

COMMUNITY PARTNERSHIP MODEL FOR PROVIDING
ALTERNATE NON-EMERGENCY SERVICES IN NEW JERSEY:
FINAL REPORT OF FINDINGS

EXECUTIVE SUMMARY

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Introduction – The use of hospital emergency departments (EDs) has been increasing over the years, both nationally and in New Jersey, and at a far greater rate than the population growth. More than one-third of this high utilization is for non-emergent primary care conditions that would be more appropriately cared for in a community-based primary care setting. The EDs have been increasingly used as a safety net not only for the poor and uninsured but also for the underserved, including those with Medicaid, who lack adequate access to appropriate primary care resources. The recession of the past few years has only compounded the problem, as many have lost their jobs and the healthcare coverage that went with them and resort to hospitals as their regular source of care. Inappropriate ED utilization for primary care needs is a particular issue among Medicaid beneficiaries, whom many studies have shown to have a higher ED visit rate than the general population or even the uninsured; even more so when looking at those with multiple ED visits in a year.

The causes of this issue are multifaceted and related to patients, providers and systemic factors. They include reasons such as patients not being able to determine whether they have a true emergency or to access more appropriate sites of care in a timely manner; private physicians charging prohibitive up-front fees; and the overall design of our healthcare system, which lacks sufficient primary care capacity and makes it difficult to link patients to specialists or manage chronic conditions. Given these barriers, it is easier for some patients to be seen at the ED rather than in an appropriate primary care setting.

Inappropriate ED utilization for primary care needs has a negative impact on patient care, as EDs are ineffective sites of care for chronic conditions, dental pain, behavioral health needs and psychosocial issues and do not provide routine management and follow-up care needed to maintain good health. It also has negative impacts on EDs with implications for hospital surge capacity, as more patients using the hospital ED for primary care services contributes to overcrowding and ambulance diversion. This is compounded by the fact that while the number of ED visits has been rising, the number of hospital EDs has been decreasing. In addition, the inefficient use of the ED's limited and expensive healthcare resources creates a significant burden on the healthcare delivery system. In New Jersey alone, more than \$400 million a year is spent on avoidable hospital ED visits. That care, if provided in an appropriate primary care setting, could cost significantly less.

Model description and implementation – In response to the rising trend of costly and inefficient use of the ED for primary care needs that could be more appropriately handled in community primary care settings, the Centers for Medicare & Medicaid Services (CMS) funded a project in New Jersey and 19 other states to provide and promote the use of alternative health care settings for individuals with non-emergent medical needs, as part of the Deficit Reduction Act of 2005. New Jersey's Community Partnership for ED Express Care and Case Management project was initiated by the New Jersey Department of Health and Human Services, Division of

Medical Assistance and Health Services (DMAHS), in partnership with the New Jersey Hospital Association's Health Research and Educational Trust (HRET) and the New Jersey Primary Care Association (NJPCA).

Implemented from September 2008 through April 2011, this demonstration project pilot tested a model for providing alternate non-emergency services to patients who presented with primary care needs in EDs. The model uses an express care process, with electronic connectivity to a community primary care provider, along with expanded capacity of that provider and its adoption of medical home domains. The plan also aimed at reducing future unnecessary visits to the ED by addressing well-documented barriers to accessing primary care services in communities – accomplished through provision of linguistically and culturally appropriate patient education, comprehensive case management, care coordination and other medical home/support services that encourage and maximize patients' future use of appropriate sites of care. This pilot program primarily targeted Medicaid patients, but its ultimate goal was to provide care to all New Jersey residents in the most appropriate, efficient and cost-effective sites.

