2.b.iii ED Care Triage for At-Risk Populations

Project Objective: To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s). Objective is also to improve provider-to-provider communication and provide supportive assistance to transitioning members to the least restrictive environment.

Project Description: Emergency rooms are often used by patients to receive non-urgent services for many reasons including convenience, lack of primary care physician, perceived lack of availability of primary care physician, perception of rapid care, perception of higher quality care and familiarity. This project will impact avoidable emergency room use, emphasizing the availability of the patient's primary care physician/practitioner. This will be accomplished by making open access scheduling and extending hours, EHR, as well as making patient navigators available. The key to this project's success will be to connect frequent ED users with the PCMH providers available to them.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Establish ED care triage program for at-risk populations.
2. Participating EDs will establish partnerships with community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.
    a. All participating PCPs Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3.
    b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.
    c. Ensure real time notification to a Health Home care manager as applicable.
3. For patients presenting with minor illnesses who do not have a primary care provider:
    a. Patient navigators will assist the presenting patient to receive a timely appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.
    b. Patient navigator will assist the patient with identifying and accessing needed community support resources.
    c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).
4. Establish protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)
5. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The WNY Community Needs Assessment revealed that Western New York performs worse than NYS as a whole for Medicaid ED care and overuse. The region has an observed rate of Medicaid potentially preventable ED visits 8% higher than the state as a whole. Chautauqua County in particular stands out with a risk-adjusted rate 46% higher than the state average. Within WNY, Medicaid patients have the highest rate of ED use, with 45% visiting an ED for care in the past year. On the other hand, primary care is underutilized, as WNY has a 28% lower primary care practitioner (PCP) visit rate than the statewide average, and a lower percentage of Medicaid beneficiaries with a PCP visit in the past year The Medicaid PCP visit rates for Erie and Niagara Counties are 30% and 29% lower than the statewide rate. Community survey respondents in all five PPS counties listed "Access to Care" as the most critical need for health care in their community, and surveyed patients indicated that they would rather go to urgent care or an emergency room because it is quicker and they do not need to wait for an appointment. Based on the findings of the CNA, CPWNY will meet the needs of the community through the expansion of resources including our health homes, patient-centered medical home primary care practices, patient navigators and Community Care Teams. These teams are multidisciplinary care management teams that support the state's highest need residents by providing individualized care plans, intensive care management, in home visits, health coaching, and beneficiary engagement with appropriate community resources. These teams are ED/hospital based and will be engaged for all Medicaid, dual eligible and uninsured patients who present in the ED based on specific criteria. Along with expansion of services will be significant provider and patient education.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The project will target two specific overlapping patient populations: (1) Frequent ED users (defined as individuals with 4 or more visits per year) and (2) Persons with behavioral health and substance abuse issues, who form a particular sub-population of frequent ED utilizers. The project will be implemented in phases. The initial focus will target the six Catholic Health System emergency departments, some of which are located where the highest concentration of Medicaid members reside (zip codes 14218 and 14220). During this first year, the remaining five emergency departments will be set up virtually with additional resources deployed in subsequent periods. For example, at Bertrand Chaffee Hospital, CPWNY PPS will deploy a virtual care management

