Performing Provider: Community Care Collaborative
Project Name: Implement a comprehensive patient navigation system
Project Identifier: 307459301.2.7

Provider: The Community Care Collaborative (CCC) is a new multi-institution, multi-provider, integrated delivery system. Launched in 2012 by Central Health, Travis County's Healthcare District, and the Seton Healthcare Family, Central Texas' largest hospital system, and now joined by Austin Travis County Integral Care, the County's Local Mental Health Authority, this 501(c)(3) will integrate safety net providers in Travis County in a ACO-like model. Patients will receive navigated, patient-centered care that will lead to better health outcomes, increased satisfaction with the system, efficient delivery of services, and lower costs.

Intervention: This DSRIP Project has three main components, all of which support the overarching goal of creating a connected, seamless patient navigation experience for patients who need additional support accessing appropriate care. This system will be composed of existing resources, expanded resources, and new programs, *all undergirded by Health Information Technology (HIT) solutions that make identifying patient issues, viewing history, and sharing appropriate information easy for the navigator*. First, system-wide evidence-based standards and protocols will be developed and applied to all existing primary and specialty care navigation programs operated by CCC providers. Second, the CCC will substantially enhance the introductory patient navigation services provided to Travis County residents enrolled in the District's Medical Access Program (MAP) and will also make like services available for residents who receive care from the CCC's providers through sliding fee scale and other programs. Third, an ED navigation program will be instituted to work with CCC patients who utilize any of the region's Emergency Departments for non-emergent conditions, ensuring connection to a primary care home and scheduling a follow-up appointment.

Need for Project: Each element in this intervention addresses a gap in provision of high quality healthcare services. (1) The fragmented delivery system has resulted in multiple navigation programs at different providers. Not only may these programs overlap or duplicate services already available in the community, but there may not be uniform practice and performance standards and measures. (2) Large numbers of uninsured patients touch the MAP eligibility system each month: the current call center receives from 5,000 to 7,000 calls from those seeking MAP assistance. Regardless of whether the caller is deemed eligible for MAP, this initial call represents an opportunity to connect with a patient and set up a follow-on strategy to encourage use of primary care. Current call center hours and capacity limit the ability to follow-up with these customers. (3) From March 2012 to February 2013, 88% of ED encounters by Travis County's low-income, uninsured and Medicaid patients were non-emergent, primary care treatable or preventable/avoidable. These patients need to utilize existing primary care resources when possible, and likely need assistance understanding how to access the right care at the right time or assistance in finding a provider that offers services at hours convenient for them.

Target population: The target population for this project is un and underinsured patients residing in Travis County, under 200% of FPL.

Category 1 or 2 expected patient benefits: We expect that patients will increase their access to the primary care system through this comprehensive navigation program. Specifically, depending on the patient's needs, un and underinsured patients will receive navigation services soon after accessing the ED, or at or immediately after enrollment or recertification into MAP. Overall, all CCC patients will experience a more coordinated patient-centered approach to health care access through standardized navigation protocols and improved HIT systems.

Category 3 Outcomes: 9.2: ED Visit rate for ACSCs

Title of Project: **Implement a comprehensive patient navigation system**

Category / Project Area / Project Option: 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

RHP Project Identification Number: **307459301.2.7 (replaces 307459301.1.5)**
Performing Provider Name: **Community Care Collaborative (CCC)**
Performing Provider TPI: **307459301**

Project Goal: Oversee, coordinate and connect existing, expanded and new patient navigation programs within the CCC provider network to increase utilization of primary care services and reduce inappropriate ED utilization.

PROJECT DESCRIPTION

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)(3) public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and developmental disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will eventually serve a defined patient population at or below 200% of the Federal Poverty Level and who meet other established eligibility requirements. The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this DSRIP project, the CCC proposes to oversee, coordinate and connect existing, expanded and new patient navigation programs within the CCC provider network to increase utilization of primary care services and reduce inappropriate ED utilization. This intervention is one of a package of 15 DSRIP projects that transform the safety net health care system in Travis County, several of which provide clinical services to those with chronic disease. The other projects are:

- Patient Centered Medical Homes
- Chronic Care Management Models
- Expanded Hours at Community Clinics
- Mobile Clinics to Underserved Areas
- Dental Care Expansion
- Telepsychiatry in Community Clinics
- Pregnancy Planning
- Disease Management Registry Functionalities
- Community Paramedic Navigator Project
- Gastroenterology in Community Clinics
- Pulmonology in Community Clinics
- Integrated Behavioral Health for Diabetics
- STI & HIV Screening and Treatment & Referrals
- Centering Pregnancy

Taken together, all fifteen projects will improve patient health and the experience of care, and control healthcare costs as the CCC launches its ACO-like safety net care system.

