

Lessons from the Evaluation of the



MEN'S
HEALTH
INITIATIVE

A PROGRAM OF THE
NATIONAL CENTER FOR PRIMARY CARE
AT MOREHOUSE SCHOOL OF MEDICINE

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Life Stressors that Severely Impact Men's "Whole Health"

- In the communities served by the Men's Health Initiative grantees, there are:
 - High poverty and unemployment rates
 - High rates of homelessness
 - High imprisonment and recidivism rates
 - High rates of violence, emotional/psychological trauma, and Post-Traumatic Stress Disorder
 - High rates of mental illness and/or substance abuse
 - High incidences of HIV/AIDS transmission and death
 - High prevalence of chronic diseases

One Men's Health Initiative grantee reported that for 117 men that were followed over a two year period (2001-2003) the top three outpatient diagnoses were all alcohol and drug dependency-related (alcohol dependence, drug dependence, and alcoholic psychoses)



Evaluation of the Men's Health Initiative Reveals that Grantees are Supporting Diverse Subgroups of Men

- Among the men served by the Men's Health Initiative grantees, there are:
 - Youth/Adolescents
 - Homeless Men
 - Ex-Offenders
 - Immigrants
 - Urban Men
 - Seniors



The Subgroups of Men Face a Number of Unique Access Barriers and Challenges that Impact their Abilities to Address “Whole Health” Issues

ALL MEN	Youth	Homeless Men	Ex-Offenders	Immigrants	Urban Men	Seniors
<ul style="list-style-type: none"> •Lack of insurance, affordable services and knowledge of options •Poor health education and lack of access to valuable information •Failure to seek care/men’s distrust of medical institutions •Insufficient medical and social services targeting men’s needs •Social stigma and biases associated with race, traditional gender roles, poverty. •Policy barriers 	<ul style="list-style-type: none"> •Social stigma associated with age, race, sexual orientation and prejudice •High-risk behaviors – sexual behaviors, drug and alcohol use 	<ul style="list-style-type: none"> •Employment/ income instability and transience •Social stigma associated with poverty, race, HIV status and prejudice •High-risk behaviors – sexual behaviors, drug and alcohol use 	<ul style="list-style-type: none"> •Judicial system involvement and limited citizenship •Employment/ income instability and transience •Social stigma associated with criminal records, race and prejudice •High-risk behaviors – sexual behaviors, drug and alcohol use •Losing points of access when transitioning back to community 	<ul style="list-style-type: none"> •Racial/ethnic stigma and prejudice •Language and cultural competence barriers 	<ul style="list-style-type: none"> •Social stigma associated with race, perceptions as criminals,sexual orientation and prejudice 	<ul style="list-style-type: none"> •Lack of coordinated efforts to address health issues •Often left out or overlooked because perception is that the Medicare system captures them.

Men's Health Grantees Implement Strategies that Are Successfully Providing and Linking Men to Needed Services

- Case Management Models Tailored to Men:
 - Employing male case managers from clients' neighborhoods who have similar backgrounds
- Training Male Outreach and Case Workers
 - Developing programs to reach and train men without regard for traditional educational requirements. There are some barriers within institutions to hiring workers who look like the target population, but have criminal records.
- Establishing Men's Health Clinics that Provide Primary Care to Men
 - Safe havens for all types of men, providing access to care services regardless of insurance status
- Co-Location of Physical Health and Mental Health Services
 - Recognition of the need for referral-less resources to address stress, trauma and violence related issues.

Men's Health Grantees Implement Strategies that Are Successfully Providing and Linking Men to Needed Services

- Forming Community Coalitions to Empower Communities to Improve Men's Health
 - Recognition of the many factors that influence men's health such as housing and employment. Helping non-traditional community partners understand their roles in ensuring high standards of health for men.
- Reproductive Health Education for Young Men
 - Providing education, beyond prevention, to a target population that does not conceive of reproductive issues as being related to their health.
- Community Dialogues and Focus Groups
 - Strategies to bring the immediacy of the men's health crisis to the consumer/resident level and empower community members to take responsibility for improving men's health.

