Medicaid Emergency Room Diversion Grants
Grant Summaries

In April 2008, CMS awarded twenty grants to twenty states for two year projects with the goal of reducing use of hospital emergency rooms by Medicaid beneficiaries for non-emergent reasons. The anticipated outcomes of these grant-funded projects are improved access to, and quality of, primary healthcare services, improved beneficiary health status and demonstrated program cost savings. Summaries of the grantees' strategies to achieve this goal are below.

Colorado (2)

Grantee: Colorado Department of Health Care Policy and Financing
Total Funding Amount: $1,816,100 for two projects for a two-year period.

Project Name: San Luis Valley Region
Description: Valley-Wide Convenient Care services will be housed in Valley-Wide's largest primary care clinic. Since Valley-Wide is the safety-net provider for primary care in the SLV, increased or alternate hours of operation will help increase access to care to help circumvent inappropriate use of the ED. While one of the primary goals is to redirect ED patients back into primary care, this model also aims to free up primary care appointment slots for patients with chronic conditions, continuity of care issues, and preventative health services. The proposed model is also intended to address interventions that correlate with decreased ED usage, including providing health education, teaching patients how to use the healthcare system, and providing counseling on social/emotional issues. Operational hours will be specifically designed to provide primary care alternatives during hours when there is no other choice than the ED (nights and weekends), while also overlapping mid-afternoon hours with the highest known frequency of visits in the ED. Valley-Wide proposes to offer a new shift Monday through Saturday from 2:00 – 10:00 p.m., and Sunday hours will be added from 9:00 a.m. – 10:00 p.m. resulting in a total of 61 additional hours of operation per week.
Funding Amount: $890,000 for a two-year period.

Project Name: Pike Peak Region
Description: As part of a collaborative effort, Peak Vista Community Health Centers and Memorial Health System propose to establish an effective referral program for non-emergency Medicaid patients seeking care at Memorial's Emergency Department (ED). Memorial's ED staff will provide initial treatment to patients entering the ED for non-emergency care, and then recommend follow-up care with Peak Vista. Funding from this grant will be used to implement the establishment of this infrastructure with a focus on Medicaid patients. This project will focus on reaching three goals: 1) to educate the Medicaid population about alternative non-emergency care options; 2) to offer real time referrals to alternative non-emergency care through the use of Outreach Case Managers; and 3) to promote the concept of a medical home for Medicaid patients so that they will have a better understanding of their healthcare options and appropriately use health care services.
Funding Amount: $926,100 for a two-year period.

Connecticut

Grantee: Connecticut Department of Social Services
Project Name: Connecticut Solution to Reduce Non-Emergent Visits to the Emergency Department and Establish Primary Care Alternative
Description: State proposes to utilize a web-based application to connect providers in federally qualified health centers (FQHCs) and hospitals in designated communities throughout the state to create a common platform to search and schedule appointments for Medicaid enrollees. The Connecticut Primary Care Association, the Connecticut membership association for FQHCs, will lead the project under contract with the State of CT. The *My Health Direct* web portal facilitates access to primary care for Medicaid recipients by removing barriers patients face to obtaining primary care appointments and enhancing linkages between emergency departments and community-based primary care providers. The My Health Direct system is also available to schedule appointments 24 hours a day, 7 days a week, 365 days a year.
Funding Amount: $793,558 for a two-year period.

Georgia

Grantee: Georgia Department of Community Health
Project Name: Georgia Alternative Emergency Services Provider Project
Description: The primary purpose of the Georgia Alternative Non-Emergency Services Provider Project (GNESPP) is to reduce non-emergent emergency room visits and increase the number of Georgians with medical homes. The anticipated results of the project will be a reduction in cost to the Georgia Medicaid Program; a decrease in uncompensated care realized by Georgia hospitals and improved health status for all Georgians. The Georgia Department of Community Health, Division of Medical Assistance (Medicaid), will administer the proposed project and plans to use a Request for Grant Application process to select a minimum of four demonstration sites.
Funding Amount: $2,500,000 for a two-year period.

Illinois

Grantee: Illinois Department of Public Aid
Project Name: Illinois Emergency Room Diversion (ERD) Program
Description: Illinois Healthcare and Family Services (HFS) proposes an Emergency Room Diversion program that locates new Community Health Center (CHC) sites on or near hospital campuses and partners with behavioral health providers so clients seeking non-emergent care may be seen in a non-emergent primary care and behavioral health settings. HFS will seek proposals from CHC/hospital collaborators and will ultimately fund two such collaborations, one in Chicago and one in a rural area.
Funding Amount: $2,006,000 for a two-year period.