This DSRIP Project has three main components, all of which support the overarching goal of creating a connected, seamless patient navigation experience for patients who need additional support accessing the appropriate care. This system will be composed of existing resources, expanded resources, and new programs, all undergirded by Health Information Technology solutions that make identifying patient issues, viewing history, and sharing appropriate information easy for the navigator. All of these elements will be integrated into the development of the CCC's care coordination plan, which is being developed simultaneously.

First, system-wide evidence-based standards and protocols will be applied to all existing primary and specialty care navigation programs operated by CCC providers. Elements of the standardized approach will include outreach, patient navigation and follow-up, and health education and information tailored to the patient's condition and needs, all delivered in a culturally and linguistically appropriate manner. Training will be provided for all navigators within the CCC network to ensure a shared understanding across care venues of the standard protocols and navigation strategies, opportunities for warm handoffs between navigation programs will be stressed, and appropriate HIT tools will be used for all patient navigators to track and coordinate patient care.

Second, navigation services available to individuals interested in Central Health's Medical Access Program ("MAP" – the county indigent program) will be substantially expanded. Currently, Information & Referral (I&R) specialists, available 8am to 5pm Monday to Friday, receive calls from individuals interested in applying for MAP. Upon successful enrollment, these specialists place outbound calls to new MAP enrollees to explain the program's benefits. They also place follow up calls to those ineligible for MAP but who were referred to safety net providers who offer services on a sliding-fee scale basis. Follow-up calls to both groups are critical to ensuring appropriate utilization of the primary care services, but the ability to make them is constrained by the volume of inbound calls and the call center's schedule. Expanding the hours of the center's operation into the evening, adding additional I&R navigation staff, and piloting a weekend program will expand the opportunity to place successful outbound calls. An additional short form Health Risk Assessment will be piloted, to identify those patients with high risk conditions who need more intense navigation services, and a few questions will be added to explore other barriers to accessing care, such as transportation, that can be addressed through social service linkages. The use of text messages, interactive chat, and automated call back will be explored as methods to preserve call center staff workload for people who need direct person to person communication and increase likelihood of connecting with patients.

Third, a new navigation program will be established for CCC patients who use regional Emergency Departments for non-emergent conditions. Within 72 hours of leaving the Emergency Department, eligible patients will be contacted by a navigator who will ensure that a connection to a primary care home is created, and arrange an appointment there as appropriate. Additional services provided by these navigators will include goal-setting, disease state awareness, health literacy assistance, pharmacy management, and linkages to social services.

Target Population: All patients benefiting from this service will be at or below 200% of FPL.

- All patients served by CCC providers will benefit from the increased coordination between navigation programs. Approximately 90% of the patients served by the safety net system are Medicaid or uninsured.
- All new enrollees into the MAP program will be contacted for post-enrollment navigation services, and patients ineligible for MAP but able to receive charity care or sliding-fee scale services will receive a connection to a primary care home.

- MAP patients who have used a regional Emergency Department for a primary care treatable or preventable condition will be connected to the new navigation program.

Project Goals: The goals of the project are to:

1) Create, implement and train providers on basic standards for all of the CCC's existing patient navigation programs;
2) Develop health information technology tools to support the work of patient navigators across the network, enhance scheduling capabilities and create care notifications;
3) Enhance and expand existing call center hours and capabilities to increase likelihood that patients seeking health care assistance can access appropriate care;
4) Increase the number of primary and preventive care appointments made and kept;
5) Reduce reuse of the ED by patients with non-emergent conditions.

Challenges or Issues Faced by the Performing Provider:

Attitudes about ED Utilization. A 2012 analysis of uninsured and underinsured patients in Travis County found that approximately 50% of ED visits provided during regular clinic hours (8am-5pm weekdays) did not require immediate care or could have been provided effectively and safely in a primary care setting. Many of these patients lived within 2 miles of an existing community-based outpatient clinic but still chose to utilize the ED instead.

