Community Partnership for ED Express Care and Case Management
NEW JERSEY MODEL TOOLKIT

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PREFACE

The Health Research and Educational Trust of New Jersey, a nonprofit affiliate of the New Jersey Hospital Association (NJHA/HRET), is pleased to offer this toolkit for implementing New Jersey's model for alternate non-emergency healthcare services, the *Community Partnership for ED Express Care and Case Management*. This toolkit is intended to help hospitals and local primary care practices, particularly federally qualified health centers (FQHC), collaborate to address the issue of patients who present with primary care needs in hospital emergency departments (ED) by facilitating the use of alternate non-emergency healthcare services.

As the use of hospital EDs grows across New Jersey, the problem of individuals using the ED for non-emergency care become more pronounced. In New Jersey alone, ED use has increased 27 percent between 2000 and 2010. Approximately 30 percent of ED use is for non-emergency primary care conditions that could be treated more appropriately – and more affordably – in a doctor's office or clinic. And more than $400 million a year is spent on avoidable ED visits, according to the National Association of Community Health Centers.

Community Partnership for ED Express Care and Case Management, a 30-month demonstration project led by the state Department of Human Services, NJHA/HRET and the New Jersey Primary Care Association, took a microscope to the issue of non-emergency cases turning up in the state's EDs. Supported by a $4.8 million grant from the Centers for Medicare and Medicaid Services, the project closely followed utilization of two hospital EDs that tested interventions to help patients receive primary care services in a more appropriate and less expensive setting.

This toolkit includes information and lessons learned from the demonstration project, a description of the intervention model and its components, step-by-step instructions for implementing the model, as well as samples of the tools and resources that were integral to the success of the project.

We hope this toolkit will provide hospitals, community health centers and HMOs throughout New Jersey with the tools they need to initiate changes for more efficient delivery systems and to educate consumers on the importance of preventive care, a medical home and appropriate use of the healthcare system.

For further information, please contact Dr. Firoozeh Vali, HRET's vice president of research, at 609-275-4145.

Elizabeth A. Ryan, Esq.
President and Chief Executive Officer
New Jersey Hospital Association

INTRODUCTION

This toolkit was designed first as an Operations Manual for the Community Partnership for ED Express Care and Case Management project, with funding from the Centers for Medicare and Medicaid Services. It was developed by the New Jersey Hospital Association's Health Research and Educational Trust, along with the New Jersey Department of Human Services, Division of Medical Assistance and Health Services and the New Jersey Primary Care Association.

New Jersey's ED Express Care and Case Management model was designed to address growing concerns over the inefficient use of hospital EDs for non-emergency care. The model described in this toolkit uses an "express care process," in which patients who come to the ED with a non-emergency situation are assessed by a clinician and provided the appropriate services. The ED staff then take extra steps to refer the patient for a follow-up visit with his/her primary care provider, or if the patient has no regular physician, immediately schedule an appointment at the partnering FQHC, supported by mutual electronic systems that could schedule appointments and coordinate care. Correspondingly, these health centers increase capacity and enhance their medical home features to meet the needs of an increased patient population.

In addition, case managers stationed at both the hospital EDs and health centers coordinate services, assist with referrals for specialty care and arrange transportation and support services as needed. Staff at both sites educate patients on the appropriate site of care for various healthcare needs and the importance of having a "medical home" for primary care needs. The sites also track patient data to identify repeat ED users and measure compliance with follow-up care.

The Community Partnership for ED Express Care and Case Management project, implemented from September 2008 through April 2011, pilot tested this model in two sites. Newark Beth Israel Medical Center and Monmouth Medical Center served as the pilot sites, in tandem with their respective local health centers, the Newark Community Health Center and the Monmouth Family Health Center.

This demonstration project and its interventions yielded progress toward the goals of promoting medical homes and appropriate sites of care and in reducing the use of hospital EDs for non-emergency conditions. Specific findings provided the following information on the non-emergency users of hospital EDs:

- The two pilot EDs documented more than 10,000 visits for situations that were not emergencies, out of approximately 52,000 total nonurgent visits, over a two-year period. All told, the two EDs cared for roughly 195,000 ED cases in that period.
- The peak day for primary care visits was Monday, and the peak times for such visits were 10 a.m. to 1 p.m. That information runs counter to the prevailing belief that most non-emergency cases come to the ED during hours that the federally qualified health centers were closed.
- Fifty-six percent of the non-emergency patients coming to the ED were uninsured, 24 percent were covered by Medicaid or NJ FamilyCare HMOs and nine percent were covered under the state's charity care program.

- Insurance status predicted the frequency of repeat ED use, with 54 percent of those returning for four or more visits covered by Medicaid or NJ FamilyCare HMOs, compared with 19 percent uninsured.

- Non-emergency patients gave the following survey responses for the reasons they used the ED: 21 percent felt they needed emergency care, 20 percent said their doctor's office was not open and 12 percent said their doctor was not available that day.

- Of the patients referred to the partner health centers, 45 percent showed up for their appointments.

The final evaluation also revealed the following results from the demonstration project's interventions:

- At the project's conclusion, ED visits for primary care needs had declined 22 percent at a time when overall ED visits increased by about one percent. Inappropriate utilization decreased 47 percent among Medicaid patients in particular.

- There was a 19 percent increase in patient volume at the community health centers, including a 30 percent increase for Medicaid patients.

- The partner health centers increased capacity through a 28 percent increase in the number of physicians, 73 percent increase in nurses and 270 percent increase in additional staff. This allowed the health centers to add appointment slots.

- Reduced ED utilization for primary care needs helped improve patient flow throughout the ED, cutting patient turnaround time by an average of 15 percent.

Key conclusions from the initiative include: the capacity and accessibility of the state's current primary care system, particularly for Medicaid populations, are insufficient; primary care solutions are needed especially for behavioral health and mental health patients; and relationships among healthcare providers are key to improving care coordination and patient education.

Hospitals and local primary care practices wishing to partner together to address the issue of ED utilization for primary care needs are encouraged to use this toolkit as a guideline. It includes detailed information about the components of the program model; process changes, infrastructure and staff needed; establishing communications between sites and roles and responsibilities of each; step-by-step procedures for implementing the model; recommendations for data collection and tracking and other tips and helpful resources. Also included are samples of the tools used to collect data and information on ED utilization, barriers and needs of patients and patient and provider satisfaction.

Firoozeh M. Vali, PhD   Jennifer Barrett Sryfi, MHA
Vice President, Research   Director, Community Programs

SECTION I: BACKGROUND

A. The Problem of ED Utilization for Primary Care Services

The use of the hospital emergency departments (EDs) has increased over the years, both nationally and in New Jersey. According to the National Hospital Ambulatory Medical Care Survey, the number of ED visits nationwide rose to 116.8 million in 2007, up from 94.9 million in 1997, a 23 percent increase at a time when the total U.S. population grew by only 12 percent (Niska, Bhuiya, and Xu, 2010; McCaig and Ly, 2002). In addition, hospital EDs have been increasingly used as a safety net not only for the poor and the uninsured, but also for the underserved, including those with Medicaid who lack adequate access to appropriate primary care resources. In interviews conducted by the Kaiser Commission on Medicaid and the Uninsured, ED physicians noted that doctors' offices in their communities had directed patients who were uninsured or covered by Medicaid, or had insurance benefits that ran out, to the ED for needed care (Paradise and Dark, 2009).

The urgency of this issue has continued to grow at a faster pace during recent years. In a new study by the Kaiser Commission on Medicaid and the Uninsured, nearly every participating ED reported a rise in volume of ED use, much of which is attributed to a new "recession" population – those who are losing jobs and the healthcare coverage that went with them and resort to hospitals as their regular source of care (Paradise and Dark, 2009; Collins et al., 2011).

High ED utilization is evident especially among Medicaid beneficiaries, whom many studies have shown to have a higher ED visit rate than the uninsured or general population. According to the National Hospital Ambulatory Medical Care Survey, the national ED visit rate in 2007 was 45 visits per 100 persons with Medicaid, compared to only 39.4 visits per 100 persons in the general population (Niska, Bhuiya, and Xu, 2010). When looking at multiple ED visits, approximately 15 percent of Medicaid beneficiaries under age 65 had two or more ED visits in a 12-month period, compared to seven percent of the uninsured and five percent of the privately insured. In 2007, the percentage of Medicaid beneficiaries under age 65 who had four or more ED visits in a 12-month period was significantly higher than among those with a similar number of ED visits who were uninsured or had private insurance (5 percent vs. 2 percent and 1 percent, respectively) (Garcia, Bernstein, and Bush, 2010).

The uninsured also are represented among hospital ED visits at rates greater than their relative population, even though those who are uninsured tend to delay seeking any treatment for a condition until it has progressed to a level that needs emergency care and hospital admission. A review of data from Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project found that the rate of ED visits per 1,000 persons was higher among the uninsured (452.1) than the insured, (367.0) in 2006 (Owens and Mutter, 2009).

Of even greater concern is the fact that much of this high utilization is for conditions that would be more appropriately cared for in a primary care setting. The National Association of Community Health Centers (NACHC) reports that about one third of these visits each year are

for non-emergent primary care conditions that can be treated in a more suitable primary care setting (NACHC, 2006a). This inappropriate use is a particular issue with Medicaid and uninsured patients. Of all the ED visits made by Medicaid patients, the visits triaged as "semi-urgent" (level 4) or "non-urgent" (level 5) totaled 31 percent, and for the uninsured this figure was 32.7 percent, which were significantly higher than the 19.7 percent for Medicare patients and 27.7 percent for those covered by private insurance (Niska, Bhuiya, and Xu, 2010). Also, relative to the population distribution in the U.S., Medicaid was billed for more treat-and-release ED visits, which are mostly for non-urgent primary care conditions (Owens and Mutter, 2009).
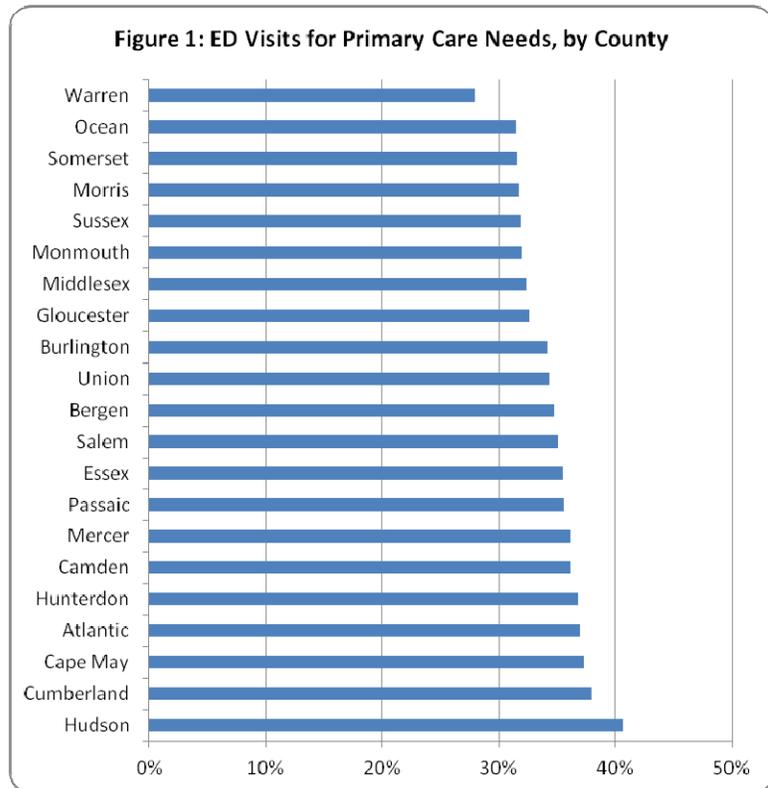
The causes of this issue are multifaceted and related to patients, providers and systemic factors. They include reasons such as patients not being able to determine whether they have a true emergency or have access to more appropriate sites of care in a timely manner; private physicians charging prohibitive up-front fees; and the overall design of our healthcare system, which lacks sufficient primary care capacity and makes it difficult to link patients to specialists or manage chronic conditions (Paradise and Dark, 2009; ACEP, 2011; Kaiser, 2011). Given these barriers, it is easier for some patients to be seen at the ED rather than in an appropriate primary care setting.

The inefficient use of limited and expensive healthcare resources, such as use of hospital EDs for primary care services, creates a significant burden on the healthcare delivery system. An estimated $18 billion is spent on non-urgent or primary care treatable hospital ED visits nationwide each year (NACHC, 2006b), of which $14 billion is spent directly on ED visits for non-urgent care (PricewaterhouseCoopers, 2010). That care, if provided in an appropriate primary care setting, could cost significantly less.

The rising trend of overall ED utilization also has implications for hospital surge capacity, which concerns many in the healthcare industry. When Medicaid beneficiaries and other patients use the hospital ED for primary care services, it contributes to overcrowding and ambulance diversion. This is compounded by the fact that during the 10-year period between 1993 and 2003, while the number of ED visits rose by 26 percent, the number of hospital EDs fell by 425 nationwide (Warden et al., 2006). In non-rural areas, in particular, from 1990 to 2009, an average of 89 hospitals with EDs (27 percent) closed each year with safety net hospitals at greater risk of closure (Hsia et al., 2011). This resulted in serious overcrowding, "boarding" and ambulance diversions and makes it difficult for hospital EDs to realize their most important and fundamental purpose – to treat seriously ill and injured patients.

New Jersey's situation greatly mirrors the national trends with ED utilization on the rise and higher ED visits by Medicaid beneficiaries. The total number of ED visits in New Jersey increased from 2,542,445 in 2006 to 3,233,719 in 2010 – a 27 percent jump in just four years. The state's ED visit rate in 2009 was 43 ED visits per 100 persons with Medicaid, compared to 39 visits per 100 persons among all residents (HRET, 2011). About 16 percent of all visits to hospital EDs in a typical year were for primary care conditions (HRET, 2011). Figure 1 on page 3 shows the percent of ED visits that were for primary care needs, by county, in 2010. Much like the national level, Medicaid patients in New Jersey also are more likely to use the hospital ED as their first source for primary care services than patients who are uninsured or have another

source of payment. In total, almost 22 percent of ED visits by Medicaid beneficiaries were for primary care diagnosis codes (HRET, 2011). There were, on average, nine visits to the ED for primary care services per 100 persons with Medicaid in New Jersey in 2009, compared to the state's total population, which had about six visits per 100 persons (HRET, 2011). In some counties, the average number of ED visits for primary care services per 100 persons with Medicaid more than doubled the statewide Medicaid rate and was about four times higher than the rate for the general population statewide. The 2009 New Jersey Family Health Survey findings confirm that Medicaid/NJ FamilyCare patients were at least three times more likely to have

Figure 1: ED Visits for Primary Care Needs, by County

Source: New Jersey Discharge Data Collection System, Uniform Billing Data, 2010

three or more ED visits in a year than patients with any other type of coverage (DeLia and Nova, 2011).

