**Category 2 Project Narrative**

**Scott & White Memorial Hospital -- 137249208.2.1**

**Project Area, Option, and Title:** 2.9.1 Patient Navigation and Chronic Illness Support for

Patients with Limited Resources

**RHP Project Identification Number:** 137249208.2.1

**Performing Provider Name:** Scott & White Memorial Hospital

**Performing Provider TPI #:** 137249208

**Project Summary:**

* **Provider Description:** Scott & White Memorial Hospital is a 636‐bed hospital in Temple, TX, and the only Level 1 Trauma Center between Dallas and Austin. SWHM serves a 29,000 square mile area and a population of approximately 3 million people. The hospital is part of Baylor Scott & White Healthcare, a large integrated system in Texas.
* **Intervention:** This project will provide patient navigation and selected chronic illness supports for a target group of patients who are members/beneficiaries of the Bell County Indigent Care Program, Medicaid, and/or participating hospitals’ charity care programs. Project components include patient navigators, chronic disease self‐management workshops, additional mental health practitioners at a free clinic, and an improved network of coordinated support for program participants.
* **Project Status:** This is a new initiative for all partners.
* **Project Need:** The impetus for this project was stakeholders’ call for improved supports for low income patients that would ultimately reduce unnecessary utilization of high cost ED and hospital services. The project addresses two main areas: 1) inappropriate utilization of the ED; and 2) fragmentation of the health care system; difficulty navigating services. This project ties to the following community need: CN.1.4 ‐ Limited access to primary health care for indigent and uninsured populations in Burnet County.
* **Target Population:** In DY2, the team will select a subpopulation for which patient navigation services will be available from among the estimated 20,000+ Bell County population of Medicaid beneficiaries and members of indigent care or charity care programs. Subpopulation selection will be based on risk for potentially avoidable ED and hospital utilization and will capture approximately 6% of the target population to allow manageable caseloads for patient navigators. The project will deliver at least one patient navigator service (e.g., screening, chronic illness self‐management workshop, mental health appointment, referrals) to 2,400 individuals across all project years. In DY4, 1,000 will be served. In DY5, 1,200 will be served.
* **Category 2 Expected Project Benefit for Patients:** Patient navigation and the planned increase in capacity for self‐management education and mental health services will connect individuals in the patient navigator program to the right care and the right community resources to meet their needs. In DYs 2‐5 the program is expected to provide at least one type of service (e.g., screening, workshops, and referrals) to 2,400 individuals. The program will help participants meet a variety of types of needs affecting their health by connecting them to available resources. Improved connections with community and health service combined with improved self‐management ability are expected to reduce utilization of ED services for concerns that can be more appropriately addressed in other settings (e.g., primary care). It is also expected to reduce exacerbation of health conditions sensitive to outpatient care and self‐care.
* **Category 3 Outcomes:** Our goal is IT‐9.2a: Reduce ED utilization among program members by at least 5% over baseline by end of DY4 and 10% over baseline by the end of DY5.

**Project** **Description:**

*Patient Navigation*

This project will provide patient navigation and selected chronic illness supports for a target group among those with financial limitations, including those on the Bell County Indigent Care Program, Medicaid, and/or participating hospitals’ charity care programs. The specific target audience will be chosen part of DY2 activities (Milestone P‐1). Core program components will be launched before or during DY3 (Milestone 3: P‐2) and will include 1) patient navigators embedded at Bell County Indigent Care Program office and at three hospitals in the county, 2) Chronic Disease‐Self Management Program (Lorig/Stanford model) workshops for program participants, 3) mental health practitioners added at one free clinic to increase accessibility of services for participants with chronic mental health needs, and 4) shared protocols and communication across sites and program components to maintain a network of coordinated support for program participants.

Scott & White Health Memorial, the performing provider, will subcontract with Bell County Indigent Care Program, Cedar Crest Hospital & RTC, Metroplex Health System, and the Central Texas Area Agency on Aging (AAA) for the cost of embedded services at those sites and for chronic disease self‐management workshops. In addition, Metroplex Hospital will also receive funds through subcontracts for.5FTE Licensed Clinical Social Worker or other qualified therapist to deliver care for program participants (and other patients at local free clinics if capacity allows). Scott & White Health Memorial will employ a .5FTE nurse practitioner to deliver mental health services in partnership with the therapist employed by Metroplex Hospital. The team will collaborate to determine the target population, develop patient navigation protocols, and create protocols for referrals and cross‐site communication. Ongoing iterations of protocols are expected as the partners recognize and respond to challenges.

The anticipated long‐term outcomes of this program are a) improved access to and utilization of appropriate levels of care, and b) reduced utilization and need for ED services among program members.

