NEW JERSEY

Community Partnership for ED Express Care and Case Management

New Jersey Department of Human Services

Division of Medical Assistance and Health Services

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Abstract

The state of New Jersey proposes a partnership with the New Jersey Hospital Association's Health Research and Educational Trust (HRET) and the New Jersey Primary Care Association (NJPCA) 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. This pilot program will primarily target Medicaid patients, but its ultimate goal is to provide care to all New Jersey residents in the most appropriate, efficient and cost-effective site.

The program will be piloted in two sites through a close working partnership of a hospital and federally qualified health center (FQHC) in each site, active involvement and support of Medicaid HMOs, and engagement of local community primary care providers. The sites are 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. This two-year pilot program has a total budget of $4,830,000.

In this model, all patients who present to the ED will be triaged and receive medical screening by an advanced practice nurse (APN) per EMTALA requirements. 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.

This pilot program will use a data-driven approach to review barriers to the efficient use of the healthcare system. Case managers will monitor ED utilization, track compliance with follow-up visits, identify repeat ED users, determine their reason for using ED and assist them with resolving barriers to using appropriate primary care sites (e.g., help patients find a more accessible permanent medical home, link patients with chronic disease to intensive management programs, etc.).

HRET will work with hospitals and NJPCA with the FQHCs to support pilot implementation and collect project process and outcomes data. HRET will also conduct surveys of Medicaid patients with primary care needs in ED on their barriers and needs and collect ED utilization and other program data from the program partners. HRET, in close collaboration with NJPCA and state's Medicaid program, will use the collected data to measure the overall success of the pilot.

Anticipated outcomes include a decline in hospital ED use for primary care services; increased capacity of primary healthcare delivery system; greater use of community clinics and medical homes; improved routine access to preventive and primary care services; improved patient help seeking behavior; increased patient satisfaction; significant short- and long-term cost savings for Medicaid; and, ultimately, a more efficient healthcare delivery that is responsive to individual needs of diverse patients, better quality of care and healthier communities.

Statement of Project / Need

The overuse and inappropriate use of hospital emergency departments (ED) for conditions that would be more appropriately cared for in a primary care setting is a growing problem nationwide and in New Jersey. According to data from the CDC's Center for Health Statistics, nationwide, ED utilization rose to 110 million visits in 2002, almost a 20% increase from 1990. The National Association of Community Health Centers (NACHC) reports that about one third of these visits each year are for non-emergent primary care conditions that can be treated in a more suitable primary care setting (NACHC, 2006).

The use of EDs for primary care services is especially alarming in New Jersey. Whereas across the United States, approximately 13 percent of all visits to hospital EDs in one year were triaged as nonurgent (CDC, 2005), in New Jersey, about 18 percent of all visits to hospital EDs in a typical year were for primary care conditions (HRET, 2007).

Many studies have shown that Medicaid beneficiaries in particular tend to have a higher ED visit rate than the general population. According to the CDC Advance Data report (CDC, 2005), the national ED visit rate in 2003 was 81 visits per 100 persons with Medicaid – more than double the general population with 40 visits per 100 persons. Although the gap in New Jersey is narrower than the national rates, it is still very high with 44 visits per 100 persons with Medicaid in 2005, compared to 30 visits per 100 persons for total residents (HRET, 2007). The ED visit rate for nonurgent care in New Jersey, however, is higher than the national average. In New Jersey, approximately 17.9 percent of ED visits by Medicaid beneficiaries were for nonurgent conditions, defined by primary care diagnosis codes; whereas in the United States, 15.5 percent of ED visits by Medicaid beneficiaries were given a "nonurgent" triage status (HRET, 2007; CDC, 2005).

Furthermore, Medicaid patients in New Jersey are also more likely to use the hospital ED as their first source for primary care services than patients who are uninsured or have another source of payment. There were, on average, nine visits to the ED for primary care services per 100 persons with Medicaid in New Jersey in 2005, compared to the state's total population, which had about five

visits per 100 persons. In some counties, the average number of ED visits for primary care services per 100 persons with Medicaid more than doubled the statewide Medicaid rate and was about four times higher than the rate for the general population statewide.