These figures do not even account for hospital admissions through EDs for conditions and medical episodes that could have been avoided through consistent access to primary care services, which amounted to 31 percent of all New Jersey hospital admissions through the ED in 2005 (Delia, 2007). Often patients who do not have routine access to healthcare services use the ED as the site of last resort for their healthcare needs. Avoidable ED utilization also includes care that is futile when provided in the ED, such as treatment for chronic conditions, dental pain, stress, behavioral health needs and psychosocial issues (Patton, 2010). This inappropriate use not only has a serious negative impact on efficient ED care, it also implies inefficient delivery of primary care services and ineffective care and management of chronic diseases. Cost implications also are significant in New Jersey, with $438 million spent on avoidable hospital ED visits in a single year (NACHC, 2006b).

The primary care system in New Jersey is currently not well-equipped to effectively provide care to patients when and where they need it. In recent years, numerous access barriers have been identified impeding use of appropriate community primary care settings (Vali, 2001), including:

- Hassles with the healthcare delivery system – e.g., lack of physicians accepting Medicaid, patients waiting months to schedule appointments and waiting for hours in the office.

- Prevention is not a priority – many low-income people do not seek medical care until a crisis emerges, and then only seek care in the ED.

- Inconvenient physicians' hours and locations – typically limited to weekdays.

- Language barriers – interpreters may be more readily available in EDs.

- Transportation barriers – assistance limited to rural settings, seniors and disabled.

- Childcare barriers – leading mothers to forgo their own care.

- Negative attitudes of healthcare providers – consumers are intimidated or "turned off" by physicians who lack cultural sensitivity and/or seem judgmental/uninterested.

Other notable issues include lack of information about availability of services in the community and insufficient or lack of programs for management of chronic conditions. In addition, numerous recent studies have demonstrated significant healthcare disparities in access to healthcare services for minority and underserved populations. This issue is especially magnified in New Jersey as it is one of the most racially and ethnically diverse states in the country. This diversity has major implications for the healthcare delivery system as it requires development of culturally appropriate services to meet the individual needs of all patients.

Several interventions have been introduced to address these issues. For example, the patient-centered medical home is one model for reducing avoidable hospital ED use for non-urgent needs. Many studies have found that the continuity of care received through a medical home provides the greatest benefits to patients in terms of primary and preventive care as well as chronic disease management. Some safety net hospitals have embraced the medical home model, implementing it within their affiliated clinics. A survey by the National Association of Public Hospitals and Health Systems of its member hospitals in 2009, revealed that 20 percent of the hospitals that had established medical homes had done so explicitly to address ED overcrowding and the inappropriate use of ED services for primary care (NAPH, 2010).

The benefits of consistent use of community clinics and health centers as a medical home for primary care needs by Medicaid patients are well documented. Medicaid patients who receive their needed care at community clinics and health centers are: less likely to seek care in the ED overall and for avoidable conditions and more likely to have lower hospital admission rates, lower lengths of hospital stays, less costly admissions and lower outpatient and other care costs (Falik et al., 2006; Falik et al., 2001). Such efficient utilization of services saves healthcare costs per Medicaid beneficiary by 30 to 33 percent (Duggar et al., 1994a; Duggar et al., 1994b).

Studies show mixed findings on the benefits of a regular source of care. Some, such as a 2007 Robert Graham Center and NACHC white paper using Medical Expenditure Panel Survey data, have found that Medicaid beneficiaries, as well as poor populations, who have a health center as their regular source of care were less likely to have any ED visits than patients of other providers. Others reported that those without a routine source of medical care were not more likely to have an ED visit or access the ED for non-urgent care than those with such sources (Garcia, Bernstein, and Bush, 2010). The 2009 New Jersey Family Health Survey also found that patients' pattern of ED use in New Jersey does not vary significantly by whether or not they had

access to a usual source of care (DeLia and Nova, 2011). These mixed findings demonstrate the need for additional work to untangle the complex interactions among the sociodemographic, health status and healthcare access factors that appear to be associated with ED visits. Connecting populations to patient-centered medical homes and other appropriate primary care sites and changing their help-seeking behavior is the key to changing the trends that are threatening the viability of hospital EDs.

Several initiatives on issues of ED overcrowding and throughput have been implemented across the country, including the Robert Wood Johnson Foundation's Urgent Matters program in 2003, where 10 hospitals received training and tools on critical concepts such as the input/throughput/output model of patient flow and ED crowding (Wilson and Nguyen, 2004). This study was repeated in 2006 in six hospitals and developed standard performance measurement for ED operations and services (Urgent Matters, 2011). Some hospitals have explored ways to identify high frequency users, regardless of reason for visit, and connect them to care management and social services through care transitions/coordination programs, that reduce their overall need to visit the ED, (Shah, 2010). Other hospitals have implemented express services that focus on those who present with primary care needs, such as Lutheran Medical Center's Triage Treat and Release system, which greatly reduced congestion and wait times in the ED. The goal of these interventions often is to determine the best ways to serve patients within the ED quickly, efficiently and at a high level of quality.

Interventions are needed to establish processes in hospitals that connect EDs and the community primary care providers and expand the capacity of the primary care system to ensure that patients have access to convenient, comprehensive, high quality care at the primary care sites, so they no longer feel the ED is the only site available to them. There also is a need to educate patients who use the ED for primary care needs about the best use of healthcare services and to connect them to the appropriate care and support services that will ensure their future use of appropriate sites of care. These are the major pillars that formed New Jersey's intervention model and demonstration project.

B. A National Approach to Addressing the Issue

Federal Legislation and CMS Initiative

Recognizing the need for alternative arrangements that ensure patients receive the care they need in a more efficient and cost-effective manner, the federal government authorized the Centers for Medicare and Medicaid Services (CMS) to provide two-year grants to multiple states' Medicaid programs for the establishment of alternate non-emergency services providers as part of the Deficit Reduction Act of 2005.

Specifically, according to CMS, "the term 'alternative non-emergency services provider' means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider – such as a physician's office, healthcare clinic, community health center, hospital outpatient department, or similar healthcare provider that:

- Can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition; and,

- Is participating in the program under this title." (CMS, 2007)

As part of this proposal solicitation, states were given the opportunity and encouraged to amend their state plans to allow hospitals to impose cost sharing on an individual who receives non-emergency care furnished in the hospital ED, following strict guidelines and exemptions laid out by CMS. It was noted, however, that nothing in the Deficit Reduction Act limits a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867 of the Emergency Medical Treatment and Active Labor Act (EMTALA), or modifies any obligations under either state or federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization. The New Jersey Legislature decided not to pursue cost sharing for ED visits by New Jersey Medicaid beneficiaries. Instead, New Jersey's Medicaid officials worked with statewide partners to design and propose a new model for providing and promoting alternate non-emergency services to these patients.

New Jersey's Innovative Model: Community Partnership for ED Express Care and Case Management

In response to the rising trend of costly and inefficient use of the ED for primary care needs that could be more appropriately handled in community primary care settings, CMS funded a project in New Jersey and 19 other states to provide and promote the use of alternative healthcare settings for individuals with non-emergent medical needs. New Jersey's Community Partnership for ED Express Care and Case Management project was initiated by the New Jersey Department of Health and Human Services, Division of Medical Assistance and Health Services (DMAHS),

in partnership with the New Jersey Hospital Association's Health Research and Educational Trust (NJHA/HRET) and the New Jersey Primary Care Association (NJPCA).

The partnership proposed to pilot-test a model for providing alternate non-emergency services to patients who present with primary care needs in hospital EDs, using an express care process, with connectivity to a community primary care provider, along with expanded capacity of that provider and its adoption of medical home domains. The plan also aimed at reducing future unnecessary visits to the ED by addressing well-documented barriers to accessing primary care services in communities – to be accomplished through provision of linguistically and culturally appropriate patient education, comprehensive case management, care coordination and other medical home/support services that encourage and maximize patients' future use of appropriate sites of care. The proposed plan was submitted to CMS and was approved for funding.

Goals and Objectives

The primary goal of this demonstration project, titled *Community Partnership for ED Express Care and Case Management*, was to promote the use of medical homes and appropriate sites of care, thereby reducing the growing utilization of hospital EDs by Medicaid beneficiaries for non-emergent, non-acute primary care services and preventing potentially avoidable hospitalizations through timely access to preventive and primary care services. The long-term goal was to significantly reduce or contain the cost of ED expenses for providing primary care services to Medicaid patients and reduce the overall cost of care for the Medicaid program by shifting the site of primary care services to community health centers/practices. This CMS-funded project was designed primarily to target Medicaid patients, but the ultimate goal was to provide care to all New Jersey residents at the most appropriate, efficient and cost-effective site.

Specific objectives of the project included:

- Forming a partnership between hospital EDs and community primary care providers.
- Establishing express primary care services in hospital EDs.
- Increasing community healthcare system capacity to accommodate the primary care needs of patients identified in the ED.
- Applying available technology to facilitate linkages between care sites (EDs, FQHCs, community providers).
- Identifying and remove patient barriers to efficient use of the healthcare system.
- Identifying provider and systemic barriers to the efficient use of the healthcare system.
- Providing education on the appropriate use of the ED and the importance of a medical home.
- Facilitating timely access to a community primary care provider and comprehensive primary care services.
- Evaluating the outcomes and impacts of the pilot program.
- Publicizing the program findings and promote its replication in other sites or statewide.

Implementation and Pilot Testing

Implemented from September 2008 through April 2011, this demonstration project pilot tested a model for providing alternate non-emergency services to patients who presented with primary care needs in EDs. The model uses an express care process, with electronic connectivity to a community primary care provider, along with expanded capacity of that provider and its adoption of medical home domains. The plan also aimed at reducing future unnecessary visits to the ED by addressing well-documented barriers to accessing primary care services in communities – accomplished through provision of linguistically and culturally appropriate patient education, comprehensive case management, care coordination and other medical home/support services that encourage and maximize patients' future use of appropriate sites of care. This pilot program primarily targeted Medicaid patients, but its ultimate goal was to provide care to all New Jersey residents at the most appropriate, efficient and cost-effective sites.

The program was piloted at two sites through a close working partnership of a hospital and a federally qualified health center (FQHC) in each site, active involvement and support of Medicaid HMOs and engagement of other community primary care providers. The pilot teams, selected through a state RFP process, were: Monmouth Medical Center with Monmouth Family Health Center, which served a moderately urbanized area surrounded by suburbs and shore towns; and Newark Beth Israel Medical Center with Newark Community Health Center, which served a heavily urbanized and medically underserved area with a very diverse population, high uninsured rate and a dearth of providers. The sites were chosen based on location in a county with high rate of ED use by Medicaid beneficiaries and others (for primary care services and in general) and select socio-demographic characteristics, as well as the merits of their proposed plans.

Lessons Learned

Despite some variations across pilot sites, overall, this program resulted in some very positive changes toward the goals of promoting the use of medical homes and appropriate sites of care, reducing utilization of hospital EDs for non-emergent, non-acute primary care services and containing the cost of ED expenses for providing primary care services.

Lessons learned over the course of the model implementation included the following:

- The capacity of the primary care system in its current form is insufficient to meet the needs of all patients, including care for populations with chronic diseases and special healthcare needs. Vulnerable populations especially need integrated and well coordinated primary care services offered in a medical home.

- Improved access to primary care does not necessarily resolve issues of access to specialists. Primary care solutions for behavioral and mental health needs must be improved, as well as access to pain management, women's health services and care for other unique needs of the population.

- Some patients are heavy users of all sites of care. Education provided to these patients must be tailored to address the reasons they visit the ED despite having an active relationship with their community primary care providers.

- Transportation does not play a major role in patient help-seeking behavior, as originally thought.

- Poverty does play a major role in patient help-seeking behavior. Poor and low-income patients are more inclined to go to EDs, where care is effectively "free," rather than pay the nominal sliding-scale fees to be seen at the FQHCs.

- Differences in populations, geographic areas and organizational set-up and culture impact the model's performance and outcomes. These unique features and characteristics imply different barriers/needs, utilization patterns and methods for behavioral change that influence different outcomes for different populations.

- The goal of reducing inappropriate use may at times conflict with hospital expansion and marketing strategies.

- Relationships among healthcare partners are key, as communication and connectivity across sites allows for efficiencies and needed data sharing. In addition to hospital EDs and FQHCs or other primary care providers, managed care organizations need to be brought on board at an early stage and connected to patients during the time of visit.

- New Jersey's strict interpretation and enforcement of the federal EMTALA regulation makes it difficult to align financial incentives and disincentives with the most efficient use of the healthcare system and counter the image of the ED among poor and low-income patients as a source of "free" one-stop comprehensive care. ED clinicians tend to order more tests and provide more complete treatment, without ever asking for upfront payment, to ensure that they are in compliance with New Jersey's regulations. This environment makes it difficult to promote true diversion. Although the model was successful in its focus on patient education and encouragement for future use of appropriate sites of care, even more might have been accomplished if the EDs were able to divert patients immediately to the nearby FQHCs or other primary care clinics/practices and/or charge a fee for completion of primary care services.

Recommendations

The findings of this initiative significantly added to the body of knowledge on healthcare access issues in New Jersey and highlighted best practices that could be employed in other areas with severe/chronic access problems. They also promoted more opportunities for collaboration among the state Medicaid program, HMOs, hospitals and community health centers clinics to initiate changes for more efficient delivery systems and educate consumers on the importance of preventive care, a medical home and appropriate use of the healthcare system.

Based on the findings, the following are recommendations for future implementation of this model:

- A statewide campaign should be conducted to educate the general public about the importance of using EDs for true emergencies. As part of this education, hospitals should be advised to target their own ED promotion messages to ensure that patients know to use their services appropriately.

