**Category 2 Project Narrative**

**Williamson County and Cities Health District – 126936702.2.1**

**Project Area, Option and Title:** 2.9.1 Provide patient navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.

**RHP Project Identification Number:** 126936702.2.1

**Performing Provider Name:** Williamson County and Cities Health District

**Performing Provider TPI #:** 126936702

**Project Summary:**

* **Provider Description:** Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
* **Intervention:** This project will provide navigation services to persons with targeted chronic conditions or pregnancy that are at high risk of disconnect from institutionalized health care to prevent hospital admissions and readmissions.
* **Project Status:** This project is an expansion of an existing initiative and will provide navigation services to a total of 3,600 unique patients in addition to the current pre-DSRIP baseline of 2,824 patients by the end of DY5.
* **Project Need:** CN.3.4 Fragmented system in navigating access to appropriate level of care for uninsured Williamson County residents. According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report,* 2005‐2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congestive Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years. The current safety‐net providers have waiting lists for new patients, making it difficult for chronically‐ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors continue to leave this population in need of navigation assistance to maneuver, learn and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.
* **Target Population:** The number of patients/clients the project will target is approximately 10,900 by DY5. The target population is patients that need assistance navigating the healthcare system to access appropriate level of care without utilizing the Emergency Department for services. Approximately 45% of patients are either Medicaid eligible, low income uninsured or indigent, so we expect they will benefit from about half of the proposed navigation services.
* **Category 1 or 2 Expected Project Benefit for Patients:** Baseline established in DY2 was 2,824 unique individuals. The project seeks to provide an additional 600 individuals with navigation services in DY3, an additional 1,200 individuals in DY4, and an additional 1,800 individuals in DY5. This reflects a total impact of 3,600 individuals by the end of DY5. (See Improvement Milestone 1‐6.4).
* **Category 3 Outcomes:** The following Category 3 measures were approved in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]), IT-1.7 Controlling blood pressure.
  + IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]): We will demonstrate improvement in the overall scores on the CSQ-8 among surveys completed by individuals receiving patient navigation services provided by WCCHD staff (facility subset).
  + IT-1.7 (Controlling blood pressure): We will demonstrate improvement in the percentage of patients with hypertension whose latest blood pressure measurement is <140/90 in the population served by Williamson County Emergency Medical Services’ Community Paramedicine program.
* **Collaboration** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have broader, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider‐related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self‐ fund the required IGT, could participate in the waiver. This project addresses the key need of diverting individuals from the emergency department for preventive care services that can be obtained through a medical home. Navigating the healthcare system when individuals are uninsured, can be complex and leave the uninsured individual to a route for care where they know they’ll be seen regardless. This practice increases unnecessary cost to hospitals but more importantly the ultimate result is the lack in continuity of care for the patient. Transforming this process will ensure individuals are connected to the appropriate level of medical care for preventive or acute instead of through the emergency department.

**Project** **Description:**

Navigation Program ‐ *The Williamson County and Cities Health District proposes to provide navigation services to persons with targeted chronic conditions or pregnancy that are at high risk of disconnect from institutionalized health care.*

The project would improve accessibility to health care services for Williamson County individuals who have a diagnosed chronic condition or pregnancy and who are at high risk of disconnect from institutionalized health care, to prevent hospital admissions and readmissions, while improving their experience of timely care. According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report,* 2005‐2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congestive Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years, with accompanying hospital charges of $179,728,355. The Community Health Profile of Williamson County Precincts (2011) <http://www.wcchd.org/statistics> and\_reports/) illustrates the social determinants of health of low income and lower educational status with higher incidence of chronic disease (diabetes example). The current safety‐net providers have waiting lists for new patients, making it difficult for chronically‐ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors, continue to leave this population in need of navigation assistance to maneuver, learn and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.

