GRANT FUNDS FOR ESTABLISHMENT OF
ALTERNATE NON-EMERGENCY SERVICES PROVIDERS

COVER SHEET

STATE: **MASSACHUSETTS**

PROJECT TITLE: **MEDICAID EMERGENCY ROOM DIVERSION**

NAME OF MEDICAID AGENCY: **OFFICE OF MEDICAID, EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES**

CONTACT PERSON:

Name and Title: Alison Kirchgasser, Director of Federal and National Policy Management, Massachusetts Office of Medicaid

Telephone Number: 617-573-1741

Fax Number: 617-573-1894

E-Mail Address: alison.kirchgasser@state.ma.us

ACKNOWLEDGEMENT OF SUPPORT FOR THE PROJECT FROM THE MEDICAID DIRECTOR

In recognition of the need to decrease non-emergency Emergency Department visits by MassHealth members, Massachusetts Office of Medicaid is pleased to submit this application for a grant to establish alternate non-emergency services. The proposal set forth in this grant application would develop and implement effective strategies to divert inappropriate emergency department utilization by increasing community capacity for urgent and primary care services. The project will build on partnerships between federally qualified health centers and community hospitals in medically underserved areas throughout the Commonwealth. This proposal has the full support of the Office of Medicaid.

Tom Dehner
Medicaid Director

APPLICANT PREFERENCE

The Commonwealth of Massachusetts requests preference in the award of this grant because this proposed project would build on existing relationships between ***community health centers*** and ***community hospitals*** and would meet both preference criteria as set forth under the applicant preference section of the grant announcement. Specifically, the grant announcement indicates that preference will be given to applicants who serve rural or underserved areas where Medicaid beneficiaries may not have regular access to providers of primary care services or providers who are in partnership with local community hospitals. Massachusetts has federally qualified community health centers (FQHCs) in medically underserved areas (MUAs). FQHCs serve medically underserved populations (MUPs) and are generally located in health professional shortage areas (HPSAs). The project described below would increase access to primary care providers for Medicaid beneficiaries in medically underserved areas by building upon and strengthening existing partnerships between community health centers and community hospitals.

The proposed project would be implemented in two phases. Phase One would focus on five FQHCs located in designated areas as noted below. Phase Two would expand participation to other FQHCs and community hospitals located in additional areas designated as HPSAs and MUAs/MUPs such as Boston, Fall River, Holyoke, New Bedford, Springfield, Worcester, and areas of Western Massachusetts and Cape Cod.

The proposed project would build upon an existing project that began in January 2007. The existing project focused on five FQHCs located in MUAs/MUPs and HPSAs. They are located in cities with significant low-income and MassHealth eligible populations and have been working with their local community hospitals to develop systems to divert patients out of the emergency department and into a more appropriate primary care setting. The five FQHCs referenced in this proposal have existing collaborative relationships with their local community hospitals. Through the existing project they have begun to develop programs specifically targeted at either diverting patients from the emergency room and/or creating greater capacity at the FQHC for primary and urgent care services. Funding for these FQHC projects was provided by the Commonwealth. Although only recently implemented, these diversion projects are beginning to demonstrate success and can be replicated in other settings. Phase One of the proposed project would focus on the five FQHCs participating in the existing project and would build on their experience and success in emergency department diversion.

The following briefly describes the delivery system in each community, the relationship between the hospital and the FQHC, the length of operation of the existing project and the impact to the current emergency delivery system:

Brockton, Massachusetts: Brockton Neighborhood Health Center's (BNHC) patient population is extremely diverse including Brazilian, Cape Verdean, Haitian, Latino, Portuguese, African American and white patients. Nearly half would be better served in their native language. Approximately 82% are from minority populations; 45% are uninsured; 40% have MassHealth; and, 4% have Medicare. Seventy-one percent of patients are living in poverty and an additional 23% have household incomes below 200% of the federal poverty

level. BNHC provided services to approximately 12,000 patients and provided close to 62,000 visits for a variety of primary care, preventive, oral health and specialty care in state fiscal year 2006.

BNHC's participation in the existing project has expanded availability of urgent care sessions, combined traditional urgent care services with case management provided by the same team, and developed regular, ongoing communication with the emergency departments at both its local hospitals. The project funding was used to hire staff, including a nurse practitioner, social worker and two medical assistants/interpreters who work together to provide urgent care and necessary care management and support services. BNHC center also developed educational and marketing materials for the community it serves about the availability of urgent care services. Finally the existing BNHC project was designed to develop regular, ongoing communication with the two emergency departments in the city to routinely refer non-acute emergency department patients to the BNHC for primary care.

This existing project was initiated in January 2007 and an evaluation was conducted on the first six months of the project (January 2007-June 30, 2007). Staff was hired in January and the expanded hours began in February. An additional 1,425 urgent care visits and 283 social service visits have occurred since that time. Communication with emergency departments has increased and patients are routinely referred to the urgent care center for post emergency room follow-up and primary care.

