Application for Grant Funds for Establishment of Alternate Non-Emergency Services Providers

Primary Care Home Initiative

Submitted by

State of Missouri
Department of Social Services
MO HealthNet Division

Contact:
Ian McCaslin, M.D., M.P.H., Director
MO HealthNet Division
Telephone: 573/751-6922; Fax: 573/751-6564
Karen.A.Lewis@dss.mo.gov

I, Ian McCaslin, M.D., M.P.H., am authorized
by the single state Medicaid agency
of the State of Missouri to support the
Application for Grant Funds for Establishment of
Alternate Non-Emergency Services Providers
being submitted on behalf of the Integrated Health Network.

APPLICANT PREFERENCE

The Missouri Department of Social Services, MO HealthNet Division (Missouri Medicaid) requests consideration for preference in the award of grants for the St. Louis Integrated Health Network "Primary Care Home Initiative" on the basis of:

- Serving underserved areas within the St. Louis region where Medicaid beneficiaries may not have regular access to providers of primary care services;
- Working within a regional network in St. Louis of primary care providers, an urgent care center, and local community hospitals;
- Establishing communication standards and protocols that will permit the free flow of information between multiple providers, health systems, regional, and state data bases; and
- Sharing software developed with grant funds with other underserved areas in Missouri at no cost to the underserved areas except for personnel, equipment, or modification to the software.

Preference Based on Serving Underserved Areas

Multiple regions within the Primary Care Home Initiative service area in St. Louis City and County qualify as "Health Professional Shortage Areas for Primary Care." A listing of these locations and their respective scores follows:

St. Louis County:

Low Inc. – Kinloch/Berkeley/Jennings

Score: **14**

Census Tracts: 2104.00, 2105.00, 2118.00, 2119.00, 2120.00, 2121.00, 2124.00, 2125.00, 2127.00, 2128.00, 2129.00

Low Inc. – East Central St. Louis

Score: **15**

Census Tracts: 2122.00, 2123.00, 2136.00, 2137.00, 2138.00, 2139.00, 2140.00, 2141.00, 2142.00, 2143.00, 2157.00, 2159.00, 2160.00

St. Louis City County:

Low Inc. – North St. Louis

Score: **14**

Census Tracts: 1053.00, 1054.00, 1055.00, 1061.00, 1062.00, 1063.00, 1064.00, 1065.00, 1066.00, 1067.00, 1071.00, 1072.00, 1073.00, 1074.00, 1075.00, 1076.00, 1066.00, 1081.00, 1082.00, 1083.00, 1084.00, 1085.00, 1096.00, 1097.00, 1101.00, 1102.00, 1103.00, 1104.00, 1105.00, 1111.00, 1112.00, 1113.00, 1114.00, 1115.00, 1122.00, 1123.00, 1192.00, 1201.00, 1202.00, 1203.00, 1211.00, 1212.00, 1213.00, 1257.00, 1266.00, 1267.00

People's Health Centers

Score: **6**

Myrtle H. Davis Comprehensive Health Centers

Score: **7**

Family Care Health Centers

Score: **5**

Grace Hill Neighborhood Health Centers
Score: **7**
Low Inc. – West St. Louis
Score: **12**
Census Tracts: 1051.98, 1052.00, 1121.00, 1124.00, 1191.00, 1192.00, 1193.00
Low Inc. – SE St. Louis
Score: **13**
Census Tracts: 1014.00, 1015.00, 1018.00, 1155.00, 1156.00, 1157.00, 1164.00, 1165.00, 1173.00, 1174.00, 1185.00, 1221.00, 1224.00, 1231.00, 1232.00, 1233.00, 1234.00, 1235.00, 1241.00, 1242.00, 1243.00, 1246.00
Low Inc. – E. Central St. Louis
Score: **12**
Census Tracts: 1171.00, 1172.00, 1181.00, 1184.00, 1186.00, 1211.00, 1214.00, 1222.00, 1255.00, 1256.00

