REPORT OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Report on the Emergency Department Care Coordination (EDCC) Workgroup (Chapter 552, Item 317.KK., 2021)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 14

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 26, 2021

MEMORANDUM

TO: The Honorable Ralph S. Northam
Governor of Virginia

The Honorable Janet D. Howell
Chair, Senate Finance and Appropriations Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services

SUBJECT: Report on Report on the Emergency Department Care Coordination (EDCC) Workgroup

This report is submitted in compliance with the Virginia Acts of the Assembly – HB1800, Item 317.KK which states:

> *"Out of this appropriation, $1,319,515 from the general fund and $3,798,129 from nongeneral funds the second year is provided to support the Emergency Department Care Coordination Program (EDCC). The Department of Medical Assistance Services, in cooperation with the Virginia Department of Health, shall establish a work group comprised of the EDCC contractor, the Virginia Health Information, Medicaid and commercial managed care organizations, health systems with emergency departments and emergency department physicians to optimize the use of the system and any enhancements to the system to facilitate communication and collaboration among physicians, other healthcare providers and other clinical and care management personnel about patients receiving services in hospital emergency departments for the purpose of improving the quality of care. The work group shall determine how to best measure performance of the system, identify utilization trends and outcomes, and make any recommendations for system improvements to the Governor and General Assembly by December 1, 2021."*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK
Enclosure

Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Report on the Emergency Department Care Coordination (EDCC) Workgroup

A Report to the Virginia General Assembly

December 1, 2021

Report Mandate:

Chapter 552, item 317KK of the 2021 Appropriations Act "*Out of this appropriation, $1,319,515 from the general fund and $3,798,129 from nongeneral funds the second year is provided to support the Emergency Department Care Coordination Program (EDCC). The Department of Medical Assistance Services, in cooperation with the Virginia Department of Health, shall establish a work group comprised of the EDCC contractor, the Virginia Health Information, Medicaid and commercial managed care organizations, health systems with emergency departments and emergency department physicians to optimize the use of the system and any enhancements to the system to facilitate communication and collaboration among physicians, other healthcare providers and other clinical and care management personnel about patients receiving services in hospital emergency departments for the purpose of improving the quality of care. The work group shall determine how to best measure performance of the system, identify utilization trends and outcomes, and make any recommendations for system improvements to the Governor and General Assembly by December 1, 2021.*"

Executive Summary

Chapter 552, item 317KK of the 2021 Appropriations Act ("the Act") mandated the establishment of a workgroup focused on the Virginia Emergency Department Care Coordination (EDCC) program, a program managing statewide use of the Emergency Department Information Exchange (EDIE) software package. The purpose of the workgroup was to identify how to optimize and facilitate communication and collaboration across providers and care domains to improve the quality of care of Commonwealth citizens receiving emergency department (ED) services. The Act stipulated that the workgroup:

1) Determine how best to measure performance of the system;
2) Identify utilization trends and outcomes; and
3) Make recommendations for system improvements.

Bringing together perspectives of a wide range of EDCC stakeholders to identify opportunities to enhance the EDCC's ability to use communication and collaboration to improve the quality of care received by Commonwealth members using ED services, the workgroup identified nine (9) EDCC Performance Measures, a system for identifying ED utilization trends and outcomes, five (5) policy recommendations for system improvements and ten (10) EDCC Advisory Council steps to enhance use of the EDCC. Specifically:

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs for more than 1.8 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 500,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for newly eligible adults, generating cost savings that benefit the overall state budget.

Performance Measures

The workgroup recommends the following performance measures, summarized in Table 1, related to domains of data quality, provider enrollment, user engagement and patient outcomes:

Table 1. EDCC Performance Measures

Domain	Indicator
Data Quality	1. % of total ED visits with valid diagnosis code & discharge date 2. % of "High Utilizer" patients (10+ visits in last 12 months) with a current *Care Insight*[a]
Provider Enrollment	3. # of enrolled downstream providers
User Engagement	4. % of hospital EDIE platform users with EHR integration 5. % of non-integrated EDIE platform users that are "engaged"[b] 6. # of actively attributed downstream patients[c] 7. # of "High Utilizer" charts viewed by a Medicaid managed care organization at least once per month
Patient Outcomes	8. % of total ED visits from patients who visited 3+ different hospital EDs within 90 days 9. % of total ED visits from patients with 10+ visits within 12 months

a: *Care Insights* are user-generated free-text descriptions of patients and their care needs created or edited within the last 18 months and viewable by EDCC users
b: "Engaged" is defined as those users who have had 5+ EDCC logins or authored 3+ *Care Insights* in a given month
c: Actively attributed patients include those for whom a valid downstream provider eligibility file has been submitted within the prior 60 days