Many traditional health strategies and approaches have to be re-conceptualized and adapted to men's "whole health" needs.

Men's Health Grantees are Beginning to Produce Noteworthy Outcomes

- Over the past two years, Men's Health Initiative Grantees have:
 - Provided case management services. One site reported reduced recidivism among case managed clients.
 - Provided teens with reproductive health care, counseling, health education or other support.
 - Reported reduction in ER use and more appropriate use of primary care services at one site.
 - Enrolled more men into public coverage programs.





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Case Management and Re-Entry



Case Management Facilitates Successful Re-Entry

- **Grantee staff and service clients observed that ex-offenders face major barriers to successful re-integration in communities:**
 - *Homelessness* which study respondents identified as being a predictor of recidivism.
 - *Joblessness* and a general lack of the material means to support or care for oneself.
 - *Lack of “Life Skills”* including formal education, parenting skills and job skills.
 - *Special Medical Needs* including mental health and substance abuse needs.
 - *Inadequate Support Systems* as many men lack relationships with family and friends. Often times their only social networks are in prisons.
 - *The Inability to Navigate Institutional Support Systems* including medical and social services. Ex-offenders know how to navigate corrections and court systems, but not support systems.
- **Case management and well-developed, strategic networks of community partnerships are integral to making certain that men being released from corrections facilities are effectively re-integrated into communities.**

Case Management Facilitates Successful Re-Entry

- **To promote successful re-entry, case management models must be relationship driven. As such, the roles that case managers play are critical.**
 - Case managers begin developing relationships with men in prisons/jails and are the first point of contact for men when they are released.
 - Case managers have hands-on relationships with both prisons/jails and the organizations that support men once they are released from prison/jail (including shelters and half-way houses, alcohol and substance abuse programs, primary health services and social services) and, as such, play important roles as “connectors” between community resources.
 - Case managers are “guides” for men and help them navigate formal and informal support systems.
 - Case managers are “capacity extenders” for support organizations and institutions as they often provide more directed and intensive one-on-one assistance.

