Healthy Outcomes Plan Application

Proviso

33.34

Sections A (1), C, D

South Carolina Department of Health and Human Services

Hospital(s): ________Piedmont Medical Center_________________________________

HOP Name: ____Piedmont Medical Center Coordinating through Collaboration________________________

Healthy Outcomes Plan (HOP) Application

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

Application Cover Page

HOP Name	Piedmont Medical Center Coordinating through Collaboration
Application Date	August 30, 2013/ ***Revised-Updated October 15, 2013***
Name of Hospital(s)	Piedmont Medical Center
Name of Partner(s)	North Central Family Practice, Catawba Care, Welvista, Keystone Substance Abuse, Catawba Mental Health, Early Learning Partnership, SC Department Mental Health Care Coordination Services

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.

Bill Masterton, CEO
Hospital Representative — August 30, 2013
Date

Ernest Brown, Executive Administrator
North Central Family Practice
Partner Representative — August 30, 2013
Date

Hospital(s): ________Piedmont Medical Center__________________________________

HOP Name: ____Piedmont Medical Center Coordinating through Collaboration________________________

Teresa Creech, Executive Director Early Learning Partnership Partner Representative	August 30, 2013 Date
Paul Cornely, PhD, Executive Director Catawba Mental Health	August 30, 2013 Date
Janet Martini, Executive Director Keystone Substance Abuse	October 14, 2013 Date
Anita Case, Executive Director Director Catawba Care	October 4, 2013 Date
Cathy Martin, Executive Director Welvista	October 10, 2013 Date
Susan Monogan, Executive Director SC Department Mental Health Care Coordination	August 30, 2013 Date

**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
[___Piedmont Medical Center________________________]
and
_____Above Listed Centers, including North Central Family Practice, Early Learning Partnership, Catawba Mental Health, Keystone Substance Abuse, Catawba Care, Welvista and SC Department Mental Health_____

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.

Hospital(s): ________Piedmont Medical Center_________________________________

HOP Name: ____Piedmont Medical Center Coordinating through Collaboration________________________

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: __North Central Family Practice_____
Name and Title: ___Ernest Brown, Executive Director___
Date: ___August 30, 2013__________________

Institution: __Early Learning Partnership___________
Name and Title: __Teresa Creech, Executive Director_____
Date: ___August 30, 2013_____________

Institution: ___Catawba Mental Health___________
Name and Title: ___Paul Cornely, PhD, Executive Director___
Date: ___August 30, 2013___________

Institution: ___Catawba Care___________
Name and Title: ___Anita Case, Executive Director Development___
Date: ___October 4, 2013___________

Institution: ___Welvista___________
Name and Title: ___Cathy Martin, Executive Director Development___
Date: ___October 10, 2013___________

Hospital(s): ________Piedmont Medical Center_________________________________

HOP Name: ____Piedmont Medical Center Coordinating through Collaboration________________________

Institution: ___Keystone Substance Clinic ___________
Name and Title: ___Janet Martini, Executive Director Development___
Date: ___October 14, 2013___________

Institution: ___SC Department Mental Health Care Coordination___
Name and Title: ___Susan Monogan, Executive Director_________
Date: ___August 30, 2013_____________________

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. • These key partners currently work with us to help see patients post acute care discharge, or post discharge from the Emergency Department. Currently there is not a formal process for intake, but all are available on first come, first serve basis if the patients meet the existing qualifications. 2. Is there an existing contractual or financial relationship with any of your proposed partners? • There is an in-kind financial gift that is provided both Early Learning Partnerships and York County Free clinic. There is no financial relationship between SC Department Mental Health, North Central Family Clinic or Catawba Mental Health.
Partner(s) Lead(s)	Ernest Brown, Teresa Creech, Paul Cornely, Anita Case, Cathy Martin, Janet Martini and Susan Monogan
HOP Implementation Sites	The names, street address, city and zip of any and all locations where the process improvement plan will be implemented. • North Central Family Clinic1131 Saluda Street, Rock Hill SC 29731 • York County Free Clinic 410 Oakland Ave, Rock Hill SC 29730 • The Early Learning Partnership of York County Withers Building, Winthrop University, Rock Hill SC 29733 • Catawba Mental Health Northlake II Building 448 Lakeshore Parkway, Suite 205, Rock Hill SC 29730 • Welvista 2700 Middleburg, Suite 105, Columbia SC 29204 • Keystone Substance Abuse 199 S. Herlong Ave, Rock Hill SC 29732 • Catawba Care 500 Lakeshore Pkwy Rock Hill, SC 29730

