2.b.iii. ED CARE TRIAGE FOR AT-RISK POPULATIONS

WORKPLAN AND PROCESSES

Project: Establish an effective ED Triage program focused on reducing preventable emergency department utilization by identifying the root causes, including social determinants of health, and addressing these causes with appropriate triage and referral. This project will employ evidence-based care coordination and a transitional care program to assist patients by linking them with primary care practitioners, improving patient understanding of appropriate use of the ED and its alternatives, and supporting self-management of personal health conditions. Key components include referral to offices meeting PCMH Level 3 standards, such as open access scheduling, and extended hours in PCMHs as well as patient navigators. The major effort will center around connecting frequent ED users with the PCMH providers available to them.

INTERVENTIONS

▶ Establish ED care triage program for at-risk populations (e.g., those using the ED for minor and preventable reasons). Participating EDs will establish partnerships with community PCPs, with an emphasis on those that are PCMH Level 3 certified or working toward achieving PCMH Level 3 certification in 2017 and have open access scheduling.

   » Jamaica Hospital Medical Center (JHMC) and Flushing Hospital Medical Center (FHMC) EDs have relationships with all providers within the MediSys network, with community providers who are part of our HealthFirst network, and are developing relationships with providers across ACP's PCMH provider network.

   » Lenox Hill and Forest Hills Hospitals have existing relationships with some community providers and will expand relationships with ACP's PCMH provider network and Health Homes.

▶ Develop a process and procedures to establish connectivity between the ED and community PCPs.

   » Connectivity between JHMC and FHMC EDs and all MediSys PCPs is implemented through the shared EHR (EPIC).

   » Connectivity between JHMC and FHMC EDs, Forest Hills and Lenox Hill EDs, and community providers and Health Homes is implemented through:

   • Appointment scheduling module for providers entered via the EPIC and Health Connect systems. Health Connect software provides a portal for Northwell-affiliated providers to receive referral notifications and other clinical information from Northwell Emergency Departments.

   • Health Connect, Continuity of Care Documentation (CCD) is automatically generated through the internal EHR and sent to providers in a secure manner for all employed and affiliated/connected providers.

   • Connectivity with other ACP network providers will occur via HEALTHIX and via ACP's care coordination system, if appropriate.

▶ Ensure real-time notification to a Health Home (HH) care manager as applicable:

   » ACP will review patients recently discharged from the ED and ensure that patients who meet HH criteria are connected with, or evaluated for inclusion in, Health Homes. Community Health Workers (CHWs) will be deployed for community outreach for hard-to-contact patients and those who have identified barriers to accessing the PCPs to whom they are referred.

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ACP
ADVOCATE COMMUNITY PROVIDERS

» If necessary, ACP will assist in transferring information and connecting the patient to the appropriate care manager to ensure continuity of care.

▸ For patients presenting with minor illnesses who do not have a PCP:

» After a required medical screening examination has been completed to validate a non-emergent situation, patient navigators employed by the emergency departments (Patient Navigators) will assist patients in selecting an appropriate PCP, helping them to receive a timely appointment within three to 10 days, and providing needed health literacy information. Please see Proposed ED Workflow for additional details.

▸ For patients presenting with minor illnesses who have a PCP:

» After a required medical screening examination has been completed to validate a non-emergent situation, patient navigators will refer the patient back to the PCP and alert the ACP care coordination department to ensure the follow-up visit occurs with three to 10 days.

▸ ACP will educate and support patients in the following ways:

» ACP staff is trained in cultural competency and in the processes to support an integrated model of care. These ACP staff members will investigate patients' social determinants of health and, where appropriate, connect patients with community-based organizations and other supportive services to address psychosocial, financial, housing, nutritional, and other factors contributing to preventable ED visits.

» ACP has developed culturally appropriate health education materials about the appropriate use of the ED and alternatives in the community for non-urgent needs. Partner emergency departments and ACP workers provide patients leaving the ED and in the community with these materials. In addition, ACP, in collaboration with community-based organizations, will host health literacy events in the community to educate patients. These events will teach patients how and where to access health care services, including the role of the primary care provider, urgent care and the emergency room, the importance of integrated care and a strong PCP relationship. All education will be provided in literacy levels and language appropriate to the community.

TARGET POPULATION

▸ All patients with Medicaid Payor (FFS / HMO / Duals) presenting to a participating Emergency Department.

