Hospital(s): **Palmetto Richland & Palmetto Baptist**

HOP Name: **Palmetto Care**

Healthy Outcomes Plan (HOP) Application

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

Application Cover Page

HOP Name	Palmetto Care
Application Date	August 30, 2013
Name of Hospital(s)	Palmetto Richland Palmetto Baptist
Name of Partner(s)	Celia Saxon Health Center Family Practice Center Palmetto Health Internal Medicine Center

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: 8.28.13

Hospital Representative — Date: 8/28/13

Partner Representative — Date: 8-28-13

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

Hospital(s): **Palmetto Richland & Palmetto Baptist**

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LETTER OF INTENT TO COLLABORATE BETWEEN
Palmetto Richland and Palmetto Baptist
and
Palmetto Health Physician Practice and Ambulatory Services
(Celia Saxon Health Center, Family Practice Center, Palmetto Health Internal Medicine Center)

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: Palmetto Richland
Name and Title: James Lathren, COO

Hospital(s): **Palmetto Richland & Palmetto Baptist**

HOP Name: **Palmetto Care**

Date:	8/28/2013

Institution:	Palmetto Baptist
Name and Title:	James M. Bridges, COO
Date:	8/28/2013

Institution:	PHPPN
Name and Title:	Judy Baskins, Physician Practice and Ambulatory Services Executive
Date:	8/28/2013

Hospital(s): **Palmetto Richland & Palmetto Baptist**

HOP Name: **Palmetto Care**

HOP Application Form

Hospital	Palmetto Health Richland Palmetto Health Baptist
Partner(s)	Celia Saxon Health Center Family Practice Center Palmetto Health Internal Medicine Center
Partner(s) Lead(s)	Judy Baskins, Physician Practices and Ambulatory Services
HOP Implementation Sites	Celia Saxon Health Center 2133 Walker Solomon Way Columbia, SC 29204 Family Practice Center 3209 Colonial Drive Columbia, SC 29203 Palmetto Health Internal Medicine Center 1801 Sunset Drive, 1st floor Columbia, SC 29203 Palmetto Richland 5 Richland Medical Park Drive Columbia, SC 29203 Palmetto Baptist Taylor at Marion Street Columbia, SC 29220 Ambulatory Care Transition Team Carolina Medical Plaza 3010 Farrow Road Suite 200 Columbia, SC 29203 Ambulatory Care Center for Evaluation and Stabilization (ACCES) Carolina Medical Plaza 3010 Farrow Road Suite 200 Columbia, SC 29203.
Clinical Lead	Donna Simon, Director – Senior Primary Care Practice 803-434-1220 Donna.Simon@palmettohealth.org
Administrative Lead	Anna Kay, Director of Business Operations – PHQC 803-296-7307 Anna.Kay@palmettohealth.org

