Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP)

PLAN

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RHP#3 CareHouston Links Project

Judy Harris
City of Houston
Department of Health and Human Services
8000 N. Stadium
Houston, Texas 77054
Judy.Harris@houstontx.gov
832-393-4345

Narrative for Category 2 Project Title:CareHouston Links

Project Option 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

Unique Project ID:0937740-08.2.2
Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Description:
CareHouston Links proposes to provide care coordination that will reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care.

CareHouston Links is an expansion of the CareHouston program that was launched as a partnership between the Houston Department of Health Human Services (HDHHS) and the Houston Fire Department (HFD) Emergency Medical Services in 2006. CareHouston Links will expand the existing program throughout the City of Houston and integrate its services with the HFD Emergency TeleHealth and Navigation (ETHAN) Program. CareHouston Links will provide case management support to ensure clients who were referred by the ETHAN program receive appropriate follow up care and are linked to a medical home. The CareHouston Links navigators will follow up with the patient to determine if the patient followed the advice provided by the ETHAN physician. The counselor/case manager will work with the client/family and their health care provider to ensure continued compliance. In situations where the client failed to follow the advice provided, the counselor will determine and record what actually occurred and the reasons why the advice was not carried out. The counselor will assess these issues and develop a care plan to address them and ensure clients are linked to the appropriate care. Additionally, the CareHouston Links program would continue the education and referral services that were provided to frequent 911 callers through the CareHouston program.

CareHouston Links is designed to address the challenges that are faced by the City of Houston in providing emergency health services to the residents of the City of Houston. According to a report from 2008, from University of Texas School of Public Health, visits to the ER were rising due to primary care cost rising. In 2008, 10.8% of all primary care related ED visits arrived by ambulance transport and 20.9% of all other ED visits arrived by ambulance.Current data shows that there are over 100,000 non-emergency transports made by HFD. HFD has also documented certain zip-codes that have a high percentage of 911 calls. The CareHouston Links project addresses these challenges by expanding a program that has proven to reduce repeat calls to 911 and thereby reducing the use of expensive emergency services through the use of face to face follow-up,

education and navigation services. The new program will build upon these past successes and not only reduce 911 calls and ambulance runs but also link callers with primary care resources as an alternative to use of expensive emergency services.The zip codes that generate a large volume of 911 calls that are non-emergent will be a primary target for this program. These zip codes will be identified by the Houston Fire Department and Emergency Medical Services data system for the previous year. The pilot was conducted in 77051 and 77033 which comprise the Sunnyside neighborhood in Houston.The methods were validated for two pilot zip codes.

Goals and Relationship to Regional Goals:

The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. These patient navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that CareHouston Links patients receive coordinated, timely, and site-appropriate health care services and will assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.

Project Goals:

1. Expand CareHouston program to other targeted low income, underserved high risk communities and partner with the ETHAN (Telehealth) Program.
2. Enhance service to the community by reducing inappropriate emergency room visits
3. Increase the number of clients appropriately linked to a medical home
4. Increase the number of clients consistently using their medical home
5. Reduce the need for hospitalizations and improve the quality of life of clients.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

Challenges:

The performing provider anticipates challenges in educating patients and families to use the program, working with Houston Fire Department and other EMS/Ambulance Services to meet alternative transportation needs of clients and overcoming barriers (such as appointment wait times) to link patients to a medical home. Additionally, the provider anticipates system capacity challenges that may be encountered by clients in follow-up on referrals for other needed services. The provider will seek to form ongoing working partnership with others providers of health care and social services to develop workable solutions to anticipated barriers.

5 Year Expected Outcome for Provider and Patient:

The CareHouston Links Program expects to reduce the number of ER visits and 911 calls to EMS for non-emergencies in high volume zip codes and thereby reduce costs to the health care system. The program also expects that patients will be linked to medical homes and be appropriately educated and supported to access services in the right setting.