Hospital(s): ________Piedmont Medical Center_________________________________

HOP Name: ____Piedmont Medical Center Coordinating through Collaboration________________________

Clinical Lead	The name, title and telephone number of the Clinical Lead responsible for clinical oversight of the proposed delivery model. • Jamillah Hasan-Jones, RN, Director Clinical Quality Improvement, (803)981-7499
Administrative Lead	The name, title and telephone number of the Administrative Lead responsible for the administrative oversight of the proposed delivery model. • Bill Masterton, CEO, (803) 329-6868
Name of HOP	Piedmont Medical Center Coordinating through Collaboration
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? • Dentistry—there are a lack of dentistry services that serve the uninsured patient population. We do not provide dentistry services in the emergency department; however we will provide the necessary antibiotics and or pain medication if appropriate. The lack of dentistry services results in revisits to the ED as the issue is not corrected, generally due to lack of funding as well as location. • General medical diagnosis, including hypertension, diabetes, kidney/urinary tract issues and COPD/Asthma.--There is currently a lack of medical homes within this area, this contributes to fragmented care. The only hospital in York County is Piedmont Medical Center; however most of the primary care physicians are owned/operated by competing systems, both out of Charlotte NC. This contributes to fragmented care, and at times, patient's leaving our area for primary care, but returning for emergency care. • Behavioral Health-- With the continued lack of funding for the mental health population, a large number of our patients are searching for long term medical management; however are unable to locate sufficient housing, medications, and stabilization once again contributing to the ED as the primary home. This area also does not have a medical detox unit, and often the emergency department, as well as the inpatient unit, becomes a place for patients to "dry out" until further medical determination can be made on a safe discharge plan, or additional medical needs. 2. Describe the gaps-in-care affecting your targeted population/panel size. • It has been proven that patients with a medical home tend to have better

	outcomes, as someone owns the coordination of care, treatments and ordering tests/results. Gaps exist because patients use competing systems and even though both systems use Cerner as their EMR, they are competing systems therefore the information is not integrated. Gaps also occur as there are limited partners in the area that operate as a "free clinic" and though it may seem that a small co-pay can be managed, at times that is not an expense that is covered through a household budget. 3. What access does your targeted population currently have to primary care? • Access for Piedmont is 24/7, with a growing network of Piedmont affiliated physicians. Access to our competitors is also great, and often times easier to access, lending the patient to going outside the community for tests, due to restrictions imposed by competition on referrals. The challenge would be in transportation, at times variety of specialists and free/sliding scale clinics for both adults and children. 4. Describe the capacity limitations of the health systems and social support systems in your community that affect your targeted population. • Lack of primary dental care clinics for the indigent, uninsured or underinsured is prevalent as poor oral care leads to poor nutrition, often times inflammation internally, leading to increased risk of stroke, heart disease, diabetes and subsequent disabilities. • Lack of free medical checkups and pharmaceutical help also makes this community challenged, as does the lack of transportation to make the necessary appointments. As Piedmont does not hold a tax exempt status, there are lifetime limits, per patient, on free medications; this is often met within one visit. Due to lack of uninsured/underinsured medical homes most chronically ill patients require additional services due to lack of continual medical care, as well as a lack of medical literacy and translation. There is also a lack of important support groups in this area, i.e. Sickle Cell, Chronic Pain (Palliative Care), Diabetes, Fibromyalgia. All distinct disease processes requiring high frequency of visits and most often social needs as well as physical.
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.--PMC used the data that we received from the SCHA, as well as internal billing and quality data

<table>
<tr><td></td><td>2. What clinical characteristics do your targeted patients demonstrate/share?---Behavioral health needs are the largest, both primary and secondary diagnosis. Hypertension is second, with the third being severe ear, nose throat infections. Fourth is dental, often associated with number three followed by kidney/urinary tract infections. These patients, at this time, do not appear to have a medical home