BNHC HPSA Score: 15
MUA Score: 43.6 and MUA ID#01512

Lawrence, Massachusetts: Greater Lawrence Family Health Center (GLFHC) cares for 42,000 patients. More than 86% of patients are Latino. Sixty-seven percent have MassHealth or other public assistance and 24% are uninsured. One third of adult patients at GLFHC are functionally illiterate. Latinos in Lawrence face linguistic and cultural barriers to accessing coverage and care. According to the 2000 U.S. Census, 64% of Lawrence residents report speaking a language other than English at home, primarily Spanish.

GLFHC's existing project expanded its urgent care hours on Saturdays and added Sunday hours. Four medical assistants were hired to work with the provider staff to manage urgent care access. As a next step in the project, the health center plans to implement a nurse triage team at each of its sites to manage phone triage and acute care walk-ins.

This project was funded beginning in January 2007 and an evaluation was conducted on the first six months (January-June 30, 2007). GLFHC has expanded urgent care capacity during evening hours that has doubled the number of patient visits. Urgent care hours on Saturday have been increased from 10 am to 9 pm and new hours have been added on Sunday from 1 pm to 9 pm. This has increased the number of urgent care hours for the first six months by 594. GLFHC also conducted a marketing campaign within the community it serves to increase awareness of expanded hours and urgent care capacity.

The community health center and the Lawrence General hospital (LGH) have a long and collaborative relationship. In addition to the existing state funded project, LGH is also working with GLFHC in helping to identify GLFHC Asthma patients seen in the ER as part of a BCBS Foundation grant that the health center received.

GLFHC admits about 50% of LGH's inpatients. In addition, 50% of the babies delivered at the hospital are patients of the health center. GLFHC and LGH have partnered to operate the GLFHC's Residency Program since it began in 1993. In that time over 100 residents have graduated, many of whom have gone on to work in underserved communities. About 25% of the graduates have decided to stay with GLFHC. The residents do all of their inpatient and ER training at LGH. GLFHC is the sponsoring organization and the residents see outpatients at its site on Haverhill Street. GLFHC currently has 24 residents, eight in each class. The health center also has an obstetrical fellowship with two fellows who stay an additional year for training.

In order to facilitate enhanced communication GLFHC and LGH shared the cost of running fiber optic cable between their facilities. This allows for the enhanced transmission of lab tests and mammography screenings. LGH radiologists read the mammography screens and LGH acts as the reference lab. The reports from both radiology and the lab are imported directly into the Electronic Medical Record at the health center.

GLFHC HPSA Score: 9
MUA Score 53.9 and MUA ID#01517

Lowell, Massachusetts: Lowell Community Health Center (Lowell CHC) also serves a diverse and low-income population. Currently 95% of Lowell CHC's population live under 200% of poverty; 45% are children; 58% are best served in a language other than English; and 40% are white, 30% Latino, 22% are Asian, 8% are African-American or African immigrants (from 15 different countries) and there is a growing number of patients from Brazil. According to the 2000 U.S. Census Lowell's population is 105,167 with 27% currently qualified for MassHealth. Twenty two percent of Lowell's population was born outside of the United States (up from 16.4% in 1990), the majority are from Asia, primarily Cambodia. Nineteen percent of the population in Lowell is uninsured. In 2006 Lowell CHC served 17,903 patients and provided 78,943 visits.

Under the existing project Lowell CHC expanded the number of urgent care sessions provided and also implemented a central call center to facilitate access to services. Next, the health center plans to implement a nurse triage system and care manager program for both pediatrics and adult medicine to conduct emergency room follow-up and case management triage. Lowell General Hospital has indicated that there are 10-15 cases each day that could be seen more appropriately at the center. In response to this, Lowell CHC has increased the number of urgent care hours provided each week. The hospital routinely notifies the center when a Lowell CHC patient comes to the emergency department.

This project was funded beginning in January 2007 and an evaluation was conducted on the first six months (January-June 30, 2007). The expanded hours under this project allowed for the addition of two sessions for adults and two sessions for pediatrics, which resulted in an additional 1,200 visits. This additional capacity has significantly improved access for residents of the community especially for those who do not have an identified provider. In addition to the expanded hours, two case managers have been hired and began working in July and August. The bilingual staff of the call center funded by the project answers over 5,000 calls per month.

Lowell CHC and Lowell's hospitals have an established collaborative relationship. Lowell CHC is a part of a multi-agency team including representatives from the local hospital emergency departments (Lowell General and Saints Memorial) to address issues that cross organizational boundaries. Lowell CHC and Lowell General hospital work collaboratively regarding care coordination for patients seen in the ED. Clinical and administrative staff from both Lowell CHC and Lowell General emergency department meet monthly to review cases and ensure communication lines are open. Lowell CHC's Nurse Manager is in regular close contact with the ED staff regarding patients seen in the ED and to connect patients with care management at the health center, as needed. Lowell General also has historically provided ED reports to the health center with information on the health center patients that have been seen in the ED to allow for direct follow up and continuity of care by the health center.

Lowell CHC admits patients requiring inpatient level of care to Lowell General Hospital. The vast majority of physicians at Lowell CHC have admitting privileges at Lowell General hospital and conduct rounds there. Lowell CHC's Medical Director holds the position of Chief of Pediatrics at Lowell General.