Starting Point/ Baseline:

The number of referrals to CareHouston program in YR 2 will be used as an initial baseline for the program.

Rationale:

The CareHouston Links project will utilize health care workers, case managers/workers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner which is essential to guiding patients through integrated health care delivery systems. Patient navigators 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. Referrals are made to social services, home health care services, FQHCs and other medical homes, as indicated. Additional follow-up in the CareHouston Links program would include home visits and patient education that would ensure that the clients are linked to appropriate services. Other assistance would include referrals to private ambulance services and Harris County rides to avoid inappropriate use of EMS and provide care coordination. Linking, assessing and referring clients to appropriate services will reduce their need to use 9-1-1 services. This program will facilitate communication among patients, family members, survivors and healthcare providers; coordinate care among providers; arrange financial support and assisting with paperwork; arrange transportation and child care; ensure that appropriate medical records are available at medical appointments; facilitate follow-up appointments and conduct community outreach and build partnership with local agencies and groups.

Cost savings from this program include savings related to reduction in ED use and redirecting and connecting patients to medical homes and services for chronic care management and reduction in EMS transports. The target group for this project are residents who access emergency services for circumstances that would be more appropriately addressed through alternative systems of care. Annually, the HFD makes over 100,000 transports for non-emergency reasons. The results from the currently ongoingCareHouston program are a robust indicator that patient navigation services are a viable solution to the challenge of assuring that

residents access primary and preventive services in lieu of emergency services where appropriate. The challenge that led to the development of the CareHouston program was the observation by HFD EMS personnel that they were making frequent ambulance runs to the same addresses and seeing no long term solution to the client's health issues. The medical director of Houston's EMS services, who also serves as the Public Health Authority, was familiar efforts by the HDHHS to assess and meet health and social service with targeted outreach initiatives in the community. To document the challenge and the effectiveness of the intervention, HFD reviewed data from April 1, 2006-June 30, 2006 for the targeted pilot area, the Sunnyside community and found that 18 patients accounted for 113 EMS responses via 9-1-1 during this period. These patients were referred to the HDHHS and were contacted in the first part of July. These same patients were reevaluated for 911 service requests at the end of September. Following contact by HDHHS personnel, the 18 addresses/patients (including several who declined participation in the program), accounted for only 33 responses, a decrease of 70.80%. Eight of the 18 study patients, approximately 40% of the identified patients, had no requests for 911 services. Through the CareHouston program, frequent 911 callers identified by HFD are referred to HDHHS for follow-up by HDHHS navigators and case managers. Clients are assessed to determine underlying problems such as lack of education regarding health condition or transportation needs. HDHHS staff educates residents and families about their health and medical condition, the proper use of the EMS system, alternate transportation services and any other unmet needs. Referrals are made to social services, home health care services and medical homes, as indicated. The program is staffed by counselors, navigators and public health nurses who reach out to the individuals referred through phone, mail, home visits or the HFD/EMS Services.

Project Components:

CareHoustonLinks program will address all of the following project components defined for the project option 2.9.1 to establish/expand a patient care navigation program.

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. The program will provide appropriate training and education to patient navigators so that they are equipped to address the needs of multiple racial/ethnic and socio-economically diverse populace of Houston.

b) Deploy innovative health care personnel, such as community health workers and other types of health professionals aspatient navigators. The program will have a strong community base component so that there is greater buy in from the target communities.

c) Connect patients to primary and preventive care. The patient navigators will be skilled in connecting patients to primary care and will follow up to ensure that patients are making the primary care visits.

d) Increase access to care management and/or chronic care management,including education in chronic disease self-management. Since many of the patients that will be enrolled in the program are expected to have multiple chronic conditions, navigators will connect them to disease self-management programs that currently exist in the community.

e) Conduct quality improvement for project using methods such as rapid cycleimprovement. Activities may include, but are not limited to, identifyingproject impacts, identifying "lessons learned," opportunities to scale all orpart of the project to a broader patient population, and identifying keychallenges associated with expansion of the project, including specialconsiderations for safety-net populations.

