PROJECT access NORTHWEST
SINCE 2006
NEWS
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By Sallie Neillie,
Executive Director

Partnerships are key to our success, now and going forward

Sallie Neillie reflects on her career as she prepares to retire

As I prepare for my retirement at the end of June, I cannot help but reflect on what my time with Project Access Northwest has meant to me. In my 11 years at the helm, this organization sometimes felt like "the little engine that could." ***I think we can, I think we can, I think we can***…

Gosh! I think we did!!

While many people believed in what we were trying to do, there were just as many people telling me that it would never work and that I was just a tad crazy! We started Project Access with a good idea—a "share-the-load," distributed model of charity care. We would work across multiple specialists, systems and counties to help people who didn't have access to the specialty care they needed. Thankfully, some key people joined me in my belief that we could make a difference—working with patients already covered by primary care services but without resources or access to much-needed secondary or tertiary care.

I consider myself one of the luckiest people alive… I got to spend the most significant and meaningful part of my work life making a difference in the lives of people every day… For all this, I humbly thank you…

In our first year, we helped just over 600 patients by partnering with two health systems and providing care for patients at two locations (Swedish's Mother Joseph Clinic and PacMed GI). We worked with a tiny handful of physicians, and we had one program—Care Coordination.

In 2016, we served over 10 times that number of patients in our **Care Coordination** program alone, and we partnered with more than 1,600 clinicians in just about every major system in King, Kitsap and Snohomish counties. We also had **three other programs** that supported both the low-income vulnerable patient population AND the hospital systems: Premium Assistance support, emergency room utilization support and in-patient discharge support. These programs served more than 6,200 additional patients in 2016.

Partnerships drive us forward

Through all this change and growth, one thing has remained constant. **Partnerships.** Partnerships with the community health centers and free clinics. Partnerships with specialty practices. Partnerships with hospital systems. Health care is complicated and complex. It's working together—in partnership—for the health of the people we serve that brings us together and drives us forward.

I consider myself one of the luckiest people alive. I live in the beautiful Northwest. My values match the values of the state where I live. And I got to spend the most significant and meaningful part of my work life making a difference in the lives of people every day. For all this, I humbly thank you for the ability to do what I so believe in—and for your support and help along the way.

New Health Home Program reaches out to patients for intensive care coordination

Health Home care coordinators help develop patient-centered Health Action Plans to support patients in achieving their goals.

Project Access Northwest has launched its newest care coordination effort, the **Health Home Program**, which provides intensive, home-based, care coordination services for individuals with one or more chronic conditions. Health Home services are covered by Washington state's Medicaid program and are designed to address complex health issues through a "whole-person" approach.

"It's a perfect, natural fit for us and our patient-centered approach," explains Executive Director Sallie Neillie. "The Health Home Program allows us to reach patients at home and meet them where they are — emotionally, spiritually, physically — to help improve their health and their lives based on their personal goals. It's like putting on steroids everything we've always done, continuing our patient-centered approach that supports using the health care system efficiently."

Our Health Home care coordinators provide in-person visits at our patient's home or another convenient setting and help develop a patient-centered Health Action Plan to support each individual in achieving personal goals. These goals can be health-related or lifestyle-related, such as being able to cook a meal independently. Patients will receive a wide variety of services to support their goals, including comprehensive care management, care coordination, health education and coaching, transitional care and follow-up, and referrals to community and social supports, so they know where to find services that meet their needs. While one patient may need a wheelchair ramp built at home to increase mobility, another may need help managing medications or understanding a doctor's instructions. Our Care Coordinators will help identify and eliminate these barriers to care.

Our pilot partner: Coordinated Care

Project Access Northwest has partnered with **Coordinated Care** to launch our pilot Health Home Program in King and Snohomish counties. While Health Home programs have been operating in other counties throughout Washington state since 2013, the program is new to Snohomish and King counties in April 2017.

Coordinated Care reached out to Project Access Northwest because of its proven track record in care coordination. Together, we will work to identify and contact Coordinated Care patients who qualify for the new Health Home benefit. Typically, patients will have at least one significant chronic medical condition or a serious mental health condition, and be at increased risk for future medical needs. Once identified, these patients will work with a care coordinator who will partner with them, their families, doctors and other agencies to ensure that everyone is on the same treatment plan. Patients will receive services for as long as they need and are moving forward in their goals.

Ambitious goals

The Health Home Program is designed to: improve the quality and coordination of care across systems; increase patient engagement and confidence in self-management of health goals; slow the progression of disease and disability; and reduce expenditures in the rising costs of care.

Encouraging results

Patients who have participated in the Health Home Program in other parts of the state report significant improvement in health or quality of life, as well as appreciation for the role of their care coordinator. Initial studies demonstrate significant health care savings as well, as patients receive the right level of care at the right time.

STAFF UPDATES

Welcome Health Home Director Symone Edwards, RN

Symone Edwards, RN

Project Access Northwest is delighted to welcome **Symone Edwards, RN** as the director of the new **Health Home Program**. Symone is a registered nurse and certified case manager, with bachelor's degrees in nursing, anthropology and sociology/psychology. She bring 17 years of experience in social services and health care, working in housing, children's services, mental health, and care management. Symone is passionate about integration of services, increasing access, and bringing about positive health changes for patients.

"I am very excited to lead this new team in providing innovative care coordination services to patients," says Symone, who previously served as the care manager for Sea Mar's Care Management program in Snohomish County. "I saw the great impact this program can have for patients, and I am excited to be continuing this incredible work."

SPOTLIGHT on our partners

Coordinated Care: A powerful partner across all our programs

coordinated care™

This month we spotlight Coordinated Care, our partner in our Care Coordination, Primary Link and new Health Home programs.

As one of the state's five managed care organizations, **Coordinated Care** serves more than 250,000 Washington residents, including children and young adults in the foster care system through Apple Health Core Connections. Though part of a large national corporation, Coordinated Care has a strong focus on serving the individual with a "whole person" approach and developing local partnerships to enable "meaningful, accessible health care."

Project Access Northwest has partnered with Coordinated Care in many ways. We work with hundreds of their clients in our **Care Coordination** program annually, helping remove barriers to care that some Medicaid patients face. We will also be partnering with them in our **Primary Link** program—working hard to ensure that patients are getting the right care in the right location and that our emergency rooms are reserved for the most urgent issues. And now Coordinated Care is our first partner as we launch our **Health Home Program.**

Jay Fathi, MD

"We are very excited to be bringing the Health Home Program to King and Snohomish counties. It empowers our patients to advocate for their own health while having the support of a caring, knowledgeable coordinator," says Coordinated Care CEO Jay Fathi, MD. "Partnering with Project Access Northwest was an easy decision—they have been doing this type of work since their inception and they are experts in care coordination."

Empowering people to manage and improve their own health aligns well with the missions and goals of both organizations. ***See page 2 for details on the Health Home Program.***

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