Performing Provider: Community Care Collaborative
Project Name: Community Health Paramedic Navigation Program
Project Identifier: 307459301.2.6 Pass 3

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

Intervention(s): Through this project, the CCC will expand the Community Health Paramedic (CHP) program currently operated by Austin Travis County Emergency Medical Services (ATCEMS) to provide short term care management and patient navigation services to low-income Travis County residents with multiple chronic conditions and have frequent recent Emergency Department (ED) utilization. In conjunction with the fourteen other DSRIP projects that build critical infrastructure, expand access to care, and ensure that patients receive the right services in the right place at the right time, this project will create patient care plans, connect patients to appropriate resources, and reduce unnecessary ED visits.

Need for the project: Qualitative data collected through surveys and from providers indicate a need for better coordination across settings of care. High rates of unnecessary ED utilization and potentially preventable hospitalizations also point to the need for better care coordination and navigation.

Target population: This project will be targeted Travis County residents at 200% of FPL or below. The majority of these patients are uninsured or on Medicaid.

Category 1 or 2 expected patient benefits: Through this project, the CCC expects to provide short term care management and patient navigation services to a cumulative total of 1,125 patients through DY5.

Category 3 outcomes: 9.2: ED Visit rate for ACSCs

Title of Project: **Community Health Paramedic Navigation Program**
Category / Project Area / Project Option: **2.9.1 Establish/Expand a Patient Navigation Program**
RHP Project Identification Number: **307459301.2.6**
Performing Provider Name: **Community Care Collaborative**
Performing Provider TPI: **307459301**

Project Description

Overall Project Description

The Community Care Collaborative (CCC) is a 501(c)3 public-private partnership that will redesign the Travis County indigent healthcare delivery system. The CCC was created in 2012 by Central Health, the taxpayer-funded Travis County Healthcare District, and the Seton Healthcare Family, Travis County's largest hospital system. Austin Travis County Integral Care, the designated provider of community-based behavioral health and development disorder services for Travis County, has also recently joined the CCC as a partner. The CCC's overarching goal is to provide high quality, cost effective, patient centered care that improves health outcomes for its targeted population. The CCC, through its contracted provider network, will initially serve a defined patient population of 50,000 uninsured individuals or below 200% of the Federal Poverty Level and who meet other established eligibility requirements.

The operational objectives of the CCC are to create effective coordination between providers across the continuum of care; increase and integrate capabilities of providers' Electronic Health Record (EHR) and the system's Health Information Exchange; and aligns payments with outcomes, rather than outputs. With significant public investment in the transformation of the indigent healthcare system, the CCC will develop and implement accountable care organization (ACO) and patient-centered medical home principles by establishing a strong, comprehensive primary care base, collective responsibility for care of patients across the delivery continuum, payments linked to quality improvements, and reliable and progressively stronger performance measurement and reporting.

Through this project, the CCC will expand the Community Health Paramedic (CHP) program currently operated by Austin Travis County Emergency Medical Services (ATCEMS) to provide short term care management and patient navigation services to enroll low-income Travis County residents with multiple chronic conditions and frequent recent ED utilization. These patients will benefit from increased access as described in this project, but also the fourteen other DSRIP projects that the CCC is proposing. These fourteen projects are:

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

The Region 7 community needs assessment found that many local safety net providers feel patients struggle with establishing and maintaining connections to appropriate healthcare and social services. Travis County safety net data show that among the population served by the safety net between May

2011-April 2012, more than 50% had potentially preventable Emergency Department visits. The CCC anticipates that many patients in its target population, including those with two or more chronic conditions, may have had little to no consistent contact with the healthcare delivery system and will need initial, intensive home-based support to get connected to regular medical homes and other support services to begin proper management of their conditions. As a result of this home support and navigation service, the CCC expects ED usage among these patients will decrease. The expanded CHP program will provide a bridge into the CCC's system of care at which point care for these patients can be managed actively by the CCC network of case managers and health providers.

