Waiver Project

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Project Title	**ER is for Emergencies Best Practices 3.0: Linking to Community Care for Patients with Behavioral Health and Chronic Care Needs**

Rationale for the Project

Problem statement – why this project is needed. One in four adults in the United States suffers from a mental disorder in a given year; those with mental illness die earlier and cost $57.5 billion nationally. Many use expensive sites of care with about 12.5% of all ED visits due to behavioral health needs.[1] A large majority of the frequent ED users (with 5 or more visits a year) have a mental health or substance abuse disorder; the remaining frequent users have high complex chronic care needs.

There is a tremendous opportunity to deliver better care and save money by finding more appropriate preventive treatment for those with behavioral health and chronic care needs. These patients often end up in crisis in the emergency department and requiring expensive hospitalization. Our proposal takes the frequent ED users and links these patients with more appropriate resources in the community. We will work with them ***outside the ED*** to gain their trust and serve as a connector to integrated care and social supports available in the community. Our proposal provides a more efficient, high quality solution than the current fractured system with each managed care plan engaged in this work.

The Washington chapter of the American College of Emergency Physicians (WAACEP), the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), and the Health Care Authority have led the way in addressing chronic care integration already by reducing ER use through the ER is for Emergencies program in the emergency department. This proposal builds on this statewide success. We propose to take the work one step further by linking hard-to-reach populations with health care and social supports ***outside the hospital setting***. From our past work we know many of the high-using ER Medicaid clients have no other Medicaid outpatient claims – indicating they have no medical home or regular source for care and support. A trained community care coordinator (sometimes referred to as a community health worker) situated in the community and/or a local clinic and using referrals of clients from the ED could gain trust from these patients, help them find a usual source of care, and help them address the social issues often causing repeated ER visits.

Supporting research (evidence-based and promising practices) for the value of the proposed project.
There are a few other areas around the country pursuing similar initiatives. In Pennsylvania, a project linking patient navigators and persons with serious mental illness reported a 59% reduction in ED ***visits*** for individuals dually eligible for Medicare and Medicaid with the least serious acuity level and a 31% reduction in ED ***visits*** for individuals with the most serious acuity level. Maryland's Access Health demonstrated a 55% reduction in hospital ***admissions*** among high ED utilizers in 2014. Our own work in ER is for Emergencies achieved significant state savings reducing the visit rate for one sector of clients by 10.7% in the first year. This work also builds on recently funded CMMI initiatives. As CMS notes in describing these initiatives, telephonic care management alone, often the current practice, has had limited success because these individuals need more intensive in-person interventions.

Relationship to federal objectives for Medicaid with attention to how this project benefits Medicaid beneficiaries.
This project would have a significant benefit for Medicaid clients – moving them from a model of sporadic care to a place where their needs would be able to be addressed on a more systematic basis. It will test cost savings and a

[1] Source http://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf

shared savings approach to sustain this work. If successful, this program could represent a basis for an Alternative Payment Model (APM) for providers and a potential future for Account Care Organizations (ACOs). It will also demonstrate the usefulness of the Accountable Communities of Health in helping to identify local social support resources.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention? Check box(es)

☒ **Reduce avoidable use of intensive services**
☒ **Improve population health, focused on prevention**
☒ **Accelerate transition to value-based payment**
☒ **Ensure Medicaid per-capita growth is below national trends**

Which Transformation Project Domain(s) are involved? Check box(es)

☒ **Health Systems Capacity Building**
☒ **Care Delivery Redesign**
☒ **Population Health Improvement – prevention activities**

- *Region(s) and sub-population(s) impacted by the project.*
  The target population is Medicaid enrollees who are frequent users of the ER and whom have a behavioral health and/or chronic care need. There were 740,000 visits for Medicaid ED visits in 2014. With a conservative estimate of 20% of those visits from high frequency utilizers (86% of which have a mental health disorder based on the work of the ER is for Emergencies), there are roughly 150,000 visits and potentially 15,000 to 20,000 clients who would be the target for intervention.