The program was piloted in two sites through a close working partnership of a hospital and federally qualified health center (FQHC) in each site, active involvement and support of Medicaid HMOs, and engagement of other community primary care providers. The pilot teams, selected through a state RFP process, were Monmouth Medical Center (MMC) with Monmouth Family Health Center (MFHC), which served a moderately urbanized area, surrounded by suburbs and shore towns, and Newark Beth Israel Medical Center (NBIMC) with Newark Community Health Center (NCHC), which served a heavily urbanized and medically underserved area, with a very diverse population, high uninsured rate and a dearth of providers. The sites were chosen based on location in a county with high rate of ED use by Medicaid beneficiaries and others (for primary care services and in general) and select socio-demographic characteristics, as well as the merits of their proposed plans.

The major components of the project model include:

- ED express care – Pilot hospitals provide express primary care services, using APNs or other ED clinicians. All patients who present to the ED are triaged and receive medical screening. Once it has been determined that a patient has non-emergency primary care needs at low acuity level, the APN or other clinician provides clinically appropriate services for the diagnosis and treatment of the condition and writes any necessary prescriptions, either as part of the triage and medical screening or immediately following.
- Referral for primary care follow-up – As part of ED Express Care discharge process, the ED clinician refers the patient for a follow-up appointment with a primary care provider in the community, for the next day or as appropriate. If the patient has no primary care provider (e.g., Medicaid fee-for-service or uninsured), or does not like or cannot access the current HMO PCP, the clinician sets up this appointment at the partner FQHC using a secure Web-based link to the FQHC appointment scheduling system. This electronic interface also allows the hospital ED to share the patient information and clinical notes/summary with the FQHC.

Partnering primary care sites/FQHCs had to expand service hours and clinical staff to offer additional, convenient follow-up appointment times and incorporate features needed to serve as patients' medical home, such as use of the same providers for a patient's care to the extent possible, access to providers by phone or in person 24/7, care management, etc.

- Patient education – During the ED Express Care discharge process, the ED clinician educates the patient on the appropriate site of care for various healthcare needs and the importance of using a medical home for primary care services, contacting their PCP after-hours before going to the ED and limiting ED visits to true emergency situations. This education continues at the FQHC visit, and the patient is provided culturally and linguistically appropriate educational materials on these topics.
- Care coordination and management – The ED clinician provides some care management along with express care. FQHC physicians offer patients appropriate care coordination and management services, including reviewing patient medications, screening for chronic diseases, behavioral health and other co-morbidities and special health needs and making appropriate referrals to specialty care and disease management programs, as needed.
- Case management – Case managers stationed at both the hospital ED and FQHC coordinate patient care and arrange transportation and other support services needed. In addition, ED case managers track and monitor ED utilization, identify repeat ED users and determine their reasons for using the ED; while FQHC case managers track compliance with follow-up visits, assist with referrals for specialty care and disease management programs and help patients resolve barriers to using appropriate care sites.
- Communication/linkage between partners – Each hospital ED maintains ongoing contact with partners (FQHC and/or HMOs/community practices) to track patient utilization patterns and coordinate efforts by FQHC/HMOs to outreach, educate, address barriers and extend additional support services as needed. Successful implementation of the model relies heavily upon reliable and ongoing communication between electronic systems and between staff/clinicians of the sites.

Evaluation design and measures – In order to assess the successes, outcomes and impacts of this demonstration project's model and interventions, several research methods were utilized, including surveys of patients and providers and use of existing/administrative data. A variety of analytical techniques were applied, including pre- and post-project intervention designs and non-parametric tests of statistical significance. The evaluation plan involved review of administrative data, collection of data from project sites that had been routinely tracked throughout the implementation of the project and a series of surveys or focus groups of patients and providers. Anticipated outcome and impact measures included increased capacity of community primary care sites; improved medical home features of community health centers; improved patient satisfaction, compliance and sense of partnership with their providers; decreased ED utilization for primary care needs; and reduced cost of care in general and specifically for the Medicaid program, due to decreased inappropriate use of EDs.