The current CHP program began in 2009 upon the realization that a few high utilizers of the 9-1-1 system were incurring a significant number of emergency medical calls, resulting in a significant amount of community resources to support these patients. It was clear the patients were receiving medical care in an inappropriate and ineffective setting. A goal was established to identify the highest utilizers of emergency transport services and to provide navigation and connectivity to the appropriate setting and reduce dependency on the 9-1-1 system as their source of care. In 2012, this program reported a 62% reduction in emergency transport visits for 57 patients identified as high utilizers upon comparison of 9-1-1 utilization from pre-entry and discharge from the program. This proposed CCC project will expand the current program and modify its structure to provide targeted navigation services to CCC patients with two or more chronic conditions and have had two or more visits to the ED within a 30 day time period.

The CHP Navigation Program will perform a key role in the CCC to achieve established goals by providing initial medical assessments in the home of the patient with chronic conditions and high recent ED utilization. Services will vary according to patient needs but may include vital sign assessment, medical screening, home safety assessment, prescription drug assessment, access to a pharmacy and needed prescription refills, establishing appointments for patients with no existing care provider, direct transportation service or arrangement for transportation to medical appointments, behavioral health screening and navigation to appropriate behavioral health services providers. The expanded program will also allow CHP staff to provide certain medical services to patients in the home as governed by care protocols to be developed by the program's medical director.

Travis County has a population of just over 1,000,000 residents. 27% of adults aged 18-64 in Travis County are uninsured. Of the 50,000 patients within the CCC patient population, an estimated 18,000 have multiple chronic conditions. Within this group, congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD), and hypertension are top diagnoses. In Travis County and in Region 7 as a whole, rising rates of chronic disease, combined with a growing general and elderly population, will produce an even greater demand for effective chronic disease management. This will place a greater emphasis on access to proper care and patient self-management.

Upon entry to the program, the CHP program will establish contact to schedule a home visit. The CHP is trained to provide first response treatment for the target chronic conditions patient population and will be guided by clinical protocols established by the ATCEMS medical director. The CHP will initiate a questionnaire to establish if the patient has a medical home, is adhering to prescribed medications, and properly self-managing their care. Language barriers will be addressed, as a requirement of the program is that each CHP paramedic speaks both English and Spanish. If

further interpretive services are necessary; the CHP will utilize the language interpretive services offered by the current 9-1-1 system.

Many patients with chronic conditions have mobility issues and are at high-risk for a fall that could result in serious injury or death. According to a report released by the Travis County Medical Examiner, accidental falls were the second highest cause of accidental deaths, with 168 deaths that occurred in 2011 (http://www.co.travis.tx.us/medical_examiner/pdfs/annual_report2011.pdf). Because of this risk, another aspect of the CHP program is a risk assessment of the home and identification of high-risk areas within the home that could result in a serious fall. The risks will be communicated to the patient to help avert this dangerous condition.

Once the initial assessments are completed, the CHP and the patient will work together to create a patient care plan. The CHP will visit the patient at least once a week for a period of up to 30 days to monitor adherence to the patient care plan and continue connecting patients to the appropriate services. Including:

- Connection to primary care and scheduling appointments if necessary
- Addressing transportation barriers
- Facilitating appropriate and affordable access to prescriptive medicines
- Navigation to social service needs, including behavioral health
- Reinforcing self-management care instructions to patient or caregiver

Project Goals

- Reduce preventable ED visits among targeted Medicaid, MAPand uninsured patients with multiple chronic conditions
- Provide essential navigation services to allow patients to receive proper care in the most appropriate and cost-effective setting
- Reduce risk of accidental deaths or serious injury by eliminating risk of accidental fall

Challenges or Issues Faced by the Performing Provider

- Patients with multiple chronic diseases and frequent utilizers of the ED may have a number of barriers to care, including language or cultural barriers, or lack of transportation.
- Patients with multiple chronic conditions often have a co-occurring behavioral health issue.
- Establishing and maintaining providers to accept program participants.
- Integrating patient care data from the patient's 30-day care plan into the CCC HIE.

