Oklahoma Health Care Authority
Establishment of Alternate Non-Emergency Services Providers

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COVER SHEET

Oklahoma, CHCI Emergency Room Diversion Project, Oklahoma Health Care Authority

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COVER SHEET

Oklahoma, CHCI Emergency Room Diversion Project, Oklahoma Health Care Authority

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Applicant Preference- Community Health Centers, Inc., is requesting consideration of preference based on our partnership with Oklahoma University (OU) Medical Center and Saint Anthony Hospital in Oklahoma City, Oklahoma and the service area census tracts proposed to serve, has been declared a Medically Underserved Area (MUA) and some census tracts are Health Professional Shortage Areas (HPSAs). (*See Attached Map: Service Sites to be included with Applicant Preference)*

The proposed service area will be from N.E. 63rd Street on the North, Pennsylvania Avenue on the West, Reno Avenue on the South and to Interstate I-35 on the East. A demographic overview of the service area shows a total population of 76,900 with 22.9%- White; and 77.1%- Minorities, predominantly African American compared to 68.1%- White and 31.9% minority population for Oklahoma County as a whole. More than 25% of the population is under age 18 and 24% over 60 years of age.

These MUAs accounted for 18.5% of the low acuity encounters seen at the OU Emergency Room during 2005, with one half of those encounters coming from a single zip code- 73111. The 2005 Analysis conducted by the Oklahoma City-County Health Department (OCCHD) Epidemiology Services concluded that a total of 81,815 encounters occurred during this time period. When sorted according to CPT acuity codes, it was found that 56,544 (69.7%) of these visits were coded as either 99281 (Self limited or Minor Acuity) or 99282 (Low to Moderate Acuity). Diagnoses comprised 70% of Level 1 and 2 encounters. These diagnoses included acute upper respiratory infection (6.6%), abdominal pain (3%), asthma (2.21%), and fever (1.78%). Most if not all of these conditions can be managed cost effectively in a primary care setting.

Hospital data showed Medicaid and Self-pay comprised the majority of Level 1 and 2 encounters, with 45.7% and 36.2% respectively. Managed Care or Commercial made up 10.3% of encounters; Medicare, 5.5%, and other third-party payors, such as Tri-Care, made up 2.3%. These data suggest the largest population of ER visits were made by Medicaid recipients, and not just the uninsured may be over utilizing the ER, but those with Medicaid as well.

ABSTRACT- Community Health Centers, Inc., (CHCI) a 501 (c)(3) non-profit corporation and sponsors of Mary Mahoney Memorial Health Center, Healing Hands Health Care Services, Mary Mahoney Health Center @ Langston, and Central Oklahoma Healthy Start Initiative has been providing high quality, accessible and affordable primary health care to central Oklahoma for 34 years. In 2006, CHCI provided services to 17,204 unduplicated individuals, of which 2,834 were homeless, and produced 45,351 encounters.

On 08/30/2007, CHCI received a Notice of Grant Award (NGA) from Health Resources and Services Administration funding a new access point for northeast Oklahoma City. This new Federally Qualified Health Center (FQHC), which is less than 5 miles from collaborating hospitals, will be operational within 120 days, and will be supported by physicians, advanced-level practitioners, nurses, case managers, ancillary and support staff.

CHCI has a long history of working in complete cooperation with the University of Oklahoma's Medical Center (OU), St. Anthony Hospital and Central Oklahoma Integrated Network Systems, Inc. (COINS). Education plays a crucial role in the well being of individuals when it comes to their health status.

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 (1.0FTE) Health Educator and two (1.0FTE) Community Health Workers (CHWs) and two (0.5FTE) CHW's to develop an Emergency Department Reduction Pathway and a Medical Home Pathway in conjunction with (COINS) Project Access. 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. **Total funds requested for two year project: $1,030,536.**

The CHWs will be supervised by the Health Educator who will be directly responsible to the Medical Director of CHCI. All staff will be located at the new clinic with a proposed address of 201 N.E. 48th Street, Oklahoma City, OK 73105, less than 5 miles from either hospital.

CHCI's Health Educator will provide ongoing guidance to the CHWs, monitor progress, evaluate the outcomes and offer educational classes for Medicaid recipients suffering from chronic illness such as diabetes, hypertension, COPD, obesity, etc. The CHWs will work directly with an already identified Medicaid recipient population known to frequently utilize the emergency department. Those patients who have an identified medical home will be assisted in navigating their primary care system. If the Medicaid recipient does not have a medical home and is in need of alternate non-emergency services, they will be referred to, and assisted in establishing a medical home. CHW's will also make referrals and offer case management.