Indiana

Grantee: Indiana Family and Social Services Administration
Project Name: Indiana Partnership for Alternatives to Emergency Room Services
Description: State will partner with Wishard Health Services in Marion County (urban) and Tippecanoe Community Health Center and St. Elizabeth's Hospital in Tippecanoe County (rural) to establish 2 convenient care health clinics as alternate non-emergency care providers. Both convenient care clinics will be staffed by advanced practice nurses and a patient navigator who will help link patients with primary care providers, mental health and/or other community services. One of the advanced practice nurses at each site will have a mental health background in order to assist in screening for underlying mental health concerns that may drive individuals to seek hospital emergency room services.
Funding Amount: $1,610,380 for a two-year period.

Louisiana

Grantee: Louisiana Department of Health and Hospitals
Project Name: Louisiana Operation REDIRECT: A Redirection Management Approach for Establishing Networks of Alternate Non-Emergency Services Providers
Description: State will expand a network of hospital and federally-qualified health center primary care providers to offer extended evening and weekend access and urgent care services. Approach will include targeted outreach using "redirection management" to provide education and navigation assistance to beneficiaries identified as high utilizers of emergency room services. There will also be a Point-of-Contact onsite at participating hospital emergency departments who will interact with the presenting beneficiary, with non-emergent health needs, to determine why s/he had not accessed care with their primary care provider, refer them back to their linked primary care provider, and offer the beneficiary the option of selecting a network provider. If appropriate, some will be redirected to urgent care facilities. Both approaches will be facilitated through technology integration and access to beneficiary data.
Funding Amount: $3,769,653 for a two-year period.

Massachusetts

Grantee: Massachusetts Office of Medicaid
Project Name: Massachusetts Medicaid Emergency Room Diversion
Description: The project that would be implemented in two phases. Phase One focuses on five major urban centers in two regions of the state that are designated as Medically Underserved Areas or Populations and Health Professional Shortage Areas. Phase Two of the project would include an assessment of other areas of the Commonwealth where federally-qualified health centers (FQHC) 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 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.

Funding Amount: $4,606,434 for a two-year period.

Maryland

Grantee: Maryland Department of Health and Mental Hygiene
Project Name: Maryland Improving Access to Care by Reducing Inappropriate Use of Emergency Rooms While Promoting Community Alternatives
Description: Maryland proposes to reduce unnecessary emergency room use and improve access to primary and specialty physician care for the uninsured and underinsured through the establishment of three regional information infrastructures and coordinated care management systems. Each care management system will include a hospital and community partners. The 5 key program strategies are: the implementation of an information exchange system between pilot hospitals and community partners; the redirection of patients who are inappropriately using hospital emergency rooms to an appropriate source of care; the promotion of community alternatives; the evaluation and tracking of program outcome measures; and the development of sustainable funding for these projects and other projects throughout the State.
Funding Amount: $1,789,195 for a two-year period.

Michigan (2)

Grantee: Michigan Department of Community Health
Total Funding Amount: $498,804 for a two-year period.

Project Name: Montcalm Area Health Center/Spectrum Health United Memorial Hospital
Description: The Montcalm Area Health Center opened in Greenville, Michigan in November, 2007. It is a branch of Cherry Street Health Services, a Federally Qualified Health Center (FQHC). The Health Center will partner with Spectrum Health – United Memorial Hospital in an effort to reduce inappropriate emergency room admissions. A precipitating factor in the implementation of this program is the significant reduction over the past few years in the number of local primary care physicians who are willing to accept Medicaid and the consequent overuse of the emergency room by those who have Medicaid coverage. The Program will educate staff in the hospital and staff in the Montcalm Area Health Center regarding the improvement in preventive and chronic disease care that is possible if certain patients can be diverted from using the emergency room as their regular place of care to the FQHC. Systems will be developed so that staff can easily refer patients with non-emergent conditions for immediate care or for follow up care from the emergency room to the Montcalm Area Health Center. Patients will be diverted to care at the FQHC through community marketing efforts intended to help them seek care appropriately when the ER is not needed, through hospital telephone triage and through direct referral of those who do come in to the emergency room.
Funding Amount: $250,000 for a two-year period.

