Healthy Outcomes Plan Application

Proviso

33.34

Sections A (1), C, D

South Carolina Department of Health and Human Services

Hospital(s): _Greenville Health System_____

HOP Name: Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership

Healthy Outcomes Plan (HOP) Application

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

Application Cover Page

HOP Name	Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership
Application Date	August 30, 2013
Name of Hospital(s)	Greenville Health System: Greenville Memorial, Hillcrest Memorial, Greer Memorial, and Laurens County Memorial Hospitals
Name of Partner(s)	New Horizon Family Health Services (FQHC), Carolina Health Centers, LLC (FQHC); Greenville Free Clinic; Taylors Free Medical Clinic; Greenville County Emergency Medical Services; and Good Shepherd Free Medical Clinic of Laurens County

I attest that, on behalf of the above named hospital(s), I am the organization representative approved to submit 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 in SCDHHS 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.

Please see attached signed and scanned Cover Page and Letter s of Intent

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

Hospital(s): _Greenville Health System_____

HOP Name: Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership

LETTER OF INTENT TO COLLABORATE BETWEEN
[_____]
and
_____

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, 2014, 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.

Institution: _____
Name and Title: _____
Date: _____

Institution: _____
Name and Title: _____
Date: _____

Institution: _____
Name and Title: _____
Date: _____

Institution: _____
Name and Title: _____
Date: _____

Hospital(s): _Greenville Health System_____

HOP Name: Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership

HOP Application Form

Hospital	Greenville Health System: Greenville Memorial, Hillcrest Memorial, Greer Memorial, and Laurens County Memorial Hospitals
Partner(s)	Name(s) of all partnering Federally Qualified Health Centers, FQHC Look-A-Likes, Rural Health Centers, Free Clinics, other providers and/ or community service organizations/agencies. Include a brief statement regarding previous collaborations with proposed partners. Is there an existing contractual or financial relationship with any of your proposed partners? Greenville Health System (GHS): GHS comprises six campuses, over 1200 licensed beds, 8 outpatient sites and 167 affiliated practice sites. In 2012, GHS provided more than $107 million in charity and government sponsored healthcare to meet the medical needs of the uninsured. In the same year, GHS had a total of 81,000 Emergency Department visits. Of those, 22,680 visits were from patients without insurance. GHS has a strong history of collaboration with its health partners in an effort to provide innovative quality medical services to the community. Greenville County Emergency Medical Services (GCEMS): In 2011 GHS and GCEMS were awarded a Blue Cross Blue Shield South Carolina Foundation grant for a Community Care Outreach Grant. The project is in its second year of implementation and has produced a number of best practices aligned with the strategic goal of reducing the number of unnecessary EMS transports and Emergency Department visits. To date, a nurse triage call center is in place and diverting patterns daily, a the nurse/paramedic quick response vehicle pilot is in place, and later this year paramedical will be rounding on frequent utilizers in high usage zip codes. GHS has a BAA with GCMES for the facilitation of the grant partnership. New Horizon Family Health Services (FQHC): Today we have several partnerships with New Horizon, including a population health management imitative focused on a targeted Medicaid population and an ED high utilizers patient population. GHS partnered with New Horizon in achieving a lease on their new facility, an increased capacity that will include urgent care services. This is a contractual relationship with specifications on the functioning of the partnership once the new facility is functional. New Horizon has five locations as well as mobile units for medical and dental care. Greenville Free Clinic (GFC): GHS providers volunteers in the clinics and supports GFC's critical provision of medical services to the uninsured population. The GFC has four locations in the upstate. Currently, over 70 GHS physicians volunteer services, as well as nurses and other clinical staff. In addition to basic urgent care, GFC offers preventive gynecology care, ophthalmology services, specialty care, dental services, and an on-site pharmacy. GHS is the fiscal agent for AccessHealthGreenville, a safety net capacity grant via the South Carolina Health Association and The Duke Endowment that includes the services of NHFHS and GFC.