HDHHS will utilize trained health care navigators to identify ED users, increase access to care management and education programs, reduce ED use and non-emergency ambulance runs and connect patients to primary and preventive care. HDHHS will build upon the experience and success of the CareHouston program to implement the CareHouston Links program. Additionally, HDHHS will conduct quality improvement activities for the project as described in the RHP planning protocol.

Unique community need identification numbers the project addresses:

- CN-8 High rates of inappropriate emergency department utilization
- CN-20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN-23 Lack of patient navigation, patient and family education and information programs.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:

The existing CareHouston program has been reprogrammed as CareHouston Links. The program will be expanded to include the following: 1) addition of patient care teams to expand the number of patients that can be seen in the program 2) an increase in referrals to the program to include not only frequent 911 callers but also callers that were determined through the telehealth program to need an alternative form of care other than emergency room care 3) a more robust follow-up program to not only make referrals to medical homes but also provide actual navigation support and follow-up to connect clients to medical homes and to assure usage 4) an increase in the number of 911 callers referred to the program by changing the criteria for inclusion in the program.

Related Category 3 Outcome Measures:

OD- 9 Right Care, Right Setting

IT-9.4Other Outcome Improvement Target (ED appropriate utilization due to enrollment in CareHouston Links Program)

- Rate of Non Emergent 911 callers referred to CareHouston Links

Reasons/rationale for selecting the outcome measures:

We chose the above outcome measure because it will allow us to track the tangible benefits of implementation of CareHouston Links. Since the CareHouston program's implementation in 2006, the HFD EMS unit hasexperienced a 72% decrease in 911 calls from specific geographic areas allowing them to redirect more than $4.6 million to other services.

By expanding to other targeted low income, underserved high risk communities, with a large volume of 911 calls, the program could expand HDHHS's capacity to connect and link clients to needed services in a timely mannerand further reduce costs associated with non-emergency EMS transports and inappropriate ER visits.Linking, assessing and referring clients to appropriate services will reduce their need to use 911 services. Each time an ambulance service is dispatched to transport patients; the cost is approximately $1470. During Fiscal Year 2012, the Care Houston program diverted 1,458 clients from using EMS transports to emergency departments for non-emergencies, diverting costs of $2,143,260.

Relationship to Other Projects:

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

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served/Project Size, 3) Alignment with Community Needs 4)Cost Avoidance,5) Partnership Collaboration, and 6)Sustainability. Each factor was then given a weighted score and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services, and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The CareHouston Links Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.

UNIQUE IDENTIFIER 0937740-08.2.2	*RHP PP REFERENCE NUMBER: 2.9.1*	*PROJECT COMPONENTS: 2.9.3(a-c)*	*PROJECT TITLE: CareHouston Links*
Performing Provider Name: City of Houston Health and Human Services			*TPI - 0937740-08*
Related Category 3 Outcome Measure(s):	0937740-08.3.7	*IT – 9.4*	*Other Outcome Improvement Target (ED appropriate utilization)*
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Process Milestones and Metrics			
Milestone 1 [P – X1]: Plan scope, range, current capacity and needed resources for CareHouston Links Metric 1: Provide report detailing Program Planning Materials, Meeting minutes, Sign-in sheets, Draft Clinical Protocols, Staff Qualifications, Staffing Plan Goal: Produce a comprehensive report documenting all points above Metric 2: Provide report providing final protocols, List of Partners/Stakeholders, Final Implementation Plan Goal: Produce a comprehensive report documenting all points above Data Source for Milestone 1: Program Documentation	**Milestone 4[P-3]:** Provide care management/navigation services to targeted patients. P-3.1. Metric: Increase in the number or percent of targeted patients enrolled in the program a. Numerator: Number of targeted patients enrolled in the program b. Denominator: Total number of targeted patients identified Baseline: Establish baseline number of patients enrolled in program Data Source: Enrollment reports Milestone 4 Estimated Incentive Payment: $ 1,244,451 **Milestone 5 (P-X.):** Establish baselinenumber of PCP referrals for patients without a medical home	**Milestone 6 (I-6.):** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. I-6.1. Metric: Increase medical home empanelment of patients referred from navigator program. Goal: Increase by 5% over baseline the number of patients that were given PCP referrals a. Numerator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) that are seen in primary care setting and empanelled to the medical home. b. Denominator:Number of new patients referred for services from	**Milestone 7 (I-6).:**Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. I-6.1. Metric:Increase medical home empanelment of patients referred from navigator program. Goal: Increase by 10% over baselinethe number of patients that were given PCP referrals a. Numerator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) that are seen in primary care setting and empanelled to the medical home.

