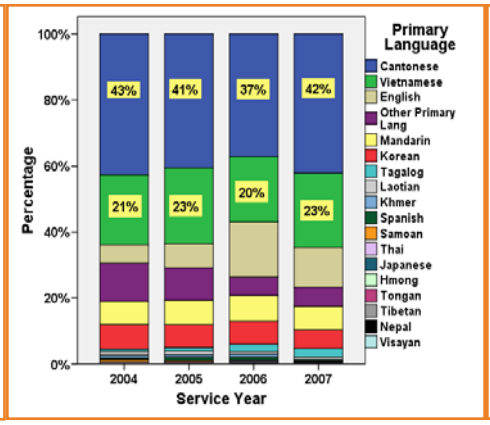
	# of Patients	# of Services	Average Age	% Female
2004	11,718	26,847	43	62%
2005	12,872	26,954	41	61%
2006	8,969	18,577	41	61%
2007	10,527	26,267	41	61%
Average	11,022	24,661	42	61%

RESULTS

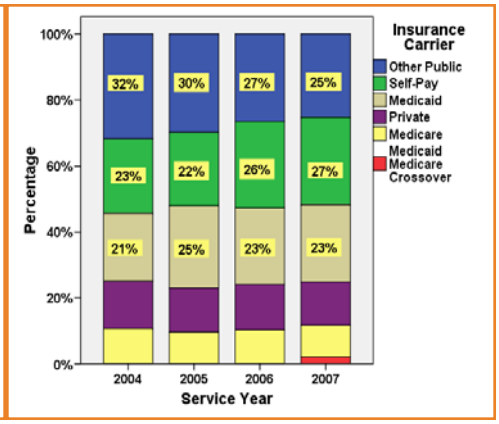
Enabling Service Patients: 2004 - 2007



Chinese and Vietnamese comprised the majority of the patient population.



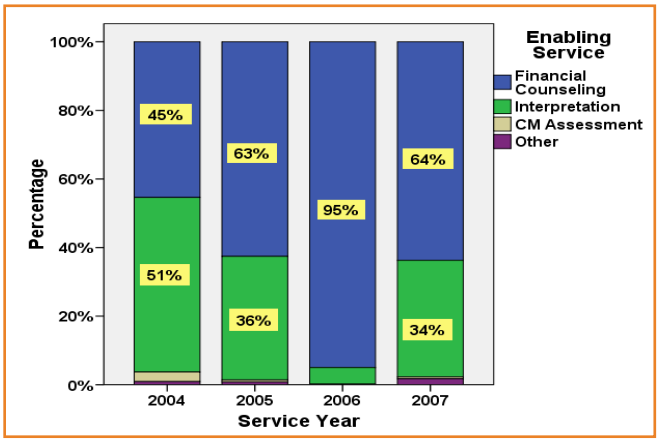
Cantonese and Vietnamese were consistently the most spoken languages.



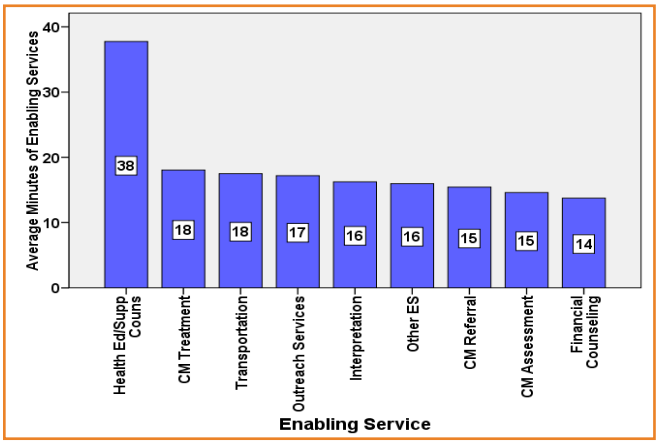
Other Public and Self-Pay were consistently the most common insurance sources.

Examination of Enabling Services at ICHS

Enabling Services: 2004 - 2007

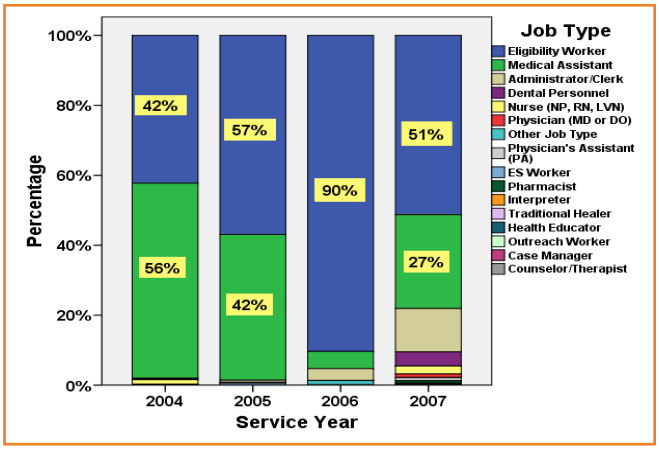


Financial Counseling and Interpretation consistently were the most common enabling services.

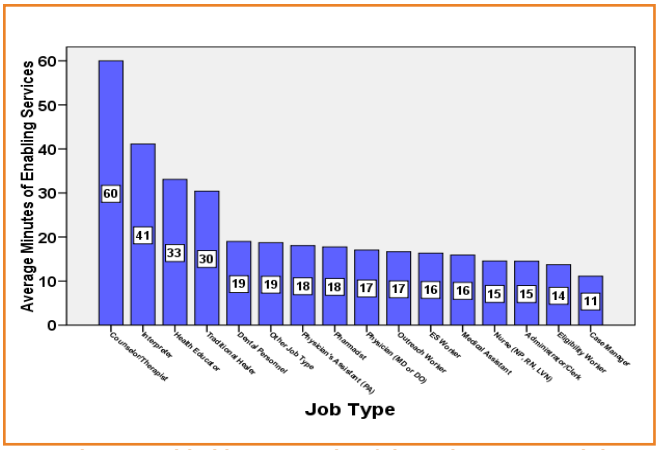


Health Education/Supportive Counseling (38 min.) averaged the longest time.

Enabling Service Providers: 2004 - 2007



Eligibility Workers and Medical Assistants consistently provided the most services.



Services provided by Counselors/Therapists averaged the longest time (60 min.).

SUMMARY

- The majority of enabling services patients were female (61%).
- The average age of enabling services patients was 42 years old.
- The most common ethnicities served at ICHS were Chinese (51%) and Vietnamese (23%).
- The most common languages spoken by patients were Cantonese (41%) and Vietnamese (22%).
- The most common insurance sources were Other Public (29%), Self-Pay (24%) and Medicaid (23%).
- 42% of patients were on Managed Care.
- Most enabling services were Financial Counseling (54%) and Interpretation (34%).
- Most enabling services lasted 10 minutes (62%) and 20 minutes (31%).
- Health Education/Supportive Counseling (38 minutes) averaged the longest service time.
- Eligibility Workers (58%) and Medical Assistants (35%) consistently provided most enabling services.
- Services provided by Counselors/Therapists averaged the longest service time (60 minutes).

CONCLUSIONS

Culturally and linguistically appropriate enabling services are essential to Asian Americans, Native Hawaiians, and Pacific Islanders and other underserved minorities that receive health care services from community health centers nationwide, such as International Community Health Services.

By documenting enabling services and examining health outcomes through AAPCHO's Enabling Services Accountability Project, we demonstrate to policymakers the value of enabling services in improving access to care and quality of care to underserved minorities.

