Healthy Outcomes Plan Application

Proviso

33.34

Sections A (1), C, D

South Carolina Department of Health and Human Services

Hospital(s): Carolinas Hospital System- Marion

HOP Name: Marion County HOP

Healthy Outcomes Plan (HOP) Application

Proviso 33:34 Sections A (1), C, D

Application Cover Page

HOP Name	Marion County HOP
Application Date	8/16/2013
Name of Hospital(s)	Carolinas Hospital System- Marion
Name of Partner(s)	Health Care Partners (FQHC) Helping Hands Free Medical Clinic RHCs Advanced Medical Associates Marion Medical Group Marion Pediatrics Pee Dee Pediatrics

I attest that, on behalf of the above named hospital(s), I am the organization representative approved tosubmit a Healthy Outcomes Plan (HOP) process improvement proposal. I further attest that the partner(s) signature(s) is also the approved representative for the respective organization(s) to request participation in the HOP with the above named hospital.Additionally, I attest that all partners will participate inSCDHHS HOP evaluation activities.

By signing this form, the representatives certify that the information contained herein has been reviewed by all parties and all parties have had the opportunity to consult with their respective legal entity.

Hospital Representative	8/29/13 Date
Clifford Portis Partner Representative	8-29-2013 Date
Harold E Tucker Partner Representative	8-29-13 Date
Partner Representative	Date
Partner Representative	Date
Partner Representative	Date

**Additional signature lines may be added for additional community serviceand primary care safety net partners participating in the proposed collaboration.*

Hospital(s): Carolinas Hospital System- Marion

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LETTER OF INTENT TO COLLABORATE BETWEEN
Carolinas Hospital System- Marion
and
Health Care Partners, Helping Hands Free Medical Clinic, Advanced Medical Associates, Marion Medical Group

Marion Pediatrics, Pee Dee Pediatrics

We, the "Parties" listed above, intend to develop a Collaborative Partnership based upon the following principles:

The Parties desire to undertake this collaboration to build on existing relationships and/or form new relationships in order to implement a new service delivery model that aims to coordinate care for the uninsured, high utilizers of ED services and the chronically ill, and to support the Triple Aim initiative which will lead to improved health of the population, improved patient experience of care and reduce per capita cost of health care.

The Parties recognize that this is a general overview regarding the roles of the individual parties in this proposal, and a formal Memorandum of Understanding between the Parties will be agreed upon and submitted by the beginning of the Performance Period, October 1, 2013, if selected for participation.

The Parties shall enter into good faith negotiations for the purpose of establishing a Memorandum of Understanding for each of the activities described in the Process Improvement Plan. The rights and obligations of each Party will be contained within the Memorandum of Understanding.

Consistent with applicable law and each Party's policies and procedures, the Collaborative Partnership may enter into agreements to support and perform each of the activities described in the Process Improvement Plan for the purpose of realizing any or all of the objectives of the collaboration.

The Parties agree to adhere to the highest scientific quality, values and ethical standards in their joint activities.

The Parties have designed this HOP Process Improvement Plan based upon a commitment to maintain an equal partnership and long term sustainability in a manner which maximizes their mutual ability to: generate and disseminate knowledge; apply that knowledge to solve priority health problems; and measure and assess improvement plan output throughout the collaboration.

The term of this Letter of Intent to Collaborate (LOIC) shall be for the duration of the performance period, if approved.

Either Party may terminate this LOIC without cause upon at least thirty (30) days' prior written notice to the other Party and agrees to notify the South Carolina Department of Health and Human Services of the termination.

Hospital(s): Carolinas Hospital System- Marion

HOP Name: Marion County HOP

Institution: Carolinas Hospital System- Marion
Name and Title: Ronnie Daves: CEO
Signature: _____
Date: 8/29/13

Institution: Health Care Partners (FQHC)
Name and Title: Clifford Portis: CEO
Signature: _____
Date: 8-29-2013

Institution: Helping Hands Free Medical Clinic
Name and Title: Harold E. Tucker: Executive Director
Signature: _____
Date: 8-29-13

Institution: Advanced Medical Associates
Name and Title: Ronnie Daves: CEO
Signature: _____
Date: 8/29/13

Institution: Marion Medical Group
Name and Title: Ronnie Daves: CEO
Signature: _____
Date: 8/29/13