These figures do not even account for hospital admissions through EDs for conditions and medical episodes that may have been avoided through consistent access to primary care services, which amounted to 31% of all New Jersey hospital ED admissions in 2005 (Delia, 2007). Often these patients do not have a medical home and use the ED as the healthcare site of last resort, which has a serious negative impact on efficient delivery of chronic care services.

The inefficient use of limited and expensive healthcare resources, such as use of hospital EDs for primary care services, creates a significant burden on the healthcare delivery system. An estimated $438 million is spent on avoidable hospital ED visits in New Jersey each year (NACHC, 2006). That care, if provided in an appropriate primary care setting, could cost significantly less.

Unfortunately, the primary care system in New Jersey is currently not well-equipped to effectively provide care to patients when and where they need it. In recent years, numerous barriers to primary care access have been identified as reasons for these populations seeking care in hospital EDs rather than more appropriate community primary care settings (Vali, 2001), including:

- Hassles with the healthcare delivery system – e.g., lack of physicians accepting Medicaid, patients waiting months to schedule appointments and waiting for hours in the office;
- Prevention is not a priority – many low-income people do not seek medical care until a crisis emerges, then only seek care in the ED;
- Inconvenient physicians' hours and locations – typically limited to weekdays;
- Language barriers – interpreters may be more readily available in EDs;
- Transportation barriers – assistance limited to rural settings, seniors and disabled;
- Childcare barriers – mothers forgo their own care;
- Negative attitudes of healthcare providers – consumers are intimidated or "turned off" by physicians who lack cultural sensitivity and/or seem judgmental/uninterested.

Other notable barriers include lack of information about availability of services in the community and insufficient or lacking management of chronic care conditions. In addition, numerous recent

studies have demonstrated significant healthcare disparities in access to healthcare services for minority, underserved and disenfranchised populations. This issue is especially magnified in New Jersey as it is one of the most racially and ethnically diverse states in the country and that diversity continues to grow. This diversity has major implications for the healthcare delivery system as it requires more responsive services to meet the individual needs of all patients.

The rising trend of overall ED utilization also has implications for hospital surge capacity, concerning many in New Jersey's healthcare industry. When Medicaid beneficiaries and other patients use the hospital ED for primary care services, it contributes to overcrowding and ambulance diversion. This makes it difficult for hospital EDs to serve their important primary function – to treat seriously ill and injured patients.

Alternative arrangements must be adopted to ensure patients receive the care they need in a more efficient and cost-effective manner. The proposed initiative combines successful features from various models currently being employed in New Jersey and other states, along with new innovative and promising strategies, to shift the locus of obtaining primary care services from hospital EDs to community clinics and PCPs among Medicaid patients.

Project Description

The state of New Jersey proposes a partnership with the New Jersey Hospital Association's Health Research and Educational Trust (HRET) and the New Jersey Primary Care Association (NJPCA) 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 linguistically and culturally appropriate patient education and support services to encourage and maximize their future use of appropriate sites of care. The *Community Partnership for ED Express Care and Case Management* will primarily target Medicaid patients, but its ultimate goal is to provide care to all New Jersey residents in the most appropriate, efficient and cost-effective site.

This model will be piloted in two sites through a close working partnership of a hospital and federally qualified health center (FQHC) in each site, the active involvement and support of

Medicaid HMOs, and the engagement of local community primary care providers. The sites will be selected based on the following criteria:

- Location in a county with a high rate of ED use per 100 persons with Medicaid;
- Location in a county with a high rate of ED utilization for primary care services by Medicaid beneficiaries;
- Location in a medically underserved area, as defined by HRSA, DHHS; and,
- Commitment of a community hospital and a nearby FQHC (or other primary care provider) to participate, commit resources and make necessary process changes.

The geographic areas where the pilot project is to be implemented will be two of the five counties identified with highest rates of ED use (for primary care services *and* for all services) by Medicaid beneficiaries, namely Atlantic, Cumberland, Mercer, Monmouth and Ocean Counties.