Lowell CHC HPSA Score: 6
MUA Score 61.9 and MUA ID# 01522

Lynn, Massachusetts: Lynn Community Health Center (Lynn CHC) served 26,604 patients in 2006 and provided 145,085 visits. Fifty-four percent were on MassHealth or other public payers and 31% were uninsured. Forty-three percent of the total population served individuals at or below 100% of the federal poverty level and another 45% are between 100% and 200% of poverty. Five percent of the population is Asian, 14% are African American, 45% are Hispanic and 26% are White. Thirty-four percent are best served in a language other than English.

Under the existing project Lynn CHC has expanded urgent care services at its main site and has implemented an on-site nursing triage service at the two local community hospitals' emergency departments. Senior management at the North Shore Medical Center with hospitals in Lynn and Salem are committed to working collaboratively with Lynn CHC to encourage patients who use the emergency department for primary care sensitive conditions to seek this care at the community health center. Lynn CHC has created a template in the health center's electronic medical record to track emergency department visits to determine which visits were appropriate, the reasons for the visit and whether follow-up services were

received. As part of this effort Lynn CHC provides the emergency departments with a block of appointment times when they can schedule patients for follow-up at Lynn CHC.

This project was funded beginning in January 2007 and an evaluation was conducted on the first six months (January-June 30, 2007). A new physician was hired in January to see walk-in patients and this has increased volume by 2,217 visits during this period. Lynn CHC's triage nurses speak daily with the emergency department nurses and meet frequently. This enhanced communication has resulted in more patients receiving services in the most appropriate setting. Lynn CHC has also implemented a follow-up system for patients seen in the emergency department. During state fiscal year 2007 Lynn CHC saw 418 new patients referred by the hospital emergency departments. Preliminary data from the tracking system suggests that there are still a number of visits that could be more appropriately handled at the Lynn CHC.

The Lynn CHC and North Shore Medical Center (along with its affiliated hospitals Union Hospital in Lynn and Salem Hospital in Salem) have had an affiliation and strong collaborative relationship since 1999. North Shore Medical Center has provided financial support for the development of Lynn CHC's walk-in clinic. More recently, as described above, North Shore Medical Center and Lynn CHC have collaborated to refer patients seen in the emergency department at both hospitals to Lynn CHC for follow up care and primary care. As part of this project, the hospitals provide the health center with daily reports of Lynn CHC's patients who were seen in the emergency department. Nurse case managers at the health center use this information to attempt to contact each patient regarding follow up and education. These nurse case managers also visit the local emergency departments almost daily to interact with the emergency department staff.

Lynn CHC HPSA Score: 13
MUA Score 55.7 and MUA ID#01518

Quincy, Massachusetts: Manet Community Health Center (MCHC) served 13,628 patients and provided 50,908 visits during 2006. Eight percent were Asian, 3.5% were African American and 75% were white. Forty nine percent were at or below 100% of the federal poverty level and another 7% are between 100% and 200% of poverty. Thirty-seven percent are on MassHealth or another public payer and 9% have Medicare.

MCHC operates a site at the local community hospital, Quincy Medical Center (QMC). This site was at maximum capacity. MCHC's existing project funded an increase in the number of exam rooms and increased provider staff and hours of availability, allowing ER physicians to refer to MCHC for follow up and primary care. Funds have also been utilized to hire a nurse case manager/patient navigator, a physician who works 50% of the time at the Quincy Medical Center site and a part-time endocrinologist to work with MCHC diabetic patients (frequent emergency department users).

This project was funded beginning in January 2007 and an evaluation was conducted on the first six months (January-June 30, 2007). MCHC in collaboration with Quincy Medical Center expanded its site at the Quincy Medical Center by two exam rooms and developed a

hospital tracking module to monitor emergency department utilization by MCHC patients. The physicians have been hired and will begin working in the late summer. The nurse case manager began work in June and has established on-going communication with the emergency department nurses at Quincy Medical Center as well as at South Shore Mental Health to work with high emergency department users who are patients at both facilities.

MCHC has a long history of collaboration, over 27 years, with Quincy Medical Center. In 2000, MCHC established its fifth practice site, a fully independent site, within the walls of the hospital. The MCHC site at QMC is among the busiest of Manet's five sites. Once a patient presents at the hospital they establish a 'comfort zone' with the environment; a referral to a primary care site with co-location removes the potential barriers of being referred to an unfamiliar location or site. Referrals from QMC to MCHC average over 25 a month. Together, MCHC and QMC have collaborated on many community projects such as Women, Infants and Children (WIC) grant services, diabetes management projects, numerous fitness/prevention initiatives, joint diversity training for all employees at both institutions with a grant from a local health care foundation, and the creation of the non-profit Quincy Asian Resources, Inc.

MCHC/Quincy HPSA Score: 4
MUA Score 57.0 and MUA ID#01523

Attached are letters of support for this project from community hospitals:

Caritas Good Samaritan Medical Center

Affiliated with Tufts University School of Medicine

235 North Pearl Street
Brockton, MA 02301
tel: 508•427•3000
www.caritasgoodsam.org

September 19, 2007

Ms. Joi Grymes
Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Grymes:

The *Caritas Good Samaritan Medical Center* is pleased to write a letter of support for the Massachusetts' Medicaid Emergency Room Diversion Project. Over the past several years, we have experienced an increasing number of patients whose level of care is more suited for that of the urgent care setting of the Brockton Neighborhood Health Center.