Preference Based on Providers in Partnership with Local Community Hospitals

Partnership between primary care providers and local community hospitals exists through the St. Louis Integrated Health Network and the Primary Care Home Initiative (PCHI) presented in this proposal. Participants in the PCHI Network include:

- All four area Federally Qualified Health Centers: Family Care Health Centers, Grace Hill Neighborhood Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers, People's Health Centers;
- St. Louis County Health Centers, which provide primary care services to Medicaid beneficiaries and the uninsured;
- St. Louis ConnectCare, a safety net urgent care and specialty care provider;
- 7 hospital emergency departments in St. Louis's areas of high need: St. Mary's Health Center, DePaul Health Center, Cardinal Glennon Children's Medical Center, St. Louis University Hospital, Barnes-Jewish Hospital, Christian Northeast Hospital, St. Louis Children's Hospital;
- St. Louis City and County Departments of Health; and
- Washington University and St. Louis University Schools of Medicine.

Since May 2007, Community Referral Coordinators have worked in two pilot emergency department sites (Barnes-Jewish Hospital and St. Mary's Health Center) to connect Medicaid and uninsured non-emergent patients with a primary care "health home" and health care resources. Community Referral Coordinators meet with non-emergent patients in the emergency departments to schedule a primary care appointment for them and provide them with education regarding the availability of appropriate health care services. Community Referral Coordinators are employed by the Integrated Health Network, a partnership of primary and specialty care safety net providers, and have access to timely scheduling at the area Federally Qualified Health Centers. Health coaches at the community health centers contact patients to ensure that they attend the follow-up primary care appointment and help with arranging transportation as needed. Expansion of this program to a third emergency department is anticipated in early 2008. Funding of this proposal would enable expansion to a fourth emergency department site.

In addition, the proposed Network Master Patient Index (NMPI) will ensure data flow between emergency departments and primary care providers to enhance care coordination, quality and efficiency of care through health information exchange. Through implementation of a Network Master Patient Index (NMPI), the seven participating community hospital emergency departments, as well as the alternative primary care/non-emergency providers, will increase knowledge about the patients presented to them electronically. Targeted information will include: (1) Patient demographics; (2) History of primary care home assignment and use; and (3) Previous visit history, including: encounter dates; discharge date, time and disposition; chief complaint; diagnosis code(s) and description. The NMPI will allow participants to make use of their patients' information to improve primary care referral patterns, identify primary care homes, avoid service duplication, and better coordinate care overall. Participating providers have invested significant time and community resources over the past 18 months in the development of a detailed implementation plan for the NMPI and the Primary Care Home Initiative.

Significant impact to the current emergency services delivery system is anticipated from the Primary Care Home Initiative programs discussed. The specific anticipated project outcomes include:

1. Increase utilization of primary/preventive care by non-emergent Medicaid and uninsured patients identified in participating emergency departments. Based on current non-emergent ED volumes, and experience with the Community Referral Coordinator pilot project, this is estimated to be an increase of 12,700 Medicaid visits and 5,800 uninsured visits referred from emergency departments to primary care providers during the project period.
2. Reduce non-emergent ED usage by 10% for Medicaid and uninsured patients that do not already have a primary care home. Based on the current volume of non-emergent patients in participating emergency departments, and allowing for project initiation time, this is estimated to be a reduction of 3,200 non-emergent Medicaid visits and 1,500 non-emergent uninsured visits during the project period.
3. Reduce non-emergent ED usage by 20% for Medicaid and uninsured patients that already have a primary care home. This is estimated to be a reduction of 9,500 non-emergent Medicaid visits and 4,300 non-emergent uninsured visits during the project period.

This project will provide substantial benefits to Medicaid and uninsured patients, MO HealthNet, and participating providers by not only reducing non-emergent usage of area emergency departments, but also by connecting patients with a regular primary care home for ongoing preventive care.

