2.b.ii Development of Co-Located Primary Care Services in the Emergency Department (ED)

Project Objective: To improve access to primary care services with a PCMH model co-located/adjacent to community emergency services.

Project Description: Patients in certain communities are accustomed to and comfortable with seeking their health care services in the hospital setting, frequently leading to overuse of emergency department services for minor conditions while missing preventive health care services. This project will allow faculty to have a co-located primary care PCMH adjacent to the ED. The PCMH practice will have extended hours and open access scheduling. This will allow patients presenting to the ED who, after triage, are found not to need emergency services be redirected to the PCMH, beginning the process of engaging patients in comprehensive primary care.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Ensure appropriate location of the co-located primary care services in the ED to be located on the same campus of the hospital. All relocated PCMH practices will meet NCQA 2014 Level 3 PCMH standards within 2 years after relocation.
2. Ensure that new participating PCP meet NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of Demonstration Year (DY) 3. At start up, participating PCPs must have open access scheduling extended hours, and have EHR capability that is interoperable with the ED.
3. Develop care management protocols for triage and referral to ensure compliance with EMTALA standards.
4. Ensure EHR utilization including supporting secure notifications/messaging as well as sharing medical records between the participating providers via Meaningful Use standards.
5. Establish protocols and training for care coordinators to assist patients in understanding use of the health system, promote self-management and knowledge on appropriate care.
6. Implement a comprehensive payment and billing strategy. (The PCMH may only bill usual primary care billing codes and not emergency billing codes.)
7. Develop protocols for connectivity to the assigned health plan PCP and real-time notification to the Health Home care manager, as applicable.
8. Utilize culturally competent community based organizations to raise community awareness of alternatives to the emergency room.
9. Implement open access scheduling in all participating primary care practices.
10. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For example, identify how the project will develop new resources or programs to fulfill the needs of the community.

The population of Nassau and Queens is 3,648,322. Nassau County is home to 223,518 Medicaid beneficiaries (16% of the county's population) and Queens is home to 964,928 Medicaid beneficiaries (42% of the county's population). Approximately 121,639 people in Nassau County (9.0%) and 404,127 people in Queens (17.6%) are without health insurance. In combination, Medicaid and uninsured persons exceeds 47% of the total population within Nassau and Queens Counties. There are 324,510 ED visits combined in both counties. In addition, Queens has 246 federally designated Health Professional Shortage Areas (HPSAs) for primary care, with 11% of the Medicaid population living in a HPSA, further contributing to residents' reliance on the ED for non-emergent care.

Approximately half of participants in the Medicaid member community survey (51% in Queens and 47% in Nassau) reported that they or a family member went to the ED in the previous year. SPARCS data indicates that 71% of Medicaid ED visits in Nassau and 75% in Queens were classified as potentially avoidable. Adults likely to have acute illnesses (ages 18-44) comprised 39% of all avoidable ED treat and release visits and 29% of all ED visits in the region. Adults more likely to have chronic disease (ages 45+) made up more than 20% of the region's avoidable ED Treat and Release visits. General symptoms, diagnosed respiratory infections, and chronic obstructive pulmonary disease drove the utilization and accounted for nearly 50% of ED visits.

When survey respondents were asked why they sought care in the ED, they indicated: the ED is the closest provider, they have no other place to go, they could not get an appointment with a health care provider, or their doctor's office was not open. 10% of respondents noted that all of their care was received in the ED.

A primary care practice is preferred to the ED both in order to manage chronic conditions and more quickly provide episodic care for illness. The NQP CNA indicates a lack of provider continuity and poor handoffs from the ED to community-based physicians, resulting in poor implementation of treatment plans, potentially leading to avoidable hospitalizations and readmissions. The project will provide screening and facilitated access to co-located Level 3 PCMHs and promote effective patient engagement for improved care continuity. This will interrupt current patterns of inappropriate utilization and reliance on the ED. As designed, it will accelerate triage prior to patients arriving in the ED and refer patients to the PCMH for non-emergent conditions.

The limits of public transportation contribute to ED use. A cohort of patients regularly turns to the ambulance to access the ED for non-emergency care. With regulatory waivers (but within EMTALA) we will work in collaboration with EMS to support triage of patients to alternative, more clinically appropriate and cost-effective sites of care.