- Patient education messages should be crafted clearly to avoid confusion and direct patients on how to seek care at appropriate sites.

- Education provided to patients who are heavy users of all sites of care needs to be tailored to address the reasons they visit the ED despite having an active relationship with their community primary care providers (FQHCs, etc.). They can be educated about the importance of utilizing their primary care provider as their medical home.

- FQHCs should promote their services competitively, using business models, and more actively market the availability and quality of their services for all populations.

- Medicaid HMOs should increase their involvement and the network of primary care providers.

- Since contact with the HMOs is best initiated from a hospital or a provider's office at the time of the visit, HMOs also should use the opportunity to improve easy access and communications by updating their contact information, including e-mail addresses, which are less likely to change than phone numbers.

- Medical home features should be incorporated in primary care practices and should be designed to tailor their services to account for unique demographic characteristics and needs of populations served, as well as the individual needs of patients.

- Connectivity between the EDs and community primary care providers (FQHCs, etc.) is essential to this effort. These sites should have the infrastructure and access to support appointment setting, information sharing and identification of high utilizers to target with intensive outreach.

- Access to community-based primary care for mental/behavioral healthcare and substance abuse needs must be expanded to properly serve patients' needs and keep their issues from getting exacerbated, resulting in ED visits.

- Similarly, access to specialists, pain management, women's health services and care for other needs also must be improved within the primary care system/sites so that more patients can be served effectively in the community setting.

- Incentives must be modified to ensure that the out-of-pocket cost of care and perception of quality at the EDs and the FQHCs are aligned. Policy changes are needed to create economic incentives for Medicaid patients to use primary care sites (e.g., FQHCs) when appropriate.

- A thorough review and clarification/adjustment of current policies, such as EMTALA and New Jersey regulations, as well as new policies are needed to ensure the goals of the model are supported. These policies and regulations must be as clear as possible to avoid confusion. Reduced ambiguity leaves less room for interpretation for protection of patients or providers.

- Community-based systems of primary and specialty care must be redesigned with increased capacity and efficiency, not only to handle a large-scale influx of patients diverted from EDs, but also to absorb newly-insured individuals in the wake of full implementation of healthcare reform.

SECTION II: PROGRAM IMPLEMENTATION

C. PROGRAM SET-UP

Infrastructure

This model is designed not simply to introduce a series of new activities, but rather a significant reorganization of the processes for providing services and education to patients who have been using the ED for primary care services. **Each program partner – with the full cooperation of the organization's leadership, administrators, clinicians and lead staff – will need to make substantive process changes in order to implement all components of this model consistently and to gain successful outcomes.**

<u>IT and Space / Resources Needed</u>

Program partners at each site – hospital ED and FQHC – will need to work closely on implementing or upgrading their IT systems to include the following features:

- Web-based access from hospital ED into the FQHC appointment-making system to set follow-up appointments for identified patients;

- Compatibility and capacity to send patient information from hospital ED to FQHC to be included in patient chart for follow-up visit; and,

- Capacity to store and retrieve information about patients in the program to demonstrate outcomes of the model.

Program partners should decide how best to ensure the compatibility and access needed to achieve these requirements.

In addition, each hospital ED should provide a dedicated area apart from other ED services for APN and case managers/social workers to meet and talk with patients as part of ED Express Care services. Each FQHC should ensure that there is enough physical space for new program staff to increase the clinic's capacity to accommodate program activities. Both hospital EDs and FQHCs must provide program staff with the tools and resources needed to conduct program activities, including: access to workspace; computer(s) with internet connection and appropriate office software; printer, copier and telephone; and related technical and administrative support services.

<u>Required Administrative and Process Changes: Hospital ED</u>

Participating hospital EDs will need to make the following changes:

- **Staffing.** Assign/hire and train appropriate staff for the program. Roles and responsibilities for these staff, as pertains to this program, are described in Table 1 on page 16. Specifically, provide the following staff for implementation of the program:

    □ APNs – to provide ED Express Care coverage during peak hours (typically a 12-hour period), at least three APNs will be needed;

- □ Additional ED clinicians (physicians, PAs and APNs) – to provide ED Express Care services during off-peak hours and additional support during peak hours;

- □ Case manager and/or social worker – at least one FTE case manager should be available, covering regular business hours or afternoon-to-evening hours, for case management, coordination and outreach activities; and,

- □ Medical records, data processing and/or other support staff – as needed, depending on plans for patient outcomes data tracking.

- ▪ **Triage.** Make necessary adjustments to the triage throughput process to be compatible with this model so patients who are triaged and determined to be presenting with non-emergency primary care needs are identified and immediately assigned to express care services.

- ▪ **Express care.** Express care providers (APNs or other licensed practitioners) are to see identified patients in the designated ED Express Care area immediately after the triage process, provide all the care needed and any necessary prescriptions.

- ▪ **Discharge.** Plan extra time for the APN or other ED clinician to conduct additional discharge planning activities and associated paperwork involved in this model, including:

  - □ Setting up the primary care follow-up visit via the Web-based connection;

  - □ Educating patients on the importance of a medical home and the appropriate use of various sites of healthcare services;

  - □ Distributing educational materials in the appropriate language;

  - □ Discussing and recording patients' reasons for seeking ED care and their barriers and needs; and,

  - □ Linking patients to available support services.

- ▪ **Patient information.** Establish communication channels and a mechanism for sharing information about identified patients with case managers at the partner FQHC and designated contact persons at the Medicaid HMOs, as appropriate.

- ▪ **Data Tracking.** If the partnership decides to monitor program outcomes, hospital ED staff will need to enter information about ED Express Care patients into a database (sample provided in section F). Time allowances should be made for this additional task.

Required Administrative and Process Changes: FQHCs

Participating FQHCs will need to make the following changes:

- ▪ **Staffing.** Assign/hire and train appropriate staff for the program. Roles and responsibilities for these staff, as pertains to this program, are described in Table 2 on page 17. Specifically, FQHCs should provide the following staff for implementation of the program:

  - □ Physician – at least one additional physician to expand the hours of operation and volume of patient appointments or walk-ins;

- □ Nurses, medical assistants and/or other support staff, as needed;

- □ Case manager – at least one FTE case manager should be available, during regular business hours, for coordination and outreach activities; and,

- □ Medical records and/or data entry staff – as needed, depending on plans for patient outcomes data tracking.

- **Service expansion.** Expand clinic operations in order to quickly and conveniently accommodate ED patients' follow-up visits as well as the overall influx of new primary care patients, including:

  - □ An increase in clinical hours, particularly evenings and weekends;

  - □ An increase in clinical staff to open up more appointment times and walk-in capacity during all clinical hours;

  - □ Process improvements necessary to handle this growth (e.g., scheduling, patient flow, lab testing, links to specialists, etc.); and,

  - □ Enhanced transportation arrangements (e.g., expanding contracts with van and livery services or purchasing a van and hiring a driver) to ensure that program patients have transportation to the clinic for their follow-up and future visits.

- **Patient education.** Allow extra time during the initial ED follow-up visit for the case manager/social worker to conduct patient education and support activities, including:

  - □ Educating patients on the importance of a medical home and the appropriate use of various sites of healthcare services;

  - □ Distributing educational materials in the appropriate language; and,

  - □ Linking patients to available support services.

- **Patient information.** Establish communication channels and a mechanism for sharing information about identified patients with case managers at the partner hospital.

- **Data Tracking.** If the partnership is monitoring the outcomes data, FQHC staff will need to enter information about referred patients into a database (sample provided in section F). Time allowances should be made for this additional task.

Medicaid HMO Participation

Partner Medicaid HMOs will need to make the following administrative and process changes:

- Assign a program liaison to each program site to serve as the contact for all communications regarding this program and work closely with HMOs' case managers.

- Assign case manager(s) or patient liaison(s) to each program hospital ED (on-site or through a direct phone line) to facilitate their enrollees' access to primary care services via their PCPs; and remove the barriers to proper use of primary care services and work with the HMO's program liaison (above) to track patient data and services provided.

- Provide a designated phone line for program staff to directly connect to HMO's program liaison and case manager(s)/patient liaison(s).

Table 1: Hospital ED Program Team Members, Roles and Responsibilities

TEAM MEMBER	ROLES/RESPONSIBILITIES
Administrator	- Help oversee program activities - Ensure that required process changes are put in place
Chief Clinician (Physician)	- Help oversee program activities - Supervise services provided to patients
APN / Other ED Clinician (Physician, PA)	- Conduct triage or work closely with triage station - Provide primary care services to identified patients - Identify special healthcare needs and refer as appropriate - Set up primary care follow-up visits (via Web connection) - Educate patients on medical home and appropriate ED visits (distribute informational materials and resources) - Discuss patients' barriers and support/services needed - Provide Medicaid application info/assistance to uninsured - Link patients to transportation and other support services - Document patient visit in program tracking database - Communicate with case manager re: patient status and needs
Case Manager / Social Worker	- Speak with patients or contact patients at home to ensure that all needed arrangements are made for primary care follow-up (transportation, other services, Medicaid application, referrals, etc.) - Help patients find an acceptable permanent medical home - Communicate with FQHC case manager for following up on program patients and their compliance with appointments - Identify program patients who return to ED for primary care services - Coordinate with FQHC case manager and HMO contacts on outreach to no-shows and frequent ED users - Provide case management to frequent ED users - Maintain database for tracking program patients
Medical Records / Data Entry / Other Support Staff	- Assist team with patient case management - Enter, if needed, and maintain data for tracking program patients

Table 2: FQHC Program Team Members, Roles and Responsibilities

TEAM MEMBER	ROLES/RESPONSIBILITIES
Administrator	▪ Help oversee program activities ▪ Ensure that required process changes are put in place
Chief Clinician (Physician / Nurse)	▪ Help oversee program activities ▪ Supervise services provided to patients
Clinical Staff (Physicians, Nurses, Medical Assistants)	▪ Provide primary care services to an expanded patient population ▪ Review medical charts of referred patients to determine ED utilization patterns and special medical needs ▪ Screen for chronic diseases and mental health issues and offer/link patients to disease management programs, behavioral healthcare and other appropriate specialty care ▪ Offer medication management
Case Manager	▪ Review appointments made via connection and medical info received ▪ Contact patients at home for appointment reminders and to ensure that all needed arrangements are made for primary care follow-up ▪ Link patients to transportation and other support services needed ▪ Educate patients on medical home and appropriate ED visits (distribute info materials and resources) ▪ Coordinate lab tests, specialist visits and future follow-up visits ▪ Assist with referrals (healthcare program enrollment, etc.) ▪ Help patients access affordable medication ▪ Assist uninsured patients with completion of Medicaid enrollment process, if applicable ▪ Document patient visit in program-tracking database ▪ Follow up on no-shows ▪ Coordinate with hospital case manager re: patient status and on outreach to no-shows and frequent ED users ▪ Provide intensive case management to frequent ED users ▪ Maintain database for tracking program patients
Medical Records / Data Entry / Other Support Staff	▪ Assist team with patient care coordination and case management (referrals, follow-up on no-shows, etc.) ▪ Enter, if needed, and maintain data for tracking program patients

Program Partnership Coordination and Communication

As demonstrated by the program team member roles and responsibilities, successful implementation of this model relies heavily reliable communication between both the electronic systems and the program staff. Plans should be established for routine program staff meetings and reliable information-sharing mechanisms.

Each program partner should form an internal team of program staff. Each team should meet often (at least once per week), and the partner hospital and FQHC teams should meet together regularly (at least once per month), to provide updates on the program status, share ideas and tackle any issues that arise. More frequent meetings may be needed initially during the program set-up and the first six months of implementation. In addition, hospital and FQHC case managers should especially be in contact very frequently, if not on a daily basis. They will need to share information about new patients, follow up on appointments and utilization patterns and collaborate on targeted outreach and various monitoring activities.

Program partnerships should have a Memorandum of Agreement or Business Associate Agreement in place between the hospital and FQHC, and each organization's leadership should be in regular contact with its program staff as well as the leadership at the partner organization.

D. Program Model and Process Guidelines

Description of Program Model Components and Activities

In this model, all patients who present to the ED are triaged, per EMTALA requirements, and receive medical screening by an advanced practice nurse (APN). Patients who are identified as having low-acuity primary care needs are diverted to the ED express care process, where the APN provides primary care services and prescriptions as needed. As part of discharge planning for Medicaid and uninsured patients, the APN sets up the follow-up appointment with a primary care provider in the community, such as the participating FQHC, using a secure Web-based electronic information system. The FQHCs provide expanded service hours and appointment blocks, as well as active case management, patient transportation, if needed, and additional features that allow them to serve as patients' medical home. During ED discharge and FQHC follow-up visits, program staff educate identified patients on the appropriate site of care and the importance of using a medical home for primary care services and limiting ED visits to true emergencies. Medicaid HMO patients also are connected to their HMOs for further assistance, education and case management.

The following includes a description of the program model's major components.

- **ED Express Care.** Each hospital provides express primary care services, using APNs during the peak hours when patients are most likely to present with primary care needs (approximately 11:00 a.m. to 11:00 p.m.) and an ED physician or other clinician (e.g., physician assistant or APN) during off-peak hours. All patients who present to the ED are triaged and receive medical screening by an APN or current triage staff per EMTALA requirements. Once it has been determined that a patient has non-emergency primary care needs at low acuity level, the APN or other clinician provides clinically appropriate services for the diagnosis and treatment of the condition and writes any necessary prescriptions, either as part of the triage and medical screening or immediately following. "Primary care conditions" and their corresponding ICD-9 codes used for this program's pilot phase are listed in Table 3 on page 25. "Non-emergency" for this program is defined as low acuity (level 4 or 5).

- **Referral for primary care follow up.** As part of ED Express Care discharge process, the APN or other ED clinicians on the team refer the patient for a follow-up appointment with a primary care provider in the community, for the next day or as appropriate. If the patient has no primary care provider (e.g., Medicaid fee-for-service or uninsured) or does not like or cannot access his/her current HMO primary care provider and is willing to consider another community provider, the APN or another ED clinician sets up this appointment at the FQHC using a secure Web-based electronic information system. This system facilitates communication between providers and allows the hospital ED access to the FQHC appointment scheduling system in real time. It also allows the hospital ED to share patient information and the clinical notes/summary with the FQHC provider, per their standing business associate agreement.