Representatives from all partnering organizations will form the project's steering committee, which will oversee project implementation. Through quarterly meetings and regular communication, this committee will review the program's progress, discuss issues that arise and adjust the program design as necessary. New Jersey's Medicaid HMO plans – who cover more than 80 percent of the state's Medicaid beneficiaries – will also be invited to join the project, to include their representatives in the steering committee and, if they feel they would benefit from the outcomes of this program, to commit resources for additional case management of their enrollees in the pilot areas.

In this program model, each pilot hospital will use an advanced practice nurse (APN) to provide express care services during the peak hours when patients are most likely to present with primary care needs (approximately 1:00 p.m. to 1:00 a.m.). All patients who present to the ED will be triaged and receive medical screening by the APN, per EMTALA requirements. Once it has been determined that a patient has non-emergency primary care needs, the APN will provide clinically appropriate services for the diagnosis and treatment of the condition and write any necessary prescriptions, either as part of the triage and medical screening or immediately following. The cost of care under this arrangement will be significantly less, since in this model ED rooms and expensive equipment are not used, or are freed up quickly, and the APN's time is less costly and/or is charged much less than an ED doctor.

As part of discharge planning for a Medicaid or uninsured patient who has received express care services for primary care needs, the hospital APN will set up a follow-up appointment for the patient with a primary care provider in the community, for the next day or as appropriate. This appointment will be made with a primary care provider with whom the patient is comfortable – the assigned primary care physician (PCP), if the patient has one with whom he/she is satisfied, or with the participating FQHC. The partnering primary care clinics and FQHCs will block and dedicate convenient appointment times each day for the follow-up visits of ED referrals. Uninsured patients will also be screened for Medicaid presumptive eligibility and assisted with their enrollment.

Pilot FQHCs will expand service hours (nights and weekends) and clinical staff to offer additional, convenient follow-up appointment times. Through this program, a van and driver will be available to transport patients to and from their primary care appointments. A case manager will be assigned at each pilot FQHC to receive referrals, follow-up with patients and coordinate patient transportation and other possible support services as needed, among other duties.

Pilot hospitals and FQHCs, and possibly other primary care clinics, will share information using a secure Web-based electronic information system. This system will facilitate communication between providers and allow the hospital ED access to FQHC appointment scheduling in real-time. The system will also provide a format for entering and tracking basic information on the population using the ED for primary care services, for follow-up and later analysis of outcomes.

During ED discharge for express care patients, the hospital APN will also educate patients on the appropriate site of care for different healthcare needs and the importance of using a medical home for primary care services and limiting ED visits to true emergency situations. HRET will develop culturally and linguistically appropriate educational materials on these topics for APNs to distribute and use as a tool to reinforce their patient education. Also, to maximize efforts to discourage inappropriate use of the ED for primary care services, 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 the patients and provide additional targeted outreach and education.

This pilot program will use a data-driven approach to understand the characteristics of

frequent ED users and to review barriers to the efficient use of the healthcare system. Each pilot hospital will assign a case manager to work closely with the corresponding FQHC case manager, as well as Medicaid HMOs and other partners, to:

- Follow-up on the referral of Medicaid patients from ED express care services;
- Track patient compliance with follow-up visits;
- Monitor ED utilization by the identified Medicaid population; and,
- Identify repeat ED users.

Upon collecting information about repeat ED users, hospital case managers will contact those patients to determine their reasons for using hospital EDs instead of FQHCs or PCPs. Whenever possible, the hospital and FQHC case managers will assist these patients with resolving barriers to utilizing appropriate primary care sites (e.g., help patients find a more accessible permanent medical home, link patients with chronic diseases to intensive management programs, etc.). HRET will also conduct a stand-alone survey of patients waiting in a hospital ED for primary care services during FQHC hours of operation to gather information about their knowledge of available primary care services and their reasons for choosing to use the hospital ED.