Overall, enabling services reduce health disparities and result in improved health outcomes for underserved populations. They are a vital investment in preventive care and reduce emergency room utilization.

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An Examination of Enabling Services at Kalihi-Palama Health Center (KPHC) 2004 - 2007

Enabling Services Accountability Project

www.kphc.org

Association of Asian Pacific Community Health Organizations

INTRODUCTION

Asian Americans, Native Hawaiians, and Pacific Islanders (AAPIs), especially those that are medically underserved, face substantial financial, cultural, and linguistic barriers that prevent them from obtaining appropriate health care. Enabling services (ES), non-clinical services such as interpretation and financial counseling, aimed to increase access to health care, are believed to improve health outcomes for underserved minority patients. They also help to promote better management of chronic diseases. However, there is little evidence to support this claim, as there is currently limited data on enabling services. In addition, these services are not reimbursed or adequately funded by payors. The limited data is a crucial barrier to securing financial support for these essential services at Community Health Centers (CHCs) such as Kalihi-Palama Health Center (KPHC) in Honolulu, Hawaii.

The Enabling Services Accountability Project, which is a collaborative effort between the Association of Asian Pacific Community Health Organizations (AAPCHO) and its member clinics, aims to fill this information gap by developing an enabling services data collection model, and examining the impact of these services on health care delivery and health outcomes. Four AAPCHO community health centers serving primarily AAPIs, including KPHC, are participating in this project and utilizing this ES data collection model.

This fact sheet provides an overview of enabling services utilization at KPHC for the years 2004-2007 that includes data collection methods, patient type, encounters, and provider type. AAPCHO is assisting these health centers as they document enabling services utilization so we may provide much needed data on this topic, and better understand the impact of these services on access to care and quality of care for medically underserved AAPIs. The information is also useful for health centers in their efforts to secure staffing, funding and added resources that support enabling services provision, as well as to support advocacy efforts for enabling services reimbursement and funding. Overall, the documentation and examination of enabling services supports the national efforts to improve cultural and linguistic appropriate health care delivery and reduce and eliminate health disparities for underserved AAPI populations.

METHOD

Enabling Service Data Collection Procedure

(1) Define enabling service measures & data collection variables
(2) Develop enabling service encounter form & data codebook
(3) Develop data collection protocol and assess face and content validity
(4) Conduct enabling service data collection and assess inter-rater reliability

Please contact AAPCHO for definitions and data collection protocol.

Enabling Services Measures

- Case Management (CM) Assessment, Treatment, and Referral
- Eligibility Assistance
- Health Education or Supportive Counseling
- Interpretation
- Outreach
- Transportation
- Other Enabling Services

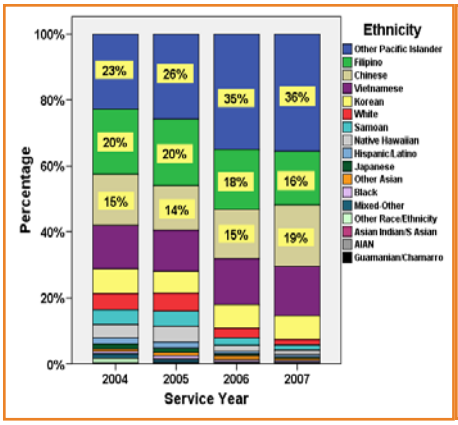
Enabling Service Patients Comparisons 2004 - 2007

	# of Patients	# of Services	Average Age	% Female
2004	2,651	7,510	38	65%
2005	3,702	15,876	37	64%
2006	3,358	16,624	39	66%
2007*	3,134	11,469	41	68%
Average**	3,237	13,337	39	66%

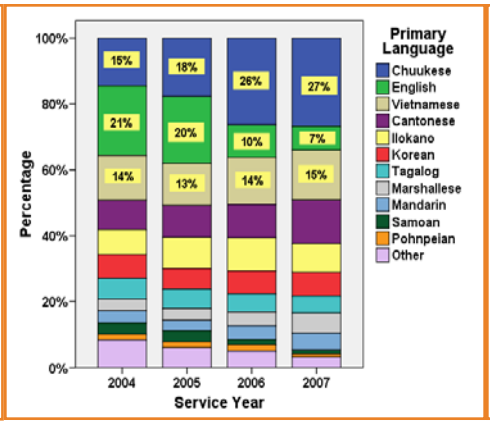
*Data from Jan-Aug 2007; data from Sep-Dec 2007 was not available
** Yearly Average for 2004-2006

RESULTS

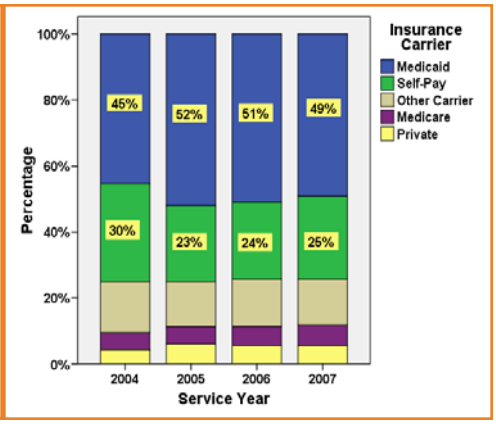
Enabling Service Patients: 2004 - 2007



Other Pacific Islanders, mostly Chuukese, was the largest ethnicity group.



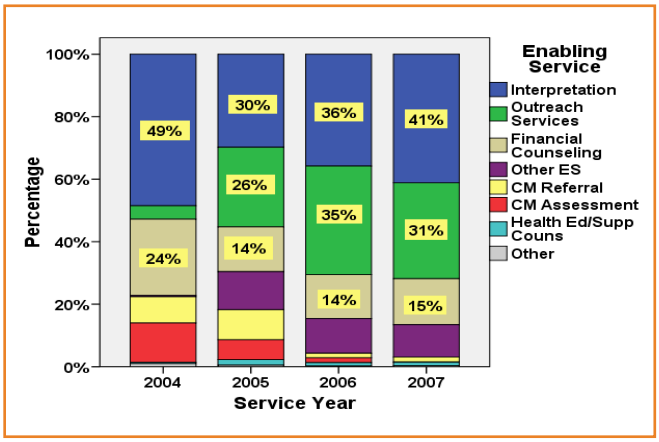
Chuukese, English and Vietnamese were the most common languages spoken.



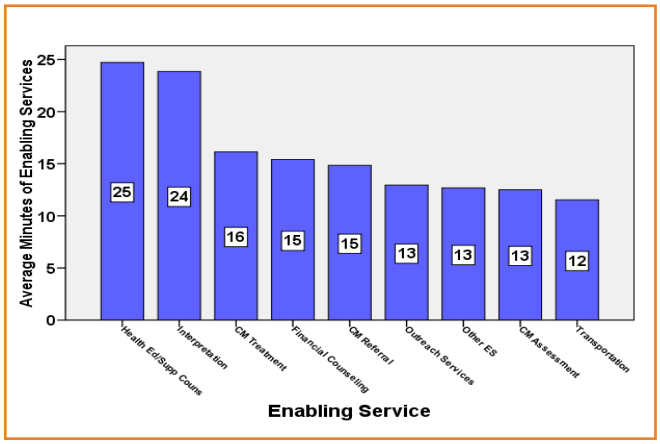
Medicaid and Self-Pay were consistently the most common insurance sources.