How the Project Addresses those Challenges

- To ensure cultural sensitivity in interacting with patients, all CHPs will be certified by DSHS as Community Health Workers. This certification will help prepare the CHPs to interact with patients in a way that responds best to their cultural needs.
- Spanish and English language skills will be emphasized for CHPs. Translation services are also available via established 9-1-1 protocols.
- Patients will be linked to current transportation providers as a resource to this program.
- CHP will have links to behavioral health resources within the CCC.

- CHP program staff and the CCC will constantly work to maintain good relationships with providers to ensure smooth transitions for patients into the program and then into needed care settings.
- CHP and CCC technical staff will establish a way through the CCC's HIE to communicate program care plan data and other health information to primary care providers in a seamless fashion.

How the Project is Related to RHP Goals

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

- **5-Year Expected Outcome for Providers and Patients:** Through this project, the CCC expects to provide short term care management and patient navigation services to a cumulative total of

1,125 patients through DY5. Through improved care management and navigation, the CCC aims to reduce preventable ED visits among targeted CCC and uninsured patients with multiple chronic conditions.

Starting Point/Baseline

Baseline Data

0 (New program)

Rationale

Reason for Selection of Project Options and Components

As outlined within the Region 7 Community Needs Assessment, qualitative data collected through surveys and from providers indicate a need for better coordination across settings of care. Quantitative data regarding unnecessary ED utilization and potentially preventable hospitalizations also point to the need for better care coordination and navigation. A 2011 analysis of ED visits by uninsured and underinsured patients in Travis County found that almost 50% of ED visits were for services that could have been provided in a primary care setting. Similarly, DSHS estimates that adult residents of Travis County have approximately 6,000 potentially preventable inpatient hospitalizations per year. Potentially preventable hospitalizations for CHF, diabetes complications, COPD, and hypertension contributed to over $500 million in hospital charges in Travis County between 2005 and 2010.

The Austin/Travis County 2012 Community Health Assessment, which drew heavily from focus groups and resident surveys, also found that transportation challenges, especially for low-income residents, often mean limited access to healthcare services (http://austintexas.gov/sites/default/files/files/Health/CHA-CHIP/cha_report_8-24-12.pdf, p. vii).

Project option 2.9.1 includes five required components:

a) **Identify frequent ED users and use navigators as part of a preventable ED reduction**

program. Train healthcare navigators in cultural competency. The current system

identifies high ED utilizers through the 9-1-1 system and will expand to include the CCC patient record system, where ED visits will be monitored for frequent utilization. Additionally, a new training component will be added for all community health paramedics in the program to ensure they are certified as Community Health Workers by DSHS. This training includes an emphasis on developing cultural competency.

b) **Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.** This program will utilize EMS paramedics that are trained to quickly triage patients and follow known clinical protocols that are under the supervision of the ATCEMS Medical Director. Established "pathways" of available referral options and resources will be developed to facilitate the navigation process.

c) Connect patients to primary and preventive care. Connecting enrollees to primary and preventive care is a primary task of the community health paramedic. Frequently, community health paramedics conducting a home visit will call the patient's primary care provider to schedule appointments and arrange transportation to services if needed. Patients without an existing provider will be connected with a Patient Centered Medical Home through the CCC. The goal is to facilitate connections to continued sources of support for improved health.

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management. Because the target population is comprised of patients with multiple chronic conditions, specific protocols for addressing chronic disease management will be developed and incorporated into community health paramedic training. Internal systems will be built to ensure that clinical information is regularly communicated between the CCC and field staff.

e) Conduct quality improvement for project using methods such as rapid cycle improvement. Process assessment and redesign milestones in DY4 and 5 will ensure that CQI activities are utilized.

Reason for Selection of Milestones & Metrics

During DY 2, the CCC, ATCEMS, and key stakeholders will achieve the milestone P-X -Complete a Planning Process – to develop an expansion plan for the CHP program. Additionally the provider will develop a set of standard operating procedures to govern patient referrals to needed services. Finally, medical program staff will develop a set of clinical protocols to govern CHP medical services provided and the development of the 30-day care plan.