Project Name: Hamilton Community Health Network Inc. /Hurley Medical Center
Description: Hamilton Community Health Network (HCHN) and Hurley Medical Center, a nearby non-profit hospital, have a history of working in partnership on many community projects. The implementation of the **A** (access) **C** (case management) **E** (establish primary care

providers) project will involve the implementation of three key components. **A**ccess to after-hours care through expansion of open access availability by HCHN providers for non-emergent visits weekday evenings and Saturdays. A long term goal is the establishment of an Urgent Care facility located within Hurley Medical Center and staffed by contracted HCHN providers. **C**ase Management Services for Medicaid patients identified as frequent utilizers of the ER for non-emergent care and those patients who have identified chronic care conditions. **E**stablish a primary care home for Medicaid patients who do not have an identified primary care provider.
Funding Amount: $248,804 for a two-year period.

Missouri

Grantee: Missouri Department of Social Services
Project Name: Missouri Primary Care Home Initiative
Description: The Primary Care Home Initiative (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 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.
Funding Amount: $1,726,074 for a two-year period.

New Jersey

Grantee: New Jersey Division of Medical Assistant and Health Services
Project Name: Community Partnership for ED Express Care and Case Management
Description: State will partner with the NJ Hospital Association's Health Research and Educational Trust and the NJ Primary Care Association to pilot test a model for providing alternate non-emergency services to patients who present with primary care needs in hospital emergency departments (ED), as well as patient education and support services to encourage and maximize their future use of appropriate sites of care. The program will be piloted in 2 sites selected based on location in a county with high rate of ED use by Medicaid beneficiaries (for primary care services and in general); location in a medically underserved area; and commitment of a community hospital and a nearby FQHC (or other primary care provider) to participate, commit resources and make necessary process changes. All patients who present to the ED will be triaged and receive medical screening by an advanced practice nurse (APN). Once a patient is determined to have non-emergency primary care needs, the APN will provide express primary

care services and prescriptions, either as part of the triage/medical screening or immediately following. As part of discharge services for Medicaid/uninsured patients, the APN will set up the follow-up appointment with a primary care provider in the community, such as the participating FQHC, using a secure Web-based electronic information system. Pilot FQHCs will expand service hours and clinical staff to offer active case management and additional, convenient follow-up appointment times and will provide patient transportation as needed. During ED discharge, the APN will also educate express care patients on the appropriate site of care and the importance of using a medical home for primary care services and limiting ED visits to true emergency situations. Clinical information about specific patients' use of ED for primary care needs will be shared with FQHCs and HMOs so they may take responsibility for their patients and provide more outreach/education.
Funding Amount: $ 4,830,000 for a two-year period.

North Carolina

Grantee: North Carolina Department of Health and Human Services
Project Name: Alternative Non-Emergency Provider Program
Description: Project will provide incentives and support to 40 large Community Care practices, which are willing to become alternative non-emergency providers ("advanced medical homes") in the communities they serve. Project expects to have at least 2 non-emergency provider sites in each of the 14 Community Care networks. The majority of the provider sites will be in rural areas and that each site will work closely with its community hospital in implementing the program. By creating the non-emergency providers within the Community Care medical home infrastructure – creating the "advanced medical homes" with after hours and weekend coverage – they will assure that continuity and coordination of preventive, primary and chronic health care needs are met.
Funding Amount: $2,260,531 for a two-year period.

North Dakota

Grantee: North Dakota Department of Human Services
Project Name: Emergency Diversion Project
Description: The project will establish 2 primary care pilot sites in rural North Dakota with diverse populations and geography. The first site is Presentation Medical Center, a critical access hospital located in Rolla, ND. The second site will be Coal Country Community Health Center, a non-profit, independent, community based health center located in Beulah, ND with satellite clinics located in Center and Halliday, ND. The Coal Country Community Health Center physicians are on the medical staff at the local non-profit hospital in Hazen, ND. A progressive study will be done tracking the utilization patterns of the emergency room, confirming appropriate use and misuse of the ER, developing and launching an educational awareness outreach plan, and determining and implementing a cost-effective corrective action plan, which may or may not result in expanded non-emergency provider hours or staff at the pilot sites.
Funding Amount: $287,500 for a two-year period.