We have a long and positive working relationship with the Brockton Neighborhood Health Center and most recently we have engaged in a collaborative effort to refer non-emergent patients to the Center for follow-up and on-going primary care. As a health care institution, we believe that connecting patients to the most appropriate site for care and to have that connection result in the patient having a medical home will create a more integrated and comprehensive continuum of care. Working closely with the community health center and referring patients to BNHC for follow-up care and primary care services makes this more feasible. We have experienced positive patient outcomes and patient satisfaction through this collaboration.

The *Caritas Good Samaritan Medical Center* strongly encourages a favorable review of the Massachusetts' proposal. Should you have any questions or need additional information, please do not hesitate to contact me.

Thank you for your consideration in this matter and we look forward to working on this important initiative.

Sincerely,

John Holiver,
President

Lawrence
General
Hospital

1 General St.
PO Box 189
Lawrence, MA 01842-0389
(978) 683-4000

September 20, 2007

Ms. Joi Grymes
Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Grymes:

The Lawrence General Hospital is pleased to write a letter of support for the Massachusetts Medicaid Emergency Room Diversion Project.

We have a long and positive working relationship with the Greater Lawrence Family Community Health Center (GLFHC). As a health care institution, we believe that connecting patients to the most appropriate site for care and to have that connection result in the patient having a medical home will create a more integrated and comprehensive continuum of care. Working closely with the community health center and referring patients to GLFHC for follow up care and primary care services makes this more feasible.

Thank you for your consideration in this matter and we look forward to learning more about this important initiative.

Sincerely,

Joseph S. McManus
President and Chief Executive Officer

September 21, 2007

Grants Management Specialist
Centers for Medicare and Medicaid Services
Office of Acquisitions and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

To Whom It May Concern:

I am very pleased to write an enthusiastic letter of support for the Massachusetts' Medicaid Emergency Room Diversion Project on behalf of Lowell General Hospital (LGH) and our close association with Lowell Community Health Center (LCHC) in Lowell, Massachusetts. Since 1970 when the health center was started by LGH through the time when LCHC became separately incorporated in 1985, LGH has valued our partnership and fully support LCHC's high quality efforts to serve the diverse community of Lowell. LGH is the admitting hospital for all of LCHC's 25,000 patients seen annually, should they need in-patient or emergency room care.

Currently, LGH and LCHC work together on strategies for improving access to care across the City including the Greater Lowell Health Alliance and the Task Force on Access to Care for Uninsured, Underinsured, and Low Income people. In regards to emergency room diversion, we have worked collaboratively to ensure smooth transitions of patients from the ER to LCHC and to educate patients regarding appropriate utilization of the ER.

We look forward to further strengthening our efforts to the benefit of the community, our patients, and the health care system as a whole.

Sincerely,

Amy Hoey, RN
Vice President Patient Care/CNO

295 VARNUM AVENUE ❦ LOWELL, MA 01854-2193
www.lowellgeneral.org ❦ 978.937.6000

NSMC
NORTH SHORE MEDICAL CENTER

81 Highland Avenue
Salem, Massachusetts 01970
Tel. 978 741-1200

September 19, 2007

Ms. Joi Grymes
Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Grymes:

The North Shore Medical Center, along with its affiliated hospitals Union Hospital in Lynn and Salem Hospital in Salem, is pleased to write a letter of support for the Massachusetts' Medicaid Emergency Room Diversion Project. Over the past several years, we have experienced an increasing number of patients who use the emergency room for non-emergent and/or who present without a primary care provider.

The Lynn Community Health Center and North Shore Medical Center have had an affiliation and strong collaborative relationship since 1999. Recently, we have engaged in a collaborative effort to refer non-emergent patients to the center for follow-up and on-going primary care. As a health care institution, we believe that connecting patients to the most appropriate site for care and to have that connection result in the patient having a medical home will create a more integrated and comprehensive continuum of care. Working closely with the community health center makes this more feasible. During FY 2007, 418 new patients were referred to Lynn CHC by Salem or Union hospital emergency department. A recent analysis of 746 patients referred from the Salem and Union Hospital emergency departments during FY 2006 and 2007 shows that they had 3,628 visits at the health center during that period, a strong indication that these patients are now receiving on-going primary care at the health center.

The North Shore Medical Center strongly encourages a favorable review of the Massachusetts' proposal. Should you have any questions or need additional information, please do not hesitate to contact me.

Thank you for your consideration in this matter and we look forward to working on this important initiative.

Sincerely,

Lori Long
Director of Community Relations

PARTNERS HEALTHCARE

QUINCY MEDICAL CENTER
The Boston Medical Center Alliance For Quality

BOSTON MEDICAL CENTER

Boston University School of Medicine

Tomorrow's Care Today!