Identification of Utilization and Outcomes

The workgroup agreed that the EDCC Advisory Council's current method for monitoring and stratifying utilization and outcomes among ED High Utilizers constituted an effective way of identifying ED utilization and outcomes. This method includes visualizing the following *Emergency Department Measures* for each of the *High Utilizer Groups* defined below:

Emergency Department Measures:

- Number of Patients
- Total ED Visits
- Median ED Visits
- Total Admissions from ED patients
- Median Admissions from ED patients
- Average ED Length of Stay
- Percent with Behavioral Health Diagnosis
- Percent Suspected Homeless
- Percent with Care Insight

High Utilizer Groups:

- Rising Risk (10-19)
- High Utilization (20-49)
- Super Utilization (50-99)
- Extreme Utilization (100+)
- Total (All of above risk classes)

System Improvement Recommendations

The workgroup discussed and identified both legislatively-focused policy recommendations and steps the EDCC Advisory Council could implement to improve the EDCC:

Policy Recommendations

1. Allocate general fund monies for state-run psychiatric hospital enrollment in the EDCC.
2. Allocate the Virginia Department of Health (VDH) and Virginia Health Information (VHI) general fund monies for one-time incentive payments to downstream provider practices that newly enroll in the EDCC in state fiscal year 2022-23.
3. Allocate VDH and VHI general fund monies for one-time incentive payments to hospitals with emergency departments that newly integrate EDCC within their respective electronic health records EHRs in state fiscal year 2022-23.
4. Provide DMAS with CMS match-eligible general fund monies and authority to cover Chronic Care Management services and billing codes to facilitate provider use of EDCC.

5. Support selected recommendations from the *Medicaid Payment Policy and Care Coordination Workgroup* to improve community primary care and behavioral health access, which would optimize use of the EDCC system.

EDCC Advisory Council Steps

1. Amend Article II (Membership) of the Virginia EDCC Program Advisory Council's bylaws to add two members to the EDCC Advisory Council, representing Community Service Boards and the Psychiatric Society of Virginia.
2. Align the EDCC Advisory Council's performance measures with those identified by this workgroup.
3. Establish quantitative EDCC performance measure targets by 1/1/2023.
4. Review the EDCC's performance against its targets, and revisit performance improvement plans, every 4 months.
5. Include a report of the EDCC's performance in VDH's annual EDCC Report.
6. Reevaluate and revise the EDCC's performance measures, and associated performance targets, every 2 years
7. Investigate opportunities to integrate behavioral health and social determinants of health (SDOH) resources with the EDCC.
8. Report on the feasibility of a value-based contract linking payment of state funds to an IT EDCC vendor to performance against EDCC performance targets.
9. Collaborate with DMAS to enhance MCO use of, and generation of, EDCC *Care Insights*.
10. Collaborate with DMAS to ensure this workgroup's Performance Measures are directionally aligned with CMS performance measures wherever possible.

Introduction

In response to the mandate outlined in Chapter 552, item 317KK of the 2021 Appropriations Act ("the Act"), a workgroup was established to evaluate the Virginia Emergency Department Care Coordination (EDCC) program managing statewide use of the Emergency Department Information Exchange (EDIE) software package. The purpose of the workgroup was to identify how to optimize and facilitate communication and collaboration across providers and care domains to improve the quality of care of Commonwealth citizens who receive emergency department services. The Act stipulated that the workgroup:

1) Determine how best to measure performance of the system;
2) Identify utilization trends and outcomes; and
3) Make recommendations for system improvements.