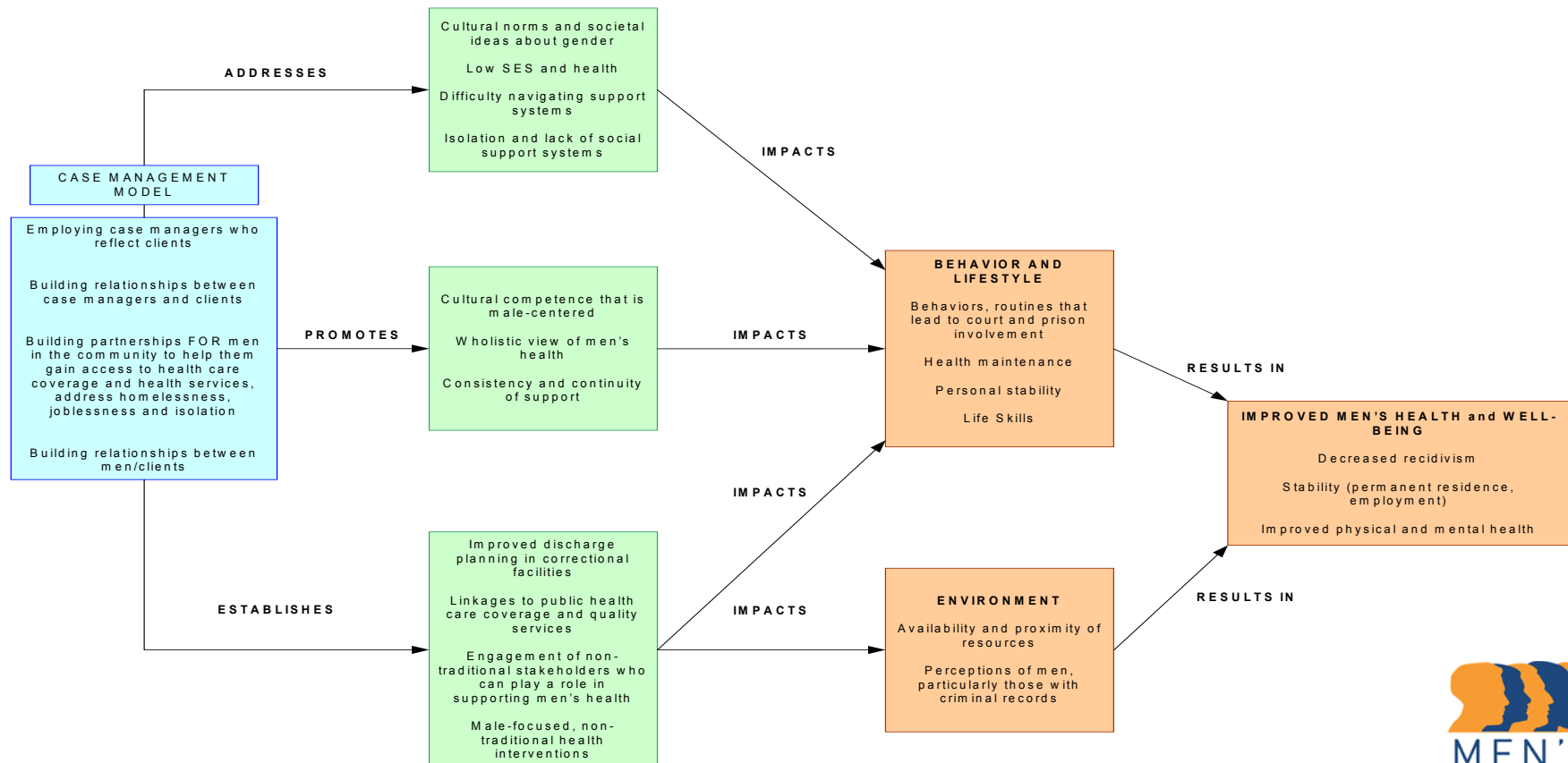
Again, WHO the case manager is matters! Case managers must be culturally competent – prepared to meet clients where they are, be it in prisons, shelters, half-way houses or on the street. The right case manager comes from and/or understands these men’s life circumstances and is not intimidated by the settings in which they work nor by the men themselves.

Case Management Facilitates Successful Re-Entry

- **To ensure the effectiveness of case management for re-entering men, the right resources have to be networked in the community. The hospital and public health institutions that sponsored case management services under the Men's Health Initiative:**
 - Developed partnerships with local jails and prisons that improved corrections discharge processes by getting case managers into facilities to assist men in exiting, enroll them into public health care coverage programs and direct them to clinical services (especially mental health and alcohol and substance abuse services).
 - Developed relationships with local courts and case managers serve as advocates for men regarding legal matters (including criminal and child custody issues)
 - Developed relationships with institutions that could provide transitional or permanent housing.
 - Developed relationships with organizations that provide adult learning opportunities, job training and employment assistance. Case managers are critical advocates here as they often vouch for ex-offenders with potential employers.
 - Created forums for connecting men with one another so that they could begin developing healthy social support networks that help them deal with many re-entry issues (i.e., reconnecting with families and children, changing life habits that led to incarceration, etc.).

Case Management Facilitates Successful Re-Entry

- As opposed to abstracting a model from the Men's Health Initiative of the "correct" community configurations that must be established to support re-entering men, we propose a model that draws on the initiative to illustrate a pathway to improved health and well being for men who have been incarcerated.



