I. PROJECT SUMMARY

PCC Community Wellness Center (PCC) is a Federally Qualified Health Center (FQHC) dedicated to providing high-quality, accessible health care to underserved and low-income communities in Westside Chicago and the near west suburbs. As part of our ongoing effort to achieve this goal, PCC's performance improvement and care management departments are working together to identify, contact, and connect with patients who are missing key preventative health services. Specifically, the proposed project seeks to increase the number of patients assigned to PCC by Medicaid who establish care with our medical home while reducing emergency department visits. Achieving these goals will thereby improve patient access to preventative care with a primary care provider while improving health outcomes.

Patients with compound chronic conditions and high-risk psychosocial factors account for a disproportionate amount of health expenses. These individuals often do not establish care at a medical home and instead seek event-based care at emergency departments. This utilization behavior makes it difficult for emergency department providers to coordinate care with primary care providers to positively impact the patient. Further, under a fee-for-service arrangement, there are no incentives for emergency department providers to arrange care management during the crucial periods in between visits. Yet, evidence demonstrates care management during this time is most effective for improving patient and population outcomes.[i]

To address this need, PCC's care management program will extend services to this special population. A care coordinator will utilize a three-tiered approach to deliver patient-centered interventions while optimizing the use of health center resources. The scaled approach will begin with telephonic patient outreach and progress to on-site outreach in the

emergency department or the home when needed. Meanwhile, PCC will strengthen partnerships with hospitals where patients receive event-based emergency care. Evidence suggests this approach provides the greatest impact on quality, hospital utilization, and costs. When individuals reach an optimum level of wellness and functionality, the individuals, their personal support networks, health care providers, and reimbursement sources benefit.

PCC's existing care management team serves as a reliable resource for this project. PCC's care coordinators function much like community health workers by conducting outreach, promoting healthy behaviors, and providing information about health and health resources. With a thriving care management department, PCC feels this project will be most sustainable if implemented by a specialized care coordinator. The care management team is supervised by the Chief Population Health Officer and is embedded within primary care and support service operations. Additional resources include PCC's electronic health records system and performance improvement department. Our health center quality measures are reviewed monthly by performance improvement and leadership staff. For this project, time will be allocated to a performance improvement assistant who will track program progress and establish project baselines for expansion.

Staffing limitations and lack of reimbursable care management activities prevent full implementation of the proposed project. Therefore, PCC seeks financial assistance to support increased staffing, equipment, and training to extend care management to emergency department utilizers. PCC respectfully request $16,600 from the Illinois Community Health Foundation to match PCC's financial contribution for this important initiative.

II. PROJECT NARRATIVE

A. STATEMENT OF NEED

Now that the Affordable Care Act has successfully expanded health insurance to millions of individuals who previously did not have coverage, the health care environment is shifting its focus to "super utilizers," individuals who often visit the emergency department for care rather than a primary care medical home. A recent *Health Affairs* article noted that while the need is intense for this subgroup, it is often temporary; 28% of the individuals who initially identified as super utilizers did not identify as super utilizers less than a year later.[ii] This demonstrates that care management would be best positioned to focus on predictive modeling to distinguish avoidable and unavoidable emergency department use. Some examples of key predictors of avoidable use of the emergency department are social factors, such as housing, transportation, food insecurity, access to medication, treatment for substance use, and employment. Additionally, high-cost Medicaid beneficiaries are often young and have comorbid mental health and substance abuse conditions as compared to high-cost Medicare beneficiaries who instead may present with three or more chronic conditions. These trends along with the episodic nature of emergency department utilization require a different model of care to optimize outcomes. In response, PCC designed this project to help identify interventions for decreasing avoidable occurrences.

PCC is a large health center, serving approximately 47,000 patients annually. In an urban setting like Chicago, patients have access to a large number of hospitals to use when seeking acute or emergent care. PCC hosts Walk-In Wellness Centers at two of our four partner

hospitals in order to divert unnecessary emergency department visits. However, some patients continue to utilize the emergency department as a substitute for preventative or primary care.