Hospital(s): _Greenville Health System_____

HOP Name: Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership

	Greer Memorial Hospital , a Greenville Health System hospital, has formally partnered with the Greenville Free Clinic since its opening in 1998. For the past two fiscal years, Greer Memorial has provided $1,096,191 in free services (lab, X-ray, CT and MRI scans) for the patients of the Greenville Free Clinic. The Free Clinic operates one day per week in the Greer Downtown area providing primary care, pharmacy dispensing, and referral services. Taylors Free Clinic: Greer Memorial provides diagnostic services for the uninsured population served by Taylors Free Clinic. The Clinic provides critical access to medical care to the Greer Memorial service area. Laurens County Memorial Hospital (LCMH), a Greenville Health System hospital licensed for 90-beds (76 acute care/14SNF) and operating a 19-bed emergency department with a 7-bed behavioral health unit and tele-psychiatry. Carolina Health Centers, Inc. (CHC), a federally qualified health center (FQHC) has been serving the Lakelands area of SC for over 36 years. CHC currently serves as the health care home for approximately 25,000 patients in 9 family medicine centers, 2 pediatric centers with integrated early child development programs, one GYN practice, a seasonal migrant health clinic, and one school based clinic. In addition to the medical practices, CHC operates 2 pharmacies serving both 340B eligible and retail patients and delivering to all outlying CHC practice locations. CHC provides outpatient behavioral health services through a partnership with the Beckman Center for Mental Health and provides oral health services to patients using a network of contracted dentists. Good Shepherd Free Medical Clinic of Laurens County (GSFMC) serves residents of Laurens County who do not have Medicaid, Medicare, VA benefits, employer or private health insurance and whose household incomes fall under 150% of the Federal Poverty Guidelines. Hours of operation are Tuesdays, Wednesdays and Thursdays from 8:30 am until 3:00 pm and Thursday evenings from 5-9:00 pm. The clinic is staffed by one full-time Executive Director and three part-time administrative staff. Medical services are provided by volunteer doctors, nurses, nurse practitioners and a physician's assistant. The clinic provides primary care, referral services to area specialists and eye-care, including screenings and glasses. The clinic also provides pharmaceuticals for its patients in partnership with the Presbyterian College School of Pharmacy in Clinton, S. C. The Laurens County Memorial partners have a long history of collaboration and contractual agreements. Through a Duke Endowment grant, LCMH has in the past provided support for a mid-level provider position. On an ongoing basis LCMH supports GSFMC through the in-kind donation of ancillary services. CHC and LCMH worked collaboratively to open a CHC pediatric practice (HomeTown Pediatrics) which is staffed by a LCMH employed pediatrician through a medical capacity lease agreement. In addition, CHC leases space from LCMH to house both Hometown

Hospital(s): _Greenville Health System_____

HOP Name: Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership

	Pediatrics and the new Laurens County Community Care Center (LC4). All the community partners collaborate and coordinate efforts through their participation on the LCMH sponsored Ambulatory Task Force. This community-based task force includes representation from not only the medical community, but also a wide variety of agencies including social services and law enforcement.
Partner(s) Lead(s)	Greenville Free Clinic: Suzie Foley New Horizon Family Health Services: Regina Mitchell Greenville County Emergency Medical Services: Tim Miller Good Shepherd Free Medical Clinic of Laurens County: Cynthia Perry Carolina Health Centers, Inc.: Sue Veer Taylors Free medical Clinic: Karen Salerno
HOP Implementation Sites	Greenville Memorial Hospital 701 Grove Rd. Greenville, SC 29605 Hillcrest Memorial Hospital 729 S.E. Main Street Simpsonville, SC 29681 Greer Memorial Hospital 830 South Buncombe Rd. Greer, SC 29650 Laurens County Memorial Hospital 22725 Hwy 76 East Clinton, SC 29325 Carolina Health Centers, LLC Laurens County Community Care Center (LC4) 227525 Hwy 76 East Clinton, SC 29325 Greenville County Emergency Medical Services 301 University Ridge Greenville County Square Greenville, SC 29601 Greenville Free Medical Clinic 600 Arlington Rd. Greenville, SC 29601 Greenville Free Medical Clinic – West Greenville 925 North Franklin Rd. Greenville, SC 29617

Hospital(s): _Greenville Health System_____

HOP Name: Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership

	Greenville Free Medical Clinic - Greer 202 Victoria Street Greer, SC 29651 Greenville Free Medical Clinic-Simpsonville 1102 Howard Dr. Simpsonville, SC 29681 Taylors Free Medical Clinic 400 W. Main Street Taylors, SC 29687 New Horizon Family Health Services - Downtown 130 Mallard Street Greenville, SC 29601 New Horizon Family Health Services – West End 811 Pendleton St., #11 Greenville, SC 29601 New Horizon Family Health Services-Travelers Rest 1588 Geer Highway Travelers Rest, SC 29690 New Horizon Family Health Services – Greer 111-A Berry Avenue Greer, SC 29650 (also site for Healthcare for the Homeless) New Horizon Family Health Services – Dental 1 Memorial Medical Drive Greenville, SC 29605 Good Shepherd Free Medical Clinic of Laurens County 245 Human Services Rd. Clinton, SC 29325
Clinical Lead	Angelo Sinopoli, MD Chief Medical Officer VP, Clinical Integration 701 Grove Rd. Greenville, SC 29605 864-455-7000
Administrative Lead	Jennifer Snow Strategic Project Director 701 Grove Rd. Greenville, SC 29605

