South Carolina Health & Human Services

Healthy Outcomes Plan Guidelines

Proviso 33.34 A(1), C, D

HEALTHY OUTCOMES PLAN

Proposals

South Carolina's Proviso 33.34 Healthy Outcomes Plan (HOP) will support participating hospitals who propose service delivery models to coordinate care for chronically ill, uninsured, high utilizers of emergency department (ED) services.

Successful proposals will demonstrate a model that improves the coordination of care for the uninsured, improves health and lowers health care costs and facilitates the development of a high-performing and replicable system of care at the end of the performance period.

This Triple Aim approach will lead to improved health of the population, improved patient experience of care and reduced per capita cost of health care.

Important Dates

Announcement Date:
- Aug. 1, 2013

HOP Due Date:
- Aug. 30, 2013 by 5 p.m. EST

SCDHHS HOP Review Complete:
- Sept. 20, 2013

Period of Performance:
- Oct. 1, 2013-June 30, 2014

CONTENTS

I. HEALTHY OUTCOMES PLAN (HOP) REQUIREMENTS

A. Criteria

1. TARGETED OUTCOMES

Successful strategies will demonstrate capacity building and the integration of evidence-based practice to achieve the Triple Aim initiative.

The following strategic objectives with strategic measures will be observed. *Strategic measures to document progress on objectives are outlined in the next section.*

Strategic Objectives

- Increase in number of patients with Social Determinants Screening.
- Reduce ED utilization.
- Reduce systems fragmentation and address the social determinants of health that affect health behaviors and influence health outcomes.
- Improve patient access to and utilization of quality, affordable care.
- Promote adherence to clinical, evidence-based guidelines.
- Integrate the biopsychosocial (medical, behavior health, social) approach into a comprehensive patient care planning process.
- Establish a medical home.
- Improve coordination of transitions of care.
- Increase provision and utilization of comprehensive, routine primary care.

Any optional, additional outcomes selected for inclusion should be clear and simple to monitor and report. It is recognized that initial outcomes may increase measurables in early periods of a process improvement strategy in order to achieve long-term goals and objectives.

An appropriate outcome may be the recognition of a major problem and the structure of a long-term resolution.

Examples of additional targeted outcomes might include:

. Transition from ED care to non-emergent care.
. Reduction in volumes of the measure/metric.
. Progress as defined by specific plan.
. Increase (or improve) provider relations.
. Long-term programs.
. Overall volume reductions.
. Cost savings.

2. TRIPLE AIM STRATEGIC MEASURES

It is strongly encouraged that all proposed delivery models include, and be able to document the following metrics for evaluation. In the event that this information cannot be collected a detailed explanation and a plan to capture this information for the subsequent reporting period must be provided. The baseline measurement period is April 1, 2012-March 31, 2013.

Triple Aim Strategic Measures

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.
  - Type of community service referral, per patient.
  Examples: housing, nutrition/food, mental health or drug and alcohol resources, etc.
- % of target population with Health Affordability Programs Eligibility Screening.
  - Number of patients eligible and % enrolled in Medicaid as a result of the Health Affordability Programs Eligibility Screening.
  - Number of patients enrolled in a Health Affordability Program, other than Medicaid, as a result of the Health Affordability Programs Eligibility Screening.
  - Health Affordability Program type, per patient, as applicable.
- % 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.
  - Number of encounters, per patient. Encounters may include captured telephone, office-visit, home-visit or any face-to face visit in any location by any member of the patient's care team.
  - Encounter type, per patient.

Cost Metrics

- ED utilization, rate.
- Inpatient utilization, rate.
- Total charges per patient.

Health Metrics

Clinical metrics embedded in Patient Care Plans should be clear, defined and predicated on the ability to obtain accurate data with sufficient quantities.

- Prevelance of targeted condition.
- Clinical process measurements based on Patient Care Plan clinical metrics.

Examples of clinical metrics might include:

. A1C.
. Re-admissions.
. Case mix index.
. Shifts in points of care.
. Blood pressure readings.
. Medication utilization/compliance.