CHCI has gained experience in the Community Health Worker model. A pilot program was developed at Healing Hands with a CHW to decrease the number of homeless clients using the emergency room as their medical home and thereby improve their health status. Emergency room visits decreased and health status of patients improved, i.e. reduced HbA1C from 11.3 to 7.7 in three months for one diabetic patient.

NARRATIVE

Statement of Project/Need- Oklahoma's state rate of Medicaid recipients' emergency room usage for non-emergency care according to HEDIS measurement for CY 2006 for SCC Choice was 69.37 visits/1000 member months and the HEDIS CY 2006 ER utilization rate for TXIX was 93.89 visits/1000 member months compared to the national average of emergency room visits of 39.9/100. The Oklahoma Health Care Authority does not track ER visits per 100 members, as they use member months.

Notice of Grant Award (NGA) was received from the Health Resources and Services Administration (HRSA) on 08/30/2007 to expand health care services to a service area of N.E. 63rd Street on the North, Penn Ave. on the West, South to Reno and I-35 on the East. This area has been designated a Medically Underserved Area (MUA) and some census tracts are Health Professional Shortage Areas (HPSAs).

The Needs Assessment for this area scored 100%; there are many disparities among this highly uninsured and Medicaid minority population. With the addition of this satellite clinic, we will be able to continue our mission to eliminate disparities by improving access to high quality, cost-effective, culturally and linguistically appropriate and affordable preventive and primary health care services while decreasing emergency room visits for primary care.

A demographic overview of the service area shows a total population of 46,900 with 22.9%- White; and 77.1%- Minorities, predominantly African American compared to 68.1%- White and 31.9% minority population for Oklahoma County as a whole. More than 25% of the population is under age 18 and 24% over 60 years of age.

This MUA accounted for 18.5% of the low acuity encounters seen at the OU Emergency Room during 2005, with one half of those encounters coming from a single zip code- 73111. The 2005 Analysis conducted by the Oklahoma City-County Health Department (OCCHD)

Epidemiology Services concluded that a total of 81,815 encounters occurred during this time period. When sorted according to CPT acuity codes, it was found that 56,544 (69.7%) of these visits were coded as either 99281 (Self limited or Minor Acuity) or 99282 (Low to Moderate Acuity). Diagnoses comprised 70% of Level 1 and 2 encounters. These diagnoses included acute upper respiratory infection (6.6%), abdominal pain (3%), asthma (2.21%), and fever (1.78%). Most if not all of these conditions can be managed cost effectively in a primary care setting. Hospital data showed Medicaid and Self-pay comprised the majority of Level 1 and 2 encounters, with 45.7% and 36.2% respectively. Managed Care or Commercial made up 10.3% of encounters; Medicare, 5.5%, and other third-party payors, such as Tri-Care, made up 2.3%. These data suggest the largest population of ER visits were made by Medicaid recipients, and not just the uninsured may be over utilizing the ER, but those with Medicaid as well.

Statistics indicate over 84% of all Level 1 and 2 encounters occurred between the hours of 8:00 a.m. and 12:00 a.m. Sundays had the highest number of visits- 15.8%, and Fridays the lowest- 13.06%, but overall there was little variation in number of encounters per week. Our CHWs will be available with extended hours to get the Medicaid patient into a non-emergency provider. CHCI providers are available by phone 24 hours/day and 7 days/week to triage patients, call-in prescriptions and assure patients they can been seen the next business day.

Project Justification- CHCI is a community benefit partner with a successful track record in using federal/state investments to enhance access for medically underserved populations. The organization has a strong reputation for high quality and consumer-focused care, including accountability to the consumer through consumer-majority governance. CHCI offers one-stop shopping for comprehensive, case-managed primary health care and related services. CHCI

health centers have demonstrated their commitment to community-based health care, public health, disease prevention and health promotion.

The health centers provide care in a cost-effective manner. Treatment of non-emergent conditions in the Emergency Room (ER) can cost anywhere from $300-$450 which is significantly higher than the $92 medical cost per visit reported in CHCI's 2006 Uniform Data Systems (UDS) report. The delivery of non-emergent care in a primary care setting saves from $208 to $358 per visit. In addition, by providing a "medical home" that stresses prevention and early intervention, chronic conditions such as diabetes, asthma and hypertension can be managed to prevent the development of acute exacerbations that are more costly to treat. According to HRSAs Bureau of Primary Health Care, annual cost of Community Health Center care in Oklahoma is $400 per year based on 2.8 – 3.2 visits.