Building Effective Case Management Models

- The model on the previous slide indicates that case management tailored to men is critical to addressing their “whole health” needs:
 - Effective models must balance outreach and case management
 - Staff must reflect the client population
 - Relationship-building is foundational to providing effective outreach and case management
 - Case management has to be provided with an eye towards providing men with support systems that they often lack in their lives (i.e., family, peers, etc)
 - Case managers must be trained to identify and address the emotional/psychological trauma that is at the heart of men’s health-affecting behaviors and overall well-being.

Researchers conducting the Men’s Health evaluation learned that the physical health focus of case management programs is a critical gateway to dealing with men’s “whole health” issues. Once case workers and providers prove that they can deliver remedies and/or support for physical health concerns, men are likely to continue to pursue assistance in other areas of their lives.

Barriers to Providing Effective Case Management

- While the model illustrates a clear path to men's improved well being, establishing case management systems based on this model is not easily accomplished as:
 - Hospitals, public health departments and other case management-sponsoring institutions are often resistant to hiring case managers who look like the client population (i.e., men with relatively little formal education, men with criminal records, etc.)
 - Case management programs cannot provide men with health care coverage if coverage options for men do not exist at federal and state levels.
 - This model greatly depends on the integrity of the relationships that men form with case workers. If trust is not established between case managers and clients, men will NOT:
 - Put forth the effort to attend medical and social service appointments,
 - Follow-up with physicians and
 - Regularly use the resources made available through case management programs.





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**Cultural Competency, Health Education and
Community Involvement**



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Establishing Cultural Competency Standards, Policies and Practices Specific to Men

- Providers and institutions are still struggling to integrate and implement the standards, policies, and practices of cultural competence into their organizational structures:
 - Dealing with individuals with diverse sexual orientations and identities
 - The fear of men of color and poor men
 - Institutions not sensitive to issues that are faced by homeless men and men who have been in prison
 - Institutions having difficulty providing for men with mental illness and substance abuse issues.



Improving Health Education for Men and the People who Care for Them

- Health education (not simply information) that targets men and the people who care for them is sorely needed:
 - Preliminary evidence reveals that many men do not understand what reproductive health is and what it has to do with them.
 - Neither men that we spoke with nor providers we interviewed raised HIV/AIDS as a concern. Messages about the proliferation of the disease in poor and minority communities does not seem to be getting through and there is still a deafening silence around the issue.
 - Men desire information that is detailed and specific, enabling them to feel as though they have mastered a skill as opposed to having received a lecture.
- Health education is also needed for providers and other community stakeholders:
 - Providers and other community stakeholders need to be educated about the men who are most in need in order to dispel fears and prejudices that prevent the provision of adequate treatment and support.

Community Support Is Essential to Addressing Men's Health

- Community buy-in and community organization around men's health issues are essential to supporting men and sustaining work focused on men's health:
 - The sites that were most effective in learning about, reaching and providing support for men either already had or developed broad community networks through which they were able to build political will for men's health efforts, marshal resources, create or tap service extensions, and offer men more comprehensive support options.
 - These sites were also successful in transferring capacity (knowledge, resources, etc.) to other community stakeholders that will prepare and empower them to address men's health needs.
 - The broad community buy-in that some sites are developing will ensure that the work to support poor men and men of color will be sustained in the community even if the local grantee organization is not taking the lead in continuing the work.



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**Messages from Men Being Served by
Initiative Grantees**

Messages from Men Being Served by Initiative Grantees

- Evaluators interviewed men participating in Men's Health Initiative programs across the six grantee sites. As a part of these interviews, we asked men a number of questions that we extracted from the 2003 National Health Interview Survey (NHIS) to learn:
 - About the places that they most frequently go for primary care;
 - Whether or not they have places that they regularly go for care;
 - About the frequency with which they visit physicians;
 - About the types of physicians that they tend to visit;
 - About the access barriers that have prevented them from getting care.