UNIQUE IDENTIFIER 0937740-08.2.2	*RHP PP REFERENCE NUMBER: 2.9.1*	*PROJECT COMPONENTS: 2.9.3(a-c)*	*PROJECT TITLE: CareHouston Links*
Performing Provider Name: City of Houston Health and Human Services			*TPI - 0937740-08*
Related Category 3 Outcome Measure(s):	0937740-08.3.7	*IT – 9.4*	*Other Outcome Improvement Target (ED appropriate utilization)*
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment: $ 873,535.66 **Milestone 2 [P –X 2]:** Establish Baseline data for the number of non-emergent calls and visits that are the target of this program for a 12 month period. Metric 1: Number of non-emergent 911 calls by zip code Metric 2: Number of non-emergent ED visits by zip code Baseline: the total number of Year 2 calls and visits (12 months) by zip code Milestone 2 Estimated Incentive Payment: $ 873,535.66 **Milestone 3 [P-2.1]:** Expand a health care navigation program to provide support to patient populations who are most at risk of receiving	who use the ED, urgent care, and/or hospital services. Metric 1 [P-X.1]: Collect data to establish baseline number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Baseline: Establish percentage of patients that were given PCP referrals Data Source: Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program. Milestone 5 Estimated Incentive Payment: $ 1,244,451	Patient Navigator Program (CareHouston Links) from repeat 911 callers. **c. Data Source:** Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program. Milestone 6 Estimated Incentive Payment: $ 2,476,458	**b. Denominator:** Number of new patients referred for services from Patient Navigator Program (CareHouston Links) from repeat 911 callers. **Data Source:** Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program. Milestone 7 Estimated Incentive Payment: $ 2,205,721

UNIQUE IDENTIFIER 0937740-08.2.2	*RHP PP REFERENCE NUMBER: 2.9.1*	*PROJECT COMPONENTS: 2.9.3(a-c)*	*PROJECT TITLE: CareHouston Links*
Performing Provider Name: City of Houston Health and Human Services			*TPI - 0937740-08*
Related Category 3 Outcome Measure(s):	0937740-08.3.7	*IT – 9.4*	*Other Outcome Improvement Target (ED appropriate utilization)*
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. P-2.1. Metric: Number of people trained as patient navigators. Workforce development plan for patient navigator recruitment, training and education Goal: Complete workforce development plan Data Source: Documentation of workforce development plan Milestone 3 Estimated Incentive Payment: $ 873,535.68			
Year 2 Estimated Milestone Bundle Amount: $2,620,607	Year 3 Estimated Milestone Bundle Amount: $ 2,488,902	Year 4 Estimated Milestone Bundle Amount: $ 2,476,458	Year 5 Estimated Milestone Bundle Amount: $ 2,205,721
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundles amounts over DYs 2-5)***:**$ 9,791,688			

Narrative for Category 3 Outcome Measure Associated with Category 2 Project Title: CareHouston Links

Title of Outcome Measure (Improvement Target):IT-9.4Other Outcome Improvement Target

Unique RHP Outcome identification number(s):0937740-08.3.7

Outcome Measure Description:

IT-9.4 ED–Other Outcome Improvement Target (EDAppropriate Utilization)

- By providing patient navigation, non-emergent 911 callers and those that were seen by EMS can be redirected to the CareHouston Links Program. This program provides care coordination, by more accurately assessing the non-emergent 911 caller's needs and connecting them to the required services. This will reduce unnecessary repeat calls to 911 and result in savings to the healthcare system.