ABSTRACT

For both quality of care and cost-saving reasons, St. Louis and other communities across Missouri and the country have been active in efforts to reduce non-emergent emergency department use. The Integrated Health Network (IHN), a nonprofit organization in St. Louis, employs a collaborative approach to improving quality, accessibility, and affordability of health care services for all St. Louis residents, with an emphasis on the community's 300,000+ Medicaid beneficiaries and uninsured. The IHN developed the Primary Care Home Initiative with the goals of reducing the use of hospital emergency departments for non-emergencies; connecting Medicaid and uninsured patients in the St. Louis region to a primary care health home; and enhancing care coordination, quality, and efficiency of medical care through health information exchange. Participants of the IHN Primary Care Home Initiative include all four area Federally Qualified Health Centers (FQHCs), St. Louis County Health Centers, St. Louis ConnectCare, seven community hospital emergency departments in high need areas, the St. Louis City and County Departments of Health, and two schools of medicine. The IHN members serve over 175,000 unique individuals in over 400,000 primary care encounters and 250,000 specialty care encounters each year, serving over 20% of the residents in St. Louis City and County.

The MO HealthNet (Missouri Medicaid) Division is requesting $1,726,074 to support implementation of the Primary Care Home Initiative (PCHI). The PCHI includes three major interrelated components that will facilitate appropriate access to primary care for Medicaid beneficiaries through a network of alternative non-emergency providers.

- Community Referral Coordinator Program – Referral Coordinators in hospital emergency departments schedule a timely primary care appointment for non-emergent patients and provide education regarding appropriate services;
- Health Education and Literacy Program (HELP) – Health coaches at FQHCs strengthen patients' connection to the primary care home and assist with system navigation;
- Network Master Patient Index (NMPI) – Health information exchange across emergency departments and primary care providers improves referral patterns and care coordination.

This experience would be applicable to other areas of Missouri, in partnership with local community hospitals, where participants may not have regular access to primary care providers.

Significant impact to the current emergency services delivery system is anticipated from the Primary Care Home Initiative programs discussed. The anticipated project outcomes include:

4. Increase utilization of primary/preventive care by non-emergent Medicaid and uninsured patients identified in participating emergency departments. This is estimated to be an increase of 12,700 Medicaid visits and 5,800 uninsured visits referred from emergency departments to primary care providers during the project period.
5. Reduce non-emergent ED usage by 10% for Medicaid and uninsured patients that do not already have a primary care home. This is estimated to be a reduction of 3,200 non-emergent Medicaid visits and 1,500 non-emergent uninsured visits during the project.
6. Reduce non-emergent ED usage by 20% for Medicaid and uninsured patients that already have a primary care home. This is estimated to be a reduction of 9,500 non-emergent Medicaid visits and 4,300 non-emergent uninsured visits during the project period.

This project will provide substantial benefits to the MO HealthNet program, uninsured patients, and participating providers by not only reducing non-emergent usage of area emergency departments, but also by connecting patients with a regular primary care home for ongoing preventive care.

NARRATIVE

I. Statement of Project/Need

Many patients in St. Louis who are Medicaid beneficiaries or lack a medical home rely on hospital emergency department services as a regular source of care, even though a safety net health care system is in operation. Although emergency departments are not a preferred source of primary or preventive care services, patients who struggle to navigate the St. Louis health care system often use local emergency departments for non-emergent medical conditions. Patients may rely on emergency departments because they are unaware of the safety net providers in St. Louis and thereby struggle to find a provider who will treat them, or because it is known in the community that the emergency department must treat them. Yet non-emergent utilization of emergency departments remains problematic for patients and providers alike as emergency department care is often the least subject to coordination with other services and the most expensive route of care in a community.

For both quality of care and cost-saving reasons, St. Louis and other communities across Missouri and the country have been active in efforts to reduce non-emergent emergency department use. The Integrated Health Network (IHN), a nonprofit organization in St. Louis, employs a collaborative approach to improving quality, accessibility and affordability of health care services for all St. Louis residents, with an emphasis on the community's 300,000+ Medicaid beneficiaries and uninsured. The IHN developed the Primary Care Home Initiative to reduce the use of hospital emergency departments for non-emergencies; to connect Medicaid and uninsured patients in the St. Louis region to a primary care health home; and to enhance care coordination, quality, and efficiency of medical care through health information exchange. Participants of the IHN Primary Care Home Initiative include all four area Federally Qualified

Health Centers (FQHCs), St. Louis County Health Centers, St. Louis ConnectCare, seven hospital emergency departments in underserved areas of high need, the St. Louis City and County Departments of Health, and two schools of medicine. The IHN members serve over 175,000 unique individuals in over 400,000 unique primary care encounters and 250,000 specialty care encounters each year, serving over 20% of the residents in St. Louis City and County.