The EDs that will have co-located primary care practices established in this project include NUMC/NuHealth, Winthrop and South Nassau, which operate the three EDs serving the largest number of Medicaid lives in Nassau County. LIJ, Cohen Children's Medical Center, Franklin, Mercy and St. Johns will also participate in this project. 5 of these 8 hospitals are safety net providers (NUMC, LIJ, Franklin, Mercy, St. John's). Co-locating primary care services in level 3 PCMHs adjacent to the EDs in these hospitals will promote improved care continuity and reduce inappropriate ED utilization. PCMH sites are also more capable of providing care that is culturally and linguistically competent.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The target patient population for this project is current and future ED utilizers who have emergent care needs. In order to strengthen primary care access in the highest need neighborhoods and reach out to the local Medicaid population with targeted educational efforts, the focus will be to improve primary care (PC) access for residents in communities designated as medically underserved (Elmont, Freeport, Hempstead, Jamaica, Long Beach, Far Rockaway, Roosevelt and Westbury). The neighborhoods surrounding NUMC/NuHealth, Winthrop, South Nassau, LIJ, Mercy and St. John's will also be targeted as they generate large numbers of avoidable ED visits. Salient data indicate that the cohorts with the highest utilization include African American and Latina women between the ages of 18 and 44, so this project will also have a positive impact on reducing racial disparities. Additionally Explorys, a population health analytics engine used by Care Solutions, has multiple tools to prospectively identify patients likely to use the ED unnecessarily. These cohorts will be targeted. Some of the specific conditions that can be effectively diverted from the ED to primary care include musculoskeletal injuries, acute respiratory illness and substance use disorders. Treatment in a Level 3 PCMH will offer Medicaid beneficiaries significant clinical benefits and will provide NQP with substantial potential cost savings.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

NUMC has started construction of a project to co-locate a primary care center next to its ED. The primary care practices onsite in pediatrics and internal medicine already have 2011 Level 3 PCMH recognition; this project will support the achievement of PCMH recognition under the 2014 standards, as required by DSRIP. South Nassau Communities Hospital has also located its ED near a PCMH on the hospital's first floor and an additional PCMH co-located within another site. Cohen

Children's Medical Center of New York, a dedicated pediatric emergency room, located on the campus of Long Island Jewish Medical Center (LIJMC), in Queens, has the ability to expand ambulatory care space to meet 2.b.ii requirements. Long Island Jewish Hospital (LIJ), the adult ED for both medical & behavioral health, of LIJMC, also has the ability to expand ambulatory care space to meet 2.b.ii requirements.
The knowledge gained by NQP partners in achieving current PCMH recognition will be leveraged to help to educate and transform other practices into PCMHs, as many practices in NQP have not begun the transformation needed to meet PCMH standards. These existing PCMHs can assist with lessons learned and best practices. In addition, LIJ has an algorithm-driven nurse triage hotline that provides symptom-based directions to the right level of care: ambulance, urgent care, or ED. The triage hotline model is readily expandable to other sites that will be participating with the project and can support appropriate referrals prior to patient's arrival in the ED. The LIJ-affiliated Center for Emergency Medical Services (CEMS), the largest private ambulance service in the metro NYC region, provides evaluation and treatment in the home by paramedics for high risk seniors enrolled in an admission abatement program. Additionally, LIJ has instituted a split flow model in the ED. This operational expertise can be leveraged to direct patients to a co-located ED. NUMC operates an Ask-A-Nurse line as part of its care transition program, available 24 hours/day. Callers speak with an RN, who directs them to the most appropriate setting for follow-up care. Finally, all the EDs have fast track services that include protocols for referral to PCMH and are designed to enhance linkages to primary care for appropriate follow-up.
Existing staff capabilities will be leveraged, and if necessary, ED staff can be retrained and redeployed to work in PCMH settings. Care coordinators will be needed in the PCMH to manage the care of individuals with complex conditions, especially high utilizers, and to assist patients in connecting with a PCP. Patient education will be an essential component of the PCMHs. Patients will be educated on how to manage chronic conditions effectively, and how to deal with non-acute care symptoms in the future. In addition, the hospitals will work with their existing outreach programs and with community based organizations to develop educational materials that are appropriate to the diverse populations we serve, recognizing that cultural competency extends beyond traditional cultures and ethnic backgrounds to include special populations such as the LGBT community, individuals with HIV/AIDS, individuals with behavioral issues, homeless individuals and families.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