As an alternative non-emergency room provider with Board certified licensed physicians and advanced-level providers that treat individuals with respect and dignity, regardless of their payor status, and can offer culturally and linguistically appropriate services, makes a Community Health Center an excellent alternative. The cost savings could allow care for almost twice as many patients to receive care in lieu of emergency room services.

Project Goals and Outcomes- Recent national focus with collaboration from HRSA, American Academy of Pediatrics, business and health leaders, have identified principles for effectively improving program outcomes: 1) identify individual most at-risk; 2) confirm evidence based intervention; 3) measure health outcome and cost-savings; and 4) simplify contracting, eliminate duplication, and promote efficiency (source: Collaborative Statement developed by the America to Outcome Initiative- December, 2006).

The goal of CHCI, along with collaborating partners, is to develop and enhance an

already proven pilot program. CHCI and Central Oklahoma Integrated Network Systems, Inc. (COINS) are using an outcome model developed by the Ohio Community Health Access Project (CHAP) for our pilot demonstration initiative. We have received technical assistance from the CHAP developer, Dr. Mark Redding.

In building an outcome model, according to CHAP, first we define a critical outcome to produce a Pathway. CHAP developed the Pathways Model as a strategy to track and improve accountability for positive and measurable changes as the CHW helped their clients work through the system in dealing with specific health and social problems. The initial focus of the Ohio program on a critical outcome was on poor birth outcomes. CHCI has been successful in decreasing ER overuse by the homeless with a proven Emergency Department Reduction Pathway. The pathway is as follows:

Emergency Department Reduction Pathway
Assess Emergency Department Usage 1. Identified by Risk Assessment Tool; or 2. Identified by Hospital or Medical Provider; or 3. Identified by Oklahoma Health Care Authority to Medical Provider; or 4. Identified by other data set
Enroll High Utilizing Patient into Pathway HUP = More than 4 times in 1 year
Implement Education Intervention 1. When to Go to Emergency Department Tools 2. Using Motivational Interviewing, develop an ED Decision Plan
Firmly Connect Medicaid Client to Primary Care Provider 1. Assist client in navigating through their medical home 2. Advocate for client within their medical home
Assess Underlying Chronic Conditions 1. Assess Substance Abuse- connect, advocate and assist in navigating through substance abuse treatment program 2. Assess Mental Health status- connect, advocate and assist in navigating through mental health system 3. Assess Social Support System- connect, advocate and assist in navigating through social support system
OUTCOME- Reduce each Medicaid enrolled individual inappropriate Emergency Department use by 50% over a one year period.

The second step in building this outcome model is to build the Medical Home Pathway. The Medical Home Pathway includes initiation, action and completion steps. The action steps are evidenced-based interventions that build upon one another to lead to a positive outcome. See Medical Home Pathway below:

Medical Home Pathway
Initiation Step Medicaid Recipient within the target population who; 1. Cannot identify a medical home, or 2. Confirmed to be using medical home inappropriately Client and supporting family member (when available) will be provided with a Medical Home Education packet (Developed by Health Educator) 1. Identify and eliminate potential barriers 2. Complete Emergency Department data set Assist client/family as needed in connecting to a qualified non-emergency provider (This may include scheduling, arranging transportation, submitting forms, etc.) 1. Confirm appointment was kept 2. If appointment <u>not kept</u>, identify and eliminate barriers **Completion Step** Documented compliance with Medical Home Visit 1. Document follow-up instructions 2. Document type of medical home in client's record 3. Begin Medical Home Continuity Pathway (to be developed)

The third step in building and outcome model is developing the checklist of questions to find which Pathways may be needed. Checklists are used to screen individuals to identify those most at-risk. Some questions currently being used are: What are your health problems? Do you have a primary care provider (PCP)? Who is the assigned PCP?, etc. In this proposed project, the Health Educator and CHWs would further identify any needed Pathways to be developed, develop a risk assessment tool and further refine current assessment tools.

The fourth step of building an outcome model is integration of Pathways and checklist

into a care coordination process that will allow documentation of outcome productions. The Pathways will continually be evaluated by the Health Educator and medical provider to identify and remove barriers and to increase outcome production.

Estimate of Impact to Beneficiaries- Most recent Oklahoma Health Care Authority data (2006 Annual Report) states there are 143,042 Medicaid/SoonerCare enrollees in Oklahoma County compared to State of Oklahoma total- 613,556. Of these Oklahoma County enrollees, 10,450 are dual eligibles (persons enrolled in both Medicare and Medicaid). The racial breakdown of enrollees is: White- 62%; Hipanic- 10%; Asian- 1%; American Indian- 12% and African American- 15%.