Institution: Marion Pediatrics
Name and Title: Ronnie Daves: CEO
Signature: _____
Date: 8/29/13

Institution: Pee Dee Pediatrics
Name and Title: Ronnie Daves: CEO
Signature: _____
Date: 8/29/13

Hospital(s): Carolinas Hospital System- Marion

HOP Name: Marion County HOP

HOP Application Form

Hospital	Carolinas Hospital System- Marion
Partner(s)	Health Care Partners Helping Hands Free Medical Clinic Advanced Medical Associates Marion Medical Group Marion Pediatrics Pee Dee Pediatrics 1. Carolinas Hospital System Marion has had Very limited collaboration, some with Helping Hands in providing access to primary care for uninsured. 2. Carolinas Hospital System- Marion owns the RHCs listed in the partnership
Partner(s) Lead(s)	Carolinas Hospital System- Marion: Ronnie Daves- CEO Health Care Partners: Clifford Portis- CEO Helping Hands Free Medical Clinic: Harold E. Tucker- Executive Director RHCs: Ronnie Daves- CEO
HOP Implementation Sites	Health Care Partners: 1106 Lombardy Street, Marion, 29571 Helping Hands Free Medical Clinic: 230 S.Main St. Mullins, SC 29574 Advanced Medical Associates: 511 S Main St Mullins SC 29574 Marion Medical Group: 1205 N Main St Marion SC 29574 Marion Pediatrics: 2845 US Hwy 76 Mullins, SC 29574 Pee Dee Pediatrics: 2845 US Hwy 76 Mullins, SC 29574
Clinical Lead	Linda Parnell, CNO Carolinas Hospital System- Marion 843-431-2070
Administrative Lead	Ronnie Daves, CEO Carolinas Hospital System- Marion

Hospital(s): Carolinas Hospital System- Marion

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	843-431-2408
Name of HOP	Marion County HOP
Background and Rationale Maximum 1,000 words	Concerns with payment of medical bills, lack of access to dependable healthcare providers, and lack of education are the greatest barriers between the uninsured patients and preventive, timely medical care for their chronic conditions. Due to steadily increasing healthcare costs over the last decade, access to affordable healthcare for uninsured patients has become increasingly scarce. Compared to adults with private or public coverage, uninsured adults were less likely to have a usual source of care or an office visit and more likely to have unmet need for prescription drugs, eye care, or mental health (Kaiser 2012). Many uninsured patients are choosing to forego preventive care of chronic illnesses either for fear of slipping further into debt or because they cannot locate a physician willing to routinely care for an uninsured patient. According to a Gay Becker study published in the Western Journal of Medicine; in almost all of the studied cases, the uninsured reported that they sought care only when they had persistent symptoms that interfered with their daily lives. Without routine cancer screenings, blood pressure and cholesterol checks, patients are at a higher risk of being diagnosed in the later stages of diseases and die earlier than patients with insurance (Kaiser 2012). This ultimately leads to these patients presenting in the ED and having to spend extended, costly, periods of time as admitted patients in the local hospital. These stays in the hospital not only build insurmountable debt for the patient; they cost the hospital millions of dollars annually that they will see little to no collection on. Lack of knowledge severely affects people's ability to manage their chronic illnesses and many of our uninsured patients fall into this uniformed category. Several key problems that they face are: *Lack of understanding of illness* 1. Many uninsured patients know how they feel but do not know why they feel that way. *Lack of recognition of danger signs* 2. Due to lack of education, patients do not recognize danger signs in a timely manner. *Home remedies as replacement for medical regimen* 3. Uninsured patients will sometimes attempt to remedy severe illness by using home remedies instead of seeking immediate medical attention (Becker, 2001) The behaviors, conditions, and gaps in healthcare presented in this research accurately reflect the uninsured population and the shortfalls of delivering that group acceptable healthcare in the Pee Dee area. The Health Systems and local social support systems for Diabetes (type 1 and type 2) and Hypertension have similar and unique challenges in our community.