Messages from Men Being Served by Initiative Grantees

- Results from the NHIS questions that were posed to interviewees about their health seeking habits reveal that:
 - Fifty percent (50%) of the men we spoke with most often seek primary care at neighborhood or hospital-based clinics.
 - Seventy-five percent (75%) of the men we spoke with had seen a primary care physician or general practitioner in the past 12 months.
 - Several men that we spoke to made visits to specialists over the past 12 months:
 - One quarter (25%) saw physical, speech, respiratory, or occupational therapists.
 - Approximately equal numbers (20%) saw mental health professionals, optometrists or ophthalmologists, and chiropractors.
 - On average, men that we spoke with had last seen a dentist seven (7) months prior to the the time of our interview. However, several men had not seen a dentist in over a year.




Messages from Men Being Served by Initiative Grantees

- Results from the NHIS questions that were posed to interviewees about the access barriers that have prevented them from obtaining adequate primary health care reveal that:
 - One quarter (25%) of the men we spoke with most often delayed care due to a lack of transportation.
 - Equal numbers of men (20%) most often delayed care because:
 - They could not contact their doctors by phone to schedule an appointment;
 - They could not get appointments soon enough; and
 - Once they got to the doctors office, had to wait too long.
 - Forty percent (40%) of the men we spoke with did not receive dental care that they needed because they could not afford it.



Messages from Men Being Served by Initiative Grantees

- In addition to asking men about their health seeking habits, Abt staff asked interviewees to more broadly discuss their experiences with physicians, medical professionals and medical institutions. Over the course of our discussions several insights emerged that might help us to calibrate health care services and programs to men's needs.
 - Several men that we spoke with commented that they would rather see female physicians than male physicians.
 - They noted that female physicians are easier to “connect with”;
 - Many commented that they felt less self-conscious about undressing in front of a woman.
 - Several men commented that they have begun participating in group therapy sessions through the Men's Health Initiative and observed that these sessions are positive, non-threatening interventions through which they can address life stressors and mental health issues.
 - Men told us that they can learn to navigate health and social service systems if there are adequate and accessible educative resources.



**Policy Implications from the
National Center for Primary Care at
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**Addressing Men's Lack of Insurance through
State-Sponsored Coverage Programs**

State Coverage Programs

- The Medicaid program and related waiver and exception programs offer too few coverage options for men without dependent children:
 - By and large, state Medicaid programs do not provide coverage for low-income men who do not have a dependent child in the household.
 - In recent years, states have taken advantage of federal waiver programs (*the HIFA Section 1115 Waiver*) that allow them to extend coverage to adults without children.
 - Currently, fifteen states and the District of Columbia operate programs that cover single, childless adults.
 - Most of these take advantage of federal matching funds provided through Medicaid waiver programs.
 - However, most Medicaid waiver or exception programs (*Medicaid Section 1931, Medicaid TMA and SCHIP Expansions*) still target families and do not seek to extend coverage to populations that are not Medicaid eligible including single adult men.

State Coverage Programs

- The Men's Health Initiative evaluation team performed a review of state-sponsored coverage options in each of the states participating in the Men's Health Initiative. Results of the review show that:
 - All states in which Men's Health grantees operate offer some kind of coverage program for low-income, uninsured residents.
 - Of the 22 coverage programs that were identified across the five states, only 11 cover adult men under the age of 65 for primary and emergency care.
 - Other programs for which men are eligible include categorical programs. These include disease/condition (HIV/AIDS, kidney disease) specific programs and prescription drug assistance programs.

In order for men to be eligible for coverage under many state-sponsored programs they, often times, cannot be Medicaid eligible, must have exhausted all other payment resources (Medicaid and Medicaid waiver benefits, if eligible) and/or be suffering with a chronic condition or disease.

State Coverage Programs

- Another important finding from our review of state-sponsored programs, is that all identified programs are in some way constructed around the Medicaid program as they do at least one of the following:
 - Draw on or apply Medicaid resources in “new” or alternative ways;
 - “Extend” Medicaid by providing coverage where Medicaid benefits end;
 - Model eligibility criteria on the Medicaid program, employing similar income/asset thresholds and program designs that still primarily support families (i.e., women and children).