3. What social and demographic characteristics does your targeted population share?--The largest patron zip code area is 29730 (209/473=44%), second 29732 (88/473=18%) and third is 29745 (74/473=15%).
4. What portion of the estimated total population meeting the program criteria does the targeted sample represent?--During the time period April 1, 2012-March 31, 2013 Piedmont Medical Center ED had 67, 770 visits. Of those patients that were discharged from the ED 19,960 were either classified financially as Charity or Self-Pay/Uninsured. Of the ED patients that were admitted 1,336 were financially classified as Charity or Self Pay/Uninsured. According to the SCHA data 472 patients were defined as having being high utilizers of service with 4 or greater visits for chronic disease management between the time period of April 2012-March 2013</td></tr>
<tr><td>Strategic Objectives</td><td>Statement of each strategic objective as listed in IA1 of the HOP Guidelines you are trying to accomplish with this model.
• We will be asking our strategic partners to:
o Offer additional slots for follow up visits, ensure they have access to hospital records from previous visits and assist in creating a safe medical home with care plan and a safety net plan for contact and management
o Establish a care coordinator for at risk patients, or those defined by this requirement
o Maintain a log of those patients who are referred to them and clearly document if they have made their appointments
o Provide monthly feedback on patients who we share, visit information, additional needs identified, additional services that they were connected with
o Provide pharmaceutical and lab support when appropriate and available
• We will be asking our emergency department to:
o Use existing resources to identify patients without a current payor source, offer financial sign up or help when appropriate
o Work in tandem with an identified Program Navigator to identify patients who may frequent the emergency department to identify trends and potential inclusion into this program</td></tr>
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Hospital(s): ________Piedmont Medical Center________________________________

HOP Name: ____Piedmont Medical Center Coordinating through Collaboration________________________

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We will be asking our Case Management staff to:

Assist in identifying those patients with multiple readmissions related to chronic diseases, with or without a payment source. The diseases identified are COPD/ Asthma, HTN, Diabetes, and Behavioral Health
Assist in identifying patients without local support groups, i.e. COPD/Asthma, Pain patients
Notify appropriate persons in house so that we can work with patients in house to establish an appointment for follow up, to include screening and completing a comprehensive discharge plan, with a passport completed to the appropriate next level of care

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<tr><td>Strategic Measures</td><td>
The metrics you will use to measure each objective and your process for measurement.

Billing data to reflect the baseline period of April 2012-March 2013 versus October 2013 forward.

Number of ED visits for baseline population, then versus moving forward
Number of patients that have been assigned a Medical Home
Number of patients that have been signed up for a healthcare exchange and or eligible community services
Regularly scheduled reconciliation of patients referred to outside partners for establishment of care plans, additional needs identified and those that are outstanding, adherence to maintaining appointments and recommended interventions

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<tr><td>Description of HOP

Maximum 1,000 Words</td><td>
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:

Evidence based guidelines and provider adherence
Needs identified in the Social Determinants of Health Assessment
Needs identified in the Behavioral/Mental Health Assessment

Using our Zinx system that is currently integrated into our Cerner system we would have access to evidenced based medicines and therapies associated with the disease process. We are also participating with Premier as part of the SC Partnership for Patients project leading to access to best practice portals.
The emergency department uses Allscripts and we will review the standard discharge instructions to ensure follow up information is present, to include clinic