In this project, PCC will focus our pilot on a specific group of health plan (CountyCare) patients who receive care in the emergency department. Because PCC receives real-time alerts during event utilization, PCC's care coordinator can target this discrete population during this short-term pilot stage. On average, PCC receives alerts for 22 emergency department visits per week from the CountyCare population. From July to December 2015, PCC's CountyCare population had completed 524 emergency department visits. Of these visits, only 17% completed a follow up appointment with their primary care provider within seven days of discharge. Further, PCC has embedded a care coordinator at West Suburban Medical Center for more than two years. This care coordinator meets with hospitalized patients prior to discharge and arranges follow up appointments at a PCC health center. The model has allowed us to begin to target some barriers associated with transitions of care. However, only half of these patients return for their scheduled medical appointments. Also, over 50% of admissions were related to a medical condition exacerbated by substance use – most often opioid dependence. This echoes what literature has documented for the population. Lastly, while PCC care coordinators currently provide telephonic outreach to greater than 90% of these patients, fewer than 20% return to care at a PCC health center. These discrepancies reflect the need for an enhanced, patient-centered approach that can be translated for emergency care patients.

PCC would like to enhance existing infrastructures in order to improve care management services for high utilizers of the emergency department. This includes active PCC patients as well as patients assigned to PCC by Medicaid who have not yet established care with

a health center. PCC proposes to establish a three-tiered approach that will include the following interventions conducted by a specialized care coordinator:

1. Patient engagement: While PCC care coordinators already provide telephonic outreach to patients who visit the emergency department, the specialized care coordinator will intensify the telephonic outreach for those who do not initially respond or take action with a primary care provider. This is escalated to in-person outreach (e.g. home visit) as needed to help a patient establish care with primary care provider post-event.
2. Event-based interventions: When appropriate, the care coordinator will attend to a patient on-site in the emergency department during the utilization event. If appropriate, a home visit will be provided. The care coordinator will provide patient education regarding avoidable emergency department use and will target home to hospital transitions in an effort to reduce super utilization behavior and hospital admission.
3. Cross-care setting care coordination: In partnership with the care management team, the care coordinator will strengthen PCC provider relationships with hospital networks. This individual will provide relationship-based referrals and establish best practices for care transitions. The care coordinator will also build a comprehensive referral database.

B. PROJECT OBJECTIVES

In this pilot project, PCC will first target Medicaid patients who utilize the emergency department. Specifically, PCC will track a subgroup of patients who utilize CountyCare that are current PCC patients or are assigned to PCC but have not established care within the past year.

Outcome Objectives

Objective 1: Increase percentage of PCC-assigned patients who have established care with a primary care provider at their medical home

- *Indicator:* 55% or more of patients with emergency department visits have a follow-up appointment scheduled prior to discharge (baseline 45.9%)
- *Indicator:* 20% or more of patients with emergency department visits have completed follow-up visits within 7-14 days of discharge (baseline 9.1%)

Objective 2: Reduce rate of patients' emergency department visits (targeting avoidable visits)

- *Indicator:* Emergency department utilization rate of 5% or less (baseline 6%)

Process Objectives

Objective 3: Establish cross-setting care coordination between PCC's and hospital care management departments

- *Indicator:* Develop a comprehensive database depicting vital connections and resources at local hospitals in surrounding communities

Objective 4: Establish operational baselines for project in order to build future programming

- *Indicator:* Identify the hospitals most frequently visited by PCC patients based on trend analysis of emergency department visits per every 1,000 patients
- *Indicator:* Determine medical cost per patient using population health management analytics framework

C. PLAN OF OPERATION

Funds from the Illinois Community Health Foundation will be utilized for personnel costs associated with creating a new, part-time care coordinator role. This individual will attend to the three-tiered approach and will comprehensively assess patients' risk and needs, monitor

patient care plans, engage family members, facilitate transitions from the hospital, and provide referrals to community resources. PCC will match funds to support the part-time salary of a performance improvement assistant who will perform quality evaluation. Together, each individual staff person will contribute to improved health care outcomes for patients.