In order to address men’s health, we must consider the degrees to which Medicaid provides a sufficient model for alternative coverage vehicles. We must explore and/or cultivate resources outside of the Medicaid pool and structure programs that include eligibility criteria that are calibrated to men’s health needs.

Health Care Coverage Options in the Men's Health Initiative States

Medicaid						State Programs		
	Section 1115	Section 1931	HIPP	TMA	HIFA	Coverage Options	High-Risk Pool	Tax Incentives
Colorado					✓		✓	✓
Florida		✓					✓	
Georgia			✓					✓
Maryland		✓					✓	
Massachusetts	✓		✓			✓		
Mississippi							✓	

State-sponsored programs that provide primary and emergency care coverage for men in the Men's Health Initiative States

State Coverage Programs

Colorado	Florida	Georgia	Maryland	Massachusetts	Mississippi
<ul style="list-style-type: none"> ■ Cover Colorado ■ Colorado Indigent Care Program ■ “Colorado Community Health Network” 	<ul style="list-style-type: none"> ■ “Medically Needy Program” 	<ul style="list-style-type: none"> ■ “The Indigent Care Trust Fund” ■ “The Disproportionate Share Hospital Program” 	<ul style="list-style-type: none"> ■ Maryland Primary Care (MPC) ■ Maryland Pharmacy Assistance Program* 	<ul style="list-style-type: none"> ■ “MassHealth Basic” ■ “Center Care” 	<ul style="list-style-type: none"> ■ None were identified

*Participation in the Maryland Pharmacy Assistance Program is a pre-requisite for participation in the Maryland Primary Care Program

State Coverage Programs

- States have implemented coverage options that men can access that should be examined and considered for replication:
 - **Colorado: Cover Colorado** is a non-profit entity created by the Colorado Legislature to provide medical insurance for eligible Colorado residents who, because of a pre-existing medical condition, are unable to get coverage from private insurers. Cover Colorado offers a statewide major medical plan, with five deductible levels to choose from, using a local PPO network. An individual is eligible for coverage if they have applied for individual health insurance and:
 - The application was accepted within the last 60 days, but at a premium rate higher than a comparable Cover Colorado plan rate;
 - Were denied coverage within the past 6 months because of a pre-existing condition;
 - Have had medical insurance involuntarily terminated (not including exhaustion of COBRA benefits); or
 - Be uninsured and be diagnosed with a recognized presumptive medical condition.

State Coverage Programs

- Overview of model state options (cont.):
 - **Florida:** The **Medically Needy Program** is designed to assist people with high medical bills but whose income is too high to qualify for traditional Medicaid programs. The program mostly covers people who have experienced a very serious illness and either have no health insurance or have exhausted their benefits. This is a “share of cost” (like a deductible) system and the amount varies depending on the family’s size and income. To qualify, individuals must have total gross incomes after medical expenses that fall below the thresholds for regular Medicaid:
 - For a household with one person, his gross income after medical expenses must be less than \$5,000.
 - For a household of four persons, total gross income after medical expenses must be less than \$6,500.

State Coverage Programs


- Overview of model state options (cont.):
 - **Georgia: The Disproportionate Share Hospital** program is a federal program that aims to increase health care access for the poor. Hospitals that treat a "disproportionate" number of Medicaid and other indigent patients qualify to receive DSH payments through the Medicaid program based on the hospitals' estimated uncompensated cost of services to the uninsured.
 - Hospitals must qualify for DSH to provide coverage under this program by meeting several federal and state criteria.
 - Many of the qualifying criteria call for hospitals to provide non-emergency obstetrical services, serve Medicaid recipients and provide care for infants and children. ***As such, men may still have great difficulty accessing this program.***
 - The **Indigent Care Trust Fund** – which is funded through voluntary intergovernmental transfers or contributions from public hospitals and other governmental entities and matching federal funding – represents the largest component of DSH payments distributed through Georgia Medicaid. With this funding, uninsured people – including many men – who are not Medicaid qualified can receive care.

