STATE OF NORTH DAKOTA

Emergency Diversion Grant Proposal

"Why Are You Here & What is Your Emergency?"

North Dakota Department of Human Services
CFDA: 93.790

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September 19, 2007

ACKNOWLEDGEMENT/SUPPORT:
State Medicaid Director

September 20, 2007

Ms. Maggie D. Anderson, Director
Division of Medical Services
ND Department of Human Services

Re: Grant Funds for Establishment of Alternate Non-Emergency Services Providers
HHS-2008-CMS-ANESP-0005
CFDA – 93.790

To whom it may concern:

I would like to take this opportunity to verify my support for this grant application. As you will see within the application, there is significant opportunity for improving the appropriate use of emergency rooms in rural frontier North Dakota. However, given our extreme rural population and low population density, establishment of additional providers (e.g. walk-in clinics) may not be reasonable or feasible in some areas.

This grant would give the North Dakota Department of Human Services, working with the North Dakota Healthcare Association, the opportunity to determine the best strategy going forward. We have the opportunity to work with established rural health care providers in significant rural areas in North Dakota. The impacted population includes one county with an emergency room visitation rate of essentially 50% - and that is just during the first 7 months of 2007. We need to determine how to improve this utilization.

Once again, ND Medicaid fully supports this grant application and we look forward to the opportunity this grant will provide.

Sincerely,

/s/

Maggie Anderson
Director, Medical Services

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APPLICANT PREFERENCE

The applicant is requesting preference for our program as we meet the following criteria:

a) We serve rural or underserved areas where Medicaid beneficiaries may not have regular access to providers of primary care services; and

b) Providers are in partnership with local community health centers

The applicant has enclosed the following support documents regarding our request for Applicant Preference.

- MUA Designation provided by UND Center for Rural Health
- HPSA Designation as found at http://datawarehouse.hrsa.gov/ and http://www.hpsafind.hrsa.gov/HPSASearch.aspx

MUA Designation:

Rolette County: Whole County – Rolette Service Area
IMU Score (47.4)
MUA/P ID (02583)
MUA/P Service Area (38079)

Mercer County: Partial County Census Tract 9614.98 – West Mercer County
IMU Score (58.7)
MUA/P ID (07298)
MUA/P Service Area (3807961498)

HPSA Designation:

Rolette County: Updated 12-15-03 per Teri Lang, UND Center for Rural Health

Criteria:

State: North Dakota
County: ROLETTE
Date of Last Update: All Dates
HPSA Score (lower limit): 0

Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All Types

Results: 3 records found.

HPSA Name	ID	Type	FTE	# Short	Score
079 - ROLETTE COUNTY					
ROLETTE	138079	Single County	1.7	2.8	17
BELCOURT PHS INDIAN HOSPITAL	1389993838	IHS	11.0	0	20
ROLLA CLINIC PC	1389993870	RHC			0

NEW SEARCH MODIFY SEARCH CRITERIA

Mercer County: Updated 5-11-07 per Teri Lang, UND Center for Rural Health

Criteria:

State: North Dakota
County: MERCER
Date of Last Update: All Dates
HPSA Score (lower limit): 0

Discipline: Primary Medical Care
Metro: All
Status: Designated
Type: All Types

Results: 2 records found.

HPSA Name	ID	Type	FTE	# Short	Score
057 - MERCER COUNTY					
MERCER	138057	Single County	2.4	0	10
COAL COUNTRY COMMUNITY HEALTH CENTER	1389993846	Community Health Center			4

NEW SEARCH MODIFY SEARCH CRITERIA

ABSTRACT:

The appropriate use of Emergency Rooms (ER) is of growing concern! A recent study by the **Institute of Medicine** found that Emergency Room visits increased from **90.3 million in 1993** to **113.9 million in 2003**. Numerous studies have found that a number of these visits are for **non-urgent medical care** that could be treated in **primary care settings**. By knowing which patients are more likely to make inappropriate visits to these departments, efforts can be directed to encourage more suitable care.

The **goal of this project** is to identify and evaluate the concerns regarding emergency room misuse and to determine appropriate, alternative methods for providing non-emergent health care services. The question to be answered, as described in an article, "Rural Emergency Department," is **"What is an Emergency?"** The answer depends on who you ask: the patient, the physician, the family member or the nurse. We need to understand the issue and develop a correction plan to address the problem. Although the grant is for the establishment of alternate non-emergency services providers, it may not be feasible or reasonable to simply add an additional provider in rural frontier areas of ND – the population density simply may not justify that approach. The model that works for 'rural' settings may not be the fit for rural frontier settings.