In addition to supporting pilot implementation by their constituent organizations, HRET will work with hospitals and NJPCA with the FQHCs to collect the program's process and outcomes data described above. HRET will also collect ED utilization and additional program data from other partners. HRET, in close collaboration with NJPCA and state's Medicaid program, will use the collected data to measure the overall success of the pilot program.

Program findings will be summarized in a report to be distributed widely among professional groups within the fields of healthcare and public policy and made available to all others interested. Publicity will be provided by various newsletters published by the New Jersey Hospital Association, NJPCA and the state. At the end of the project period, HRET will host a statewide conference to share the findings of the program evaluation and the overall pilot outcomes. If successful, the HRET will also host various regional educational sessions, using speakers from the pilot sites, for other hospitals, FQHCs and community clinics to learn about the lessons learned from the

Community Partnership for ED Express Care and Case Management and promote its replication.

This program is designed to foster the needed improvements to New Jersey's primary care system that would result in reduced inappropriate use of hospital EDs and more efficient use of healthcare resources. Those needed improvements include:

- Increased capacity of the primary healthcare delivery system;
- A system that is more user-friendly and more responsive to individual needs of diverse patients;
- Greater access to preventive and primary care services;
- Improved patient safety and quality of care;
- Changes in patients' help-seeking behavior; and,
- Greater patient satisfaction.

A more efficient healthcare delivery system would not only significantly reduce Medicaid program expenses and contain the overall cost of healthcare, but it is also critical for improving quality of care and life for all residents and would lead to healthier communities.

Project Justification

The purpose of this program is to facilitate appropriate access to primary care for Medicaid recipients by offering alternative non-emergency providers in lieu of emergency room services for delivery of non-emergency care and by encouraging patient use of appropriate non-emergency primary care providers in the community. This program focuses on reducing inappropriate ED use by Medicaid beneficiaries for primary care services by addressing documented barriers these patients routinely face that result in their high use of EDs for primary care conditions, as discussed in the previous section. The proposed plan for establishment of express primary care services in hospital EDs, along with patient education, support and active case management, will address the identified barriers in the following ways:

- Ensure timely access to care by connecting patients to an alternate non-emergency care provider (PCP/FQHC) at the time of their ED visit;
- Facilitate patient access to follow-up care and reduce repeat visits to the ED by creating a computer data exchange system linking the ED and the alternate primary care provider (PCP/FQHC) and tracking patient utilization patterns;

- Improve patient understanding of the importance of a medical home and encourage their future use of a more regular source of care via patient education and follow-up;
- Secure patient's access to care after hours by expanding PCP/FQHC hours of operation or by connecting them with providers who have expanded hours of operation;
- Improve patient access to primary care services by increasing capacity of the primary care delivery system and the availability of more providers;
- Ensure faster access to future care for the patients by blocking open appointments for walk-in patients at the PCP/FQHCs and educating patients on the availability of these appointments;
- Reduce accessibility barriers by providing transportation for patients to and from alternate primary care provider (PCP/FQHC) sites;
- Provide better management of chronic care conditions of Medicaid enrollees by identifying Medicaid patients with such conditions at the point of access and linking them to disease management counseling and screening;
- Address cultural and linguistic barriers of patients by linking them to providers that meet their needs; and,
- Improve patient access by educating providers on patient and systemic barriers to accessing care and how to be responsive to the individual needs of all patients.

To summarize, by creating an interconnected patient tracking and scheduling system, blocking follow-up appointments for ED patients, increasing primary care capacity, expanding alternate primary care providers hours of operation or linking patients to providers with convenient hours, providing continuous patient education at the point of contact, conducting patient follow-up, creating open channels of communication between the ED APN and the PCP/FQHC Community Nurse for appointments, case management and counseling, and by reducing accessibility barriers (i.e. transportation) for the patient, this program aims to substantially reduce current ED use among Medicaid enrollees in selected program sites/areas.