Hospital(s): _Greenville Health System_____

HOP Name: Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership

	864-455-4227
Name of HOP	Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership
Background and Rationale Maximum 1,000 words	Provide a background of the problem this model will address, as well as a rationale supporting the design of this model. Include appropriate data from the environmental scan and/or applicant's own data as evidence of the problem and to support the rationale. Include statements addressing the following questions: What problems have contributed to high ED utilization in your targeted panel? Describe the gaps-in-care affecting your targeted population/panel size. What access does your targeted population currently have to primary care? Describe the capacity limitations of the health systems and social support systems in your community that affect your targeted population. The high rates of Emergency Department utilization in the targeted population are associated with lack of insurance that would allow access to care in more appropriate settings, lack of capacity amongst safety net providers, and social determinants creating obstacles to care. Uninsured patients are often without a primary care physician or medical home, thus necessitating their use of high cost/low value emergency care. Internal data indicates that the top utilizers of emergency care comprise patient illnesses that could have been managed in a primary care setting (sinusitis, GI distress, upper respiratory infections, urinary tract infections, wound care, migraine, and depression) and those of a more chronic nature (COPD, CHF, asthma, diabetes-related conditions, and atrial fibrillation). Additionally, minimal opportunities for community behavioral health services result in the appearance of these patients in the ED. According to the South Carolina Hospital Association, data collected from April 2012 – March 2013 indicate high utilizers of the ED with the targeted chronic diseases as follows: Greenville Memorial Hospital experienced 1279 ED patients with the selected chronic diseases, resulting in 7335 visits and an average charge of $6339. Total behavioral health patients were 763 with 2982 visits and average charges of $5124. Greer Memorial Hospital experienced 465 ED patients with the selected chronic diseases with 2591 visits and an average charge of $3068. Total behavioral health patients were 300 with 1212 visits and average charges of $2964. Hillcrest Memorial Hospital experienced 400 patients with 2165 ED visits at an average charge of $2892. The Greer data indicate 248 behavioral health patients with 917 visits at an average charge of $2395. Laurens County Memorial Hospital had 1060 ED patients with the targeted disease states and 1595 ED visits at an average charge of $1854, with 191 behavioral health patients with 291 ED visits and an average charge of $2345. Further analyses of gaps in care for a set of 2009 data from Laurens County Memorial indicated that that the ED had over 30,000 visits annually and experienced a high incidence of behavioral health "holds" of long duration. Initial review of the ED data

	indicated that approximately 75% of the visits were coded as Level 1 or 2, suggesting a high proportion of visits for ambulatory sensitive conditions (ASC) that could be managed in a primary care setting. More in-depth review indicated that many patients with serial ED visits had poorly managed chronic disease and a prevalence of mental and behavioral health symptoms. In-person interviews of patients in the ED waiting room conducted over a 1-week period suggested the following contributing factors: 1) overall shortage of primary care providers; 2) restricted access to primary care for Medicaid patients; 3) lack of affordable primary care for uninsured and underinsured patients; 4) services not available when needed (both hours of operation and wait times for appointment); 5) perception that "they have to see me and can't make me pay"; and 5) a multi-generational pattern of behavior. Current gaps in care are related to insufficient access to primary care, care coordination and behavioral health services. A Patient-Centered Medical Neighborhood approach can facilitate the shift of patients from the Emergency Department by increasing access to care and increased care management for the prevention of chronic disease exacerbation. Building off of existing points of primary care access via the FQHCs, hospital clinics, and community free clinics named as partners within this proposal can enhance the opportunities for the uninsured to access appropriate and consistent care. The community partners have established a solid framework that can be further leveraged to impact the target population identified in this proposal. The partners seek to leverage this framework by moving from a "reactive" process of screening and referral to a "proactive" process of identifying and engaging a specific target population in a collaboratively-driven and measurable plan of care as described in this proposal.
Targeted Population and Inclusion Data Maximum 1,000 Words	Describe the population that you are targeting in the proposed service delivery model. Include specifics as specified in Section IA, or criteria in the HOP guidelines. Explain the methodology you used to select your targeted population. What clinical characteristics do your targeted patients demonstrate/share? What social and demographic characteristics does your targeted population share? What portion of the estimated total population meeting the program criteria does the targeted sample represent? The initial target population will be uninsured individuals with a history of high utilization of the network's Emergency Departments as a source of primary care or as a provider of last resort when failure to attain primary care results in a more acute condition or exacerbation of a chronic clinical condition (diabetes, hypertension, asthma, etc.). The methodology for patient selection includes review on an individual basis by a multidisciplinary team composed of care management, social work and behavioral staff for enrollment eligibility. Broad clinical characteristics shared by the patients include emergency department utilization related to chronic disease and behavioral health. The majority of our ED high utilizers reside in two zip codes, 29611