Hospital(s): **Palmetto Richland & Palmetto Baptist**

HOP Name: **Palmetto Care**

Name of HOP	Palmetto Care
Background and Rationale Maximum 1,000 words	Chronic illnesses account for 70% of deaths and over 75% of direct health care costs in the United States, according to the Centers for Disease Control and Prevention (http://www.cdc.gov/chronicdisease/overview). Unfortunately, health care systems are largely oriented to procedure-based acute care medicine. Consequently, the management of persons with multiple chronic conditions is often suboptimal, leading to increased disability, re-hospitalizations, and the need for placement in skilled or assisted living environments. While the burden of chronic disease is significant in patients who have access to primary care, that burden has the potential to be even more significant in patients who have no access to regular care and treatment. A 2005 study commissioned by the Robert Wood Johnson Foundation found that almost half of uninsured adults with chronic conditions forgo needed medical care or prescription drugs, due to cost (http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2005/rwjf11441). At Palmetto Health, like other hospital systems in the state and nation, we often see patients in our emergency departments who because of the lack of necessary care, have exacerbations of their illness and seek care at our emergency departments. In the last 12 months, we have seen almost 7,500 patients who were uninsured and have a chronic condition with the most prevalent issues being mental health issues, hypertension, diabetes and asthma. This project intends to address the basic system of care available to a set of these patients. We intend to expand on our ACTT and ACCES programs which have been proven to be successful and to implement additional data tracking and care processes that will meet the needs of the population. Both within Palmetto Health and the surrounding community, there are a variety of social and medical safety net programs that provide assistance and care for patients who are uninsured. In the Midlands, there are resources for primary care such as the Eau Claire Health Cooperative and the Free Clinic. Within Palmetto Health, Celia Saxon Health Center, the Family Practice Center and Internal Medicine Center all provide safety net primary care to a significant number of uninsured patients. There are also screening and other health events hosted by Palmetto Health, other providers, and community groups, such as the annual Mission event. Prescription assistance may be available through the primary care locations patients are seen or through programs such as Wellvista. For specialty care, which many patients with chronic disease often also need to access, care is provided at the clinics owned by Palmetto Health (surgery, ob/gyn, etc.) as well as through the Richland Care Program. Richland Care, a department of Palmetto Health, provides for coverage for specialty physician professional services for patients referred as outpatients to those specialists in Richland County who meet specific income criteria. Each year, Richland Care provides payment for over 1,000 patients at specialists in the midlands who have agreed to accept a reduced rate for their services. Over the last three years, Palmetto Health has started several new programs that were aimed at beginning to fill in the gaps in healthcare services that exist for patients. The first two of those are the Ambulatory Care Transition Team (ACTT) and the Pediatric Ambulatory Care Transition Team (PACTT). Through the use of an inter-disciplinary

	team, including physicians, nurse care coordinators, social workers, and pharmacists, patient transitions are enhanced by: • Providing clinical information between hospitals and community resources • Finding medical homes for patients to receive comprehensive primary care • Connecting patients to community resources to satisfy individual needs (obtaining medications, transportation, meals, appropriate housing, etc.) • Educating patients through self-management approaches to the treatment of chronic conditions • Addressing unmet needs (eligibility for social support and financial aid) to maintain independence and overall health. More recently, in April 2012, Palmetto Health opened the Ambulatory Care Center for Evaluation and Stabilization (ACCES) as an innovative approach to ensure rapid access to ambulatory care. The ACCES Clinic works with hospital physicians and staff to identify high-risk patients (individuals that have multiple chronic diseases and a history of frequent hospital admissions, those that have frequent use of Emergency Room, etc.) as they leave the acute care setting. The ACCES Clinic provides patients with a short term medical home to ensure prompt follow-up care by a multi-disciplinary team as they make this transition. This multi-disciplinary team helps manage medical, mental health, social, and substance abuse issues. ACCES provides a short term (4-6 week) medical home for these complex patients. Through ACTT and ACCES, we've developed valuable experience in dealing with a population that is similar to (and in some cases exactly the same as) that we are targeting through Palmetto Care. While ACTT and ACCES also serve patients who have Medicaid and other payment sources, a significant percentage of their patients are uninsured. Further, the social, cultural, educational, and health issues we encounter are indicative of those we anticipate we will find with the Palmetto Care population. While some patients may have a primary care physician, the majority of patients in this population do not. Based on data we pulled internally on patients who had 5 or more visits to the emergency room over the last year, less than half of the patients indicated at the time of registration care by a primary care physician. Of those that did indicate a primary care physician, the majority of those were outdated or inaccurate (for example, physicians listed that the patient hadn't seen for years or who may not even still be in practice in the area). In addition to uninsured patients often not being established with a primary care physician, additional challenges we have found through ACTT and ACCES have been that patients lack the basic resources to accomplish their plan of care even when care by a provider is arranged. For example, lack of transportation, non-prescription medical supplies, DME, access to prescription drugs, and basic resources such as adequate food and housing all contribute to inability to manage a chronic condition. Mental health or substance abuse problems may compound the complexity of the situation. In addition, we have found that this population often lacks the health literacy necessary to comply with discharge instructions as they are often communicated and require a significant amount of education and teaching about self-care, their condition, and the resources available to them.