Process Milestones:

- DY2:
  - P-3: Develop and Test Data System
- DY 3:
  - P-4: Conduct and Update Plan-Do-Study-Act for quality improvement
  - P-5: Disseminate findings, lessons learned and best practices

Outcome Improvement Targets for each year:

- DY 4:
  - IT-9.4Other Outcome Improvement Target (ED appropriate utilization (Stand-alone measure) - Reduce ED visits that are non-emergent (including ACSC)
- DY 5:
  - IT-9.4Other Outcome Improvement Target (ED appropriate utilization (Stand-alone measure**) -** Reduce ED visits that are non emergent (includingACSC)

Rationale:

A version of the proposed CareHouston Links program was previously targeted to the Sunnyside community in Southeast Houstonwhere an HFD-EMS analysis showed that 26% of all 9-1-1 calls were non-emergency related in this low income, underserved community. Since the CareHouston program's implementation in 2006, the HFD EMS unit experienced a 72% decrease in calls in this area allowing them to divert more than $4.6 million in costs associated with the transport of non-emergency callers to the emergency rooms for services. The CareHouston Links program will reduce future emergency room visits by providing navigation services to clients, educating them about the appropriate use of services and linking them with primary and preventive care services. Ineffective navigation of the health care system by patients may lead to poorer outcomes and

inefficiencies because of delayed care, failure to receive proper care or treatments, or care being received in more expensive locations (i.e., emergency rooms).

Linking, assessing and referring clients to appropriate services will reduce their need to use emergency services. Each time an ambulance service is dispatched to transport patients; the cost is approximately $1470. During Fiscal Year 2012, the Care Houston program diverted 1,458 clients from using EMS transports to emergency departments for non-emergencies, saving the COH $2,143,260. Each diverted ambulance transport is also associated with a diverted emergency room visit.

The Other Improvement Target for Reducing Inappropriate ER Use, will be used as our Category 3 Outcome measure. According to Agency for Healthcare Research and Quality, visits to the Emergency Department for non emergent care results in increasing health care costs and overcrowding. A report from Health and Human Services Commission on Rider 56, House Bill 1, from August 2012, states "one of the key strategies to reducing non-emergent ED use is to steer clients to more appropriate sources of care. Integral to achieving this goal is ensuring adequate access to prevention and primary care services. The medical home model is a building block to achieving this objective as is promoting the use of urgent care facilities and retail health clinics when clients cannot go to their medical home." (Article II, Health and Human Services Commission, Rider 56, H.B. 1, 82nd Legislature, Regular Session, 2011).

Outcome Measure Valuation:

The Outcome measure was valued at 11.41% of the overall assigned project value for the associated Category 2 project in year 3, 11.41% in Year 4 and 11.41% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health

Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The CareHouston Links Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.

The following are avenues of cost savings to the health care system that can be facilitated by a program that seeks to reduce ER usage, such as CareHouston Links.