- *Relationship to Washington's Medicaid Transformation goals.* This project will reduce avoidable use of intensive services and help ensure Medicaid cost-per-capita growth remains below national trends.

- *Project goals, interventions and outcomes including relationship to improving health equity.*
  We aim to achieve at least a 20% reduction in ER visits from this targeted population in a shared savings model that can be sustained after the waiver. We also anticipate savings from a reduction in admissions.

  The goal will be accomplished through improving the care delivery system by better care coordination. All patients that are the target of this intervention will be enrolled with a community care coordinator and will have care tracked in real time through a management system that integrates with the existing Emergency Department Information Exchange program – a system that shares care plans among providers and provides real time notification to the care manager and primary care provider of a high utilizer patient's arrival in the emergency department for an unscheduled visit.

  Disparities and health equity will be addressed, since there are clear data showing non-whites are less likely to have access to and receive needed mental health care.[2] African-American and Hispanic people in particular often do not get the treatment they need.

- *Links to complementary transformation initiatives.* This work builds on recent CMMI initiatives such as a project funded through Rutgers where teams identify high utilizers and assist patients by addressing social service needs and a project in Camden, New Jersey where community health workers supported by a nurse-led interdisciplinary team work to improve access to care.

- *Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants)*

[2] (Centers for Disease Control and Prevention, *Racial And Ethnic Disparities in Men's Use of Mental Health Treatments,* http://www.cdc.gov/nchs/data/databriefs/db206.htm#ref1)

needed to be engaged to achieve the results of the proposed project.
This program will be administered by the triad that has been the organizing force for the ER is for Emergencies program in Washington for the past five years-- WAACEP, WSHA, and WSMA. We will also seek the input and participation of HCA, the ACHs, the Washington Council for Behavioral Health, and Medicaid health plans.

Core Investment Components

Describe proposed activities and cost estimates ("order of magnitude") for the project.

1. ***Establishment of a leadership council.*** The leadership council will be composed of representatives from WAACEP, WSHA, and WSMA. The council, with input from other key players, will be responsible for establishing program standards, authorizing local hospital partners for funding, and providing ongoing monitoring of performance. The council will hire a medical director, project leader, and administrative support to oversee the work. ***($1 million annually for staffing and organizational support)***
2. ***Hiring and deployment of community care coordinators***. A significant portion of the upfront funding ***($8 million annually)*** will go to hiring community workers, about 100 across the state. Unlike smaller scale individual hospital projects, a statewide program provides the opportunity to demonstrate and evaluate effectiveness as well as quickly spread promising approaches.
   All Washington hospitals working with their ED leaders will be provided resources to hire a community care coordinator or a portion of a community care coordinator or a team-based workforce. Allocations will be based on the hospital's number of ER users per month from the targeted group (Medicaid patients with frequent ED use). Larger hospitals with high numbers of users would have resources to support a full-time position, while smaller hospitals may only get a part-time position and may need to pool resources other entities. Hospitals and their ED leads would make proposals to the leadership council on the placement of these workers in their communities, either at large primary care centers or other community sites. Criteria for the proposals would emphasize the need to work cooperatively with other local hospitals and any existing effective structures already engaged in this work. Participating hospitals, in their administrative role, would be asked to agree to specific program conditions, which include providing access to information from the health record for these patients, assigning a designated project lead at the hospital, and agreeing to link the hospital discharge planner with a community care coordinator.
3. ***Training.*** Community care coordinators will be chosen for their skills in working with people. An important element of success will be to provide them with standardized training, with a specific focus on behavioral health as well as how to link to social service programs in the community. They will be trained on culturally appropriate practices and have access to interpreters. ***($500,000 annually)***
4. ***Linking with Community Providers***. The community workers need to know the providers and social services available to their patients in the community. Regional organizations such as the Accountable Communities of Health would play a convening role to create buy-in for this project from the local organizations. Identification of these resources is critical for implementation. The important relationships would include: community mental health, primary care, managed care plans, residential and housing providers, other social services, and crisis and other intervention resources. The regional organizations will be funded to convene the community care coordinators and the local community support groups on a quarterly basis. The regional organizations will receive a regularly updated data dashboard based on the work of the community care workers on barriers caused by resource shortages in the community, such as housing or Medicaid outpatient therapists. The regional organizations will be asked to address solutions. ***($ 1million annually)***
5. ***Support of community health workers***. Local support will be provided by their employers, the hospitals and the ED director will work directly with the workers. The workers would also be supported on a regional and/or statewide basis by a hub of professionals working under the medical director. The hub is an interdisciplinary team(s) that may include a therapist or psychiatrist, pharmacist, social worker, nurse, and a hospital emergency department based clinician. ***($750,000 annually)***
   Support would also come from a collaborative learning environment. The leadership council would convene the community health workers to meet on a regular basis to learn from each other and share best practices. Meetings would be monthly via phone call and in-person quarterly and would provide ongoing trainings from state and national leaders. The format would be the WSHA Safe Table program which brings participants in a