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Targeted Population and Inclusion Data Maximum 1,000 Words	In the Palmetto Care Project, we intend to target patients according to the following criteria: 1. Patient has a chronic condition or ambulatory sensitive condition as included in the data set provided by the Office of Research and Statistics as part of this project. 2. Patients who live in Richland County. 3. Patients who have had at least one non-ED visit with a PH service or safety net program or another partner site. 4. Patients who seek ED care within the first 60 days of the project. 5. Patients who have the highest number of ED visits. Palmetto Health's target panel size (including that for Palmetto Richland and Palmetto Baptist) is 662 patients. The total listing, including all targeted conditions and ambulatory sensitive conditions provided, of patients who had at least 4 emergency room visits over the last year and were uninsured, totaled 1268 patients. We are including the entire panel, however, will rank and contact patients according to the criteria above, until we reach the targeted panel size of 662 patients or above. In this set of 1268 patients, they accounted for almost 7,500 visits to the EDs at Palmetto Richland and Palmetto Baptist in the last 12 months. These visits resulted in almost 600 admissions and generated almost $38 million in charges. While these patients are seen for a host of conditions, the most common chronic conditions they suffer from are mental health issues, diabetes, asthma, and hypertension. Below is the rationale behind each of the criteria included in our ranking. Patients who live in Richland County: When we have examined internal data on the patients who utilize Palmetto Health's emergency departments most often, we have found that over 80% of the patients are from a Columbia address. We see patients who have a primary address of Lexington, West Columbia, Sumter, Orangeburg, Charlotte and other locations around the state. We believe that we will be most effective in attempting to work in this pilot with patients who live in the immediate surrounding area. Logistically, this will minimize travel time both for staff and patients and will give us the highest probability that patients will meet the criteria to be accepted as patients from the community and other service partners we will be working with. Patients who have had at least one non-ED visit with a PH service, safety net program or another partner site: We believe that establishing a relationship with patients who are part of the program will be the first hurdle in getting them to accept enrollment and then further will make their participation more successful going forward. While the vast majority of patients in the program will not be a current established patient at a primary care location within Palmetto Health or another partner, many will have at some point received services from one of our locations. This will give us an opportunity to partner with these departments and programs that people are familiar with and already trust and will improve the likelihood that patients will respond to the offer to take part in this program. This will make our initial outreach efforts more effective and improve the likelihood that we will be able to reach the target enrollment within the time period

	allocated. Patients who seek ED care within the first 60 days of the project: Patients who seek emergency department services within the first 60 days of the project will not only have provided a way to make contact with them but will likely have experienced an event that could serve as a point to talk with the patient about the need for change and intervention. For this project to be successful, the patients involved must be receptive to the services being offered. We have found in other similar programs that an acute health event (such as the need for an ED visit or inpatient admission) can improve the patient's receptiveness to intervention. Patients who have the highest number of ED visits: Assuming we do not reach the target panel size based on the criteria above, it is our plan to continue to contact patients who are in the target population but do not meet one of the criteria above starting first with those who have had the highest number of visits. This will ensure that we are targeting our efforts at the patients who are most in need of intervention.
Strategic Objectives	Strategic Objectives – The Palmetto Care project will address all of the Strategic Objectives of the Healthy Outcomes project. • Increase in number of patients with Social Determinants Screening: social determinant screening as well as other necessary screenings will be conducted upon initiation into the Palmetto Care Program. • Reduce systems fragmentation and address the social determinants of health that affect health behaviors and influence health outcomes: the care coordination plan for each Palmetto Care participant will address their individual social needs and resources and referrals will be provided as appropriate. • Improve patient access to and utilization of quality, affordable care: improved capacity for primary care and other services is included in the Palmetto Care Plan. • Promote adherence to clinical, evidence-based guidelines: each primary care provider is part of the PHQC, providing an infrastructure and accountability structure to track performance against evidence based care guidelines. • Integrate the biopsychosocial (medical, behavior health, social) approach into a comprehensive patient care planning process: each patient will have a care plan that integrates these factors into his or her plan of care. • Establish a medical home: an attempt will be made to establish each patient in a primary care medical home as part of their care plan. • Improve coordination of transitions of care: each patient will be assigned to a care coordinator, responsible for providing oversight of their care plan, referring the patient to appropriate services, and securing necessary resources (transportation, etc.) to make the patient successful in his or her plan. • Increase provision and utilization of comprehensive, routine primary care: each