The process evaluation was planned to assess the progress and effectiveness of the project's implementation processes and activities toward achieving its goals and objectives, monitor its

timeline and ensure activities were accomplished as planned. As part of this component, a standardized protocol was developed and systematically implemented for ongoing collection and reporting of pilot sites' organizational data on related activities/interventions and system operations. Focus groups were conducted with all members of the project's steering committee, as well as subsets of this group with knowledge/expertise on the topic or issue under consideration, such as ED teams, FQHC teams and Medicaid managed care group.

To collect data on project outcomes and impacts, existing administrative and program databases from partner hospitals and FQHCs were used to extract detailed information on ED utilization, referral and other relevant demographic characteristics of project patients on an ongoing basis, which were collected and reported through an electronic data tracking template. Surveys of patient barriers and needs were conducted to collect more detailed information about project patients' reasons for using the ED for primary care conditions and identify their needs and barriers to accessing the primary care system in their communities, using two versions of an instrument for initial and repeat users. The project also designed a separate short survey instrument to collect information about ED patients who were referred to an FQHC and missed their scheduled follow-up appointment(s) at the FQHCs. A medical home survey was used to collect information from project patients consistently seeking post-follow-up care (i.e., regular visits) at the partner FQHCs about their current health status and experiences with the care and services received. A provider satisfaction survey instrument was also used to obtain feedback from clinicians at the hospital EDs and FQHCs, who cared for this project's patients, on performance of the project model at their sites and its impact, if any, on their work. Finally, ED volume and cost data was collected from each partner hospital and FQHC, along with Medicaid fee-for-service claims data from DMAHS.

Key findings and lessons learned – Despite some variations across pilot sites, overall, this project resulted in some very positive changes towards the goals of promoting the use of medical homes and appropriate sites of care, reducing utilization of hospital EDs for non-emergent, non-acute primary care services and containing the cost of emergency room expenses for providing primary care services. Key findings included:

- Pilot EDs identified and served 8,718 patients with primary care needs, accounting for 10,351 visits (including 5,770 patients/6,334 visits at NBIMC and 2,948 patients/4,017 visits at MMC). Of these patients, 1,146 patients returned to the pilot EDs for primary care needs, accounting for 1,633 repeat visits.
- Peak days for primary care visits to the ED were Mondays (19%), with a downward trend the rest of the week, for both repeat and initial visits. Weekend usage was surprisingly low (10%). Peak times for primary care visits to the ED were 10:00 a.m. to 1:00 p.m., with a steady decline into the evening and very low utilization in the late evening or overnight. Contrary to findings of other studies, ED utilization by this project's patients was generally during the open hours of the FQHCs and many other primary care offices. The project patients' ED utilization followed typical seasonal peaks, such as the winter flu season. Initial visits declined steadily while repeat visits peaked in winter and then declined, suggesting vulnerability of the population not fully linked to a medical home.