Examination of Enabling Services at KPHC

Enabling Services: 2004 - 2007

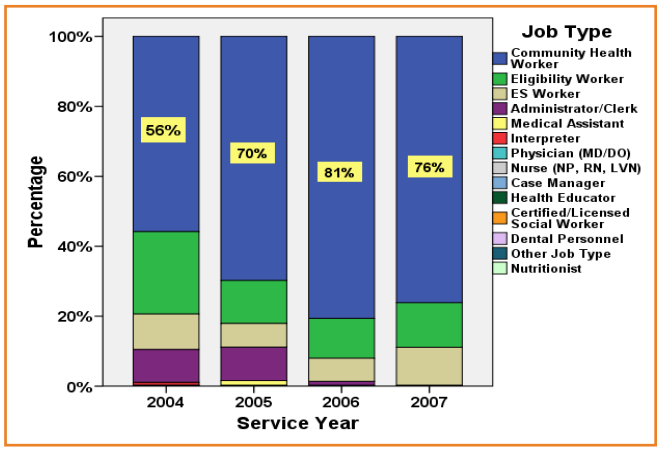


Interpretation, Outreach Services and Financial Counseling were the most commonly used ES services.

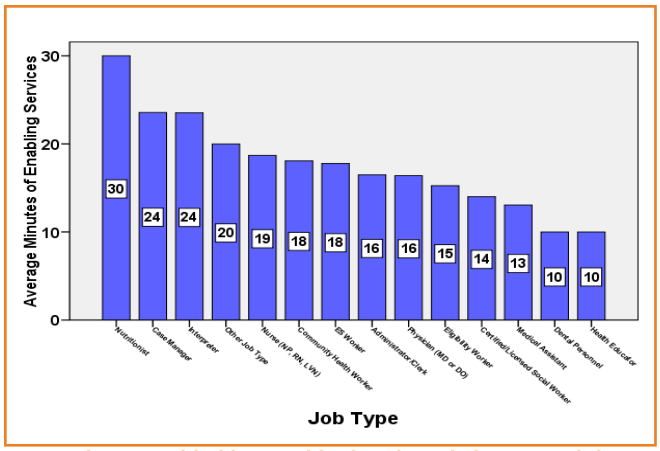


Health Education (25 min.) and Interpretation (24 min.) averaged the longest time.

Enabling Service Providers: 2004 - 2007



Community Health Workers consistently provided the most enabling services.



Services provided by Nutritionists (30 min.) averaged the longest time.

SUMMARY

- The majority of enabling services patients were female (66%).
- The average age of enabling services patients was 39 years old.
- The most common ethnicities served at KPHC were Other Pacific Islander (31%), Filipino (19%) and Chinese (14%).
- Chuukese (21%), English (18%) and Vietnamese (11%) were the most common languages spoken.
- The most common insurance sources were Medicaid (47%) and Self-Pay (29%).
- 33% of patients were on Managed Care.
- Interpretation, Outreach Services and Financial Counseling were the most commonly used enabling services for each year.
- Most enabling services lasted 10 minutes (54%) and 20 minutes (22%).
- Health Education/Supportive Counseling (25 minutes) and Interpretation (24 minutes) averaged the longest service time.
- Community Health Workers (73%) consistently provided the most enabling services.
- Services provided by Nutritionists averaged the longest service time (30 minutes).

CONCLUSIONS

Culturally and linguistically appropriate enabling services are essential to Asian Americans, Native Hawaiians, and Pacific Islanders and other underserved minorities that receive health care services from community health centers nationwide, such as Kalihi-Palama Health Center.

By documenting enabling services and examining health outcomes through AAPCHO's Enabling Services Accountability Project, we demonstrate to policymakers the value of enabling services in improving access to care and quality of care to underserved minorities.

Overall, enabling services reduce health disparities and result in improved health outcomes for underserved populations. They are a vital investment in preventive care and reduce emergency room utilization.

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An Examination of Enabling Services at Waianae Coast Comprehensive Health Center (WCCHC) 2004 - 2007

Enabling Services Accountability Project

Since 1972
www.wcchc.com

Association of Asian Pacific Community Health Organizations

INTRODUCTION

Asian Americans, Native Hawaiians, and Pacific Islanders (AAPIs), especially those that are medically underserved, face substantial financial, cultural, and linguistic barriers that prevent them from obtaining appropriate health care. Enabling services (ES), non-clinical services such as interpretation and financial counseling, aimed to increase access to health care, are believed to improve health outcomes for underserved minority patients. They also help to promote better management of chronic diseases. However, there is little evidence to support this claim, as there is currently limited data on enabling services. In addition, these services are not reimbursed or adequately funded by payors. The limited data is a crucial barrier to securing financial support for these essential services at Community Health Centers (CHCs) such as Waianae Coast Comprehensive Health Center (WCCHC) in Waianae, Hawaii.

The Enabling Services Accountability Project, which is a collaborative effort between the Association of Asian Pacific Community Health Organizations (AAPCHO) and its member clinics, aims to fill this information gap by developing an enabling services data collection model, and examining the impact of these services on health care delivery and health outcomes. Four AAPCHO community health centers serving primarily AAPIs, including WCCHC, are participating in this project and utilizing this ES data collection model.

This fact sheet provides an overview of enabling services utilization at WCCHC for the years 2004-2007 that includes data collection methods, patient type, encounters, and provider type. AAPCHO is assisting these health centers as they document enabling services utilization so we may provide much needed data on this topic, and better understand the impact of these services on access to care and quality of care for medically underserved AAPIs. The information is also useful for health centers in their efforts to secure staffing, funding and added resources that support enabling services provision, as well as to support advocacy efforts for enabling services reimbursement and funding. Overall, the documentation and examination of enabling services supports the national efforts to improve cultural and linguistic appropriate health care delivery and reduce and eliminate health disparities for underserved AAPI populations.

METHOD

Enabling Service Data Collection Procedure

(1) Define enabling service measures & data collection variables
(2) Develop enabling service encounter form & data codebook
(3) Develop data collection protocol and assess face and content validity
(4) Conduct enabling service data collection and assess inter-rater reliability

Please contact AAPCHO for definitions and data collection protocol.

Enabling Services Measures

- Case Management (CM) Assessment, Treatment, and Referral
- Eligibility Assistance
- Health Education or Supportive Counseling
- Interpretation
- Outreach
- Transportation
- Other Enabling Services

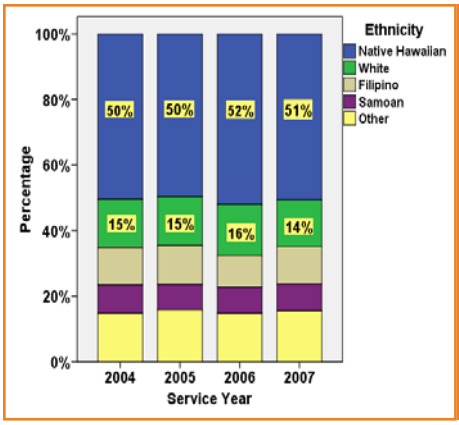
Enabling Service Patients Comparisons 2004 - 2007

	# of Patients	# of Services	Average Age	% Female
2004*	4,803	14,861	30	61%
2005	5,216	22,145	33	63%
2006	5,948	30,055	34	60%
2007	6,022	26,843	32	62%
Average**	5,729	26,348	31	59%