The Act specified the following stakeholders participate in the workgroup: the Department of Medical Assistance Services (DMAS), Virginia Department of Health (VDH), EDIE contractor (Collective Medical), the Virginia Health Information (VHI), Medicaid and commercial managed care organizations, health systems with emergency departments and emergency department physicians. In keeping with the request to optimize and facilitate communication and collaboration across providers and care domains, primary care and ambulatory subspecialty physicians and care management personnel were included as workgroup members (see Appendix 1: Workgroup Participants). DMAS assembled the workgroup members for three meetings held on July 28, August 25, and September 14, 2021.

This report summarizes discussions carried out by workgroup members during, preceding and following the workgroup's three formal meetings, as well as policy options, underlying forces and considerations discussed by the workgroup. Each of the five system improvement Policy Recommendations included in the report received a majority of "generally support" votes from workgroup member representatives. Policy options that were preliminarily discussed, but were ruled-out before being put to vote, are listed in Appendix 4: System Improvement Recommendations Not Receiving Consensus Support.

Background

Origins

The 2017 Virginia General Assembly established the Emergency Department Care Coordination (EDCC) Program (§ 32.1-372) within the Virginia Department of Health (VDH) to facilitate real-time communication and collaboration among

healthcare providers and care management staff across all hospitals operating emergency departments (EDs) in the Commonwealth of Virginia. The goal of the EDCC is to improve the quality of patient care services by improving provision of the right care, by the right provider, at the right time. In state fiscal year 2018, VDH contracted with ConnectVirginia HIE (CVHIE) to fulfill the legislative requirements of the EDCC Program. Collective Medical (CM) was subsequently chosen as the EDCC Program technology vendor, and effective July 1, 2019, ConnectVirginia and Virginia Health Information (VHI) completed a statutory merger, with ConnectVirginia now a program of VHI. As outlined in the 2017 Budget Amendment, VHI has established an EDCC Advisory Council, made-up of state, provider, payer, and contractor representatives to oversee the EDCC Program. As of June 30, 2019, all hospitals operating EDs, Medicaid managed care organizations (MCOs), private Medicare and commercial health plans—excluding Employee Retirement Income Security Act (ERISA) plans—in the Commonwealth have been required to enroll in the EDCC.

Functions

The EDCC performs the following core functions:

- Receives and distributes real-time HIPAA-compliant electronic patient visit information to and from every hospital emergency department in the Commonwealth, including visit and diagnosis data, standardized care documents, and user-generated *Care Insight* summaries of patient events and care plans; and
- Provides data around hospital treatment and care coordination to primary care providers (PCP) and managed care organizations (MCO).

In addition to these core functions, recent enhancements of EDCC functions include single-sign-on capabilities with select health system EHRs and development of real-time provider alerts (e.g., COVID-19 positive or pending lab results).

Enrollment and Use

Since its inception, 100% of Commonwealth emergency departments (21 health systems, 106 emergency departments) and 100% of non-ERISA-regulated private health plans (across 11 major health plans; health plans with fewer than 1000 covered lives excluded) have enrolled with the EDCC. Multiple non-hospital "downstream" providers have also enrolled in the EDCC, including primary care providers, nursing homes, community services boards (CSBs), private behavioral health providers, federally qualified health centers (FQHCs), specialty care, and accountable care organizations. A total of 1,300 patient *Care Insights* were authored or edited during 2020.

Opportunities for Improvement

Improve data comprehensiveness

As an aggregator and disseminator of patient data, the baseline value of the EDCC is determined by the comprehensiveness and accuracy of its data. These data largely fall into three domains:

1) Standardized patient utilization and diagnosis data that Commonwealth EDs are legislatively required to submit to the EDCC via Admission, Discharge, Transfer (ADT) feeds;
2) Partially standardized Care Coordination Documents (CCD) summarizing more comprehensive health data (i.e. medical history, allergies, active medication) electively made available to the EDCC by health systems who contract with a third-party vendor, carequality®; and
3) User-generated *Care Insights* allowing providers to produce patient-specific free text descriptions of patients and their care for other providers.