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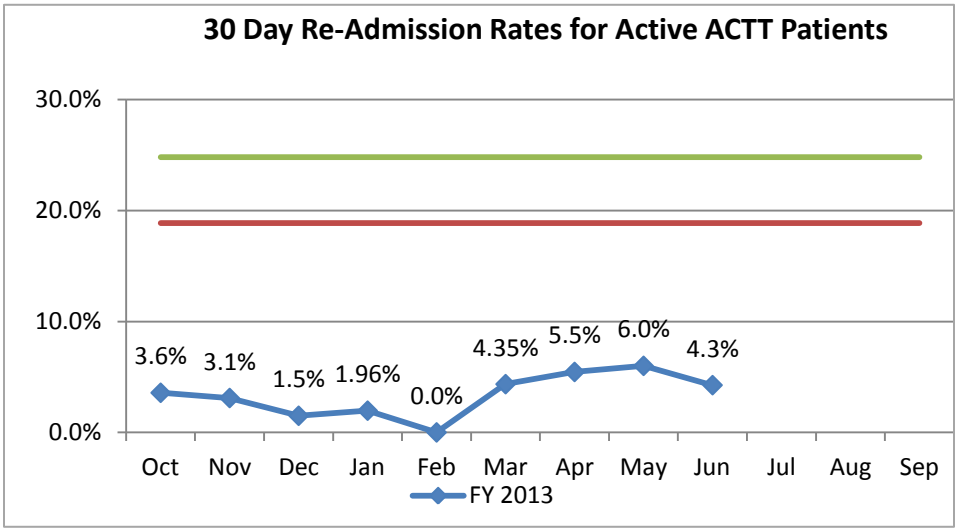
	patient will be referred to a primary care home with a PHQC participating provider. • Reduce ED utilization: care coordinators will work with patients to ensure that each is assigned to a primary care provider as well as provide education about appropriate usage of the ED and other settings of care.
Strategic Measures	Palmetto Health will report the following metrics to address the strategic objectives above: Care Metrics: • % of successful contact with target population within the first 30, 60 and 90 days of program. - Record reason(s) for unsuccessful contact for each contact period. • % of target population established with a medical home (primary care physician). • % target population with Social Determinants Screening within first 30, 60 and 90 days of program enrollment. • % of target population connected to one or more community services as a result of Social Determinants Screening. • % of target population with Health Affordability Programs Eligibility Screening • % of target population with a Patient Care Plan within first 30, 60 and 90 days of program enrollment. • % Patients that have had at least one primary care encounter that includes preventive care, screenings and interventions Cost Metrics • ED utilization, rate. • Inpatient utilization, rate. • Total charges per patient. Clinical Metrics: • Prevalence of targeted conditions. • All Cause 30 day Readmission Rate • In Office Diabetes HbA1C Management – Ages 18-75 with A1c > 9.0% {CMS PQRS 1} • In Office Diabetes LDL Management – Ages 18-75 with LDL <100 mg/dL {CMS PQRS 2} • In Office Diabetes High Blood Pressure Control – Ages 18-75 with BP < 140/90 mmHg {CMS PQRS 3}
Description of HOP Maximum 1,000 Words	Palmetto Health has already begun to develop the infrastructure necessary to care for a population of patients through our work developing Patient Centered Medical Homes and embedding PCMH care coordinators into our primary care practices, development