- Project patients were more likely to be female (55%), young adult (45%) and African American (55%). The mean age of patients for project visits was 31.9, with a standard deviation of 16 years.
- 56% of project patients were uninsured/self-pay, 24% were covered by Medicaid/NJ FamilyCare HMOs and 9% were covered under charity care. Insurance status predicted frequency of return for repeat ED use, with 54% of those returning for 4 or more visits covered by a Medicaid/NJ FamilyCare HMO, compared to 19% covered by self-pay. The examination of this association for initial visits showed an inverse trend.
- Of the patients responding to a survey of barriers/needs and reasons for going to the ED for primary care needs and reporting having a PCP, 21% felt they needed emergency services, 20% said their doctor's office was not open and 12% said their doctor was not available that day. Most patients identified that they needed either a PCP (43%) or health insurance (24%).
- Of the patients referred to the partner FQHCs (86% of visits), 45% showed up for their appointments. Among those who showed the first time, the show rate to subsequent visits was significantly higher. The most often cited reason for missing appointments was a conflict with other family commitments.
- Primary care capacity was increased across the two FQHCs through a 28% increase in number of physicians, 73% increase in nurses and 270% increase in additional staff. There was also a 114% increase in multilingual providers/staff. This allowed the FQHCs to increase evening and weekend hours and open more appointment slots to serve more patients, significantly reducing wait times for an appointment (by 75%).
- Comparing baseline to post-project implementation periods, there was a 22% decrease in ED visits for primary care needs, while at the same time overall ED visits were up slightly (0.6%). Utilization decreased 47% among Medicaid patients in particular.
- Comparing baseline to post-project implementation periods, there was a 19% increase in patient volume at FQHC sites. Utilization increased 30% among Medicaid patients.
- Reduced ED utilization for primary care needs helped to clear up the EDs, with a 19% decrease in turnaround time for acuity level 4 and 5 patients, 7% decrease in turnaround time for all treat-and-release patients and 18% reduction in wait time for ED presentation to inpatient beds for admitted patients.
- Along with decreased ED visits for primary care needs, the cost of care for these visits decreased, while the total costs of all ED visits increased during the same period. Patient volume at the FQHCs, on the other hand, increased from baseline to post-project implementation period, as did the associated costs reflecting this increased volume, as anticipated. Additional data and a more comprehensive cost analysis is needed to assess the extent to which the FQHCs' increased costs offset the savings experienced in the EDs and determine the net savings that resulted from this project model.
- Some differences were found across the two sites. Newark served more patients who were uninsured and had significant social and life skills needs, while Monmouth served many Medicaid HMO patients. Newark patients experienced a more significant decrease

in wait times to make FQHC appointments. Monmouth patients had higher repeat use at the ED as well as higher show rates at the partner FQHC. MMC experienced a more significant decrease in ED visits for primary care needs.

Lessons learned over the course of the project included:

- The capacity of the primary care system in its current form is insufficient to meet the needs of all patients, including care for populations with chronic diseases and special healthcare needs. Vulnerable populations, especially, need integrated, coordinated primary care services offered in a medical home.
- Improved access to primary care does not necessarily resolve issues of access to specialists. Primary care solutions for behavioral and mental health needs must be improved, as well as access to pain management, women’s health services and care for other unique needs of the population.
- Some patients are heavy users of all sites of care. Education provided to these patients must be tailored to address the reasons they visit the ED despite having an active relationship with their community primary care providers.
- Transportation does not play a major role in patient help-seeking behavior, as originally thought.
- Poverty does play a major role in patient help-seeking behavior. Poor and low-income patients are more inclined to go to EDs, where care is effectively “free,” rather than pay the nominal sliding-scale fees to be seen at the FQHCs.
- Differences in populations, geographic areas and organizational set-up and culture impact the model’s performance and outcomes. These unique features and characteristics imply different barriers/needs, utilization patterns and methods for behavioral change that influence different outcomes for different populations.
- The goal of reducing inappropriate use may at times conflict with hospital expansion and marketing strategies.
- Relationships among healthcare partners are key, as communication and connectivity across sites allows for efficiencies and needed data sharing. In addition to hospital EDs and FQHCs or other primary care providers, managed care organizations need to be brought on earlier and connected to patients during the time of visit.
- New Jersey’s strict interpretation and enforcement of the federal EMTALA regulation makes it difficult to align financial incentives and disincentives with the most efficient use of the healthcare system and counter the image of the ED among poor and low-income patients as a source of “free” one-stop comprehensive care. ED clinicians tend to order more tests and provide more complete treatment, without ever asking for upfront payment, to ensure that they are in compliance with New Jersey’s regulations. This environment makes it difficult to promote true diversion. Although the project model was successful through its focus on patient education and encouragement for future use of appropriate sites of care, even more might have been accomplished if the EDs were able

to divert patients immediately to the nearby FQHCs, or other primary care clinics/practices, and/or charge a fee for completion of primary care services.