Foundation funds will also be used to purchase a laptop for the care coordinator. This will optimize mobility for attending to patient care and provider network relations. New software or consultants are not necessary at this time. PCC will provide training to the specialized care coordinator in the areas of direct practice, motivational interviewing, care plan development, self-management goals, and mental health first aid. PCC's department managers will oversee this project but will not require funding support at this time.

PCC recognizes that optimal patient outcomes and quality improvement will result from utilizing the care coordination team for this project. PCC's care management program embeds care coordinators directly into clinic operations. This includes involvement in team-based care, a health care delivery model that connects each patient with a multi-disciplinary team. Trained on topics such as motivational interviewing and mental health first aid, these staffs address social risk factors experienced by the patient. An individualized care plan devised in collaboration with the patient and medical provider establish a relationship-based intervention. Attributes of our successful care coordination program include interdisciplinary teamwork, coaching and behavior-change techniques, standardized medication management processes, effective use of health information technology, and established outcome measurement protocols. Operational implementation related to patient engagement and hospital to home

transitions will follow existing care coordination workflows. This detailed clinical workflow is available upon request.

Due to the short timeframe of the grant period, creating a new role based on an existing position will efficiently build upon the best practices of current care coordination work flows. We aim to promote an internal candidate with care coordination experience who can attend to this specialized project. This will contribute to improved network relationships as well as optimal coordination within PCC health centers. Strengthened network relationships with hospitals will be pursued at the time of funding. Specifically, PCC's Chief Population Health Officer will initiate meet and greet forums with network hospitals to share strategies and plan for project implementation. Relationships will be maintained by PCC's Care Coordination Manager and the care coordinator employed for this project.

PCC has sufficient quality assurance and technical resources to implement the project at the time of funding. Quality management for this project will be overseen by PCC's Director of Performance Improvement. There is adequate infrastructure to implement workflows and run reports within the performance improvement department. Electronic health records which will source the defined quality metrics are in place. Further, PCC currently receives real-time emergency department alerts from both Aetna and CountyCare. In order to focus on a discrete population with readily available quality and performance data, evaluation will focus on CountyCare patients for this pilot project. Indicator data pertaining to emergency department utilization and appointment follow-up will be obtained from the Medical Home Network ACO *Clinical Integration Quality Dashboard.* This information is updated and disseminated weekly.

D. PROJECT EVALUATION

The proposed project will be integrated into the care management program within the population health department, led by Katherine Suberlak. In 2015, PCC appointed Ms. Suberlak as Chief Population Health Officer. In this position, Ms. Suberlak operationalized care coordination interventions and has grown a staff from six to 17 in just one year. In collaboration with finance and performance improvement departments, this tremendous growth has led to transformational, evidence-based initiatives and services that will enhance clinical quality outcomes, establish best practices, and reduce health care costs. The modifications that will occur as a result of this quality initiative are related to health program development and provider network relations with hospitals. For example, staff will automate a quality artifact that documents these bidirectional relationships for our patients and primary care providers.

Using the Medical Home Network ACO *Clinical Integration Quality Dashboard,* the Director of Performance Improvement will be responsible for monitoring indicators and reporting results to the project team on a monthly basis. The assigned performance improvement assistant will track and report progress for the process objectives regarding the development of a comprehensive database for cross-setting care coordination as well as a population health management analytic framework to key trends among our patient base. All four indicators will be reported as final products at the completion of the pilot.