T
E
A
M
W
O
R
K

September 19, 2007

Ms. Joi Grymes
Grants Management Specialist
Centers for Medicare & Medicaid Services
Office of Acquisitions and Grants Management
Mail Stop C2-21-15
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Grymes:

Quincy Medical Center (QMC) is pleased to write a letter of support for the Massachusetts' Medicaid Emergency Room Diversion Project. Over the past several years, we have experienced an increasing number of patients who use the emergency room for non-emergent issues and/or who present without a primary care provider.

Quincy Medical Center has a long history of collaboration, over 27 years, with Manet Community Health Center (Manet CHC). In 2000, Manet CHC established its fifth practice site, a fully independent site, within the walls of the hospital. As part of our collaboration, we have engaged in an effort with Manet to identify Manet patients who are treated at the QMC Emergency Department for outreach to coordinate their follow-up and on-going primary care. As a health care institution, we believe strongly in an integrated and comprehensive approach to the continuum of care whereby patients have a medical home and are treated at the most appropriate site for their care. Patients appreciate being referred to primary care services at the Manet's QMC site because of their familiarity with the hospital and the emergency room. At Quincy Medical Center we have observed a 3% decrease from 2006 to 2007 in the proportion of ED patients who do not have primary care providers and anticipate further improvements as we continue our collaboration with Manet.

Quincy Medical Center strongly encourages a favorable review of the Massachusetts' proposal. Should you have any questions or need additional information, please do not hesitate to contact me.

Thank you for your consideration in this matter and we look forward to working on this important initiative.

Sincerely,

Gary Gibbons, MD
Chief Executive Officer
Quincy Medical Center

114 WHITWELL STREET • QUINCY, MA 02169-1899 • 617 773-6100 • www.quincymc.org

Quincy Medical Center is a teaching affiliate of Boston University School of Medicine.

PROJECT ABSTRACT

The Massachusetts Executive Office of Health and Human Services, Office of Medicaid (MassHealth) is requesting $10M in funding for an Emergency Room Diversion Project that would be implemented in two phases and would build on existing relationships between community hospitals and federally qualified community health centers (FQHCs). Phase One focuses on five major urban centers in two regions of the state that are designated as Medically Underserved Areas or Populations (MUAs/MUPs) and Health Professional Shortage Areas (HPSAs). These sites were selected based on the degree of collaboration they currently have with their community hospital/s and on their ability to expand their ER diversion projects as described in the Applicant Preference section above.

Phase Two of the project would include an assessment of other areas of the Commonwealth where FQHCs are beginning to work with their local community hospitals to identify strategies to divert non-acute and patients without a primary care provider to the FQHC for follow-up and ongoing care. Phase Two of the proposed project would provide technical assistance to communities identified by the Commonwealth as ready to strengthen FQHC and local community hospital collaboration. Such technical assistance would include identification of projects and project implementation assistance. Lessons learned from Phase One of the project will inform projects developed in Phase Two.

The overall **goals** for the proposed project are:

- *A reduction in emergency room utilization for non-emergent care.*
- *Improved access to urgent care at local FQHCs.*
- *Improved access to on-going primary care (a medical home) for MassHealth beneficiaries without a stable source of on-going primary care.*
- *Increased education concerning appropriate emergency room use and the advantages of a medical home for MassHealth beneficiaries.*
- *Cost savings through diversion of Medicaid funds from inappropriate ED visits to urgent and primary care services.*
- *Enhanced communication and collaboration between FQHCs and community hospitals.*

Specific **objectives** to meet these goals are:

- *To expand existing emergency room diversion projects in underserved communities.*
- *To assess, identify and implement additional projects in communities with significant emergency room utilization by MassHealth beneficiaries.*
- *To expand community-based urgent care and primary care capacity.*
- *To expand information technology to monitor and track project outcomes and to improve communication and collaboration between community hospitals and FQHCs.*
- *To increase the use of alternative non-ED sites for urgent care that are closely linked with primary care for MassHealth beneficiaries.*

MEDICAID EMERGENCY ROOM DIVERSION PROPOSAL

PROJECT NARRATIVE

STATEMENT OF PROJECT/NEED:

The Massachusetts Executive Office of Health and Human Services, Office of Medicaid (MassHealth) is requesting $10M in funding for an Emergency Room Diversion Project that would be implemented in two phases and would build on existing relationships between community hospitals and federally qualified community health centers (FQHCs). Phase One focuses on five major urban centers in two regions of the state that are designated as Medically Underserved Areas or Populations (MUAs/MUPs) and Health Professional Shortage Areas (HPSAs). These sites were selected based on the degree of collaboration they currently have with their community hospital/s and on their ability to expand their ER diversion projects as described in the Applicant Preference section above.

Phase Two of the project would include an assessment of other areas of the Commonwealth where FQHCs are beginning to work with their local community hospitals to identify strategies to divert non-acute and patients without a primary care provider to the FQHC for follow-up and ongoing care. Phase Two of the proposed project would provide technical assistance to communities identified by the Commonwealth as ready to strengthen FQHC and local community hospital collaboration. Such technical assistance would include identification of projects and project implementation assistance. Lessons learned from Phase One of the project will inform projects developed in Phase Two.