**Goals and Relationship to Regional Goals:**

The project goal is to meet the health needs of program participants in ways that reduce unnecessary ED utilization. Patient navigation and the planned increase in capacity for self‐management education and mental health services will connect persons with resource limitations and health needs to the right care and right community resources to meet their needs. The program will help participants meet a variety of types of needs affecting their health by connecting them to available resources. Improved connections with community and health service combined with improved self‐management ability are expected to reduce utilization of ED services for concerns that can be more appropriately addressed in other settings (e.g., primary care).

**Project Goals:**

* Reduce avoidable ED visits in the target population; and

**This Project meets the following Regional Goals:**

* Improving access to timely, high quality care for residents of the County, including those with multiple needs;
* Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
* Reducing inappropriate utilization of services.

**Challenges:**

The two primary challenges anticipated by the partners are 1) creating and maintaining an efficient and secure data system for sharing information about program participants and navigator actions across sites, and 2) identifying timely sources of healthcare and social services to meet participants’ needs in the community. The hospitals, AAA, and County have collaborated closely on the development of this plan and will leverage our effective working relationships to address these and other challenges throughout the project. Regular program calls/meetings will use standard agendas to review program data and day‐to‐day challenges, develop action plans, and agree on how best to disperse program funds to meet program challenges. We expect protocols to go through iterations as we try processes, identify opportunities to improve, and adjust to better meet program participant needs.

**5‐Year Expected Outcome for Provider and Patients:**

In five years, we expect to reduce overall ED visits for all Indigent Care Program members, Medicaid beneficiaries, and hospital charity care program members by impacting both metrics in the selected subgroups of this low‐income population. The patient navigator program will be developed and improved over time to meet the needs of this population such that they perceptions of need and medical need for high‐intensity services are reduced because needs are met in other ways through outpatient services and community services.

**Starting Point/Baseline:**

No patient navigation exists for the target population in Bell County. Therefore, no baseline exists. Baseline will be established in DY2 (Milestone 1: P‐1) after the project team reviews administrative billing data from the participating hospitals and claims data from the County Indigent Health Care Program (CIHCP) as part of its work to identify the target population for the program (among individuals who are part of the CIHCP, Medicaid, or hospital charity care programs). Once the target population for the patient navigation program has been established, we will use the same data sources to establish baseline ED utilization within the target group. Our intention is to establish baseline rates based on data from July 2011 – June 2012 because this period best represents the most accurate estimates of utilization for Bell County Indigent Care Program. Claims payment was temporarily suspended for that program later in the summer of 2012 through the end of the County’s fiscal year and is therefore not an accurate representation of utilization for Indigent Care Program members, one important group to be represented in the target population. Baseline for Category 3 is set on Calendar Year 2013 data.

**Rationale:**

**Community Needs Addressed:**

* Community Need Areas: C.3 – Lack of coordinated care for those with multiple needs
* Specific Community Need: C.3.5 ‐ Discontinuity of care and limited awareness of available resources and services among indigent, uninsured and Medicaid populations in Bell

County leads to potentially avoidable ED and hospital utilization.

The impetus for this project was the expressed need for improved support for Indigent Care Program members. This need was identified by the program director and county officials. The identification of that need resonated with the hospital partners on this application. While

health services are generally available in Bell County, Texas, connecting citizens to the right care at the right time is a challenge, especially for citizens with limited financial and other resources (e.g., transportation, health literacy). Multiple studies are underway at Scott & White Healthcare to understand the experiences of members of medical aid programs (e.g., Medicaid, our internal charity care program) when they return home from the hospital and to understand how primary care utilization is associated with ED utilization among Medicaid beneficiaries nationally. Preliminary, unpublished data point to the complexity of needs affecting where and when persons with resource limitations seek care. At the same time, the demand for Bell County Indigent Care Program reimbursement for members’ care exceeded that program’s capacity in Fiscal Year 2011. That is, the cost of care for at least one program in our County is beyond our resources.

Patient navigation was chosen as the intervention to address complex patient needs and the growing economic burden of healthcare in our County because Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions.21 Tying inpatient and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost and quality of care. The intent of this patient navigator program is to empower citizens with resource limitations to access the medical and human services they need when those services are most needed to prevent exacerbation of health conditions leading ED and hospital services. Preventing ED and hospital services is expected to also reduce the cost of care for this population while more appropriately meeting persons’ needs.

This project is a unique partnership among hospitals, the county, and a community‐based organization. We recognize that the needs of persons with resource limitations cannot be met from any of our locations alone. We will therefore form a network of support for the target population to better meet their needs at the times and places program participants want and need support. No similar network exists currently. This is a new initiative for all partners, including Scott & White Healthcare.