▸ Within that population, intervention will be focused on:

» High utilizers of ED services (defined as four or more visits to the emergency department for non-urgent conditions within the last 12 months);

» Patients with chronic conditions such as cardio-vascular disease, asthma, and diabetes that can be managed in an office setting;

» Patients with minor acute conditions that can be managed at home or in an office setting;

» Patients whose repeated ED use stems from social determinants of health (e.g., unstable housing, lack of access to care, food insecurity), who will be connected with appropriate community-based organizations.

PROPOSED ED WORKFLOW

1) All patients with a Medicaid payor (FFS/HMO/Duals) presenting to the emergency departments at JMHC and FHMC will be identified at Registration.

2) The ED Physician determines the patient discharge disposition and the potentially avoidable use of the ED for each incident. After required medical screening examination has been completed to validate a non-emergent need and required medical care provided, eligible patients presenting with non-urgent/non-emergent care needs will be immediately fast-tracked and sent to the ED Patient Navigator's digital "Basket Alert." A non-urgent need is defined for the purposes of this implementation as a patient who does not require treatment within the next 24-48 hours.

3) The Patient Navigator receives pertinent patient information, interviews the patient, and completes one or more of the following, as appropriate:

» Identifies patients currently in, or potentially eligible for, a Health Home (HH) or Health Home at Risk program (HHaR) and connects an appropriate ACP affiliated resource.

» For patients presenting with minor illnesses who do not have a PCP, the Patient Navigator will guide patients to select an ACP PCP with open access scheduling. For those with a PCP, the patient will be referred back to the PCP and the ACP care coordinator/CHW will be informed to allow for follow-up with the patient, and to assure a timely appointment is completed. If the patient cannot be contacted by phone, a CHW will be sent to the patient's home to make sure a PCP follow-up appointment is made and kept within three to 10 days.

» Patient Navigators will help patients receive a timely appointment within three to 10 days for treatment and ongoing management. All efforts will be made to schedule patients with their PCP as soon as possible, and patients will be encouraged to receive follow-up care. As ACP continues to evolve its Integrated Delivery System, achieving more immediate appointments (same day/next business day) is a defined goal.

» Patients with additional identified needs/risks (e.g., super-utilizers, patients with behavioral health/substance abuse diagnoses, patients with chronic conditions) will receive appropriate referrals to consulting services in the ED, including but not limited to:

  • Specialty consult, including behavioral health/substance abuse.

  • Social work, including referral to housing, nutrition, transportation, financial, and other resources.

» For those patients who, after medical screening, do not require emergency treatment, but who need an appointment within two days, ACP's partner, Rapid Care Solutions, will be contacted by the ED staff for home visit follow up.

4) All participating patients will leave the ED with a Discharge Summary (available in multiple languages), including information on medications, follow-up appointments, and disease-specific patient-education material that has been developed or adopted by ACP's health literacy team from professionally developed material. This document is automatically generated in the EMR, and is printed out and handed to the patient at discharge.

5) Continuity of Care Documentation (CCD) is automatically generated and sent to the patient's PCP.

6) ACP's care coordination system will additionally survey the remaining patients to identify appropriate Health Home patients and assist in connecting the patient with the care manager, transferring information, and ensuring continuity of care.

7) The program will be evaluated in terms of its success by meeting follow-up appointment attendance goals. Modifications will be made as needed following review by ACP's Care Management Committee.

8) ACP will explore telemedicine options for patients with equivocal symptoms so that they have an accessible source of reliable medical advice based on evidence-based protocols.

PATIENT NAVIGATOR
JOB DESCRIPTION

Position Title: ED Patient Navigator
Primary Duties:

▸ Provide excellent customer service in assisting patients in the ED to coordinate post-discharge care and planning;

▸ Schedule a timely follow-up PCP appointment prior to discharge and provide this appointment to the patient;

▸ For patients with no PCP, assist patient in selecting a Provider, taking into account patient preferences, including location, language, and gender, with an emphasis on connecting patients to PCMH providers;

▸ Verify patient information including PCP information;

▸ Enter follow-up appointment information into the medical record;

▸ Facilitate referrals to appropriate follow-up services such as behavioral health and substance abuse treatment and Health Home as indicated by the ED Provider;

▸ Confirm patient receipt of the After Visit Summary, including follow-up appointment information;

▸ Coach patients on the importance of maintaining follow-up appointments;

▸ Ensure communication with the patient and follow-up appointment by using appropriate IT systems, such as Cadence and EPIC CareLink, Health Connect and others.

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