program, via electronic connectivity with "real time" care management staff until additional staff is recruited, trained and deployed.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Necessary resources for the project include: (1) broadened access to primary care with emphasis on patient centered medical homes (current resources plus expansion), (2) the development, procurement and deployment of patient navigators (needed community resources to be developed), and (3) additional clinical resources including RN Case Managers and Social Workers to all participating EDs. The normal protocol for patient ED presentation will remain intact; care management intervention to primary care services will be provided as an augmentation of immediate treatment and stabilization. (1) Access needs to be evaluated from the perspective of the beneficiary—many have limited transportation options and often people cannot leave work for an appointment without losing pay or putting their job at risk. This will include the incorporation of: (a) Medical and Health Homes. Patient Centered Medical Homes and health homes (current resources) typically have extended hours (weekends and evenings), same day appointments, and continuity with one provider. In some models, patient navigators schedule appointments at patient centered medical homes for frequent users. Currently, approximately 60% of patient population in SOCH and Catholic Medical Partners IPA are part of a Patient Centered Medical Home. There is minimal advancement of PCMH with our rural partners. Resources will be needed to enhance PCMH in these areas using existing resources of Clinical Transformation Specialists with additions to the staff. (b) Alternative Primary Care Sites. Given that two-thirds of emergency visits occur after business hours (weekdays 9 am - 5 pm), identifying primary care sites and /or urgent care centers available after business hours is one strategy for improving appropriate access to health care services. This may include electronic access to primary care appointment calendars for direct scheduling as well as data sharing through connectivity through the RHIO, HealtheLink. 24/7 nurse help lines are needed as well to improve healthcare access for the Medicaid population. Some offices do have this in place but will need to be expanded to the small independent practices /rural area partners. (c) Interoperability of outpatient, inpatient, and ER is necessary. Use of existing staff with enhancement of staff numbers to be put in place will be needed ASAP. (2) Patient navigation is rooted in a simple premise. If barriers to timely healthcare access are eliminated, and patients are supported throughout the healthcare continuum, healthcare outcomes will improve. These barriers are often broader than most realize. They include more commonly discussed issues such as financial constraints and lack of medical insurance. Yet they also include less obvious, but equally paralyzing, factors. These are the emotional, cultural, communication and logistical barriers that cause people to disengage from the healthcare system, neglecting preventive care or chronic disease treatment. The best healthcare advances mean nothing if a patient misses their appointments because of child care issues. A cost effective resource for community or payer organizations, provider facilities, in at-home care settings, and organizations serving Medicaid populations, lay patient navigators can connect the care team around the patient and augment the work of physicians, nurses, care managers and social workers. For disadvantaged patients, patient navigators forge person-to-person connections on a patient's own terms, connections that have historically been missing for many. (3) The following available assets can be mobilized

to implement this project, but must be augmented: an ED care triage program, and partnerships between participating EDs and community primary care practitioners (with an emphasis on PCMH providers).

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Challenges and anticipated issues are: 1. The design, development of the patient navigator position/role is a relatively new concept in health care delivery particularly in the ED setting. There are no formal training programs in our existing academic institutions. Our plan will be to establish an educational/training curriculum which will encompasses basic foundational health care concepts with a focus on connectivity with appropriate and timely primary care services. This person will be partnered with care management staff at all ED settings to enhance coordination of care. 2. Policy, protocols and clinical pathways standardization among our partners may be a challenge as the goal would be to assure/provide consistency in care and reduction of practice variation. Our plan to address this will be the promotion of our multiple electronic platforms in terms of uploading key documents, templates, clinical pathways that will alleviate/reduce variation. We will also implement fast track decision provider committees relative to policy, procedure and clinical guidelines to promote standardization. 3. Cultural and language needs of patients that exist in pocket areas of the Community Partners of WNY service area (zip codes 14218 and 14220) and our ability to meet those needs. Our plan to address this issue is to insure that cultural competency training is in place, especially for the patient navigator. Hiring patient navigators who are of the same culture and linguistic abilities will be promoted. 4. Coordination of care is a problem for the health care community. IT interconnectivity needs are a priority. Our plan will be to explore possibilities with our partners that close this gap.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

Community Partners of WNY and Millennium have worked together since early August to coordinate our planning and projects. We have conducted a joint CNA with UB Regional Institute and P2 Collaborative. We have agreed on six (6) similar DSRIP projects and are working with HealtheLink, our Regional Health Information Organization, on interoperability, reporting, consent and data governance. ED Care Triage for At-Risk Populations is one of those six projects. We expect coordination will be accomplished through the sharing of data across the region (i.e. ED alerts), coordinated care management, utilizing shared knowledge of community interventions and use of best practices.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the

application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☒

If yes: Please describe why capital funding is necessary for the Project to be successful.

To support electronic access to primary care appointment calendars for direct scheduling. Improved data sharing via HealtheLink. Improvements to community assessments; tools for patient navigators; guidelines for risk stratification; patient registries for tracking and reporting.

a. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☐	☒

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.