Project Goals and Outcomes

This pilot program is designed to address ongoing concerns about the high and rapidly growing utilization rate of hospital emergency departments for primary care needs, particularly by Medicaid beneficiaries, which exacerbates the problem of crowded EDs and makes inefficient use of the most expensive site of care. It targets well-documented barriers to accessing primary care

services in communities through establishment of alternate non-emergency services to patients who present with primary care needs in hospital EDs and through provision of comprehensive case management, education and other support services that encourage their future use of healthcare services in community clinics.

The primary goal of the program is to promote the use of medical homes and appropriate site of care, thereby reducing the growing utilization of hospital EDs by Medicaid beneficiaries for non-emergent, non-acute primary care services and preventing potentially avoidable hospitalizations through timely access to preventive and primary care services. The ultimate goal is to significantly reduce/contain the cost of emergency room expenses for providing primary care services to Medicaid patients and in the long run reduce the overall cost of care for the Medicaid program by shifting the site of primary care services to community clinics.

The pilot program's central objective is to first provide express access to primary care services at the time of ED visit and then to reduce future unnecessary visits to the ED via referral, education/information, follow-up, patient tracking and support services to remove a wide spectrum of access barriers. The specific objectives are to:

- Form a partnership between hospital EDs and community primary care providers;
- Establish express primary care services in hospital EDs;
- Facilitate timely access to a community primary care provider;
- Provide education on the use of a medical home;
- Increase community healthcare system capacity to accommodate the primary care needs of patients identified in the ED;
- Apply available technology to facilitate linkages between care sites (EDs, FQHCs, community providers);
- Identify and remove patient barriers to efficient use of the healthcare system;
- Identify provider and systemic barriers to the efficient use of the healthcare system;
- Evaluate the outcomes of the pilot program;
- Demonstrate project impacts and outcomes, specifically:
    - Increased capacity of primary healthcare delivery system;
    - Establishment of a system that is more user-friendly and more responsive to individual needs of diverse patients;

  - More use of community clinics and medical homes;
  - Improved routine access to preventive and primary care services;
  - Improved patient safety and quality of care;
  - Improved patient help seeking behavior;
  - Increased patient satisfaction;
  - Less use of ED for primary care services;
  - Significant short-term cost savings for Medicaid through provision of alternate non-emergent primary care services;
  - Significant long-term cost savings for Medicaid through provision of primary care services in less expensive sites;
  - More efficient healthcare delivery system and, ultimately, healthier communities;
- Publicize the program findings and promote its replication in other sites or statewide.

Estimate of the Impact to Beneficiaries

In 2005, more than 240,000 Medicaid enrollees in New Jersey visited various hospital emergency departments for all types of care. Almost 48,000 or 20% of those visits were for non-emergent or primary care services that could have been provided by an alternate primary care provider. Among those primary care-related ED visits by Medicaid enrollees, more than 84% (40,411 visits) were concentrated in hospital EDs located in ten counties. Of those, five counties had the highest rates of ED use by Medicaid beneficiaries, ranging between 79 and 128 ED visits per 100 persons with Medicaid. These same counties also had the highest rates of inappropriate ED use by Medicaid beneficiaries for primary care services. These five high usage rate counties are: Atlantic, Cumberland, Mercer, Monmouth and Ocean.

The two pilot sites established as part of this program will be located in two of the five identified areas of highest ED usage rate (among Medicaid beneficiaries), with each pilot site having the capacity to provide triage, medical screening and treatment, education, direct linkage to an alternate provider, and follow-up on patient care during heaviest hours of ED use (between 1:00 p.m. and 1:00 a.m.). Potentially, all Medicaid enrollees who present at the selected ED sites between those hours for non-emergent conditions will be targeted by the program. Although the exact

number of impacted beneficiaries will depend on the final selection of pilot site partners (hospitals and FQHCs), the size of the program model impact in any two counties combined, looking at historical average annual ED intake, will range between 13,268 and 17,120 Medicaid beneficiaries who utilize the ED for primary care services.