	and 29605. GHS and Greenville County Emergency Medical Services (GCEMS) have an initiative in place to create patient-centered medical neighborhoods in five community neighborhoods in these zip codes. A primary target population will be the uninsured patients in these five neighborhoods; a secondary focus will be enrollment of members in surrounding communities as appropriate. At the time of application, the portion of the estimated total population meeting the program criteria that the targeted population represents is unavailable. Further analyses based on both internal analytics and enrollment screening will allow the development of a reliable estimate.
Strategic Objectives	Statement of each strategic objective as listed in IA1 of the HOP Guidelines you are trying to accomplish with this model. 1. Reduction in utilization of the Emergency Department 2. Reduction in non-emergency use of transport services 3. Increase provision and utilization of primary care 4. Adherence to multi-faceted care plan based on evidence-based standards 5. Coordination among providers providing care to the targeted population
Strategic Measures	The metrics you will use to measure each objective and your process for measurement. The following Triple Aim measures are proposed and associated data will be collected and monitored to ensure the progress of the project and for the purposes of reporting at the required intervals. Cost Metrics 1. Emergency Department utilization for ambulatory sensitive conditions will decrease by 5% in this population 2. EMS transports in Greenville County will be reduced by 5% in the targeted population 3. Total charges per patient in the targeted population will be reduced by 5% Care Metrics 4. Primary care visits will increase by 5% in the targeted population 5. Placement with a primary care medical home if none stated 6. 50% of individuals within the targeted population, identified with a chronic disease diagnosis and eligible for care management will have a care management plan established Health Metrics 7. Clinical process measurements based on the following Patient Care Plan

	metrics: A1C monitoring 8. Readmissions will be reduced by 5% These outcomes will be measured through a review of registration data for membership enrollment; review of ED utilization reports; review of EMS call data; audit of electronic health records to document the establishment of linkage with a medical home; and establishment of a plan of care to monitor follow-up visits and health status.
Description of HOP Maximum 1,000 Words	Describe the new service delivery model that you propose to implement that supports the Triple Aim initiative. How do you propose to achieve the plan objectives in your targeted population? Include statements addressing the following questions: How will you coordinate and manage the care and transitions of these patients, including the incorporation of the following into the patient's care plan: a. Evidence based guidelines and provider adherence b. Needs identified in the Social Determinants of Health Assessment c. Needs identified in the Behavioral/Mental Health Assessment What methodology will you use to screen a patient's eligibility for Medicaid and other health affordability programs? (e.g. Benefit Bank, Community Health Center plans, Access Health SC, etc.) How will the proposed delivery model improve the health of the patients served? How will the proposed delivery model facilitate reduction in ED utilization? How will the proposed delivery model lower the hospital's overall patient care costs? GHS and community health partners propose to address the obstacles to care and care fragmentation for 1000 uninsured individuals using a Patient-Centered Medical Neighborhood approach. This model leverages the innovations and partnerships unique to each hospital in the system and incorporates local health resources familiar to and trusted by the patient. The plan involves two strategies: 1) creating access to appropriate care for the uninsured via system and community partnerships; and 2) providing a comprehensive care management plan across the partnership network for the targeted population. Based on the environmental scan of the service area, as well as internal analytic data, the coordination and management of care and care transitions for the targeted patients will be addressed as follows: We are proposing Care Managers (Nursing and Social Work) to be placed strategically in the hospital Emergency Departments of Greenville Health System as aligned with baseline numbers of uninsured frequent utilizers. At Hillcrest Hospital, inpatient care management already exists, and these care managers will be cross-trained for this population by the GMH Director of Outpatient of Care Management in order to maximize existing resources. Outpatient care management is available at the other