How the Project Addresses those Challenges:

The DY2 needs assessment will gather quantitative and qualitative information about ED use to understand better why patients access care in this place when better alternatives exist. This information will be used in navigation program design, along with existing research on the subject.[1]

How the Project is Related to RHP Goals:

The Project aligns with Regional Healthcare Partnership 7's Goals 1, 2 and 3:

1) Prepare and develop infrastructure to improve the health of the current and future Region 7 populations; and
2) Reduce health system costs by expanding opportunities for patients and families to access the most appropriate care in the most appropriate setting; and
3) Improve the patient experience of care by investing in patient-centered, integrated, comprehensive care that is coordinated across systems.

5-Year Expected Outcome for Providers and Patients:

Patients are expected to increase their use of primary care for conditions treatable by their PCP. They will be able to access primary care at the appropriate time to best manage complex conditions. By doing so, they will lessen their use of potentially preventable ED visits and increase use of primary care screening services.

Starting Point/Baseline

The CCC will collect baseline data in DY3 on the patient population.

Reason for Selection of Project Options and Components

A number of statistics make the case that Travis County patients need to be better connected to care in non-acute settings.

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[1] Falik M, Needleman J, Wells BL, et al. Ambulatory care sensitive hospitalizations and emergency visits: Experiences of Medicaid patients using federally qualified health centers. Med Care 2001;39(6):551-556.

- From March 2012 to February 2013, Travis County's low-income, uninsured and Medicaid patients had 174,220 ED encounters. Of the visits, 88% were non-emergent, primary care treatable or preventable/avoidable.[2] Of those, 37% did not have any clinic visits in that same year.
- An average of 633 new MAP enrollees are sent to the Information & Referral team each month, which complete an average of 393 successful calls to these enrollees (62%). A mere 13 patients per month (2%) are transferred directly from these successful calls to the scheduling center at the county's largest FQHC. A full 20% do not see a PCP within three months of enrollment, and 13% do not see a PCP within four months of enrollment.
- Each month and average of 680 patients seeks MAP coverage but are ineligible, and so are referred to a CCC provider for services on a sliding-fee scale basis. Only 50 (7%) of these patients receive a follow-up call from the call center navigators, who often learn that the patient did not make an appointment or couldn't get an appointment.

With a focus on patient-centered care, this project will build a network-wide patient navigation system that intersects multiple dimensions of care, integrates detached patient navigation efforts, standardizes navigation protocols, and bolsters navigation at points where patients could most benefit from navigation support (e.g., hospital discharge, eligibility screening for the county indigent coverage program).

The project will address all of the option's required core components:

a) It will *identify frequent ED users and use navigators as part of a preventable ED reduction* program. Certain frequent utilizers will be connected to the expanded Community Paramedic Program (307459301.2.6) which identifies patients based on 9-1-1 and EMS utilization patterns. Other ED users will be brought into the program through record review and will receive a phone call from a navigator within 72 hours of ED utilization.

b) This project will *deploy innovative health care personnel*, such as case managers/workers, community health workers and other types of health professionals as patient navigators. Information and Referral Specialists will also be included in the program.

c) The navigators will *connect patients to primary and preventive care*. The call center navigators will place follow-up calls and connect patients to primary care providers and preventive services, advocating for patients and obtaining them appointments as necessary. ED navigators will connect patients to a primary care medical home and ensure patients make medical appointments there.

d) By directing patients to appropriate care resources, and providing supplemental coaching and education, the navigators will *increase access to care management and/or chronic care management, including education in chronic disease self-management*.

e) *Quality improvement* for the project will be conducted through participation in learning collaboratives and other continuous quality improvement initiatives, particularly for the high-volume call center.

Reason for Selection of Milestones & Metrics

The milestones and metrics in this project focus on increasing access to primary care for patients to eventually reduce their utilization of acute, episodic care.

DY2 includes milestones on planning (P-X) and conducting a needs assessment to better specify the patient population and the capacity of the patient navigation system (P-1). In DY3, we will establish a baseline of patients served through the CCC system patient navigation programs (P-

[2] NYU Center for Health and Public Service Research ED utilization algorithm: http://wagner.nyu.edu/faculty/billings/nyued-background

X) and begin training 5 health navigators on standard navigation protocols and provide enhanced navigation services to 500 patients through the call center (P-2). In DY4 and DY5, the program will increase the number of navigators trained to 35 FTEs over baseline of zero (P-2). The percentage of patients both with and without a primary care provider who are referred to a PCP in the ED will increase to 10% and 20% in DY4 and DY5, respectively (I-6). Every year, the providers will participate in learning collaboratives (P-8).