Oklahoma

Grantee: Oklahoma Health Care Authority
Project Name: Community Health Centers Inc. (CHCI) Emergency Room Diversion Project
Description: The primary focus area of this proposed project will be access to a full array of primary and preventive health care for Oklahoma County Medicaid recipients, specifically addressing the overuse of hospital emergency department use. This focus will provide a two-pronged educational approach emphasizing healthy behaviors and navigating the health care system to establish a medical home. The projected outcomes are decreased emergency room visits and improved health status. The project focus is to add a Health Educator and two Community Health Workers (CHWs) and two CHW's to develop an Emergency Department Reduction Pathway and a Medical Home Pathway in conjunction with the University of Oklahoma's Medical Center (OU), St. Anthony Hospital and Central Oklahoma Integrated Network Systems, Inc., "COINS." COINS will be the vehicle that will provide the CHW training at Metro Technology Centers. This is a four week training to develop competencies in pathway development, health care system operations, social services, communication skills, motivational interviewing, health education and self-management of chronic diseases. CHCI will contract with OU College of Medicine to have resident physicians to provide medical services for additional 20 hours per week thereby increasing access.
Funding Amount: $1,030,536 for a two-year period.

Pennsylvania

Grantee: Pennsylvania Department of Public Welfare
Project Name: Establishment of Alternative Non-Emergency Service Providers, Emergency Department Triage and Improved Access to Non-Emergency Care in McKeesport, PA
Description: The project's main goals are to decrease non-emergent ED visits, improve quality of care and promote the concept of advanced medical home and therefore decrease overall Medicaid ED spending in the targeted area. To support this initiative, DPW will conduct a statewide campaign to educate Medicaid recipients on the appropriate use of ED services. The proposed system will include a triage line at the UPMC McKeesport, Hospital Emergency Department (ED), a new Urgent Care Center (UCC) within a separate wing of the hospital, the Latterman Family Health Center (LFHC) and additional resource support at Health First, the largest private practice serving the Medicaid population. UPMC Health Plan will establish an alternate delivery model that focuses on the provision of non-emergent services in the outpatient environment through partnering with the primary care physicians of the target population. Additional resource support, including the quantity of staff, expanded hours of operation, and a 24/7 triage phone line, will allow UPMC Health Plan to establish alternate non-emergency providers to serve the target population.
Funding Amount: $1,664,560 for a two-year period.

Rhode Island

Grantee: Rhode Island Executive Office of Health and Human Services
Project Name: Alternate Non-Emergency Provider Network Project
Description: The Medicaid Non Emergency Provider Network components are: 1) Emergency Department Psychiatric Diversion Project and 2) RIte Care Emergency Department Utilization Project. The Rhode Island Non-Emergency Provider Network would build on the collaboration established between the RI Community Health Center Association and the Hospital Association of Rhode Island, the efforts underway with the managed care health plans to reduce ED utilization, the established medical and behavioral health collaborative practice models, and recognized Child Psychiatry Access Project models.
Funding Amount: $4,200,000 for a two-year period.

South Dakota (6)

Grantee: South Dakota Department of Social Services
Total Funding Amount: $7,671,199 for six projects for a two-year period.

Project Name: Sioux Falls School-Based Health Pilot
Description: The proposed project would pilot a school based health center in one of three public high schools in Sioux Falls, SD. By providing convenient, alternative access to non-emergent health care, this program is intended to reduce the number of Sioux Falls high school students seeking non-emergent care in area emergency rooms. Currently, space outfitted for clinical use is available. Selection of the pilot sites would be based on healthcare needs, with the expectation that the program would grow from a pilot to encompass additional schools, including area middle schools. A mid-level health care provider will be available to students each day of the week for four hours for primary care. The provider would be employed by Avera McKennan Hospital & University Health System, a local tertiary care facility. The existing school nurse will fill the critical role of helping to build awareness of the services provided, triage cases, and identify students in need.
Funding Amount: $732,022 for a two-year period.

Project Name: Urgent Care Clinic Development
Description: This project proposes to open an urgent care clinic, to provide services from 5pm to 10pm Monday through Friday and Saturday 10am to 5pm, thus almost doubling the current available hours of non-emergency health care services in this community. Currently there is no available building capacity for offering urgent care. The clinic rooms are small, and not able to be renovated to house urgent care equipment. This project will allow for three clinic rooms to be contracted and outfitted for urgent care needs. Additionally, a provider will be hired to cover the extended shifts. It is estimated that 1800 visits, representing several hundred people, will be made to the urgent care clinic.
Funding Amount: $907,609 for a two-year period.