While basic ED visit and diagnosis data are available in the EDCC for the majority of Commonwealth ED visits, comprehensiveness of data is limited by several factors:

- Routine EHR system updates occasionally interrupt ADT systems and data feeds, warranting iterative auditing on the part of Collective Medical and collaboration on the part of emergency department EHR IT staff;

- Although select health systems facilitate CCD sharing by voluntarily contracting with carequality®, these documents are not consistently available, standardized, or available to all EDCC users (e.g., MCOs are not currently allowed access to CCD documents); and
- Production of *Care Insights* is fundamentally driven by and limited to the degree of downstream user enrollment and engagement.

The workgroup identified that the EDCC may be able to improve the comprehensiveness of its data in multiple ways. VHI and Collective Medical can continue to collaborate with health systems and hospitals to audit and maintain the comprehensive ADT feeds that Commonwealth hospitals with EDs are expected to submit to the EDCC. Additionally, the enrollment and engagement of downstream providers and managed care organizations is expected to enhance the number and value of *Care Insights* for all users. Workgroup members agreed that while availability of CCD documents is desirable, the requirement that systems contract with carequality® to made CCDs available to the EDCC currently complicates efforts to improve access.

To promote these efforts, the workgroup has included Data Quality metrics in its proposed performance measures and outlined steps the EDCC Advisory Council can take to set performance targets and advance performance against those targets (i.e., by assessing the feasibility of attaching payment to performance in future IT vendor contracts). Additionally, the workgroup's policy recommendations include support for modifications that would address barriers to downstream user enrollment and *Care Insight* generation. For a summary of Recommendations (including Performance Measures, Policy Recommendations and EDCC Advisory Council Steps) to advance data comprehensiveness, see Appendix 2: Crosswalk Between Workgroup Identification of Opportunities for Improvement and Workgroup Recommendations.

Increase downstream provider enrollment

While the EDCC generates some healthcare utilization data that can be informative to hospital-based ED providers—particularly regarding utilization across multiple health systems with non-compatible EHR products—these providers do not always have the opportunity to impact fundamental drivers of low-value care and poor health outcomes. This is due to both the non-ambulatory nature of emergency department care, and the significant time and resource constraints experienced by ED providers. Maximally leveraging the full value of EDIE requires increased EDIE access and use of non-ED "downstream" providers, including inpatient, ambulatory primary care, and ambulatory specialty care clinicians.

Several obstacles confront VHI's and CM's attempts to bring additional downstream users onto the platform, including:

- User fees (levied by CM on providers who engage in risk-based contracting);
- Other direct costs of use (i.e. retention of legal services to inform contracting with CM, external IT support to receive/share EDCC data);
- Indirect costs of use (i.e. staff training, unreimbursed clinician time, internal IT staff assignment); and
- A lack of clear financial incentives for downstream providers (i.e. inability to share in financial savings, limited avenues for fee-for-service reimbursement).

While hospitals with emergency departments are required to submit data to and enroll with the EDCC, enrollment for downstream providers and inpatient facilities without emergency departments remains elective. The workgroup supported allocation of funds to ensure access for state psychiatric providers to EDCC data. To monitor performance on these fronts, the workgroup included the number of enrolled downstream providers as a system performance measure. To ensure optimal accountability of the IT vendor (currently CM) for the EDCC's performance on outcomes of importance, the workgroup proposed that the EDCC Advisory Group investigate the feasibility of linking future payment to the IT vendor to performance per the EDCC's performance targets. For a summary of Recommendations (including Performance Measures, Policy Recommendations and EDCC Advisory Council Steps) to advance downstream provider enrollment, see Appendix 2: Crosswalk Between Workgroup Identification of Opportunities for Improvement and Workgroup Recommendations.

Enhance user engagement

Utilization of EDIE software is often limited by the degree to which it is integrated into existing EHR platforms (e.g., those used by clinical staff) and care management workstreams (e.g., those used by managed care organization administrative staff). While efforts have been made to increase single sign-on (SSO) capabilities, allowing clinicians to view EDCC data within their EHR systems, as of December 2020, only 10% of Virginia health systems and hospitals had established such capabilities. Additionally, although SSO integration can increase visualization of EDCC data, it does not currently allow users to edit EDCC data (e.g., create or amend *Care Insights*) via their EHR interface and complicates Collective Medical's ability to track use of the EDIE.