The WCCHD Navigation Program proposes to optimize and individualize services of a collaborative team of community health workers, Program Navigators, Case Managers (Social Workers and Public Health Nurses) and other types of health care professionals to persons by:

* Hiring community health workers/promotoras within each of the 4 smaller sectors of the county. The team will cover all 4 Public Health Center sites in Georgetown, Round Rock,
* Cedar Park and Taylor. These Public Health Centers are geographically spread through the larger cities in the county and are central to each of the major rural areas.
* Cross‐training with staff in other agencies with some similarity of functions, such as EMS personnel, to support consistency of core purpose and processes.
* Having Patient Navigators able to meet people in their own communities to build trust and find those in need of healthcare services before they present to an Emergency
* Department (ED) or for late prenatal care.
* Helping patients’ access care by connecting them with enabling services, such as transportation.
* Using electronic tools such as Health Information Exchange (HIE) and Electronic Health Records (EHR) to support consistent communication about health needs and treatment for people with chronic diseases, pregnancy, and high‐ED utilization.

Patients will be identified for navigation services proactively through intake calls received from the community (quite often from citizens with chronic health conditions seeking access to care), from daily hospital reports, HIE ICare reports, other agency and provider referrals, and ongoing personalized visits within communities by members of the team. Additionally, another project is focused on outreach and communication strategies that will supplement connection to those in need of patient navigation services, with an emphasis on reaching pregnant women.

Patients will, based on their condition or need, be able to participate in assessments to include health literacy, risk stratification, and health risk appraisals, while navigators work to ensure financial access to care, appointment with a Primary Care Provider (PCP)/ Obstetrician (OB), and enabling services in place, such as transportation. Patients may choose to also participate in case management and health education services within their home communities. These multi‐agency/multi‐community services will be offered in a culturally and linguistically appropriate manner.

Documentation of patient navigation will be initiated in the WCCHD CHASSIS electronic system. Tracking of encounters, services/service types, appointments with PCP/OB, dates of entry into prenatal care, completion of eligibility for healthcare funding programs will be monitored and tracked. A process for patient satisfaction measure tracking will be developed during DY2. Hospitalization and ED usage will be monitored through HIE reports to assist in compiling a complete picture of the needs and results from patient navigation services.

**Goals and Relationship to Regional Goals:**

The goal of this project is to use community health workers, case managers, social workers and registered nurses as patient navigators to provide enhanced care coordination, community outreach, social support, and culturally competent care to high‐risk patients with COPD, CHF, hypertension and/or diabetes. Patient navigators will help and support these patients to navigate through the continuum of health care services, and establish a medical home. Patient Navigators will ensure that patients receive coordinated, timely, and site‐appropriate health care services, and are linked to chronic disease education and/or self‐management tools.

**Project Goals:**

* Increase over baseline in patients with a PCP appointment to establish a medical home
* Increase in patient satisfaction with receiving timely care, appointments and information

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

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

**Challenges:**

Williamson County is among the ten fastest growing counties in the US, with 16.5% of the population uninsured (approximately 80,000 people). The challenge for this project in such a rapidly changing environment, is to target and reach populations and people in need in the most direct and streamlined fashion, in a culturally competent manner with understanding of each person’s unique situation. Lack of public transportation has been consistently identified as a priority need in Williamson County, especially in the rural areas. WCCHD will continue to work with existing community transportation coalitions addressing this challenge.

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

WCCHD expects to see reductions in inappropriate hospitalizations and ED use for patients with targeted chronic conditions, increase in patients accessing prenatal care in their first trimester of pregnancy and increased use of a medical home, while meeting the project goals above.

**Starting Point/Baseline:**

WCCHD has had a nurse and social worker case management programs for many years. These have been for a variety of patient populations and each program has answered to different goals and metrics of the funding source. Additionally, there has been a “Health Care Helpline” in place for many years, again, acting as an entry point into the health care system for people who are lost in navigating to meet their needs. There are currently four positions that have been “re‐purposed” this fall to begin a Patient Navigation system within WCCHD. This project will allow for substantial expansion of Patient Navigators into the communities, thereby increasing access for those most difficult to reach. Additionally, this program will allow for a community‐wide system of care to develop with unified data, reporting and communications. Mechanisms to gather more standardized data on which to build improvements and manage it electronically, is essential to moving away from the current fragmented system internally and externally.