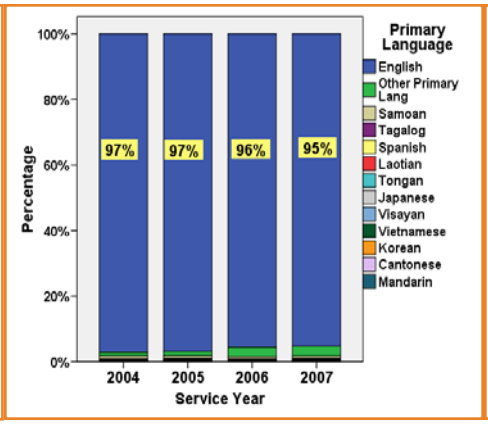
*Data from Apr- Dec 2004; Data from Jan-Mar 2004 was not available
**Yearly Average for 2005-2007

RESULTS

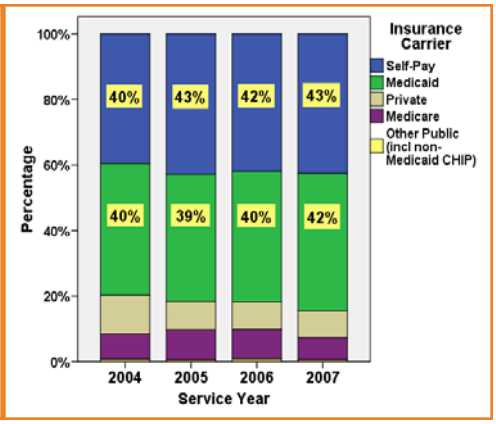
Enabling Service Patients: 2004 - 2007



Native Hawaiians comprised the majority of the patient population.



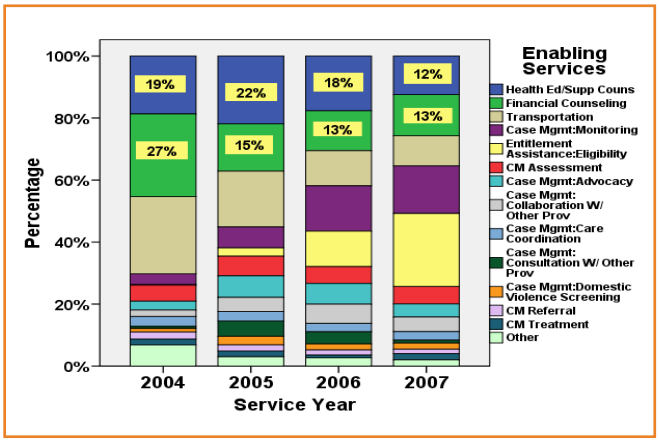
English was consistently the most spoken language. Other Primary Language consisted mostly of Hawaiian.



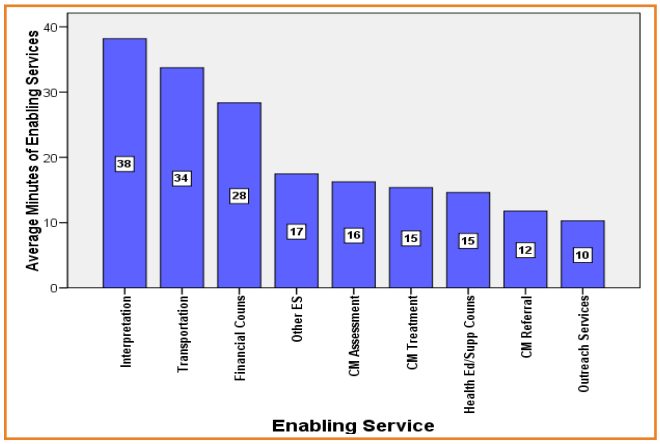
Self-Pay and Medicaid were the most common insurance source.

Examination of Enabling Services at WCCHC

Enabling Services: 2004 - 2007

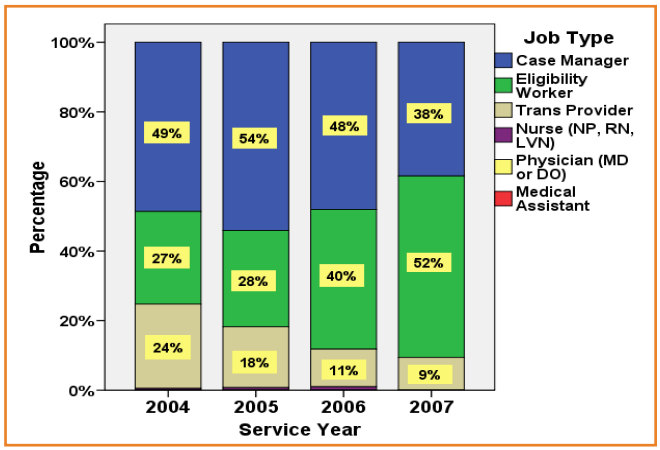


There was an increase in CM Monitoring and a decrease in Transportation from 2004-2007.

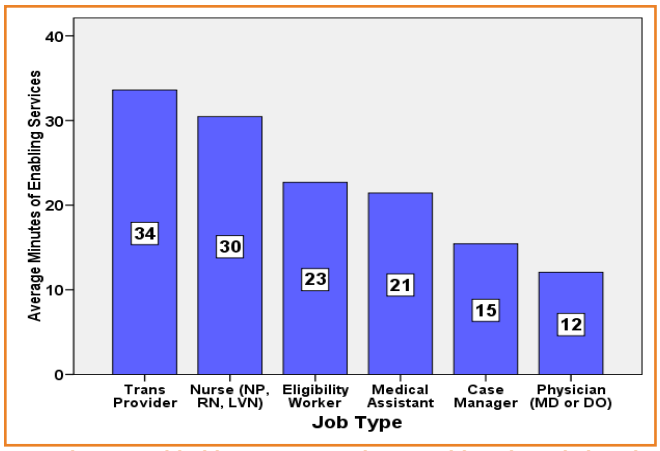


Interpretation (38 min.) and Transportation (34 min.) averaged the longest time.

Enabling Service Providers: 2004 - 2007



Case Managers, Eligibility Workers and Transportation Providers provided the most services.



Services provided by Transportation Providers (34 min.) and Nurses (30 min.) averaged the longest time.

SUMMARY

- The majority of enabling services patients were female (59%).
- The average age of enabling services patients was 31 years old.
- The most common ethnicities served at WCCHC were Native Hawaiian, White and Fillipino. Native Hawaiian comprised half of the patient population (49%).
- The most common language spoken by patients was English (96%).
- The most common insurance sources were Self-Pay (44%) and Medicaid (40%).
- Most enabling services in 2007 were Eligibility Assistance (24%), followed by Case Management Monitoring (16%).
- Most enabling services lasted 10 minutes (49%). Average time of enabling services decreased from 2004-2007 (2004: 27 minutes; 2005: 21 minutes; 2006: 19 minutes; 2007: 19 minutes).
- Interpretation (38 minutes) and Transportation (34 minutes) averaged the longest service time.
- Case Managers (47%), Eligibility Workers (38%) and Transportation Providers (14%) consistently provided most enabling services.
- Services provided by Transportation Providers (34 minutes) and Nurses (30 minutes) averaged the longest service time.

CONCLUSIONS

Culturally and linguistically appropriate enabling services are essential to Asian Americans, Native Hawaiians, and Pacific Islanders and other underserved minorities that receive health care services from community health centers nationwide, such as Waianae Coast Comprehensive Health Center.

By documenting enabling services and examining health outcomes through AAPCHO's Enabling Services Accountability Project, we demonstrate to policymakers the value of enabling services in improving access to care and quality of care to underserved minorities.

Overall, enabling services reduce health disparities and result in improved health outcomes for underserved populations. They are a vital investment in preventive care and reduce emergency room utilization.