Downstream providers face additional barriers to use—namely, before they can view EDCC data, receive EDCC alerts, or edit *Care Insights*, ambulatory providers must manually submit a report denoting the existence of their treatment relationship to Collective Medical, and do so on a regular and ongoing basis. Even then, increasing provider documentation requirements, stagnant reimbursement rates and the absence of clear financial incentives limit these providers' engagement in population health and care coordination activities outside directly reimbursable office visits. Patients' lack of insurance coverage, or lengthy wait times, among the insured, for providers in key specialties (e.g., ambulatory behavioral health services) further limits the EDCC's ability to facilitate high-value care.

The workgroup identified several opportunities to enhance high-value user engagement with the EDCC. These include: defining performance measures that capture utilization; recommending funds to offset the costs of integrating the EDIE into existing EHR platforms via SSO arrangements; and funding ED-embedded behavioral health Medicaid MCO staff to use and generate EDCC data. At the same time, the workgroup recognized that awareness of individuals' needs, without the resources needed to intervene on root causes, is unlikely to drive meaningful change. To that end, the workgroup identified resources that are frequently lacking, such as better access to ambulatory behavioral health care, which could further leverage the value of the EDCC to individuals and the Commonwealth if made more widely available. For a summary of Recommendations (including Performance Measures, Policy Recommendations and EDCC Advisory Council Steps) to advance user engagement, see Appendix 2: Crosswalk Between Workgroup Identification of Opportunities for Improvement and Workgroup Recommendations.

Recommendations

Performance Measures

This workgroup discussed and reviewed a range of measures intended to capture the EDCC's value, including measures recently developed by a subgroup of the EDCC Advisory Council. This workgroup reached general consensus on, and recommends the following EDCC performance measures, which can be categorized into the following domains: *Data Quality*, *Provider Enrollment*, *Provider Engagement*, and *Patient Outcomes*.

Data Quality

1. % of total ED visits with a valid diagnosis code & discharge date in the EDIE
2. % of "High Utilizer" patients (10+ visits in last 12 months) with a current EDIE *Care Insight* [a]

Provider Enrollment

3. # of EDCC-enrolled downstream providers

User Engagement

4. % of hospital EDIE platform users with EHR integration
5. % of non-integrated EDIE platform users that are "engaged" [b]
6. # of actively attributed downstream patients in the EDIE [c]
7. # of "High Utilizer" EDIE charts viewed by a Medicaid managed care organization at least once per month

Patient Outcomes

8. % of total ED visits from patients who visited 3+ different hospital EDs within 90 days

9. % of total ED visits from patients with 10+ visits within 12 months

a: *Care Insights* are user-generated free-text descriptions of patients and their care needs created or edited within the last 18 months and viewable by EDCC users
b: "Engaged" is defined as those users who have had 5+ EDCC logins or authored 3+ *Care Insights* in a given month
c: Actively attributed patients include those for whom a valid downstream provider eligibility file has been submitted within the prior 60 days

Utilization & Outcomes

In addition to measuring performance, the workgroup addressed how an entity might use EDCC data to visualize Emergency Department care utilization and outcome trends. The workgroup proposed the adoption of measures currently used by the EDCC Advisory Council for the purpose of stratifying use among ED High Utilizers. These are:

- **Emergency Department (ED) Measures**
  - Number Patients
  - Total ED Visits
  - Median ED Visits
  - Total Admissions from ED patients
  - Median Admissions from ED patients
  - Average ED Length of Stay
  - Percent with Behavioral Health Diagnosis
  - Percent Suspected Homeless
  - Percent with Care Insight
- **High Utilizer Populations** (ED visits per 12 months)
  - Rising Risk (10-19)
  - High Utilization (20-49)
  - Super Utilization (50-99)
  - Extreme Utilization (100+)
  - Total (All of above risk classes)

See Appendix 3: EDCC Advisory Council Outcomes, Stratification of ED High Utilizer Metrics for an illustrative visualization of these utilization and outcome trends.

System Improvements

The workgroup discussed and made two sets of recommendations for systems improvements:

- Policy recommendations to the Virginia General Assembly, which were supported by a majority of workgroup members; and
- Non-legislative system improvement steps which EDCC Advisory Council members participating in the workgroup voiced consensus support for, and agreed should be sent to the EDCC Advisory Council for consideration.