**Rationale:**

**Community Need Addressed:**

* Community Need Area: CN.3 ‐ Lack of coordinated care for those with multiple needs
* Specific Community Need: CN.3.4 ‐ Fragmented system in navigating access to appropriate level of care for uninsured Williamson County residents
* Other Community Needs:
  + CN.1.6 – Limited access to primary care and preventive services
  + CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals diagnosed with chronic disease

This project option supports the integration of many of the initiatives of both WCCHD and the community at large. WCCHD was one of the first “integrated eligibility” sites in Texas in the 1980s, looking for ways to reduce redundancy in patient applications and verifications to receive funding for healthcare services. This quest for integration of processes to support vulnerable populations in accessing health care in the broadest sense is the catalyst for selecting this project option. As noted earlier, the vulnerable citizens with chronic conditions account for large, potentially preventable healthcare expenditures of $179,728,355 in a five‐ year period, and 22% of pregnant women do not access care in their first trimester. The common denominator for these vulnerable populations, and hence the selection of this project is the need for advocacy, information and connection for their situations in accessing care in a coordinated system. This project will allow us to focus on expanding internal capacity to serve patients with limited health literacy levels, as well as to tie those to other community services in a more seamless and effective system. Currently, clients continue to call the “Healthcare Helpline” for assistance in navigation, but the need has exceeded the capacity of this model. This project will allow for expansion of the comprehensive patient navigation services through the team model into the community. The project will:

* 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;
* Ensure that patients receive coordinated, timely, and site‐appropriate health care services;
* Assist in connecting patients to primary care physicians and/or medical home sites;
* Coordinate with other RHP projects that focus on diversion of non‐urgent patient care from the ED to site‐appropriate locations;
* Assist in connecting patients to potential healthcare funding programs; and
* Assist nurse and social work case managers in connecting patients/families to appropriate health education and community resources.
* Through an Electronic Health Record, screening and eligibility tool and Healthcare Helpline, staff will monitor and track metrics, activities and patients assisted by this project.

While there is no one common definition of patient navigators, the WCCHD project will use a team‐based model that includes nurses, social workers and community health workers/promotoras based in their respective communities. While there is no set education required for a patient navigator to be successful, a successful navigator should be:

* Compassionate, sensitive, culturally attuned to the people and community being served and able to communicate effectively.
* Knowledgeable about the environment and healthcare system.
* Connected with critical decision makers inside the system.
* Hiring practices will focus on these key interpersonal skills and abilities.

**Project Components:**

We propose to meet all of the required project components through the Patient Navigation program.

1. *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* The hospital partners will initially identify ED frequent users through daily reporting. Connection to navigators will be geographically‐based, so that outreach into communities will be facilitated. Initial and ongoing training in cultural competency will be part of the work in DY2 and 3.
2. *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* Based on the Public Health Center model, many of the various professionals and staff will be deployed in navigation roles.
3. *Connect patients to primary and preventive care.* Connection to a medical home is imperative in this project, with follow‐up to assess barriers and completion of transition to this medical home.
4. *Increase access to care management and/or chronic care management.* Patient Navigators will assist patients in connecting to these services that are offered through WCCHD and other providers in a comprehensive and coordinated manner.
5. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Core WCCHD interdisciplinary teams will monitor and use Plan, Do, Study, Act (PDSA) cycle for rapid improvement throughout the patient navigation program. Several of these teams are currently in place and include epidemiology, case management, patient navigation, nursing, marketing and communications, community relations and research staff.

**Continuous Quality Improvement:**

WCCHD is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as “lessons learned” and identifying project impacts. In addition, we are participating in a regional learning collaborative which share information such as challenges, lessons learned and considerations for safety net populations.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project allows for a large enhancement of patient navigation into the community, using multiple venues and partners in a coordinated approach. As noted above, the “skeleton” of this project is in place; this project will allow for full transition from the

“Health Care Helpline” concept to a fully‐integrated patient navigation program serving patients in a coordinated, rather than episodic fashion.