**Core Components:**

Shared protocols will include the core components for this Category 2.9.1 project in the following ways:

1. *Identify frequent Emergency Department (ED) users among the target population and use navigators as part of a preventable ED reduction program.* The details of the program’s efforts to prevent avoidable ED utilization will be determined by the program partners in Demonstration Year 2 (Milestone 1: P‐1) after looking at patterns of use and gathering information from partners about potential causes in our region. One improvement expected from the program’s efforts is an increase in referrals to PCPs for program participants who use the ED. Cultural competency will be among the topics of required patient navigator training.
2. *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* In this project, the team of navigators—embedded in and employed by various partners, will be trained in multiple disciplines such that the shared expertise of the navigator group can address the varied needs of program participants. For example, we expect to need nursing, social work, and social services training represented among the navigators. We also expect to need expertise working with Hispanic/Latino patients, with military families, and with medical aid programs.
3. *Connect patients to primary and preventive care.* One of several advantages of embedding navigators in local healthcare systems is the opportunity to optimize referral processes to each setting by partnering with a patient navigator form within each system. Sufficient primary and preventive care services are available in the County through multiple community‐based clinics affiliated with two of the participating hospitals and three free clinics. Protocols will address proactive evaluation of participants’ needs for recommended preventive services (e.g., vaccinations) and protocols for coaching patients to choose where to access services and then to make/attend appointments for those services.
4. *Increase access to care management and/or chronic care management, including education in chronic disease self‐management.* Protocols will include referrals to self‐ management education programs offered through this program to participants and to other area self‐management education (e.g., diabetes education). Self‐management education will be launched in DY2 (Milestone 2: P‐4) to help increase patient engagement, and will continue through DY5. The addition of mental health services at one local free clinic will give navigators and participants improved access to mental health services to address chronic mental health issues.
5. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Regularly‐scheduled program meetings/calls will have the primary purpose of continuous quality improvement. The Model of Improvement will be among the content areas in patient navigator training. The partners will use PDSA cycles to create iterations of protocols throughout the project. Data on program implementation (e.g., types of navigation services provided to patients) will be employed by the team to help monitor quality and test the impact of program changes (Milestone 4: P‐5).

**Related Category 3 Outcome Measure(s):**

IT‐9.2.a ED Appropriate Utilization

Patient navigation services will address needs identified by the team as influences on inappropriate ED utilization for individuals with resource limitations in Bell County. This measure was chosen because it represents the consequences of gaps in services or patient engagement that lead to unnecessary utilization of high‐cost, high intensity services. In some cases, services are needed because steps to prevent illness or exacerbations of conditions were not taken. In other cases, utilization of these services may represent a lack of access to or lack of awareness of access to other services designed to meet individuals’ non‐urgent and non‐emergent needs. The multidisciplinary network of patient navigators that will be deployed for this project will be embedded across the county in both healthcare and community locations to help ensure that program members have easy and continued access to coaches, educators, and clinicians to connect them to the services that best match their needs. We will meet our improvement targets by reviewing data on processes (e.g., fidelity of implementation of program protocols) and outcomes over time. When problems with processes or lack of progress toward targets are identified, we will launch changes to address identified problems. Navigators will meet regularly to discuss challenges and progress. A project manager will help gather and report on program to allow the navigator team to monitor progress and make appropriate adjustments.

**Relationship to Other Projects:**

This project is related to the Pass 1 and Pass 2 projects proposed for Baylor Scott & White Health Llano. All three projects will address avoidable utilization of services. The Llano hospital projects will work with stakeholders in the county to identify areas for reducing unnecessary use of EMS services and avoiding court orders to transfer persons with behavioral health crises. The demand for both types of emergent services are believed to be higher than necessary in that county and both may be leading to unnecessary ED utilization. All three projects will be monitored by personnel on Baylor Scott & White Healthcare’s Quality & Safety team to identify opportunities to exchange lessons learned in the two counties for addressing needs proactively in ways that reduce avoidable utilization of services.

Category 4 reporting for this project may show changes in hospital‐wide rates of potentially avoidable hospital admissions and 30‐day hospital readmissions if the impact on the program‐ population is strong enough to show in the rates for the entire hospital population.

**Relationship to Other Performing Provider’s Projects and Plan for Learning Collaboratives:**

Baylor Scott and White Health Llano has two projects that are related to this one:

* #020840701.2.1 Patient Navigation
* #020840701.2.2 Sheriff Transport
* Williamson County and Citied Health District also has a navigation project (#126936702.2.1).

Scott & White Health Memorial will participate in a RHP 8 learning collaborative that meets semi‐annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects.

**Project Valuation:**

The scope of this project was determined by the available IGT and number of hospitals and community organizations that indicated a willingness to partner. The project value is based on two categories of cost and a hospital incentive for participation. The incentive is intended to cover cost of program planning, unanticipated program costs or new program aspects needed to fully address needs, and assumption of risk inherent in program participation.

* Estimated direct cost of personnel for service delivery, project management, data reporting per year
	+ At Baylor Scott & White Healthcare: $234,045
	+ Subcontracts for services: $484,944
* Estimated indirect cost cost/year (off‐campus rate = 19%): $117,559
* Incentive to Performing Provider: $15,275