Description of Magnitude of the Impact to Medicaid

Access to primary care services is a multifaceted and multidimensional problem, with many different factors impacting the patterns of patient utilization of healthcare services, particularly among Medicaid beneficiaries, resulting in high inappropriate use of hospital EDs for their primary care needs. The proposed program model addresses many of the identified patient, provider and systemic barriers and is ultimately expected to have the greatest impact and benefit for the Medicaid program and the patients themselves.

This program is anticipated to result in improved access to primary care services in the community; increased use of preventive care; better chronic disease management, leading to reduced complications and fewer avoidable hospitalizations; and more appropriate healthcare utilization by Medicaid beneficiaries. The impact of this project for the Medicaid program will be substantial. The features of this pilot program, mainly the increased capacity of the public healthcare system to provide more accessible and higher quality services and the shift of healthcare utilization by Medicaid beneficiaries to less costly sites of care, will lead to a more efficient and client-friendly system of care and, ultimately, the improved health status of Medicaid beneficiaries. These features will not only result in significant cost savings for the Medicaid program, but they will also help with containing the rising cost of healthcare overall throughout the state.

Description of Sustainability of the Project

It is anticipated that the outcomes of this pilot program will create ample benefits for all types of agencies partnering in the program, providing incentives to justify continuation of the project's model and interventions in each facility after the grant expires. Although all facilities will benefit from healthier communities and see a positive return on program costs, each type of facility's

benefit from the project outcomes will be unique and different.

Hospitals, which regularly experience significant financial losses due to uncompensated care provided to needy patients in the ED, will benefit from the continued use of an APN for express primary care services in the ED to provide both immediate care at lower cost and case management that links patients to accessible medical homes in their communities. FQHCs will receive more referrals and see an increase in their pool of patients, making added clinical staff capacity and expanded hours worthwhile. Even Medicaid HMOs, which cover 80 percent of New Jersey's Medicaid beneficiaries, will see significant savings in the cost of patient care through reduced ED visits for primary care services and will benefit from ongoing communication with hospitals and FQHCs to red-flag their members in need of outreach, education and case management.

Not only will these benefits convince all partnering agencies to continue and sustain the program features, but the project's plans to publicize its findings and encourage replication of the model in other sites will also lead to wide adoption of the model statewide.

Evaluation Plan

To measure effectiveness of the project plans, an evaluation system will be designed and participating hospitals, FQHCs and Medicaid HMOs will be instructed to collect and report data about their site activities/interventions, using uniform reporting guidelines, forms and procedures. Project staff will employ other strategies and collect additional data through surveys and focus groups of patients and providers and use of existing data to evaluate the project.

Process Evaluation. Review of the project implementation plans will be ongoing and will focus on the project's progress toward achieving its main objectives and goals. HRET, in collaboration with NJPCA, will closely monitor the project's proposed timeline to ensure that activities take place when anticipated. Process evaluation will include: timely collection and processing of data from hospitals EDs, FQHCs and Medicaid HMOs on their process changes, primary care services and extensive use of case management of patients using ER for primary care needs; monitoring of linkages across care sites; production and distribution of educational resources; assessment of system/organizational

obstacles, as well as patients' barriers and needs; tracking data on outcomes/impact indicators; and monitoring successful implementation of all project's proposed activities. Semiannual, annual and final reports will allow HRET to assess the progress achieved, whether tasks are accomplished according to timeline and if spending is on target, in order to make any needed adjustments.

Outcomes/Impact Evaluation. Several measures will be used to evaluate project's outcomes and impacts. We collect baseline data on current utilization of EDs for primary care services, as well as current services and utilization patterns across different sites and compare the data post project interventions with this baseline to assess the significance of change over time. We expect to observe a decline in hospital ED use for primary care services compared to previous years – employing time series analysis techniques and fitting a linear trend to data to measure significance of the rate changes over time. We also expect to observe: increased capacity of primary healthcare delivery system; more use of community clinics and medical homes; improved routine access to preventive and primary care services; improved patient help seeking behavior; and increased patient satisfaction. We also expect that the project alternate non-emergent primary care services in less expensive sites will create significant short-term and long-term cost savings for Medicaid as well as Medicaid managed care plans, allowing more resources to be allocated to efforts that improve community health. HRET will work closely with the Medicaid program to collect cost data on ED utilization of Medicaid beneficiaries for primary care services in pilot areas over time to assess the significance of change due to this project's interventions. More efficient healthcare delivery and establishment of a system that is more user-friendly and responsive to individual needs of diverse patients is expected to improve quality of care for all and ultimately lead to healthier communities.