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Impact of Enabling Services Utilization on Health Outcomes

Enabling Services Accountability Project

Association of Asian Pacific Community Health Organizations

INTRODUCTION

Asian Americans, Native Hawaiians and Other Pacific Islanders (AA&NHOPIs), especially those that are medically underserved, face substantial financial, cultural, and linguistic barriers that prevent them from obtaining appropriate health care. Enabling services (ES) are non-clinical services such as interpretation, health education, and case management, that can increase access to health care and quality of care at Community Health Centers (CHCs). However, little data is available about the impact of enabling services on quality improvement and health outcomes among medically underserved patients. Because the value of enabling services has not been demonstrated by the existing data, enabling services have not been reimbursed or adequately funded by payers. The limited data is a crucial barrier to securing financial support for these essential services at CHCs.

The Enabling Services Accountability Project is a collaborative effort between the Association of Asian Pacific Community Health Organizations (AAPCHO) and four federally qualified health centers serving predominantly AA&NHOPIs, including Waianae Coast Comprehensive Health Center in Waianae, HI, Charles B. Wang Community Health Center in New York, NY, International Community Health Services in Seattle, WA, and Kalihi-Palama Health Center in Honolulu, HI. This project aims to fill the information gap by developing an enabling services data collection model for CHCs, and examining the impact of enabling services utilization on national quality measures.

The analysis includes eight enabling services measures and two performance measures including adult diabetes and child immunization. The study also compares the demographics between enabling services users and non-users. **The results indicate that enabling services utilization is associated with better diabetes outcomes and child immunization.** It also suggests that enabling services users, compared to nonusers, are more likely to be minorities and with public or no insurance. The project demonstrates the vital role of enabling services in reducing health disparities and improving health services quality. It also illustrates the importance of developing long-term federal and state initiatives to fully support these essential and currently poorly-reimbursed services at CHCs across our nation.

PROJECT GOALS

- To provide a better understanding of the relationship between enabling services utilization and health outcomes for AA&NHOPIs
- To provide useful information that helps policy makers effectively address health centers, as they strive to improve access and quality care to medically underserved AA&NHOPIs and other safety net patients

METHOD

Enabling Service Data Collection Procedure

(1) Data collection period: 1/1/07-12/31/07
(2) Enabling services encounter form used to collect data
(3) Enabling services data collection protocol used as a guideline
(4) Developed study logic model and methodology

Please contact AAPCHO for definitions and data collection protocol.

Enabling Services(ES) Measures

- Case Management (CM) Assessment, Treatment, and Referral
- Eligibility Assistance
- Health Education or Supportive Counseling
- Interpretation
- Outreach
- Transportation
- Other Enabling Services

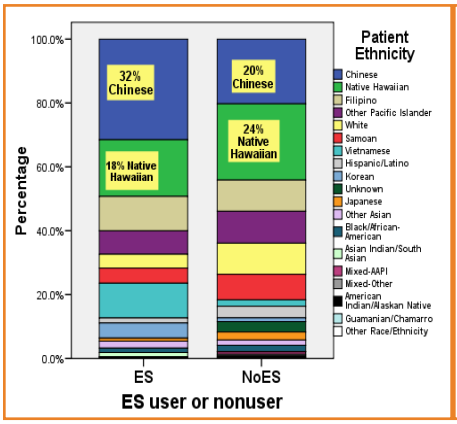
Performance Measures and Study Sample

	Population	Performance Measure	ES Users	ES Nonusers	Total	ES User%
Diabetes	Adult patients 18-75 years of age as of December 31, 2007 with a diagnosis of type 1 or type 2 diabetes	Most recent hemoglobin A1c level in 2007	1,337	1,731	3,068	43.6%
Immunization	Children who turned two years of age in 2007	Appropriate immunizations	291	1,331	1,622	17.9%

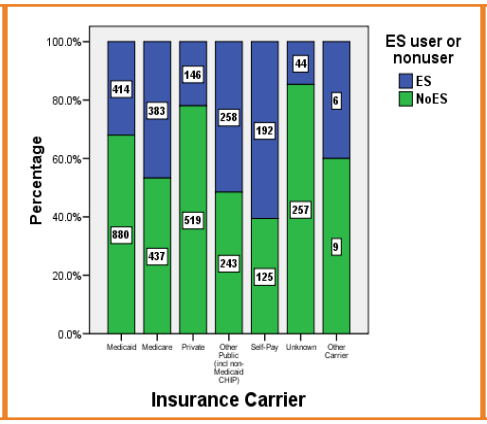
Impact of Enabling Services Utilization on Health Outcomes

RESULTS

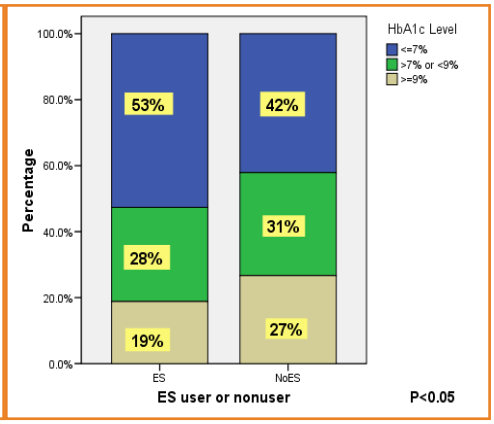
Adult Diabetes



Most patients were AA&NHOPIs.

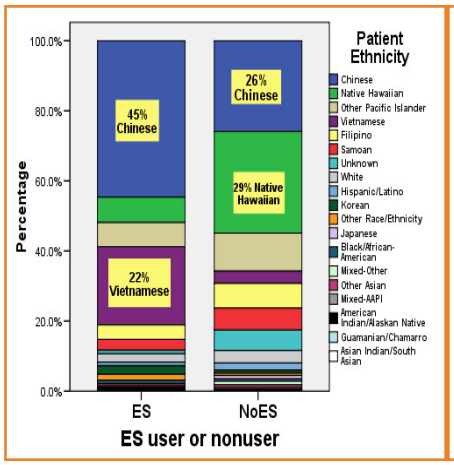


Patients with public or no insurance had the highest percentage of ES utilization.

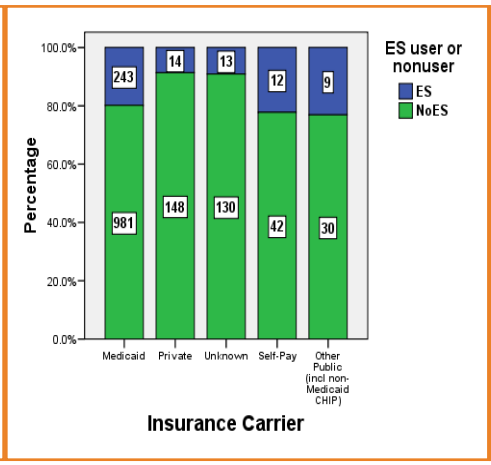


More ES users had their HbA1c under control compared to ES nonusers.

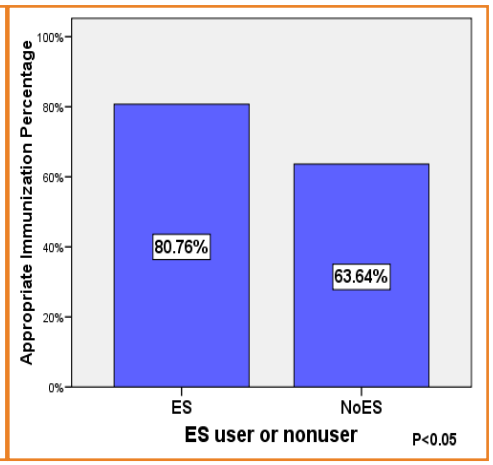
Child Immunization



Most patients were AA&NHOPIs.