In its 2007 Access to Care report, the St. Louis Regional Health Commission (RHC) estimates that approximately 72,525 non-emergent visits were made to emergency departments by Medicaid beneficiaries in the St. Louis region in FY06. This amount represents approximately 45% of all visits to emergency departments by Medicaid recipients in the region. In the St. Louis region, the average Medicaid ED visits per 100 is 104.3.[1] Additionally, 75.4% of the total Medicaid ED visits in the region occur at the seven hospital emergency departments participating in the PCHI. The St. Louis regional average is markedly higher than the national average of 81.0 ED visits per 100.

In its detailed Primary Care Home Initiative Business Case Analysis for the St. Louis Integrated Health Network, IBM Consulting Services estimated that the MO HealthNet Program (the Missouri Medicaid program) could save at least $900,000 per year in net savings through the implementation of the IHN's Primary Care Home Initiative, as described in this proposal. These savings could then be reinvested in providing needed services to additional beneficiaries in a more effective, efficient MO HealthNet each year going forward.

---

[1]Data provided by the Missouri Hospital Association, MO HealthNet Division, and the St. Louis Regional Health Commission.

II. Project Justification

The IHN Primary Care Home Initiative includes three major interrelated components that will facilitate appropriate access to primary care through a network of alternative non-emergency providers. The three components are: (1) Community Referral Coordinator Program; (2) Health Education and Literacy Program (HELP) and (3) Network Master Patient Index (NMPI).

Community Referral Coordinator Program Overview: The Community Referral Coordinator pilot project uses referral coordinators in hospital emergency departments to connect non-emergent Medicaid and uninsured patients with a primary care provider. Referral coordinators provide the patient with education regarding the resources available for primary/non-emergent care and schedule a follow-up visit and transportation for the patient with a primary care provider or health home while they are in the emergency department. In particular, patients are connected with the participating FQHCs and St. Louis County health centers for care, which collectively offer 17 primary care locations in the St. Louis region. During the patient's first visit to the referred health center, patients are connected with a HELP health coach to provide information regarding primary care services and strengthen the patient's connection with the primary care home (see HELP overview below). The initial pilot sites currently in operation include St. Mary's Health Center emergency department, Barnes-Jewish Hospital emergency department, and the health centers participating in the Primary Care Home Initiative. The IHN anticipates expanding to a third emergency department pilot site through local funding sources shortly. This proposal would enable expansion of the program to a fourth emergency department pilot location serving a high volume of Medicaid beneficiaries.

Health Education and Literacy Program (HELP) Overview: The Health Education and Literacy Program utilizes 60 trained health coaches employed across the 4 FQHCs and St. Louis

County Health Centers in the IHN to assist patients with system navigation, health literacy, and chronic disease management. As discussed above, health coaches work with patients that are referred from the emergency departments to welcome them to the health center, explain specific programs available, provide education regarding emergency department usage, and provide follow-up services regarding future appointments. In addition, health coaches work on an ongoing basis with patients that are identified as needing particular assistance with system navigation, health literacy, and disease management. The IHN has found that health coaches help ensure that patients utilize primary/preventive care, improve their chronic disease management, and avoid usage of emergency care for non-emergencies. To date, the program has provided services to over 2300 Medicaid beneficiaries and uninsured individuals for a total of over 6000 encounters.