The findings of this initiative will significantly add to the body of knowledge on access issues in New Jersey. The new local-level data and knowledge about the needs in pilot areas and the wide distribution of findings about the project model will provide the state Medicaid program, HMOs, hospitals and community clinics with the tools they need to initiate changes for more efficient delivery systems. They will also educate consumers in areas with severe/chronic access problems on the importance of preventive care, a medical home and appropriate use of the healthcare system.

Description of Project Implementation Readiness

The New Jersey state Department of Human Services, the New Jersey Hospital Association's Health Research and Educational Trust, the New Jersey Primary Care Association and other key partners are in full support of this program and prepared to move forward. The implementation timeline below details the steps to be taken to successfully pilot the program model.

year Timeline *Quarter:*	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
I. Set up project administration.								
Form partnership among HRET, NJPCA and DHS-DMAHS.								
Identify and contract with pilot hospitals and FQHCs.								
Form a partnership with Medicaid HMOs and execute contracts/MOU.								
Coordinate execution of MOU/MOA between hospital FQHCs and other partners.								
Develop project operations, case management guidelines and manual for pilot sites.								
Develop standardized data collection protocols and guidelines for pilot sites.								
Identify a secure Web-based electronic information system to facilitate communication of patient information between providers.								
Train selected sites on project's overall express care model, case management and electronic system plans and data collection and reporting requirements.								
Conduct routine communication with partners for ongoing feedback and needed adjustments in plans, resources, training curriculum, etc. (mtg., conf call, e-mail).								
Provide periodic progress and financial reports to Medicaid/CMS as required.								
II. Increase community healthcare services/systems capacity to accommodate the primary care needs of patients identified in the ED.								
Expand the primary care service capacity (staffing) and days/hours of operation.								
Block daily time slots for convenient ED follow-up appointments.								
Set up/provide transportation services to and from FQHCs if needed.								
III. Establish express primary care services in hospital EDs.								
Use an advanced practice nurse (APN) to identify patients who present to hospital EDs with primary care service needs via the triage and medical screening process.								
Use an APN to provide clinically appropriate services for the [redacted] and treatment of patients' conditions that need primary care.								
IV. Establish linkages between care sites (EDs, FQHCs, community providers) to facilitate timely access to primary care.								
Utilize case management and referral mechanisms to arrange follow-up appointments with primary care providers.								
Refer & make f/up appts. to appropriate primary care providers for Medicaid pts., part of ED express care discharge planning, using electronic scheduling system.								
V. Provide education on the use of a medical home.								
Provide patient education as part of ED discharge services on importance of medical home and appropriate site of primary care services.								
Assist patients with connecting to their current PCP or with selecting a primary care medical home that can meet their ongoing needs.								
Encourage patients to change healthcare behaviors, limit ED visits to emergencies.								
Distribute educational resources to reinforce APN education on the use of appropriate care sites for different needs.								
Use the electronic system to allow hospital EDs to directly schedule patient follow-up appointments at FQHCs or other partnering primary care sites in real-time.								

2-year Timeline *Quarter:*	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
VI. Identify and remove patient barriers to efficient use of the healthcare system.								
Conduct a survey of patients in the ED for primary care services during FQHC available hours to collect information about their reasons and barriers.								
Identify repeat ED users through routine monitoring of ED utilizations and tracking patient compliance with follow-up visits using the electronic information system.								
Contact these patients through active case management, phone follow up and interviews and identify their reasons for using ED and not community providers.								
Assist patients with tracking identified barriers such as switching to a more								

Analyze data and prepare summary tables/charts.								
Demonstrate project impacts and outcomes.								
Formulate program recommendations and prepare a final report.								
IX. Publicize the program findings and promote its replication in other sites or statewide.								
Prepare summary of program accomplishments and features of model tested.								
Plan statewide seminar to publicize project outcomes and promote replication throughout state.								*ongoing*
Plan and host regional training sessions for hospitals, FQHCs and other community providers to educate them about the model for establishment of alternative non-emergency primary care services and promote replication of the model statewide.								