Patients with public or no insurance had the highest percentage of ES utilization.



ES users had a higher percentage of patients that received appropriate immunizations.

CONCLUSIONS

- Patients utilizing ES, were more likely to have their HbA1c levels under control, than ES nonusers.
- Patients utilizing ES were more likely to have received appropriate child immunizations, compared to ES nonusers. (81% v.s. 64%)
- The majority of patients were AA&NHOPIs. Chinese, Vietnamese and Native Hawaiian were the largest groups. This is consistent with the characteristics of patients seen at participating CHCs.
- Uninsured (self-pay) patients and patients with public insurance were more likely to use enabling services; patients with private insurance were less likely to use enabling services.
- Enabling services provided at each health center vary greatly; overall, the majority of enabling services provided at CHCs included case management, financial counseling, interpretation and health education.

IMPLICATIONS

- This study demonstrates that enabling services are critical to improving health care outcomes and reducing health disparities for medically underserved populations.
- Health centers which provide a vast number of enabling services deserve to be recognized and reimbursed to sustain these critical services to underserved patients.
- More research is necessary to evaluate the impact of different enabling service measures on health outcomes and other performance measures.

LIMITATIONS

- This study is not a randomized controlled study. ES users and nonusers had unequal sample sizes. ES users, compared to nonusers, were more likely to be minorities and uninsured.
- Enabling services provided were not specific to each performance measure. Future studies will more specifically measure the impact of each enabling service measure.

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Evaluation of Culturally Appropriate Community Health Education on Diabetes Outcomes

Association of Asian Pacific Community Health Organizations
Waianae Coast Comprehensive Health Center

INTRODUCTION

Preliminary evidence based on experiences of staff at a number of health centers suggest that health education plays a critical role in improving health access and outcomes for underserved populations. However, there have been no definitive studies to support this claim due in part to the current lack of health education data collection and evaluation to demonstrate its essential impact on quality of care. Without sufficient understanding of its impact, health education will continue to be inadequately financed, if at all. In fact, the lack of definitive data about health education has been a crucial barrier to demonstrating its value and securing financial support for these essential services at community health centers. This study seeks to fill this information gap by examining the impact health education has in improving HbA1c outcomes of health center patients with diabetes.

As part of the Enabling Services Accountability Project, the Association of Asian Pacific Community Health Organizations (AAPCHO), in collaboration with Waianae Coast Comprehensive Health Center (WCCHC), examined the impact of health education utilization on underserved diabetes patients at WCCHC, a federally qualified health center serving predominantly Native Hawaiian patients. The study compared active and nonactive health education users on diabetes HbA1c or blood sugar levels, an essential measure of diabetes. The results indicated that increased health education visits are associated with improved HbA1c levels, and thus are essential to patient health care. Through this project, we demonstrate the vital role of health center educational services in reducing diabetes health disparities. This project also illustrates the importance of developing long-term federal and state initiatives and funding to fully support these essential and currently poorly-reimbursed services at community health centers across our nation.

Fig. 1 Race/Ethnicity

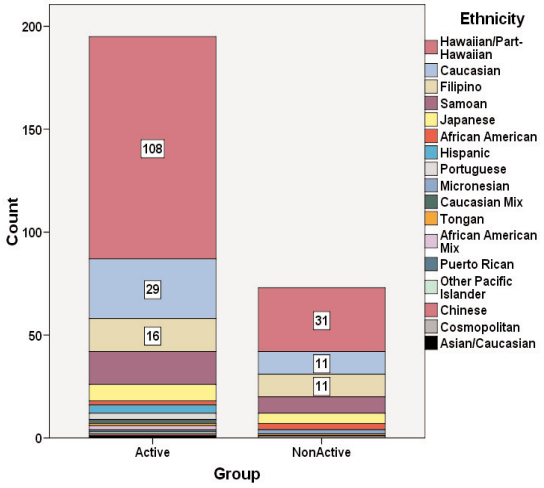
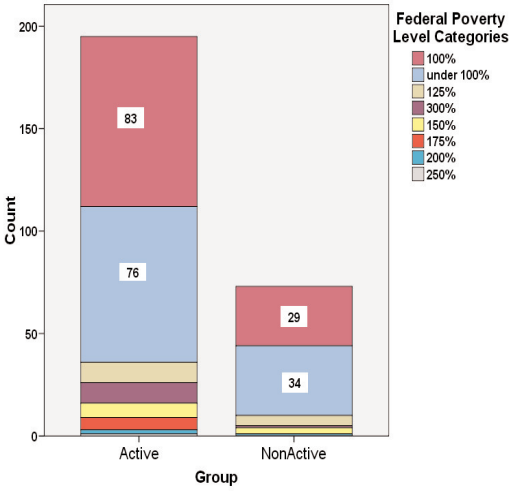


Fig. 2 Poverty Level



METHOD

Sample

- Setting:

Waianae Coast Comprehensive Health Center (WCCHC), a federally qualified health center located in Waianae, Oahu, Hawaii. WCCHC serves over 25,000 patients, 73% of whom are at or below 200% poverty level and 76% are Asian Americans, Native Hawaiians and Other Pacific Islanders (AA&NHOPIs).

- Sample:

The sampling frame included adult diabetes patients (>18 years old) at WCCHC with three or more primary care visits annually between 1/1/02-12/31/05.

- Groups:

Active Group: Diabetes patients with 2 or more health education visits annually between 2002-2005 (195 patients: 46% Male, 54% Female; Mean Age = 47.9 years).

NonActive Comparison Group: Diabetes patients with less than 2 health education visits annually between 2002-2005 (73 patients: 53% Male, 47% Female; Mean Age = 51.9 years).

Data Collection

- Archival electronic patient records were used for analysis.
  - Patients were randomly drawn from the eligible patient population into the two groups based on administrative and clinical data.

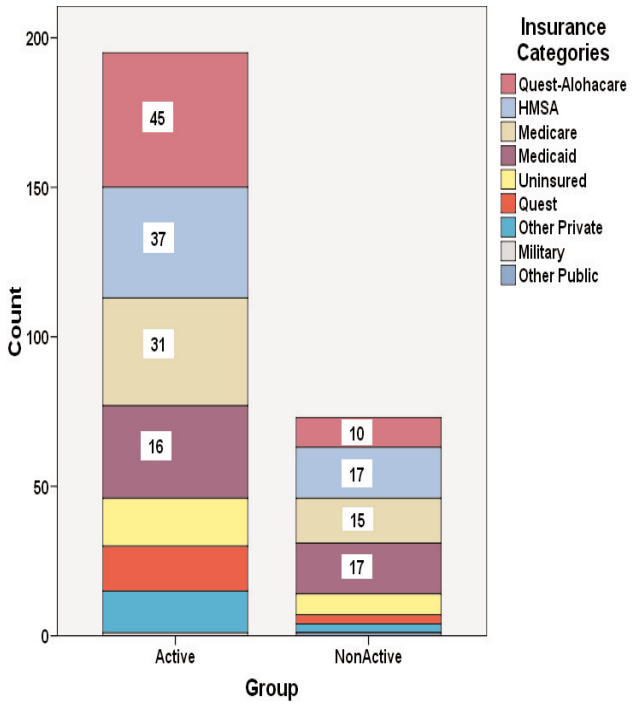
Analysis of Covariance

- Independent Variables: Group (Active, NonActive); Gender (Male, Female)
- Covariates: Age;1st HbA1c value (baseline)
- Dependent Variable: 2nd HbA1c value (average: 12 months later)

Evaluation of Culturally Proficient Community Health Education on Diabetes Outcomes

Association of Asian Pacific Community Health Organizations, Waianae Coast Comprehensive Health Center

Fig. 3 Insurance Status



HEALTH EDUCATION

Diabetes health education at WCCHC is unique as it is based upon the Chronic Care Model that adopts a multidisciplinary approach that includes disease management, medication management, insulin administration & apparatus management (self-monitoring blood glucose for Diabetes Mellitus). Furthermore, WCCHC services are culturally appropriate and tailored to the underserved populations it serves. For example, the health education staff are from the community and therefore are able to develop rapport from shared experiences, facilitating and sustaining engagement.