Network Master Patient Index (NMPI) Overview: Through implementation of a Network Master Patient Index (NMPI), emergency departments and alternative primary care/non-emergency providers will increase knowledge about the patients presented to them electronically. Targeted information will include: (1) Patient demographics; (2) History of primary care home assignment and use; and (3) Previous visit history, including: encounter dates; discharge date, time and disposition; chief complaint; diagnosis code(s) and description. The NMPI will allow participants to make use of their patients' information to improve primary care referral patterns, identify primary care homes, avoid service duplication, and better coordinate care overall. Having this information available to treating clinical staff before some care decisions are made presents opportunities to provide more appropriate and economically efficient medical care for Medicaid beneficiaries:

- *Joe walks into the ED to be treated for the flu. When he is registered, the staff accesses the NMPI to determine if Joe has a primary care home. Seeing no assignment of a primary care provider, a referral coordinator identifies a primary care home for Joe. Joe is treated for his symptoms and discharged. Education about the primary care provider is given to Joe, along with an appointment with his new primary care provider for follow-up care, enabling him to access an alternative non-emergency services provider.*
- *Yolanda goes to the ED for a high ankle sprain. While there, the staff discovers her blood pressure is dangerously elevated. The referral coordinator accesses Yolanda's information from the NMPI to determine if she has been seen for her elevated blood pressure. A follow-up appointment with her assigned primary care physician using the NMPI information is made for Yolanda. While at her primary care home, she receives information from a HELP program health coach about managing her high blood pressure, which encourages management of her condition before it worsens and becomes more costly.*

During implementation and periodically after, care sites will evaluate how the NMPI programs can impact their core processes and work continually to optimize use to improve patient care and efficiency.

III. Project Goals and Outcomes

Participants in the Primary Care Home Initiative (PCHI) include the following provider organizations: All four area Federally Qualified Health Centers: Family Care Health Centers, Grace Hill Neighborhood Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers, People's Health Centers; St. Louis County Health Centers; St. Louis ConnectCare, a safety net urgent care and specialty care provider; 7 hospital emergency departments in St. Louis's areas of

high need: St. Mary's Health Center, DePaul Health Center, Cardinal Glennon Children's Medical Center, St. Louis University Hospital, Barnes-Jewish Hospital, Christian Northeast Hospital, St. Louis Children's Hospital; St. Louis City and County Departments of Health; and Washington University and St. Louis University Schools of Medicine.

The goals of this project are to utilize this collaborative partnership to reduce the use of hospital emergency departments for non-emergencies; to connect Medicaid and uninsured patients in the St. Louis region to a primary care health home; and to enhance care coordination, quality, and efficiency of medical care through health information exchange. The specific project outcomes include:

7. Increase utilization of primary/preventive care by non-emergent Medicaid and uninsured patients identified in participating emergency departments. Based on current non-emergent ED volumes, and experience with the Community Referral Coordinator pilot project, this is estimated to be an increase of 12,700 Medicaid visits and 5,800 uninsured visits referred from emergency departments to primary care providers during the project period.
8. Reduce non-emergent ED usage by 10% for Medicaid and uninsured patients that do not already have a primary care home. Based on the current volume of non-emergent patients in participating emergency departments, and allowing for project initiation time, this is estimated to be a reduction of 3,200 non-emergent Medicaid visits and 1,500 non-emergent uninsured visits during the project period.
9. Reduce non-emergent ED usage by 20% for Medicaid and uninsured patients that already have a primary care home. This is estimated to be a reduction of 9,500 non-emergent Medicaid visits and 4,300 non-emergent uninsured visits during the project period.

This project will provide substantial benefits to Medicaid and uninsured patients, the Medicaid program, and participating providers by not only reducing non-emergent usage of area emergency departments, but also by connecting patients with a regular primary care home for ongoing preventive care.

IV. Estimate of Impact to Beneficiaries

The project target area is the St. Louis region, specifically St. Louis City and St. Louis County. St. Louis City and County comprise the largest urban population of the State. The population of this target area is approximately 1.4 million residents, or approximately 30% of the population of the State of Missouri. The impact of this project will focus on: (1) the 62,000 Medicaid beneficiaries served annually by the IHN community health centers; and (2) the Medicaid beneficiaries and uninsured individuals that currently utilize emergency rooms for non-emergent use over 106,000 times each year. It is estimated by the St. Louis Regional Health Commission that approximately 40% of this population in area emergency departments do not have a primary care home. The intent is to link these individuals with one of the existing safety net providers in the region.