Policy Recommendations

Policy recommendations supported by a majority of workgroup members are listed below. Additional recommendations given preliminary consideration are included for reference in Appendix 4: System Improvement Recommendations Not Receiving Consensus Support.

1. **Allocate general fund monies for state-run psychiatric hospital enrollment in the EDCC**: Providing funds to increase EDCC enrollment of state-run psychiatric hospitals would improve awareness of the acute care utilization and needs of patients with significant behavioral health-related drivers of care, while simultaneously increasing the availability of patient-authorized behavioral health *Care Insights* to medical providers providing care to these patients.

2. **Allocate the Virginia Department of Health (VDH) and Virginia Health Information (VHI) general fund monies for one-time incentive payments to downstream provider practices that newly enroll in the EDCC in state fiscal year 2022-23**: Onboarding of downstream provider practices to the EDCC often requires upfront costs both prior to and upon enrollment (e.g., EHR system enhancements, retention of legal services, and dedicated staff time to manually report patient-provider relationships). A one-time payment would incentivize enrollment of practices into the EDCC—a prerequisite to consumption and production of high-value EDCC information for citizens of the

Commonwealth. This is consistent with recommendations of the *Medicaid Payment Policy and Care Coordination Workgroup*.

3. **Allocate VDH and VHI general fund monies for one-time incentive payments to hospitals with emergency departments that newly integrate EDCC within their respective EHRs in state fiscal year 2022-23:** Integrating EDCC access into EHRs requires investments in human capital and IT infrastructure, but can dramatically increase accessibility of EDCC information for Emergency Department and other health system users.

4. **Provide DMAS with CMS match-eligible general fund monies and authority to cover Chronic Care Management services and billing codes to facilitate provider use of EDCC**: Current fee-for-service healthcare payment arrangements fail to reimburse providers for dedicating the time, or hiring the clinical staff, necessary to generate and monitor EDCC data that may help reduce inappropriate acute-care utilization. Authorizing DMAS to cover select care management billing codes (i.e. 99490, 99439, 99487, 99489, 99491), also supported by the *Medicaid Payment Policy and Care Coordination Workgroup*, would facilitate enhanced EDCC content and utilization by downstream and emergency department providers.

5. **Support the following recommendations from the *Medicaid Payment Policy and Care Coordination Workgroup* to improve community primary and behavioral health access, which would optimize use of the EDCC system.**
    a. **Fund and authorize DMAS to develop value-based primary care payments, in keeping with recommendations of the Governor's Primary Care Task Force, to improve downstream provider EDCC utilization and engagement**: Beyond the addition of Complex Care Management services, supporting value-based Medicaid payments to primary care providers is expected to further enhance the value and utilization of the EDCC platform.
    b. **Fund a pilot of an embedded behavioral health Care Coordination model among DMAS managed care organizations (MCOs)**: Providing funding for MCOs to pilot embedded behavioral health care coordinators is expected to promote greater uptake of high-value behavioral health among Medicaid members with unmet behavioral health needs which frequently contribute to high emergency department utilization.
    c. **Invest in state ambulatory behavioral health resources for insured and uninsured populations**: Investments in access to, and coverage of, behavioral health services for both Medicaid-insured and uninsured populations can ensure that behavioral health needs identified by the EDCC are addressed. Without improved access to care for these populations, EDCC communication will be unlikely to impact utilization for uninsured individuals.

EDCC Advisory Council Steps

Members of the workgroup representing the EDCC Advisory Council—whose members were invited to participate in workgroup discussions and calls—reached consensus in support of the EDCC Advisory Council's consideration of the following non-legislative system improvement steps, beginning at the EDCC Advisory Council's next scheduled meeting:

1. Amend Article II (Membership) of the Virginia EDCC Program Advisory Council's bylaws to add the following members of the EDCC Advisory Council:
    - 1 representative from the Virginia Association of Community Services Boards, nominated by the Virginia Association of Community Service Boards (VACSB); and
    - 1 representative from the Psychiatric Society of Virginia, nominated by the Medical Society of Virginia (MSV).
2. Align the EDCC Advisory Council's performance measures with the performance measures identified by this workgroup.
3. Establish quantitative EDCC performance targets, associated with the aforementioned performance measures, by 1/1/2023.