Project Name: Bennett County Hospital and Horizon Health Care, Inc Alternate Non-Emergency Services Partnership
Description: This project will facilitate appropriate access to primary care for Bennett and Todd County Medicaid recipients by offering extended clinic hours at the Federally Qualified Health

Centers (FQHCs) in Martin and Mission, a patient education program through the Federally Qualified Health Center and the Bennett County community hospital, expanded laboratory, radiology and pharmacy services, as well as improved patient care coordination through the deployment of a common Practice Management/Electronic Medical Record. This project is a partnership between the Bennett County Hospital in Martin and the two FQHCs in Martin and Mission which are operated by Horizon Health Care, Inc. The goal of the project is to provide appropriate access to primary care for the 66% of Medicaid patients in Bennett County FQHC and 54% of Medicaid patients in the Mission FQHC by offering alternative non-emergency providers in lieu of emergency room services.
Funding Amount: $2,513,917 for a two-year period.

Project Name: South Dakota Telehealth Urgent Care Clinic Project
Description: The South Dakota Telehealth Urgent Care Clinic Pilot Project will allow patients to receive local primary care, after hours, in their home clinic. Three pilot sites will be selected and will each have a nurse facilitate needed urgent care through advanced telehealth technology linked to an urgent care physician located in an urban community in the state. By providing telehealth consults, one provider is able to assist many remote sites with smaller volumes. Additional staffing is only needed for the RN to facilitate the visits. This not only stretches staffing dollars, but makes better use of the physician's time, and allows the patient convenient access to after hours care, thus reducing the number of unnecessary emergency room visits. This service will offer the additional benefit of providing local access to specialty consults, making it easier for individuals to seek timely care for management of serious chronic conditions, such as diabetes and chronic heart failure. This in turn, has been shown to improve disease management and reduce ER visits. The provision of this service will decrease inappropriate emergency room use, increase access to urgent care, and result in better health outcomes for South Dakotans in rural counties.
Funding Amount: $492,955 for a two-year period.

Project Name: Pine Ridge, South Dakota Chronic Care Clinic Access
Description: This project will increase access to non-emergency health care services that will result in less use of inpatient and emergency room services and improved health status for South Dakotans on the Pine Ridge Indian Reservation in Shannon and Todd Counties. Regional Health System will provide chronic disease management clinics for Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Diabetes and Warfarin management will be held twice a month staffed by a Board Certified Cardiologist, Endocrinologist or Internal Medicine physician, Registered Nurse and a P. C. Technician. Between clinics a Physician Assistant will accomplish follow-up visits through the aid of telemedicine functionality. On-site wellness classes will be available to all patients. The project will impact approximately 210 individuals. The project will provide increased access to regular, non-emergency health care through specialized clinics to address chronic diseases that are prevalent in the American Indian population in South Dakota and cause unnecessary emergency room visits.
Funding Amount: $1,486,239 for a two-year period.

Project Name: Developing Medical Homes on South Dakota's Pine Ridge Indian Reservation
Description: This project will provide medical homes to children and pregnant women on the Pine Ridge Reservation through a variety of innovative mechanisms. Recruiting additional

providers is key, as is developing the capacity to provide care in nontraditional locations. The geography of the reservation coupled with the stark poverty of the population results in needing to bring services to outlying communities via a Mobile Health Clinic. Medical homes will also be provided to children at schools located on the reservation, and the school clinic at Red Shirt will be operationalized to maximize access to regular primary care. Lastly, education on accessing available non-emergent health care services, wellness promotion, and prenatal care will be provided as part of this project to ensure that valued outcomes including decreasing inappropriate use of emergency rooms and increased health status outcomes are met.
The projected number of individuals who will be directly affected by the project is 4000 people. 900 children and pregnant women will receive health care directly through services provided by the project. Additionally, education supported by the project will impact additional people, such as parents, spouses, partners, education system faculty and community members.
Funding Amount: $1,538,457 for a two-year period.

Tennessee (3)

Grantee: Tennessee Department of Finance and Administration
Total Funding Amount: $4,472,240 for three projects for a two-year period.

Project Name: Haywood County Clinic
Description: This partnership will establish a community health center clinic site in close proximity to Haywood Park Community Hospital and be available to provide primary care services for TennCare patients presenting to the emergency room at Haywood Park Community Hospital for non-emergent medical care. Because of the scope of service that community health centers must offer, Hardeman County Community Health Center will establish agreements with other agencies including dental, mental health, translation, and transportation to ensure financial arrangements for patients needing such services. The proposed project site would be a vacant space leased from Haywood Park Community Hospital. Services would be provided at the community health center site four (4) days or thirty-two (32) hours per week. The site would be open at times when the traditional physician's office is closed. The community health center site will provide services to patients referred by the emergency room.
Funding Amount: $750,000 for a two-year period.