- **Patient education.** During the ED Express Care discharge process, the APN or another ED clinician educates the patient on the appropriate site of care for various healthcare

needs and the importance of using a medical home for primary care services, contacting their PCP after hours before going to the ED and limiting ED visits to true emergency situations. This education continues at the FQHC visit, and the patient is provided culturally and linguistically appropriate educational materials on these topics.

- **Care coordination and management.** The hospital APN or other ED clinician provides some case management along with express care. FQHC physicians who see the program patients offer appropriate primary care services per site's clinical care protocols including: reviewing patient medications; screening for chronic diseases, behavioral health, other co-morbidities and special health needs; and making appropriate referrals to specialty care and disease management programs, as needed.

- **Case management.** Case managers stationed at both the hospital ED and FQHC coordinate patient care and arrange transportation and other support services as needed. In addition, ED case managers track and monitor ED utilization, identify repeat ED users and determine their reasons for using the ED; while FQHC case managers track compliance with follow-up visits, assist with referrals for specialty care and disease management programs and help patients resolve barriers to using appropriate primary care sites (e.g., help them find a more accessible permanent medical home, etc.). Intensive case management could include home visits, if necessary. Hospitals share information related to specific program patients' use of ED for primary care needs with FQHCs and HMOs so they may take responsibility for their patients and provide additional targeted outreach and education.

- **Communication/linkage between partners.** Each hospital ED maintains ongoing communications with community partners (FQHC and/or HMOs/community practices, depending on patient situation and referral preference) to track patient utilization patterns and coordinate efforts by FQHC/HMOs to outreach, educate, address barriers and extend additional support services as needed. Successful implementation of the model relies heavily upon ongoing communication between both the electronic systems and the staff/clinicians from both sites. Plans should be established for routine staff meetings and reliable information-sharing mechanisms across sites.

Program Process Guidelines

These process guidelines are designed to provide the uniformity needed to allow consistent measurement of outcomes of this demonstration. However, given the procedural nuances within each organization, some variation to accommodate unique circumstances may be necessary.

The following describes the guidelines and steps each team partner (ED or FQHC) should follow for typical encounters of a patient from the initial appearance in the hospital ED with primary care needs, through the follow-up visit at the FQHC (or other primary care provider), to future encounters at either site. The processes include different scenarios to reflect variations in patients' healthcare coverage. These guidelines also include steps to be followed by partnering Medicaid HMOs. (See Figure 2 on pages 26-27 for a flowchart depicting the throughput process envisioned for the program model).

Hospital ED Procedures

1. Triage patient and assess needs (including whether patient needs language services).

2. Direct any patient who meets ***both*** of the following criteria at triage to ED Express Care:

   ▪ Presents with symptoms related to a primary care condition (see Table 3 on page 25).

   ▪ Is determined to be at acuity level of 4 or 5.

   Note: Patients with acuity level 1 - 3 will not be included in program's pool of patients…

   ▫ Even if the reason for visit stems from an unmet primary care need;

   ▫ Even if the ICD-9 code for the visit meets the criteria; and/or,

   ▫ Even if the ED uses similar follow-up procedures, discharge planning and referral processes for these patients.

3. Provide primary care services as needed and identify and record patient co-morbidities and special needs.

4. Provide patient with an explanation of the difference between emergency care and primary care needs as part of the discharge communication and collect information from patient about reasons for seeking care in ED for primary care needs, as well as barriers and needs, using a brief survey instrument (sample provided in section F).

5. Educate patient on the importance of seeing a regular doctor instead of going to the ED for primary care needs and of limiting ED visits to true emergency situations.

6. Refer patient for primary care follow-up visit in appropriate non-urgent community site.

7. Set or help patient set follow-up appointment, based on type of coverage and preference:

   ▪ <u>Private coverage</u>

   ▫ Encourage patient to make an appointment with his PCP at the earliest convenience.

   ▫ If patient prefers a follow-up visit with the FQHC, set the first available and convenient follow-up appointment at the partner FQHC via Web-based connection. Electronically forward patient information, including ED visit diagnosis code and physician note.

   ▪ <u>Medicaid HMO</u>

   ▫ Ask whether the patient knows who the primary care provider (PCP) is. If patient does not know, check the HMO card or contact the HMO to identify patient's PCP. Educate the patient about who the PCP is.

   ▫ Ask whether patient prefers the current PCP. If yes, encourage patient to make an appointment with PCP at earliest convenience and contact a designated case manager/liaison at the patient's HMO for follow-up, appointment-setting and case management.

> ▫ If the patient prefers a new private physician, contact the HMO liaison or 24-hour hotline for re-assigning PCP (HMO should also help set up a follow-up appointment with the new PCP).
>
> ▫ If patient prefers a follow-up visit with the FQHC, set the first available and convenient follow-up appointment at the partner FQHC via Web-based connection. Electronically forward patient information, including ED visit diagnosis code and physician note. Alert the FQHC that this patient should be presented with the affidavit to switch to the FQHC as PCP.

- ▪ Medicaid FFS

  > ▫ Set the first available and convenient follow-up appointment at the partner FQHC via Web-based connection. Electronically forward patient information, including ED visit diagnosis code and physician note.

- ▪ Uninsured

  > ▫ Set the first available and convenient follow-up appointment at the partner FQHC via Web-based connection. Electronically forward patient information, including ED visit diagnosis code and physician note.

8. Assist patient with any arrangements or services needed for FQHC visit (e.g., transportation, connection to social services, Medicaid screening and application/enrollment assistance for uninsured patients, etc.).

9. If the partnership is monitoring the outcomes data, enter information about the patient and the visit into the database (sample provided in section F).

FQHC Procedures

1. Receive ED referral for follow-up visit and electronic copy of patient information via Web-based appointment scheduler and shared information systems.

2. Contact patient for an appointment reminder and to arrange transportation and offer other support services.

3. (For Medicaid HMO patients) During initial intake, provide patient with the affidavit to use FQHC for services one time or to designate FQHC as PCP, if patient agrees.

4. Provide initial follow-up primary care services and identify/verify and address patient co-morbidities and special needs (e.g., chronic diseases, mental/behavioral health and other special healthcare needs); manage and adjust patient's medications; make referrals for lab tests, screening, specialty services and related chronic disease management programs, etc.

5. Provide further education on the importance of a medical home and provide case management, which includes but is not limited to:

   - ▪ Coordinate patient care and assist with referrals for specialty care and disease management programs.

   - ▪ Arrange transportation.

- Provide connections to social/support services needed and other relevant resources in the community.

- Follow up on Medicaid eligibility and provide continued application/enrollment assistance for uninsured patients.

- Link ineligible/underinsured patients to medication assistance programs.

- Discuss patient barriers/needs and help patients resolve barriers to using appropriate primary care sites (e.g., help them find a more accessible permanent medical home).

6. If the partnership is monitoring the outcomes data, enter information about the patient and the visit into the database (sample provided in section F).

7. Share information about status of referred patients with ED case manager.

8. If patient does not show up for appointment:

- Contact patient to obtain information on patient's reasons for not showing and determine barriers and needs using a brief survey instrument (sample provided in section F).

- Reschedule the appointment.

- Provide intensive case management (including home visits, if necessary, along with additional targeted outreach and education) and support services needed.

- Share information about status of referred patient with ED case manager.

Medicaid HMO procedures

1. Receive referrals of plan's beneficiaries from hospital APN via call to dedicated phone line, via daily e-mail summary or in person, if applicable (plans with staff stationed at program site may be reached by hospital ED in person).

2. Provide care coordination and case management services, including:

- Verify whether referred patient prefers current PCP. If not, assist with switching PCPs.

- Assist referred patient with setting follow-up appointment with PCP.

- Assist referred patient with any arrangements or services needed for PCP visit (e.g., transportation, connection to social services, etc.).

- Provide case management to referred patient, as necessary.

3. Provide intensive case management for beneficiaries red-flagged by hospital APN as repeat users, including home visits, if necessary, along with additional targeted outreach and education.

4. Communicate information with program partners. Coordinate with each hospital/FQHC partner on efforts to outreach, educate, address barriers and extend additional support services as needed (e.g., communicate efforts to follow up with repeat users and FQHC no-shows who are Medicaid HMO patients).

5. Track and document care coordination and case management services provided to referred HMO patients, as well as needs identified, other services offered and regular patient utilization of PCP care after the ED visit.

Future Patient Encounters (ED or FQHC/other primary care site)

▪ If a patient returns to the hospital ED with primary care needs, ask about reasons for continuing to seek care in ED, as well as barriers and needs, using a brief survey instrument unique to repeat visits (sample provided in section F) and notify the FQHC and/or the appropriate Medicaid HMO to coordinate patient outreach, education and intensive case management.

▪ If a patient returns to the FQHC for follow-up of a repeat ED visit, provide more intensive case management and support services as needed.

▪ If a patient returns to the FQHC for regular primary care, continue to provide holistic preventive/primary care services that are culturally and linguistically appropriate, care coordination (lab tests, referrals, etc.) and case management, to serve as the patient's medical home. Also provide patient appointment reminder calls and follow-up calls for regular visits.

▪ If a patient returns to another PCP for regular primary care, the HMO should encourage primary care providers/offices to enhance care and services to serve as the medical home.

Table 3: Selected Primary Care Conditions and Associated Codes

ICD-9-CM CODES	DIAGNOSTIC CATEGORY
010.xx - 018.xx	Tuberculosis
037	Tetanus
042.xx	Symptomatic HIV
79.99	Unspecified viral infection, in conditions classified elsewhere and of unspecified site
090.xx - 099.xx	Syphilis and other sexually transmitted diseases
174.xx; 198.81; 233.0x; 793.8x	Abnormal breast findings, female
180.xx; 198.82; 233.1x; 795.0x	Abnormal cervical findings
250.xx; 775.1x; 790.2	Diabetes mellitus
260.xx - 269.xx; 779.3x; 783.3x - 783.4x	Lack of expected normal physiological developments (such as delayed milestone; failure to gain weight; failure to thrive) – does not include sexual or mental development; nutritional deficiencies
276.5x	Dehydration
290.xx 293.xx - 302.xx (excluding 296.xx, 300.0x, 300.21, 300.22, 300.23, 300.29, 300.3, 300.4, 301.13)	Other mental disorders, excluding drug or alcohol dependence (includes mental retardation)
291.xx; 303.xx; 305.0x; 357.5x	Alcohol dependence
292.1x - 292.8x; 304.xx; 305.2x - 305.9x; 357.6x; 648.3x	Drug dependence
296.xx, 300.4x; 301.13; 311.xx	Depression and other mood disorders
300.0x, 300.21, 300.22, 300.23, 300.29, 300.3; 308.3; 309.81	Anxiety disorders including PTSD
312.8x, 312.9x; 313.81; 314.xx	Attention deficit and disruptive behavior disorders
381.xx - 382.xx	Otitis media and eustachian tube disorders
391.xx - 392.xx; 410.xx - 429.xx	Heart disease (selected)
401.xx - 405.xx	Hypertension
462	Acute pharyngitis
465.9	Acute upper respiratory infections of unspecified site
466	Acute bronchitis
493.xx	Asthma
558.9	Other and unspecified noninfectious gastroenteritis and colitis
599	Urinary tract infection, site not specified
770.xx; 771.xx; 773.xx - 779.xx (excluding 779.3x)	Selected perinatal medical conditions
724.2	Lumbargo
780.6	Fever
784	Headache
786.5	Unspecified chest pain
786.59	Other chest pain
789	Abdominal pain, unspecified site
845	Unspecified site of ankle sprain and strain
847	Neck sprain and strain
883	Open wound of finger(s), without mention of complication
920	Contusion of face, scalp, and neck except eye(s)
959.01	Head injury, unspecified
991.xx - 992.xx	Exposure to heat or cold
V58.3	Attention to surgical dressings and sutures

Figure 2: Flowchart of Model Processes
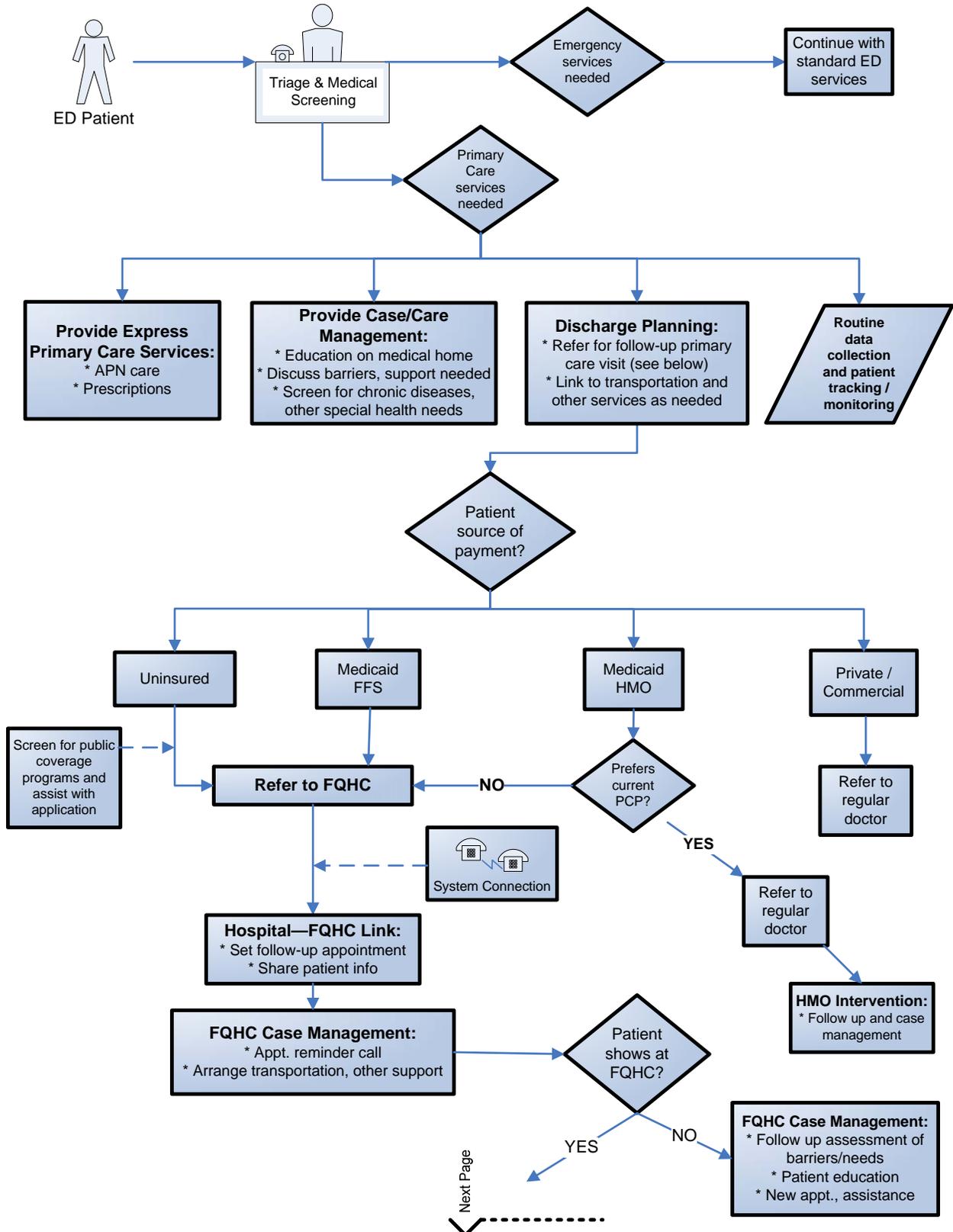
Flowchart of Model Processes, cont.