4. Review the EDCC's performance against the aforementioned performance targets, and revisit performance improvement plans, every 4 months.
5. Include a report of the EDCC's performance, relative to the aforementioned performance targets, in VDH's annual EDCC Report.
6. Reevaluate and revise the EDCC's Performance Measures, and associated performance targets, every 2 years
7. Investigate opportunities to integrate behavioral health and social determinants of health (SDOH) resources with the EDCC.
8. Report on the feasibility of a value-based contract linking payment to an IT EDCC vendor to performance against EDCC performance targets, and describe what such a contract would entail, by the Year 5 annual EDCC report (anticipated 4/1/2023).
9. Collaborate with DMAS to identify ways MCO use of, and generation of *Care Insights* in, the EDCC might be optimally incorporated into managed care contracts.
10. Collaborate with DMAS to ensure this workgroup's Performance Measures are directionally aligned with CMS performance measures wherever possible.

Conclusion

The Virginia General Assembly EDCC Workgroup reviewed and discussed perspectives from a wide range of stakeholders to identify opportunities to enhance the EDCC's ability to use communication and collaboration to improve the quality of care received by Commonwealth members using emergency department services. Three key areas for improvement were identified: improving data comprehensiveness, increasing downstream provider enrollment, and enhancing user engagement. To address these opportunities, the workgroup identified a set of nine EDCC Performance Measures, a system for identifying ED utilization trends and outcomes, and provided system improvement recommendations in the form of five Policy Recommendations and ten EDCC Advisory Council Steps.

Appendix 1: Workgroup Participants

The following were among those invited to participate in the 2021 General Assembly mandated EDCC Workgroup:

- **Commonwealth of Virginia**
  - Dr. Norm Oliver (VDH)
  - Jeff Stover (VDH)
  - Dr. Chethan Bachireddy (DMAS)
  - Dr. John Morgan (DMAS)
  - Dr. Andrew Ramsey (DMAS)
  - Melissa Mannon (DMAS)
  - Dr. Alexis Aplasca (DBHDS)
  - Ralph Orr (DHP)
- **EDCC Contractor**
  - Michael Lundberg (VHI)
  - Kyle Russell (VHI)
  - Kelly Richards (VHI)
  - Kelly Butler (CM)
- **Healthcare Payers**
  - Doug Gray (VAHP)
  - Dr. Ira Bloomfield (Aetna MCO)
  - Dr. Natalie Feldman (Anthem MCO)
  - Precious Tembo (Anthm MCO)
  - Dr. Mohamed Ally (UHC MCO)
  - Dr. Ann Vaughters (Molina MCO)
- **Health Systems with Emergency Departments (ED) & ED Physicians**
  - Aimee Perron-Seibert (VACEP)
  - Kelsey Wilkinson (MSV)
  - Dr. Sam Bartle (ED)
  - Dr. James Dudley (ED)
  - Dr. Joran Sequeria (ED)
  - Lanette Walker (VHHA)
  - David Vaamonde (VHHA)
  - Charity Piccoc (VCU)
  - Kayte Williamson (Sentara)
  - Dr. Joseph Evans (Sentara)
- **Downstream Providers**
  - Dr. John Daniel (Primary Care)
  - Dr. Aaron Goldberg (OBGYN)
  - Dr. Stephen Morgan (Primary Care)
  - Summer Lynch (Bon Secours)
  - Dr. Tom Eppes (Primary Care)
  - Dr. Michael Charles (Primary Care)
  - Dr. James Thompson (Addiction Medicine)

VDH: Virginia Department of Health
DMAS: Department of Medical Assistance Services
DBHDS: Department of Behavioral Health and Developmental Services
DHP: Department of Health Professions
VHHA: Virginia Hospital and Healthcare Association
VHI: Virginia Health Information
VCU: Virginia Commonwealth University
ED: Emergency Department Physician
CM: Collective Medical
VAHP: Virginia Association of Health Plans
MCO: Medicaid Managed Care Organization
VACEP: Virginia College of Emergency Physicians
MSV: Medical Society of Virginia