	of the PHQC, a clinically integrated network of physicians who have come together to improve quality and reduce cost, and through the development of programs that meet specific needs of high risk populations such as the Ambulatory Care Transition Team and the ACCES clinic. Through the Healthy Outcomes program at Palmetto Health, we will expand and integrate these services to address the needs of some of our most at-need patients. We will integrate and build upon the services we have already developed to identify the patients eligible for the Healthy Outcomes program and offer them an array of services that will meet their needs. Through developing an individualized care plan for each participant, connecting each with a primary care home (and expanding our capacity for primary care), expanding the services available to help our participants be successful in managing their chronic conditions, and in providing better transitions of care, we will improve quality and reduce cost. We have included our initial outcomes from the ACTT and ACCES programs to further show that expansion of these programs is likely to result in a reduction of ED visits, hospital admissions, and overall costs. The services to be provided are as follows: 1. Initial screening and contact: Initial contact with each patient will consist of educating patients about their eligibility to take part in Palmetto Care, screening for health affordability programs (to include the insurance exchange). Initial screening will take place using Patient Access Services staff at Palmetto Health and staff at partner organizations (such as Community Health workers in partnership with Healthy Columbia and others). 2. Development of an individualized care plan for each participant: Individual care planning will start with the administration of a screening for social determinants of health, administration of the PAM (Patient Activation Measure) assessment, and the GAIN Short Screener. The information from these screenings as well as the patient's specific clinical and social information will be used to create a care plan that meets the needs of each patient served. The care coordinator will follow the patient through transitions of care and continually during the term of this program. This care coordination model for Palmetto Care will be based on expanding the model implemented with ACTT program. This coordinator will serve as a link to other resources, will serve as a primary point for patient education and communication, and will help facilitate communication with the rest of the care team. From August 2010 to June 2013, 528 patients have participated in the ACTT program. In the last nine months, ACTT has served 188 patients, serving between 46 and 66 patients in any given month. The team has conducted, during the most recent 9 months, over 3000 patient contacts, with 615 of those being home visits, 250 visits with the patient to a physician visit, and 664

involving referring a patient to an appropriate resource or provider. During that same time period, the program provided transportation to 885 participants through taxi vouchers to meet patient's need for transportation, provided needed medical supplies 380 times, and provided 581 medications. Other resources provided included DME, housing assistance, and gas cards. Over the last nine months, ACTT has aided in preventing 91.49% of the program's patients from a hospital re-admission within 30-days of their hospital discharge (30-day readmission rate: 8.09%).



We have recently completed an ROI study of those patients for which we have a full year of data on costs both for the year prior to admission to ACTT and the year following the discharge from ACTT. For the 94 patients for which we have data on during this period, payments to Palmetto Health (cost to the health plans the patients with coverage were in) decreased from the year prior to participation in ACTT to the year after by just under $2 million.

3. Access to an interdisciplinary team that are part of the Healthy Outcomes project as well as resources to meet short term needs that will ensure the patient receives the care he or she needs. The Healthy Outcomes team that will work as support to each care coordinator will consist of social work, nursing, pharmacy, as well as other Palmetto Health and community staff. Direct services that can be provided will include social work visits and referrals as well as pharmacy consults.

4. Expansion of the ACCES clinic: During initial enrollment and/or at transitions from exacerbation of illness such as from inpatient to the outpatient setting, patients who need more resources than are available in their normal primary care location will be cared for through expansion of these two settings. The ACCES clinic will also serve as a short term medical home while care at partner sites or providers within the community can be established.