WCCHD receives funding from the U.S. Department of Health and Human Services but will not use those funds for this project.

**Related Category 3 Outcome Measures:**

The following category 3 measure has been proposed in 2014 to describe improvements to the patient population: IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]), IT-1.7 Controlling blood pressure.

* + IT-6.2.a (Client Satisfaction Questionnaire 8 [CSQ-8]): We will demonstrate improvement in the overall scores on the CSQ-8 among surveys completed by individuals receiving patient navigation services provided by WCCHD staff (facility subset).
  + IT-1.7 (Controlling blood pressure): We will demonstrate improvement in the percentage of patients with hypertension whose latest blood pressure measurement is <140/90 in the population served by Williamson County Emergency Medical Services’ Community Paramedicine program.

Reasons/rationale for selecting the outcome measures: We selected these two measures as representative outcomes to reflect: IT-6.2a: The patient‐centered model of care we will be providing and the patient’s perception of timeliness, appointments and information in meeting perceived needs. This increase in satisfaction should be reflective of continuously improving the Patient Navigation process and relationships to support patients more individually, effectively and efficiently. Ensuring linkage to a medical home by navigating the health care system will provide patients with opportunities to seek appropriate level of care, knowledge of chronic condition, and promotion through encounters with the medical provider. IT-1.7: If the patients are receiving the benefit of the combined efforts of the WCCHD Interdisciplinary Team and the Williamson County EMS Community Paramedicine Team, we should expect that patients with hypertension would have their blood pressure under control as a result of these interventions. Thus, the IT-1.7 outcome is an appropriate measure of our effectiveness.

**Relationships to Other Projects:**

All the proposed projects are oriented toward providing more coordinated care throughout Williamson County, to simplify healthcare system access for patients, to lower costs and to improve the quality of care at the place of service.

This project will coordinate with the following other WHHCD projects in Williamson County:

* Expanded Capacity to Access Care (#126936702.1.1)
* Implement project to enhance collection, interpretation, and/or use of REAL data (#126936702.1.3)
* Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for Non‐emergent conditions (#126936702.1.2)
* Engage in population based campaigns or programs to promote healthy lifestyles using evidence‐based methodologies including social media and text messaging in an identified population (#126936702.2.2)

This project also coordinates with a project performed by St. David’s Round Rock Medical

Center will expand access to primary care (#020957901.1.1).

**Relationship to Other Performing Providers; Projects and Plan for Learning Collaborative:**

Scott & White Memorial Hospital (#137249208.2.1) and Scott & White Hospital – Llano (#020840701.2.1) have patient navigation projects.

The Williamson County Wellness Alliance (WWA) and the WilCo Integrated Care Collaborative are forums where we will be exchanging ideas, successes and needs as we move through this delivery system improvement. Both of these groups include other performing providers, as well as schools, businesses, consumers, agencies, government, etc., so that we will have a full‐ focus on progress in these areas.

**Project Valuation:**

The valuation of each WCCHD project takes into account the degree to which the project accomplishes the triple‐aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. WCCHD considers this project as high value because it will serve a significant number of residents in the community, where they “live, work, play and pray.” Helping people navigate the healthcare system proactively will significantly decrease the overall cost of care by assisting in avoidance of ED visits for primary care services, teaching about and supporting healthier lifestyles and choices to help prevent or manage chronic illness, and by giving babies a “Healthy Start”. Additionally, the project seeks to accomplish delivery system reform by understanding that the diversion of inappropriate non‐emergent care services through the ED, to connection to appropriate level of care, would improve patient care and decrease the cost for preventable services currently performed in the ED and decrease preventable hospitalizations. The cost of this project for DYs 2‐5 is estimated at $844,630 which is an added savings of over $4,000,000 when compared to the costs of ED visits*.*