In DY 3, the CCC and ATCEMS will start the process of designating additional community health paramedics to serve in the community health program to achieve milestone P-X – Designate/Hire Personnel to Support/Manage Project. This milestone will also ensure the personnel have the appropriate equipment and vehicles to perform both standard paramedic and CHP functioning. All CHPs will also be certified as CHWs. Additionally, the team will work to incorporate CHP program data, including information from the 30-day care plan, into the CCC HIE. This work will achieve the milestone P-X- Implement, adopt, upgrade, or improve technology to support the project.

In DY 4, the CCC and ATCEMS will bring the program to full staffing (P-X – Designate/Hire Staff) and begin increasing the number of patients served by the program (I-10: Improvements in Access to Care of Patients Receiving Navigation Services, Metric 10.3: Increase patients served by the program). In addition, it will essential to participate in face-to-face meetings with other

providers to make improvements, or "raise the floor" for performance (P-8: Participate in face-to-face meetings to collaborate with providers and improve performance)
In DY 5, the number of patients served will continue to increase (I-10, Metric 10.3).Face-to-face meetings will also continue (P-8: Participate in face-to-face meetings to collaborate with providers and improve performance)

Unique Community Need Identification Number
CN.7 Lack of coordination of care across settings of care, multiple conditions, and/or physical and behavioral health.
CN.8 High rates of non-emergent emergency department usage and potentially preventable inpatient admissions
CN.9 High rates of chronic disease such as cardiovascular disease, cancer, and rising rates of diabetes
CN.10 Many residents in Region 7 have multiple chronic conditions

Related Activities Funded by U.S. Dept. of Health and Human Services (DHHS) None

Related Category 3 Outcome Measure(s)

Category 3 Outcome Measures(s) Selected:
9.2: ED Visit rate for ACSCs
Relationship to Other RHP Projects

How Project Supports, Reinforces, Enables Other Projects
The CCC's fifteen projects are all interrelated and will provide high quality, cost effective, patient-centered care that improves health outcomes for its targeted population. The CCC projects most closely related to Community Health Paramedic Navigation Program are outlined below.

- 307459301.2.1 - Patient-Centered Medical Home
- 307459301.2.2 – Expand Chronic Care Management Models
- 307459301.1.2 – Expanded Primary Care Hours at Community-Based Outpatient Settings
- 307459301.1.3 – Expand Primary Care via Mobile Health Clinics
- 307459301.1.1 - Disease Management Registry

List of Related Category 4 Projects
RD-1: Potentially Preventable Admissions
RD-2: 30-day Readmissions

Relationship to Other Performing Providers' Projects in the RHP

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

With its aim to improve management of chronic conditions, this project has a similar target population to University Medical Center Brackenridge's Chronic Care Management for Adults (137265806.2.6) and ATCIC's project to Integrate Primary and Behavioral Health Care Services (133542405.2.1). With its focus on patient navigation, this project also has a similar intervention to the following projects from University Medical Center at Brackenridge:

- 137265806.2.1 – OB Navigation
- 137265806.2.3 – Substance Abuse Disorder Navigation
- 137265806.2.4 – Behavioral Health Assessment and Resource Navigation
- 137265806.2.8 – Women's Oncology Care Navigation
- 137265806.2.6 – Chronic Care Management - Adults

Plan for Learning Collaborative

Plan for Participating in RHP-wide Learning Collaborative for Similar Projects

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

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

Project Valuation

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

Other factors considered include information published by the Texas Department of State Health Services that reports potentially preventable hospitalizations for CHF, diabetes complications,

COPD, and hypertension contributed to over $500 million in hospital charges in Travis County between 2005 and 2010. For each hospitalization averted through improved care management and patient navigation, the potential cost avoidance ranges from approximately $20,000 in average hospital charges per admission for hypertension to more than $36,000 per admission for diabetes long-term complications.