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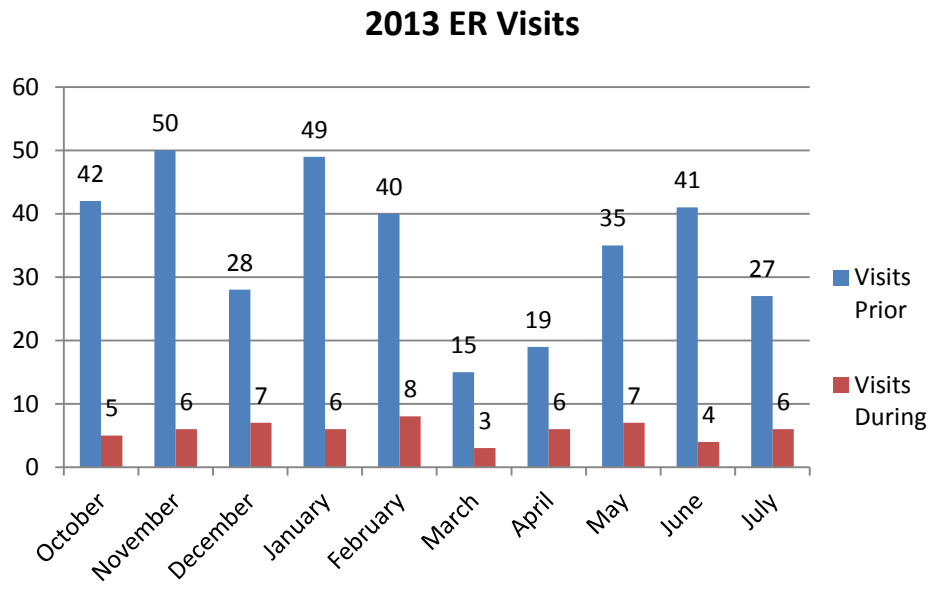
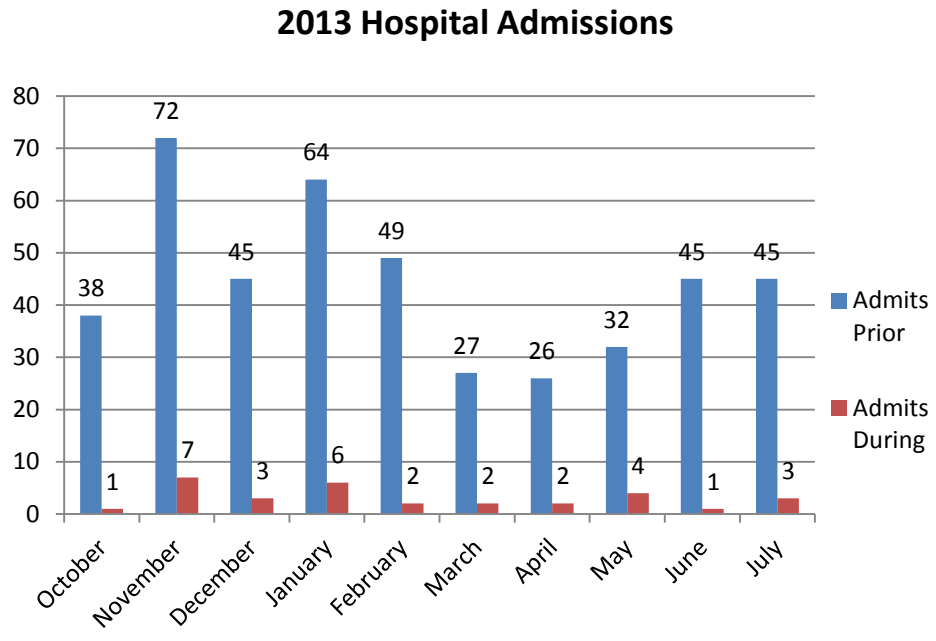
Year to date information for utilization of ER and number of inpatient admissions for ACCES patients is provided in the graph below. For the month of July 2013, ACCES discharged 41 patients. Those patients had 27 ER visits prior to ACCES and 6 ER visits while being managed at ACCES clinic, as well as 45 hospital admissions prior to ACCES and 3 admissions during ACCES.





5. Expansion of primary care services available to Palmetto Care participants. Each Palmetto Care participant will be enrolled for primary care within a Palmetto

<table>
<tr><td></td><td>Health or Palmetto Health partner site of care. Currently, there is limited capacity for primary care for unfunded patients. We intend through this program to expand our capacity for primary care services both through utilizing current sites of care as well expanding throughout the term of the program to incorporate additional partner sites.