Project Name: Volunteer State Health Plan Partnership
Description: The collaboration between VSHP, Erlanger Health System, and Erlanger's Federally Qualified Health Centers, will direct members back to their primary care home before a pattern of excessive non-emergency ED use develops. Patients with low acuity levels will be directed away from the ED to a facility that will address their immediate health issue and encourage them to seek care from their primary care physician, unless their needs clearly require attention in the ED. The program will include an Erlanger main campus Health Center for patients who enter the ED with low acuity levels, but who need and desire treatment. The direction of these low acuity patients from the Erlanger ED to the Erlanger campus Health Center will be coordinated by the Community Access Facilitator, who assists with any needed follow up and patent education in coordination with the VSHP Care Coordination staff. Following a patient visit, the VSHP Early Detection Emergency Department Care Coordination

(EDEC) unit will receive information daily from Erlanger Health Center on members who visited the ED for non-emergency treatment.
Funding Amount: $2,368,116 for a two-year period.

Project Name: Nashville Medical Home Connection
Description: "Medical Home Connection," is a partnership with Medicaid/TennCare Managed Care Organizations, hospitals in Nashville Tennessee and United Neighborhood Health Services, a Federally Qualified Health Center with five health centers in underserved Nashville neighborhoods. "Medical Home Connection," will link hospital emergency room Medicaid/TennCare members in Nashville/Davidson County with alternate non-emergency primary care providers for their non-emergency care. "Medical Home Connection" will have three components offered to all TennCare/Medicaid members using emergency rooms for non-emergency care:

- UNHS Waverly Family Heath Center Connection
- UNHS Madison Health Center Connection
- In-hospital clinics

The two established UNHS Centers will provide an alternative provider to 6 hospitals by maintaining extended hours during times that emergency rooms experience their heaviest utilization. Staff at the hospitals will facilitate the link to the clinics and transportation will be provided. Two in-hospital clinics will provide an alternative provider during busy times seven days a week.
Funding Amount: $1,354,124 for a two-year period.

Utah

Grantee: Utah Department of Health
Project Name: Diversion of Utah Medicaid Non-Emergent Emergency Department Usage
Description: Utah will expand its Medicaid Care Coordination and Restriction Program. The Care Coordination and Restriction Program currently identify recipients who use the Emergency Department (ED) three or more times in a 12-month period for non-emergent care. Those persons are placed in the Care Coordination and Restriction Program and must work through specific protocols to receive services. The proposed expansion will add 2 additional FTEs, some consulting services, and printing and mailing costs to allow the State early identification of recipients receiving non-emergent ED care. These employees will monitor non-emergent use of the ED and make contact in a timely manner to educate recipients on appropriate use of the ED. The program staff will then assist these recipients in finding a primary care home. Preference of primary care homes may be given to participating community health centers, which include Federally Qualified Health Centers, in statewide communities. This program will allow staff to contact and educate specific beneficiaries after their first non-emergent visit to the ED.
Funding Amount: $503,655 for a two-year period.

Washington

Grantee: Washington Department of Social and Health Services
Project Name: Community Collaboration for Appropriate Emergency Department Care
Description: Washington will issue a request for proposals (RFP) to establish community health clinics (CHCs) as alternate non-emergency service providers. The RFP will require that

participating CHCs be located in a HPSA and have a collaborating community hospital as a partner. The project will reduce ED utilization through three strategies:

1. Assure 24 hour access to professional services for Medicaid enrollees by providing a nurse-triage line to Medicaid enrollees in project communities. All new enrollees will receive a mailing about the service including self care information on common non-emergent conditions;
2. Improve the ability of CHCs to be effective medical homes and alternate emergency care providers by providing funds for CHCs to expand primary care services into the evenings and/or weekends, initiate behavioral health services as a component of the medical home, or to locate services with or close to Hospital EDs; and
3. Create a case management system to follow-up on Medicaid ED visits. Case management will be integrated with the nurse-triage system to:
   - Contact Medicaid beneficiaries after an ED visit to follow-up on their health status;
   - Assure the client knows how to contact their primary care provider (PCP);
   - Make follow-up appointments with their PCP; and
   - Connect them with other needed services such as disease management programs for asthma/diabetes, housing assistance, mental health services or substance abuse treatment.

EDs will use low literacy and translated educational materials which explain how to address non-emergent conditions that most frequently send patients to the ED and that provide information on how to contact the nurse-triage line.

Funding Amount: $1,963,581 for a two-year period.