Conclusion and recommendations – New Jersey’s Community Partnership for ED Express Care and Case Management project provided a test of a model that combined the elements of a multifaceted approach needed to address the issue of inappropriate ED utilization for primary care needs, including: patient education and behavior change, provider education and behavior change and systemic improvements, such as increased capacity, connectivity and medical home features. Overall, this project resulted in some very positive changes toward the goals of reducing utilization of hospital EDs for non-emergent, non-acute primary care services through promoting the use of appropriate sites of primary care.

The findings of this initiative significantly add to the body of knowledge on access issues in New Jersey. The new local-level data and knowledge about the needs in pilot areas and the wide distribution of findings about the project model will provide the state Medicaid program, HMOs, hospitals and community health centers clinics with the tools they need to initiate changes for more efficient delivery systems. They will also educate consumers in areas with severe/chronic access problems on the importance of preventive care, a medical home and appropriate use of the healthcare system.

Based on the findings, the following are recommendations for future implementation of this model:

- A statewide campaign should be conducted to educate the general public about the importance of using EDs for true emergencies. As part of this education, hospitals should be advised to target their own ED promotion messages to ensure that patients know to use their services appropriately.
- Patient education messages should be crafted clearly to avoid confusion and direct patients in the specific steps to seeking care in appropriate sites.
- Education provided to patients who are heavy users of all sites of care needs to be tailored to address the reasons they visit the ED despite having an active relationship with their community primary care providers (FQHCs, etc.). They can be educated about the importance of utilizing their primary care provider as their medical home.
- FQHCs must promote their services competitively, using business models, and more actively market the availability and quality of their services for all populations.
- Medicaid HMOs must increase their involvement and the network of primary care providers.
- Since contact with the HMOs is best initiated from a hospital or a provider’s office at the time of the visit, HMOs should also use the opportunity to improve easy access and communications by updating their contact information, including email addresses, which are less likely to change than phone numbers.

- Medical home features should be incorporated in primary care practices and should be designed to tailor their services to account for unique demographic characteristics and needs of populations served, as well as the individual needs of patients.
- Connectivity between the EDs and community primary care providers (FQHCs, etc.) is essential to this effort. These sites should have the infrastructure and access to support appointment setting, information sharing and identification of high utilizers to target with intensive outreach.
- Access to community-based primary care for mental/behavioral healthcare and substance abuse needs must be expanded to properly serve patients' needs and keep their issues from getting exacerbated, resulting in ED visits.
- Similarly, access to specialists, pain management, women's health services and care for other needs must also be improved within the primary care system/sites so that more patients could be served effectively in the community setting.
- Incentives must be modified to ensure that the out-of-pocket cost of care and perception of quality at the EDs and the FQHCs are aligned. Policy changes are needed to create economic incentives for Medicaid patients to use primary care sites (e.g., FQHCs) when appropriate.
- A thorough review and clarification/adjustment of current policies, such as EMTALA and New Jersey regulations, as well as new policies are needed to ensure the goals of the model are supported. These policies and regulations must be as clear as possible to avoid any confusion. Reduced ambiguity leaves less room for interpretation for protection of patients or providers.
- Community-based systems of primary and specialty care must be redesigned with increased capacity and efficiency, not only to handle a large-scale influx of patients diverted from EDs but also to absorb newly insured individuals in the wake of full implementation of healthcare reform.

The initial two-year pilot study was unable to demonstrate a complete picture of the cost savings associated with the model, due to inadequate cost data from the health centers, whose higher reimbursement levels for primary care may partially offset the ED savings. Future pilots should incorporate a more comprehensive cost impact model and more thoroughly review and assess the savings of the program. Further testing of this model is also needed to identify additional barriers and nuances of the model before wider implementation statewide or nationally. Policy changes that nurture the project model approaches and encourage implementation of its successful features, including appropriate alignment of incentives, are also critical to have in place to reduce the systemic issues identified by this pilot.