MEDICAID EMERGENCY ROOM DIVERSION PROPOSAL

The Commonwealth has proposed this project with the goal of reducing non-emergent/preventable/avoidable emergency department visits which are more appropriately addressed in a clinic or office setting. The Commonwealth of Massachusetts average rate of emergency room visits per 100 Medicaid Enrollees is 40.2 compared to the national average of 81.0. The 5 sites in Phase 1 of this project have rates per 100 Medicaid Enrollees which range from 30.6 to 61.6. (Data are for MassHealth eligible members 10/2005-9/2006 utilizing member months.) A study by the Massachusetts Division of Health Care Finance and Policy published in February 2007 using Fiscal Year 2005 data shows that fifty-three (53%) of emergency department visits for Medicaid beneficiaries that did not result in an admission were preventable and avoidable. Twenty-four percent (24%) of these preventable and avoidable visits were for non-emergent cases. The remaining twenty-nine percent (29%) were either emergent and treatable by a primary care provider or emergent but preventable and avoidable.

The Commonwealth recognizes there is a need to shift these visits from more expensive emergency department settings to less expensive and more clinically appropriate clinic or office settings. According to the study, even if a portion of these visits were shifted to clinics or office settings, the Commonwealth could see significant savings. In addition, through such emergency department diversion, Medicaid enrollees would receive care in more appropriate settings with access to primary care follow up and care management.

PROJECT JUSTIFICATION:

The proposed Massachusetts Medicaid Emergency Room Diversion Project is built on enhancing relationships between FQHCs and local community hospitals through increased communication and collaboration, and by expanding urgent care and primary care capacity within the network of FQHCs across the state. Enhanced communications and increased FQHC capacity would allow an emergency room clinician who has completed an assessment of a non-emergent patient to refer the patient to the appropriate treatment and/or primacy care follow up at the partnering FQHC. Key to the success of the proposed project would be frequent and consistent communication between the FQHC and emergency room staff. Such communication would allow both entities to identify and refer patients to the appropriate level of care. The mechanisms for the communication may vary from region to region and would build upon existing strengths and relationships.

Interventions to expand urgent care and primary care services at the FQHCs will include:

- Establishment of urgent care hours (after 6 pm and on weekends) where there are none provided;
- Expansion of existing urgent care hours and primary care sessions;
- Expanded nurse triage capacity;
- Enhanced linguistic support during urgent care hours; and,
- Improved clinical and health information technological support.

Phase One

Phase One of the project will build upon a current state funded ER diversion project to allow the five identified FQHCs to expand upon the strategies they have already begun to implement as

described in the Applicant Preference section above. The identified FQHCs' new strategies under Phase One of the proposed project are described below:

Brockton, Massachusetts: Brockton Neighborhood Health Center (BNHC)

BNHC's urgent care program is at capacity with the current staff. The health center would utilize funds from this proposed project to expand capacity by hiring additional staff. The health center proposes to hire an additional Nurse Practitioner (1 FTE), in addition to the two Nurse Practitioners currently on staff. BNHC would also hire the following additional staff to meet the needs of the urgent care program: 2 Social Workers (2 FTEs to make the ratio of social workers to primary care staff 1 to 1, the program's goal); 1 LPN to support the additional Nurse Practitioner; and 1 community outreach/medical assistant. BNHC's urgent care program also needs $40,000 in equipment to allow the urgent care program to operate independently. Without such equipment, the urgent care program will need to share space with the adult medicine department, which would not allow for growth in either department.

Lawrence, Massachusetts: Greater Lawrence Family Health Center (GLFHC)

GLFHC has recently expanded its urgent care hours on Saturday and added Sunday hours. The health center offers evening hours Monday – Saturday at its main site and also provides some additional evening appointments at its satellite sites. Because GLFHC expanded hours and has capacity for additional primary care patients, the health center will focus on enhancing its ability to case manage patients seen in the emergency department and increase coordination/ communication with the emergency department. GLFHC proposes to build on a project, funded with support from a local health care foundation, which hired case managers to follow patients

with asthma and coordinate with the hospital when those patients are seen in the emergency department or admitted to the hospital. While the project is still new, anecdotal evidence suggests that there has already been an impact resulting in decreased emergency department utilization. The health center proposes to expand this model to include its general population of patients, not just those patients with asthma. The health center would hire additional case managers to follow up with patients seen in the emergency department to ensure follow up occurs and connections are made with primary care. The case managers would play a key role in building relationships with emergency department staff and educating patients about the importance of establishing a primary care relationship and the appropriate uses of the emergency department. An additional component of the project would use grant funds to improve the capacity of the health center and hospital to share electronic data directly for those individuals who are patients of the health center.

Lowell, Massachusetts: Lowell Community Health Center (Lowell CHC)

The local hospital emergency department estimates that there are an additional 10 – 15 individuals seen per day in the emergency department for non-emergent issues that could be referred to Lowell CHC if the health center had additional capacity. To provide urgent care services for these additional patients, Lowell CHC proposes to expand its urgent care capacity by hiring 1 FTE physician or nurse practitioner, a nurse, a medical assistant, a registration staff person and a half-time floating medical assistant/registration position. The health center is also at capacity for space, even with the recent construction of six additional exam rooms. In addition to the increased staff, Lowell CHC would utilize a portion of the funding to expand exam room space to allow for increased capacity in both urgent care and primary care.