CHCI estimates impacting at least 50% of Medicaid beneficiaries in Oklahoma County who overuse the Emergency Department at OU Medical Center and St. Anthony Hospital from 10/2007 through 09/2009. This impact will provide a cost-savings to the State of Oklahoma while improving the health status of Oklahoma County Medicaid recipients. Education will be available, not only to the Medicaid recipients that over-utilize the emergency departments (ED), but will be made available to all Medicaid recipients that utilize the OU Medical Center or Saint Anthony emergency departments.

Description of Magnitude of the Impact to Medicaid- Funding of the proposed project is projected to vastly decrease ED over-utilization of the two area hospitals participating in the project, thereby creating direct correlative cost savings to the State of Oklahoma Medicaid program of approximately $895/patient/per year, based on 2.5 visits/year. For instance, if 500 Medicaid recipients who use the ER at least 2.5 visits/year were diverted to a community health center, the cost-savings would total approximately $447,500 per year. Nearly one-half million dollars per year could be saved. Outcomes will also determine the cost-savings to the State and

local hospitals.

Description of Sustainability of the Project- The proposed project will be sustained by reinvesting cost-savings from this project and requesting more State legislative appropriation dollars. The Oklahoma Health Care Authority and CHCI will continue seeking Federal, State, local and private funding opportunities. Also the collaborating hospitals will be requested to redirect a portion of their cost savings to continue the successful program.

Evaluation Plan- Community Health Centers, Inc. currently uses this model for quality improvement in our participation with the Bureau of Primary Health Care (BPHC) Disparities Collaboration. The Model for Improvement, developed by Associates in Process Improvement, is a simple yet powerful tool for accelerating improvement. This model has been used very successfully by hundreds of health care organizations in many countries to improve many different health care processes and outcomes.

The model has two parts:

- Three fundamental questions, which can be addressed in any order: 1) What are we trying to accomplish? 2) How will we know that a change is an improvement? 3) What changes can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) cycle to test and implement changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement (source: Bureau of Primary Health Care, Health Disparities Collaborative)

CHCI will use this model in developing and testing the Community Health Worker Pathways, (i.e., Emergency Department Reduction Pathway and Medical Home Pathway); but, there are Outcome Production Principals.

The Central Oklahoma Project Access Program (COPA) has been selected by HRSA's

Office of Performance Review as one of four demonstration sites in the Nation. In addition, COPA is participating in a national initiative "The Movement of America to Outcomes", (also through the HRSA Office of Performance Review), to develop an outcome production-focused care manual, benchmarks, and tool kit; and effective strategies to improve health equity in the America to Outcome Project developed by HRSA.

The plan for evaluation will be completed with input from participating hospitals and monthly reporting by CHW's and assessed by the Health Educator at least quarterly. All findings will be shared with area hospitals, Oklahoma Health Care Authority and CHCI Quality Improvement Committee.

All three common principles of programs effectively improving outcomes identified by HRSA will be followed for evaluation: 1) identify individuals most at-risk; 2) confirm evidence based intervention; 3) measure outcome health and cost savings; and 4) simplify contracting, eliminate duplication and promote efficiency (source: Collaborative Statement developed by the America to Outcome Initiative- December, 2006).

Description of Project Implementation Readiness- After receipt of Notice of Grant Award (NGA) by the Oklahoma Health Care Authority, CHCI will begin the implementation of the Project. Not later than January 2, 2008, Community Health Centers, Inc., will recruit a (1.0FTE) Health Educator, two (1.0FTE) Community Health Workers and two (0.5FTE) Community Health Workers, a (0.5FTE) Registered Nurse and (0.5FTE) Receptionist to work extended hours from 6 p.m. until 10 p.m. This will provide CHW coverage to each hospital emergency room from 6:30 a.m. until 10:00 p.m. five days per week. The days per week will be assigned according to the most highly utilized ER visit days of the week. Community Health Workers will be trained by Central Oklahoma Project Access (COPAs) staff at Metro Technology Centers

in Oklahoma City. The four day training is mandatory before any contact is made with the community. The Health Educator will develop Policies and Procedures for the project.

A contract will be signed within 90 days with OU Health Sciences Center College of Medicine's Residency Program for contract services of approximately 20 hours per week to expand CHCI's hours of operation.

Within 30 days of completion of CHW training, CHCI will implement the Establishment of Alternate Non-Emergency Services to the Medicaid population in Oklahoma County. Medicaid recipients will be educated on appropriate emergency room utilization and will be re-directed to non-emergency providers for a more comprehensive approach to their overall health care and improvement of their health status.