Unique Community Need Identification Number

- CN.7: Lack of coordination of care
- CN.8: High rates of non-emergent ED usage and potentially preventable inpatient admissions
- CN.9: High rates of chronic disease

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative

As discussed above, a number of safety net providers have their own "patient navigation" programs. These vary in size, scope and capability. A major part of this DSRIP project will be to establish certain standards for these existing programs.

This project will also significantly enhance the ability of the CCC to reach patients who have indicated a need or interest in obtaining coverage through MAP, whether they are eligible for benefits or not. Extra hours, including the possibility of weekend outreach, along with additional staff, will increase successful call rates and result in more connection to the primary care system. A health risk assessment will also be added to these follow-up phone calls which will indicate which patients need to be directed to more intensive patient programming.

Finally, no ED navigation program exists within the CCC right now. This project establishes one.

All of these efforts will be supported by new Health Information Technology applications that allow navigators to see appropriate, timely information regarding the patient. Other technology applications include texting services to remind patient of appointments, and other patient-friendly tools to increase connection to the primary care system.

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS)

There are no related activities funded by HHS.

Related Category 3 Outcome Measure(s)

9.2: ED Visit rate for ACSCs

Reasons/Rationale for Selecting the Outcome Measure(s)

This project aims to navigate patients into the appropriate primary care setting. Project success can therefore be measured by the number of these patients who access primary and preventive treatments, which will result in better health. The three outcomes selected represent best primary and preventive care practices, and will be made available to those patients accessing care by means of the three navigation elements in this project.

Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects

This patient navigation project links closely with other CCC "infrastructure" projects that establish care protocols (307459301.2.2), expand PCMH principles (307459301.2.1) and establish the Disease Management Registry HIT tools necessary to manage safety net patients' chronic conditions (307459301.1.1). This project's success relies on DSRIP projects that expand access to care:

expanded primary care hours (307459301.1.2); increased dental capacity (307459301.1.4); mobile vans (307459301.1.3); community-based pulmonology (307459301.1.7) and gastroenterology (307459301.1.6); and a behavioral health intervention for patients with chronic disease (307459301.2.3). Additionally, patient care navigators will be able to engage the Paramedic Navigators to assist in managing complex patient needs (307459301.2.6).

List of Related Category 4 Projects

RD-1: Potentially Preventable Admissions; RD-2: 30-day readmissions

Relationship to Other Performing Providers' Projects in the RHP

List of Other Providers in the RHP that are Proposing Similar Projects

- 137265806.2.3 UMCB: Substance Abuse Navigation;
- 137265806.2.4 UMCB: Behavioral Health Assessment and Resource Navigation;
- 137265806.2.5 UMCB: Care Transitions Intervention;
- 137265806.2.8 UMCB: Women's Oncology Care Navigation;
- 137265806.2.1 UMCB: OB Navigation Project;
- 201320302.2.5 City of Austin: Healthy Families;
- 201320302.2.4 City of Austin: Pre & Post Natal Program.

Plan for Learning Collaborative

RHP 7's performing providers, IGT entities, and anchor recognize the importance of learning from each other's implementation experiences and will make regular efforts to share ideas and solve problems. Region-wide, anchor-led meetings will be held at least annually and will offer an opportunity to share, listen, and learn what providers have encountered while implementing their DSRIP projects. RHP 7 envisions continuing the regular, anchor-led calls that are open to all performing providers and IGT entities, as launched during plan development. These calls have brought value to the process, and will be continued on a schedule that will be helpful throughout the waiver period. Further, the region will continue to use its website (www.texasregion7rhp.net) to share information, updates and best practices as has been done during this first waiver year.

As useful, Central Health, as RHP 7's anchor, will foster the development of topical learning collaboratives – smaller meetings than the annual regional summit – that will bring together all levels of stakeholders who are involved in DSRIP projects that share common goals, outcomes, themes or approaches. This multi-pronged approach should allow for continuous improvement of regional projects, which will in turn better serve RHP 7's low-income population and transform its healthcare delivery system.

Project Valuation

In valuing its projects, the Community Care Collaborative considered the extent to which the project fulfilled the Triple Aim, supported Waiver goals and addressed community needs. The size of the required investment was also considered, which included considerations of personnel, equipment, time and complexity. Finally, the CCC reflected on the scope of the project: the number of patients that would be affected, including the type of patients; the number of patient visits or encounters; how many providers or staff members would be added; the costs that would be avoided as a result of the project; and the "ripple effect" the project would have on all members of the healthcare system. These factors were weighed against the amount of funding available.