Lowell CHC also proposes to use the funding to train triage nurse staff and implement a system where triage nurses can utilize the electronic medical record to enter triage notes, particularly for urgent care patients. This system would allow the triage nurse to efficiently capture critical health information about the patient and communicate it to the provider in cases where the individual's paper health record may not be readily available.

Lynn, Massachusetts: Lynn Community Health Center (Lynn CHC)

Lynn CHC proposes to build on its current nurse triage system which is closely tied to the two local community hospitals. Currently, triage nurses employed by the Lynn CHC follow up with all patients seen in the emergency departments, spend regular on-site time at the local emergency departments, and coordinate/manage care for individuals to ensure follow up occurs and connections are made with primary care. Lynn CHC would utilize the funding to hire an additional triage nurse and/or pay overtime to current triage nurses to provide evening outreach to patients. The triage nurses currently find it is often difficult to follow up with patients during the daytime and feel additional outreach during the evening would enhance the nurse triage system. Lynn CHC also proposes to implement a new patient orientation session for patients new to the health center. The sessions would be offered on a regular schedule and conducted by a nurse. The orientation would focus on the preventative part of the care continuum and provide education to patients on how to make primary care appointments, how to access the health center's walk-in services, how to reach on-call providers after-hours, and what to do in a case of urgent or emergent needs. The health center would conduct a feasibility assessment on how to best address incoming calls when the health center is closed. Lynn CHC would explore the

possibility of implementing a nurse triage after-hours line where appointments could be made in real time by the triage nurse service.

Quincy, Massachusetts: Manet Community Health Center (MCHC)

MCHC proposes a three phased approach to expanding capacity at its hospital-based site. In the first phase, MCHC would coordinate with its local hospital, Quincy Medical Center (QMC), the location of its hospital-based site, to add additional exam rooms. QMC is willing to provide additional space to the health center and grant funds would be used to renovate the space and make the space licensure compliant. The second phase would be to hire additional staff and extend the current hours of operation. MCHC proposes to hire at least two additional primary care providers along with a nurse, medical assistant and administrative staff to support the additional patient visits and extended hours of operation. The health center would also explore the possibility of hiring an emergency room discharge planner who would be available on weekends in the emergency department to coordinate care on-site and in real-time for MCHC patients. The third phase would focus on building the health center's information technology infrastructure in order to implement an electronic medical record which would improve patient care, particularly for those patients seeking urgent care from the health center.

Phase Two

During Phase Two of the proposed project, the Commonwealth would identify, through an open and competitive process, additional FQHCs to participate in the project. Selection will be based on the following criteria:

- Willingness of the community hospital and FQHC to work collaboratively on emergency room diversion;
- Number of MassHealth patients seen (including MassHealth MCO enrollees and enrollees in Commonwealth Care, the new subsidized insurance products under the Massachusetts Health Care Reform and authorized by the MassHealth 1115 waiver for individuals between 100% and 300% of federal poverty);
- ER visits per 1,000 Medicaid enrollees;
- Ability to expand hours beyond 9-5 Monday through Friday and to increase primary care capacity; and
- Likelihood of ED diversion project to become self-sustaining.

PROJECT GOALS AND OBJECTIVES:

The overall **goals** for the project are:

- *A reduction in emergency room utilization for non-emergent care.*
- *Improved access to urgent care at local FQHCs.*
- *Improved access to on-going primary care (a medical home) for individuals without a stable source of on-going primary care.*
- *Increased education concerning appropriate emergency room use and the advantages of a medical home for MassHealth beneficiaries.*
- *Cost savings through diversion of Medicaid funds from inappropriate ED visits to urgent and primary care services.*
- *Enhanced communication and collaboration between FQHCs and community hospitals.*

Specific **objectives** to meet these goals are:

- *To expand existing emergency room diversion projects in underserved communities.*
- *To assess, identify and implement additional projects in communities with significant emergency room utilization by MassHealth beneficiaries.*
- *To expand community-based urgent care and primary care capacity.*
- *To expand information technology to monitor and track project outcomes and to improve communication and collaboration between community hospitals and FQHCs.*
- *To increase the use of alternative non-ED sites for urgent care that are closely linked to primary care for MassHealth beneficiaries.*

ESTIMATE OF IMPACT TO BENEFICIARIES:

Phase One of the project will impact Medicaid beneficiaries in the five major urban centers of Brockton, Lawrence, Lowell, Lynn and Quincy, Massachusetts. From October 1, 2005 through September 30, 2006, there were approximately 200,000 unique individuals enrolled in Medicaid in these five communities. This represents fourteen percent (14%) of the statewide Medicaid beneficiaries. This project would provide these individuals with greater access to non-ED urgent and primary care at FQHCs, which are well suited to deal with the needs of this population.

Through the addition of new project sites under Phase Two of the project, many of the remaining 1.3 million Medicaid beneficiaries in the Commonwealth would benefit from increased access to urgent and primary care at the FQHCs.