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	phone numbers and follow up instructions. • Use the two tools Social Determinants tools provided by the SCHA, to appropriately screen patients for medical literacy, disease understanding and specific information regarding resources and engagement barriers. 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.) • We currently have Medial Eligibility partners in the Emergency Department and they screen candidates for appropriate venues for funding to be pursued. Our goal is to have staff trained as Certified Application Counselors also to help with upcoming healthcare exchange programs. 3. How will the proposed delivery model improve the health of the patients served? • By identifying patients needs, prior to discharge, and understanding our partners criteria for entry into the appropriate center we can create a two way dialogue that introduces the patient prior to arrival. This also engages the patient in what is expected, as well as creates a log for care continuum. Our partner agencies will establish a contingency plan on who to contact, and how to contact, before using the ED. This will be tracked and reported on monthly. Initially I anticipate that there will be monthly meetings to discuss progress and barriers. 4. How will the proposed delivery model facilitate reduction in ED utilization? • By establishing a medical home theoretically one should see a reduction in returns to the ED for chronic disease management. By identifying outstanding social needs the medical homes can assist in identifying resources and guiding patients to remain in the community versus the hospital. By creating patient safety nets they will hopefully tap into their safety net, recognizing the ease in access, versus coming to the ED. 5. How will the proposed delivery model lower the hospital's overall patient care costs? • By establishing a medical home theoretically one should see a reduction in returns to the ED for chronic disease management. By identifying outstanding social needs the medical homes can assist in identifying resources and guiding patients to remain in the community versus the hospital. By creating patient safety nets they will hopefully tap into their safety net, recognizing the ease in access, versus coming to the ED.
Resources Required for	1. Describe your current capacity, including affiliated services and partners such as owned physician practices, EMS, etc.

Hospital(s): ________Piedmont Medical Center________________________________

HOP Name: ____Piedmont Medical Center Coordinating through Collaboration________________________

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<td>Implementation of HOP

Maximum 1,000 Words</td>
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- PMC operates an acute care hospital with 24 hour ED services. The 2012 annual ED visits were approximately 67, 000. There are employed physicians and practices, both within the facility as well as in practices outside. PMC has just expanded its Primary Care Physician support within walking distance to the facility. PMC does own its ambulance service; however they do not own non-critical transport at this time.

2. Provide a statement of the anticipated resources that will be required to implement and operate this plan. Resources may include staffing, assets, etc.:

- From a Piedmont Medical Standpoint we are going to identify a Registered Nurse and or Social Worker to assist in the role of Patient Navigator. These roles will be the primary support for ensuring that patients are connected with the next level of care upon discharge from the ED and or Inpatient units.

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)?

- Hours that is flexible with a preference for some early opening days and some late appointment offerings. Offering appointments within 24-48 hours of patients been discharged from the hospital. Coordination of care with the Nurse Navigator for those patients who have been seen and those outstanding. Transportation is an issue within this community so we will need a partner who can provide non-emergent transportation to and from appointments, as well as basic life needs such as grocery store trips. For those patients that are suffering from drug and alcohol dependencies without a home, working with a partner who can assist in shelter and possible job training/rehabilitation within some United Way agencies is also a plus. For parents providing assistance for children, both before and after school, as it relates to medical care will also be a plus, allowing for fewer missed days, decreased drop out or repeat school years related to illness and lack of study.

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?

- We have met with the partners and some are securing additional resources, i.e. personnel. North Central is going to add additional personnel to this project, much like we are, in the role of patient navigator. North Central has also been provided a grant to hire/train staff to become Certified counselors to help people sign up for the upcoming insurance exchange. York County Free Clinic is

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	determining what resources will be needed; however it requires Governing Board approval. Their resources include a mobile dental truck with additional needs being securing the dentist. SC Department of Mental Health has a Clinical Care Coordinator beginning in September in the Rock Hill office, with another to be added upon hire. Early Learning Partnership is seeking grants and funding for an information gathering system to allow for easier data collection and storage. 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? • Identifying additional resources, i.e. clinics that offer sliding scale payments with the current resources to accept patients, as well as analyzing ways to bring specific needed services to the community, i.e. dental care for the uninsured. • The next will be to creatively work within established and non-established partners to strengthen our community, i.e. our United Way agencies, our churches for food drives and shelters and our own facility for those employees interested in providing some donated time for volunteerism.
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 collaborative group will use existing resources to gather data. For some they have existing systems, for others Piedmont Medical Center will provide the initial data and help create databases if needed so that data will be collected in a uniform manner. • Data will be mined from various sources: a. Proactively we will use ED visit data, or if patient is in house, track through in patient referrals. b. On a regular basis, in the beginning monthly, we will use collaborative meetings with our partner agencies to reconcile patients, determine additional needs and strategically ensure that the hours of operation for all clinics is conducive to meeting the community needs.
Performance Period	Start and end date of the activity period. • Baseline period is calendar April 2012- March 2013 .