The **project budget** includes the components that will facilitate the proposed project. The applicant is requesting $287,500.00. The dollars will be used to offset the cost of the time and commitment the participating rural facilities will incur as the intense project is implemented. It will also include a comprehensive utilization study and analysis which includes research, data collection and evaluation components to answer the question, **"Why are you here and what is your emergency?"** Finally, the budget will include a multi-media outreach public education campaign which will provide people decision making skills regarding the appropriate use of the emergency room.

The **grant dollars will be used** to establish two 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.

January to July 2007 statistics from the ND Medicaid office show utilization rates of ER services at **49%** and **29%** respectively for the service area proposed in this grant**.** The **expected outcome** will be to reduce inappropriate use of the **ER by 5-7% by the end of the grant period.**

Project Narrative:

Statement of Project/Need:

Health plans and disease management companies are seeking to reduce the use of the Emergency Room for non-urgent care. Directing non-urgent care to primary care settings can reduce costs, improve the coordination of care for patients, and preserve the ER for those who truly need emergency care. However, the current data available in the State of ND does not provide enough information and does not reflect the impact of geographic access to the ER in a rural frontier state such as ours. This project is critical to understand the utilization and need of the Emergency Rooms in not only the project area but ultimately throughout the State of North Dakota.

Data that is obtainable regarding Medicaid patients reveals that in Mercer and Rolette County alone there are 4,466 Medicaid Eligible patients. Out of these patients, there were 2,162 patient ER visits billed to Medicaid during the January to July 2007 time period. This reflects a **46% ER Utilization Rate**. Thus, there is a critical need for this project, namely the reduction of inappropriate ER utilization by Medicaid recipients.

The ER in rural frontier areas is often used as a 24/7 convenience clinic. Not only do urban areas often have more non-emergency care options available with longer hours, urban area (larger city) ER's have been able to cope by triaging patients and directing care to an appropriate care setting (such as an Urgent Care Center), usually within or immediately adjacent to the hospital itself. Such centers are staffed later hours, and in some cases full-time (24x7). Rural ER's do not have the staffing and dollars to

accommodate the urgent care centers that the urban facilities have established; therefore, we must find alternative means to facilitate the health care needs of the Medicaid population.

Rural medicine, in the delivery of primary care, and in ERs, is very dissimilar to urban medicine! Urban Emergency Departments/Urgent Care Centers are staffed 24/7 with Emergency and Trauma physicians and staff. ERs in rural settings are not. Typically the primary care physician/primary care provider, on call, may live several miles away from the hospital. Each time a patient enters the ER the physician is called to the ER. In urban settings, the on site Emergency & Trauma physician will likely handle that encounter. The primary care physician in the urban setting is not disturbed unless an admission is required. In many cases that physician may not see the patient until the next morning. Reducing the non-emergent, inappropriate visits to the ER will also increase the retention of rural health care physician and providers.

In addition, other valuable resources are often exhausted with non-urgent ER visits. Additional staffing/cost is required to cover ER call backs for nursing, lab, radiology, ancillary staff, etc. The typical small rural ER can quickly become congested and the staff becomes overwhelmed. In addition, the non-urgent visits that occur throughout the early morning hours add to the frustration and fatigue builds as unnecessary ER visits take a toll on staff. When truly critical emergencies arrive, the staff and physicians do not have the energy and compassion that may be required.

As described in the conclusion of the April, 2007 paper by the Association for Community Affiliated Plans and the National Association of Community Health Centers, "The Impact of Community Health Centers & Community – Affiliated Health Plans on Emergency Department Use," improving access to primary care services clearly reduces ER use, which in turn creates a more efficient and affordable health care system. Implementing formal ER utilization reduction programs can further enhance health center and health plans' ability to reduce ER visits. This reduction in ER use can lead to savings for Medicaid because providing preventative care is usually less costly than providing care in the ER.

The report shows a 2006 annual expenditure waste on avoidable emergency visits at **$41,491,015** for North Dakota. The report also lists lessons and recommendations which include; 1) health center and health plans have found lack of start-up funding to be a major barrier to implement a comprehensive ER reduction program, 2) understanding the community's needs can make an ER reduction program more effective, 3) A strong relationship between the hospital and health center/health plan may positively impact a health center or health plan's ability to reduce ER use, 4) patient education for non-emergent issues is important but may work best when coupled with targeted case management. Educational materials should be tailored to targeted patient populations, at appropriate literacy levels and 5) investment in health information technology (HIT) would make communication between hospitals and ER reduction programs much easier.

Communication between providers, patients and healthcare facilities is critical. The need for unified medical records is evident. Duplicative testing is performed in the ER when there is the lack of a unified medical record, and the inability for the patient to see "their provider" encourages duplication of testing and services for chronic stable problems with acute flairs. Example: A patient of Dr. X presents to ER for chronic dizziness. Dr. O sees the patient, the patient does not remember what testing he has had done, he just knows that he is dizzy. Dr. O orders, lab, ultrasound, MRI and an echocardiogram……all of which had just been done last month.