The performance improvement department, under the direction of the Director of Performance Improvement, will utilize a multifaceted evaluative approach to assess PCC's progress meeting the outlined objectives. The department will utilize a combination of existing quality metrics, such as emergency department utilization and appointment follow-up, to gauge project performance. The team, with targeted support from a performance improvement

assistant will share progress towards outcome measures with PCC's Steering Committee. The Steering Committee serves as an additional resource for program assessment and project improvement. The committee is comprised of PCC's executive leadership team, site medical directors, community health fellows, and program directors. During monthly meetings, the committee reviews detailed summaries of organizational activities and discuss programming that requires further evaluation. Sharing project data with the Steering Committee will drive future program improvements and create a sustainability plan for these new interventions.

E. SUSTAINABILITY

PCC acknowledges that current program design will require support from operational funds in order to be sustainable over time. PCC proposes this is possible through negotiations with health plans based on care management services available to PCC assigned patients. Sustainable health improvement projects are dependent on support from health plans for the patients we serve. PCC can only actively explore these contracts if we can demonstrate population based change related to affordable, quality care. During the course of this project, PCC will update baseline measures related to population health in the areas of emergency department utilization and medical cost per medical patient. These attractive metrics – evidence of population care management – will be shared with health plans and should support negotiations for care management dollars. Overall, it is PCC's intention to provide care management to all patients; therefore, this critical project will position PCC's care management program to become sustainable over time.

[i] McCarthy,Ryan and Klein. "Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis" The Commonwealth Fund pub 1843 Vol 31.

[ii] Johnson, et al. "For many patients who use large amounts of health care services, the need is intense yet temporary." Health Affairs August 2015 34:8.

III. PROJECT BUDGET

Project Expenditures

Expenditure Category	Description	Total Amount Required	Amount Provided by Applicant/Others	Amount Requested from Grant
Equipment	Laptop and case	850	0	850
New Software	n/a	n/a	n/a	n/a
Personnel	0.5 FTE Care Coordinator	15,600	0	15,600
	0.5 FTE Performance Improvement Assistant	15,600	15,600	0
	Benefits (16.5%)	5,148	4,998	150
Consultants	n/a	n/a	n/a	n/a
Training	Continuing Education Units (CEUs)	600	600	0
Other	n/a	n/a	n/a	n/a
TOTAL		37,798	21,198	16,600

Narrative: Describe costs and budgeting assumptions.

Funds will be utilized for personnel costs associated with creating a new, part-time care coordinator role. PCC will match funds to support the part-time salary of a performance improvement assistant who will perform quality evaluation. Together, each individual staff person will contribute to improved health care outcomes for patients. Foundation funds will also be used to purchase a laptop with case for the care coordinator. This will optimize mobility for attending to patient care and provider network relations. PCC will provide training to the specialized care coordinator in the areas of direct practice, motivational interviewing, care plan development, self-management goals, and mental health first aid.

PCC
Community Wellness Center

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January 13, 2016

Bruce Johnson, Chair
Illinois Community Health Foundation
500 S. Ninth St.
Springfield, IL 62701

Dear Mr. Johnson,

On behalf of PCC Community Wellness Center (PCC), I am pleased to submit this proposal to the Illinois Community Health Foundation seeking $16,600 to support PCC's quality improvement project. PCC proposes to use care management to target individuals who access the emergency department with a goal of increasing access into a primary care home and decrease emergency department utilization rates. PCC's care management department will collaborate with the performance improvement department to improve patient access to preventative care with a primary care provider while improving health outcomes.

PCC Community Wellness Center is a Federally Qualified Health Center with 12 sites that deliver primary care and support services to underserved patients living in Westside Chicago and the near west suburbs. We provide accessible, affordable health care to over 47,000 annually, many of whom present with compound medical and social risk factors. Care management at PCC is a collaborative process with a goal is to provide options and health services to meet individuals' and families' comprehensive health needs.

PCC would be honored to establish a partnership with the Illinois Community Health Foundation to address the health care needs of our community members. If you have any questions, please contact Toni Bush, Director of Development at 708-406-3922 or at tbush@pccwellness.org.

Sincerely,

Robert J. Urso
President & CEO