	hospital sites but will not accommodate the increased capacity. All care management will be coordinated via Greenville Memorial Hospital. Additional evaluation of baseline data within the 45-day report period, and results from the Patient Activation Measure (PAM) and the GAIN-SS behavioral health screenings taken at enrollment, may drive a shift in the distribution of Care Managers across the hospitals. These screenings will also provide geo-specific information concerning obstacles to care, such as transportation or lack of extended hours in local primary care clinics that will allow a patient-centered approach to resource distribution according to peak usage days/times. Connection with care management and a medical home will occur for both ED walk-in patients and patients outreached by telephone. Uninsured individuals arriving at the ED for non-emergent care will connect to care management and screening via an on-site care manager or referred for screening by ED nursing staff. For initial contact with patients selected from internal utilization data, the GHS Nurse Call Center, HealthPals outreach students from GHS Center for Family Medicine, and additional hospital specific staff will contact patients by phone to obtain screening information, explain the scope of services, and schedule face-to-face appointments in a system clinic or partner clinic location. Slots at these locations will be designated for the targeted patients and extended hours will be available in some locations as detailed in forthcoming Memoranda of Understanding (MOU). The PAM and the GAIN-SS v.3 social determinant tools will be administered either at the ED intervention or at a subsequent medical home visit. The initial medical home visit (which may be separate from a illness visits for ED walk-in patients) will also include health history, physical examination, testing as appropriate, and a plan of care with patient education. Follow-up labs, diagnostic testing, and medication dispensation will be provided at GHS or clinic facilities as outlined in ongoing/new partnerships and forthcoming MOU. Patients will be placed on appropriate care management protocols and monitored by care managers for provider and patient adherence. All intensive care management protocols are based on a successful model tested at GHS and based national guidelines. Patients are stratified by complexity of disease and social determinants, and interventions (communication, education, and clinical), intervention intervals, and transition of risk levels are standardized. Referrals to behavioral health support and patient education will be offered on an individual basis and for families when appropriate. For example, the Greenville Free Clinic will offer Diabetic Support Classes monthly, led by a volunteer Diabetes Nurse Educator from the Greenville Health System. Care management staff will note/flag the targeted population in the Electronic Medical Record (EMR) for utilization tracking. Currently, Greenville Free Clinic is not on EMR, but monthly care management partner meetings are in place (Community Care

	Meetings) to monitor utilization. All other partners are connected via EMR and BAAs for data sharing are being established. DECO screening bank will provide assessment services for Medicaid and other health assistance programs at the time of enrollment. Laurens County Memorial Hospital will utilize a trained South Carolina Benefit Bank Counselor (also the Laurens County Community Care Center (LC4) Clinical Coordinator) for eligibility screening. Emergency Department utilization is also monitored via the following existing GHS programs: Emergency Medical Services (EMS) - Nurse Call Center- Based on a South Carolina Blue Cross Blue Shield grant, patients in Greenville County calling 911 for non-acute complaints are transferred to a nurse call center to ascertain appropriate care and referral to a medical home if needed. If the patient does have a medical home but has other obstacles to access, these needs will be addressed via strategies such as next day appointment slots and transportation funds. For Greer Memorial Hospital, which is located in Spartanburg County, similar strategies are in place with Spartanburg County EMS. Referrals to care management will be made via phone screenings and subsequent telephonic follow-up, which occur within 24 hours of 911 calls. Extended Hours Clinic (ED Diversion) - Will be implemented at Greenville Memorial to address lack of access to primary care providers and to address social determinants such as after work access and the limited availability of transportation. This is an episodic after-hours clinic. The proposed plan builds on strong care coordination relationships with FQHCs (Greenville Memorial and Laurens County Memorial) as well as Free Clinics (Greenville Memorial, Laurens County Memorial, Greer, and Hillcrest) by increasing health care access and disease care management in identified hot zones through the strengthening of safety net resources. A Patient-Centered Medical Neighborhood care model reaches patients where they live and provides consistent care management across the network through health partner relationships and communication pathways. This approach facilitates more appropriate use of emergency facilities, as well as avoidable admissions and re-admissions through earlier disease intervention, generating patient care savings to the healthcare system and fostering healthier populations.
Resources Required for Implementation of HOP Maximum 1,000 Words	1. Describe your current capacity, including affiliated services and partners such as owned physician practices, EMS, etc. Provide a statement of the anticipated resources that will be required to implement and operate this plan. Resources may include staffing, assets, etc.: List and describe the roles of each member of the patient's care team in the proposed delivery model. *Care Team*

