An Organizational Meeting to Discuss:
A Regional Collaborative Participating in IHI Prototyping Initiative on Reducing Avoidable Emergency Department (ED) Use

July 8, 1:00-2:30 pm
Hosted at CDPHP Offices, 500 Patroon Creek Blvd, Sacandaga Room
Sponsored by the Healthy Capital District Initiative, CDPHP, MVP Healthcare, and Blue Shield of Northeast New York

In attendance: Cliff Waldman (CDPHP), Sara Butterfield (IPRO), Christine Stegel (IPRO), Jerry Salkowe (MVP), Jeff Burns (Albany Memorial), Sue Vitolins (Samaritan), Jackie Cabreja (Ellis), Dave Smingler (Ellis), David Howells (Northeast Health), Rose Maria Tirino (St. Peter's), Amy LaGrange (Ellis), Carol Weeks (Ellis), Sister Gail Waring (St. Peter’s), Dennis McKenna (AMC), John Janikas (Samaritan), Erin Elfeldt (Whitney Young), Tara Salvagio (Whitney Young), Robert Cellia (St. Peter’s), Heidi Schelleng (Seton Health), Colleen Hatman (Seton Health), Lyn Hohmann (BSNENY), Lou Snitkoff (Capital Care), Kallanna Manjunath (Whitney Young), HCDI staff: Kevin Jobin-Davis, Courtney Burke, Barbara Stubblebine

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<td>Project Overview</td>
<td>The meeting opened with introductions, followed by a brief overview of CDPHP’s relationship with IHI; and an overview of HCDI’s R5 Initiative and how R² and IHI projects might complement each other.</td>
<td>Discuss comments/concerns with IHI. See if there is a way we could adapt what we might do with them.</td>
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| Discussion       | Overview of IHI Initiative – a rapid prototyping and testing initiative that is a good model for improvement, which may provide opportunities to work with other regional groups. IHI’s Triple Aim Initiative aims to improve care quality and patient’s experience, plus lower costs. The goal is to recognize who goes to the ED and how to intervene and change future behaviors for non-emergent ED use. Questions/discussion for the group:  
  - How could joining IHI best complement the R² Initiative?  
  - What are the key organizational and public health benefits of an IHI moderated working collaboration on improving ED utilization in the Capital District?  
  - What does your organization hope to gain by joining our collaborative on the IHI initiative?  
  - What “patient streams” are potentially of the most interest to the groups here today?  
  - How would our organizations work together as a collaborative?  

General comments
It was discussed that the group should focus on understanding and addressing the motivation behind ED use, and not just the medical reasons.

Also important is learning at what level the PCP addresses the issue before the patient goes to the ED. This is not just a PCP problem, however. How do providers respond to urgent care needs where a person needs to be seen within a few hours, but still stay a part of the system?

Some PCPs do not have the capacity to serve urgent care cases, (and capacity is in the eye of the beholder).
From the public health perspective, a consistent, persistent message is needed in order for the public to comply – all areas of health care need to be on the same page: PCPs, hospitals, churches, and other community organizations, etc. Example – CDC’s “get smart” campaign re: antibiotics.

Potential benefits of the collaborative
It was noted that IHI and R5 initiatives meshed well – and that there were several overlapping themes. It was also noted, however, that it should not sidetrack R5 Initiative deliverables.

One participant commented that it would be good to have IHI faculty with expertise and knowledge of needs in our area. Another thought it could also be beneficial to have faculty with no expertise about our area – as it could open us up to new ideas.

Short-term learning would help get the collaborative started (6-9 months). It is also important that the collaborative not take on too much in the beginning.

Potential patient streams
Suggested potential patient streams included: dental; chronic conditions – 30 day readmissions for CHF, COPD, end-stage renal disease, etc.; pediatric conditions: otitis media, URI (kids and adults); addiction and behavioral health, especially with the homeless population.

Another issue surrounding the addicted population is transportation. EMS has only two choices – have the patient sign a refusal for treatment and transport, or transport them to the ED. An alternate outlet for care for this population when they have non-emergent needs would be good.

It was noted that different practices have different models, and serve different populations. The addicted and behavioral populations are a struggle, especially those who are homeless. There are some community groups that are trying to address these populations – and they often try to get them insured as soon as possible and then get them set up with a PCP.

It was noted that California performs medical screening exams, and refuses to treat non-emergent cases in the ED. In Colorado, hospitals collaborate with community health centers to transfer non-emergent cases. Are either of these models something that this region would be interested in or willing to try?

One participant commented that this would be a good model for addiction services – and wondered if anyone knew if it had been adopted anywhere else.

A suggestion was made to involve HIXNY in the process (it was noted that a collaborative meeting was scheduled with HIXNY for July 20).

Speak with HCDI executive board to hear their views.

Speak with other upstate planning entities to determine if a larger “upstate regional collaborative” might be a beneficial model to pursue with IHI.