Each primary care provider that is part of the Healthy Outcomes project will be part of the Palmetto Health Quality Collaborative, a clinically integrated network that has the infrastructure and processes already in place to track compliance with evidence based guidelines of care and other quality metrics on a practice and individual physician level. We will use this infrastructure to ensure that each physician receives data on his or her performance on evidence based care metrics for the Healthy Outcomes population.</td></tr>
<tr><td>Resources Required for Implementation of HOP

Maximum 1,000 Words</td><td>Palmetto Health is an integrated delivery system with a number of services that will be part of the infrastructure used in the Palmetto Care program. The health system operates several teaching clinics (the Palmetto Health Internal Medicine Center and the Family Medicine Center), a community based health center – Celia Saxon Health Center, as well as a variety of primary care sites around the Midlands. In addition, we have several locations that offer mental health and substance abuse services, transitional care services (ACCES and ACTT), as well as other support and education services (diabetes education and nutrition counseling, for example), that may be needed to provide services for Healthy Outcomes participants.

There are current limitations, however, on the capacity for additional patients. To address those limitations, we are working to identify locations (for example, sites where space isn't utilized at capacity) and staff that could be utilized in the short term as resources are added (and staff are hired) to accommodate the Palmetto Care population.

As part of the development of the Palmetto Care project, we anticipate the following staffing needs (30.6 FTEs listed in the table below with role descriptions below):

Community Health Workers: 3
RN Care Coordinators: 5
Non – RN Care Coordinators: 3
Pharmacists 2
Social Work Case Managers 5
Medical Assistants 3
Admin / Clerical / Patient Access: 6
Program Management 1
Mid-level Providers 2.6

• Community Health Workers: outreach to eligible members to help enroll them into the program, patient education and communication
• RN Care Coordinators: Lead the care coordination team, development of care plans, patient teaching, interface with physician office and hospital staff.
• Non-RN Care Coordinators: communication with patients, facilitating referrals and</td></tr>
</table>

	patient appointments. • Pharmacists: provide support to care team regarding options for medication management, direct patient teaching. • Social Work Case Managers: identification of social needs, referral to resources, patient education, resource for care team and providers • Medical Assistant, Mid-level Providers: additional clinical staffing for ACCES program. • Patient Access: screening for financial assistance and qualification for health affordability programs. Additional resources will be required for transportation, medical supplies, pharmaceuticals, and adding additional primary care capacity. While the ACTT and ACCES programs as well as Celia Saxon Health Center and the Palmetto Health Clinics have some of the resources above, they are very limited. Within ACTT and ACCES, they are staffed according to the model we are anticipating under the Palmetto Care Project, however, do not have the staff necessary to accommodate the size of the patient panel projected under this project. At other partner locations, they are extremely limited if available at all. In order to meet the needs of the patient population, additional staff will be added to supplement those available in the partner locations. The staff will be centrally trained and hired, however, will work in partnership with partner locations and at times, even embedded in those locations of care. In addition to the staffing necessary for the program above, a budget for the provision of transportation, medications, medical supplies and other needed interventions will be necessary. An important component of this program will not only be to utilize the resources within Palmetto Health, but to utilize our current relationships with providers in the community (for example, DMH, DAODAS, the Columbia Housing Authority, Mercy, Harvest Hope Food Bank, etc.) as well as to develop new relationships and partnerships that will help meet the needs of our patient population.
Reporting Capacity	Documentation of care and clinical measures above will be tracked for patients who are part of the Healthy Outcomes project as part of the Palmetto Health ambulatory EHR, the ambulatory billing system, and the inpatient medical record system, and the inpatient financial system. While Palmetto Health hasn't traditionally tracked these specific metrics for uninsured patients with visits to our emergency departments, we currently track the same or very similar metrics to the cost and care metrics listed in this proposal for our ACTT and ACCES programs and are already tracking the clinical metrics for various populations within the system (BCBS patients under the PCMH pilot, for example). Care measures will be individually documented for each type of screening, each referral, and each patient visit, enabling reporting on each at the end of each reporting period. Cost metrics will be pulled from the financial tracking systems at Palmetto Health. Clinical Metrics will be obtained from information in the ambulatory EMR for any Palmetto Health owned practices. For patients who are already established with care providers that are not part of Palmetto Health or who seek care within the project period outside of Palmetto Health, data will be incomplete.

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Performance Period	October 1, 2013 – June 30, 2014