... continued

Patient shows at FQHC?

YES →

FQHC
Primary Care Follow-up:
* APN/Physician care, Rx
* Screen for chronic diseases or behavioral health needs

Serve as Medical Home:
* Provider continuity
* Increase access – expanded hours, clinicians, on-call

Provide Care Coordination & Management:
* Appointment reminder calls
* Make referrals for chronic disease management programs, behavioral health, specialist care, etc.
* Coordinate lab tests, referrals, etc.
* Provide link to affordable Rx

Provide Case/Care Management:
* Education on medical home
* Discuss patient barriers, support needed; and link patient to services and resources
* Monitor insurance status and assist uninsured with application for public coverage program

Routine data collection and patient tracking / monitoring

Patient returns to ED?

NO → **Continue to monitor**

YES

ED Case Manager:
* Inform FQHC case manager
* Alert Medicaid HMO case manager, if appropriate
* Data collection and patient tracking

ED, FQHC & HMO Case Managers:
Collaborate and follow-up on patient

FQHC Case Manager:
* Patient outreach and education

HMO:
* Patient outreach and education
* Provider outreach

Coordinating Hospital ED and FQHC Roles

Given the potential overlap in the roles of the program case managers situated in the hospital ED and at the partner FQHC, it is important that these staff maintain a high level of communication and coordinate their efforts to maximize results. In some circumstances, redundancy is beneficial, such as in providing education and support to patients. For other activities, separate responsibilities or a clearly defined feedback loop are necessary. For example, patient monitoring and follow-up requires a great deal of cooperation, as follows:

- The FQHC case manager monitors the service utilization of identified patients and gathers information on patient compliance with follow-up visits, identifying no-shows, and then shares this information with the partner hospital ED case manager;

- The hospital ED case manager monitors ED utilization by program patients and red flags frequent ED users; and,

- The hospital ED case manager shares information about identified red-flag patients with the FQHC case manager (and/or Medicaid HMO liaisons, if appropriate) who will then coordinate collaborative outreach to identified patients to determine their needs, barriers and reasons for using the ED and provide intensive case management.

E. TIPS FOR PATIENT-CENTERED CARE

Promoting the Medical Home to Improve Access to Care

Many studies have found that the continuity of care received through a "medical home" provides the greatest benefits to patients in terms of primary and preventive care, particularly among Medicaid patients. Compared to Medicaid patients treated elsewhere, Medicaid patients who consistently use community clinics and health centers as a medical home for primary care needs (Falik et al., 2006; Falik et al., 2001):

- Are between 11 and 22 percent less likely to be hospitalized for avoidable conditions;

- Are 19 percent less likely to use the ED for avoidable conditions;

- Have lower hospital admission rates, lower lengths of hospital stays, less costly admissions and lower outpatient and other care costs; and,

- Save as much as 30 to 33 percent in total healthcare costs per Medicaid beneficiary.

There are many variations in the definition of a medical home. For example, the American College of Physicians defines a patient-centered medical home as "a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes," while the U.S. Department of Health and Human Services' Bureau of Primary Health Care defines a it as "a primary care delivery model that is patient-focused, well organized, easily accessible, comprehensive, continuous, safe, accommodating, equitable, culturally appropriate, and evidence-based." However, the stated goal is the same – to provide patients with a holistic approach and a broad spectrum of care across all life stages that result in improved health and healthcare delivery.

The bureau further identifies the core elements of a medical home as including:

- Personal physician;

- Physician-directed medical practice;

- Whole person orientation;

- Coordinated and integrated care;

- Quality and safety;

- Enhanced access; and,

- Payment reform.

Additionally, the National Committee for Quality Assurance provides its own standards for the features of a medical home, including (Hudson Scholle, 2008):

- Access and communication;

- Patient tracking and registry functions;

- Care management;

- Patient self-management support;

- Electronic prescribing;

- Test tracking;

- Referral tracking;

- Performance reporting and improvement; and,

- Advance electronic communications.

The state of New Jersey has developed its own standards as it considers restructuring the Medicaid payment system to support primary care practices that use a medical home model. The focus of these changes, which will be included as measures in this program's evaluation, include:

- Care coordination through multi-disciplinary teams;

- Patient or family education for patients with chronic diseases;

- Home-based services;

- Telephonic communication;

- Group care; and,

- Culturally and linguistically appropriate care.

The benefits of using a medical home as the gateway for all healthcare needs should be conferred, in laymen's terms, to patients during the patient education encounters. The American Academy of Pediatrics has partnered with Family Voices and other organizations to produce some useful tools aimed at parents of children with special healthcare needs, which can be adapted for use by this program. These are available at www.medicalhomeinfo.org. For example, their fact sheet describes the "Benefits of Medical Home" as follows:

- You regularly see the same primary care clinician and office staff who know your child and family, partner with you in coordinating care for your child and exchange information with you honestly and respectfully as you learn from one another;

- Your family feels supported in finding resources, for all stages of growth and development of your child;

- Your family is connected to information and family support organizations; and,

- Your medical home partnership promotes health and quality of life as your child grows and develops into an adult.

Seeing the same primary care physician is an important component of providing a medical home. To promote this sense of care continuity, the appointment-setting staff at the FQHC or other primary care office should first ask the patient which doctor he/she has seen in the past and whether the patient would prefer to see that same doctor again or would like the first available doctor.

Culturally and Linguistically Appropriate Care

The following lists some tips for providing culturally and linguistically appropriate care:

- **Do unto others**… Don't apply the "Golden Rule" when dealing with members of other cultures. What is viewed as polite, caring, quality healthcare in one culture may be considered rude, uncaring or even evidence of poor standards of care in another.

  <u>Hint</u>: *Don't treat patients as you want to be treated. Try to learn how they want to be treated.*

- **Address all adult patients from other cultures by their surnames unless specifically told to use a first name**. Most other cultures are more formal than American culture and many people who were born and brought up in another cultural environment consider it a lack of respect to address others (or to be addressed) by their first name. This is especially true when there is a big difference in age among caregiver, staff member and patient.

  <u>Hint</u>: *In many Asian cultures the family name precedes the given name. Therefore, someone whose name is Chen Lee would be addressed as Mr. Chen, not Mr. Lee. When in doubt, ask the patient how s/he wishes to be addressed.*

- **Don't raise your voice.** When speaking to a patient who seems to have a limited knowledge of English, don't shout. Remember, the patient is hard of understanding, not hearing. Speak slowly and softly. Try to avoid words and expressions that are dependent upon one's knowledge and familiarity with American life and culture.

  <u>Hint</u>: *You can improve the patient's understanding of what you are saying by repeating it several times in different ways and using gestures, pictures and other non-verbal forms of communication.*

- **Every culture has its own rules for touching and distance**. Americans feel uncomfortable when someone stands less than three feet away from them; people from the Middle East like to stand almost nose to nose with the person with whom they are speaking; Latino/Hispanic patients expect the physician to shake hands with them at the beginning of the interview; Japanese patients may feel very uncomfortable shaking hands; Koreans believe that the soul rests in the head and may become fearful if a provider or staff member pats their child on the head or ruffles his/her hair.

  <u>Hint</u>: *Refrain from judging persons from other cultures by such culturally determined matters as the strength of the handshake, whether the person maintains eye contact or keeps a distance that is comfortable. Observe the patient closely and try to "negotiate" distance so that it is acceptable to both of you.*

- **Don't ask a limited speaking patient, "Do you understand?"** If the patient nods his or her head or answers "Yes" to your question, it may only mean that the patient heard you, not that s/he understood your question and agrees with your diagnosis or plan of treatment.

Hint: Try to ask questions beginning with the words "when," "where," "what," "why" and "how." Then listen carefully to the answers for clues to the patient's degree of understanding or means of agreement. You can also check understanding and agreement by asking the patient to repeat to you step by step exactly what you have said about how s/he should follow the treatment.

- **Patient compliance with treatment is heavily dependent upon the "fit" of the treatment plan with the patient's lifestyle and eating habits**. Try to learn when patients have their main meal of the day before prescribing a medication to be taken with the evening meal, if you wish it to be taken with the largest or heaviest meal of the day. Adapt any dietary regimes to include the patient's main food staples.

  Hint: Lifestyle and eating habits are heavily influenced by the patient's degree of assimilation (don't be fooled by a patient's ability to speak English.), the region of the country from which the patient is from and his or her social class, economic circumstances and education.

- **When possible, use the patient's preferred form of medication (pills, injection, tonic, etc.) when giving or prescribing drugs**. Often both compliance and satisfaction can be increased by learning something about the patient's expectations. You can learn a great deal simply by asking patients a few questions regarding the type of treatment their local doctors or healers would give for similar or relative illnesses and whether or not they feel that treatment would be effective.

  Hint: Patients from certain cultures may equate the quality of care with the giving of a prescription. If a particular patient seems disappointed because the doctor has not prescribed a medication, try to determine what had been expected. Even a minor suggestion regarding change in diet or living style may satisfy the patient's desire for his or her complaint to be validated by some form of treatment.

- **Always offer an explanation before a test or procedure is performed (by a nurse or other medical support staff person)**. American nurses and technicians are far better trained and play a much greater role in patient care than in many other counties. Many culturally diverse patients are unfamiliar with our system of using professional staff other than a physician for initial work-up tests and follow-up procedures such as taking the patient's pulse or drawing blood. They may act rudely because they are fearful that they are not getting treatment from qualified staff.

  Hint: A simple explanation such as "Dr. X has asked me to take your pulse so that he has as much information as possible before seeing you" or "I have received special training to do this test" will usually make the patient feel more comfortable and at ease with our system.

- **Consent forms and regulations can be extremely upsetting and frightening for patients who have been taught to believe that talking about an event may make the event take place or for those whose conceptual framework does not include "what**

if" conjectures. Anyone administering the consent form should patiently explain that the form is only a formality and that there is very little likelihood of a negative outcome.

Hint: Consent forms, like our entire medical system, will seem strange and sometimes frightening to a patient from another culture. Therefore, it is always necessary to explain each procedure to these diverse patients as if it were the first time s/he is hearing about it – nine times out of 10, it is.

- **Making telephone calls is about the most difficult thing to do in a foreign language. Patients with limited skills in English may simply avoid calling to make or break appointments or to ask for an explanation about how or when to take a medication**. This fear of making a telephone call in English not only results in missed appointments, patients dropping in without appointments or misuse of the ED, but can also lead to death because a patient may refrain from calling until it is too late for treatment.

  Hint: Make a concerted effort to lower the stress of making a phone call. When speaking to anyone who has a foreign accent over the telephone, speak very simply, slowly and clearly. Don't show impatience. Give the person all your attention. Since the person may not be able to explain what he or she means, try to listen to what is said "between the lines" as well as what is said directly.

- **Don't underestimate the intelligence of patients who are unable to describe or trace the course of a complaint. English-speaking cultures, as reflected in our language, tend to be precise and ruled by the dates and the clock**. Americans tend to think and talk linearly. Many other cultures think globally and pay less attention to a particular hour or day than to events or seasons.

  Hint: If a patient seems to be having difficulty telling when, what day or what hour a particular symptom appeared, help him or her by connecting this occurrence to another event (season, meal time, sunshine, moonlight, etc.) and then go on from there.

- **Studies have shown that for many culturally diverse patients, satisfaction with treatment is heavily influenced by their "comfort level" with a physician and office staff as well as the quality or successful outcome of treatment**. Patience, willingness to take the time to explain, making sure that the patient understands and responding to the patient's needs and expectations will not only bring culturally diverse patients back but also encourages them to bring in their friends and relatives.

  Hint: The best place to start and end with a culturally diverse population is to never assume that the patient wants what you want or expects the same type of care and service that you do. Instead, take the time to learn about your patient's culture and traditional health/illness beliefs and practices. To demonstrate your knowledge and interest, customize your rules of courtesy, procedures and treatment plans to suit your patients' needs and expectations. (HRET, 2007)

Screening for Medicaid Eligibility

Uninsured patients who are identified by this program should be screened for their Medicaid eligibility (a.k.a. NJ FamilyCare) and assisted with the application and enrollment process, starting in the hospital ED and continuing at the FQHC, if necessary. Special concern should be paid to these patients during the patient education encounters to ensure their understanding of both the importance of a medical home and the ways to navigate a primary care-based healthcare system.

Program staff, outreach workers or other staff helping patients complete the applications do not have to screen for eligibility perfectly, but here are a few tips to make the process more efficient:

- Informational materials – share informational or educational materials about the program and general eligibility requirements with uninsured patients

- Application format
    - Online application, available at www.njfamilycare.org (fastest)
    - Download or order paper applications and mail
    - Application assistance by phone, in many languages, at 1-800-701-0710

- Requirements
    - Signed application form with Social Security number
    - Proof of income
    - Proof of citizenship and identity or proof of immigration status
    - Letter showing termination of previous insurance (if applicable)
    - HMO and PCP selection

- Special situations
    - <u>Special circumstances</u> – In cases where there are complex family or socio-economic issues, brief anecdotal information may be included in a letter on agency letterhead to clarify issues for the eligibility unit. For example, explanations about issues such as custodial relatives or recent job loss/change are often helpful in determining eligibility.
    - <u>Unborn child</u> – When a woman is pregnant, the unborn child counts in determining the family size. Such cases should be referred to the County Board of Social Services if the family is likely to be at or below 200 percent of the federal poverty level ($46,100 for a family of four in 2012).
    - <u>Newborn with no birth certificate or Social Security number</u> – Crib cards may be used as documentation of a newborn when the birth certificate is not yet available. If the newborn remains in the hospital for an extended period, a letter from the attending physician may be used. The Social Security number must be provided as soon as it is obtained. If other family members are already covered by NJ FamilyCare, the parent can simply report the birth of the child over the phone.

