Project Option 2.9.1 Establish/Expand a Patient Care Navigation Program: A4 UTHealth Regional Patient Navigation

Unique RHP Project Identification Number: 111810101.2.8
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.9 Establish/Expand a patient Care Navigation Program: (Option 2.9.1)

A patient care navigation program will be designed and implemented within the UT Health system of medical homes. The program will target patients at high risk of disconnect from institutionalized health care. Specifically, patients that entered Memorial Hermann Hospital-TMC through the ED, and then referred from the UT Health Hospitalist Service, will be sought after by the care navigators. Care navigators - community health workers (CHWs) - recruited and trained to deliver culturally competent care will assist the patients in linking up with a primary care provider within the UT Health medical homes. The patient navigators will help and support these patients to navigate through the continuum of health care services, ensuring that patients receive coordinated, timely, and site-appropriate health care services, by assisting in connecting patients to primary care physicians and/or medical home sites, as well as diverting nonurgent care from the Emergency Department to site-appropriate locations. Finally, quality improvement processes will be put in place to assess project impacts and opportunities for continuous improvement.

Goal and Relationship to Regional Goals:

Help and support patients especially in need of coordinated care navigate throught the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings.

The care navigation project will make it easier for patients to access the right care in the right place, thereby attaining the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services..."

Challenges:

Need: 1) High rates of inappropriate emergency department utilization. 2) Lack of patient navigation, patient and family education and information programs.

Implementation: 1) Access to Memorial Hermann Hospital ED data. 2) Recruitment and retention of care navigators. UT Physicians have had good working relationship with the Memorial Hermann Hospital System and this project will enable further collaboration to tackle one of the greatest challenges of the US health care system - inappropriate emergency department use.

5-Year Expected Outcome for Provider and Patients:

We expect to achieve increased uptake of primary care services by people who tend to rely on the ED for their health care needs. We expect to see a decrease in 30 day readmission rates for discharges with an index COPD admission.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

Our region has high rates of inappropriate use of the ED. Frequent ED users do so for various reasons that often include inability to afford care, lack of knowledge on how to navigate the health care system, poor access to good quality promary care, and so on. Care navigators can help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. There are different kinds of services that could be offered by navigators and this may include: setting up contacts with primary care, facilitating communication among patients, family members, survivors and healthcare providers, coordinating care among providers, arranging financial support and assisting with paperwork, and facilitating follow-up appointments.

Community health workers have close ties to the local community and serve as important links between underserved communities and the healthcare system, hence they will amke excellent care navigators. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities.

Project Components:

Through the UTHealth Regional Patient Navigation Program, we propose to meet all required project components listed below.

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in 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.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
e) Conduct quality improvement for project using methods such as rapid cycle improvement.

For the UTHealth Regional Patient Navigation Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1.]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program.
Metric 1 [P-1.1.]: Provide report identifying the following:
- Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy).
- Gaps in services and service needs.
- How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts).
- Ideal number of patients targeted for enrollment in the patient navigation program
- Number of Patient Navigators needed to be hired
- Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients

Milestone 2 [P-2.]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.

Metric 1 [P-2.1.]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.

Improvement Milestones and Metrics:

Milestone 3 [I-6.]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.
Metric 1 [I-6.2.]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED
Milestone 4 [I-6.]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.
Metric 1 [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment

Unique community need identification numbers the project addresses:

This project addresses community needs CN.8 (High rates of inappropriate emergency department utilization) and CN.23 (Lack of patient navigation, patient and family education and information programs).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

This project represents a new initiative. This program does not currently exist with UT Physicians and Memorial Hermann Hospital-TMC. This project proposes to target patients at high risk of disconnect from institutionalized health care with an intervention for getting them into primary care settings, where they can receive regularized care and avoid the need for episodic acute care.

Related Category 3 Outcome Measure(s):

OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)
Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission.

Relationship to other Projects:

1.1 (C3) - Expanded primary care services will ensure there is reserve capacity to handle the increased demand anticipated by the succesful diversion of nonurgent care from the Emergency Department to primary care settings.
1.2 (A2, SPH1) - The SPH1 project will ensure their is sufficient supply of CHWs to serve as care navigators and the training received by residents (A2) will help the physicians understand how to integrate CHWs as members of the health care team.
1.3 (C12) - The disease management registry will enable the identification of patients who default from care so that they can be actively sought and brought into compliance, which will help to reduce frequent ED use.