Appendix 2: Crosswalk Between Workgroup Identification of Opportunities for Improvement and Workgroup Recommendations

Area for Improvement	Implicated workgroup recommendation
Improve data comprehensiveness	Performance Measures #1, 2
	Systems Improvement Policy Recommendations #2, 4 and 5a
	Systems Improvement EDCC Advisory Council steps #2 – 6, 9 – 10
Increase downstream provider enrollment	Performance Measure #3
	Systems Improvement Policy Recommendations #1
	Systems Improvement EDCC Advisory Council steps #8
Enhance user engagement	Performance Measures #4, 5, 6, 7
	Systems Improvement Policy Recommendation #3, 5b, 5c

Appendix 3: EDCC Advisory Council Outcomes, Stratification of ED High Utilizer Metrics

The following example table is taken from the EDCC Advisory Council's June 2020 utilization report.

Patients with patterns of high ED utilization

Patients with at least one visit in Virginia from July 2019 - June 2020

Collective Utilization Category	Visit Count in 12 Months	Number of Patients	Total ED Visits	Median ED Visits	Total Inpatient Admissions	Median Inpatient Admissions	Average Length of Stay (Days)	Percent with a Behavioral Health Diagnosis	Percent that are Suspected Homeless	Percent with Care Insight
Rising Risk	10 - 14	11,678	133,312	11	19,479	1	3.8	65.5%	0.3%	3.4%
	15 - 19	3,152	52,291	16	7,104	1	3.6	73.7%	0.4%	5.4%
High Utilization	20 - 29	1,797	41,851	23	5,130	1	3.5	81.0%	0.6%	10.2%
	30 - 49	732	27,062	36	2,887	2	3.3	87.3%	0.7%	14.8%
Super Utilization	50 - 74	207	12,315	59	947	3	2.7	89.4%	1.0%	19.8%
	75 - 99	68	5,742	82	319	3	2.9	91.2%	1.5%	23.5%
Extreme Utilization	100 +	72	9,855	129	324	2	3.9	97.2%	4.2%	36.1%
Grand Total		17,706	282,428	12	36,190	1	3.7	69.9%	0.4%	5.3%

Appendix 4: System Improvement Recommendations Not Receiving Consensus Support

The following system improvement recommendations were considered but failed to receive consensus support by the workgroup on account of being perceived as infeasible, causing unintended consequences that outweighed potential benefits, falling outside the primary scope of the workgroup, or because they were felt to be better represented by items included in the formal *System Improvements* (either *Policy Recommendations* or *EDCC Advisory Council Plans*).

- Provide funding for provider systems to join the carequality® network to allow for more efficient interoperability and exchange of CCD (Continuity of Care Document) data
- Require all health systems to have an EDCC alert on an electronic emergency department "trackboard" (i.e. as opposed to available only via fax)
- Require EDCC and health systems to develop standardized color-coordinated notifications to more efficiently communicate to providers the nature of alerts
- Provide financial incentives for hospital emergency departments to collaborate with managed care organizations (MCOs) to generate and use EDCC data
- Require discharge instructions to be available in the EDCC
- Incentivize members to pursue the optimal level of care via targeted patient education and increased uptake of insurer nurse utilization hotlines
- Provide emergency department and Primary Care Providers with quarterly reports regarding their utilization of EDCC and member ED use to highlight members with outstanding needs
- Secure full funding for EDCC program if federal funds were to ever be exhausted
- Require PDMP integration into the EDCC
- Require healthcare and MCO staff to leverage the EDCC to develop processes to identify and follow-up with patients within 24 hours of ED presentation to address underlying needs
- Require Collective Medical to provide dedicated training to hospital leadership teams to improve awareness of the value of the EDCC to promote high value and high quality care
- Require all state EDs to report a subset of CCD and ADT data elements for at least 95% of ED patient encounters monthly, as specified by the EDCC Advisory Council, or report a corrective action plan to the EDCC Advisory Council by 1/1/2023
- Provide funds and authority for the development of EDCC standards, based on this workgroup's proposed Performance Measures, that state funding of EDCC services would be required to be based on beginning in 2023
- Preclude downstream providers who provide services to Medicaid patients, and who engage in risk-based contracting, from being charged for EDCC access or functionalities