	If the diagnosis of Diabetes or Hypertension is revealed in the early stages of the disease process, dietary controls and behavior modification can be instrumental in slowing the disease process. The problem arises, in our community of a lack of proactive screening and testing, before a crisis event involves these patients. The community currently does not offer an outreach program that identifies the unfunded patients and high risk population who are geographically located in an area. This compiled data base would assist in developing a structured program for patient identification and capture, before the disease process evolved. State Agency support for follow up care through the Department of Health and Environmental Control (DHEC) can only provide limited resources and staffing. Many times this lack of immediate follow up post inpatient discharge, from the inpatient leads to readmissions and noncompliance. Patients without insurance are also historically non-compliant, many times by choice, but also due to transportation or an inability to pay for their needs. Our community does offer income contingent programs with a sliding scale fee provision. But, this is staffed by physicians who specialize in Family Medicine and offers limited referral sources to specialist for diseases specific concerns. Transportation within the county is also very limited. A strong community outreach program, would identify capture, treat and follow up on these patients to proactively prevent readmission and increase compliance, before acute crisis intervention is necessary through emergent hospitalization.
Targeted Population and Inclusion Data Maximum 1,000 Words	Community Health Systems has partnered with Press Ganey Services to review our facility's patient demographics as provided by our internal data capture programing. This data is provided and reviewed 30 days after the data input and we have the availability to run filters from Diagnoses Code, Payer Sources, Case costs, discharge disposition and readmission percentiles. We estimate based upon the data that was supplied by the State of South Carolina in connection with this program that hypertension and diabetes represent 40 to 50 percent of the high utilizers of the emergency department. These patients have associated comorbidities and complications that also are associated with their chronic condition. Clinically, the diabetic patients are also diagnosed with obesity in most cases, which may be controlled through consistent behavioral management to slow the disease process. The hypertensive patient may also be a long term tobacco abuser, with multiple risk factors for a cerebral vascular incident or an acute myocardial infarction. In both cases of these chronic conditions, monitoring and follow up in the health care delivery subsystem is vital to prevent a crisis situation in the acute care setting. The social and demographic characteristics in our community are not racial or ethnic in origin, but more culturally driven. The Southern population has historically been raised with fried foods, products with high sugar content and tobacco products. Any

	combination of these three things can be attributed to most all chronic conditions that present in Carolina's ED. Though these three factors are considered more detrimental to the African American population, the community has an equal portion of white and Hispanic patients diagnosed with the same health concerns. On a long term basis, without preventative care, the African American population will suffer a higher readmission rate and increased cost per case due to the severity of their complications. For example dialysis often follows untreated hypertension in this patient group and peripheral vascular disease is commonly linked to the diabetic patient.
Strategic Objectives	• *Increase in number of patients with Social Determinants Screening* To achieve the Triple Aim initiative we need to screen our ED patients effectively and provide them the resources to ensure our community population is healthier and more independent. Our ED case manager or social worker will screen and flag these patients that qualify under Social Determinants and provide follow up to try to help them have access to safe and affordable housing, education, access to healthy foods and transportation. • *Reduce ED utilization* Implementation of these screening tools and educating and providing other means for care will directly impact the reduction of uninsured high risk patients through the ED. The high volume of ED users will be filtered out to other FQHCs, Free Clinics or RHCs to provide them with the care they need. • *Reduce Systems fragmentation and address the social determinants of health that affect health behaviors and influence health outcomes* Our facility will need to work collectively with local and state agencies to address the social determinants of health for this targeted population. Carolinas Hospital will need to be aligned through extensive communication and understanding with these other organizations, to submit and utilize resources that are being used effectively and productively with no waste. • *Improve patient access to and utilization of quality, affordable care* This is the main premise and goal of this initiative. Our hospital can only benefit from this system, where all healthcare providers are addressing the catastrophic dilemma of large uninsured populations due to the lack of health insurance coverage. All healthcare providers' EDs are inundated with uninsured populations using the ED as their family physician and adding more debt to the hospital's bottom line. By providing more affordable and more appropriate access to healthcare (with a focus on prevention and wellness), will improve the overall efficiency of healthcare services throughout our region and nation. • *Promote adherence to clinical, evidence-based guidelines* Early primary prevention of diabetes has been identified as the best practice for clinically treating and controlling diabetes. Carolinas Hospital Systems' on-campus Diabetes and Nutrition Center will facilitate these screened patients and provide the necessary resources to this targeted population. A team-based care approach is considered to improve blood pressure control as a health systems-level for hypertension. We would implement this team-based approach to include: the patient, patient's primary care provider, nurses, pharmacists, dietitians and community health workers. • *Integrate the biopsychosocial (medical, behavior health, social) approach into a comprehensive patient care planning process* As part of the biopsychosocial approach, staff will explore barriers to compliance with the patients. Staff will provide resources to overcome identified barriers. Patients will be presented with options for education and support.