*For those metrics where baseline data is unavailable, the measurement may be "NULL."

**SCDHHS reserves the right to randomly audit documentation of results.

3. MEASUREMENT PERIODS

Reporting for strategic measures must be provided to SCDHHS. Monthly reports are due no more than 30 days past the following program periods:

- First 30 days
- First 60 days
- First 90 days

Quarterly reports are due no more than 45 days past the following dates:

- December 31, 2013
- March 31, 2014
- June 30, 2014

All baseline reports for the metrics associated with the proposed delivery model must be submitted within 45 days of the beginning of the performance period.

4. TARGETED POPULATION

Plans should target a population to meet obtainable objectives. Environmental scan, past payment and claims data should be evaluated to identify those persons eligible and intended for inclusion in this initiative. The size of a HOP's population must be determined using the Targeted Population Table, which will be available on the SCDHHS website by August 1, 2013.

Approved hospital partnerships must demonstrate that they have attempted contact with all the persons identified for participation in the plan within the first 30, 60 and 90 days of the performance period. A report demonstrating contact must be submitted within 30 days of each of these monthly performance periods.

5. TARGETED CONDITIONS

Participants should choose from the below targeted conditions to meet obtainable targeted outcomes. High-prevalence conditions identified in the hospital's environmental scan specifically targeting Palmetto Small Area Deprivation Index (SADI) and other high deprivation areas should be prioritized.

Targeted Conditions:

- Diabetes.
- Behavioral Health Conditions.
- Cardiovascular Disease.
- End Stage Renal Disease.
- Hypertension.
- Chronic Obstructive Pulmoniary Disease.
- Sickle Cell.
- HIV/AIDS.

*Additional conditions may be requested for consideration upon demonstration of meeting the criteria for the Target Population.

6. PATIENT ELIGIBILITY FOR PROGRAM INCLUSION

Patients must meet the following eligibility criteria:

a. Must be high-utilizers of ED;
b. Must be uninsured;

c. Must have one or more of the targeted conditions.

7. PATIENT ELIGIBILITY FOR HEALTH AFFORDABILITY PROGRAMS

Due to the rapidly changing environment regarding health affordability programs, the SCDHHS recognizes that persons who may qualify to participate in this program at the beginning of a performance period may have a change of participation status after January 2014. SCDHHS requires that all patients are screened for Medicaid eligibility, as well as any other health affordability programs including eligibility to participate in the federal health insurance exchange, at the beginning of the performance period and again within the first 90 days of Calendar Year 2014. The Healthy Outcomes Plan must include the mechanisms used to screen a patient's eligibility in the Description of the Process Improvement Strategy.

8. SOCIAL DETERMINANTS OF HEALTH ASSESSMENT

The SCDHHS recognizes the importance of social determinants of health and its influence on health outcomes. These environmental conditions may include safe and affordable housing, education, access to healthy foods, transportation, local emergency/health services and various quality of life indicators. Identifying the potential conditions adversely impacting a patient's health is critical in developing a comprehensive patient care plan. All patients participating in the proposed service delivery model must have a Social Determinants Screening performed within 60 days of the start of enrollment. The Social Determinants Screening will be available for download on the SCDHHS website by August 15, 2013.

9. PATIENT CARE PLANS

All patients participating in the proposed service delivery model must have a Patient Care Plan within 60 days of enrollment.The SCDHHS recognizes the importance of a comprehensive Patient Care Plan, addressing the physiological, mental and behavioral health and social needs and the influence each of these components have on a patient's health outcome. The Patient Care Plan should be framed by the biopsychosocial approach, with the following minimum components:

Diagnoses and disease management

- List all primary and secondary diagnoses.
- Disease management strategies should be based on evidence-based guidelines

Medications

- List ll medications and the plan address issues affecting access, adherence and compliance.
- Patient Care Plans should demonstrate medication reconciliation between care transition points.

Social Needs Assessment

- Identify social determinant issues and demonstrate appropriate referral to community-based resources and follow-up to identified patient needs.