Rural medicine tries to achieve the concept of a **"medical home,"** a model giving people a regular access point for their healthcare that they can utilize as required or needed. They feel welcomed and are comfortable being there or calling there. Patients need to better understand what is emergent, urgent and routine health care. Financial constraints, personnel issues, and lack of resources truly committed to providing extended hours for health care makes this "medical home" more difficult for rural areas. The burden falls upon a high cost, low comfort resource like rural ER's. This in turn wastes more resources which could be better utilized to serve more people.

The focus of this project will evaluate the following for the study locations:

1) What are the utilization patterns and numbers in the identified pilot locations?
2) Why do people need to go to the ER? Could their issue be addressed at their **"medical home?"**

3) What public education and awareness is needed?

4) What resources could be saved?

5) What resources could be extended / is adding resources appropriate?

6) What is the financial impact of identified cost savings?

7) What are the outcome measurements and their impact on the continuity of health care when ER utilization is reduced?

Project Justification:

Education, education, education! Throughout this proposal education and awareness is identified and stressed. It is critical that the Medicaid population, as well as the entire population, is educated on the appropriate use of the rural, frontier emergency rooms. Patients need to be made aware of the fact that alternative non-emergent care is available through primary care clinics in lieu of emergency room services. This objective can be accomplished only through a combination of utilization pattern analysis and consumer education for alternative choice.

This proposal will evaluate the need for additional services in the service area defined in the application. The critical element of the review for additional services will be a clear analysis of the economy of scale and fiscal realities of long distances between health care services and the consumer. It will be essential to identify a number of economically feasible alternatives for the population while at the same time not compromising adequate health care.

Project Goals and Outcomes:

The **goals of the project** are to:

- Produce a defined research, data collection and evaluation methodology tool.
- Reduce inappropriate utilization of emergency rooms by identifying members who may inappropriately use the Emergency Room and intervene before they do so.
- Create ER alternatives that are economically feasible and clinically appropriate.
- Create patient education programs that help patients understand when Emergency Room use is appropriate.

Desired Outcomes:

- Analysis of comprehensive data that will assist the team in producing an appropriate educational and awareness campaign and materials.
- A reduction of ER utilization of 5% - 7% by the end of FY 2009.
- The delivery of defined education resource materials regarding appropriate ER usage.

Estimate of Impact to Beneficiaries:

The project target area includes the communities of Rolla, Beulah, and Hazen (including the communities of Center and Halliday as part of the Coal Country Community Health Center service area) North Dakota, along with various smaller communities in the service area. The project includes a **multi-county service area** which includes 5 counties: Dunn, Mercer, Oliver, Rolette and Towner counties. The information gathered

from this project will be disseminated at a state wide level through the North Dakota Healthcare Association, the Community HealthCare Association of the Dakotas, North Dakota Department of Human Services, and other organizations such as the UND Center for Rural Health.

The project will affect 4,843 Medicaid eligible recipients in Dunn, Mercer, Oliver, Rolette and Towner counties. The project will indirectly serve and affect the entire service area with a population of 30,859.

Description of Magnitude of the Impact to Medicaid:

As stated in the **Estimate of Impact to Beneficiaries,** the project will include the counties of Dunn, Mercer, Oliver, Rolette, and Towner in North Dakota. The following table describes the current utilization of emergency services by Medicaid eligible recipients:

County Name	County Population	Number of MA Eligible Patients	ER Claims Jan – July 2007	%
Dunn	3,600	196	39	20%
Mercer	8,644	404	119	29%
Oliver	2,065	62	15	24%
Rolette	13,674	4,062	1,999	49%
Towner	2,876	119	34	29%
Totals	**30,859**	**4,843**	**2,206**	**46%**

**** ER Visits represent the county which the Medicaid Eligible patient is located.***

Description of Sustainability of the Project:

The State of North Dakota is building a sustainable model. Rural frontier states such as ND understand the **need of sustainability** which in **essence means survivability** for states of our size. Sustainability is the building block to this proposal. The reduction of dollars spent on unnecessary visits can be utilized to expand the education services to other areas of the state. In addition, information collected from the model that is created can and will be disseminated to other rural health facilities across the State of ND. In addition, the NDHA will provide video conferencing (BT-WAN) capability for the project to sites that are connected within our state. This will provide an immediate means to disseminate and educate other sites in the state.