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	• *Establish a medical home* The focus of our improvement efforts will be here as well as we attempt to educate and steer this patient population to more affordable and appropriate care for their chronic conditions and needs. The care received in the ED continues to be symptomatic and not systematic. • *Improve coordination of transitions of care* The ED nurse, ED case manager and social workers will coordinate the plan of care from our ED doors to the receiving FQHC, Free Clinic or RHC. This includes the initial call to selected FQHC or RHC, their discharge plan; possibly their medications, transportation, potential medical home and then following up with the patient post discharge within the "Care Metrics" time frame of 30, 60 and 90 days of enrollment. • *Increase provision and utilization of comprehensive, routine primary care* Our ED case manager and social workers will provide the available resources to this targeted population. This will include select Carolinas Hospital primary care provider clinics and partnered FQHC, Free Clinic and RHCs. This will provide increased primary care outlets for this population to access.
Strategic Measures	We will be measuring our success through multiple data capture products. Through Press Ganey data collection we will be able to filter and identify billing DRGs corresponding to our selected diagnosis of diabetes and hypertension. A second filter, during the same timeframe of this data, is then run to screen for only uninsured patients. This historical value has identified a baseline of the population we will improve. Next we will build an internal patient identification tool, through our information system department to utilize our registration system data to screen the same factors for a current or 'real time' daily sampling of the past 30 days of the same patient population. This will be used as an identifier for geographical areas of opportunity, as well as identifiers of chronic Emergency Room patients that require immediate intervention. Finally, the RN Case Manager assigned to readmissions and patient follow-up phone calls will utilize an internal 30 day Excel spread sheet program. Data capture and easy manipulation of the values will provide the required target population referrals in 30, 60 and 90 day increments. This tool will provide the following: • Successful contacts with identified patients. • Unsuccessful attempts for each contact period and a social service follow up request. • Those newly established with a medical home. • Social determinants identified, at the 30, 60 and 90 day marks. • The type of community service referral identified. • The number of patients enrolled in the Health Affordability Program. • The resulting number of patients eligible and enrolled in Medicaid and/or an insurance from the Federal exchange. • Number of patients with at least one health care encounter, including preventative care and screenings.
Description of HOP Maximum 1,000	We propose an aggressive community outreach program, to identify and capture these patients, before the emergency room is utilized as the primary source of care. The patient population can be captured through existing emergency room visit records in

Words	our internal database to identify geographic areas of concern by neighborhood and even to the street level. *Diabetes / Hypertension* "Primary prevention is clearly the best way to avoid morbidity and mortality from diabetes. The best strategy for prevention of type 2 diabetes are weight control and adequate physical activity among people at high risk or with impaired glucose tolerance; it is also important to maintain focus on population oriented approaches to improving health and minimizing disability and premature death, rather than the clinical care of individuals. Recommendations for clinical care of people with diabetes can be obtained from the American Diabetes Association (ADA), and screening recommendations are available from the U.S. Preventive Services Task Force." (usa.gov, 2000). Team-based care (hospital and partners) to improve blood pressure control is a health systems-level, organizational intervention that incorporates a multidisciplinary team to improve the quality of hypertension care for patients. Team-based care is established by adding new staff or changing the roles of existing staff to work with a primary care provider. Each team includes the patient, the patient's primary care provider, and other professionals such as nurses, pharmacists, dietitians, social workers, and community health workers. Team members provide process support and share responsibilities of hypertension care to complement the activities of the primary care provider. These responsibilities include medication management; patient follow-up; and adherence and self-management support. Team-based care interventions typically include activities to: • Facilitate communication and coordination of care support among various team members • Enhance use of evidence-based guidelines by team members • Establish regular, structured follow-up mechanisms to monitor patients' progress and schedule additional visits as needed. Including sugar levels and BPs • Actively engage patients in their own care by providing them with education about hypertension medication, adherence support (for medication and other treatments), and tools and resources for self-management (including health behavior change)" (usa.gov, 2000). Eligibility Screening Services is partnered with our parent company Community Health Systems to provide hospital eligibility services to our facilities. This company provides on-site patient eligibility screening services of self-pay patients to determine the potential reimbursement from a Federal/Local program. They conduct these services as a community outreach program, assisting patients through the eligibility process. Our main payors consist of Medicaid, Supplemental Security Income (SSI), County Indigent and Victims of Crime. ESS provides eligibility specialists to the ER to screen uninsured patients for potential Medicaid eligibility. They establish DHHS interviews for eligible patients and provide transportation as necessary.