1. Cost savings attributed to using navigators as part of a preventable ED reduction program
2. Cost savings related to connecting patients to medical homes, increase access to primary and specialty care, and increase access to chronic care management
3. CMS reimbursement rate for EMS transports; Cost savings to CMS when alternate transportation is used
4. Cost savings to CMS for ED visit redirected to a clinic

References:

1. ER Visits with an ambulance transport. Report from Center for Health Services Research Collaborative. UT School of Public Health, Houston, Texas. Accessed on 10/2/12 from https://sph.uth.edu/research/centers/chsr/hsrc/.Stakeholder input from RHP 3Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)
2. Agency for Healthcare Research and Quality. Enhancing Primary care Access after Emergency Department Visits .http://www.innovations.ahrq.gov/issue.aspx?id=135The State of Health – Houston and Harris County, 2012.
3. Dixon BE, Hook JM, McGowan JJ. Using Telehealth to Improve Quality and Safety: Findings from the AHRQ Portfolio (Prepared by the AHRQ National Resource Center for Health IT under Contract No. 290-04-0016). AHRQ Publication No. 09-0012-EF. Rockville, MD: Agency for Healthcare Research and Quality. December 2008.

Unique Cat 3 ID: 0937740-08.3.7	Ref Number from RHP PP: IT-9.4 ED	*Other Outcome Improvement Target (ED appropriate utilization)*	
Performing Provider Name: City of Houston Health and Human Services			*TPI –0937740-08*
Related Category 1 or 2 Projects:	Unique Cat 2 ID: 0937740-08.2.2		
Starting Point/Baseline:	*Baseline will be established in DY 2-3*		
Year 2	**Year 3**	**Year 4**	**Year 5**
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
Process Milestone 1 (P-3): Develop and Test Data System Metric 1: Provide documentation of It resources and system needed Metric 2: Documentation of testing and installation of data system Goal: Set up a workable electronic system through which effective and efficient data can be collected. Data Source: Program documentation and electronic system. Process Milestone 1 Estimated Incentive Payment: $137,927	**Process Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve Metric: Document use of PDSA in planning process Goal:Ensure highest quality on program process and improvement. Data Source: Step-wise documentation of PDSA in program documentation Process Milestone 2 Estimated Incentive Payment: $138,272.5 **Process Milestone 3 [P-5]:** Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Provide report documenting identification of best practices and lessons learned	**Outcome Improvement Target 1 [IT-9.4]:**Other Improvement Target(Stand-alone measure) Milestone 1: Reduce all ED visits that are non emergent (including ACSC) in specific zip codes due to participation in Navigation program Numerator**:** Non Emergent 911 callers connected to CareHouston Links, who would have otherwise been transported to ED Denominator**:** All non Emergent 911 callers Baseline: Reduce by 5% below baseline the proportion of non-emergent ED visits (Baseline will be established in Yr.2-3 from program data by establishing the proportion of non emergent 911 callers that were connected to	**Outcome Improvement Target 2 [IT-9.4]:**Other Improvement Target(Stand-alone measure) Milestone 1: Reduce all ED visits that are non emergent (including ACSC) in specific zip codes due to participation in Navigation Program. Numerator: Non Emergent 911 callers connected to CareHouston Links,who would have otherwise been transported to ED Denominator**:** All non Emergent 911 callers Goal: Reduce by 5% below Yr. 4 the proportion of non emergentED visits that were averted during enrollment in this program Data source: Program data electronic records, EMS Data

Unique Cat 3 ID: 0937740-08.3.7	Ref Number from RHP PP: IT-9.4 ED	*Other Outcome Improvement Target (ED appropriate utilization)*	
Performing Provider Name: City of Houston Health and Human Services			*TPI –0937740-08*
Related Category 1 or 2 Projects:	Unique Cat 2 ID: 0937740-08.2.2		
Starting Point/Baseline:	*Baseline will be established in DY 2-3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Data Source: Documentation of report Process Milestone 3 Estimated Incentive Payment: $138,272.5	CareHoustonLinks.) Data source: Program data electronic records, EMS Data Outcome Improvement Target 1 Estimated Incentive Payment: $275,162	Outcome Improvement Target 2Estimated Incentive Payment: $551,430
Year 2 Estimated Outcome Amount: $ 137,927	Year 3 Estimated Outcome Amount: $ 276,545	Year 4 Estimated Outcome Amount: $ 275,162	Year 5 Estimated Outcome Amount: $ 551,430
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):*$1,241,064			