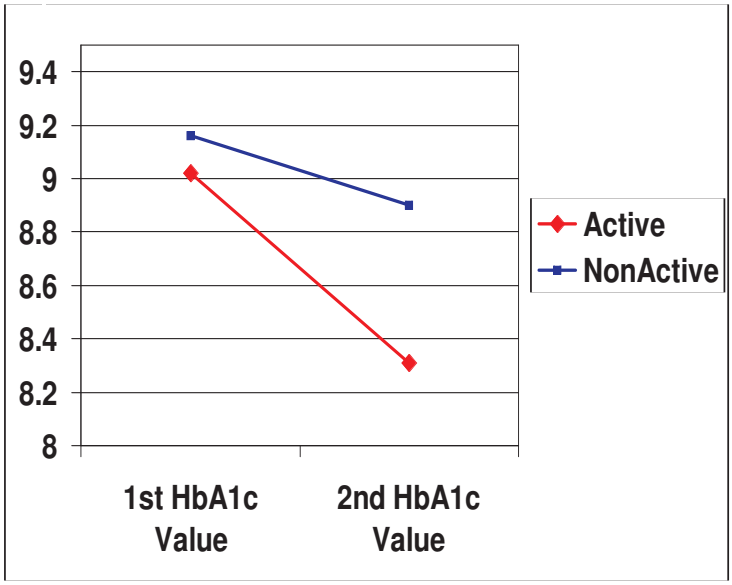
The majority of the health education services included in this study were related to diabetes, although diabetes patients may have received them for other conditions. They were defined as: (1) health education or provision of materials to an individual or family on disease management or (2) education and monitoring of chronic disease through self-management plan.

Since 2000, there has been a decreasing number of diabetes health educators at WCCHC as funding to cover the services has been inadequate to serve the growing numbers of diabetes patients. This study demonstrates the important role of health center educational services in improving diabetes and supports national efforts to demonstrate the value of these essential and currently non-reimbursed services at community health centers.

RESULTS

There were no significant differences between Active and Nonactive groups by gender, age, ethnicity, poverty level, or insurance (Fig. 1,2,3), indicating that diabetes patients in the two groups have similar demographic profiles. A significant difference existed between diabetes health education Active and NonActive users at 12-months after baseline HbA1c value ($F=5.6$, $p< .02$). There was a main effect of HbA1c values indicating that HbA1c values improved for both groups ($F=133.5$, $p<.00$) (Fig. 4). These results suggest that health education improved diabetes outcomes for AA&NHOPI patients, and thus are essential to improving quality of diabetes care for these populations.

Fig. 4 HbA1C Value by Group



CONCLUSIONS / IMPLICATIONS

- The study demonstrates the critical impact of health education on patient health and the importance of sustaining funding for critical health education services at community health centers.
- Culturally & linguistically appropriate health education services are integral components of health center care for underserved populations and reduce barriers to care and health disparities.
- More research is necessary to determine whether other related factors impact diabetes health outcomes, such as presence or attention of providers, number of providers available, and timing of health education service.

LIMITATIONS

There are several limitations to consider in interpreting results. First, although results are promising, it is important to note that health education services were not specific to diabetes management and prevention. Health education sessions were not consistent throughout the study period of 2002-2005 with major fluctuations in health education staffing. In future studies, it will be important to more specifically measure the types and levels of health education and staffing available for these programs. This study also raises issues about the importance of sustaining health education services at community health centers and other healthcare providers. Health education services may have a significant impact as long as there is continual support for sustaining these services. We also cannot exclude the impact of the presence or attention of providers and continuity of care and care management on patients that may have influenced behavior and lead to improvement in their HbA1c levels. We plan to conduct more research to assess the impact of health education and continuity of care on diabetes outcomes.

For further information, please contact Rosy Chang Weir at AAPCHO, 300 Frank H. Ogawa Plaza, Suite 620, Oakland, CA 94612; rcweir@aapcho.org; 510-272-9536 x107.

Highlighting the Value of Enabling Services through Data Collection

Hui Song, MPH
Rosy Chang Weir, PhD

Association of Asian Pacific Community Health Organizations

Purpose of Presentation

- Overview of the Enabling Services Accountability Project
- Review enabling service data collection process
- Discuss implications and importance of enabling services data collection
- Share study findings demonstrating the critical impact of enabling services in improving health

Enabling Services are defined as:

…non-clinical services that are provided to health center patients that promote, support and assist in the delivery of health care and facilitate access to quality patient care.

MGMA 2000

Background & Significance

- Underserved minorities (Asian Americans, Native Hawaiians, Pacific Islanders) face barriers to health care access
- Enabling services assists to increase health care access and reduce health disparities
- Enabling services are inadequately funded
- Little is known about the utilization of enabling services and its impact on health outcomes

Background – Continued

- Budgetary pressures and rising health care costs
- Racial/ethnic disparities in health
- National focus on quality of care and Patient-Centered Medical Home (PCMH)

Enabling services are inadequately funded

- Interpretation services:
  - Nearly 1/3 of CHC patients (6 million people) have limited English proficiency (LEP)
  - LEP services on average take 15 minutes longer, almost double the time for non-LEP patients
- Issue: Only 5% of CHCs reported receiving payment
- Lack of comprehensive data on interpretation and other enabling services is a crucial barrier to securing financial support for these services

Why should health centers collect enabling services data?

- To advocate for sustainable funding for enabling services
- Provide data for reducing barriers to care and racial & ethnic disparities for AA&NHOPIs
- Highlight value of enabling services as integral component of quality health care
- Bring attention to the need for comprehensive care for vulnerable, underserved, & diverse populations
- Be involved in pioneering group of health centers in establishing a common dataset of enabling services

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Objectives

- Develop and implement a new method for enabling services data collection and create a database for enabling services.
- Describe enabling services and the patients who utilize them.
- Evaluate the impact of enabling services on access, outcomes, and utilization of primary care.
- Disseminate findings to health centers and policymakers to guide information for effective resource allocation.
- Facilitate research and expansion opportunities to other health centers.

Partners

- Association of Asian Pacific Community Health Organizations(AAPCHO)
- 4 CHCs
  - Charles B. Wang Community Health Center, New York, NY
  - International Community Health Services, Seattle, WA
  - Kalihi-Palama Health Center, Honolulu, HI
  - Waianae Coast Comprehensive Health Center, Waianae, HI
- Recently Joined
  - Asian Pacific Health Care Venture, Los Angeles, CA
  - Kakua-Kalihi Valley Comprehensive Family Services, Honolulu HI
  - North East Medical Services, San Francisco, CA
  - Waimanalo Health Center, Waimanalo HI
- **AAPCHO is also collaborating with the National Association of Community Health Centers to expand the ES model to all CHCs**

How do health centers benefit?