	After identification of the correct neighborhoods are mapped, our facility will compile a team of health care providers, social service volunteers, on site screening opportunities that inexpensively identify the markers for evolving diabetics and hypertensive patients. Along with the preliminary screening offered at the health fair, social service concerns may be addressed and the ability to provide Medicaid funding or identify existing Veterans' benefits will be done at that time. By taking our services to the areas of our community that historically have shown the need, we will improve our communities overall health, provide needed preventative screenings, lower improper utilization of the Emergency Room and costs incurred. While with equal importance, also capturing opportunities to initiate existing funding – that could have already been in place. The proposed model is expected to lower the overall cost of providing care due by diverting unfunded patients from high cost treatment areas. The emergency room is an extremely costly way of treating patients with an average cost 3 times that of providing care in a clinic setting. Uncontrolled hypertension without complication that results in an inpatient admission can cost over $3,000 per admission. Uncomplicated uncontrolled diabetes resulting in admission to the hospital can cost the patient over $2,000 per admission and with major comorbidities can cost over $3,000. These costs for unfunded patients are written off either to charity care under our charity policy or to bad debt due to the patient's inability to pay even minimal costs. With this plan we anticipate decreasing ER costs and our bad debt and charity associated with this population. Funding to provide adequate social service support in our community is one of the main limitations. At one time, there was a Pulmonary Hypertension Group of the Pee Dee Region, which met at our facility, but it is no longer in existence. Florence County DHEC's diabetes education program is no longer available. If one became available, access to the programs would be a barrier.
Resources Required for Implementation of HOP Maximum 1,000 Words	We offer nursing case management 7 days a week in our facility 0730 to 4pm to address the identified patient population and prevent unnecessary admissions. One licensed clinical social worker is on staff to assist in complex disease management and psychiatric issues. Our facility also has a network of employed physicians for follow up appointments, as needed, on a pro bono or discounted sliding scale format. We have a long standing contract with a local EMS /Ambulance provider, with an outstanding history of service to the hospital and the community. We do not deny care for capacity issues, though time frames of service may be increased, we List and describe the roles of the patient care team in the proposed delivery model. • Case managers Registered Nurse case managers provide discharge planning assessments within Joint Commission guidelines 7 days a week. This allows identification patient needs and inclusion

	of family members in the discharge planning process. Medical Equipment required as well as medication needs are identified and compared to payer sources and availability, insuring a safe transition of care. The basic requirements of our partners will be that they operate in the same manner of their current day-to-day business operations. After our case workers identify eligible patients to be moved to their system, our partners will hope to offer a timely appointment opportunity (same day or next day) so that we both will have the greatest chance of capturing that patient, educating them, and establishing a medical home for them. Once the patient is in their system, it will be the FQHC, Free Clinic or RHC's responsibility to continue to track the patient and record/report metric data to support our initiative.
Reporting Capacity	Reporting will be performed by the Hospital and Partners in the proposal. Sources of data and methods of capture will include: • ED source data captured by information system in the hospitals. This will include identifying all ED visits of the target patients and reasons for the ED visit. • Hospitalization data will be captured by the hospitals operating systems. This will include the capture of diagnostic codes for the primary diagnosis and reason for admission. This data will include length of stay and cost based upon cost to charge ratios. • Calls and contact information will be tracked via a database documenting successful contact, social screening, establishment of a medical home, community services accessed, preventative care and screenings, and Medicaid or other health care plan eligibility screening. • Calls and visits will also document any mental health screenings provided by our social workers. • Patients that are tracked as part of this proposal will be asked to sign consent for our case managers to gather information regarding their medical home visit. Press Ganey data collection filtered by the identified billing DRG's corresponding to our selected diagnoses of Diabetes and Hypertension for the uninsured population will also be used to measure the results of the program
Performance Period	October 1, 2013- June 30, 2014