1.6 (C11)- Navigators will be a resource available to the nurse triage line to help ensure patients get the right care at the right time and and in the right setting.
1.9 (C4) - The expansion of specialty care in the primary care setting will help patient navigators ensure that patients get appropriate specialist input into their care when and where needed.
2.1 (C1-2) - Care navigators will assist frequent ED users in getting enrolled with a primary care team at UT Medical Homes, which will aid in reducing inappropriate ED use.
2.2 (CL3, C5 - C9) - Getting frequent ED users enrolled in a UT Medical Home, where they can receive guidance and regular evidence-based care for chronic diseases will reduce the need for acute care services being received in the ED.

Relationship to Other Performing Providers' Projects in the RHP:

To be described by RHP Anchor.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be rated on a 10-point scale each project. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds available for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of available funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with a couple of exceptions. First, we did not use two of the criteria and second, we began with a 5-point scale for each criteria rated, then doubled the score to put it on a 10-point scale. Following are the criteria, the way points were awarded for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria. Score – 1 point for each of the following: improves access; improves quality; improves costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)).

This project's score for this criteria: 2 X 2 = **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. Score - Four points for the whole population, 3 points for a relatively large population, 2 points for a moderate-sized population, and 1 point for a relatively small population. If a significant proportion of the target population is uninsured/Medicaid, add 1 additional point.

This project's score for this criteria: 1 X 2 = **2**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the

health/healthcare need(s) the project addresses. Score A - CNA indication: 2 points for strong support (bottom 25%), 1 point for moderate support. Score B - Severity: 3 points for issues judged to have significant impact on population health, healthcare access, and quality; 2 points for moderate severity issues.

This project's score for this criteria: 2 X 2 = **4**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. Score – 5 points for very low cost per person, 4 points for low cost per person, 3 points for moderate cost per person, 2 points for high cost per person, 1 point for very high cost per person.

This project's score for this criteria: 4 X 2 = **8**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth plans to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another, so giving the projects the same, or very similar ratings on this criteria would have again had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **3.2**

111810101.2.8	***OPTION 2.9.1***		***A4 UTHEALTH REGIONAL PATIENT NAVIGATION***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.19*	*IT-3.9*	*Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1.]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric 1 [P-1.1.]: Provide report identifying the following: - Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). - Gaps in services and s Baseline/Goal: TBD Data Source: Program documentation, EHR, claims, needs assessment survey Milestone 1 Estimated incentive payment: $ 1,507,247		Milestone 2 [P-2.]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.1.]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline/Goal: TBD Data Source: Program records, training records, policies and procedures Milestone 2 Estimated incentive payment: $ 1,655,144	Milestone 3 [I-6.]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2.]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: TBD Data Source: UT Physicians administrative data on patient encounters and scheduling records from patient navigator program. Milestone 3 Estimated incentive payment: $ 1,770,619	Milestone 4 [I-6.]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: TBD Data Source: UT Physicians administrative data on patient Milestone 4 Estimated incentive payment: $ 1,710,743

111810101.2.8	***OPTION 2.9.1***		***A4 UTHEALTH REGIONAL PATIENT NAVIGATION***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.19*	*IT-3.9*	*Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $1,507,247		Year 3 Estimated Milestone Bundle Amount: $1,655,144	Year 4 Estimated Milestone Bundle Amount: $1,770,619	Year 5 Estimated Milestone Bundle Amount: $1,710,743
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $6,643,753				

Title of Outcome Measure (Improvement Target): OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

Unique RHP outcome identification number(s): 111810101.3.19

Outcome Measure Description:

IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)
Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission.

Process Milestones:

DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:
IT-3.9 Reduce by 3% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
DY5:
IT-3.9 Reduce by 5% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Rationale:

When a patient is discharged without optimal follow-up, it could have terrible consequences such as hospital readmission and possibly death Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.19	*3.IT-3.9*	*Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.8*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 79,328	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 91,952 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 91,953	Outcome Improvement Target 1 [IT-3.9]: Reduce by 3% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Data Source: Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 196,735	Outcome Improvement Target 2 [IT-3.9]: Reduce by 5% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Data Source: Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 427,687
Year 2 Estimated Outcome Amount: $ 79,328	Year 3 Estimated Outcome Amount: $ 183,905	Year 4 Estimated Outcome Amount: $ 196,735	Year 5 Estimated Outcome Amount: $ 427,687
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 887,655			