Initial data from May-September 2007 indicate that approximately 50% of the individuals that meet with a Community Referral Coordinator request an appointment with a primary care home; the show-rate to the primary care appointment has been 95%. It is anticipated that 12,800 Medicaid beneficiaries and 5,800 uninsured individuals will access a primary care home as a result of participation in this project during the project period. Additionally the 175,000 patients utilizing the primary care health centers will benefit from this initiative through improved coordination among the emergency departments and health centers.

V. Description of Magnitude of the Impact to Medicaid

The IHN's Primary Care Home Initiative is specifically designed to reduce the emergency department use of Medicaid recipients in the St. Louis region and to serve as a demonstration for other Missouri communities. In 2006, there were 16,900 traditional Medicaid beneficiaries, 143,423 managed care Medicaid beneficiaries, and 30,163 individuals dually eligible for Medicare and Medicaid services in the St. Louis City and County area. Of these, approximately 62,000 unique Medicaid recipients are seen by IHN members, are current beneficiaries of the Missouri Medicaid program, and will benefit from this initiative through better coordination of care between the area emergency departments and community health centers.

In addition, those individuals not currently linked with a primary care home but utilizing emergency departments for non-emergent reasons will be connected to an FQHC through the initiative. As discussed, it is anticipated that 12,800 Medicaid beneficiaries and 5,800 uninsured individuals will access a primary care home as a result of participation in this project during the project period. IBM Consulting services has estimated that if 5% of Medicaid beneficiaries seen at the emergency departments through the Primary Care Home Initiative are linked to a primary care home, MO HealthNet (the Missouri Medicaid program) will realize a net savings of approximately $900,000 annually. As mentioned above, initial data from May-September 2007 indicates that approximately 50% of the individuals that meet with a Community Referral Coordinator request an appointment with a primary care home; the "show-rate" to the primary care appointment has been 95%. Thus, the likely net benefit to the Missouri Medicaid program will be much larger once full implementation of the initiative is completed.

VI. Description of Sustainability of the Project

In the Primary Care Home Initiative business plan recently completed, IBM has estimated an annual benefit of $2.52 million to participating hospitals and health centers in the St. Louis region, not including estimated project costs. The estimated benefit for MO HealthNet (the Missouri Medicaid Program) is over $960,000 annually, using a conservative estimate of a 5% reduction in non-emergent use of area emergency departments. Overall, when the full cost of the project is included, a communitywide benefit of $2.89 million is anticipated for the first four years of the project. All benefits calculations are very conservative. It is the expectation of the participating partners that once the pilot phase is completed in 2009 and the benefit model has been confirmed, each participating organization will contribute to the ongoing costs of operating the primary care home initiative in proportion to the benefit that the organization has achieved. This sustainability plan is in keeping with best practice funding models utilized in other communities that have achieve success to date in maintaining collaborative information and programming efforts in the health care sector. While community partners are committed to sustainable funding models once the benefit model has been confirmed, one-time investment from outside funding sources is critical to initiating implementation of the NMPI technology solution and maintaining the strong momentum that the project has garnered to date.

VII. Evaluation Plan

The IHN has hired the National Opinion Research Center (NORC) to evaluate the Primary Care Home Initiative. Initial evaluation efforts will focus on the Community Referral Coordinator program; evaluation of additional elements of the initiative is anticipated upon notification of funding. NORC, and the team proposed, has extensive experience producing detailed and meaningful evaluation results for similar initiatives impacting low-income and other

vulnerable populations, including the following projects: National Evaluation of the Healthy Communities Access Program (HCAP) for HRSA; Finding Answers: Disparities Research for Change, a national program for the Robert Wood Johnson Foundation; and Assessing the Impact of Medicaid Waivers for the Kaiser Commission on Medicaid and the Uninsured (KCMU).