DESCRIPTION OF THE MAGNITUDE OF THE IMPACT TO MEDICAID:

According to a study published in February of 2007 by the Commonwealth of Massachusetts Division of Health Care Finance and Policy, Massachusetts Medicaid patients made 236,814 visits to the emergency departments for primary care treatable causes in state fiscal year 2005. If all of these visits were to occur in a community health center setting it would save the MassHealth program at least $21.3M per year. The Massachusetts Office of Medicaid anticipates this proposed project may greatly reduce emergency department costs by decreasing preventable/avoidable emergency department visits as well as getting people into primary care to avoid other potential hospitalizations. The proposed project will reduce inappropriate emergency department visits by shifting care to more appropriate community-based providers whose charges for non-emergent services are much lower than emergency room charges. The proposed project will also work to increase primary care connections and the development of a medical home for Medicaid beneficiaries; thus preventing a portion of inappropriate visits altogether and ensuring better preventive care and better health outcomes.

DESCRIPTION OF SUSTAINABILITY OF THE PROJECT:

This project would focus on identifying efforts at health centers that would likely become self-sustaining by generating administrative savings, increasing revenue, and/or reducing inappropriate care. The Commonwealth intends to utilize this grant to provide health centers with initial start up funds to hire new staff, purchase equipment, expand space and perform other activities necessary to increase their urgent care and primary care capacity. Once the individual programs are operational and have the capacity to see new patients, the focus will be on growing visit volume by diverting non-emergent cases from the hospital EDs to the level where urgent

and primary care visit revenue would cover the costs of operations. It is our expectation that these programs would be self sustainable by the end of the grant funding period.

EVALUATION PLAN:

The Commonwealth's Executive Office of Health and Human Services, Division of Health Care Finance and Policy, in conjunction with a contractor procured through an open and competitive process consistent with the Commonwealth's regulations**,** would be responsible for the oversight and evaluation of this emergency room diversion project. The Commonwealth will submit quarterly reports to CMS documenting the grant expenditures and the progress of this project as set forth in federal regulations at 45 CFR Part 92.

As a condition of participating as a project site under this grant, the Commonwealth would require the health centers to submit quarterly reports to the Commonwealth on the progress of implementation of the project. The report will include:

- Summary Project Description
- Project Status, including a valid explanation if the project is not following its approved Work Plan
- Detailed Project Status of all Work Plan items
- Status of Performance Measures
- Key Accomplishments/Highlights/Problems and Action Required
- Budget Status

Project evaluation measures will be outcome focused and will include a baseline assessment for ED utilization for non-emergent care that will be the comparison for determining the

impact of the project. Some of the project site initiatives may need to include qualitative and process measures as well. Possible measures for evaluation that may vary depending on the project site include:

- *Number of emergency room visits per 100 Medicaid beneficiaries*
- *% of week day/work hour emergency room visits per total number of emergency room visits*
- *% of week day/work hour emergency room visits that are non-emergent*
- *% of emergency room visits with no primary care provider identified*
- *# of expanded after hours services including but not limited to enhanced nurse triage, beneficiary outreach and education, language capacity and access to primary care.*

DESCRIPTION OF PROJECT IMPLEMENTATION READINESS:

All alternate non-emergency services providers participating as project sites in this project will be operational within 18 months of the start date of the grant award. The first task for the Commonwealth will be to procure a contractor to provide oversight and management of the FQHC project sites. The Commonwealth anticipates the entire procurement and contract negotiation for a contractor will be completed by January 2008. Once the contractor is selected, Phase One of the project will begin. The initial five sites in Phase One were selected in part due to their ability to ramp up and implement expansion and enhancement strategies quickly. Because all five sites already have collaborative relationships with their local hospitals, the Commonwealth believes these health centers can begin implementation of these enhanced emergency room diversion projects by July 1, 2008. During the initial six month planning period of Phase One, the Commonwealth's contractor will work with the health centers to develop

detailed work plans, project budgets, timelines for implementation and select performance measures. The Phase One project sites will complete their project implementation by September 30, 2009.

Phase Two will run concurrently with Phase One. The Commonwealth's contractor will identify additional project sites that meet the criteria as described above by June 30, 2008. The planning and implementation of Phase Two, which will occur six months later than the planning and implementation of Phase One, will build upon the experiences of the project sites in Phase One. The Phase Two sites will complete their project planning by December 31, 2008, begin implementation by January 1, 2009 and will complete their projects by September 30, 2009.

Implementation Tasks and Timeline (Assumes Award Notification on October 31, 2007)

- **Procurement of Commonwealth's contractor for project oversight:**
  - Anticipated completion: December 31, 2007
- **Phase One: Initial Five Projects Sites**
  - Phase One Planning Period
    - Anticipated start date: January 1, 2008
    - Anticipated completion: June 30, 2008
  - Phase One Implementation:
    - Anticipated start date: July 1, 2008
    - Anticipated completion: September 30, 2009

- **Phase Two: Assessment, Selection and Implementation of Additional Project Sites**
  - Selection of additional project sites:
    - Anticipated start date: January 1, 2008
    - Anticipated completion: June 30, 2008
  - Phase Two Planning Period:
    - Anticipated start date: July 1, 2008
    - Anticipated completion: December 31, 2008
  - Phase Two Implementation
    - Anticipated start date: January 1, 2009
    - Anticipated completion September 30, 2009