The availability of appropriate physical space proximate to the ED is variable among the participating institutions. Other hospital functions may need to relocated, space may need to be rearranged, equipment purchased, and additional staff will be needed.
Another implementation challenge is establishing appropriate protocols to deal with patients who show up at the ED with non-emergent conditions, and who also have a designated PCP with whom

they may have a clinical relationship. The goal is to insure that the Medicaid patient population receives primary care in a more appropriate setting than an ED, even co-located next to the ED. Patients with non-emergent complaints who are directed to the co-located primary care practice will be educated about primary and preventive care. Rigorous protocols will be established to engage the patient in primary care with their assigned provider if such a provider exists, to direct and manage the transition to the appropriate level of care, and to communicate with the community-based primary care practice. The billing implications associated with this process will present additional challenges and will need to be addressed as a part of the project implementation plan.

Patient compliance with being re-directed to a co-located primary care practice after an evaluation in an ED will need to be dealt with appropriately, as will EMTALA regulatory issues. Extensive patient education will be required. EMTALA requires that an ED must provide a clinical assessment for any patient that signs in, so a diversion to a co-located PCMH may lead to duplicative care. A main focus of the project will be on EMTALA compliant referral protocols that redirect patients to primary care before they arrive in the ED. The use of the LIJ triage hotline and NUMC's Ask-a-Nurse hotline will also be expanded to direct patients to the appropriate level of care prior to showing up at the ED. Finally, patients will be alerted to the open access PCMH practices via signage and other promotional materials such as pamphlets, available in multiple languages and formats. Other initiatives such as posting average wait times for the ED versus the primary care clinic will help influence patient decision making about location of care.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

In Nassau, NQP does not overlap with any other PPS, although patients are free to receive care across the PPS's geographic boundaries and many do. Overlap will occur in Queens. Advocate Community Partners (ACP) has included eastern Queens in its service area; however, it has not included the Rockaway Peninsula. NY Hospital Queens and Health & Hospitals Corporation PPSs also serve Queens. Due to their geographic proximity, particularly eastern Queens, it is possible that overlap will occur.

LIJ is a member of the ACP with Board of Directors representation. Leveraging the LIJ role in the NQP and in the ACP PPS, LIJ will be able to rapidly communicate and share information and best practices or problems being encountered with the other PPS as they arise. ACP does not plan to pursue project 2.b.ii.

In developing protocols and policies for triage and communication, neighboring PPSs will have to be addressed. Overlapping PPSs will develop protocols for re-directing patients who use EDs in multiple PPSs to appropriate primary care. This will include expectations for alerts and communication of visit outcomes both for patients out-migrating to EDs outside NQP and for those in-migrating whose primary care lies outside NQP. In the absence of integrated medical records a process will be needed to flag duplicate patient records and coordinate efforts, which NQP will develop.

2. Scale of Implementation (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

IT investments will be necessary for development of internal communications tools and electronic medical records, community para-medicine connectivity, access to remote monitoring equipment, and expanded text messaging capabilities. Integrated communication tools, real time alerts via email or text messaging, transmission of continuity of care documents will all be vital to communicating both within the NQP and with overlapping PPSs.

The PCMH model requires multidisciplinary team-based care including augmentation in staffing such as: nurse care managers, social workers, psychologists, pharmacists, and community health workers. Many of these individuals will need to speak multiple languages, particularly Spanish.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
NUMC/NuHealth	Medical Home Demonstration Project		2014	Demonstration project that focused on PCMH status via residency training, in order to achieve NCQA 2011 standards for PCMH.
LIJ	Medical Home Demonstration Project	1/1/2013	4/1/15	NYS funded demonstration project that focused on transforming resident-clinics into PCMHs. Additionally focused on high quality care transitions and reduction in ED and hospital utilization.
South Nassau	Medical Home Demonstration Project		2014	Demonstration project that focused on PCMH status via residency training, in order to achieve NCQA 2011 standards for PCMH.

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

Project 2.b.ii will establish primary care adjacent to hospital EDs. While these sites are similar to the medical home demonstration projects, these primary care sites will be PCMHs, which has not only residency training requirements, but other requirements. The PCMH requirements were revised in 2014 so the proposed PCMH sites may have to update resources and policies/procedures in order to meet the new standards. In addition, as these PCMHs will be adjacent to hospitals EDs, they will focus on a population that has historically been difficult to steer away from an acute care setting, with the goal of shifting care to a more cost-effective setting.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.