NORC will evaluate the following elements: (1) the impact of the new coordinated referral process for connecting emergency department patients to primary care homes in area health centers, not just for immediate follow-up care but for their ongoing primary care and preventive care needs and (2) the impact of the program on non-emergent emergency department usage. NORC will utilize a combination of qualitative and quantitative research methods such as: analyses of enrollment data, including patient demographics and encounter information, as recorded by the referral coordinators and community health coaches; and a site visit including focus groups of enrollees and in-person interviews of health center health coaches, and hospital and health center providers. NORC will also utilize ED utilization data to examine the potential impact of the program.

Five key research questions will be investigated by NORC: (1) Is the Primary Care Home Initiative connecting patients to a primary care home? (2) Once connected, is the patient utilizing the primary care home for ongoing primary care and preventive health needs? (3) Is the Primary Care Home Initiative reducing non-emergent emergency department use? (4) What are the barriers to and/ or the drivers of the success of the Primary Care Home Initiative? (5) How can the Primary Care Home Initiative be improved post-pilot? What are the lessons learned? NORC will use a systematic method of mapping program goals, hypotheses, and research questions to evaluation activities and specific measures and data sources.

NORC will utilize data from hospitals, health centers, and site visits in its analysis. By securing pre-program data on enrollees from the hospitals, NORC will explore enrollees' ED use trends pre- and- post program exposure. For example, enrollment data will enable NORC to examine if, and how many times, enrollees accessed the ED in the three-year period prior to the program. By utilizing health center data, NORC will examine enrollees' usage of their primary care homes and coordinated care management programs. In addition, to assess whether the Primary Care Home Initiative has been successful in meeting its project goals, NORC will conduct site visits that will capture valuable qualitative information that both documents the program experience and identifies important perceptions regarding the program among key individuals. NORC will use a combination of in-person interviews and focus groups to collect information and document the impact of the program through the eyes of enrollees, providers, and hospital staff.

VIII. Description of Project Implementation Readiness

The IHN and its hospital partners have approved moving forward with all Primary Care Home Initiative components, and over $2 million in local funds have been invested to date in this project for implementation planning and current pilot efforts. Funding has been secured for implementation of the HELP health coaches program through 2009, the Community Referral Coordinator pilot at Barnes-Jewish Hospital and St. Mary's Medical Center through 2009, and the expansion of the Community Referral Coordinator pilot to St. Louis University Hospital. Critical governance issues have been resolved and the St. Louis community stands ready to expand this program into the next phase of implementation. In addition, an NMPI vendor has been selected and is ready for deployment once implementation funding has been fully identified.

However, not all funding has been identified to complete critical project components, and securing a funding source for the NMPI technology build is an important success factor for maintaining project momentum and solidifying the benefits to the Medicaid recipients that are currently being achieved.

Key next steps for the Primary Care Home Initiative are: (1) expanding implementation of the community referral coordinator program to an additional emergency department; (2) implementing expanded use of health coaches for working with non-emergent emergency department patients; (3) securing funding for the NMPI technology build; (4) executing a detailed communications plan that has been developed; (5) finalizing the contract with the technology vendor; and (6) beginning implementation of the NMPI build phase. A detailed timeline for these activities is provided below:

KEY MILESTONES	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Community Referral Coordinator Program								
Conduct planning with new ED location								
Place referral coordinators/ongoing operations								
HELP Health Coaches Program								
Conduct planning for expanded use of health coaches to work with patients referred from EDs								
Ongoing operation of health coaches								
Network Master Patient Index								
Complete ongoing funding planning – secure funding for technology build								
Communications – ongoing general updates,								

targeted funding support communications, outcomes publication								
Confirm guidelines and policy for rules, financial, clinical, business operations and legal for NMPI								
Conduct contracting with technology vendor								
Technical – develop detailed implementation plan, install hardware and software, implement system interfaces, test								
Adoption – develop change management/training resources, develop go live and support resources								
Deployment – testing, training and go live								
NMPI Ongoing Operations								
Evaluation								
Conduct planning								
Ongoing data collection and evaluation completion								