Coordinated Quality Improvement Program for a candid sharing of information and best practices. ***($250,000 annually)***

6. ***Data backbone***. An important component of the project is real-time data for tracking and strong data analytics with an ongoing needs assessment dashboard for the community. Patients would be enrolled in the project based on information from EDIE, the Emergency Department Information Exchange. Enrolled patients will be flagged as participants and this data set will be used to study the results of the intervention. The community health workers would also be able to leverage Link4Heatlh to determine if the client has a usual source of care. In addition, community health workers would each be required to log their contacts and complete a monthly report on metrics – clients served, time spent per client, barriers to linkage, and key resources for successful linkages. ***($500,000 annually for development of data reports, data analysis, and laptops/equipment)***
7. ***Addressing other ER user needs.*** The leadership council, working with other organizations, such as the Community Mental Health Council, will develop a model to provide immediate intervention for other ER users who are in danger of having repeat ER visits, such as those with a psychotic episode in the ER, but not in need of admission and no clear link to outpatient treatment.
8. ***Development of a shared savings model***. The intent of the project is to be sustainable via development of a shared savings model, with savings after program expenses shared between the state/managed care plans and the local participating hospitals and ED physicians and other local partners as directed by the leadership council.

Annual Budget: Total cost of the project is roughly ***$12 million per year.***

How long it will take to fully implement the project within a region where you expect it will have to be phased in. If approval of the projects were achieved in July 2016, the leadership council would meet to establish the standards, application process for local participation, and other required processes for deployment by September 2016 with a go-live date by initially interested local partners by January 1, 2017. The triad would also begin discussions with the state and the managed care plans on an evaluation mechanism and a shared savings approach to be launched at the same time as the program.

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline. The program has a conservative goal of reducing use by 20%. With 150,000 targeted ER visits, this is a reduction of 30,000 visits annually. At an estimated program cost of $1,500 per visit, this results in savings of $45 million per year prior to program costs (of $12 million). The shared savings would be returned to the state/health plans and the program participants as an incentive for strong participation in the success of the program and establishment of key linkages with the community outside the hospital setting.

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Wherever possible describe key process and outcome measures.

Year one key process metrics include establishment of the leadership council, hiring the administrative support structure, and development of the training and data backbone. The process metrics include having the community care workers on-the-ground: receipt and approval of proposals from participating hospitals/ED leads; hiring and training of the community care coordinators; development of periodic data reports; linkages and agreement on structure with regional (ACH) organizations. They also include agreement with the state on metrics and a shared savings approach. Initiation of tracking and reduction of ED visits with a target of more than 20% to achieve the goal savings for the shared savings program. Year two key process and outcomes metrics include regular Safe Table meetings, hospital designated lead and community care coordinator participation in ACH or regional quarterly meetings, and reduction of ER visits by the identified group by the end of the year.

What efforts will be undertaken to establish benchmark performance ahead of implementation**?**

The leadership council outlined in the project would provide oversight and development of key benchmarks. Benchmarks will include increased visits in the target population to non-ER providers and decrease of ER use rates and hospitalization among the target group.