Evaluation Plan:

Evaluation will involve a strong partnership with the health care providers, rural facilities and the ND Department of Human Services. This health care team will be the essential player in the project evaluation plan. The project will have many evaluation components: 1) the initial evaluation, data collection and research that will be performed obtaining answers to, “Why are you here and what is your emergency?” This will assist the team in determining the approach that needs to be taken in educating the patients, 2) the continuous evaluation of the services being offered and location they are being offered, and 3) the evaluation of ER utilization in which the ER visits will be monitored semi-yearly by the State Medicaid program to determine the reductions experienced by the project.

Description of Project Implementation Readiness:

The State of North Dakota has the ability and plan to implement the previously described project. The following description includes high-level implementation tasks and timelines/milestones. Below please find the timeline with estimated completion times. The table is broken down into quarters that represent the project period outlined in the grant guidelines – October 2007 through September 30, 2007.

Task Description	Quarter 4 2007	Quarter 1 2008	Quarter 2 2008	Quarter 3 2008	Quarter 4 2008	Quarter 1 2009	Quarter 2 2009	Quarter 3 2009
Grant announcement and award. Grant paperwork signed.								
Project team meets to sign any needed agreements, review project goals and determine RFP components with announcement and/or research group to engage								
RFP issued and/or research team secured								
Evaluation, surveys, etc. performed								
Ongoing evaluation of services offered including location of services								
Survey results and evaluation								
Development of public awareness campaign								
Implementation of campaign								
Evaluation of clinical hours and emergency room utilization								
State of ND – Utilization data review								
Utilization tracking								

BUDGET:

Estimated Budget Total - $287,500

Description	2007 Oct - Dec	2008 Jan - Dec	2009 Jan - Sept	Total 24 month
Personnel / Fringe Benefits	$4,685	$18,745	$14,070	$37,500
Contractual	$0	$55,000	$30,000	$85,000
Supplies	$0	$65,000	$25,000	$90,000
Equipment	$0	$0	$0	$0
Other Costs / Facilities	$9,375	$37,500	$28,125	$75,000
BT/WAN Video Network	In Kind	In Kind	In Kind	In Kind
Total Costs	**$14,060**	**$176,245**	**$97,195**	**$287,500**

Total Estimated Funding Requirements for Each Year:

The estimated funding for category by each year is shown on the table above. Narrative for each of the categories is outlined below.

Today, the project envisions an intense focus on research, data collection, evaluation and public awareness outreach. It also envisions an intense commitment from the rural frontier facilities described in the application. As the project unfolds, the team may determine that a heavier need for dollar allocation to the rural facilities will be necessary versus contractual/supply expense. Therefore, we would like to see the dollars between the categories flexible to ensure the best possible project outcome.

Personnel/Fringe Benefits:

Personnel and Fringe Benefits have been allocated at 15% of the project cost (the project cost is projected at $250,000, personnel and fringe benefits is 15% of that, or $37,500, for a total budget of $287,500). The salary factor is $28,125 and fringe benefits factor is $9,375 or 25% of $37,500.

The management, administration, and reporting requirement for the project will be performed by the North Dakota Healthcare Foundation. The Foundation will report directly to the ND Department of Human Services, Medical Services Division. Arnold (Chip) Thomas, President of the Foundation, will be the Project Manager and contact. Mr. Thomas will assign duties within the NDHA to effectively and efficiently manage the project. The President of the Foundation will be responsible for the day to day operation of the project, issue any RFP's, manage the data collection and evaluation, and report and disseminate information learned from the project.

Contractual Cost:

Contractual costs include the issuing of RFP for research, data collection and evaluation. It also includes the multi-media public awareness campaign that will be launched throughout the project period. This will include, but is not limited to, brochures, mailers, posters, public service announcements, etc.

The Research/Data/Evaluation costs will be higher in early 2008 and the supplies costs will be more in the later part of 2008 and 2009.

Supplies:

Supply costs throughout the project period will consist of education materials, printing, surveys, data collection, etc.

Contractual Cost / Supply Note:

The budget for items for these two categories is broken down into two categories – contractual and supplies. Please note that there are no costs associated in these two categories in 2007 as this will be the period in which the grant is awarded, agreements are signed and the RFP is issued.

Equipment:

The applicant is not allocating any costs related to equipment.

Other Cost:

Other costs associated to the project will be agreements with the participating pilot sites. This cost will include reimbursement to the participating sites for the time, commitment, ancillary costs, mileage, meetings (staff, team and community), etc. It will also include stipends for physician participation.

BT/WAN – In addition, video conferencing required for the project will be provided as an in-kind service to the sites that are connected within ND.

SF 424: Application for Federal Assistance – State of ND

SF 424A: Budget Information

SF 424B: Assurances

SF LLL: Disclosure of Lobbying Activities