- □ <u>Retroactive coverage</u> – Families who fall below 133 percent FPL ($30,657 for a family of four in 2012) may be eligible for retroactive coverage of medical expenses (from Medicaid providers) for the three months prior to the date of their application. If applicable, they should submit income verification for the three previous months.

- □ <u>No proof of income</u> – For applicants, such as migrant workers and day laborers, who are paid cash or "under the table" and have no pay stubs as proof of income, an outreach worker should try to get documentation on the employer's letterhead. If not provided, application assistants should create an Income Verification Form on their own letterhead after speaking to the employer.

- □ <u>Immigrant public charge</u> – Public charge is defined as an individual who is likely to become primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense; it has been part of U.S. immigration law as a ground of inadmissibility and deportation. Among immigrant populations there may be reluctance to apply for NJ FamilyCare for fear of being considered a public charge. Even eligible members of mixed-status families may be afraid to enroll and open the rest of the family up to scrutiny by the U.S. Citizenship and Immigration Services (USCIS, formerly INS). These families should be informed that the USCIS does not consider the receipt of NJ FamilyCare benefits a reason to classify any immigrant as a public charge.

- ▪ Help the families gather as much supporting documentation as possible to expedite the application process and be sure to keep copies/printouts of the applications.

F. DATA MONITORING AND EVALUATION

In order to assess the successes, outcomes and impacts of this demonstration model and interventions, several research methods can be utilized, including surveys and use of existing/administrative data. A variety of analytical techniques could be applied, including pre- and post-program intervention designs and non-parametric tests of statistical significance. A robust evaluation plan would involve review of administrative data, collection of data from program sites routinely tracked throughout implementation of the program and a series of surveys or focus groups of patients and providers.

Anticipated outcomes and impacts include:
- increased capacity of community primary care sites;
- improved medical home features of community health centers;
- improved patient satisfaction, compliance and sense of partnership with their providers; decreased ED utilization for primary care needs; and reduced cost of care in general and specifically for the Medicaid program, due to decreased inappropriate use of EDs.

Collecting and Tracking Data

The data collection on outcome and impact measures should include baseline data covering six months prior to program implementation and post intervention data collected during and at the completion of the program implementation. Below are detailed descriptions of each method and its corresponding data sources and data elements.

- **Hospital/FQHC Administrative Data.** Existing administrative and program databases are used to extract detailed information on ED utilization, referral and other relevant demographic characteristics of program patients on an ongoing basis. New Jersey hospitals collect and store this data as part of the New Jersey Discharge Data Collection System (NJDDC; based on UB-04).

  - Standardize measures and format data from hospitals and FQHCs by designing two electronic tracking system templates – a patient information tracking database and an organizational data tool (samples provided on pages 43-45).

  - Populate the patient tracking database using administrative data and information obtained during or after each program patient encounter.

  - Track patients across sites and in different data sets for the purpose of program evaluation by assigning each program patient a unique ID code.

  - Use the same unique program ID code for each patient through all future ED and FQHC visits for tracking purposes. The same unique IDs should be used in patient surveys and other data collection tools.

  - Other measures collected and compiled through this template include:

    - Demographic characteristics;
    - Insurance status;

- Date and time of visit;
- Reason for visit and ICD-9 code;
- Co-morbid conditions;
- Follow-up referral site (FQHC, HMO PCP or other); and,
- FQHC show-up status.

▪ **Partner's Organizational Data Reports.** Organizational data elements from each of the program partner's data reports can be obtained using the electronic data set to measure outcomes and impact evaluation, including ED utilization overall and broken down by:

  □ Insurance/payer source;

  □ ED procedures (e.g., number of referrals to HMOs or FQHCs);

  □ Average ED wait time and average ED peak days and peak hours;

  □ FQHC patient volume overall and by payer source;

  □ Appointment show rates; and

  □ Overall FQHC procedures (e.g., number of patients provided with education and case management services, number of patients enrolled in chronic disease management programs, number of patient calls to providers during business hours and off-shift, use of language line for LEP patients and use of transportation services or vouchers).

▪ **Patient Barriers and Needs Assessments – Initial and Repeat Users Survey.** To collect detailed information about program patients' reasons for using the ED for primary care conditions and identify needs and barriers to accessing the primary care system in their communities, ED staff should ask patients questions about their use of ED using two survey instruments – one administered during *initial* patient visits and one during *repeat* visits. These short survey instruments should include questions on patient insurance, primary care provider (if applicable) and the reasons for not using their doctor's office, leading to inappropriate use of ED services. Also include questions on patients' needs for future use of appropriate sites of care, as well as questions on their level of education and ability to speak English. (See pages 46-49 for sample survey instruments for initial and repeat users.)

Initial and repeat surveys will be administered by the hospital ED APN or case manager during the patient's visit at the ED or through follow-up phone calls. Enter this information into a data set with appropriate linkages to data tracking files. The results of these surveys are reviewed by program sites regularly throughout the implementation process to identify issues and develop targeted strategies to educate patients and change their help-seeking behavior.

▪ **Missed Appointments Survey.** A separate short survey instrument should be used to collect information about ED patients who were referred to an FQHC and missed their scheduled follow-up appointment(s). Include questions about the patient's reasons for missing the appointment, such as "forgot the appointment," "need to reschedule," "conflicts with other family commitments or other unexpected events," "want a different

PCP," "need transportation" or "need language interpreter." (See page 50 for a sample survey instrument.) An FQHC case manager should administer this survey over the phone or through other patient encounters. Enter information from this survey into a data set with appropriate linkages to data tracking files.

- **Medical Home Survey.** To collect information from patients seeking post-follow-up care (i.e., regular visits) at the partner FQHCs about their current health status and experiences with the services received, use a "Medical Home" survey instrument. Include questions on patient's help-seeking behavior, perception of health status and health outcomes as compared to pre-program implementation, perception of health center's medical home domains (i.e., continuity of care, care coordination, communication with doctor/staff, communication about medications and language service needs) and overall patient satisfaction to determine their use of the health center as their medical home and not returning to the ED for a non-emergency case. Responses are collected using a five-point Likert scale from 5 (always) to 1 (never). The instrument should use a language at low literacy level and be translated into Spanish. (See pages 52-60 for a sample survey instrument in English and Spanish, along with instructions and talking points.)

  Program patients who meet the survey criteria (those who were initially referred from an ED and returned for at least a second visit to the FQHC for routine primary healthcare) should be approached after checking in for their appointments by FQHC staff and invited to participate in the study and complete the survey. Completed surveys collected from patients by FQHC sites should be entered into a data set with appropriate linkages to data tracking files.

- **Provider Satisfaction Survey.** A short "Provider Satisfaction" survey instrument will help to obtain feedback from clinicians at the hospital EDs and FQHCs who work on this program and care for program patients, on performance of the model at their sites and its impact, if any, on their work. Two versions of this provider survey should be used – one specifically for ED providers and one for FQHC providers, to capture the unique features and needs of each environment (samples provided on pages 61-64). Survey questions should include:

  - Usefulness of the program model features on a five-point Likert scale from 5 (very useful) to 1 (not useful at all);

  - Extent of difficulty experienced for the model implementation on a three-point scale from 1 (no difficulty) to 3 (significant difficulty);

  - Satisfaction with processes, workflow and performance of the model on a five-point scale from 5 (very satisfied) to 1 (very dissatisfied); and,

  - Whether they recommend all or some components of the model to other healthcare facilities.

Sample Data Collection Templates and Instruments

See pages 41-64 for sample tools and survey instruments as described under *Collecting and Tracking Data.*

Recommended Data Tracking Tool

The following are some of the patient data elements that should be collected and entered in a database by the hospital ED staff, if relevant:

- Patient Name
- Medical Record # (internal use)
- Project ID # (if applicable)
- Home Zip Code
- DOB (mm/dd/yyyy)
- Gender
- Hispanic Origin
- Race
- Primary Language Spoken
- Insurance Status. . . . . Medicaid HMO, Medicaid FFS, Medicare, charity care, self-pay, private insurance/other, unknown
- HMO Name (Medicaid Patients)
- Pt. Visit # @ ED . . . . Number of the ED visit ("1" = first visit, etc.)
- ED Visit Date/ED Referral Date
- Time of ED Visit (24:00)
- Reason for ED Visit (Condition) . . . .Primary diagnosis
- ICD-9 Code
- Co-Morbid Conditions
- Referral Status
- ED Additional Notes

Data from patient visits to the FQHC could be tracked in a separate database or appended to a shared database with the hospital and should include:

- Patient Name
- Medical Record # (internal use) . . . . Chart # or other ID used by facility (optional)
- Project ID # (if applicable)
- Pt. Visit # @ HC . . . . Number of the FQHC visit ("1" = first visit, etc.)
- Type of HC Visit . . . . "ED Referral" if appt. was made by the ED for following up after an ED visit for primary care needs "Regular Visit" if project patient returns for regular primary care services
- Appt. vs. Walk-in
- Show-up Status (by appointment). . . Showed at 1st Appt. / Rescheduled / No Show
- Date of HC Visit
- Time of HC Visit (24:00)
- Reason for HC Visit (Condition) . . . Primary diagnosis
- ICD-9 Code
- Case Mgmt. Provided (Y/N)
- Education on Med. Home (Y/N)
- FQHC Additional Notes

Monthly Organizational Data Tracking Tool – ED

HOSPITAL NAME	MONTH, YEAR
ED STAFFING	
Staffing levels (daily average, in hours):	
Physicians	
Mid-level clinicians (APNs, PAs)	
Nurses (RNs)	
Other direct care staff (MAs, PCAs)	
# of Providers who attended any cultural competency training program (classroom or online)	
# of Multilingual providers / staff	
Languages spoken: (list)	
ED UTILIZATION	
Total # of ED vsits	
# of Patients using ED for primary care needs by payer source:	
Total patients (all payers combined)	
Self-pay patients	
Charity care patients	
Medicare patients	
Medicaid HMO patients	
AMERIGROUP	
AmeriChoice of New Jersey	
Health Net	
Horizon NJ Health	
University Health Plans (UHP)	
Other sources (including commercial plans)	
Average ED waiting time (in minutes):	
Turn around time for Level 4 and 5 patients	
Turn around time for all treated-and-released pts.	
ED presentation to in-patient bed for admitted pts.	
ED PROCEDURES, OVERALL	
# of Referrals to HMO PCPs	
# of Referrals to FQHCs	
# of Patients placed on Charity Care	
# of Patient education and case management services provided *(on proper use of ED)*	
Average ED peak DAYS this period	
Average ED peak HOURS this period	

Monthly Organizational Data Tracking Tool – FQHC

FQHC NAME	MONTH, YEAR
FQHC STAFFING	
Staffing levels (daily average, in hours):	
Physicians	
Residents	
Nurses (RNs only)	
Other direct care staff (LPNs, MAs, PCAs)	
# of Providers who attended any cultural competency training program (classroom or online)	
# of Multilingual providers / staff	
Languages spoken: (list)	
FQHC CAPACITY	
Days and times of operation	
Are appointment slots available during off-regular hours?	
Are sick visits and walk-ins taken during off-regular hours?	
Average waiting times:	
Waiting time for an available appointment (in days)	
Waiting time in office until registration complete (in minutes)	
Waiting time in office until seen by provider (in minutes)	
FQHC UTILIZATION	
Total # of FQHC visits	
# of Referrals from ED	
Appointment show rates:	
Total patients (all payers combined)	
Medicaid patients (fee-for-service or HMO)	
Project patients referred by ED	
FQHC PROCEDURES / SERVICES	
# of Patient education and case management services provided *(on medical home, proper use of ED and preventive care)*	
# of Patients receiving HbA1C screening	
# of Patients enrolled in FQHC chronic disease mgmt. programs	
# of Phone calls to healthcare providers:	
During business hours	
During off shifts	
Linguistic access for LEP patients:	
# of telephonic language services provided	
# of face-to-face interpretations provided	
# of Transportation services / vouchers provided	

INITIAL ED VISIT SURVEY

Patient ID #: _____

Date of Service: _____

HOSPITAL: _____

APN / CASE MANAGER: _____

PATIENT NAME: _____

Instructions for Hospital ED APN / Case Manager:

During the initial ED visit by patients with <u>primary care needs only</u>, please use the questions below as part of your discharge process to collect information about their reasons for using the ED and their barriers to accessing healthcare services at appropriate sites. This information is needed for the program evaluation plans and also will help with assessing patient needs and devising strategies to educate patients and change their help-seeking behavior.

During your discharge communication with the patient, please explain briefly to the patient what an emergency condition is and that the type of condition he/she has is not an emergency. We suggest that you continue with the following statement and questions:

We are happy to care for you today, but in the future you should go to your doctor's office or community clinic for this type of illnesses.

1. Do you have a primary care doctor?   Yes   /   No

    If NO, skip to Question 5.

    If YES, continue with the questions below.

2. Who is your primary care doctor? _____

3. Have you gone to your <u>current</u> primary care doctor?   Yes   /   No

CONTINUE ON NEXT PAGE

4. Why are you here instead of using your doctor's office or a clinic for this visit?
   (Please mark all reasons specified by patient)
   - ☐ Doctor's office is not open at this time
   - ☐ Doctor's office/staff told me to go to the ED
   - ☐ Doctor was not available today
   - ☐ Doctor's office is too far away
   - ☐ Long wait time to make an appointment with my doctor
   - ☐ Difficult to make appointment with my doctor that fits my schedule
   - ☐ I don't have transportation
   - ☐ Cannot afford to visit a clinic or pay co-pay fees
   - ☐ I felt I needed emergency services
   - ☐ ED is more convenient (flexible hours, accepts non insured patients, etc.)
   - ☐ Do not understand English and had no interpreter available that day
   - ☐ Other, specify: _____

5. What would help you use a primary care doctor instead of coming to the hospital ED for this type of condition?

   _____

   _____

   _____

In order to plan helpful support services, we also need to know…
Please collect this information from adult patients or parent/guardian/proxy if patient is a minor and less than 17 years of age.