	members may include CHWs, community paramedics, case managers, staff from community and social service organizations, patient navigators, etc. 2. What are the basic requirements of your partners (such as particular equipment requirements, professional and non-professional staffing, particular services, operating hours, case management)? 3. Do the partners already have all of the resources available? If not, how will you facilitate the development of their capacity to perform the activities of the collaboration? 4. How will you overcome 1-2 capacity limitations of the health systems and social support systems in your community that affect your target population? Current capacity includes hospital-based clinics at the Laurens Memorial and Greenville Memorial sites, as well as the associated Free Clinic sites for Laurens Memorial, Greenville Memorial, Hillcrest Hospital, and Greer Memorial. Two FQHCs, Carolina Health Centers, Inc. (CHC) and New Horizon Family Health Services (NHFHS) provide safety net access within the network. Care managers are currently in place in the GHS Internal Medicine Clinic, GMH Emergency Department, and New Horizon Family Health Services. The network will need to increase care management capacity, inclusive of nursing, social work, pharmacy, and licensed counseling, to accommodate the targeted population. Fully equipped clinic space, telephone, and computer/EMR access is available to the partners. Access to equipment (such as EKG), labs/diagnostic, and pharmacy areas, if not available currently available in the community clinics, are accessible via the hospitals within the network. An existing GHS Behavioral Health Social Worker will be dedicated to the proposed population and will address a network limitation for behavioral health/ substance abuse. This is a state-wide healthcare deficit that will not be easily solved. With consultation support from the network Care Managers and dedicated behavioral health support from social work, the project may facilitate improved triage, referral, and services for more acute psychiatric care. Anticipated resources for enhanced capacity and access necessary to close care gaps for the targeted population include the following: Care Managers to augment the existing care management staff. Specification for social work or nurse care managers, as well as the specific locations, hours and days will be adjusted to meet the needs of the population, particularly as it relates to transportation. Two critical points of access in the network are the rural site in Laurens and the Greer site, which has limited access to primary care for the unfunded: One (1) Nurse Practitioner and one (1) Medical Assistant for dedicated continuity of care between Greer Memorial and the Greenville Free Clinic to cover 35 hours per week of clinical service, with 5 hours for follow-up calls and phone triage. Following the pattern of

Hospital(s): _Greenville Health System_____

HOP Name: Improving Access and Care Coordination for the Uninsured: An Upstate Medical Partnership

	the Greenville Free Clinic, it is expected that Greer Clinic hours will be from 1-8 pm Monday, Wednesday, Thursday and Friday, with one weekend day. One (1) Nurse Practitioner/Care Manager/HOP Counselor for dedicated continuity of care between Laurens County Memorial Hospital and its local safety net providers (Good Shepherd Free Medical Clinic of Laurens County and LC4). The NP will compile and review all available clinical records for each patient in the target population and present a summary of each patient to the Laurens Clinical Lead, Dr. Brian Weirick, to determine any indication for exclusion. The NP will contact those patients not excluded to begin the process of enrolling them in the program. The NP counselor will be responsible for conducting the initial clinical evaluation and social determinants of health assessment. In collaboration with Dr. Weirick and the LC4 Care Coordinator/Social Worker a plan of care will be developed that includes identifying intervention for social needs identified. One (1) Paramedic trained for clinical/environmental/social rounding on high-utilizers in hot zone neighborhoods for environmental/social The network model will not use Community Health Workers (CHW) at this time, but GHS is positioned to participate in the second round of CHW training with SC Department of Health and Human Services.
Reporting Capacity	Describe the applicant's and partner's capacity to report the metrics outlined. Include sources of data, methods of capturing data and potential support/assistance needed to ensure successful reporting. The use of the electronic health record and internal analytics will facilitate data collection and reporting. Care management staff will note/flag the targeted population in the Electronic Medical Record (EMR) for utilization tracking. For our partners without EMR capacity, Greenville Free Medical and Taylors Free Clinic, GHS will attempt to create a care management record in eClinicalWorks in order to track care management activity, and monthly care management partner meetings are in place (Community Care Meetings) to monitor utilization and facilitate ongoing reporting. All other partners are connected via EMR and BAAs for data sharing are being established. Greenville Health System has access to statisticians and public health researchers to assist if needed in data collection and analysis.
Performance Period	October 1, 2013 – June 30, 2014