Behavioral Health and Mental Assessment

- Identify behavioral health diagnoses and/or issues.
- Patient Care Plan should demonstrate appropriate referral and follow-up to identified patient needs.

10. QUALITY AND COST TRANSPARENCY
Partnerships agree to participate in Section A(2) of Proviso 33.34. SCDHHS will publicly share summary outcomes of this initiative, to include the number of partnerships formed, the number of patients in the program, utilization, outcomes and monies spent on the program.

11. PLAN EVALUTION
The evaluation of participant submissions will be based on the identified goals and objectives stated in each plan. Participants are encouraged to address all questions in each section of the plan guidelines and to include process goals and objectives identifying key activities related to building partnerships, identifying target populations, documenting the intervention and describing the ability to capture both baseline and ongoing data to measure the efficacy. To effectively evaluate the proposed intervention, the participants are encouraged to provide details on the use of hospital claims data, referral patterns with connections to primary care safety net partners, reduction in hospital readmissions and unnecessary emergency department utilization.

II. PROPOSED PLAN AND SUBMISSION INFORMATION

A. Program Development Methodology

1. Identify patients demonstrating the highest ED utilization in which patient care was rendered for April 1, 2012 to March 31, 2013, or the most current year to date available prior to the performance period.

2. Narrow the target panel to the uninsured.

3. Evaluate the environmental scan, past payment and claims data to identify relevant disparities in your catchment area that affect these populations.

   Considerations:
   - What area/zip code(s) has the highest disease prevalence?
   - What is the disease prevalence in your catchment area?
   - What is your SADI deprivation class? What are the social determinants in your area that impact ER utilization?
   - How does the environmental scan data overlap with your claims data and/or other data sources(s)?

4. Review your own claims data. Build a report within identified parameters (identified parameters might include the high-prevalence disease identified by your environmental scan or other clinical trends identified in your high ED utilizers).

   Considerations:
   - Exclude those who do not meet the participation criteria for the targeted population (high ED utilizers, chronic illness and uninsured).

5. Query EMR or patient record data to identify relevant fields available to track patients and progress/ outcomes.

Considerations:

- Include clinical process (e.g., diagnoses, treatment, care coordination, prescriptions (filled/unfilled)) and outcomes metrics associated with the diseases, as well as patient demographic data, such as sex, DOB, zip code and ethnicity.
  Example: For patients with Diabetes, you might query data using the diagnoses and procedure codes in the HEDIS 2013 administrative specifications for Diabetes.

6. Identify the targeted population.

   The patients populated at this point in the process should meet the eligibility criteria in the project development.

7. Prioritize patients within the population.

Considerations:

- Risk stratify the patients in this report; consider total health care expenditures, ED and inpatient utilization during the year prior to the performance period.

8. Identify your target population.

Considerations:

- Select those patients with the highest risk stratification. The number of patients should meet your panel size requirements. Be prepared to target patients outside of this margin if those identified are disqualified after eligibility screening for health affordability programs.

9. Identify potential partner primary care safety net providers and community service providers.

Considerations:

- In which zip code/area/county does your targeted panel reside? Identify safety net and community service providers in those areas as potential partners in coordinating care for these high-risk patients.
- Identify agencies/resources to help patients overcome the social determinants of health influencing their health outcomes.

10. Engage potential partner(s) and develop a process improvement strategy.

Considerations:

- Begin a dialogue with the potential partners that you have identified. Review the targeted panel and brainstorm ways to achieve the objectives of Proviso 33.34 Sections A(1), C, D. Considerations include: What will be the role of each partner? How will your patients' care be coordinated? How will you work with your partners? What agreements and processes will need to be in place for effective partnerships?

11. Complete the application packet and submit the Healthy Outcomes Plan (HOP) for review.

B. Plan Content and Form

Applications must be submitted using the official Application Form. Instructions for including the additional required documentation will be provided.

C. Plan Submission/Eligibility Announcement Dates and Times

HOP Due Date:	August 30, 2013 by 5 p.m. EST
SCDHHS HOP Review Complete:	September 20, 2013
Period of Performance:	October 1, 2013-June 30, 2014