State Coverage Programs

- Overview of model state options (cont.):
 - **Maryland:** The **Maryland Primary Care** program offers office based medical services to low income adults requiring regular attention for chronic medical conditions. Medical care providers furnish services including treatment for acute and chronic illnesses as well as age appropriate health care promotion screening. To qualify, individuals must:
 - Be between the ages of nineteen and sixty-four;
 - Hold a valid Maryland Pharmacy Assistance Program card (meaning that individuals must be Medicaid ineligible and have monthly incomes that do not exceed \$900);
 - Have no access to medical care through insurance, medical plans, Medicare, federal Medical Assistance, employer , Workers Compensation coverage or Veterans Administration etc. and
 - Have a qualifying medical condition.

State Coverage Programs

- Overview of model state options (cont.):
 - **Massachusetts: MassHealth Basic** provides coverage for:
 - Individuals or members of a couple who receive EAEDC cash assistance who have no health insurance;
 - Department of Mental Health clients less than 65 years of age who are not receiving unemployment compensation, and have been unemployed for more than a year, are not eligible for unemployment, and do not have other health insurance. If there is a spouse, he/she must be working less than 100 hours a month.
 - Eligibility is dependent upon family size and families' combined gross monthly incomes as compared to federal poverty guidelines.
 - For many applicants, there is no asset limit under this program.



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Opportunities and Threats

Public Policy Opportunities

- A March 1, 2004 press release from the Sullivan Commission announces Senator Bill Frist's (R) efforts to pass the "Closing the Health Care Gap Act" which aims to eliminate racial disparities in health care. The proposed bill, if passed as it is currently drafted will:
 - Enhance education and research opportunities for minority populations;
 - Increase access to quality care for minority populations;
 - Improve data collection with regard to clinical and administrative information about minority populations;
 - Create more opportunities for public-private partnerships that benefit minority populations; and
 - Make permanent the Office of Minority Health at the Health and Human Services Department.

Public Policy Opportunities

- On March 10, 2000, the Georgia General Assembly passed House Bill 1235, which created the *Georgia Commission on Men's Health*, to address the ongoing, increasing and predominantly silent crisis in the health and well-being of Georgia men.
- Since its establishment, the Commission on Men's Health has worked to:
 - Develop strategies, public policy recommendations, and programs that are designed to educate Georgia's men on the benefits of regular physician check-ups, early detection and preventive screening tests and healthy lifestyle practices;
 - Focus on improving health outcomes in diseases such as prostate and testicular cancer, cardiovascular diseases, depression and suicide, and diabetes;
 - Monitor state and Federal policy and legislation that may affect the areas of men's health;
 - Recommend assistance, services, and policy changes that will further the goals of the Commission; and
 - Submit annual reports on the Commission's findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Public Policy Threats

- An April 7, 2004 press release from the Sullivan Commission announces that the U.S. Congress is proposing several changes to the proposed “Closing the Health Care Gap Act” that overlook the importance of race as a health disparity determinant and minimize the bills original intent to close the racial divide. Proposed changes would:
 - Cut financing for clinical programs supporting minority populations; and
 - Reduce financing for scholarships for minority and disadvantaged students pursuing medical careers.



Key Informant Policy Targets

- Key Informants interviewed for the Evaluation of the Men's Health Initiative identified several other policy targets that influence health care financing and public policy targets:
 - Health Education:
 - Health education targeting men must be integrated into primary and secondary school curricula;
 - Messages about men's health must also be directed at the individuals and networks that support men including women and care providers.
 - Reliable funding for Men's Health
 - Efforts to improve men's health are still in demonstration and experimental phases. Because many are still unsure about what men's health is and how to address it, resources to support men's health efforts are often inconsistent and fragmented.



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