Healthy Outcomes Plan Application

Proviso

33.34

Sections A (1), C, D

South Carolina Department of Health and Human Services

Hospital(s): ____

HOP Name: ____

Healthy Outcomes Plan (HOP) Application

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

Application Cover Page

HOP Name	
Application Date	
Name of Hospital(s)	
Name of Partner(s)	

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.

_________________________________ ______________

Hospital Representative Date

_________________________________ ______________

Partner Representative Date

_________________________________ ______________

Partner Representative Date

Hospital(s): ____

HOP Name: ____

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

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.

Hospital(s): ____

HOP Name: ____

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: ________________________

HOP Application Form

Hospital	The name of the hospital(s) submitting this proposal.
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. 1. Include a brief statement regarding previous collaborations with proposed partners. 2. Is there an existing contractual or financial relationship with any of your proposed partners?
Partner(s) Lead(s)	
HOP Implementation Sites	The names, street address, city and zip of any and all locations where the process improvement plan will be implemented.
Clinical Lead	The name, title and telephone number of the Clinical Lead responsible for clinical oversight of the proposed delivery model.
Administrative Lead	The name, title and telephone number of the Administrative Lead responsible for the administrative oversight of the proposed delivery model.

Hospital(s): ____

HOP Name: ____

Name of HOP	
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: 1. What problems have contributed to high ED utilization in your targeted panel? 2. Describe the gaps-in-care affecting your targeted population/panel size. 3. What access does your targeted population currently have to primary care? 4. Describe the capacity limitations of the health systems and social support systems in your community that affect your targeted population.
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. 1. Explain the methodology you used to select your targeted population. 2. What clinical characteristics do your targeted patients demonstrate/share? 3. What social and demographic characteristics does your targeted population share? 4. What portion of the estimated total population meeting the program criteria does the targeted sample represent?
Strategic Objectives	Statement of each strategic objective as listed in IA1 of the HOP Guidelines you are trying to accomplish with this model.
Strategic Measures	The metrics you will use to measure each objective and your process for measurement.
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: 1. 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

Hospital(s): ____

HOP Name: ____

	2. 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.) 3. How will the proposed delivery model improve the health of the patients served? 4. How will the proposed delivery model facilitate reduction in ED utilization? 5. How will the proposed delivery model lower the hospital's overall patient care costs?
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. 2. Provide a statement of the anticipated resources that will be required to implement and operate this plan. Resources may include staffing, assets, etc.: a. 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.* 3. What are the basic requirements of your partners (such as particular equipment requirements, professional and non-professional staffing, particular services, operating hours, case management)? 4. 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? 5. How will you overcome 1-2 capacity limitations of the health systems and social support systems in your community that affect your target population?
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.
Performance Period	Start and end date of the activity period.