6. Which of the following best describes your level of education?
   - ☐ None or less than elementary school
   - ☐ Less than middle school
   - ☐ Less than high school
   - ☐ High school diploma
   - ☐ Some college
   - ☐ College degree or higher
   - ☐ Other (Please specify: _____)

7. How well do you understand and speak English?
   - ☐ Very well
   - ☐ Well
   - ☐ Not well
   - ☐ Not at all

REPEAT ED VISIT SURVEY

Patient ID #: _____

HOSPITAL: _____

APN / CASE MANAGER: _____

PATIENT NAME: _____

Instructions for Hospital ED APN / Case Manager:

During a second or later ED visit of a patient with primary care needs who has previously been identified as a program patient, please use the questions below to ask these patients about their reasons for repeatedly using ED for primary care services and their barriers to accessing these services at appropriate site of care. This information is needed for the program evaluation plans and also will help with assessing patient needs and devising strategies to educate patients and change their help-seeking behavior.

During your discharge communication with the patient (or follow-up phone call), please explain briefly to the patient what an emergency condition is and that the type of condition he/she has is not an emergency. We suggest that you continue with the following statement and questions:

You are here again for an illness that is not an emergency. We are happy to care for you, but in the future you have to go to your doctor's office or community clinic for this type of illness.

1. Do you have a primary care doctor?   Yes   /   No

   If NO, skip to Question 5.

   If YES, continue with the questions below.

2. Who is your primary care doctor? _____

3. Have you ever gone to your primary care doctor's office?   Yes   /   No

CONTINUE ON NEXT PAGE

4. Why are you here instead of using your doctor's office or a clinic for this visit?
   □ Doctor's office is not open at this time
   □ Doctor's office/staff told me to go to the ED
   □ Doctor was not available today
   □ Difficult to make appointment with my doctor that fit my schedule
   □ Long wait time to make an appointment with my doctor
   □ Long wait time in my doctor's office
   □ Doctor's office is too far away
   □ I don't have transportation
   □ Difficult to take time off from work
   □ Do not understand English and had no interpreter available that day
   □ Felt that my doctor does not understand my cultural views
   □ Felt that my doctor is often judgmental or uninterested in my problems
   □ Other, specify: _____

5. It seems you prefer to come to the hospital ED instead of a doctor's office or health center. This is your [# of times] time you are here for a non-emergency condition. What can we do to help you use a primary care doctor instead of coming to the hospital ED for this type of condition?

   _____

   _____

   _____

FQHC MISSED APPOINTMENT SURVEY

Patient ID #: _____

FQHC: _____

CASE MANAGER: _____

PATIENT NAME: _____

Instructions for FQHC Case Manager:

Please use the questions below in following up with patients who do not show up for their appointments for primary care services – via phone or other encounter – to identify their reasons for missing appointments. This information is needed for the program evaluation plans and also will help with assessing patient needs and devising strategies to educate patients and change their help-seeking behavior.

Hi **[name of patient]**, *I am* **[your name]**, *your clinic case manager. You had an appointment scheduled for* **[date of missed appointment]** *with* **[doctor's name]** *and you did not show up. I am calling to find out why you missed your appointment and what we can do to help you keep your future appointments.*

1. Patient's reasons specified:
   - ☐ Forgot I had scheduled an appointment
   - ☐ Tried to cancel the appointment
   - ☐ Conflicted with other family commitments
   - ☐ Appointment wasn't with the doctor of my choice
   - ☐ Felt too ill to attend
   - ☐ Felt better/ problem was resolved before my scheduled appointment
   - ☐ Had no transportation
   - ☐ Was unable to get time off work
   - ☐ Do not understand English and had no interpreter available that day
   - ☐ Other, specify: _____

2. Do you want your appointment rescheduled with the same provider?   Yes   /   No

3. Do you have transportation to get here?   Yes   /   No

4. Do you need a phone call reminder the day before your scheduled visit?   Yes   /   No

5. How else can we help you keep your future appointments?

   _____

   _____

   _____

Case Manager Follow-up

Please check all that apply:
- ☐ Rescheduled this patient's appointment at least once.
- ☐ Patient cancelled appointment, no reschedule.
- ☐ Made 3 - 4 follow-up phone calls to reschedule, unanswered.
- ☐ Sent follow-up letter to reschedule.
    - ☐ Letter returned due to bad address.
- ☐ Rescheduling this patient's appointment.
- ☐ Plan to assist patient with transportation or other support service needs.
- ☐ Patient is not interested in receiving services from health center.

Other Notes:
_____
_____
_____

Community Partnership for ED Express Care and Case Management
MEDICAL HOME SURVEY
** INSTRUCTIONS **

The purpose of this survey is to collect information from ED program patients about their current health status and experiences with the care and services received. These are patients who were referred to your health center by your partner hospital ED and have returned for follow-up visits. We want to find out about your patients' perception and satisfaction with their care to determine their likelihood of returning to the ED for a non-emergency case.

The following are special instructions and tips for administering the Medical Home Survey.

Selecting the Patients

- Each morning (or the evening before), the program's case manager (or other program staff) should check the appointments and identify program patients scheduled for a visit on that day (if the health center does not mark/flag the charts of program patients as such, an up-to-date copy of the patient data tracking file should be used for this purpose).

- Select program patients who have already had at least one follow-up/primary care visit at the health center since their ED visit to participate in the survey.

- Flag the charts of the selected patients and/or make a list of their names and appt. times.

Survey Administration Instructions

- Instruct registration staff to identify program patients selected to take the survey when they check in, using the list created by program staff.

- Inform the patient/proxy about the purpose of the survey (using talking points provided) after registration is completed, and ask if he/she would be willing to complete the survey.

  o If the patient/proxy **agrees**, provide the survey (Spanish for Spanish-speaking patients; English for others), along with a clipboard and pen and ask the patient to complete and return it before leaving. Inform the patient/proxy of staff available to answer questions.

  o If the patient/proxy **does not agree**, provide more information about the survey and its confidentiality and if the patient still is not interested, thank him/her and do not insist any further.

- Designated staff should be available to clarify questions if patients need assistance. When providing assistance, staff should be careful not to encourage any given response or include their own assumptions.

- Mark each survey with the patient's Program ID number <u>after it is completed</u>.

Community Partnership for ED Express Care and Case Management
MEDICAL HOME SURVEY
** TALKING POINTS **

The following talking points are general guidelines/suggestions to use when informing patients about the purpose of the Medical Home survey, determining their willingness to complete the survey and getting them started.

- *Good morning [afternoon]. We are conducting a survey of patients about their health, experiences here at the health center and any suggestions they have to improve our services. The survey does not ask for your name or personal information, and your answers will be confidential and not shared with anybody. It takes about 10 minutes to do the survey. Would you mind helping us by filling this out?*

    o **Yes**

    Thank you. Please answer the questions the best you can and when you're done give your completed survey to the front desk staff before you leave. If you have any questions, let us know and we can help you.

    o **Not sure**

    This health center has been participating in a program designed to educate patients about use of their doctor's office or a health center for their non-emergency and primary care needs, instead of hospital emergency departments. This survey will help us determine how useful the program's efforts have been.

    Your answers are completely confidential – I won't even be reading them.

    o **No**

    Thank you anyway.

Medical Home Survey:
Patient Report of their Health & Healthcare Services

Your healthcare provider and his/her office staff are participating in a program designed to educate patients to use their doctor's office or a health center for their non-emergency and primary care needs, instead of hospital emergency departments. The purpose of this survey is to gather information on how patients feel about their health in general and the services that they received at their regular doctor's office as part of plan to determine how useful the program's efforts have been.

We need your help and would appreciate if you complete this survey and provide information about your health, experiences at your doctor's office and the services you receive and your suggestions to improve these services.

You do not need to identify yourself in any way. Your responses will be kept fully confidential and not shared with anybody. It takes approximately 10 minutes to complete the survey. Please answer **all questions** to the best of your knowledge, PRINT CLEARLY and return your completed survey to the office staff. If you have questions about the survey and how the collected information will be used, please see the health center staff that provided you with the survey.

Thank you for your assistance.

Medical Home Survey:
Patient Report of their Health & Healthcare Services

PLEASE ANSWER ALL QUESTIONS BELOW BY CHECKING THE BOX ☑ NEXT TO YOUR RESPONSE.

The first three questions are about how healthy or unhealthy you feel.

1. In general, would you say your health is:

    ☐ Excellent   ☐ Very good   ☐ Good   ☐ Fair   ☐ Poor

2. Compared to **one year ago**, how would you rate your health in general **now**?

    ☐ Much better now   ☐ Somewhat better now   ☐ About the same   ☐ Somewhat worse now   ☐ Much worse now

3. In general, how would you rate your own health **compared** to other people?

    ☐ Healthier than most people   ☐ About as healthy as most people   ☐ Less healthy than most people

The following questions are about the quality of care that you received at this health center and how satisfied you are with your care.

4. Do you have a personal doctor at this practice (a doctor you see for most of your visits)?

    ☐ Yes   ☐ No

5. When you are sick and need an immediate appointment with your doctor, how long do you have to wait?

    ☐ 1 day or less   ☐ 2 – 3 days   ☐ 4 days – 1 week   ☐ More than 1 week

6. How long do you usually sit in the waiting area before seeing your doctor? _____ (in minutes)

7. Next to each statement below, circle the response that best describes your experience of care. If the statement does not apply to you, please circle "8" under the "NA" column.

	Always	Often	Sometimes	Rarely	Never	NA
I can get an appointment with a doctor here when I need it (including same day, evenings, weekends, etc.).	5	4	3	2	1	8
The office staff follow up with me if I have missed an appointment.	5	4	3	2	1	8
I see the same doctor for my routine care, instead of different doctors every visit.	5	4	3	2	1	8
Visits with my doctor are long enough to deal with my needs and answer all of my questions.	5	4	3	2	1	8
My doctor explains things in a way that I can understand (e.g. explaining terms clearly, helping me prepare for visits).	5	4	3	2	1	8
My doctor listens to my concerns and questions.	5	4	3	2	1	8

	Always	Often	Sometimes	Rarely	Never	NA
My doctor treats me with courtesy and respect.	5	4	3	2	1	8
The office staff respects my needs and requests.	5	4	3	2	1	8
Before giving me any new medicine: 1. The doctor/nurse explain what the medicine is for.	5	4	3	2	1	8
2. The doctor/nurse gives instructions on how much to take and when to take it.	5	4	3	2	1	8
3. The doctor/nurse describes possible side effects in a way I can understand.	5	4	3	2	1	8
I can reach a doctor or nurse at this health center 24 hrs a day, 7 days a week (by phone or in person) if I have questions or need help.	5	4	3	2	1	8
I receive clear directions for who to contact or where to go for different medical problems.	5	4	3	2	1	8
When or if I ask, my doctor or office staff helps me to explain my needs to other doctors.	5	4	3	2	1	8
The health center has a staff person(s) who coordinates my care and: 1. Helps me with difficult referrals, payment issues and follow-up activities.	5	4	3	2	1	8
2. Helps me find needed services (e.g. transportation, home care, etc.).	5	4	3	2	1	8
3. Makes sure the care I receive meets my needs.	5	4	3	2	1	8
4. Helps each person involved in my care communicate with each other (with my consent) and me.	5	4	3	2	1	8
Staff asks about my language needs at registration or while I am scheduling my visit.	5	4	3	2	1	8
If I need it, my clinic provides me with an interpreter (face-to-face, telephonic, video, etc.).	5	4	3	2	1	8
If needed, I am able to get all written information (clinical or educational) in my preferred language.	5	4	3	2	1	8
Staff asks about my hearing and vision needs at registration or while I am scheduling my visit.	5	4	3	2	1	8

8. Think about your health needs and the services you received at your doctor's office/health center, overall how satisfied or dissatisfied are you with those services?

☐ Very satisfied   ☐ Somewhat satisfied   ☐ Somewhat dissatisfied   ☐ Very dissatisfied

9. Would you recommend your doctor (or health center) to your family or friends?

☐ Definitely yes   ☐ Probably yes   ☐ Probably no   ☐ Definitely no

10. Do you have any suggestions to improve the care you receive at this practice?
_____

Thank you for completing our survey.

Medical Home Survey:
Solicitud Sobre la Salud de los Pacientes y los Servicios de Salud

Su doctor y el personal de la oficina están participando en un proyecto* diseñado para educar a los pacientes acerca de cuándo deben acudir al consultorio de su médico o a un centro de salud para sus necesidades de atención médica, en vez de acudir a la sala de emergencias de un hospital. El propósito de esta encuesta es para obtener información sobre cómo los pacientes se sienten acerca de su salud y de los servicios que reciben en este centro de salud. Esto forma parte de los planes para determinar que tan útil han sido los esfuerzos del proyecto.

Necesitamos su ayuda y le agradeceríamos que llenara esta encuesta y nos de información sobre su salud, su experiencia con los servicios que recibe en este centro de salud y sus sugerencias para mejorar estos servicios.

No es necesario que se identifique. Sus respuestas se mantendrán en total confidencialidad y no se compartirán con nadie. Llenar la encuesta le tomará aproximadamente 10 minutos. Por favor, **conteste todas las preguntas** de la manera más honesta posible, ESCRIBA CON LETRA LEGIBLE y devuelva el cuestionario lleno al personal de la oficina. Si usted tiene preguntas acerca de la encuesta y cómo su información será utilizada, por favor hable con el personal del centro de salud que le entregó la encuesta.

Gracias por su ayuda.

Medical Home Survey:
Solicitud Sobre la Salud de los Pacientes y los Servicios de Salud

POR FAVOR RESPONDA TODAS LAS PREGUNTAS MARCANDO SUS RESPUESTAS CON EL SÍMBOLO ☑.

Las tres primeras preguntas son acerca de qué tan saludable o poco saludable usted se siente.

1. En general, usted diría que su salud es:

    ☐ Excelente   ☐ Muy buena   ☐ Buena   ☐ Regular   ☐ Mala

2. ¿En comparación con **un año atrás**, cómo calificaría **actualmente** el estado de su salud en general?

