Domain 2: *System Transformation Projects*
Project ID*: 2.b.iii*
Project Title*: ED Care Triage for at-risk Populations*

Objective:

To develop an evidence-based care coordination and transitional care program that will assist patients to link with a primary care physician/practitioner, support patient confidence in understanding and self-management of personal health condition(s). Objective is also to improve provider-to-provider communication and provide supportive assistance to transitioning members to the least restrictive environment.

Description:

Emergency rooms are often used by patients to receive non-urgent services for many reasons including convenience, lack of primary care physician, perceived lack of availability of primary care physician, perception of rapid care, perception of higher quality care and familiarity. This project will impact avoidable emergency room use, emphasizing the availability of the patient's primary care physician/practitioner. This will be accomplished by making open access scheduling and extending hours, EHR, as well as making patient navigators available. The key to this project's success will be to connect frequent ED users with the PCMH providers available to them.

Target Patient Population:

Patients with frequent ED utilization and those presenting in the ED with minor illnesses who do not have a primary care provider.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients presented at the ED and after medical screening examination were successfully redirected to PCP as demonstrated by a scheduled appointment.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, skilled nursing facilities / nursing homes, , community based organizations, and others.

Project Milestones
Establish ED care triage program for at-risk populations
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.   a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.   b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.   c. Ensure real time notification to a Health Home care manager as applicable
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.   b. Patient navigator will assist the patient with identifying and accessing needed community support resources.   c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non- acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)
Use EHRs and other technical platforms to track all patients engaged in the project.