Budget

Estimated Budget Total

- Total two-year budget: $4,830,000
- Federal grant amount requested: $4,830,000
  - Federal fiscal year 2008: $2,502,500
  - Federal fiscal year 2009: $2,327,500

Total Estimated Funding Requirements for Each Year

YEAR ONE:

- Personnel / Fringe benefits: $2,005,740

  Salary and fringe will support staff positions at each partnering agency. Pilot site hospitals will each cover three full-time APNs to provide express care, patient education and case management, such as arranging primary care follow-up appointments; a full-time case manager to conduct patient tracking, follow-up and support and prepare ED use data; and a part-time medical records assistant (0.5). Pilot site FQHCs will each hire a full-time community nurse case manager to conduct patient intake, tracking, follow-up and support, prepare FQHC use data and perform some clinical duties; a full-time physician and full-time medical assistant to expand clinic capacity; a part-time medical records assistant (0.5); and a full-time van driver to transport patients to and from appointments if necessary. HRET staff assigned to this program include a project director (0.3), who will oversee full project implementation, supervise development of guidelines and resources, data collection and analysis and will design and conduct project evaluation; a full-time project coordinator, who will support everyday project operations, including pilot site set-up and training, development of guidelines and educational materials, and collection of data; and an administrative support position (0.4). An NJPCA program evaluator (0.2) will support collaboration of FQHCs and their implementation of case management, ensure technological linkages and the collection of data from FQHCs and assist with project evaluation; and a nurse case manager (0.5) will assist with medical records abstractions and the sharing of patient data. A full-time New Jersey DMAHS coordinator will link all partners to the state and Medicaid HMOs.
- Travel: $1,700

  Representatives from the state DMAHS, HRET and NJPCA will participate in three site visits per pilot site each year. The travel budget will cover travel reimbursement (at $0.0485 per mile), tolls, parking and per diem.
- Equipment: $217,000

  Equipment funds will cover the purchase of laptop computers for HRET and each pilot site location to support databases for collecting patient information and project data. Each pilot hospital will also need technology and software licenses (estimated at $60,000 each) to facilitate linkage between hospitals and FQHCs for setting appointments. Each FQHC will purchase a van for patient transportation.
- Supplies: $3,600

  Each partnering agency will need a nominal amount to cover the purchase of supplies that support project work, including file folders and other general office supplies.
- Other costs: $48,000, specifically:
  - Telephone and Postage

    Each partnering agency will need a nominal amount to cover telephone and

postage costs for daily contact across pilot sites regarding patient follow-up, sending educational materials, submitting program data and reports, etc.

- Printing

  In addition to regular printing costs for printing patient information, appointment reminders, program data and grant reports, printing funds will also cover printing educational tools and resources for patients, in multiple languages.

- Meetings

  Most "other costs" will be incurred as part of meeting expenses, which will cover a computer lab-based training for pilot site staff on project implementation, including use of a linked information system and steering committee meetings to steer implementation of the program.

YEAR TWO:

- Personnel / Fringe benefits: $2,064,110

  Same as year one, with five percent increase in salaries.

- Travel: $1,500

  Same as year one.

- Supplies: $3,600

  Same as year one.

- Other costs: $47,800, specifically:
  - Telephone and Postage

    Same as year one.

  - Printing

    Year two funding will cover printing costs for printing patient information, appointment reminders, program data and grant reports and additional copies of educational tools and resources for patients, in multiple languages, if needed.

  - Meetings

    Most "other costs" will be incurred as part of meeting expenses, which will cover steering committee meetings to steer implementation of the program; a statewide conference to publicize program findings and promote expansion of the model; and regional trainings on the model to support this expansion.