    ☐ Actualmente mucho mejor   ☐ Un poco mejor ahora   ☐ Igual que antes   ☐ Un poco peor ahora   ☐ Mucho más peor ahora

3. En general, ¿cómo usted calificaría su salud en **comparación** con otras personas ?

    ☐ Más saludable que la mayoría de las personas   ☐ Igual de saludable que la mayoría de las personas   ☐ Menos saludable que la mayoría de las personas

Las siguientes preguntas son acerca de la calidad del cuidado que usted recibe en este centro de salud y qué tan satisfecho está usted con su cuidado.

4. ¿Tiene usted un médico personal en este consultorio (un médico quien le atiende la mayor parte de sus visitas)?

    ☐ Si   ☐ No

5. Cuando usted está enfermo y necesita hacer una cita de inmediato con su médico, ¿cuánto tiempo tiene que esperar?

    ☐ 1 día o menos   ☐ 2 – 3 días   ☐ 4 días – 1 semana   ☐ Más de 1 semana

6. ¿Cuánto tiempo usted usualmente espera para ser atendido por el médico? _____ (en minutos)

7. Al lado de cada afirmación, marque con un círculo la respuesta que mejor describe su experiencia con la atención médica recibida en este centro de salud. Si la afirmación no aplica a su caso, por favor marque el círculo en el número "8" que está bajo la columna "NA".

	Siempre	Con Frecuencia	A Veces	Raramente	Nunca	NA
Puedo hacer una cita con un médico de aquí cuando lo necesito (incluyendo el mismo día, noches, fines de semana, etc)	5	4	3	2	1	8
El personal de la oficina me contacta si no llego a mi cita.	5	4	3	2	1	8
En mis citas de rutina me atiende el mismo médico, en lugar de médicos diferentes en cada visita.	5	4	3	2	1	8
Durante las citas con mi médico hay suficiente tiempo para atender mis necesidades y responder mis preguntas	5	4	3	2	1	8

	Siempre	Con Frecuencia	A Veces	Raramente	Nunca	NA
Mi doctor me explica las cosas de una manera en que yo pueda entender (por ejemplo, explica con claridad los términos médicos, ayuda a prepararme para las citas).	5	4	3	2	1	8
Mi doctor escucha mis preocupaciones y preguntas.	5	4	3	2	1	8
Mi doctor me trata con cortesía y respeto.	5	4	3	2	1	8
El personal de la oficina respeta mis necesidades y peticiones.	5	4	3	2	1	8
Antes de recetarme cualquier medicina: 1. El doctor/la enfermera explica para que es la medicina.	5	4	3	2	1	8
2. El doctor/la enfermera me da instrucciones sobre cuánto debo tomar y cuándo.	5	4	3	2	1	8
3. El doctor/la enfermera describe los posibles efectos secundarios de una manera en la que puedo entender.	5	4	3	2	1	8
Puedo comunicarme con un doctor/enfermera en este centro las 24 horas del día, los 7 días a la semana (por teléfono o en persona) si tengo alguna pregunta o necesito ayuda.	5	4	3	2	1	8
Recibo claras instrucciones sobre a quién contactar o donde ir en caso de diferentes problemas de salud.	5	4	3	2	1	8
Si pregunto o cuando pregunto, a mi doctor o el personal del consultorio, me ayudan a explicar mis necesidades a otros médicos.	5	4	3	2	1	8
El centro de salud cuenta con un miembro del personal que coordina mi atención médica: 1. Me ayuda con las referencias difíciles, problemas con el pago y los procedimientos de seguimiento.	5	4	3	2	1	8
2. Me ayuda a encontrar los servicios que necesito (ejemplo, transporte, cuidados médicos en el hogar, etc.)	5	4	3	2	1	8
3. Se asegura que la atención que recibo satisface mis necesidades.	5	4	3	2	1	8
4. Ayuda a cada persona que participa en mi cuidado a tener una mejor comunicación entre ellos (con mi consentimiento) y conmigo.	5	4	3	2	1	8
El personal pregunta sobre mis necesidades en cuanto al idioma al momento de registrarme o cuando se programa mi cita.	5	4	3	2	1	8
Si lo necesito, la clínica me provee un servicio de interprete (cara a cara, vía telefónica, por video, etc)	5	4	3	2	1	8
Si lo requiero, puedo obtener toda la información escrita (médica o educacional) en el idioma de mi preferencia.	5	4	3	2	1	8
El personal pregunta sobre mis necesidades auditivas y de visión al registrarme o cuando programo una visita	5	4	3	2	1	8

8. Piense en sus necesidades de salud y los servicios que recibe en este consultorio / centro de salud, en general ¿qué tan satisfecho o insatisfecho está usted con los servicios?

☐ Muy satisfecho ☐ Un poco satisfecho ☐ Un poco insatisfecho ☐ Muy insatisfecho

9. ¿Recomendaría a su médico (o centro de salud) a su familia o amigos?

☐ Definitivamente si ☐ Probablemente si ☐ Probablemente no ☐ Definitivamente no

10. ¿Tiene alguna sugerencia para mejorar la atención que usted recibe en este consultorio?
_____

Muchas gracias por completar este cuestionario.

Provider Survey (Hospital)

As you may know, your facility participated in the ED Community Partnership program that tested a model for providing alternate non-emergency services to patients who present with primary care needs in hospital emergency departments. See attached for a summary of the program scope and features of the model.

This brief survey is designed to obtain your feedback on performance of the model at your site and its impact, if any, on your work. We are collecting this information as part of the program's overall evaluation and assessment of its impact. It should take you about 5 minutes to complete the survey. As always, we guarantee strict confidentiality of your responses. The survey findings will be reported only in aggregate form and no single individual or facility will be identified.

For questions, please contact [name of contact and contact information]. Please submit your completed survey no later than [date].

1. To the best of your knowledge, please indicate how useful the following program features have been to you and your work by checking the number for each item that best describes your opinion/experience.

	Not at All Useful	A Little Useful	Somewhat Useful	Moderately Useful	Very Useful	Not Sure/ Don't Know
Set up of the ED Express Care process for patients using ED for primary care needs	1	2	3	4	5	8
Use of APNs to triage ED patients, identifying those with primary care needs	1	2	3	4	5	8
Use of APNs to provide express primary care services to identified patients	1	2	3	4	5	8
Tools for determining reasons for use of ED	1	2	3	4	5	8
Providing patient education at ED	1	2	3	4	5	8
Partnership between ED and FQHC	1	2	3	4	5	8
Making patient follow-up appointment at FQHC using electronic appointment system	1	2	3	4	5	8
Sharing patient information with FQHC via electronic connection	1	2	3	4	5	8
Referring patients to other primary care providers	1	2	3	4	5	8
Sharing information with Medicaid HMOs re: beneficiaries' visits for primary care needs	1	2	3	4	5	8
Tracking patient utilization of ED for primary care needs and identifying repeat ED users	1	2	3	4	5	8

2. Please indicate the extent of difficulty you experienced by checking the number for each item that best describes your opinion/experience.

	No Difficulty	Some Difficulty	Significant Difficulty	Not Sure/ Don't Know
Convenient workflow and patient flow	1	2	3	8
Using electronic connection with FQHC	1	2	3	8
Offering same level of education and case management *after hours*	1	2	3	8
Connecting patients to other providers and/or their HMO *after hours*	1	2	3	8
Other, *please specify*: _____	1	2	3	8

3. Please indicate your satisfaction with the program by checking the number for each item that best describes your opinion/experience.

	Very Unsatisfied	Somewhat Unsatisfied	Not Sure	Somewhat Satisfied	Very Satisfied
ED operations and process changes	1	2	3	4	5
ED workflow and patient flow	1	2	3	4	5
Transition between ED and primary care	1	2	3	4	5
Overall performance of the program model	1	2	3	4	5

4. Would you recommend this program model to other hospitals?

☐ Yes, I would fully recommend implementation of this program model at other sites.

☐ Yes, but I would recommend implementation of only some components of this program model.

   Please specify: _____
   _____

☐ No, I would not recommend any component of this program model.

   Please clarify your concerns: _____
   _____

5. Please provide your contact information (optional)

Name: _____   **Title:** _____

Hospital: _____

Telephone: _____   **E-mail:** _____

THANK YOU FOR COMPLETING THIS SURVEY!

Provider Survey (FQHC)

As you may know, your facility participated in the ED Community Partnership demonstration program that tested a model for providing alternate non-emergency services to patients who present with primary care needs in hospital emergency departments. See attached for a summary of the program scope and features of the model.

This brief survey is designed to obtain your feedback on performance of the model at your site and its impact, if any, on your work. We are collecting this information as part of the program's overall evaluation and assessment of its impact. It should take you about 5 minutes to complete the survey. As always, we guarantee strict confidentiality of your responses. The survey findings will be reported only in aggregate form and no single individual or facility will be identified.

For questions, please contact [name of contact and contact information]. Please submit your completed survey no later than [date].

1. To the best of your knowledge, please indicate how useful the following program features have been to you and your work by checking the scale level that best describes your opinion/experience for each item.

	Not at All Useful	A Little Useful	Somewhat Useful	Moderately Useful	Very Useful	Not Sure/ Don't Know
Expanding capacity (i.e., adding service hours and/or clinical staff)	1	2	3	4	5	8
Enhancing health center services to function as patients' medical home	1	2	3	4	5	8
Building the care team (MD, RNs, MAs, Case Manager, etc.)	1	2	3	4	5	8
Partnership between ED and FQHC	1	2	3	4	5	8
Blocking same-day/quick appointment times for follow-up visits	1	2	3	4	5	8
Receiving follow-up appointments from ED using electronic appointment system	1	2	3	4	5	8
Receiving patient information from ED via electronic connection	1	2	3	4	5	8
Providing all domains of medical home services and serving as patients' medical home	1	2	3	4	5	8
Providing patient education and case management	1	2	3	4	5	8
Providing additional patient support (e.g., access to providers by phone 24/7, transportation, interpreters, etc.)	1	2	3	4	5	8
Tools for patient tracking, determining patient needs and reasons for missed appointments	1	2	3	4	5	8
Providing intensive case management for repeat ED users	1	2	3	4	5	8
Sharing information with Medicaid HMOs re: beneficiaries' utilization of FQHC	1	2	3	4	5	8

2. Please indicate the extent of difficulty you experienced by checking the scale level that best describes your opinion/experience for each item.

	No Difficulty	Some Difficulty	Significant Difficulty	Not Sure/ Don't Know
Handling increased capacity (hours, clinical staff, etc.)	1	2	3	8
Adopting medical home features and serving as patients' medical home	1	2	3	8
Using electronic connection with ED	1	2	3	8
Handling increased patient volume	1	2	3	8
Maximizing the referred patients' show rates	1	2	3	8
Connecting with no-show patients	1	2	3	8
Access to needed specialty services	1	2	3	8
Ensuring patients' future use of FQHC for primary care needs	1	2	3	8
Other, *please specify*: _____	1	2	3	8

3. Please indicate your satisfaction with the program by checking the scale level that best describes your opinion/experience for each item.

	Very Unsatisfied	Somewhat Unsatisfied	Not Sure	Somewhat Satisfied	Very Satisfied
FQHC operations and process changes	1	2	3	4	5
FQHC workflow and patient flow	1	2	3	4	5
Transition between ED and FQHC	1	2	3	4	5
Overall performance of the program model	1	2	3	4	5

4. Would you recommend this program model to other healthcare sites?
   - ☐ Yes, I would fully recommend implementation of this program model at other sites.
   - ☐ Yes, but I would recommend implementation of only some components of this program model.

     Please specify: _____

     _____

   - ☐ No, I would not recommend any component of this program model.

     Please clarify your concerns: _____

     _____

5. Please provide your contact information (optional)

Name: _____   Title: _____

FQHC: _____

Telephone: _____   E-mail: _____

SECTION III: BIBLIOGRAPHY

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H. ADDITIONAL RESOURCES

ED Process Resources

The American College of Emergency Physicians provides a number of helpful resources that can be beneficial to the objectives of this program at www.acep.org. These resources include:

- The Dynamics of Organizational Change;
- Efficiency in the Emergency Department;
- The Nature of ED Services;
- A Uniform Triage Scale in Emergency Medicine;
- Triage Scale Standardization;
- Medical Screening of Emergency Department Patients;
- Optimizing Emergency Department Front End Operations;
- EMTALA and On-call Responsibility for Emergency Department Patients;
- Managing Non-emergency Care in the Emergency Department;
- Resource Utilization in the Emergency Department: The Duty of Stewardship;
- Emergency Medicine's Role in Public Health;
- Health Information Technology;
- Patient Medical Records in the Emergency Department;
- Emergency Department Medical Records Elements;
- The Role of Metrics in Managing Clinical Operations; and,
- Service Management Tools.

The Emergency Nurses Association provides resources at www.ena.org, such as the *Scope of Emergency Nursing Practice.*

Primary Care Process Resources

In addition to the wealth of resources already provided to the FQHCs and other primary healthcare clinics by the Bureau of Primary Health Care (http://bphc.hrsa.gov and www.hrsa.gov/servicedelivery), a new Web-based resource is available on the AHRQ Health Care Innovations Exchange Web site (www.innovations.ahrq.gov), called *Linking Clinical Practices and the Community for Health Promotion.* It is designed to help healthcare professionals find new ways to work together to help patients adopt healthy behaviors and better manage their health. This resource helps create new ways to connect patients with services in primary care offices and community settings and increase accessibility to these services. Other features include profiles of innovations that have successfully integrated clinical, public health and community health services and tools to assist in developing partnerships and referral linkages. The Health Care Innovations Exchange Web site was launched in 2007 to support healthcare professionals in sharing and adopting innovations that improve the delivery of care to patients.

Another good source of information is the Partnership for Prevention (www.prevent.org), which has worked with the Centers for Disease Control and Prevention to bridge the gap between research and practice by developing *The Community Health Promotion Handbook: Action Guides to Improve Community Health*. This evidence-based tool consists of an Introduction and five Action Guides addressing diabetes management, physical activity and tobacco-use treatment. Each Action Guides translates a specific recommendation from *The Guide to Community Preventive Services* into "how to" guidance to help public health practitioners and others interested in promoting health implement effective community-level health promotion strategies.

Case Management Resources

The National Association of Social Workers provides resources at www.socialworkers.org, such as *Standards for Social Work Case Management* and *Standards for Cultural Competence in Social Work Practice*.