- Better understanding of enabling services (e.g., volume, time)
- Increased capacity to advocate for enabling services reimbursement and funding
- Increased capacity to track enabling services for research and for funding accountability
- Ability to evaluate staff activities and allocate resources more effectively
- Enabling service staff empowerment

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CHC 1 – Example of Data Use

- Track staff productivity; contribute to employee performance evaluation
- Provide data and list of services for grant reporting
- Places value on enabling service providers, therefore, advocating for more of them
- Provides a means to conduct research, particularly regarding the impact of ES on specific high risk conditions

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CHC 2 – Example of Data Use

- Data collected on how much time staff was spending on each service
- Data revealed much time was spent on managed care enrollment
- Management decision made in response:
  - Bring in managed care plans to enroll patients
  - Free staff time for other services
- Do more case management

CHC 3 - Values & Benefits

- Staff realized that their work was important
- Staff aware of all other enabling services
- Able to develop a standard for the support staff
- Hired more Micronesian interpreters (the need was supported by the data)

EMR ES Implementation- Benefits

- ES staff find that collecting data via EMR is faster than on paper.
- Data is posted in real time.
- Staff documentation is also available in EMR for the provider or other staff to review.
- Once data is made electronic, reports can be pulled for performance appraisals, productivity or grant reports, etc.

Requirements for Implementation

- Clinic provides enabling services
- Senior leadership and management of data collection project
- Commitment to learning the data collection process and to collect appropriate and accurate data
- Workflow and documentation of services needs to be clear and consistent with staff.

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Implementation Plan

- ES categories identified and defined
- Data file layout and transmission protocol established
- ES encounter form established
- Protocol booklet and staff training established
- Data validation and project evaluation
  - Routine meetings
  - Written evaluations
  - ES staff interviews
  - CHC evaluations
  - Cross-check of encounter data

Sample Timeline

Activity	Approximate Timeframe	Available Resources
Complete enabling services needs assessment	1 week	Fact sheets, FAQs, Needs assessment tool
Presentation to key staff to obtain buy-in	1 month	ES project introduction ppt
Develop enabling services encounter form	1 week	Sample encounter forms
Prepare enabling services database	1 month	Sample database, File layout manual
Train enabling service staff to collect data	1 month	Fact sheets, Implementation training protocol, Handbook for enabling services data collection
Train data analysts to enter, code, and clean datasets	1 month	Handbook for enabling services data collection
Complete enabling services implementation readiness assessment	3 weeks	Implementation readiness assessment tool
Implement pilot data collection	4 months	Handbook for enabling services data collection, Handbook quick reference card
Evaluate data entry	3 weeks	Data evaluation tool
Evaluate implementation process	1 week	Implementation evaluation tool
Analyze data	2 weeks	Sample Analysis & Report
Report data	1 week	Sample Analysis & Report
Total Approximated Timeframe	*11 months*	

Previous Studies

Study 1: Evaluation of Culturally Appropriate Community Health Education on Diabetes Outcomes

•What is the the impact of culturally proficient health education utilization on HbA1c outcomes of underserved diabetes patients?

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Methodology

Sample

The sampling frame included adult diabetes patients (>18 years old) at Waianae Coast Comprehensive Health Center (WCCHC) with three or more primary care visits annually between 1/1/02-12/31/05.

Groups:

1. The **Active Group** consisted of diabetes patients with 2 or more health education visits annually between 2002-2005.
   - 195 patients: 46% Male, 54% Female
   - Mean Age = 47.9 years
2. The **NonActive Comparison Group** consisted of patients with less than 2 health education visits annually between 2002-2005.
   - 73 patients: 53% Male, 47% Female
   - Mean Age = 51.9 years

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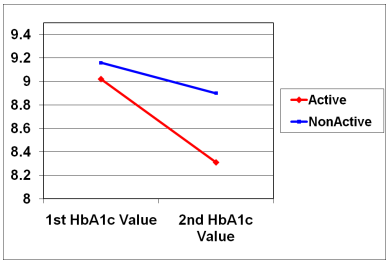
Results

- Significant difference between diabetes health education Active and NonActive users 12-months after baseline HbA1c value (F=5.6, p< .02).
- HbA1c values improved for both groups (F=133.5, p<.00).
- No significant demographic differences between groups.



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Study 2: The Impact of Enabling Services Utilization on Health at Community Health Centers Serving Asian Americans, Native Hawaiians, and Pacific Islanders

Purpose: To analyze the impact of Enabling Services (ES) utilization on health outcomes; and to provide an overview of the demographics of enabling service users and nonusers.

- Diabetes
- Immunization

Goals:

- To provide a better understanding of the relationship between enabling services utilization and process/health outcomes by AA & NHOPIs.
- To provide useful information to help policy makers effectively address health center needs as they strive to improve access and quality care to medically underserved AA & NHOPIs and other safety net patients.

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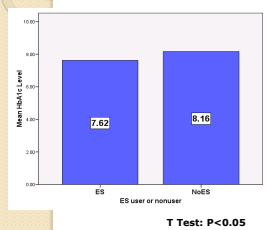
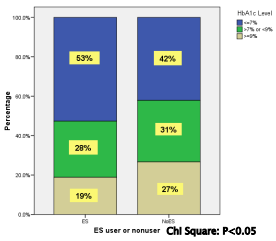
ES users showed significantly better Diabetes outcome than nonusers



T Test: P<0.05



Chi Square: P<0.05

HbA1c level > 7% indicates poorly controlled diabetes

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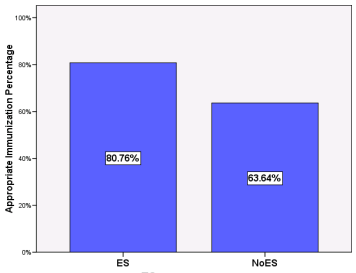
ES Users had a significantly higher percentage of patients that received appropriate Immunizations



T Test: P<0.05

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Overall Conclusions/Implications

- Culturally & linguistically appropriate enabling services are integral components of health center care for underserved populations and reduce barriers to care and health disparities.
- Health centers which provide a vast number and array of enabling services deserve to be recognized and reimbursed to sustain their critical services to underserved patients
- Because health centers go above and beyond by providing critical enabling services, enabling services deserves careful consideration as a standard for medical home criteria **– AAPCHO is now working with NACHC to establish, develop, and issue guidance on nationally recognized standards for enabling services and data collection**

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ENABLING SERVICES DATA COLLECTION IMPLEMENTATION PACKET

notes

ENABLING SERVICES DATA COLLECTION IMPLEMENTATION PACKET

Participate in Enabing Services Data Collection

To demonstrate the quality of care and services that my health center provides for our patients

To highlight the value of enabling services as an integral component of achieving positive health outcomes at my health center

To demonstrate the extent to which we provide enabling services and that our patients rely on these services for their access to care

To support and advocate for providing adequate reimbursement rates and appropriate funding for enabling services for my health center

To support the provision of enabling services to reduce barriers to care and racial and ethnic disparities for underserved patients

To highlight the importance and need for enabling services and bring attention to comprehensive and quality care for vulnerable, underserved, and diverse populations

To obtain a better understanding of enabling services utilization, encounters, and how it affects health care at my health center

To track the time my clinic staff spends on enabling services to support quality management efforts, evaluate services, and design interventions. For example, the data can be used as a management tool by showing patient utilization patterns and use of resources.

To link with other providers/systems to support advocacy of enabling service reimbursement

To be involved in a pioneering group of community health centers serving underserved minorities in establishing a common dataset of enabling services

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